



RHTP Letters of Interest: Summary of Submissions and Outcomes

The Alaska Rural Health Transformation Program (RHTP) Letter of Interest (LOI) portal was open from February 17 through March 11, 2026. During that period, the Alaska Department of Health (DOH) received 1,795 submissions from organizations across Alaska and beyond seeking Year 1 funding opportunities.

The table below lists all submitted LOIs and the outcome of the initial LOI review process for each submission. Some organizations submitted multiple LOIs and may appear more than once. These determinations reflect whether a proposal is advancing to the next stage of the RHTP process and do not represent final funding awards.

LOI Outcome Categories:

- **Advance to Implementation Application:** The LOI has been selected to advance to the full application stage for potential implementation pathway funding.
- **Advance to Planning:** The LOI has been selected to advance for planning pathway consideration.
- **Deferred or Not Advanced:** The LOI is not advancing in the current funding round. This category includes both LOIs that demonstrated meaningful alignment with RHTP priorities but may be better suited to future or more targeted funding opportunities as the program evolves, and LOIs that did not demonstrate sufficient alignment with RHTP priorities, health system transformation goals, federal allowability requirements, or the scope of this funding opportunity. Organizations whose LOIs did not advance in this round may apply in future funding cycles as the program evolves.

The information shown for each submission was provided directly by the applicant organization as part of the LOI process. Project descriptions and approaches reflect the applicant’s own language and have not been edited by DOH.

Under Alaska law and the terms of the federal cooperative agreement with the Centers for Medicare & Medicaid Services (CMS), DOH retains final authority over all RHTP funding determinations. The Alaska Community Foundation (ACF) serves as the program’s contracted grant administration partner and supported the LOI intake process

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Organization Name	Project Title	Location	Project Concept Opportunity	Project Concept Approach	Estimated Funding Range for First Year of Funding	Health Care Provider Primary Type	Geographic Reach of Project	Project Service Area	DOH Determined LOI Outcome
41-4273054 (Anchorage Orthopedic Society Inc.)	Expanding Pediatric Specialty Vision Access in the Mat-Su Borough	AK	Children and adolescents in the Mat-Su Borough and surrounding communities face growing challenges accessing specialty pediatric vision services beyond routine eye care. Vision screenings are conducted in local schools, often with support from Lions Clubs International, helping identify students who need further evaluation. However, there is currently no coordinated referral pathway connecting these screenings with specialty pediatric vision services in the borough. Recent changes in school health staffing and screening coordination have made follow-up more difficult. At the same time, reduced availability of local vision therapy and neurodevelopmental vision services has limited specialty capacity in the region. As a result, children with binocular vision disorders, developmental visual dysfunction, or concussion-related visual symptoms among student athletes may face delays in evaluation or must travel outside the borough for care. Because vision therapy often requires multiple visits over several weeks, travel outside the region can create significant barriers for families. Unlike many states that require comprehensive eye exams before kindergarten, Alaska relies primarily on vision screenings, increasing the importance of accessible specialty follow-up care. This project will establish the first coordinated pediatric specialty vision referral hub in the Mat-Su Borough, strengthening referral pathways and expanding access to care for complex pediatric visual conditions.	This project proposes establishing a coordinated pediatric specialty vision referral hub within the Mat-Su Borough to expand local access to evaluation and treatment for complex visual conditions affecting children and adolescents. The initiative will focus on conditions such as binocular vision disorders, developmental visual dysfunction, and concussion-related visual symptoms among youth. The project will build specialty clinical capacity through the development of advanced binocular vision diagnostics, developmental visual assessment, and vision therapy services designed to address complex pediatric visual conditions locally. In parallel, the project will work with schools, school health staff, and community partners to improve referral pathways following vision screenings so that students identified with potential visual concerns can receive timely specialty evaluation. Partnerships with youth athletics programs and healthcare providers will also support referral and evaluation of student athletes experiencing concussion-related visual symptoms. These efforts will help ensure that youth with visual challenges affecting learning, reading, and recovery from injury have access to appropriate specialty care within the borough. The project will also develop systems for tracking referrals, monitoring follow-up care, and evaluating improvements in access to specialty pediatric vision services. By strengthening collaboration between schools, healthcare providers, and community partners, the initiative aims to improve continuity of care and reduce the need for families to travel outside the Mat-Su region for specialty vision services.	\$50,000-\$250,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Copper River Census Area; Denali Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

A List Assisted Living LLC	Alaska Rural Health Child Placement Agency (CPA) Cooperative in Partnership SOA OCS	AK	Creation of a Child Placement Agency (CPA). This project is attempting to address is the disproportionate # of rural Alaska Native children and families with CINA cases who are removed from their culture, home community, and family due to the lack of accessible local trauma-informed, culturally appropriate safe and stable home placements as well as community based SUD and behavioral health services, and psychiatric care often requiring costly travel to regional hubs disrupting continuity of care. The Cooperative proposes a phased expansion of the services listed above, delivered as close to home as possible. The pilot will launch in a rural community agreed upon by OCS and the cooperative, then scale statewide using lessons learned. The model emphasizes stabilization, cultural responsiveness, safety, and reunification, when clinically appropriate, while building a sustainable workforce and care infrastructure in rural and frontier communities. Model & Services. The Cooperative integrates: (1) therapeutic foster home capacity and standard foster homes with training/licensing readiness and ongoing oversight; (2) BRS clinical oversight, treatment planning, therapy, telehealth nursing/medical coordination, and medication management; (3) waiver coordination and habilitative services; and (4) safety inspections and certification compliance.	Phased Implementation. Validate workflows, expand geographically to more remote villages based on operational learning and capacity. Staffing & Training: Magnolia Wellness will add three child-specialty therapists (play therapy, CBT, DBT-informed skills, EMDR, PCIT, and systemic family therapy) and will expand to add medical providers for child medication management, under a Clinical Director for fidelity and QA. Family therapy, caregiver groups, and SUD counseling are included as indicated. A List Assisted Living, LLC (ALAL) will add 1 Admin staff, 1 Program Manager responsible for assisting with the building out and expansion of capacity, training and supervision of all therapeutic home foster parents in maintaining licensing and treatment requirements, including licensing training and therapeutic program requirements. 1 Program Director, responsible for financial oversight, strategy development, team leadership, audit management, and client and partnership relationships with the state, tribes, and other stakeholders. ALAL, within the first year will also hire a consultant for grant oversight and management, performance measurement, data/reporting design; accountability for reporting, sustainability, and procurement of additional funding. Frontier Safety and Supply, LLC (FSS): will add 2 full time safety trainers, 1 full-time resource family licensing worker and 1 Program Director. • A List Assisted Living (ALAL): Prime; program administration, fiscal oversight, compliance, reporting aggregation, procurement, stakeholder engagement training, support and supervision of foster homes and therapeutic foster homes. Billing medicaid for therapeutic foster home services and any waiver services, if necessary. • Monarch Psychiatry of Alaska (MPA): referral resource for services that MPA and ALAL do not provide. • Magnolia Wellness (MW): Behavioral health access expansion, BRS oversight, therapy, telepsychiatry workflows, and training and supervision of BHAs and peer support folks in villages and rural communities via telehealth. • Blue Heron Consulting (BHC): Project management, performance measurement, data/reporting design; accountability for reporting, sustainability, and procurement of additional funding. • Frontier Safety & Supplies (FSS): Equipment procurement/deployment, safety/EMS gear, provide required licensing training for foster parents and also train and supervise all licensing staff and support tribal staff who are assisting in licensing.	\$1M-\$5M	Home- and community-based services provider	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Matanuska-Susitna Borough; North Slope Borough; Sitka (City and Borough); Skagway (Municipality)	Deferred or Not Advanced

About Fresh	Improving health and wellbeing in Alaska through food-as-medicine infrastructure	MA	Across Alaska, but particularly in rural communities, households struggle to afford the essential costs of life, including food. Insufficient nutrition and poor nutrition contribute to serious and life-threatening health conditions like high blood pressure, cardiovascular disease, and diabetes. In favor of solving for hunger, households enduring poverty oftentimes resort to shopping for lower-cost food that is less nutrient-dense and contributes to metabolic disease, particularly in regions that depend mostly or entirely on food shipped from further distances. It’s imperative that healthcare providers are equipped to combine clinical interventions and education with a solution to address cost as a barrier toward healthy eating. It is impossible for a low-income patient to adhere to dietary recommendations without changing their economic conditions.	Our project will focus on increasing access to nutritious food for Alaskans by increasing the number of producers and retailers who accept Fresh Connect and other OTC cards and partnering with healthcare providers and health plans to embed food-as-medicine programs into clinical care. We work with large retailers (like those available to residents of Anchorage, Fairbanks, and other population-dense areas) as well as small independent stores, individual farmers and producers, and farmers markets to make it possible for food sellers and producers to accept our Fresh Connect food as medicine technology as a form of payment. Expanding Fresh Connect to more retailers and food producers in Alaska will empower clinical providers to address cost as a barrier to healthy eating and increase nutritious food consumption among patients. Our team has extensive experience working with rural and tribal communities to leverage Fresh Connect as a therapeutic intervention that improves food security and health outcomes and would be honored to partner with Alaskan communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Accenture	AI-Enabled Administrative Automation and Documentation Support (Hospital Sustainability)	IL	Administrative burden continues to strain rural hospitals and community health systems. Time spent on administrative tasks diverts clinicians and staff time away from patient care. Deploying AI-driven automation to streamline scheduling, billing, prior authorizations, and documentation workflows will reduce costs, improve accuracy, and allow clinicians and staff to focus on direct patient care. As Alaska’s RHTP initiatives aim to bring innovation and advance the rural, Tribal, and frontier healthcare landscape, Accenture offers best-in-class AI tools and the professionals to successfully support implementation of solutions for scheduling, billing, prior authorizations, and documentation workflows. Based on our research, over 30% of appointments are missed or rescheduled, leading to massive revenue leakage. Inefficient scheduling contributes to underutilized resources, staff burnout, and patient dissatisfaction. In rural areas, scheduling inefficiencies lead to increased wait times and reduced patient access to the care they need. Our solutions allow for seamless integration with existing EHRs, and our AI technology learns patient and clinical patterns to adapt to the rural provider’s needs. Through our proposed AI solutions, Accenture will support Alaska in reducing administrative burden and modernizing the hospital and clinic back office across Alaska’s healthcare landscape.	Our proposed approach leverages AI enabled administrative automation to reduce the operational strain facing rural, Tribal, and frontier healthcare providers while strengthening long-term provider sustainability. Accenture will partner collaboratively with Alaska and its providers to identify high value administrative use cases that align with local priorities and readiness, ensuring solutions are practical, secure, and responsive to the realities of rural care delivery. Once pilot use cases are selected, such as provider scheduling, documentation, billing, and/or prior authorizations, Accenture will deploy secure AI and natural language processing tools that integrate seamlessly with existing EHR and administrative systems. These tools automate routine, time intensive tasks, improve accuracy, and adapt over time based on patient and clinical patterns. A shared service model would allow multiple providers to participate, expanding access to advanced capabilities while minimizing individual cost and implementation burden. Accenture brings deep healthcare implementation experience and a robust ecosystem of AI technology partners to support rural providers at scale. With more than 200 revenue cycle and operations experts, our team will work alongside hospital leadership and frontline staff to ensure successful adoption, change management, and workforce enablement. By reducing administrative burden, this approach allows clinicians and staff to focus on patient care, administrators to improve staff satisfaction, and the State to help rural providers capture lost revenue. Accenture is committed to advancing Alaska’s goal of futureproofing its healthcare system through responsible innovation. Our team is available to discuss with Alaska the demonstrated success of our AI solutions and share testimonials from clients across government, healthcare, and nonprofit organizations.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Accenture	AI-Enabled Healthcare Workforce Analytics Dashboard and Asset Maps	IL	The AI-Enabled Healthcare Workforce Analytics Dashboard and Asset Maps initiative is designed to address critical workforce shortages in rural healthcare by integrating fragmented data sources into a unified, actionable platform. The purpose is to provide state leaders with real-time insights into the healthcare workforce pipeline, barriers to workforce development, and the distribution of key assets. This initiative directly supports RHTP by enabling targeted, data-driven actions and investments to recruit, retain, and sustain talent in underserved areas. Alaska’s RHTP funding presents an opportunity to strengthen analytical capabilities and invest in a tool that illuminates insights to support decision-making surrounding resource allocation. Our AI-enabled analytics platform is designed to complement and enhance existing systems by providing dynamic, real-time insights that reveal where workforce investments will be most impactful. By cutting through perceived barriers and offering a more granular view of workforce pipelines, our platform empowers agencies and rural healthcare entities to make data-driven decisions that optimize resource allocation, address workforce gaps, and ultimately improves healthcare access for Alaskans. For example, by combining education and licensure data, the State can easily identify licensure and placement bottlenecks preventing providers from entering the workforce.	Our proposed solution is a modern, AI-enabled analytics platform that integrates data from education, licensure, labor markets, childcare availability, and healthcare assets. This platform will provide hyper-local insights into workforce gaps, education pipeline constraints, and asset clustering, enabling leaders to allocate resources strategically. The inclusion of an AI chatbot will allow leaders to query the data in natural language, generating real-time visualizations and insights to inform decision-making. This initiative supports rural health transformation by enabling the state to: • Identify workforce gaps by provider type at the local level and overlay with community need to ensure investments are impactful. • Pinpoint education pipeline constraints, such as clinical placement capacity and faculty shortages, and target incentives for student placement. • Monitor licensure bottlenecks and streamline processes to reduce time-to-license. • Target RHTP incentive programs to geographical areas and provider types where there is greatest need. • Evaluate the effectiveness of workforce recruitment and retention initiatives through measurable KPIs.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Accenture	Project Management Office & Grant Administration	IL	The opportunity this project addresses is the opportunity of the Rural Health Transformation Program (RHTP) funding and the State’s capacity to administer aggressive timelines and reporting requirements under a uniquely demanding federal award structure. RHTP is not a traditional grant; it is a five-year cooperative agreement in which CMS maintains an active role in oversight, collaboration, and implementation review. Continued funding depends not only on compliance, but on the State’s ability to establish meaningful outcome metrics, demonstrate progress, and report performance in support of annual funding decisions, as well as manage all subrecipients and vendors. For states balancing competing policy, operational, and fiscal priorities, sustaining this level of accountability can be challenging. Successful RHTP implementation requires rapid establishment of governance, oversight, staffing, and reporting infrastructure, while also coordinating stakeholders, budgets, procurements, and program activities on an accelerated timeline. This creates a clear opportunity for a trusted partner with deep experience in federal compliance, cooperative agreement administration, and PMO execution to help the State align grant requirements with program operations, strengthen reporting and risk management, and position RHTP investments to achieve lasting rural health outcomes while maintaining eligibility for continued funding.	Accenture will support Alaska across the full RHTP award lifecycle by applying an evidence-based PMO approach to grant administration that helps refine initial planning, bolster mobilization, and launch & manage RHTP initiatives from award acceptance through implementation and performance reporting. Because RHTP is structured as cooperative agreement with active CMS oversight, successful execution requires more than routine grant management; it requires disciplined coordination of compliance, program operations, and performance monitoring including across subrecipients. Our approach begins with establishing the governance, programming, and operating structures needed to manage the award effectively. Accenture will assist Alaska in establishing robust governance structure, managing reporting cadences, escalation pathways, and implementation workplans so that leadership has clear visibility into progress, risks, and dependencies. This foundation is especially important for this RHTP award, where continued funding depends on significant performance, compliance, and demonstrated implementation progress. Accenture will provide integrated support across financial management, stakeholder coordination, and procurement tracking. Our PMO tools and methods will enable Alaska to demonstrate effective and efficient alignment across CMS RHTP terms and conditions. Key elements of the approach include: Program Governance and PMO Setup: Establish and operate the RHTP Program Management Office, including decision-making authority, escalation pathways, risk management processes, and performance tracking. Accenture will support executive, advisory, and workgroup committees and convene quarterly advisory meetings to guide implementation. Grant Administration and Monitoring: Support subrecipient monitoring, fiscal oversight, and outcome reporting across the grant lifecycle to ensure compliance and accountability. Stakeholder Engagement and Change Management: Produce tailored communications, FAQs, and briefing materials; facilitate cross-agency collaboration; and design structured feedback mechanisms (surveys, listening sessions, reporting templates).	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Access Behavioral Services	Comprehensive Positive Behavior Support in Remote Alaska: help with complex needs in frontier Alaska	AK	Presently, Access travels to remote locations across the state to provide behavior consulting and training on appropriate Positive Behavior Supports for specific students and individual client teams that meet a certain eligibility criteria through either a school district's special education department or the state's Complex Behavior Collaborative program. This criteria typically includes high risk behaviors such as self injury or aggression towards others and the possibility of losing one's housing and services due to a lack of behavioral stability. In these locations, however, there are a multitude of other individuals who do not quite meet the eligibility requirements to receive services who would greatly benefit from them. This project is aimed at serving those who "fall through the cracks" between the standard assistance available through regular medical and mental health services and those we are typically contracted to provide for as specialists. The goal being providing intervention for these individuals before their circumstances elevate to the level that they qualify for specialty assistance which will improve the overall quality of life for the individual and their families, caretakers, and other major stakeholders.	Utilizing the current referral and delivery structure already in place for those qualifying for services under the eligibility requirements found within the CBC and present school-based contracts, Access' goal is to extend those same services to those who do not fully qualify under a closest-to-furthest scale of receiving services: those closest to qualifying receive services first. Referrals will be derived from major stakeholders already established including care coordinators, teachers, service providers, primary care agencies, etc. as an already established process, however, those referrals will be provided directly to Access as the providing agency instead of application process for other programs. Once referred, individuals/client teams will be provided with observation, coaching, mentoring, and training on the most appropriate Positive Behavior Supports to affect behavior in a therapeutic trend, ensuring all interventions are trauma informed and respect the local culture and traditions of those participating in services. Working collaboratively with local entities and stakeholders, Access will provide the intervention structure and interactive trainings to give the "boots on the ground" service providers the tools necessary to continue and maintain interventions while our consultants slowly fade their presence, minimizing the potential for long term dependence on our input and allowing for natural environment supports to remain in place permanently. Other aspects of this project would include accessibility options for families including childcare during training sessions, transportation to and from, and food accommodations to minimize potential barring factors associated with potential income disparities and the reality of life in remote locations with limited resources beyond daily survival.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Copper River Census Area; North Slope Borough; Northwest Arctic Borough; Prince of Wales-Hyder Census Area	Deferred or Not Advanced

Access TeleCare	Access TeleCare - Supporting Strong Rural Communities Through Specialty Telemedicine	TX	The U.S. projects a shortage of more than 34,000 specialty physicians by 2034. Forty percent of physicians will reach retirement age in the next decade. And in rural communities, nine percent of physicians are asked to care for almost a quarter of Americans. In Alaska specifically, geographic challenges compound these problem areas making access to specialty care even more difficult. Specialty telemedicine is a powerful solution that Access TeleCare is delivering on every day in all parts of the country and is eager to extend support to additional partners in Alaska to help Alaskans receive specialty care close to home. With funding from the Rural Health Transformation Program, Alaska’s rural hospitals have a new opportunity to strengthen local access to care, improve financial sustainability, and support the clinicians who serve their communities every day. For many rural hospitals, the question is no longer whether transformation is needed, but how to operationalize it in a way that is realistic, scalable, and sustainable. Access TeleCare has now worked alongside rural hospitals for more than 20 years to answer that question and will continue to support sustainable, hospital-first telemedicine solutions.	By partnering with Access TeleCare, grantees needing telemedicine support will be able to leverage Rural Health Transformation Program funds to offset telemedicine startup and early program costs. Access TeleCare implements custom programs for rural hospitals to align with their staffing model, workflows, patient demand, and community needs. Creating a tailored approach that aligns in these key areas ensures a sustainable program is in place for long-term impact, shifting rural hospital’s approach from “stabilize and transfer” to local definitive treatment. The first step is in taking inventory of models of care and identifying where a rural hospital or delivery partner is in order to know where to begin. Answering key questions with our potential partners can help determine the direction needed to support their challenge and opportunity areas. Unlike standard low-acuity telehealth, this project embeds board-certified specialists (TeleNeurologists, TeleIntensivists, TelePsychiatrists, etc.) directly into on-site workflows via the Telemed IQ platform. Deployment of services includes three core areas. 1. Technology Deployment: We will implement telemedicine carts with high-resolution PTZ cameras and digital stethoscopes in the ED and ICU, ensuring virtual specialists have "at-the-bedside" clinical precision. 2. Clinical Integration: The project will utilize a "pod" model, assigning a consistent team of physicians to each facility to build trust with on-site nursing staff and ensure continuity of care. 3. Service Line Expansion: Immediate implementation of TeleNeurology (for stroke), TelePsychiatry (for behavioral health crisis), TeleICU (for critical care retention), etc. allow a facility to treat complex cases locally that would otherwise bypass their facility. As outlined above, a data-driven approach can guide the formation and deployment of a sustainable and tailored telemedicine program that helps fill a current gap in care identified for Alaskans. With an Access TeleCare program, partners get unparalleled specialty and subspecialty coverage delivered via telemedicine that supports the patient-provider relationship. The technology prioritizes ease of use, high-reliability, and proactive 24/7 technical support with a clinical sense of urgency.	\$250K-\$1M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Adaego Recovery	Behavioral Health Pathways: Ending Alaska Youth Psychiatric Crisis With Full In-State Continuum Care	AK	Alaska has a legal obligation to provide psychiatric care to adolescents in the most integrated setting possible. The U.S. Department of Justice found Alaska in violation of the Americans with Disabilities Act in 2011 for its over-reliance on out-of-state psychiatric placements. Fourteen years later, Alaska still sends roughly 100 youth out of state every year — spending \$25 to \$40 million annually on care that separates children from their families and disconnects Alaska Native youth from the cultural identity that is their greatest protection against lifelong mental illness. The human cost is staggering. Alaska Native youth have a suicide rate 3.5 times higher than non-Native Alaska youth. Alaska has only 10 involuntary psychiatric beds for the entire state, meaning adolescents in crisis wait days in emergency departments while law enforcement manages situations that require clinical care. There is no residential treatment facility anywhere in Alaska between an acute hospital stay and outpatient services — that single gap forces out-of-state placement for hundreds of youth who could be treated closer to home. Alaska already spends enough to solve this. The \$25 to \$40 million currently leaving the state annually would fully sustain Adaego Recovery Center's operations. This is not a request for new spending — it is a request to redirect existing spending back into Alaska.	Adaego Recovery Center establishes Alaska's first complete three-tier adolescent psychiatric continuum, anchored in Anchorage with telepsychiatry extending to every corner of the state. Tier 1 — Acute Inpatient Unit (40 beds): Rapid stabilization for high-acuity crises including suicidality, psychosis, and severe mood dysregulation. Stays of 5 to 10 days with 24/7 psychiatric monitoring, comprehensive evaluation within 24 hours, crisis-focused CBT and DBT skills, medication management, and discharge planning that begins on day one. Annual capacity: 600 admissions. Tier 2 — Psychiatric Residential Treatment Facility (20 beds): Medium-length therapeutic intervention of 60 to 120 days for youth who need more than acute stabilization but do not need to leave Alaska. Evidence-based therapies include Trauma-Focused CBT, Dialectical Behavior Therapy for Adolescents, and Functional Family Therapy — all proven to reduce symptoms 40 to 80%. Daily credit-bearing education keeps youth on track academically. Cultural programming with Alaska Native elders is embedded throughout. Annual capacity: 90 admissions. Tier 3 — Step-Down Services (50 slots): Partial hospitalization and intensive outpatient programs sustain gains and prevent readmissions after residential treatment. Annual capacity: 300 youth. Telepsychiatry Hub: Reaches 75+ rural communities with urgent psychiatric consultation for rural emergency departments, virtual family therapy during residential stays so rural families stay engaged, and post-discharge telehealth preventing relapse. Annual capacity: 5,000+ encounters. Priority populations are Alaska Native youth, targeted at 45% of enrollment, and rural youth, targeted at 60% of enrollment — the two groups most failed by the current system. The model is built around DOJ compliance, cultural responsiveness, and keeping families together throughout.	Over \$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Advanced Dermatology of Alaska	Alaska Rural Dermatology Centers of Excellence & Access Network	AK	Rural Alaska faces near-complete absence of sustainable dermatologic specialty care outside Anchorage. In Fairbanks, Juneau, and frontier communities, 100% of Mohs surgery and advanced dermatologic cancer procedures occur in facility-based settings or out of state. Historically, single-provider rural dermatology practices have collapsed due to workforce instability, creating repeated service gaps and costly referral leakage. Alaska has high melanoma incidence and disproportionately elevated non-melanoma skin cancer rates, compounded by an outdoor-dependent, high UV-exposure population. Rural CAHs have no dermatology on-call coverage, leaving hospitalists and emergency providers without specialist support for inpatient skin conditions, wound care, and oncology consults. Chronic inflammatory diseases including psoriasis and hidradenitis suppurativa with established links to cardiovascular disease, metabolic syndrome, and depression are managed without subspecialty oversight, resulting in hospitalizations, and preventable complications. The opportunity exists to build a permanent, integrated, multi-component rural dermatology system that eliminates these gaps through place-based expansion, telehealth, workforce development, and a self-sustaining physician pipeline.	ADA implements a five-component model under unified statewide infrastructure: shared EMR, centralized scheduling, and coordinated clinical leadership. First: Urban Hub Clinics: Fairbanks & Juneau Full-service dermatology centers providing medical dermatology, Mohs surgery, IGSRT, dermoscopy, skin cancer surveillance, and inflammatory disease management. Leased space is in final negotiation with Fairbanks Memorial and Bartlett Regional Hospitals, minimizing capital costs and embedding ADA within existing health systems. These hubs serve as clinical, training, and telehealth anchors for rural outreach. Second: Rural Site Teledermatology & Staff Training Up to 20 rural clinics and Critical Access Hospitals (CAHs) will be equipped with dermatoscopes and integrated into ADA's store-and-forward platform. Primary care providers will receive training in dermoscopic imaging, treatment protocols, and referral criteria. Cases receive specialist review within 24-72 hours. Complex procedures will be referred to the nearest ADA hub, creating a structured hub-and-spoke pathway while reducing unnecessary travel. Third: On-Call Coverage, Disease Management & Medication Access ADA will establish a statewide dermatology consult line providing real-time telehealth for inpatient consults, ED triage, wound care, oncology decisions and biopsy guidance. Chronic diseases (psoriasis, hidradenitis suppurativa, eczema) will be managed via teledermatology with centralized biologic coordination and prior authorization support, reducing avoidable escalations and preventable hospitalizations. Fourth: PA Training Program A two-stage PA program will formalize rotations with UA and expand a structured one-year post-graduate dermatology training program at ADA hubs. Graduates commit to rural deployment. RHTP funds will support curriculum development, preceptor compensation, loan repayment incentives and relocation assistance for long-term workforce stability. Fifth: Alaska Rural Dermatology Fellowship Grant Program (MDs) Track A- Residency Commitment Grant: Sponsors one ACGME dermatology residency per cycle with a \$40,000–\$60,000 stipend supplement and \$50,000 retention bonus, tied to a 2-year rural ADA service agreement. Each cohort funds the next. Track B- Mohs Fellowship Grant: Years 1-2 fund a supplemental slot at an established ACMS program tied to a 2-year rural commitment. ADA simultaneously pursues its own ACMS accreditation targeting in-house training by Years 3-4	Over \$5M	Specialist	Statewide	Anchorage (Municipality); Chugach Census Area; Denali Borough; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough; Prince of Wales-Hyder Census Area; Skagway (Municipality); Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Advanced Practice Registered Nurse Alliance (APRN-AK)	Advanced Practice Registered Nurse (APRN) Alliance Comprehensive Gap Analysis and Needs Assessment	AK	Alaska is the largest geographic state with the smallest population density in the US. Advanced Practice Registered Nurses (APRN) are a vital component to the healthcare delivery workforce across all of AK. The APRN workforce are RN’s with graduate and/or doctoral degrees, licensed to independently provide advanced care including diagnosis of conditions, creation of treatment plans, and prescribing medications and interventions. They are essential providers in rural and remote Alaska, especially in the 13 critical access hospitals. The collective group of APRNs consists of Board-Certified Nurse Practitioners (CNP), Nurse Midwives (CNM), Clinical Nurse Specialists (CNS), and Registered Nurse Anesthetist (CRNA). According to statistics from the AK Board of Nursing, APRNs represent over 30% of the healthcare provider workforce in AK. There are 2,920 APRNs licensed in Alaska, however only 43% have in-state mailing addresses. It is not clear which APRN specialties are represented in this number, what type of care is provided by those who live in and out of state, what percentage of care is provided through tele-medicine, what other roles they fill and future retirement or attrition variables that should be considered in planning for educational and fellowship programs. The purpose of this project is to conduct a gap analysis of the APRN workforce in Alaska and develop a five- and ten-year plan for APRN resource allocation to improve rural, remote and frontier patient access.	The “Alaska APRN Comprehensive Gap Analysis and Needs Assessment” proposes to conduct a workforce survey of all APRNs licensed in the State of Alaska to understand the scope and type of their practice. The questions will include but not be limited to those about their educational preparation, role, scope of practice, practice location, longevity, anticipated attrition (relocation or retirement), salary, and percentage of face-to-face care versus telemedicine. In addition, we will inquire about the role, scope, and influence of APRNs who reside out of state and provide care to Alaska residents. Participants will be entered into a drawing for the chance to win one of ten \$1,000 gift cards for appreciation of their time. The second part of this program will be to evaluate all major health delivery units across the state to examine their need for future growth and healthcare provider needs in support of increasing access to care, especially in rural and frontier communities. The healthcare needs for individuals across the state are complex and require advanced level of care. Certified Nurse Practitioners are the fastest growing group of healthcare providers and currently provide 52% of primary care in Community Health Centers (McCann & Flinter 2025). Understanding health center organizations forecasted needs will allow the State to be able to prepare and anticipate the need for APRNs. A survey will be sent to the CEO/director/manager of each healthcare delivery unit across the state with subsequent invitations to participate in a focus group session. The theme of both the survey and the focus group sessions will be to understand the current workforce that is in place (number of physicians, physician assistants, APRNs), the types of services provided, current care gaps for comprehensive care for the community, retention and recruitment issues and the forecasted growth over the next five and ten years. These surveys will be completed online using Qualtrics ® as the online platform, however letters will be sent to all recipients with follow-up reminder postcards. Data will be analyzed using SPSS® for statistical analysis with both descriptive and inferential statistics. The focus group sessions will undergo thematic analysis. This data will be used to develop a comprehensive gap analysis and plan for APRN education, recruitment, retention, and development of future programs and improve access to health care in rural, remote and frontier communities in Alaska.	\$50,000-\$250,000	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Agapi Inc	Healthy Beginnings Alaska: Advancing Early Childhood Nutrition and Health in Rural Communities	AK	Alaska’s food system presents a structural challenge for infant and early childhood nutrition. Food must travel long distances before reaching families, increasing cost, impacting freshness and introducing availability constraints when logistics are constrained by Alaskan weather. When food supply disruptions occur, rural families with infants and toddlers, who depend on consistent access to nutritious foods during critical stages of development, are at particular risk. The opportunity our project appeals to is to intervene at this earliest and most influential stage of life. Nutrition in the first 1,000 days helps shape brain development, growth, immune health, and long-term eating patterns. In Alaska, this challenge is amplified by high food costs, limited fresh options, and weak connections between families, institutions, and local food resources. This project addresses this opportunity by protecting the nutritional health of Alaska’s youngest children while building practical, community-based solutions that can expand outward to support children, pregnant and postpartum women, elders, and caregivers. The goal is not only to improve food choices in the moment, but to create a healthier foundation for families statewide through education, local partnerships, and scalable approaches that fit Alaska’s realities.	The project has four connected methods: (1) Nutrition Education: First, AGAPI will deliver practical nutrition education for infants and caregivers. This will include guidance on balanced feeding, ingredient selection, meal preparation, allergy awareness, and healthy use of foods that are realistically available in Alaska, including subsistence harvested, WIC and food-assistance products where relevant. The goal is to give families simple, usable strategies that improve nutrition without requiring unrealistic cost or access. (2) Cooking Classes: Second, AGAPI will provide Alaska-based instruction through cooking classes, maternal and postpartum food guidance, and elder-centered programming. These activities are designed to help families translate nutrition knowledge into daily practice. Elders and caregivers often help feed children, so strengthening intergenerational food knowledge is part of the intervention, not a side issue. (3) Tele-Cuisine: Third, the project will extend access through remote delivery and technical assistance. Tele-cuisine instruction will allow AGAPI to reach rural and frontier communities where in-person support is limited. A faceted, multi-media technical assistance framework will be established to instruct schools, senior centers, clinics, and local organizations on how to improve food quality, food education, and nutrition practices. This in turn grows community understanding that this resource is available, and makes healthier food choices easier to understand, request, and adopt. (4) Alaskan Food Access Networks: Fourth, AGAPI will strengthen food access and resilience through partnerships and pilots. The project will work to build links with Alaska growers, producers, and community partners; identify underused local resources; and test scalable approaches that help families maintain healthy infant and child nutrition during supply interruptions, product shortages, or high-cost periods. These pilots will help AGAPI identify what works at the local level while also building a statewide model that can be adapted over time. The approach is intentionally low-barrier, practical, and Alaska-centered. Before larger systems can change, families and institutions need accessible knowledge, useful tools, and trusted community support, something which AGAPI and its heritage through Bambino's Baby Food, has demonstrated success in.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

AK Afterglow	AK Afterglow	AK	AK Afterglow seeks to address a critical gap in support for Alaska families who experience the death of a child, particularly in rural, remote, and frontier communities. When a child dies, families often face immediate financial burdens related to funeral, burial, and travel costs, while simultaneously navigating overwhelming grief and trauma. In many rural areas of Alaska, these families have limited access to grief counseling, behavioral health services, or community support networks. The combination of financial strain, geographic isolation, and lack of available services can significantly impact the mental health and long-term well-being of grieving parents and siblings. This project addresses the opportunity to provide immediate financial assistance and coordinated support to families during one of the most vulnerable moments in their lives. By reducing financial barriers and connecting families to grief support resources, AK Afterglow helps ensure that families across Alaska, regardless of location, have access to compassionate care and support following the loss of a child.	AK Afterglow will address this need through the Amelia and Kannon’s Assistance Program, which provides immediate financial support and coordinated resource connections to families following the loss of a child. The program offers direct assistance for funeral and burial expenses, helping families avoid significant financial hardship during an already traumatic time. In addition to financial support, AK Afterglow works with hospitals, providers, community organizations, and local partners across Alaska to identify families in need and connect them with grief support resources and peer networks. This approach helps ensure families are not navigating loss alone and have access to emotional support even in communities where behavioral health services may be limited or unavailable. By combining rapid financial assistance with coordinated support and community partnerships, the program reduces barriers to care, strengthens support systems for grieving families, and helps ensure that families in rural, remote, and frontier communities receive compassionate assistance during one of the most difficult moments of their lives.	\$50,000- \$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

AK Child & Family	Modernizing Behavioral Health Infrastructure to Strengthen Alaska’s Workforce and System of Care	AK	Strengthening Alaska’s behavioral health system requires modern infrastructure that supports workforce capacity and improves coordination across the continuum of care. Behavioral health providers and therapeutic foster care programs in Alaska often rely on fragmented documentation and communication systems such as spreadsheets, emails, paper records, and manual tracking of requirements. These processes limit workforce capacity and reduce the time clinicians, nurses, case managers, and supervisors can spend supporting youth and families. When information is shared and stored across multiple systems, it can be difficult for treatment teams to access timely information needed to coordinate care, identify emerging concerns, and ensure youth receive the services they need. These challenges can be particularly significant in Alaska’s geographically dispersed system where coordination across providers is essential for continuity of care. Technology-enabled coordination and documentation tools offer an opportunity to strengthen Alaska’s behavioral health system by improving information sharing, enhancing communication across care teams, and reducing administrative burden. By improving documentation efficiency and coordination processes, providers can devote more time to delivering coordinated services for youth and families across Alaska’s behavioral health system, including youth who live in rural and remote communities.	This project will implement technology-enabled tools designed to strengthen care coordination, improve documentation processes, and support workforce capacity across the behavioral health continuum of care. The first component will introduce AI-assisted documentation tools (such as Clinically AI software) that integrates with the organization’s existing electronic health record. These tools can support staff by translating clinical notes into structured documentation, identifying missing information, supporting documentation consistency and assisting with regulatory and payer requirements. The technology functions within existing clinical workflows and supports best practice decision-making while reducing time spent on antiquated documentation tasks. Improving documentation efficiency will allow treatment teams to devote more time to direct support of youth and families while strengthening documentation quality and information sharing across programs. The second component will introduce a centralized coordination platform to support treatment homes and treatment parents participating in therapeutic foster care programs (such as the Binti software system). This platform will allow automated tracking of training requirements, background checks, licensing documentation, and other program/regulatory expectations for treatment homes. Automated alerts will notify staff and treatment parents when documentation or requirements are approaching deadlines. The system will also support a secure communication hub connecting treatment parents, clinicians, supervisors, case managers, nurses and other members of the multidisciplinary team. Treatment parents will be able to securely upload documentation from mobile devices, allowing faster information sharing between treatment homes and care teams. Additional coordination tools track medical, dental, and behavioral health appointments, helping treatment teams identify missed appointments or emerging concerns earlier. Early visibility into missed appointments or emerging concerns allows treatment teams to intervene sooner and coordinate additional support for youth and families. Together, these tools move providers away from fragmented administrative processes toward a more coordinated and modern infrastructure supporting behavioral health services for youth and families across Alaska.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

AK Child & Family	Strengthening Family-Based Therapeutic Care for Alaska’s Children	AK	Children and youth from rural Alaska who have experienced significant trauma require therapeutic, family-based behavioral health care to stabilize and heal. However, access to therapeutic foster homes remains limited statewide, and youth from rural communities are placed far from their home regions to receive treatment. These placements can disrupt family and community connections. They can also make it more difficult to maintain placements consistent with the Indian Child Welfare Act (ICWA), which prioritizes keeping Alaska Native children connected to family, culture, and community. Alaska’s behavioral health system includes a continuum of care spanning outpatient services, therapeutic foster homes, and residential treatment. Therapeutic foster homes provide intensive trauma-informed support in family settings for youth who need more structure than traditional foster care but may not require residential treatment. This project proposes a planning effort to strengthen Therapeutic Treatment Home Services capacity in regional hub communities including Anchorage, the Matanuska-Susitna Borough, Fairbanks North Star Borough, and the Kenai Peninsula Borough, which serve as access points for surrounding rural communities. The planning process will explore strategies to strengthen caregiver recruitment, retention, and clinical support while examining opportunities to expand kinship and fictive kin placements for youth who may benefit from therapeutic support in family settings.	This project will conduct a structured planning process to strengthen Therapeutic Treatment Home Services (TTHS) capacity in regional hub communities that serve youth from rural Alaska. The effort will focus on identifying sustainable strategies to expand therapeutic foster home availability while strengthening caregiver preparation, clinical support, and system coordination. Within the first 18 months, the project will develop a regional hub-and-spoke framework for therapeutic foster care that outlines caregiver recruitment strategies, training models, clinical consultation structures, and partnerships needed to support therapeutic foster homes serving youth from surrounding rural communities. Planning activities will examine strategies to strengthen caregiver recruitment, preparation, and retention, including peer-to-peer recruitment, regionally focused community partnerships, trauma-informed caregiver training models such as Trust-Based Relational Intervention (TBRI), enhanced clinical consultation, and peer support networks for foster parents caring for youth with complex trauma. The planning process will also explore approaches to strengthen kinship and fictive kin caregiver preparation so that relatives or trusted community members willing to care for youth have access to training, consultation, and resources needed for therapeutic caregiving roles. Additional planning activities will focus on strengthening partnerships with tribal organizations, behavioral health providers, and child welfare partners to support culturally responsive care and improve coordination across Alaska’s behavioral health and child welfare systems. The project will also examine opportunities to incorporate telehealth-supported clinical consultation and caregiver coaching to ensure foster parents have access to consistent professional support. Findings from the planning process will inform future implementation strategies aimed at increasing therapeutic foster home availability in regional hubs and improving access to trauma-informed, family-based care for youth from rural Alaska.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

AK Child & Family	Transforming Early Behavioral Health and Family Stability for Alaska's Children	AK	Across Alaska, many children and families face significant barriers to accessing timely behavioral health support. These challenges are often more pronounced in rural and remote communities where provider shortages, travel barriers, and limited coordination across systems delay care. As a result, youth with emerging behavioral health needs often do not receive support until concerns escalate to crisis or higher levels of care. Delays in early intervention increase stress for families, strain schools and community systems, and contribute to reliance on intensive services that may have been preventable with earlier support. AK Child & Family's Coordination, Advocacy, Resources, Education, and Support (C.A.R.E.S.) Program provides a family-centered wraparound model that strengthens early identification, care coordination, and stabilization for youth and caregivers. CARES staff work with families, schools, community providers, and natural supports to coordinate behavioral health support, build caregiver skills, and connect families with resources that help youth remain safely at home and in their communities. By engaging families early, CARES helps stabilize concerns before they escalate to crisis or potential involvement with the child welfare system. Telehealth consultation expands access for rural communities. This project strengthens Alaska's community-based behavioral health continuum by improving early coordination so youth receive support closer to home and community.	AK Child & Family proposes to strengthen early behavioral health support for children and families through its Coordination, Advocacy, Resources, Education, and Support (C.A.R.E.S.) Program, a trauma-informed, family-centered wraparound model that connects caregivers, schools, and community providers to identify emerging needs and stabilize families before challenges escalate to higher levels of care or child welfare, keeping youth in their community. This work builds on the organization's participation in innovation and learning initiatives focused on family stabilization and system improvement, including collaboration with national partners such as the National Center for Innovation & Excellence, Lutheran Services in America, and Chapin Hall at the University of Chicago. Drawing on more than a century of experience serving Alaska's children and families, the organization will focus on strengthening how early family stressors are recognized, coordinated, and supported across community settings. The proposed approach emphasizes earlier identification of behavioral health needs and stronger coordination among families, schools, Tribal partners, and community providers. Through the C.A.R.E.S. model, staff work directly with caregivers and youth to provide trauma-informed support, caregiver coaching, school consultation, and coordination with behavioral health providers. Telehealth consultation also allows staff to support families and community partners statewide, including youth transitioning from higher levels of care. The initiative strengthens early family stabilization strategies that support caregivers and youth experiencing stressors and destabilizing challenges. By building caregiver skills, improving communication across systems, and connecting families with available supports, the project helps communities respond more effectively when behavioral health concerns first emerge. The approach also supports stronger coordination when youth transition from higher levels of care back to their home communities. By improving communication among families, schools, and referring providers, the project helps youth safely step down from intensive services while maintaining stability in their homes, schools, and communities. Together, these efforts strengthen coordinated, community-based responses to early behavioral health needs while contributing to a more connected and sustainable behavioral health system for Alaska's children and families.	\$250K-\$1M	Behavioral health/su bstance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Ak Orca	Rural Health Transformation through Physical Activity Wellness & Data Innovation	AK	Alaska’s geography and healthcare workforce shortages create significant barriers to preventive youth care. Over 80% of Alaska communities are not connected to the road system, requiring air travel for specialty services. Rural residents face high transportation costs and limited access to pediatric specialists, sports medicine screening, sleep diagnostics, and metabolic testing. Many frontier clinics operate with small staffs and rotating providers, focusing primarily on acute care. Alaska adolescents face growing health risks. State data show roughly one-third of high school students are overweight or obese, fewer than one in five meet recommended physical activity levels, and more than one-third report insufficient sleep on school nights. Injury hospitalization rates also exceed national averages. Alaska lacks a system for longitudinal monitoring of youth wellness indicators such as sleep health, metabolic risk, and injury markers. Without early detection, many risks for diabetes, cardiovascular disease, depression, and orthopedic injury go unnoticed. Preventive screening is inconsistent outside Anchorage and the Mat-Su region, leaving many youth evaluated only after injury or illness occurs. This project establishes a preventive health model integrating biometric monitoring, metabolic screening, and sleep tracking within school-day programming and rural telehealth access.	The project utilizes a hybrid preventative health model that integrates athletics, medical diagnostics, rural telehealth connectivity, and data analytics into a unified system. The approach is organized around five core pillars designed to work together to improve youth health outcomes. The first pillar is longitudinal health monitoring. Each participating athlete receives four integrated medical assessments during the program year. These assessments include metabolic blood panels measuring fasting glucose and insulin levels, sleep architecture analysis, and heart rate variability monitoring. Together, these indicators allow clinicians to track metabolic health, nervous system recovery, and overall physiological readiness. The second pillar focuses on biomechanical injury prevention. Using dual force plate technology and motion sensors, the program identifies neuromuscular imbalances that increase injury risk. Research shows that athletes displaying greater than ten to fifteen percent asymmetry between limbs are significantly more likely to experience ACL injuries or other orthopedic damage. Early detection allows coaches and clinicians to adjust training loads and introduce corrective strengthening exercises. The third pillar expands rural access to preventative care. The program utilizes a hub-and-spoke logistics model in which urban facilities provide the central data infrastructure while rural communities participate through village diagnostic kiosks. Satellite broadband technology ensures that biometric and diagnostic data collected in remote communities can be securely transmitted to the central monitoring platform in real time. The fourth pillar integrates data analytics and clinical oversight. All biometric, biomechanical, and metabolic data are aggregated into a unified health intelligence platform that identifies emerging risk patterns. Licensed medical professionals review the data and provide readiness assessments and health recommendations. The fifth pillar focuses on workforce development and knowledge transfer. Through a Train-the-Trainer model, local coaches and program staff receive education in fatigue science, injury prevention, and wellness monitoring. This knowledge remains within communities after the grant period, strengthening long-term health literacy and capacity.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough; North Slope Borough	Deferred or Not Advanced

Ak Orca	The Connected Elders: Remote Care Coaching & Digital Health	AK	Alaska Native elders experience significant health disparities/barriers to consistent healthcare access. Many elders in the Matanuska-Susitna Borough and rural communities across Alaska live in remote areas where travel to primary care, behavioral health, or specialty services requires long distances, complex transportation, and time commitments. These barriers contribute to delayed care, unmanaged chronic disease, and preventable emergency room utilization. Alaska’s older adult population is also growing rapidly. Residents age 85 and older are projected to increase dramatically in the coming decades, placing additional strain on already limited healthcare resources. In rural Alaska, behavioral health provider availability remains extremely limited, roughly one Medicare-accepting provider for every 614 older adults. Social isolation is another health risk. Many elders live alone and report limited support networks, increasing risks for depression, cognitive decline, and poor chronic disease management. Although telehealth systems exist across Alaska, many elders lack the devices, connectivity, and digital literacy needed to participate effectively. This project addresses that gap by enabling elders to remain healthy, connected, and independent at home through culturally responsive remote care coaching supported by digital health tools. The program establishes a scalable rural elder health access model that can be replicated across Alaska Native and other remote communities.	The Connected Elders program will implement a culturally responsive remote care model that combines digital health technology, community workforce development, and telehealth engagement to support Alaska Native elders living in rural communities across Alaska. The program trains Tribal Care Coaches—local community members who provide culturally grounded support and regular virtual check-ins with elders. Coaches will receive training in digital health tools, chronic disease support, elder engagement strategies, and telehealth protocols, building local workforce capacity ensuring culturally appropriate service delivery. Participating elders will receive tablets, connectivity support where needed, and training to use digital health tools. Weekly virtual check-ins will allow care coaches to monitor wellness, support plan adherence, and assist elders with telehealth visits with healthcare providers. The program will also utilize secure digital health monitoring software allowing coaches/healthcare partners to track health indicators, identify concerns and issues when needed. Early identification of health changes can help prevent hospitalizations and unnecessary emergency room visits. When appropriate, program data will be shared with healthcare providers to support coordinated care and timely follow-up. To address social isolation, the program will host monthly virtual cultural engagement activities including talking circles, storytelling sessions, and cultural discussions facilitated by tribal leaders and elders, strengthening community connection and cultural identity. The project will be implemented in phases. Year one will focus on program launch, recruitment and training of care coaches, and enrollment of approximately 60 elders. Year two will expand participation and refine operations based on evaluation findings. Years three through five will expand enrollment to additional rural Alaska communities while establishing Medicaid and tribal health reimbursement pathways and strengthening long-term sustainability. “This approach strengthens rural Alaska’s health system by extending preventive elder support into communities where access to regular care is limited. By integrating telehealth technology, culturally grounded engagement, and community-based workforce development, the program establishes a "scalable rural Alaska elder health support model" for culturally responsive remote elder care across rural Alaska’s tribal and rural health systems.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Fairbanks North Star Borough; Kusilvak Census Area; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Akeela Inc.	24-Bed ASAM Level 3.1 Residential Stabilization and Recovery Services for Rural Alaskans	AK	Alaska’s behavioral health continuum currently has a gap between crisis stabilization or detoxification services and sustained community recovery. Individuals leaving detox or short term crisis stabilization frequently require additional time in a structured environment to stabilize, develop relapse prevention skills, and reconnect with treatment providers before returning home. Without this stabilization step individuals often return directly to environments that contributed to substance use, resulting in repeated cycles of crisis care, detoxification, and relapse. This challenge is particularly significant for rural communities where treatment resources are limited and environmental pressures can undermine early recovery. ASAM Level 3.1 programs address this need by providing clinically managed residential environments that support individuals who are medically stable but require structure, peer support, and recovery skill development. Expanding ASAM Level 3.1 capacity improves continuity of care, strengthens the behavioral health continuum, and increases successful transition from crisis services to community based recovery.	Akeela will implement a 24 bed ASAM Level 3.1 residential recovery stabilization program within its existing residential treatment campus in Anchorage. The campus infrastructure, licensing framework, and staffing platform are already established. This allows the program to launch quickly while minimizing startup costs. The facility includes two residential buildings that support gender responsive programming with one building serving men and the other serving women. Clinical services will align with ASAM Level 3.1 criteria and include individual counseling, group therapy, relapse prevention programming, peer recovery support, life skills development, and case management. Participants will work with clinical staff to develop recovery stabilization plans and prepare for successful return to their home communities. Strong referral partnerships will be developed with Alaska Tribal Health System providers, regional behavioral health organizations, detoxification programs, crisis stabilization programs, and outpatient treatment providers. These partnerships ensure individuals from rural communities can access residential stabilization when local services are unavailable. Southcentral Foundation is developing a new behavioral health facility in Anchorage that will include detoxification services and adult crisis stabilization. The proposed ASAM Level 3.1 program complements this investment by providing the next step in the recovery continuum. Akeela also operates an ASAM Level 3.5 residential treatment program at Akeela House. Individuals who require higher clinical intensity can access that program, while the proposed ASAM Level 3.1 program provides an appropriate stabilization level for individuals who are medically stable but require temporary separation from environments that contribute to relapse risk.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Akeela Inc.	Akeela Statewide Telehealth Assessment Program	AK	A significant structural barrier in Alaska’s behavioral health continuum is the lack of a consistent statewide access gateway into care. Because most treatment programs require integrated clinical assessments prior to intake, limited assessment availability creates a bottleneck that delays service entry. Treatment readiness among individuals experiencing substance use disorder (SUD) and particularly Opioid Use Disorder (OUD) is often immediate and time-sensitive; when access to assessment is delayed, engagement declines, contributing to ongoing cycles of crisis and avoidable healthcare utilization. Rural communities are particularly affected due to limited workforce availability and geographic isolation. The opportunity is to establish a statewide behavioral health front door — a telehealth-enabled access infrastructure that provides integrated assessments when individuals are ready to engage. Rather than building new treatment programs, this project strengthens system flow by expanding access to the clinical entry point required across multiple providers and sectors.	Akeela will operationalize a statewide behavioral health front door through a telehealth-enabled after-hours assessment model that extends licensed clinical workforce capacity across Alaska. Core components include: • Rotating on-call master’s-level clinicians providing integrated behavioral health assessments evenings and weekends. • Telehealth delivery enabling access from rural communities without travel requirements. • Standardized evidence-based assessment protocols ensuring consistent clinical evaluation. • Active care navigation connecting individuals to appropriate levels of care including outpatient services, residential treatment, medication-assisted treatment, tribal health programs, or community supports. • Partnership development with tribal health organizations, rural providers, housing programs, and crisis response teams to support interoperability. The model functions as shared infrastructure supporting the broader behavioral health ecosystem rather than as a stand-alone service. By addressing the statewide intake bottleneck, the project improves system efficiency, reduces duplication, and strengthens coordination across behavioral health, medical, housing, and tribal systems.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

AK-GAL DESIGNS	Memories Across the North: A Letter for You – A Cultural Storytelling Program for Alaska Elders	AK	Rural Alaska communities face significant challenges related to social isolation, loneliness, and limited opportunities for meaningful engagement among aging populations. Elders living in long-term care, assisted living, or independently in remote communities often experience reduced social interaction due to geographic distance, harsh weather, transportation barriers, and workforce shortages. These conditions increase the risk of depression, anxiety, cognitive decline, and reduced emotional well-being. Social isolation among older adults is recognized nationally as a serious public health concern, and the risk is amplified in rural and frontier communities where access to behavioral health services and structured engagement programs may be limited. For Alaska Native communities, culturally meaningful engagement is especially important because elders serve as knowledge keepers and storytelling traditions play a central role in cultural continuity. However, many existing reminiscence and activity programs used in elder care settings do not reflect the lived experiences of elders in Alaska. Memories Across the North: A Letter for You addresses this gap by providing culturally grounded storytelling and reminiscence engagement designed to reduce isolation, stimulate cognitive engagement, and strengthen emotional well-being among Alaska elders.	AK-GAL DESIGNS proposes development and implementation of Memories Across the North, a culturally responsive elder engagement program delivered through structured storytelling letters. The program integrates reminiscence therapy techniques with Alaska-specific cultural storytelling prompts to encourage reflection, conversation, and memory recall among older adults. Participants receive letters that include culturally relevant prompts, short storytelling reflections, space to record personal memories, and illustrations depicting Alaska landscapes, wildlife, and traditional activities. These materials encourage engagement between elders, caregivers, and family members. In addition to monthly storytelling letters, participants may receive encouragement postcards and seasonal greeting cards designed to maintain ongoing connection throughout the year. Elders will also have opportunities to share their own stories using postage-paid reply envelopes, strengthening two-way engagement while helping preserve personal memories and community history. Storytelling prompts will reflect shared experiences common across Alaska communities, including subsistence traditions, seasonal living cycles, village celebrations, wildlife encounters, and northern landscapes. These culturally meaningful themes support emotional well-being while stimulating cognitive engagement. The program also encourages participation from family members, caregivers, volunteers, and students, creating opportunities for intergenerational storytelling and strengthening community connections. Because the program relies on mailed storytelling materials and caregiver-led engagement rather than clinical infrastructure, it can be implemented in rural and frontier communities across Alaska. This creates a scalable, low-cost model for improving social connection, emotional well-being, and quality of life among elders in remote communities.	\$250K-\$1M	Statewide	Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough	Deferred or Not Advanced

Alaska Academy of Family Physicians	AKAFP Rural and Frontier POCUS Initiative	AK	Alaska’s rural and remote communities face significant barriers to timely diagnostic care due to geographic isolation, limited specialty access, and workforce shortages. Clinicians often must make high-stakes decisions without immediate imaging support, and patients frequently travel long distances for basic diagnostic services. There is a critical opportunity to strengthen frontline providers’ diagnostic capabilities by expanding access to point-of-care ultrasound (POCUS) training and equipment within the communities where care is delivered.	We are proposing a first year project as part of a five-year, regionally based initiative delivering a series of intensive 2–3 day, hands-on POCUS training sessions across multiple rural and frontier communities. Training will be multidisciplinary and tailored to physicians, PA-Cs, APRNs, RNs, paramedics, community health aides, and other frontline providers. Each participating community will receive handheld ultrasound devices that remain locally to ensure sustained use beyond the training period. By bringing expert instruction and equipment to communities—rather than removing clinicians from practice for extended travel—this model addresses Alaska’s geographic realities while building durable, practice-ready skills. The lead instructor has two decades of experience living and practicing in rural Alaska, including Kodiak, Ketchikan , Prince of Wales Island, and Bethel, offering deep frontline insight into the realities of delivering care in remote and frontier settings.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Dillingham Census Area; Lake and Peninsula Borough	Advance to Implementation Application

Alaska Addiction Rehabilitatio n Services, Inc.	EMR Implementation	AK	Alaska Addiction Rehabilitation Services, Inc. (“AARS”) is submitting this Letter of Interest to request one-time start-up funding to implement an electronic medical record (EMR) system for our clinical team. AARS does not currently have an EMR and is evaluating behavioral-health-focused solutions (including Opus). We can sustain ongoing licensing and operating costs within our annual operating budget; RHTP support is requested for up-front implementation costs. AARS provides residential SUD treatment and related services for adults from across Alaska, including rural and remote communities. Our campus-based services operate as part of an interconnected statewide behavioral health system in which rural residents often receive care through hub providers. Operating without an EMR limits clinical documentation efficiency, care coordination, measurement-based care, and the organization’s ability to participate in modern interoperability and data-driven quality improvement. For SUD treatment settings, technology modernization must also prioritize privacy, security, and compliance.	RHTP funds would support one-time start-up costs to implement an EMR/EHR, such as: • Implementation and configuration services (clinical templates, workflows, permissions) • Staff training and go-live support • Initial licensing/start-up fees and required integrations • Hardware or one-time IT upgrades directly required for implementation (as applicable) • Data migration/setup costs (as applicable) AARS is evaluating an EHR designed for behavioral health/SUD settings and intends to select a platform that supports secure data practices and enables future participation in statewide interoperability pathways, including connection to Alaska’s designated health information exchange where appropriate.	\$50,000- \$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

Alaska Addiction Rehabilitatio n Services, Inc.	Four-Plex Activation for Outpatient and Transitional Housing	AK	AARS provides long-term residential substance use disorder (SUD) treatment and wraparound programming for adults from across Alaska, including people from rural and remote communities who must often travel to access residential care. For many Alaskans, particularly those returning to rural communities or transitioning out of residential care, housing instability can undermine engagement in outpatient care, continuity, and employment plans. The solution is to create a low-cost, time-limited, recovery-supportive housing option that is designed to stabilize clients as they step down and transition from higher levels of care while pursuing permanent housing. AARS already has one of these 16-bed four-plex's on site and fully in use. This request is for the second one which is also on site, and only needs fixtures, furnishing, equipment, and utility/septic connection.	RHTP funds would support one-time purchases required for one-time, non-operating expenses necessary to activate an existing asset. We anticipate that these one-time funds will be expended in Summer 2026. These purchases will include: • Utility connections and septic/start-up infrastructure necessary for occupancy (scope limited to activation; no significant construction involved). • Essential furnishing and equipment packages designed for basic occupancy (including beds, storage, and essential kitchen items as necessary). • Safety and accessibility fixtures, as well as any necessary inspections or permits that are directly related to activation. This housing would be used to support: • Outpatient clients seeking a short-term, cost-effective solution for consistent engagement in services. • Transitional housing for individuals completing treatment who require temporary stability while obtaining permanent housing. • Vocational training programs that emphasize practical job skills through on-site project work.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Addiction Rehabilitatio n Services, Inc.	Furniture, Fixtures and Equipment- Gym and Recreation Center	AK	Alaska Addiction Rehabilitation Services, Inc. ("AARS") is submitting this Letter of Interest to request one-time finishes, furniture and equipment support to activate our on-campus gym and recreation/community center. This investment will improve the recovery outcomes of approximately 94 clients by providing year-round access to structured physical wellness, particularly during Alaska winters. Additionally, it will serve as a shared space and storm-shelter resource for the broader Point Mackenzie community. AARS provides long-term residential substance use disorder (SUD) treatment and wraparound programming for adults from across Alaska, including people from rural and remote communities who must often travel to access residential care. People in recovery from substance use disorders frequently face compounding physical and behavioral health risks. In Alaska, the challenges posed by dark winters, isolation, limited indoor recreation opportunities, and disrupted routines may intensify these risks, especially in residential environments where structured daily schedules are essential for treatment engagement. The aim is to integrate evidence-informed physical wellness and prosocial activities into treatment and aftercare routines by utilizing a dedicated, accessible indoor space.	RHTP funds would support one-time purchases required for the opening and operation of the gym/recreation/community center space. We anticipate that these one-time funds will be expended in Summer 2026. These purchases will include: • Commercial grade fitness equipment and durable finishes appropriate for clinical and recovery settings. • Multifunctional furniture to support group wellness programming, peer support meetings, and recovery-oriented events. • Fixtures and finishes required for safe operation in a welcoming setting designed for universal access. • Furnishings and equipment to support dual-use for community events and emergency shelter functions. This project aligns with: • Advancing Healthy Communities through physical activity, prevention-oriented wellness, and social connection supports. • Enhancing Health Care Access by increasing the effectiveness and durability of a key behavioral health access point for rural Alaskans (improved engagement and outcomes in a hub-based treatment setting). • Supporting RHTP Goal 1 (lifelong health and wellbeing) and Goal 2 (outcomes-driven systems), by building durable recovery-support infrastructure that can be maintained beyond the RHTP period.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Addiction Rehabilitatio n Services, Inc.	Furniture, Fixtures and Equipment- Residential Expansion	AK	Alaska Addiction Rehabilitation Services, Inc. (“AARS”) respectfully submits this Letter of Interest for a one-time request for \$1,500,000 (estimated) to activate our near-completed residential expansion. This funding will support the purchase and installation of finishes, furniture, and equipment necessary to open 26 additional residential treatment beds, thereby doubling our licensed residential capacity on the Point MacKenzie campus and significantly expanding access to long-term substance use disorder treatment for Alaskans statewide. Alaska continues to face substantial access constraints for long-term residential substance use disorder SUD treatment. Rural and remote residents are disproportionately affected due to geographic isolation, travel requirements to hub communities, extended wait times, and disruptions in continuity of care. AARS has already made the primary capital investment to expand its residential facility. The sole remaining barrier to placing the 26 new beds into service is the purchase and installation of essential finishes, furniture and equipment required for safe and effective operations at the expanded scale.	RHTP funds would be used for one-time start-up purchases to operationalize the completed building, including: • Bedroom finishes and furniture including beds, mattresses, dressers, lockers, seating, and bedding systems (as applicable). • Common are finishes and furniture to support the needs of daily living and therapeutic communities. • Equipment necessary for safe clinical, medical, and program-support operations. • Accessibility, security, and life-safety fixtures • Activation-related technology directly tied to patient operations (non-recurring items only). The procurement plan is implementation-ready. Funds will be allocated in Spring 2026 to ensure expanded treatment capacity becomes operational within the calendar year. This project accomplishes several RHTP goals: • Health Care Access will be improved by increasing the practical capacity of a regional hub that serves rural residents and expanding access to behavioral health/SUD treatment services. • Healthy Communities can be strengthened with sustained recovery infrastructure and supportive services that reduce relapse risk and downstream acute-care utilization. • RHTP core goals are achieved by enhancing access, improving outcomes, and implementing a durable, one-time investment that is sustainable beyond the RHTP period.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Adoption Services	Potty Training Education & Support	AK	Too many children remain in diapers beyond developmentally appropriate timelines due to limited access to supplies, transportation barriers, and lack of practical potty-training support. These challenges are especially pronounced for families in rural and underserved communities, where diapers and pull-ups may be unaffordable or difficult to obtain. As a result, children may experience prolonged diaper dependence, increased household financial strain, and greater risk of preventable diaper-related health issues. This project addresses that gap by providing consistent access to pull-ups alongside structured potty training education and comprehensive potty training kits. By equipping families with both the materials and knowledge needed to support age-appropriate toileting independence, we aim to reduce long-term diaper reliance, improve child health, and ease financial pressure on families.	By combining pull-up distribution, targeted education, accessible potty training kits, and improved operational systems, this approach supports healthy child development, increases caregiver confidence, and reduces long-term diaper dependency while strengthening the sustainability of our mobile pantry services. Our proposed approach integrates potty training support into our existing mobile diaper pantry services to address both supply and education gaps. Families will receive developmentally appropriate potty training kits that include training underwear, child-friendly potties or seats, and visual supports, along with structured, easy-to-follow educational materials. Education will focus on recognizing readiness signs, establishing routines, and using positive reinforcement strategies to support age-appropriate toileting independence. Through our mobile pantry distribution, families will have consistent access to pull-ups while transitioning out of diapers, reducing setbacks caused by supply shortages. This ensures children remain comfortable and supported throughout the potty training process. To further expand access, we will utilize Project DASH through DoorDash to deliver potty training kits and pull-ups directly to families who travel to Anchorage from rural villages and to Anchorage families with transportation barriers. Many families traveling to Anchorage lack transportation during their stay, limiting their ability to purchase essential supplies. Direct delivery eliminates this barrier and ensures children have the hygiene items they need during short-term visits. By combining mobile distribution, caregiver education, and direct delivery for families, this approach reduces diaper dependence, strengthens equitable access to preventive support services, and improves child health outcomes.	\$50,000-\$250,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Alaska Alternative Medicine clinic, LLC	Rural Integrative Mentorship & Telehealth Initiative	AK	The Problem: Rural and frontier Alaskans face a "specialty care gap." While primary care is available via Community Health Aides, patients with complex, chronic, or treatment-resistant conditions (autoimmune, chronic pain, environmental illness) have no local options. Currently, these patients must either fly to Anchorage at a massive personal and system cost or remain untreated, leading to long-term disability and reduced quality of life. Furthermore, rural providers lack access to high-level mentorship in integrative medicine—the very "root-cause" approach that can prevent medical evacuations for chronic conditions. The Opportunity: Dr. Sandra Denton represents a unique clinical asset. With 50+ years of experience—including 13 in Emergency Medicine and 41 in Integrative Practice—she is an international authority on restorative health. However, her expertise is currently "locked" behind a high-volume clinical load in Anchorage. There is a profound opportunity to transition Dr. Denton from a solo practitioner to a statewide "Tele-Preceptor." By hiring a secondary provider to manage the Anchorage hub, we can "unlock" Dr. Denton to provide specialized telehealth and clinical mentorship to the most remote corners of the state, creating a bridge between frontier clinics and world-class integrative expertise.	The "Hub-and-Spoke" Capacity Building Model Our approach utilizes a "Clinical Backfill" strategy to transform a single urban clinic into a statewide resource for rural health. The project consists of three core pillars: 1. Strategic Workforce Expansion (The Hub): We will utilize grant funds to recruit and onboard a board-certified Associate Provider (preferably within the state) at our Anchorage clinic. This provider will assume the daily management of the existing patient base. This is the "catalyst" hire that releases Dr. Denton from 40+ hours of routine clinical duty, allowing her to pivot 50% of her FTE toward rural outreach and workforce development. 2. Rural Provider Mentorship & "Train-the-Trainer" (The Spoke): Dr. Denton will establish a formal mentorship program for rural Community Health Aides (CHAs) and mid-level practitioners. • Case Consultations: Rural providers can "e-consult" with Dr. Denton on their most complex chronic cases, gaining insights into integrative protocols that can be administered locally. • Clinical Preceptorships: We will host rural providers for intensive short-term rotations in Anchorage, where they will learn non-invasive modalities (such as chelation and ozone therapy) and the "medical detective" methodology to identify environmental triggers in their home communities. 3. Frontier Telehealth Integration: We will deploy a specialized telehealth portal dedicated to patients in remote and frontier regions. This allows Dr. Denton to serve as a virtual specialist for conditions like Lyme disease and chronic toxicity—areas where she is one of the few (or only) certified experts in the state. By treating these patients in their home villages, we reduce the burden on the Medicaid travel system and ensure continuity of care. Sustainability: This approach creates a permanent legacy of knowledge. By the end of the grant period, the Associate Provider will be fully integrated into the Anchorage practice, and a cohort of rural providers will be upskilled in integrative care, ensuring that Dr. Denton's 50 years of clinical wisdom is codified and distributed throughout the Alaska Tribal Health System.	\$250K-\$1M	Private practitioner	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Assoc. for Infant and Early Childhood Mental Health	Asset Mapping for Success	AK	Babies, toddlers, preschoolers, and their families, including expecting families, are supported by professionals with diverse backgrounds across multiple systems of care. Professionals who promote and support early mental health and social-emotional well-being include not only mental health providers, but a range of allied professionals in fields such as early learning, home visiting, intervention, pediatric healthcare, and others. At present, there are several opportunities for the IECMH workforce development. However, the training and services are siloed, and organizations often do not know what other organizations are offering. This often leads to duplication of efforts or a total lack of services/training opportunities. The desired outcome of this project requires that agencies cross lines, leave silos behind, and unite around a common effort to improve the lives of Alaska's little ones. The outcomes of this project include; 1. Provide a deeper understanding of the existing gaps, needs, barriers, and areas of strength across the IECMH promotion, prevention, and intervention workforce continuum 2. Create an interactive map highlighting IECMH training for professionals 3. Use these results to inform the IECMH training and workforce needs of communities within Alaska.	A strong IECMH system that best supports young children and families in Alaska requires partnerships among agencies that are committed to providing training for professionals in the field. A consultant will be hired to convene a team or survey child-serving state agencies and community stakeholders from across IECMH disciplines. The Team will be composed of individuals who demonstrate commitment and leadership to young children and have the ability to advance IECMH practice in the state. It is anticipated that many agencies will submit letters of intent or proposals for IECMH training to the Rural Health Transformation Grant. The goal of the project is to conduct agency surveys to identify all proposed trainings, create a map of workforce development showing which agencies provide which training, and identify gaps for future training. The map will identify current and potential training across the continuum of IECMH — prevention, promotion, and intervention. The year-long project will identify potential partners, develop surveys, convene in-person gatherings, and collect information. The 12-month project will include both planning and data collection, providing an overall map of training opportunities to support those providing IECMH services. The project will also include surveys of the workforce in rural communities to determine what training they desire. This letter of intent outlines beginning thoughts for the project and will be further developed during the planning stage.	\$50,000- \$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Association for Play Therapy	Advancing Play Therapy Workforce and Research for Early Childhood Behavioral Health in Alaska	AK	Alaska faces significant behavioral health (BH) workforce shortages and limited access to developmentally appropriate evidence-based BH services for children ages 0-9 and their families, particularly in rural and remote communities. Large areas of the state are federally designated Mental Health Professional Shortage Areas (HRSA, 2023). Nationally, one in five children experience a diagnosable mental health disorder annually (CDC, 2022). In Alaska, 47% of 3-year-olds have experienced at least one Adverse Childhood Experience (ACE), and 10% have experienced four or more (Alaska Department of Health, 2023). Untreated BH challenges in early childhood have have long-term impacts on emotional regulation, school readiness, family functioning, and overall health outcomes. Despite this, many clinicians in Alaska receive minimal specialized training in developmentally appropriate evidence-based interventions. Evidence-based play therapy models are widely recognized as a gold-standard for children's interventions. Play is the primary language through which children communicate and process emotional experiences. However, access to formal play therapy training, certification pathways, and research support is extremely limited in Alaska. This project advances Alaska’s Rural Health Transformation priorities by expanding BH workforce, strengthening early intervention for young children, and improving access to developmentally appropriate BH services in rural and frontier communities.	This project proposes a three-prong initiative designed to build a BH ecosystem that strengthen Alaska’s early childhood BH workforce, expands training in evidence-based play therapy (PT), and develops research infrastructure to evaluate PT outcomes across Alaska's rural and urban communities. Initiative 1: Statewide Rural Behavioral Health Needs Assessment The first initiative establishes a statewide data foundation to guide workforce development and training priorities, examining: Behavioral health (BH) services available for children ages 0-9 and their families across Alaska; Gaps in counseling and BH services for young children, particularly in rural and frontier communities; Existing training and use of evidence-based PT models among BH providers; research involving Alaska’s diverse population to assess representation within the evidence base for PT models. Initiative 2: Statewide Training & Workforce Development Guided by the needs assessment findings, establish a statewide training program to expand provider capacity: Train two experienced clinicians to serve as statewide PT trainers; Develop foundational and advanced PT training for BH clinicians; Implement a train-the-trainer model to expand access to PT training across Alaska; Integrate Infant and Early Childhood Mental Health principles with evidence-based PT models for children ages 0-5; Delivering accessible training to BH clinicians, BH aids, home visitors, and early childhood providers. This training emphasizes play as the natural language of children and prepares providers to deliver developmentally appropriate care for children who have experienced adverse childhood experiences (ACEs), recognizing that effective treatment differs from traditional talk-based therapy approaches. Initiative 3: Establishing a Play Therapy Research Hub This hub evaluates PT effectiveness within Alaska's BH system by: Mapping existing PT research conducted within Alaska; Partnerships linking clinicians, BH aids, tribal organizations, and academic institutes for culturally responsive research; Provide pilot funding for research studies evaluating PT models in Alaska communities; Strengthening connections between training, clinical practice, and research, this initiative expands the evidence base for culturally responsible PT and builds capacity to generate locally relevant knowledge that informs policy, workforce development, and behavioral health services statewide.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Association of Conservation Districts	Creating a Produce Prescription Program for Alaska	AK	Food is medicine; but food is not prescribable, nor covered by insurance. We want to empower primary care providers in south central Alaska to prescribe one of the most powerful, legal medicines manufactured right in Alaska – locally grown produce and seafood. Many chronic diseases can be prevented or reversed with the right lifestyle behaviors – diet, exercise, weight loss, etc. However, since major insurances cover some part or all of medical visits and medicines, the patient will walk out of the exam room with a referral to either “see a specialist” or “take a medication.” Discussions about improved diet remain mere discussions between the doctor and patient, and do not manifest into priorities. There is nothing signed by the doctor, and free or nearly free to the patient. Additionally, we learned during Covid and numerous natural disasters since, that Alaska relies heavily on outside food sources. Teaching residents about how supporting local growers is the most reliable path towards food security in small Alaska communities. Six of the Healthy Alaskans 2020 goals were related to reduction of obesity; America’s Health Rankings reports only 8 percent of Alaskan adults report consuming three or more vegetables daily. And according to the National Library of Medicine NIH, Alaska Native communities face disproportionate levels of chronic diseases and vegetable and fruit intake is significantly less than their counterparts nationwide.	We would like to create a program where providers can prescribe locally grown fruits and vegetables (and possibly Alaska caught salmon) as part of a covered treatment option. This would mean providers write a prescription, the patient takes the prescription to identified hubs or programs of local growers who are participating; the patient gets their goods; and grower is reimbursed by the grant. There are many details to figure out – from who, what, how, where – the details all still have to be flushed out to create a meaningful and fundable project. But all the opportunities need time to research and develop. 1.) We need to understand the supply side of the equation to know if there are enough producers to grow the food, how long could they supply fresh food to patients during the year, and in what manner would they be most likely to deliver the produce. 2.) On the demand side of the equation, we need to know how many doctors would be interested in prescribing food to their patients, how many patients they could imagine giving prescriptions, and what kind of vegetables or seafood they would want to prescribe. 3.) The ideas and enthusiasm around this plan to improve eating habits and nutrition at home are endless. We could include a slow cooker or instant pot, salmon or other healthy seafood, or recipes to guide the patient to success. 4.) We need to figure out who would manage the prescription, what entity could act as the “pharmacy” or clearinghouse for patients to match up with farmers. Would it be best to create a list or a website to facilitate this connection? This round of funding would be used to hire someone to connect the dots with all the players, figure out what is possible and what is sustainable, and put forth a full project application for the next round of funding.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough	Deferred or Not Advanced

Alaska Association of Conservation Districts	Cultivating Preventative Care: Scaling the Anchor Gardens Model for Chronic Disease Reduction	AK	Community and home gardens bypass systemic barriers like cost or distance to fresh produce. Growing food at home reduces transport miles and makes adding nutrition to one's diet easy, fun, and habitual. A 2026 joint study by Yuka and Harvard Law School’s Food Law and Policy Clinic, "The Hidden Costs of Low-Priced Foods," found that the cheapest store-bought foods contain more additives, sugar, and sodium than pricier options. Healthy foods are often hard for low-income households to access, and diet-related illnesses are a rising burden. Healthy food should be the standard. Home-grown vegetables are a key strategy for nutrition, especially when grown by the consumer. Gardening skill is gained through experience, but a knowledge-sharing network helps gardeners produce results more efficiently. For example, many are intimidated by composting, which is vital for low-cost soil health. The network also encourages pooled resources—gardeners can access free supplies or find mentors for specialized tasks like raising chickens. Gardens also build community, bridging generational or cultural barriers by encouraging the sharing of skills, tools, and harvests.	This project would establish long-term, resilient networks for a sustainable nutrition program through home and community gardens. Gardens often operate on the fringes of their potential due to limited resources and fragmented knowledge. This project aims to transform these modest plots into beneficial hubs of health by building out a network coaching structure, bolstering physical infrastructure and pooled resources, and embedding structured educational opportunities directly into the soil of the community. We aim to scale Anchorage’s successful Anchor Gardens model, a network connecting individuals through gardening to build social capital, across Southcentral Alaska and the Kenai Peninsula. The model uses a team of coaches who volunteer their time to mentor anyone who wants to garden. Coaches support their neighbors with garden design, troubleshooting, access to resources (seeds, nursery pots, compost, etc), and connections to a community working to improve food security across the state. Anchor Gardens, developed over the past six years, has grown and strengthened through partnerships with local organizations and small pockets of funding. Organizers are eager to share these lessons and bring its success to a wider statewide network. The Anchorage, Kenai, and Homer Soil and Water Conservations Districts, along with community groups such as NeighborWorks Alaska, Alaska Master Gardeners, and other partners will collaborate to develop programming and organizational structures appropriate for each community. Hands-on workshops will demonstrate how to plan and care for gardens throughout the season, including workshops on how to preserve harvests through canning, fermenting, and drying, critical skills for food security. We will also provide training in regenerative agriculture techniques, such as composting and integrated pest management.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough	Deferred or Not Advanced

Alaska Association on Developmental Disabilities	Strengthening Alaska’s Rural Disability Workforce and Support System	AK	AADD was introduced to GoodLife Innovations at a national ANCOR conference. Founded by families, GoodLife is a community-based provider that has partnered with the University of Kansas for over 45 years to research, test, and implement evidence-based workforce strategies. Through continuous refinement, GoodLife develops practical strategies that promote healthy work-life balance for DSPs through innovative scheduling, technology that allows for remote support when requested, and a relationship-based approach to neighborhood support networks and shared living (host home) arrangements. After demonstrating strong success, GoodLife launched consulting services to help providers nationwide replicate its model. With support from the Alaska Mental Health Trust, AADD piloted this approach with two Alaska providers, producing promising early results. This project builds on that momentum to expand these strategies and advance systemwide transformation. This project strengthens Alaska’s rural healthcare ecosystem by modernizing service delivery, stabilizing the workforce, and expanding access to high-quality supports for individuals with barriers to independence. Rather than relying on short-term fixes, this approach positions Alaska to lead in next-generation service delivery—transforming workforce challenges into an opportunity to deliver more equitable, efficient, and connected care for rural communities.	GoodLife’s approach is a comprehensive, four-pillar strategy designed to move Alaska toward a transparent, high-performing service delivery model that integrates human expertise with advanced technology. Participating organizations and partners will have access to GoodLife University’s Subject Matter Experts (SMEs) to stabilize the workforce and modernize care. The strategy includes four integrated work-streams: 1. Workforce Stabilization (WF): Implementation of advanced workforce management, including scheduling and pay strategies, recruitment pipelines, and non-wage benefits. The goal is to reduce DSP vacancies and call-offs while transitioning more staff into stable, full-time positions. 2. Technology Advancements (TA): We will conduct waiver and barrier analyses to draft policy recommendations for remote and enabling support technology. Stakeholder education ensures program administrators, caregivers, and persons-served understand how technology can enhance human service models. 3. Fractional Care & Neighborhood Network (NN): This pillar introduces a fractional care model and neighborhood ecosystem capable of providing on-demand, 15-minute-unit staffing to fill care gaps traditional models often miss. Integrated with iLink Technologies, this approach ensures providers can maintain essential services and fill authorized care hours without canceling care due to staff shortages. 4. Professional & Natural Family Support (Host Home): GoodLife will expand the Shared Living concept by leveraging natural supports and Professional Family host-homes. This model improves housing stability and compensation for caregivers, creating a more durable support system for those with intensive needs. Host Homes, a future service to be added to Alaska’s 1915(c) waiver, will meet critical needs in remote communities where traditional services are not always a good fit. Support from an experienced organization like GoodLife, which has utilized and refined this model since 1999 and achieved measurable success, will greatly assist in the implementation of this service. Through these pillars, GoodLife delivers the right care at the right time, with the right human touch. Success will be measured through live metrics dashboards, tracking DSP satisfaction, wage growth, and the delivery of more authorized care hours.	\$1M-\$5M	Statewide	Anchorage (Municipality); Copper River Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Advance to Implementation Application

Alaska Association on Developmental Disabilities	The Road Home: Intensive Care and Community Integration for Alaskans with Complex Needs	AK	Alaska's is struggling to serve children and adults with complex, co-occurring behavioral needs. Changes over the past decade — increase in small providers, persistent workforce shortages, and depressed reimbursement rates — have created a destructive cycle. When a person loses their provider following an incident, the State must scramble to find an emergency placement. Inexperienced providers, drawn by higher acuity-based rates, accept referrals they lack the depth or experience to sustain. Placements fail. The trauma of repeated disruption discourages more established providers from accepting complex referrals. AADD recently completed a Trust-funded planning grant that validated this as well as further indicated some individuals are placed in settings that manage behavior through suppression rather than support, relying on approaches that keep people compliant without the clinical foundation or trained staff that person-centered behavior support requires. The Complex Behavior Collaborative has not kept pace: funding has remained flat, eligibility and referral processes are unchanged, there's a waitlist for situations requiring immediate response and a lack of clinical expertise. Coordinated transition planning is largely absent. This project also recognizes individuals who fall outside the 1915(c) waiver yet require long-term care or structured residential support due to co-occurring disabilities. This planning phase will evaluate their inclusion in this project.	Alaska is not without a roadmap. A 2009 WICHE report recommended a "three-legged stool" approach to complex care in Alaska: (1) a behavior hub providing technical assistance and consultation — fulfilled by the Complex Behavior Collaborative; (2) brief stabilization services — addressed through Mobile Crisis Teams; and (3) intensive intermediate intervention services. This project proposes to build this third leg. WICHE described this as a small ICF-IDD or intensive, structured residential setting — a step-down intervention designed to stabilize behavior so individuals can transition into community-based settings like group homes. Through AADD's Trust-funded planning grant, the team identified a successful model in Delaware that serves as the foundation for this pilot. The proposed approach is to establish two residential settings with dedicated clinical oversight — including a Board-Certified Behavior Analyst, a Licensed Clinical Social Worker, and a nurse — staffed by Registered Behavior Technicians. These would not be traditional group homes, but rather structured, time-limited intervention settings focused on assessment, behavior plan development, skill building, and planned transition back to the community. This phase will explore piloting Alaska's emerging complex care home license type as the regulatory and oversight framework for these settings, and will evaluate use of the Health Information Exchange (HIE) as a mechanism for sharing critical information across the team — including primary care, emergency services, and behavioral health — ensuring coordinated, informed support across the continuum. The project team brings exceptional depth. A veteran CBC consultant who also leads a provider organization has committed to serving as the pilot service provider. A consulting team with multi-state experience implementing complex care solutions will provide project management, technical assistance and implementation support. Eric Boyer with the Alaska Mental Health Trust have also been actively involved. SDS leadership has been consulted. AADD's director has nearly 30 years in DD services in Alaska. Together, this team combines on-the-ground Alaska expertise with national best practice knowledge. Goal 2 — to be addressed after launching the residential services — will map the broader continuum of care and develop an action plan to build capacity - highlighting preventative support options - for providing support at sub-acute level.	\$250K-\$1M	Home- and community-based services provider	Statewide	Anchorage (Municipality)	Advance to Implementation Application

Alaska Automation	Resilient Community Water SCADA to Safeguard Health Access in Rural Alaska	AK	Rural coastal and island communities in Alaska face recurring water and wastewater outages, contamination events, and slow emergency response because aging, fragmented SCADA systems provide limited situational awareness, delayed alarms, and no integrated asset context. Each incident directly threatens public health and disrupts health care access when clinics must curtail services, cancel procedures, or operate without confidence in water safety. These avoidable disruptions undermine healthy communities by increasing risk of gastrointestinal illness, skin infection, and other conditions that disproportionately affect elders, young children, and residents with chronic disease. We propose deploying Structure’s, unified SCADA platform—implemented and supported by Alaska Automation—to modernize water and wastewater monitoring and control in participating communities, including Chignik Lagoon and Yakutat (confirmed) with Juneau, Sitka, and Wrangell as additional hub sites under discussion. The opportunity is to convert raw telemetry into actionable incident workflows, automate emergency notifications to operators and clinics, and preserve institutional knowledge so that essential utilities remain reliable and safe, underpinning primary care, behavioral health, maternal health, and other services in rural Alaska.	Alaska Automation will lead a phased, operator centered deployment of Structure SCADA tailored to each participating community’s existing control network and communications constraints. • Phase 1 – Assessment and pilot (Health Care Access focus): Inventory critical water and wastewater assets; map existing PLCs, RTUs, and communication paths; and deploy Structure in parallel with legacy systems in two pilot communities (Chignik Lagoon and Yakutat) so operators and clinic partners can validate performance without operational risk. We will configure core GIS integrated views, role based access, and encrypted communications to meet cybersecurity expectations for health critical infrastructure. • Phase 2 – Workflow build out and regional expansion (Healthy Communities focus): Implement event based “Action Editor” logic for automated leak detection, stale signal and device health alerts, point of entry shutdowns, and preconfigured incident packets that include GIS maps, affected customers, and communication templates for clinics and the public. Deploy QR based inventory tracking for critical spares, develop clear SOPs embedded in the system, and extend the platform to additional communities (e.g., Juneau, Sitka, Wrangell) using a hub and spoke model that supports regional health partners. • Phase 3 – Validation, drills, and sustainment: Conduct tabletop and live simulation exercises with utility operators, clinic staff, and borough emergency managers to test response workflows and clinic notification pathways. Refine predictive alerts and escalation rules based on incident data, formalize knowledge capture requirements (incident reports, photos, corrective actions), and execute a multi year training and support plan that gradually transitions day to day oversight to local staff while maintaining remote technical support from Alaska Automation. Throughout all phases, the project will document health relevant metrics—such as outage frequency, boil water notices, and clinic service disruptions—to demonstrate impact on health care access and community health over time.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Juneau (City and Borough); Sitka (City and Borough); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Alaska Backcountry Medicine	Alaska Frontier Wilderness Medicine Scholarship & Education Center Development Program	AK	Alaska has a wilderness and rural medicine problem that nobody is systematically solving. Wilderness medicine isn't defined by a specific number of minutes — it's defined by managing a patient for hours or days with limited resources while making time-critical evacuation decisions. That reality describes most of Alaska, and it extends well beyond backcountry hiking emergencies. You don't have to go far from Anchorage before EMS response is measured in hours — in rural and remote communities, that gap can be a day or more. WFA and WFR carry no nationally standardized certification, but courses from established providers like NOLS, SOLO, WMA, and Base Medical follow Wilderness Medicine Education Collaborative standards and are widely recognized by employers, SAR programs, federal land managers, and guiding operations. More importantly, they're accessible in a way that EMT training isn't — a 16-hour WFA or 70-hour WFR fits around a fishing season, a work schedule, or a subsistence lifestyle. An EMT course requires 140–160 hours, clinical rotations, and ongoing agency affiliation. For most rural Alaskans, wilderness medicine is a realistic first step. For many, myself included, it becomes the reason they pursue EMS at all. Still, no organization is proactively bringing this stepping stone to the communities that need it most. This project removes those barriers and turns a stepping stone into a keystone for emergency preparedness in a community.	ABM will deliver zero-cost WFA, WFR, and Wilderness BLS scholarships across six Alaska regions through direct proactive outreach — we contact communities, they don't have to find us. Courses reach road-system communities, off-road hubs like Bethel and Kodiak, Southeast Alaska, and bush fly-in for the most isolated villages. Curriculum is through Base Medical, following Wilderness Medicine Education Collaborative standards — the same as NOLS, SOLO, and WMA, recognized by NPS, federal land managers, and SAR programs nationwide. WFA is 16 hours; WFR is 70+ hours with online content and in-person practical days I fly in to deliver. Wilderness BLS — developed through Base Medical's American Red Cross partnership — bridges standard BLS skills with wilderness and remote contexts. Integrated from Year 1, it gives students a recognized resuscitation credential alongside their wilderness training. I will design ABM's WFR course to meet not just WFR standards but also those of the Alaska ETT and NREMT-EMR. The ETT provides state recognition and civil liability immunity under Alaska statute; the NREMT-EMR provides national registry recognition accepted by agencies like NPS. Which credential a student leaves with is determined before the course begins based on the community's or organization's needs. Both are a direct path to EMT-1. The long-term goal is permanent infrastructure, and I've watched the model work. ODFW was one of my first clients — 24 students in 2022. In 2023 one of their staff had a serious field injury; their trained colleagues handled it correctly. That incident made it real. They came back with 42 students in 2024, 46 this year, and are becoming a Base Medical Education Center. The economics drove it: in-house instructors pay \$65/student for WFA instead of \$250+. Recertifying 50 students drops from \$13,000 every two years to \$5,410 — saving \$7,590 per cycle, indefinitely. In McCarthy I've run for-profit courses since 2022 and enrollment keeps growing. WFRs I trained now volunteer with the response group and/or SAR; several earned their EMT, which I also taught. A WFA is often the first time someone realizes they can do this work — the gateway into EMS. I instruct EMT courses for APEC statewide, and through this grant Dane Wallace and I are formalizing that connection with a wilderness add-on scholarship track for APEC graduates. APEC's separate RHTP deliverables are additional infrastructure this program connects to directly.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Prince of Wales-Hyder Census Area; Skagway (Municipality); Wrangell (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Behavioral Health	Alaska Seeds of Change Model Transition	AK	Client disengagement is a critical barrier in behavioral healthcare, especially for people with serious mental illness. Research estimates disengagement rates as high as 46% (PMID 19037573). At AKBH, more than half of clients are discharged without completing treatment. Alaska’s suicide rate of 26.2 per 100,000—nearly double the national average of 13.9—reflects the devastating cost of untreated mental illness (Alaska Dept. of Health). Evidence shows outcomes improve significantly when clients engage earlier and stay engaged, making retention the highest-leverage intervention point. Group therapy offers a proven, scalable solution: a meta-analysis of 329 randomized controlled trials and 27,000+ patients confirms group therapy produces outcomes equivalent to individual therapy for depression, anxiety, PTSD, and substance use disorders (Burlingame et al., 2016). The APA estimates that if 10% of people needing mental health care accessed group therapy, 350 million more Americans would gain access, allowing limited providers to serve far more clients (APA Monitor, 2023). AKBH currently lacks adequate group space and large motor activity space at several facilities. We see a clear opportunity to increase engagement and expand group services through our CCBHC, extending the full spectrum of behavioral healthcare to more Alaskans.	Alaska Seeds of Change has a strong record of supporting transition-age youth through hydroponic farming, gardening, vocational training, and therapeutic engagement. This project broadens that proven model to serve clients of all ages across AKBH. The initiative includes: 1) Revamping the AKSOC facility to create dedicated spaces for group therapy, physical activity, art therapy, skill development, and individual counseling—directly addressing the infrastructure gap limiting group service delivery. 2) Creating enriching therapeutic environments designed to support behavioral activation, peer connection, and skill development—evidence-based mechanisms strongly correlated with treatment retention. 3) Developing a client computer lab, kitchen space, and recreational areas to reduce participation barriers and support daily living skills. 4) Integrating vocational apprenticeships for youth including farm maintenance, customer service, event management, and exposure to behavioral health careers. This transformation will create a versatile, welcoming hub that supports clinical services, skill building, and community connection.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Single Community	Anchorage (Municipality)	Advance to Implementation Application

Alaska Behavioral Health	Behavioral Health Workforce Development, Clinical Internship Program	AK	Alaska continues to experience significant unmet behavioral health needs, with many individuals requiring complex, sustained care. There is an urgent need to expand and strengthen Alaska’s behavioral health workforce. Addressing the statewide shortage of qualified providers requires intentional investment in training pathways that prepare clinicians to deliver effective, culturally attuned care across Alaska’s broad geography. Building this workforce begins with high-quality clinical internships that offer hands-on experience, structured supervision, and training in evidence-based interventions proven effective for telehealth delivery. As a Certified Community Behavioral Health Clinic (CCBHC), a National Child Traumatic Stress Network Center, and one of Alaska’s longest-standing behavioral health providers with more than 50 years of service, Alaska Behavioral Health is uniquely prepared to meet this need. The organization has established clinical internship partnerships with over 35 universities and colleges nationwide, creating a strong pipeline of students seeking high-quality internship experiences in Alaska. Drawing on decades of experience, statewide reach, and deep clinical expertise, Alaska Behavioral Health is ready to expand and scale its clinical internship training program. This expansion will directly address the behavioral health workforce shortage while improving access to culturally responsive care for rural Alaskans.	Workforce development is essential to meeting the complex behavioral health needs of Alaskans. A critical and often limiting factor in training clinical providers is access to high-quality clinical internship placements within behavioral health organizations. These internships provide trainees with evidence-based treatment training, real-world experience, supervision, and the support needed to develop into culturally competent, highly skilled Alaskan behavioral health professionals. Master’s level clinicians are best equipped to lead clinical treatments for complex behavioral health conditions, and clinical internships are one of the most important components of these graduate programs. It is during these internships that academic knowledge is integrated into real-world health care delivery. While student fees and other resources support academic training, the clinical internship experience that occurs within community behavioral health clinics requires dedicated funding. Historically, this activity was supported through a CBHTR grant; however, the downsizing and eventual elimination of that funding has left this critical program unsupported. Without renewed investment, the capacity to train the future behavioral health workforce will be significantly diminished. With RHTP funding, Alaska Behavioral Health would support 25 master’s level clinical placements in FY 2026, directly addressing the need for highly trained providers capable of serving rural Alaskans. Interns would receive training in evidence-based treatments proven effective for delivery via telehealth, a critical strategy for reaching rural, remote, and frontier communities. Training would include MATCH-ADTC (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems), TF-CBT (Trauma-Focused Cognitive Behavioral Therapy), CBT (Cognitive Behavioral Therapy), and PC CARE (a modular, trans-diagnostic treatment for families). Interns will receive clinical supervision from on-site, Alaska-based supervisors and mentors, and will participate in a weekly didactic lecture series focused on delivering evidence-based, culturally responsive care to rural Alaskans.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Matanuska-Susitna Borough	Advance to Implementation Application

Alaska Behavioral Health	Facility Remodel for Fairbanks Crisis Stabilization Center	AK	SAMHSA identifies 3 essential elements for Behavioral Health Crisis Services: 1) Someone to Contact, 2) Someone to Respond, and A Safe Place for Help. The Fairbanks community has access to the the first element through 988 and the AKBH Crisis Line. The Fairbanks Mobile Crisis Team fulfills the second element. What is missing is the third. The lack of a Crisis Stabilization Center means that many individuals end up in the hospital emergency room or jail that would be better served in a Crisis Stabilization Center. A crisis stabilization center in Fairbanks addresses a persistent gap in behavioral health care across Interior and northern Alaska. Rural residents often face long wait times and limited local services for urgent behavioral health support. These delays increase the likelihood that a manageable crisis escalates into hospitalization, involvement with law enforcement, or extended stays in emergency departments that are not designed for behavioral health needs. The lack of timely, culturally responsive care close to home places strain on families, first responders, and small rural clinics that are already operating at capacity.	AKBH has been working with the City of Fairbanks and the Alaska Mental Health Trust Authority for several years to develop a Crisis Stabilization Center in Fairbanks. With support from Foundation Health Partners we were able to obtain a lease on a well suited facility in Fairbanks. We intend to open a Medium Intensity Crisis Stabilization Center in that facility within the next year. The building will need substantial remodeling to make it a safe, effective space for delivery of these services. We have site visits planned to facilities in other States to inform best practices for facility layout and operational procedures. We have the right clinical leadership in place to implement and operate the facility and plans are in place to recruit the staffing needed. This project request would be for the capital to complete the remodel which could be completed in the first funding year.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough	Advance to Implementation Application

Alaska Behavioral Health	Health Technology	AK	Medicaid recipients in Alaska face a two-tiered health system. Commercially insured and self-funded plan members routinely receive free wellness tools, remote monitoring devices, and prevention programs subsidized by their insurers. These interventions are associated with better chronic disease outcomes and reduced downstream medical costs. Medicaid’s traditional fee-for-service payment model, with reimbursement rates in Alaska that don’t fully cover the cost of care, has effectively excluded Medicaid recipients from these benefits. Approximately 80% of AKBH’s clients are Medicaid recipients. Inadequate reimbursement has also prevented our clinics from implementing technology upgrades that could streamline workflows, reduce staff burden, and increase client engagement. Hypertension is a leading driver of cardiovascular disease, stroke, and premature death, yet many low-income clients lack basic home monitoring tools. Insomnia and sleep disorders are highly prevalent among individuals with behavioral health conditions, with research showing that 50–80% of individuals with mental health diagnoses experience co-occurring sleep disturbances. Untreated insomnia exacerbates depression, anxiety, and substance use. This project aims to close the equity gap by providing Medicaid recipients with the same preventive and self-management tools available to privately insured Alaskans, while also equipping our clinics with technology that improves care quality and operational efficiency.	AKBH requests funding for four integrated technology components designed to improve integrated care delivery and health self-management: 1. PharmaSmart Health Kiosks - We will implement PharmaSmart kiosks in our primary care-integrated clinic locations. These clinically validated kiosks measure blood pressure, pulse rate, weight, and BMI while identifying patients at risk for hypertension and diabetes. Kiosk data integrates directly with our EHR system, eliminating manual transcription errors and reducing nurse check-in time. Patients also gain secure, private access to their own health data.2. Neurofeedback Equipment and Staff Training - For clients with treatment-resistant behavioral health conditions, neurofeedback represents a promising adjunct to traditional therapy. The technology uses real-time EEG monitoring to provide audio-visual feedback that helps clients identify and self-regulate their own brainwave activity. Research published in Applied Psychophysiology and Biofeedback supports neurofeedback as an evidence-based intervention for ADHD, PTSD, anxiety, and depression in populations where conventional medication and therapy have yielded limited results. 3. Insomnia Reduction Kits for Clients (CBT-I Support) -Cognitive Behavioral Therapy for Insomnia (CBT-I) is designated as the first-line treatment for chronic insomnia by the American College of Physicians, the American Academy of Sleep Medicine, and the VA. Unlike sleep medications, CBT-I addresses the root causes of insomnia and produces durable long-term improvements. Effective implementation of CBT-I requires basic home tools that are often inaccessible to low-income clients, including sleep masks, blackout aids, and sunrise alarm clocks that regulate circadian rhythms. AKBH will distribute insomnia reduction kits to clients engaged in CBT-I programs statewide, including rural clients receiving services via telehealth. 4. Home Blood Pressure Monitoring Kits for Clients -Hypertension is known as the “silent killer”. The American Heart Association recommends home blood pressure monitoring as a complement to clinical measurement, and studies consistently show that home monitoring leads to better blood pressure control, reduced white coat hypertension effect, and improved medication adherence. AKBH will provide validated, AHA-recommended home BP monitors to high-risk clients, paired with provider education on how to log and report readings through our telehealth platform.	\$50,000- \$250,000	Behavioral health/su bstance use disorder treatment	Multi- Community or Participating in Regional Hub-and- Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Matanuska- Susitna Borough	Advance to Implementati on Application

Alaska Behavioral Health	Patient Portal and HIE Integration	AK	As a provider serving patients across Alaska, we still lack the ability to reliably share real time health information across the many systems where patients receive care. Rural Alaskans often move between tribal health organizations, local clinics, hospitals, and behavioral health providers, but these systems are not fully connected. Without integration with Alaska’s Health Information Exchange (HIE), clinicians frequently work with incomplete medication lists, outdated histories, and limited visibility into recent care. This leads to fragmented treatment, duplicated services, and delays that disproportionately affect patients who travel long distances or rely on multiple care settings. Patients also have no easy way to view their own records, request refills, or communicate securely with their care team. For people in remote communities, this lack of access makes it harder to manage chronic conditions, stay engaged in treatment, or resolve issues without traveling. Implementing a patient portal linked to our integrated EHR would give patients direct access to their information and providers, improving continuity and reducing avoidable gaps in care. This project addresses the opportunity to create a connected, statewide information system that improves coordination, strengthens safety, and empowers patients. Integrating our EHR with the Alaska HIE and launching a patient portal would ensure that every patient, regardless of location, benefits from timely information.	The project has two core components: integrating our electronic health record (EHR) with the State of Alaska’s Health Information Exchange (HIE) and implementing a patient portal that gives individuals direct access to their health information and care team. Integrating the EHR with the Alaska HIE. The first part of the project establishes real time, bidirectional data exchange between our EHR and the statewide HIE. This includes secure sharing of medication histories, diagnoses, care plans, lab results, and encounter summaries. The integration will follow national interoperability standards and use structured interfaces to ensure consistent, accurate data flow. This allows our clinicians to see the most current information from tribal health organizations, hospitals, primary care clinics, and other behavioral health providers; reducing duplication, improving safety, and supporting coordinated treatment for patients who move between regions. The project team will work closely with the HIE’s technical staff, our EHR vendor, and internal IT to complete interface development, testing, and validation. Implementing a statewide patient portal. The second component is launching a patient portal that allows individuals to view their records, request medication refills, send secure messages, and access visit summaries from any location. This is especially important for rural Alaskans who often travel long distances for care or rely on intermittent connectivity. The portal will be configured to support mobile access, culturally responsive communication, and user friendly navigation. Staff will be trained to help patients enroll, and outreach materials will be developed to support adoption across diverse communities. Building long term capacity. The project includes workflow redesign, staff training, and patient education to ensure the new tools are fully integrated into daily practice. Policies for data governance, privacy, and secure messaging will be updated to align with statewide standards. By the end of the project, we will have a sustainable, interoperable system that strengthens care coordination, improves patient engagement, and supports continuity of care for Alaskans regardless of where they live.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Matanuska-Susitna Borough	Advance to Implementation Application
Alaska Behavioral Health	Fairbanks Mobile Crisis Team Van	AK	The Fairbanks Mobile Crisis Team serves the entire Fairbanks North Star Borough. The borough experiences both extreme cold in the winter as well as some hot days in the summer. The situations that the team respond to vary greatly and they often don't know what they will encounter until they arrive on the scene. Most of the encounters happen during the nighttime. At times, safety concerns limit the amount of time our team is able to spend with community members due to weather conditions or conditions within the location to which they are responding. Having a mobile behavioral health clinic would allow us to appropriate care in a wide variety of situations across the large, variable response area.	VanDolt is a company that designs and builds modular vehicle systems for a variety of purposes including mobile healthcare operations. They have partnered with Netsmart (AKBH's electronic health record (EHR) vendor) to create platforms designed for Mental Health Mobile Crisis Teams. They have experience building these vans for use in rural areas such as Wyoming and understand the needs of a service area like Fairbanks North Star Borough. The van will be outfitted with satellite internet for accessing the EHR. It will have safety features for transporting patients when needed; secure storage for first aid supplies; and a comfortable environment for crisis intervention.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough	Deferred or Not Advanced

Alaska Behavioral Health Association	Alaska Rural Routine Outcome Monitoring & Measurement-Informed Care Initiative	AK	Alaska’s rural and frontier communities face persistent barriers to delivering coordinated, high-quality behavioral health care. Geographic isolation, workforce shortages, limited specialty access, and fragmented electronic health record systems constrain providers’ ability to systematically determine whether treatment is effective. Most rural settings lack consistent Routine Outcome Monitoring (ROM) infrastructure that supports standardized symptom tracking and longitudinal review. ROM is a structured process in which validated outcome measures are administered at intake and at regular intervals during treatment. Scores are trended over time, allowing clinicians and patients to see whether symptoms are improving, plateauing, or worsening. When incorporated into supervision and treatment planning, ROM becomes Measurement-Informed Care, enabling earlier identification of non-response and more timely clinical adjustments—critical in communities where crisis response and specialty services are limited. Inconsistent, non-interoperable outcome data limits quality improvement, benchmarking, and readiness for value-based payment models. Establishing a standardized, EHR-agnostic ROM framework creates the clinical measurement backbone necessary to improve quality, strengthen workforce practice, and support sustainable rural health transformation aligned with RHTP priorities.	ABHA proposes a phased Routine Outcome Monitoring (ROM) implementation beginning with six to eight rural pilot behavioral health providers. The purpose of this module is to establish foundational clinical measurement infrastructure that supports Measurement-Informed Care (MIC) within participating organizations. In Year 1, ABHA will coordinate selection of geographically diverse rural sites and support implementation of a standardized, EHR-agnostic ROM platform. Participating providers will work directly with the selected platform’s clinical implementation specialists to configure validated outcome measures, integrate ROM into existing workflows, and align onboarding within current electronic health record environments. Outcome measures will be administered at intake and at regular intervals during treatment. The selected platform will enable clinicians to access symptom trend data within sessions and support supervisors in reviewing longitudinal outcome trajectories during case consultation as implementation stabilizes. The intent is to build capacity for structured measurement to inform clinical decision-making over time rather than functioning solely as documentation. ABHA’s role in this module is limited to pilot coordination, milestone tracking, and alignment with RHTP objectives. Broader quality improvement infrastructure, communications strategy, and statewide technical assistance are addressed in complementary modules and are not included in this scope. The selected platform will be EHR-agnostic to prevent vendor lock-in and reduce long-term financial risk for rural providers. Aggregated, de-identified pilot data will be reviewed to assess feasibility, clinician adoption, and early symptom trend patterns. Findings from the six-to-eight site cohort will inform decisions regarding phased expansion in subsequent years. This initiative focuses specifically on provider-level implementation of Routine Outcome Monitoring infrastructure. Complementary initiatives proposed by ABHA address supervisory training, operational alignment, statewide communications, and long-term data architecture planning.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Behavioral Health Association	Behavioral Health Operations & Quality Infrastructure Initiative	AK	As Routine Outcome Monitoring and supervisory capacity expand within Alaska’s rural behavioral health system, organizations require structured operational alignment to embed measurement into policy, workflow, and quality systems. Clinical measurement alone does not produce transformation unless it is integrated into documentation standards, supervision protocols, quality review processes, and fiscal oversight structures. Many rural behavioral health organizations operate with limited administrative bandwidth and minimal formalized quality infrastructure. Policies governing use of structured data, documentation alignment, performance review, accreditation preparation, and billing consistency are often underdeveloped due to competing operational demands. As value-aligned financing expectations evolve, organizations require internal clarity regarding governance, quality monitoring, and operational readiness. This module addresses the ancillary operational work necessary to translate Measurement-Informed Care into sustainable organizational practice. It focuses on strengthening internal policy frameworks, documentation alignment, accreditation readiness considerations, and billing consistency related to structured measurement, without duplicating regulatory or payment reform functions.	ABHA proposes establishment of an Operations & Quality Infrastructure Initiative to assist participating organizations in aligning internal systems with emerging measurement practices. During the project period, structured consultation will focus on organizational policy refinement related to outcome data use, documentation standards, supervision alignment, and internal quality monitoring processes. Participating organizations will review existing policies to determine whether updates are necessary to reflect integration of structured clinical measurement. Attention will also be given to accreditation alignment and billing documentation consistency where measurement integration affects record structure. This may include review of how structured outcome tools are incorporated into treatment plans, progress notes, supervision documentation, and internal audit practices. The objective is not regulatory compliance oversight but strengthening organizational clarity and consistency. In addition, participating organizations may complete structured readiness assessments related to quality monitoring, data governance roles, and value-aligned payment preparedness. These assessments will inform identification of operational gaps and practical next steps tailored to rural environments. ABHA’s role will be limited to development of adaptable policy templates, readiness tools, and structured consultation pacing. The initiative will not replace existing regulatory functions or payment reform activities. Findings from participating organizations will inform refinement of materials prior to consideration of broader expansion. Statewide communication alignment, clinical measurement implementation, and regional planning activities are addressed through separate complementary initiatives.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Behavioral Health Association	Behavioral Health Supervisor Academy Implementation Initiative	AK	Alaska’s rural behavioral health system faces workforce instability, supervisory variation, and limited structured leadership development pathways. Supervisors are often promoted based on clinical experience rather than formal preparation in leadership, ethical oversight, or structured performance management. In geographically isolated settings, limited access to peer consultation and training further constrains supervisory consistency. Research indicates that structured supervision is associated with increased clinician confidence, professional identity development, and perceived competence. ABHA has already convened an advisory committee of rural providers and workforce leaders to define core competency domains for a statewide Supervisor Academy. This proposal advances that established foundation into formal curriculum development and pilot cohort implementation. Curriculum domains will include structured supervision practices, ethical oversight, leadership in resource-constrained environments, and supervisor education in Routine Outcome Monitoring principles to ensure that, as clinical measurement infrastructure expands, supervisors are prepared to interpret structured data and incorporate it appropriately into supervision conversations. This academy complements Alaska’s Routine Outcome Monitoring implementation efforts by preparing supervisors to interpret structured outcome data and incorporate measurement-informed discussion into supervision practice.	ABHA proposes a structured implementation initiative to develop and launch a rural-focused Behavioral Health Supervisor Academy in partnership with the University of Alaska Anchorage School of Social Work. This module builds on existing advisory planning and advances into curriculum finalization and pilot cohort delivery within the project period. During the first three to six months, ABHA and UAA SSW will formalize a competency-based curriculum grounded in rural supervision practice. Content domains will include supervision models, ethical oversight, structured performance feedback, workforce retention strategies, leadership in resource-constrained environments, and integration of structured clinical data into supervision conversations. This ensures supervisory readiness as clinical measurement infrastructure expands through complementary initiatives. Advisory committee input will inform refinement to ensure alignment with rural provider realities. Following curriculum development and platform preparation, at least one pilot cohort of rural behavioral health supervisors will be launched during the project period. Delivery will occur through a structured virtual learning model designed to accommodate geographic isolation and workforce demands. Evaluation tools will be administered to assess changes in supervisor confidence, perceived competence, and consistency of supervision structure. ABHA’s role will include coordination, milestone tracking, and alignment with RHTP objectives. The academic partner will support instructional design, learning platform preparation, and evaluation framework execution. Findings from the pilot cohort will inform refinement prior to broader expansion in future funding cycles.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Behavioral Health Association	Behavioral Health Technology Vendor Readiness & Alignment Initiative	AK	Behavioral health providers in Alaska rely on technology platforms to support care delivery, data collection, quality improvement, and administrative operations. These platforms include electronic health records, clinical measurement systems, telehealth tools, analytics software, and other digital infrastructure. Vendors entering the Alaska market frequently lack familiarity with the state’s unique health system environment. Alaska’s behavioral health landscape includes a diverse mix of tribal systems, providers, and rural/frontier environments. Providers operate across multiple EHR platforms, often with limited interoperability and broadband infrastructure. Technology vendors may underestimate the complexity of integrating with these systems or may not understand the realities of delivering services in remote communities. As a result, providers can face significant implementation challenges, including high integration costs, limited compatibility across platforms, and tools not designed for Alaska’s geographic and service delivery context. This initiative creates a structured orientation and alignment process for vendors seeking to operate within Alaska’s system by strengthening vendor understanding of the state’s infrastructure, encouraging realistic implementation planning, and promoting approaches suited to rural/frontier environments. Tis effort also supports alignment with broader behavioral health data and measurement initiatives.	ABHA proposes to develop a structured vendor readiness initiative designed to improve alignment between technology vendors and Alaska’s behavioral health system environment. The initiative will begin with development of a comprehensive orientation framework describing Alaska’s behavioral health infrastructure. This will include guidance on the diversity of provider organizations, tribal health governance structures, rural service delivery conditions, and the wide range of electronic health record systems currently used across the state. Materials will also address interoperability challenges, integration cost considerations, and broadband limitations commonly encountered in rural and frontier communities. These materials will form the basis of a structured orientation program for vendors interested in serving Alaska’s behavioral health providers. Orientation sessions will focus on helping vendors understand the operational realities of Alaska’s system so that technology solutions can be designed and implemented more effectively. The initiative seeks to include periodic vendor convenings in both rural and urban areas designed to provide education about Alaska’s behavioral health environment and encourage dialogue between vendors and system stakeholders regarding implementation challenges. The purpose of these sessions will be system alignment and shared understanding rather than vendor promotion or endorsement, although connections may be made during the convenings. ABHA will serve as a neutral convener focused on improving system readiness for technology innovation. The initiative will not recommend specific vendors or products but will instead focus on improving the broader technology ecosystem serving Alaska’s behavioral health providers.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Behavioral Health Association	Behavioral Health Interoperability Design & Feasibility Initiative	AK	ABHA proposes a focused planning initiative to identify and contract with a qualified interoperability vendor to scope, design, and assess feasibility of a regional and statewide behavioral health data aggregation framework. During the project period, ABHA will conduct a competitive vendor solicitation process seeking firms with demonstrated expertise in multi-EHR interoperability and secure health data aggregation. The selected vendor will conduct technical analysis to determine the requirements for securely transmitting de-identified, standardized behavioral health indicators from diverse EHR systems into a unified aggregation structure. The vendor’s scope will include identification of necessary common data elements, technical transmission specifications, data normalization requirements, security protocols, estimated implementation costs, scalability considerations, and anticipated interoperability constraints across representative EHR environments. The final deliverable of this module will be a formal proposed design and implementation plan, including phased deployment options, cost modeling, risk assessment, and technical architecture specifications. No aggregation platform will be built or deployed during this phase. Advancement to implementation would occur only if feasibility findings demonstrate technical viability and fiscal prudence.	ABHA proposes a focused planning initiative to identify and contract with a qualified interoperability vendor to scope, design, and assess feasibility of a regional and statewide behavioral health data aggregation framework. During the project period, ABHA will conduct a competitive vendor solicitation process seeking firms with demonstrated expertise in multi-EHR interoperability and secure health data aggregation. The selected vendor will conduct technical analysis to determine the requirements for securely transmitting de-identified, standardized behavioral health indicators from diverse EHR systems into a unified aggregation structure. The vendor’s scope will include identification of necessary common data elements, technical transmission specifications, data normalization requirements, security protocols, estimated implementation costs, scalability considerations, and anticipated interoperability constraints across representative EHR environments. The final deliverable of this module will be a formal proposed design and implementation plan, including phased deployment options, cost modeling, risk assessment, and technical architecture specifications. No aggregation platform will be built or deployed during this phase. Advancement to implementation would occur only if feasibility findings demonstrate technical viability and fiscal prudence.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Behavioral Health Association	Behavioral Health Professional Quality of Life & Resilience Network	AK	Behavioral health professionals in Alaska frequently work in high-intensity environments characterized by crisis response, complex trauma exposure, workforce shortages, and geographic isolation. In rural and frontier communities, clinicians often manage large caseloads and community-level crises while operating with limited peer consultation and organizational support structures. Research on trauma-exposed professions demonstrates prolonged exposure to client trauma can contribute to secondary traumatic stress, burnout, and compassion fatigue. Clinicians may also experience vicarious resilience and compassion satisfaction when witnessing client recovery and strength. Supporting professional quality of life requires intentional attention to both the risks and protective factors inherent in behavioral health work. Despite these realities, Alaska currently lacks coordinated structure to support professional quality of life across behavioral health organizations and regions. Workforce turnover and burnout are frequently discussed challenges, yet few durable resources exist to help clinicians and supervisors understand and navigate the emotional impact of this work. This initiative establishes a statewide Behavioral Health Professional Quality of Life & Resilience Network designed to strengthen workforce sustainability by developing durable educational resources, facilitating peer connection, and normalizing discussion of the emotional realities of behavioral health practice.	ABHA proposes to develop a statewide network focused on strengthening professional sustainability for behavioral health clinicians and supervisors working in trauma-exposed environments. The initiative will begin with development of a durable educational resource suite addressing core professional quality-of-life topics relevant to behavioral health practice. Materials will address burnout, secondary traumatic stress, compassion fatigue, compassion satisfaction, and vicarious resilience. These resources will emphasize the realities of behavioral health work while providing practical frameworks for maintaining professional sustainability. In addition to educational materials, the initiative will facilitate periodic statewide virtual convenings that allow behavioral health professionals to engage in reflective dialogue about the impact of their work. These sessions will emphasize peer connection, shared learning, and normalization of the emotional challenges inherent in behavioral health practice, particularly in rural and frontier settings. The network will also explore strategies for supervisors and organizational leaders to incorporate professional quality-of-life concepts into team environments and supervisory conversations. While distinct from formal supervisory training initiatives, this effort will complement broader workforce development efforts by reinforcing professional sustainability and reflective practice. This initiative complements supervisory training and workforce development initiatives by addressing the emotional sustainability of behavioral health practice across Alaska. It will create durable resources and peer structures that can support the behavioral health workforce over time.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Behavioral Health Association	Behavioral Health Regional & Statewide Transformation Planning Initiative	AK	Alaska’s behavioral health system operates across highly diverse regional environments. Workforce capacity, supervisory infrastructure, service access, and integration readiness vary significantly between tribal health systems, frontier communities, and road-system providers. While statewide transformation initiatives provide structural direction, durable progress requires coordinated regional planning grounded in local realities. Across Alaska, multiple regional coalitions, alliances, and cross-sector partnerships already exist. However, there is no structured, multi-year planning process that integrates these regional conditions into a cohesive statewide behavioral health transformation framework aligned with RHTP initiative areas. Without disciplined regional planning aligned with statewide objectives, implementation efforts risk fragmentation, uneven pacing, and duplication. This module establishes a structured three-year regional and statewide behavioral health transformation planning process designed to build upon existing convenings, ensure inclusive representation, clarify priorities, and strengthen alignment across diverse regions and governance contexts.	ABHA proposes to facilitate a structured regional and statewide planning initiative culminating in a defined three-year transformation framework. The process will begin with identification and assessment of existing regional behavioral health coalitions, tribal health alliances, workforce groups, and cross-sector partnerships. This landscape review will determine where effective convening structures already exist and where representation gaps might require supplemental engagement. Rather than creating parallel planning bodies, this initiative will align with and leverage existing forums wherever feasible. Regional ABHA members will be invited to identify additional providers, tribal behavioral health leaders, and relevant stakeholders essential to accurately reflecting local conditions. This engagement model allows regional leadership to shape participation while ensuring inclusion of tribal and frontier perspectives. Regional planning sessions will examine workforce stability, supervisory capacity, clinical measurement readiness, operational infrastructure conditions, and long-term sustainability considerations. Discussions will focus on strategic prioritization and sequencing rather than organization-level technical assistance, policy drafting, or implementation activities. The Alaska Department of Health and relevant state representatives will be invited to participate in regional and statewide sessions to promote transparency and alignment between provider realities and statewide policy priorities. Participation will support shared understanding while preserving the provider-informed structure of the planning process. Regional input will be synthesized into a statewide three-year behavioral health transformation framework that identifies shared priorities, highlights regional variation, and outlines practical sequencing considerations. Periodic progress reviews will allow priorities to be revisited and refined over time without redeveloping the overall framework. Insights from regional planning sessions will also help guide the pacing and prioritization of related initiatives, including workforce development, clinical measurement infrastructure, and operational alignment efforts.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Behavioral Health Association	Behavioral Health Statewide Transformation Communication & Alignment Initiative	AK	Alaska’s behavioral health transformation efforts led by ABHA span multiple domains, including Routine Outcome Monitoring and Measurement-Informed Care (MIC) implementation, development of a statewide Supervisor Academy, operational alignment supports for providers, and exploration of data infrastructure. As these initiatives expand across rural and frontier regions, there is increasing need for consistent statewide language, sequencing clarity, and shared understanding of how the components of this transformation framework fit together. Leadership turnover, workforce instability, and shifting policy environments can unintentionally fragment interpretation of complex system initiatives. Without clear communication about the purpose, scope, and relationship of ABHA’s initiatives, providers and stakeholders may interpret them differently across regions, slowing progress and creating avoidable variability. This module addresses that statewide alignment gap by developing a structured communications approach for ABHA’s behavioral health transformation initiatives. The goal is to clarify how the Measurement-Informed Care pilots, Supervisor Academy, operational infrastructure supports, and related initiatives function together as part of a coordinated transformation strategy. This initiative focuses on statewide communication architecture and shared understanding of ABHA’s transformation initiatives rather than organization-level operational consultation.	ABHA proposes development of a Statewide Transformation Architecture & Alignment Framework that documents the structure, sequencing, and interdependencies of ongoing behavioral health initiatives. This effort will produce durable statewide resources that clearly describe initiative purpose, explain scope boundaries between modules, standardize terminology, and articulate sequencing logic. Materials will illustrate how clinical measurement infrastructure, supervisory development, operational quality supports, and long-term data planning function as coordinated components of a broader rural health transformation strategy. In addition to structured documentation, ABHA will facilitate periodic statewide alignment forums and architectural briefings designed to reinforce shared understanding across regions. These convenings will focus on clarifying initiative design, pacing expectations, and system-level interdependencies. They will not provide operational consultation or internal policy drafting, which remain within other modules, but will ensure consistent interpretation of transformation goals. Resources developed through this initiative will be adaptable for leadership onboarding, board briefings, statewide communications, and transition periods. Emphasis will be placed on clarity, neutrality, and preservation of initiative intent across administrative changes. This module functions as a statewide coordination layer, reinforcing coherence across complementary initiatives while remaining distinct from organization-level operational activities.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

ALASKA BRAIN INJURY CONSORTI UM	Transforming Care Networks for Traumatic Brain Injury in Rural Alaska	AK	Although Alaska has one of the highest rates of traumatic brain injury (TBI) in the nation, the state lacks a coordinated system for identifying individuals with TBI and connecting them to support. Many Alaskans with TBI must recognize their condition, locate services, travel long distances to reach care, and navigate complex payment systems with a brain that may be struggling with cognitive and sensory challenges. Services are often difficult to access and not consistently covered by Medicaid, IHS, or private insurance, leaving many individuals disengaged from care or unaware support exists. These barriers are especially severe in rural communities where most TBIs occur. Geographic isolation, limited specialty resources, and social stigma often leave individuals with TBI disconnected from family, employment, and community life. Cognitive and sensory changes after injury can make communication and social interaction difficult, contributing to isolation and economic instability. As a result, TBI survivors are disproportionately represented among people experiencing homelessness, incarceration, substance use treatment, domestic violence shelters, and suicide. Yet these systems rarely identify TBI or connect individuals to appropriate support. This project addresses the opportunity to create an accessible pathway for identifying rural Alaskans with TBI and connecting them to resources, navigation, and community-based supports before challenges escalate into long-term crises.	Our approach builds on extensive experience working with rural Alaska communities to create a widely distributed, community-designed safety net for Alaskans living with TBI. The model uses a hub-and-spoke structure that centralizes expertise, training, and administrative support while enabling locally adapted programs to operate across rural and frontier communities. This approach avoids the need for new facilities or a large specialized workforce while ensuring programs remain culturally relevant and responsive to community needs. The hub provides ongoing training, coordination, and shared resources that allow communities to launch and sustain local programs without duplicating effort. The first initiative, Alaska Brain Circles, is ready to launch on the Kenai Peninsula in late 2026. Brain Circles are locally organized peer networks designed to support TBI survivors, caregivers, and communities. Circles may meet in person or virtually on a monthly or bi-monthly basis and can be organized geographically, thematically, or by audience. The hub will provide training, materials, and administrative support so communities can operate their own circles while maintaining access to centralized expertise and resources. The second initiative, Alaska Brain Camps, is planned as a demonstration project in the Mat-Su region beginning in spring 2027. Brain Camps are annual, five-day residential programs designed to bring together TBI survivors, caregivers, advocates, and community members in supportive rural settings. Camps will foster social connection, increase understanding of brain injury, and provide a venue for education, implementation of novel supports, skill building, and community engagement. Camps will also amplify rural perspectives and provide a focus for recovery, research and innovation. The first camp will serve as a demonstration model that can expand over time to additional regions across Alaska. Together, Brain Circles and Brain Camps address the social isolation, stigma, and lack of coordinated resources experienced by many rural Alaskans with TBI. The hub-and-spoke structure allows communities to shape programs that reflect their local cultures and priorities while benefiting from shared expertise and infrastructure. Over time, communities will assume leadership and operational roles, allowing the model to remain sustainable while continuing to expand access to knowledge, peer support, and coordinated resources for rural Alaskans living with TBI.	\$50,000- \$250,000	Multi- Community or Participating in Regional Hub-and- Spoke	Fairbanks North Star Borough; Kenai Peninsula Borough; Kodiak Island Borough; Matanuska- Susitna Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Alaska Center for Children and Adults	Community Pathways for Early Development Project	AK	Young children in our state who are at risk for developmental delays or environmental stressors often do not receive timely, coordinated support that can set the foundation for long term health and family stability. Families frequently face barriers such as limited access to early intervention resources, inconsistent referral pathways, and a lack of culturally responsive, relationship based services. ACCA has identified these gaps through previous grant funded pilot projects, which have generated valuable data showing both unmet needs and effective strategies for early engagement. Previous projects were not focused on sustainability and discontinued without further support for integration. Utilizing this data, this project presents an opportunity to scale these promising approaches and strengthen our state’s capacity to provide early, preventive services. By building on ACCA’s proven ability to launch responsive programs in collaboration with community outreach, this initiative will expand targeted support for young children and their caregivers while promoting healthy starts, reducing future risk, and supporting resilient, thriving families in a thoughtful and sustainable manner.	ACCA’s approach builds on proven strategies, pilot data, and regional experience to reduce barriers and expand access to early intervention, health services, and family support across our vast service area with limited resources. The project integrates organizational improvements with community focused service delivery ensuring families receive timely, coordinated support regardless of geography. A core component of the approach is the creation of a single referral office to streamline access to all ACCA services. This centralized process will ensure every child is referred to appropriate services quickly and efficiently and reduces wait times while areas of need are met sooner. This coordinated “no wrong door” approach ensures each child is assessed, matched to the appropriate level of care, and connected to every program they are eligible for without multiple referral pathways or delays both internally and for external services. The approach also includes implementation of a tiered service model that tailors support to each family’s level of need while building staff capacity for serving families through workforce development plans and educational opportunities. To overcome geographic challenges, ACCA will expand the use of virtual developmental screenings, telehealth supported family coaching, and targeted in person outreach during travel to rural areas. These methods extend reach into remote communities, reduce delays caused by weather or staffing limitations, and allow families to receive consistent support in their home environments. Enhanced data sharing, tracking, and coordination with partner agencies will improve early identification of developmental and health concerns. Staff will monitor referrals, maintain timely follow up, and ensure continuity of care to support families where they are. Data collected through this project will inform service adjustments and contribute to long term planning for region specific improvements and potential eligibility reform while developing processes and structure to bill for services provided. Together, these strategies create an integrated, responsive system that increases access, improves quality, and strengthens sustainability of early childhood services for rural Alaska families.	\$250K-\$1M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Center for Children and Adults	Health Systems Integration and Modernization Project	AK	Rural communities and our hub and spoke community face persistent barriers to accessing consistent, high quality services. Relying on disconnected systems, paper forms, and mixed electronic and manual processes reduce care, are prone to errors, and make coordination across systems and the organization challenging for staff, clients, and others we coordinate care with. With limited ongoing funding available, this is an opportunity to modernize our systems to support care while reducing the administrative burden for care. This project addresses the opportunity to unify these fragmented systems into a single digital infrastructure. By implementing a universal EMR, electronic forms, integrated telehealth tools, an integrated accounting system, agency-specific applications, and secure digital access, we can streamline workflows, reduce travel burdens, improve accuracy of patient information, and increase continuity of care. This modernization would enable providers to work more efficiently across locations, support flexible and mobile care delivery, and strengthen the resilience of health services in the smallest and most isolated communities.	ACCA’s project manager will be responsible for working with technology vendors and our IT vendor to source a comprehensive EMR strategy along with billing and accounting systems that will integrate into one unified platform. The project will begin with a detailed assessment of current workflows, data gaps, and user needs across programs. This will ensure that selected technologies support rural and hub and spoke service models, including mobile care, intermittent connectivity, and multi disciplinary teams. Next, ACCA will convene clinical, administrative, and IT staff to participate in system demonstrations, vendor evaluations, and security reviews. Input from providers and administrative staff will guide the configuration of electronic forms, and telehealth tools to ensure they are intuitive, culturally appropriate, and practical for remote environments. The mobile app will require multiple stakeholders to beta test the system and confirm it is friendly for both caregiver and staff use. Once a unified system is selected, the project team will develop a phased implementation plan that includes data migration, staff training, and testing in low risk pilot locations. Lessons learned from early rollout will shape improvements before expanding to all programs and communities. Telehealth integration will be prioritized to enable immediate access to specialty care, and the agency app will be developed in parallel to support appointment management, secure messaging, and client/caregiver engagement. Simultaneously, ACCA will modernize secure building access by implementing digital credentials that integrate with staff identity management systems. This will access , support after regular business hours and telehealth hubs, and enhance facility safety. Throughout the project, ACCA will track performance measures such as visit efficiency, reduced paperwork, decreased travel burden, and improved care coordination. Continuous feedback loops will ensure the system evolves to meet the needs of rural communities and remain sustainable long term.	\$250K-\$1M	Home- and communit y-based services provider	Multi- Community or Participating in Regional Hub-and- Spoke	Bethel Census Area; Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Center for Children and Adults	Strengthening Workforce and Continuity of Care for Rural Alaska Families	AK	Alaska’s rural communities face persistent barriers to timely, high quality care due to distance, weather, workforce shortages, and limited infrastructure. ACCA’s salaries are 20–30% below market, fueling turnover and vacancies that lengthen wait times, fragment care, and erode quality. Recruitment is costly and slow; early tenure attrition compounds the problem. Yet our internal data reveals a solvable leverage point: staff who remain beyond year 3 typically continue for a decade or more, leaving mainly for retirement or out of state moves. The opportunity is to align compensation, incentives, and infrastructure to cross that 3 year threshold and convert hires into long term, rural committed professionals. Recruitment and retention compensation allows for salary catch up without compounding salary costs from year to year. Retention compensation is only paid as a set amount and will not impact on salaries. Purpose built workspace is also a gap: without modernized areas to document, coordinate, and conduct telehealth work, clinicians lose time to inefficiencies and limit virtual access that could otherwise bridge cost for distance travel and weather barriers. Professional development and licensure support remain underfunded, limiting career progression and retention. Supporting staff with this annual cost is an area identified in recent surveys as a gap and a recruitment and retention strategy that would benefit ACCA.	1) Recruitment & Retention Incentives (Five Year Commitment): a. Implement tiered recruitment and retention bonuses for positions serving rural/remote regions. b. Structure a 5 year service agreement with pro rated payback for unserved years to reinforce the proven retention threshold. c. Pair incentives with relocation assistance and first year housing and childcare stipends in hardest to staff areas. 2) Purpose Built Care Coordination & Telehealth Space: a. Refit a dedicated workspace featuring: private documentation stations with secure EHR access; team rooms for case reviews and cross provider huddles; sound treated telehealth pods with room to ensure delivery of services is appropriate for the service (demonstration or use of items to support care), HIPAA compliant with appropriate technology. b. Establish shared scheduling and room use analytics to maximize utilization. 3) Professional Development & Licensure Support: a. Fund CE/CME, supervision hours, exam fees, and study time for licensed and pre licensure staff. b. Create clinical and rural practice salary elevators (e.g., telehealth proficiency, care coordination) tied to modest step increases. c. Launch annual skills intensives focused on rural priorities (well child checks, behavioral health integration, emergency stabilization, cultural competence, and telehealth best practices). 4) Implementation & Continuous Improvement: a. Governance: designate a Workforce Stabilization Lead and cross functional steering group (HR, clinical coordinator, IT, performance and quality). b. Timeline: ramp hiring/incentives ongoing as appropriate through September 30, 2027; space build out is complete and final order can be completed by month 3 with space completed by month 6; fully operational by month 6; evaluate all areas quarterly. c. Data: track vacancies, time to fill, 1–3–5+ year retention, visit volume/mix (in person vs. telehealth), wait times, no shows, care coordination metrics, quality indicators, staff satisfaction, and cost per encounter. d. Equity & Cultural Safety: engage local partners and community advisors to tailor workflows and ensure culturally responsive care.	\$250K-\$1M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Center for Pain Relief Inc.	Alaska Rural Women’s Health Clinical Center of Excellence and Provider Support Network	AK	Access to specialty women’s health care is limited in many rural communities across Alaska. Many communities lack local obstetrics and gynecology providers, leaving primary care clinicians and Community Health Aides responsible for managing complex hormonal and reproductive health conditions without access to specialist consultation or training. Perimenopause and menopause-related conditions are frequently underdiagnosed or undertreated in rural settings. Untreated symptoms can contribute to sleep disruption, mental health challenges, increased cardiovascular risk, bone loss, and reduced quality of life for women in midlife. At the same time, rural healthcare providers often report limited opportunities for continuing education in menopause management, hormone therapy, and evidence-based evaluation of abnormal bleeding and metabolic risk in women. This project addresses these gaps by establishing the Alaska Rural Women’s Health Clinical Center of Excellence, a statewide consultation and training network designed to support rural providers through specialist consultation, clinical education, and standardized care pathways. By expanding provider capacity and improving access to specialist expertise, the initiative will improve women’s health care access for rural communities across Alaska.	The Alaska Rural Women’s Health Clinical Center of Excellence will function as a statewide hub supporting rural healthcare providers through consultation services, workforce training, clinical decision tools, and a statewide learning network focused on improving women’s health outcomes. The project will be led by Dr. Jillian Woodruff, MD, a board-certified gynecologic surgeon with expertise in hormone therapy and midlife women’s health, who will serve as clinical lead for the consultation network and provider training program. The initiative will include five integrated components. Rural Women’s Health Consultation Network Rural providers will have access to a specialist consultation network allowing them to review patient cases and receive clinical guidance. Providers may submit asynchronous consultations or schedule telehealth case discussions to develop treatment plans for complex hormonal and reproductive health conditions. Rural Provider Training Program A structured education program will provide training for Community Health Aides, nurse practitioners, physician assistants, and primary care clinicians managing women’s health conditions in rural settings. Training will focus on menopause care, hormone therapy management, abnormal uterine bleeding evaluation, metabolic risk, contraception management, and preventive health in midlife women. Case-Based Learning Network Regular case conferences will allow rural clinicians to present patient cases and discuss management strategies with specialists and peers, supporting collaborative learning and clinical mentorship. Clinical Care Pathways and Protocol Toolkit The Center of Excellence will develop standardized clinical protocols and decision-support tools designed to help rural providers manage common women’s health conditions locally. These tools will include screening tools, diagnostic pathways, hormone therapy algorithms, laboratory evaluation guides, and referral criteria. Statewide Outcomes and Learning Network Participating providers will contribute to a statewide learning network focused on improving women’s health care delivery in rural communities. The network will track implementation of clinical protocols, identify care gaps, and support continuous improvement through shared learning and collaboration among providers. This integrated model allows rural clinicians to manage more women’s health conditions locally while maintaining access to specialist expertise when needed.	\$1M-\$5M	Clinic	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Center for Pain Relief Inc.	Alaska Specialty Access & Procedural Skills (ASAP) Rural Workforce Development Program	AK	Rural healthcare providers across Alaska face critical workforce shortages that limit access to care and contribute to delays in specialty referrals. Many rural clinics lack sufficient trained clinical staff to manage patient intake, coordinate medical records, and prepare patients for specialty consultations. As a result, patients often travel long distances to regional centers only to discover that additional testing, imaging, or documentation is required before care can proceed. At the same time, many Alaska residents are interested in healthcare careers but face financial and geographic barriers to training programs. The Accelerated Skills Advancement Program (ASAP) addresses these challenges by creating a hybrid training pipeline that prepares Alaska residents for nationally recognized medical assistant certification while developing specialized skills in patient intake, care coordination, and specialty referral preparation. By strengthening the rural healthcare workforce and improving the coordination of specialty referrals, the program expands access to care while reducing delays and unnecessary travel for patients in rural and frontier communities.	The Accelerated Skills Advancement Program (ASAP) will establish a hybrid workforce training model designed to strengthen clinical support capacity in rural healthcare systems across Alaska. Participants will complete a structured three-phase training pathway. First, students complete virtual coursework covering medical terminology, anatomy and physiology, clinical documentation, infection control, patient intake procedures, and electronic medical record workflows. Second, students participate in regional clinical skills labs where they develop hands-on competencies including vital signs assessment, phlebotomy, EKG acquisition, injection techniques, and clinical workflow procedures. Third, students complete supervised clinical apprenticeships within rural healthcare organizations, tribal health systems, and community clinics. These apprenticeships provide real-world experience while strengthening the clinical teams serving rural communities. Graduates will be eligible to sit for nationally recognized certification exams such as the National Certified Medical Assistant (NCMA) or Certified Clinical Medical Assistant (CCMA). Once placed within rural clinics, these trained workers support intake visits, medication reconciliation, chart preparation, and coordination of specialty referrals. By ensuring that patient histories, diagnostic information, and outside records are complete prior to referral visits, the program improves the efficiency of specialty consultations and reduces unnecessary travel. The program will begin with pilot cohorts and expand as additional rural partners participate.	\$250K-\$1M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Hoonah-Angoon Census Area; Nome Census Area; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Center for Pain Relief Inc.	Rural Pain Access & Procedural Capacity Initiative for Alaska Communities	AK	Rural Alaskans experiencing spine-related, musculoskeletal, and neuropathic pain often face delays in specialty evaluation and treatment. In many communities, primary care clinics and emergency departments must manage complex pain conditions without access to pain specialists. This can lead to fragmented care, prolonged suffering, unnecessary opioid exposure, and costly patient travel or medical transport to regional referral centers. At the same time, some rural facilities possess imaging infrastructure and procedure space that could support basic interventional pain procedures but lack structured training pathways and specialty consultation support. This project addresses that gap by creating a model that expands access to specialty pain care while strengthening the capacity of rural providers and health systems. By combining telehealth consultation with workforce training and standardized clinical protocols, rural providers can receive specialist guidance earlier in the care process and manage more patients locally when appropriate. Earlier specialty triage and improved coordination of care have the potential to reduce unnecessary travel, repeat emergency visits, and high-cost medical transport while improving patient outcomes. This opportunity aligns with Alaska’s broader goals of strengthening rural health care access, workforce capability, and system sustainability across geographically dispersed communities.	This project will establish a rural specialty access model built around telehealth consultation, workforce training, and coordinated care pathways between an Anchorage-based specialty hub and participating rural communities. The first component will create a structured telehealth consultation pathway to support rural clinics, hospitals, and providers. Rural providers will be able to obtain specialty input through telehealth visits or asynchronous chart review. These consultations will help guide appropriate imaging decisions, conservative treatment strategies, and identification of patients who may benefit from interventional procedures or referral. The second component will focus on workforce development. Selected rural providers and facilities that already possess imaging infrastructure, such as fluoroscopy suites, will receive training, technical assistance, and standardized protocols to safely perform appropriate procedures locally. Remote specialty consultation and case review will help support quality and safety while expanding local treatment capacity. The project will begin with a pilot implementation in several rural communities representing different geographic regions of Alaska. During the pilot phase, the project will track measurable outcomes such as specialty consultation turnaround time, number of patients managed locally rather than referred out, provider participation in training, and reductions in repeat patient travel for evaluation and treatment. By integrating telehealth consultation with workforce development and coordinated referral pathways, this model aims to improve access to specialty care, strengthen rural provider capacity, and support the long-term sustainability of rural health systems. The consultation and training framework developed through this initiative may also serve as a model for expanding specialty access for other clinical disciplines across rural Alaska.	\$250K-\$1M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Hoonah-Angoon Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Children's Academy II	Facility Floor repairs, replacement of indoor and outdoor materials	AK	These improvements are essential. Updated materials will significantly enhance our ability to engage with children, providing age-appropriate tools that deepen learning and social interaction. Making these resources widely available will expand community access so more families can benefit from our programs through distributed materials and local partnerships. Additionally, renovating the walls and flooring is urgently needed to improve sanitation and create a healthier, cleaner learning environment that supports students’ well-being and academic success.	Rapid needs assessment to inventory materials, assess classroom conditions, and identify priority age groups and community gaps. Procurement of evidence-based instructional resources (books, manipulatives, kits) matched to identified needs. Facility upgrades: phased replacement/repair of walls and flooring with durable, low-VOC, easy-sanitize materials; address moisture/safety issues. Distribution network: establish resource hubs at the school and partner sites, implement a simple loaning/catalog system, and run periodic outreach pop-ups. Training: short staff and volunteer workshops on using materials and maintaining sanitation protocols. Monitoring & evaluation: track usage, families served, student engagement, attendance, and classroom sanitation metrics with a 6- and 12-month review.	Under \$50,000	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Alaska Children's Museum	Improving Alaska Early Childhood Health Outcomes through Active Play Environments & Education	AK	Alaska children face significant challenges building healthy habits that include active play, contributing to negative impacts on their physical, social, and developmental health. One in three Alaska children are overweight or obese, and in 2017, 77% of parents reported their three-year-olds receive more than one hour of screen time daily, exceeding American Academy of Pediatrics recommendations. The 2024 Early Childhood Alaska Needs Assessment indicates this trend has continued to worsen. Excessive screen use in early childhood is associated with reduced physical activity, language delays, sleep disruption, and challenges in social-emotional development. One barrier to reducing screen time and increasing physical activity is the lack of free and low-cost indoor spaces designed for young children and families to spend extended time together, particularly given Alaska’s climate. At the same time, many Alaska families face barriers to accessing early developmental education, caregiver support, and timely developmental screening services. Early identification of developmental delays and access to therapies such as occupational, physical, speech, and behavioral services are critical to improving long-term outcomes but can be difficult to access in traditional clinical settings or through home visiting programs. Social skills, emotional regulation, fine motor development, and speech services are often most effective when delivered in natural, community-based environments.	This project will create a community-based early childhood development environment housed within the Alaska Children’s Museum that integrates active play exhibits, caregiver education, and partnerships with developmental screening and therapy providers. The museum will serve as a welcoming public space where families can engage in healthy, screen-free activities that promote movement, imagination, and caregiver-child interaction. Funding will support the development of interactive exhibits that encourage physical activity, emotional learning, and cooperative play while providing engaging alternatives to passive screen entertainment. Exhibit design will draw on proven models developed by leading children’s museums, including the social-emotional learning framework used in Emotions at Play with Pixar’s Inside Out, developed by the Children’s Museum of Pittsburgh in collaboration with Pixar Animation Studios. That exhibit demonstrates how interactive experiences such as emotion mirrors, storytelling environments, and cooperative play can help children recognize and regulate emotions while strengthening empathy and communication skills. Additional inspiration comes from the caregiver-focused exhibition AlegreMENTE / Happy Brain: Celebrating Early Connections, which helps adults understand how playful interactions support early brain development and encourages caregivers to actively participate in children’s learning and health. The project will also include a hands-on nutrition learning environment modeled after children’s museum “test kitchen” programs where children and caregivers prepare simple healthy foods together while learning about nutrition and healthy habits. Caregiver workshops will provide practical guidance on early brain development, healthy media habits, nutrition, and strategies that support language, social-emotional skills, and physical activity. The museum will partner with infant learning programs, developmental screening agencies, and pediatric therapists to offer space for screenings and therapy sessions. Occupational, physical, speech, and behavioral therapists will be able to work with families in a natural play-based setting that supports developmental skill building. By combining active play environments, caregiver education, nutrition learning, and access to developmental services, this project will reduce screen reliance, increase physical activity, and strengthen early childhood development for Alaska families.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Alaska Children's Trust	One Alaska: Coordinated Enrollment & Eligibility portal for public programs and state services.	AK	Alaska has a robust array of publicly funded programs spanning health care, food assistance, housing, behavioral health, early childhood services, disability services, and more, yet these programs are administered across public and tribal health care systems and dozens of separate agencies, each with their own website, eligibility criteria, and application process. The consequences of this fragmentation are well-documented and severe. Chronic understaffing, outdated systems, and disconnected processes have created persistent backlogs in Medicaid and SNAP, leaving thousands of eligible Alaskans waiting months for benefits they qualify for. Error rates have consistently ranked among the highest in the nation, resulting in federal penalties and court orders requiring the state to meet basic processing timelines. These failures disproportionately harm rural and remote residents, who have the fewest alternative resources while they wait. The problem is not a lack of programs. It is a system too fragmented and difficult to navigate to reliably connect eligible Alaskans with the help they need. A CCE system/portal would directly reduce the administrative burden driving these failures, improving accuracy, cutting processing times, and making it easier for families, navigators, community partners and agency staff to manage applications from submission through renewal.	The project will develop a centralized Coordinated Enrollment & Eligibility (CEE) system publicly accessible online, modeled on initiatives like First Five SC, First Five Alameda and other state systems, but expanded in scope to serve Alaskans of all ages across all major state and federal program categories. The portal will be built in three phases over approximately 24 months. Phase 1 — Discovery and Design (Year 1-2): A cross-agency steering committee will be convened including representatives from DOH, DFCS, and DEED, tribal health organizations, and community navigator networks (Help Me Grow Alaska, 2-1-1, Aging & Disability Resource Centers) and community providers. This group will conduct a comprehensive gaps analysis to catalog all publicly funded programs eligible for inclusion, map eligibility criteria and data requirements, and identify existing digital infrastructure that can be integrated. Lived experience advisors, including rural residents, Alaska Native community members, and service providers, will inform user experience design priorities. Wireframes and technical specifications will be developed and reviewed. A contractor with CEE systems experience/knowledge will be hired to provide support and guide the work of the steering committee. Phase 2 — Development and Pilot (Year 2-3): A vendor will be selected through a competitive procurement process to build the portal to specification. Core features will include but not limited to: a plain-language eligibility screener; a unified program database searchable by category, age, geography, and need; a common application that pre-populates across programs; and a navigator-facing interface that simplifies referrals. In addition, the system will allow individuals to access local resource systems like Help Me Grow AK or AK 211. A pilot will be conducted in 3–5 communities representing urban, rural, and remote contexts, with structured feedback loops to refine the tool. Phase 3 — Launch and Transition (Year 3-4): Following pilot refinement, the portal will launch statewide. An outreach campaign will target both families and front-line service providers. Training materials and technical assistance will be provided to tribal navigators, community health aides, school counselors, and others who serve as trusted intermediaries. The portal will be transitioned to ongoing state agency management with a sustainability plan in place.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Children's Urgent Care and Outreach, LLC	Alaska Pediatric Integrated Access & Telehealth Network	AK	Children in rural, remote, and frontier regions of Alaska face significant barriers to timely, high-quality pediatric care due to geographic isolation, limited pediatric workforce availability, and fragmented specialty access. Many communities rely on Community Health Aides/Practitioners and small clinics without immediate pediatric consultation, resulting in delayed diagnoses, variable treatment approaches, and high rates of costly and disruptive medevac transfers. Families of medically complex children often must travel multiple times to Anchorage for separate subspecialty visits, creating substantial financial and social burden and increasing Medicaid travel expenditures. At the same time, rural providers lack standardized pediatric clinical pathways and real-time access to pediatric emergency and subspecialty expertise to support urgent care decisions. Parents and caregivers also face challenges navigating healthcare access, insurance, developmental services, and social supports across Alaska’s complex and regionally variable systems. These gaps create preventable disparities in pediatric outcomes, inefficiencies in healthcare delivery, and unsustainable costs. Alaska has an opportunity to transform pediatric care by creating a coordinated statewide network that connects rural providers and families to pediatric expertise, standardizes care pathways, and supports safe local management whenever possible.	To address gaps in pediatric access, quality, and coordination across rural and remote Alaska, the Alaska Pediatric Integrated Access & Telehealth Network (APIA-TN) will implement a statewide integrated model combining digital clinical infrastructure, centralized subspecialty coordination, and 24/7 pediatric telehealth triage. Statewide Pediatric Digital Access Platform APIA-TN will develop a secure web-based platform with two components: a provider portal and a public portal. The provider portal will include pediatric subspecialty directories, referral pathways, and evidence-based clinical algorithms for high-risk conditions such as trauma, traumatic brain injury, sepsis, respiratory distress, and behavioral health crises. The public portal will provide Alaska-specific information on accessing care, Medicaid and insurance navigation, developmental and behavioral resources, and social supports including food, housing, and emergency services. This platform will standardize pediatric care guidance and improve navigation for rural providers and families. Pediatric Subspecialty Hub with Outreach APIA-TN will establish coordinated pediatric subspecialty services in Anchorage to streamline scheduling and reduce fragmented visits for children traveling from rural regions. Centralized coordination and nurse case management will consolidate appointments and support medically complex children. The hub will deploy traveling subspecialty teams and tele-subspecialty clinics to high-need rural communities, expanding specialty access closer to home. Statewide 24/7 Pediatric Telehealth Triage Network A continuous telehealth network will connect rural clinicians, Community Health Aides/Practitioners with pediatric providers (“quarterbacks”) and on-call subspecialists. This system will support urgent decision-making, stabilization guidance, and appropriate transfer coordination, enabling safe local care when feasible and faster escalation when necessary. APIA-TN will partner with Tribal health organizations, rural hospitals, and community leaders to ensure culturally responsive implementation. In-person training in priority remote regions will build telehealth competency and pediatric emergency readiness. Continuous evaluation will track transfer rates, access, and cost impacts. Together, these components create a coordinated statewide pediatric care network that improves access, standardizes quality, and supports sustainable rural care delivery.	\$1M-\$5M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Christian College	Professional Counseling Services for Indigenous Rural College Students	AK	The mental health needs of college-age students are widespread, and their care is critical for their educational success. Students ages 18-25 suffer from many addictions, including alcohol, cannabis, and some recreational drugs. In addition, the vast majority of rural indigenous students have been abused in a variety of ways, especially the women. It is estimated that 80% of all these matriculating students have been abused in a variety of ways, including sexual, physical, and emotional. Until they come to college, they are not usually able to address the problems that have plagued many of them since early childhood. Suicide rates are extremely high with this population, and immediate care for these students is critical for their safety. Many students to date have been served by NHCC counselors to "talk them off the cliff" before they harmed themselves. Finally, these students struggle with depression and a lack of engagement. Since COVID-19, the number of students struggling with depression has been significant. Enabling better access will support the individual mental health needs of each student, regardless of their specific crisis or emotional care.	The proposed approach includes identifying, evaluating, and serving students who would benefit from professional counseling services. NHCC is the partner organization closest to the location of the students that can best accommodate the mental health needs of the college students. It is the request of the college to seek a grant, over the life of the grant, to be expended for the cost of professional services for each student who seeks care. The counseling center will charge the college the average cost of services that the grant will allow. This is a fee-for-service opportunity for each indigenous (and others) student to have no cost to them or the college. A fee will be established between the college and the counseling center for all services and interventions on a contractual basis. Students will have access to talk therapy, neurofeedback, and other interventions to meet their mental health needs.	Under \$50,000	Statewide	Kenai Peninsula Borough	Advance to Implementation Application
Alaska Church of the Nazarene - Camp Maranatha	ADA shower/toilet house	AK	Construct facility with showers and toilets for ADA guests on the property. We need an elevator to get into meeting room above the shower toilet area. Zero entrance on ground level for wheelchair	Construction project that would address all the ADA needs for the camp. This would allow inclusion for guests that are in need of ADA accommodations.	\$1M-\$5M	Statewide	Matanuska-Susitna Borough	Deferred or Not Advanced

Alaska Clubhouses, Inc.	Establish a Certified Clubhouse Model program in Anchorage, Alaska	AK	Alaska has one of the highest rates of mental health issues in the U.S., with many individuals experiencing conditions like depression, anxiety, and severe mental illnesses such as PTSD, Bipolar disorder, and schizophrenia. Mental health programs often face inadequate funding, leading to reduced services, limited staffing, and longer waitlists. The lack of mental health services and recovery programs in Alaska is a critical issue that affects not only individuals but also the broader community. Addressing these gaps is essential for promoting recovery, reducing homelessness, and improving quality of life. Many individuals with mental illness also struggle with substance use disorders, yet integrated treatment programs that address both issues are scarce. This gap can lead to worsening mental health and increased risk of homelessness or incarceration. But addressing the needs of individuals with severe mental illness in Anchorage requires a comprehensive approach that includes expanding services, improving access to care, and fostering collaboration among providers. Choices among community-based services are essential to complement clinical services and to provide opportunities for people to truly recover, work, be housed, and thrive.	Despite the demonstrated effectiveness of Psychiatric Rehabilitation models such as certified Clubhouse Model programs across the world, Anchorage currently lacks such a resource. By adhering to international clubhouse standards, we aim to implement a program that has well-documented outcomes, empowering individuals to reclaim their lives and actively participate in their communities. This initiative aims to serve the largest population in the state experiencing mental illness. The Clubhouse Model is a proven approach that fosters recovery, employment, socialization, and community integration for individuals facing mental health challenges. The RHTP opportunity can help to launch our efforts to begin to fill this gap, a program that so many Alaskans deserve. By providing a safe and welcoming space where participants can belong, recover, receive assistance with basic needs, housing, employment, and community support, we can anticipate the positive outcomes seen by clubhouse model programs throughout the country that are adhering to the standards and are fully funded. Specifically, clubhouses are effective because they provide the essentials for recovery: Support: Members engage with peers who understand their experiences, fostering connection and reducing isolation. Empowerment: Individuals are encouraged to take an active role in their recovery, promoting self-esteem and agency. Structure: Members participate in daily activities that provide structure and purpose, helping to develop skills and routine. The model emphasizes individual strengths and abilities rather than limitations, fostering a positive self-image. Integrated Services: Clubhouses often provide access to a range of services, including vocational training, social activities, and mental health support in one location. Collaboration with Professionals: Mental health professionals work alongside members, ensuring that support is tailored to individual needs. Vocational Opportunities: Clubhouses offer job training and placement services, helping members gain employment and achieve economic independence. Skill Development: Members can develop work-related skills in a supportive environment, enhancing their employability. Social and Recreational Activities: Clubhouses provide opportunities for social interaction, reducing feelings of loneliness and fostering relationships. Members participate in recreational activities that promote wellness and enjoyment, contributing to overall quality of life.	\$1M-\$5M	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Alaska Coalition on Housing and Homelessness	Update of the Homeless Management Information System for Data Sharing with the Dept. of Health	AK	The Alaska Coalition on Housing and Homelessness (AKCH2) partners with rural healthcare providers to assist with the development of supportive housing programs targeting individuals experiencing homelessness. Healthcare integration with emergency shelters and housing programs serving people experiencing homelessness is vital in bringing much needed access to high utilizers of emergency medical services and people with complex medical needs. Housing is a social driver of health, and lack of housing often leads to serious health complications. The current AKHMIS is not interoperable with existing Department of Health (DOH) data systems. A data system that can talk to other systems will increase the efficiency of referrals to federally funded housing programs, and leverage federal resources by identifying clients receiving high levels of care in multiple systems that would improve patient health outcomes. There is also potential for AKHMIS to share data with other systems operated by the Division of Public Assistance, Department of Corrections, and Office of Family and Children Services. Reducing data silos will increase efficiency, improve client outcomes and streamline service delivery.	This proposal outlines how funding will support the continued operations of the AKHMIS, identify and implement a new data system capable of integrating with health data systems, enhance data integration and matching capabilities, and expand data entry for federally funded housing programs through the Alaska Coalition on Housing and Homelessness. The proposal includes: 1. Assessment of current AKHMIS operations, identify gaps in data management, and determine integration limitations and requirements with health data systems, 2. Engagement with key stakeholders, including the Department of Health, data system users, and the Institute for Community Alliances, to gather input on system requirements and needs, 3. Establish Request for Proposals process to assess HMIS software options leading to a recommended new vendor, 4. Ensure that the funding objectives align with broader goals of improving healthcare coordination and service delivery for vulnerable populations, and 5. Implementation of a new data management system, training for all users, and overlapping with the old system. The new system will share data with the Department of Health and other agencies with shared clients, and 6. Review and analyze data quality, sharing capabilities, and opportunities for service delivery alignment or preventive care interventions.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Commercial Company (AC Stores)	Building healthier communities through containerized aeroponic mini-farms off the road system	AK	Rural Alaskans face some of the highest rates of diet-related chronic disease in the country. Diabetes, obesity, heart disease, and other conditions are directly tied to poor nutrition and this generates enormous downstream costs for health systems that are already under-resourced. The goal of this project is to reduce the incidence of these medical conditions over the long-term by providing access to healthy, fresh produce in much larger quantities than is currently available. Alaska Commercial Company operates 38 grocery stores in 35 communities off the road system. In most communities where we have stores (as well as the nearby villages), we are the main and sometimes only source of fresh produce. We are also fully aware that the availability of fresh produce is unreliable in some of our stores due to freight and logistics issues, especially in the winter. Once one of our Store Managers is sending berries and leafy greens to the landfill for the sixth week in a row due to freight issues, they often stop ordering those items. The result is that many community members simply go without fresh produce for much of the year. The problem is structural: as long as fresh produce availability depends on long, expensive, weather-sensitive freight methods, communities will remain underserved by healthy food. This project addresses that structural problem by producing fresh produce locally, year-round, eliminating freight dependency for these crops entirely.	Alaska Commercial Company will partner with SkyAcres Agrotechnologies to deploy 15 containerized aeroponic mini-farms adjacent to AC stores in rural Alaska. SkyAcres is an agricultural technology company with experience deploying these systems. Their 'fogponic' technology delivers nutrients to plant roots as an ultra-fine mist rather than circulating water through pumps and pipes. This means no plumbing, no mechanical failure points, and very low energy consumption. These systems are purpose-built to be easy to manage in a remote environment. Each mini-farm will be housed in a reefer container, which provides insulation and weatherproofing suited to the rural Alaska climate. Inside each container, SkyAcres racks will be pre-installed before shipping, so units arrive essentially ready to operate. Each rack produces approximately 500 lbs of fresh produce per year and requires only 20 minutes of weekly maintenance. A single community-based operator will be hired at each location to manage the growing system, harvest produce, and stock it directly into the adjacent AC store. RHTP funding will cover the reefer container, SkyAcres equipment, installation, and the first three months of operator labor, training, and support at each of the 15 locations. AC will provide the physical footprint, existing store infrastructure, cold storage, and the retail distribution channel that puts the produce directly in front of community members at equal or cheaper prices than the current selection of produce. Site selection will prioritize communities where freight disruption is most severe and produce availability is most unreliable. AC's store operations team has direct visibility into which locations are most affected and will lead site selection in consultation with local store managers. Containerized hydroponic systems have been attempted in rural Alaska in the past (e.g. Maniilaq in Kotzebue in 2016-17) but failed due to several issues: staffing/turnover, high cost of electricity, system complexity, and lack of clean water access. Our plan solves all of these issues. AC will provide the staffing through our existing store network, SkyAcres systems are intentionally simple and require much less electricity than hydroponics, and SkyAcres requires 90% less water than hydroponics. Water can be taken directly from the AC store shelf to run the system when there is a disruption in a community's water supply.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Consumer Direct Personal Care, LLC	Caregiver Recruitment and Onboarding Enhancement	AK	Caregiver shortages are particularly acute in rural and frontier communities, where limited training opportunities, long travel distances, lower wages, and high onboarding costs deter potential applicants. Many qualified individuals cannot afford the upfront expenses required to begin work, even though caregiver roles are in high demand. This creates a bottleneck in hiring, leaving vulnerable individuals without adequate in-home support. The opportunity exists to remove these financial barriers and create a more accessible, efficient, and reliable pathway into caregiving roles.	The project will fully fund required onboarding costs for new caregivers, including CPR/First Aid training, background checks, fingerprinting, and other mandated certifications. By centralizing and paying for these costs, we streamline the hiring process and reduce the financial burden on applicants. We will coordinate with training providers to ensure timely class availability and leverage partnerships with community organizations to promote recruitment. Additionally, we will track applicants from initial inquiry through hire to monitor improved hiring timelines, workforce growth, and overall impact.	\$50,000-\$250,000	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Consumer Direct Personal Care, LLC	Caregiver Training Modernization Project: Transition to a Centralized LMS System	AK	Current caregiver training relies heavily on paper quizzes and manual processes that are inefficient, inconsistent, and difficult to manage. These limitations disproportionately affect caregivers in rural areas who may have limited access to in-person training or face logistical challenges when submitting paper materials. Additionally, tracking compliance is labor-intensive and prone to delays or errors. The opportunity is to replace this fragmented system with a centralized, user-friendly digital training platform that improves accessibility, consistency, and accuracy for both caregivers and administrators.	The project proposes implementing a modern LMS (e.g., Workday Learning, Relias, or similar) to deliver all initial and ongoing caregiver education. The approach includes: 1.) Digitizing all onboarding, mandatory, and continuing education courses. 2.) Automating training assignments based on caregiver roles, regulatory requirements, and timelines. 3.) Providing mobile-friendly, on-demand access to coursework. 4.) Offering simple, centralized tracking dashboards for compliance and reporting. 5.) Migrating legacy materials into standardized, high-quality online modules. 6.) Training caregivers and managers on how to use the system effectively. This approach ensures training is accessible, trackable, and easy to complete regardless of location.	\$50,000-\$250,000	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Consumer Direct Personal Care, LLC	CDAK Digital Transformation Initiative: Implementing Electronic Forms and e-Signatures	AK	Alaska’s rural and remote communities face unique barriers to accessing health and caregiver support services. Paper-based forms require printing, mailing, or traveling long distances, often hundreds of miles or more, to complete essential documentation. These delays can slow service enrollment, prevent timely caregiver onboarding, and create significant inequities for individuals living in off-road or hard-to-reach regions. The opportunity lies in replacing these outdated processes with digital tools that allow clients and caregivers to complete forms electronically, improving speed, accessibility, and accuracy statewide.	The project will transition all client and caregiver paperwork to electronic, mobile-friendly forms supported by secure DocuSign e-signatures. This includes redesigning existing documents for digital use, implementing an integrated workflow for routing and tracking submissions, and training staff, caregivers, and clients in the new system. The approach focuses on accessibility: forms will be easy to complete on smartphones, available in multiple formats, and supported by remote assistance when needed. By removing reliance on physical paperwork, the project creates a seamless documentation experience that works from any location, regardless of connectivity challenges or distance from service offices.	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Consumer Direct Personal Care, LLC	CDAK Provider Directory: A Digital Solution for Matching Caregivers and Clients	AK	Rural, remote, and frontier communities face persistent shortages of qualified caregivers, limited transportation options, and long distances between clients and available services. These barriers make it difficult for individuals and families to access consistent, high-quality home and community-based care. At the same time, caregivers in these regions often struggle to find stable, nearby employment because there is no centralized way to connect with clients or showcase their skills. This project addresses the opportunity to close that gap by creating a digital platform that improves visibility, coordination, and matching between caregivers and the people who need their support, strengthening the caregiving workforce and expanding access to care across underserved areas.	CDAK will build a Provider Directory that offers a comprehensive, user-centered platform that better connects caregivers with clients, especially in rural, remote, and frontier communities where the matching process is most challenging. We will explore both in-house build options and off-the-shelf solutions that may best address this approach. Key development priorities include profile creation, search and matching capabilities, robust caregiver and client profile tools, streamlining job posting and application workflows, and integrating secure, accessible communication channels. The enhanced platform will be designed to reduce the administrative burden on families, increase visibility for local caregivers, and create a more reliable pathway for filling open caregiving roles. By strengthening this digital infrastructure, the project will create a more efficient, equitable, and responsive system for connecting people to the care they need within their own communities.	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Eating Disorders Alliance	Strengthening Alaska’s Eating Disorders Continuum of Care	AK	Eating disorders have historically been under-recognized and under-resourced in Alaska, resulting in delayed diagnoses, fragmented care, frequent out-of-state treatment, and preventable medical crises. The lack of eating disorder services across all levels of care in Alaska is especially urgent given that eating disorders have the second-highest mortality rate of all mental health conditions - surpassed only by opioid use disorders - making gaps in access a critical threat to health and survival. While progress has been made in recent years, major gaps persist across the continuum of care - particularly in regions where provider shortages and geographic isolation compound risk. Alaska lacks sufficient trained providers to screen and assess eating disorders, hospitals often feel unprepared to admit medically unstable patients, and families frequently navigate complex systems without guidance. New higher levels of care (Intensive Outpatient and Partial Hospitalization Programs) launched recently, but require specialized training and consultation to operate safely and effectively. Without coordinated investment, these gaps will continue to place Alaskans at heightened risk. This project addresses a critical opportunity: to strategically strengthen the most impactful pressure points in Alaska’s eating disorder care continuum so Alaska communities benefit from education ad earlier intervention, safer treatment, and sustained recovery support.	AKEDA proposes a multi-year, phased approach to strengthen Alaska’s eating disorder continuum of care, with an emphasis on rural access, workforce capacity, and system sustainability. Activities are organized across prevention and early intervention, treatment capacity, and aftercare, with the goal of strengthening each level so the overall system becomes more comprehensive and resilient for Alaska. 1. Prevention and Early Intervention -Expand evidence-based prevention programming statewide, including rural school districts. -Increase provider education to strengthen Alaska's healthcare workforce for improved screening and early identification, diagnosis, and assessments in primary care, behavioral health, and tribal health settings. -Support development of standardized screening and assessment pathways, coordinated patient navigation for highly complex patients, and decrease other barriers to accessing treatment. 2. Treatment Capacity Across Levels of Care -Increase provider consultation with subject matter experts to increase support and capacity within the local workforce. -Expand provider education to increase the number of outpatient providers treating eating disorders. -Strengthen Alaska partner IOP and PHP program patient recovery outcomes through expert consultation, protocol development, staff trainings, and deepening family involvements. -Collaborate with adolescent residential treatment centers (RTCs) to support patients with body dissatisfaction and/or disordered eating and integrate eating disorder care into dual-diagnosis environments. -Increase Alaska hospital readiness and capacity to admit and medically stabilize patients with acute eating disorders by training interdisciplinary teams, refining admission criteria, and supporting coordinated medical stabilization protocols. 3. Aftercare and Family Support -Expand recovery-focused facilitated support groups for individuals and families, including rural-accessible formats. -Develop and disseminate structured family education to support meal supervision, relapse prevention, and transitions from higher levels of care.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

This approach led by our organization - the only group focused on improving eating disorders outcomes in Alaska - supports sustained, coordinated efforts to strengthen a complex system of care. It is work that cannot be meaningfully accomplished within a single year, and allows for progressive improvements and partnerships that build on one another over time.

Alaska Eating Disorders Alliance	Eating Disorders Workforce Development and Interdisciplinary Training Infrastructure Initiative	AK	This project will build a coordinated statewide workforce development strategy focused on eating disorder care. Alaska faces a critical shortage of healthcare professionals trained to identify and treat eating disorders. Without adequate interventions, patients leave Alaska in crisis. And while eating disorders carry the second-highest mortality rate of psychiatric illnesses, Alaska currently lacks coordinated training pathways to develop specialized clinical expertise and to treat Alaskans. Increasingly, healthcare providers across disciplines encounter patients experiencing disordered eating, body image distress, and eating disorders, yet many report limited training or comfort level in assessment and treatment. Workforce shortages further constrain healthcare systems ability to expand services, particularly in rural communities. This project will develop scalable training pathways and infrastructure designed to strengthen provider capacity across behavioral health, primary care, nutrition, nursing, and related disciplines, engage healthcare partners across Alaska (including behavioral health providers, tribal health organizations, and healthcare systems), and formalize academic partnerships to support long-term workforce development.	AKEDA will lead a 12-month planning and early implementation phase to design and build a sustainable model and statewide infrastructure to expand Alaska's eating disorder workforce. This initiative has been developed in partnership with UAA. As the primary eating disorders community partner, AKEDA will lead the Year 1 planning phase, to include: 1) Formative Workforce Needs Assessment - Coordination of a structured assessment of workforce capacity and training needs across Alaska using a mixed-methods approach of quantitative surveys and qualitative interviews. The assessment will engage behavioral health and medical providers, primary care clinicians, dietitians, school-based professionals, rural healthcare organizations and community partners to identify gaps in eating disorder identification, referral pathways, and treatment capacities. 2) Identification of Provider Training Opportunities - Identification of existing professional education opportunities for Alaska Healthcare Providers, including physicians, registered dietitian nutritionists, nurses, physician associates, and more. Select personnel will be trained and certified in eating disorder care, to build an Alaska-based workforce of healthcare providers who can serve as preceptors and educators in scaling and building curricula and continuing education opportunities. 3) Interdisciplinary Workforce Advisory Structure - Establish an interdisciplinary advisory structure that includes clinical partners and faculty leaders from UAA's College of Health. Faculty disciplinary workforce leads will represent social work, psychology, nutrition and dietetics, nursing, and medicine. Each discipline will contribute to support workforce assessment, the identification and assessment of competencies, and curriculum development. 4) Exploration and Preliminary Planning for Graduate-Level Training - The project will explore the feasibility of an interdisciplinary graduate-level training pathway focused on eating disorder treatment. Activities will include curriculum mapping, competency development, student interest survey, and exploration of hybrid training models that support rural access. 5) Workforce Infrastructure and Sustainability Planning - Produce an implementation roadmap for expanding Alaska's eating disorder workforce through continuing education programs, interdisciplinary training models, and potential academic pathways.	\$250K-\$1M	Statewide	Anchorage (Municipality); Bethel Census Area; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; Northwest Arctic Borough; Sitka (City and Borough)	Advance to Planning

Alaska EXCEL	Alaska EXCEL Campus Expansion for Rural Transition Training & Education: Bridging the Gap	AK	Alaska EXCEL currently operates without a permanent campus, limiting long-term stability for staff, students, and program growth. Reliance on short-term housing and leased facilities creates uncertainty, constrains enrollment, and limits the program’s ability to expand services for graduates transitioning from rural communities to Anchorage or the Mat-Su region for work, training, or postsecondary education. Demand for the program continues to grow, with additional school districts requesting participation. However, the current capacity of leased housing limits Alaska EXCEL's ability to serve more students without reducing support for those already enrolled. Acquiring permanent land and developing the Alaska EXCEL Campus would provide a stable home base while expanding opportunities for rural youth pursuing careers in healthcare and other high-demand fields. The campus expansion will include transitional housing for EXCEL graduates entering employment, apprenticeships, or postsecondary programs. A small, tiny-home village will provide safe, affordable housing while graduates establish employment and financial independence. A shared bathhouse and gathering space will support wellness, cultural connection, and community. By investing in permanent infrastructure, Alaska EXCEL can expand capacity, strengthen workforce pathways, and help address Alaska’s workforce shortages while building long-term stability for rural youth and the communities they serve.	Demand for the Alaska EXCEL program continues to grow, with additional school districts requesting participation. However, the current capacity of leased housing limits Alaska EXCEL's ability to serve more students without reducing support for those already enrolled. To address this limitation, Alaska EXCEL proposes acquiring an existing large home and surrounding land to establish the permanent Alaska EXCEL Campus. Purchasing an existing property allows the program to quickly create a stable residential and program hub while providing space to expand facilities over time. The property will serve as the central campus residence for students and staff, while the surrounding land will allow for future development of small training shops and program space that support hands-on career exploration and workforce preparation. The campus expansion will also include development of a small transitional tiny-home housing village for Alaska EXCEL graduates relocating to Anchorage or the Mat-Su region to pursue postsecondary education, apprenticeships, or early employment. Transitional housing will provide safe, affordable accommodations during the critical transition period when graduates are establishing careers and financial stability. Residents will receive mentorship, case management, and connections to the workforce, education, and health resources. Consistent housing and coordinated support help reduce barriers that often prevent rural youth from completing training programs or maintaining early employment. The campus will also incorporate shared wellness and gathering spaces that foster community connection, cultural grounding, and peer support. Establishing a permanent campus will significantly expand Alaska EXCEL’s ability to serve rural students across the state. Increased housing capacity will enable the program to accept additional students from participating school districts while also supporting graduates as they transition into careers and postsecondary pathways. Over time, this investment is expected to increase the number of rural youth who complete training programs, enter Alaska’s workforce, and maintain stable employment. By providing housing stability, mentorship, and career pathways, the Alaska EXCEL Campus will strengthen workforce development, improve long-term outcomes for participants, and contribute to stronger, more resilient rural communities across Alaska.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; North Slope Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska EXCEL	Alaska EXCEL Rural Community Outreach for Healthy Villages - Community-Wide Career Exploration	AK	Rural Alaska communities face persistent barriers to postsecondary access, workforce readiness, and youth engagement. Geographic isolation, limited exposure to career pathways, high teacher turnover, and strained relationships between schools and families often leave students without consistent mentorship, leadership development opportunities, or clear post-high school plans. Many students—particularly in remote villages—have few opportunities to build employability skills or confidence navigating postsecondary systems. A large percentage of these students are first-generation college students, and many families have limited familiarity with postsecondary programs, financial aid, or enrollment processes. This knowledge gap can reduce participation and create barriers to trust and engagement. Alaska EXCEL has successfully implemented this approach before. In 2016, the organization led a five-year initiative that included a Community Outreach plan, resulting in strong outcomes and the publication of two peer-reviewed studies by the Institute of Social and Economic Research (ISER) at the University of Alaska Anchorage. Building on this proven model, Alaska EXCEL will implement community-based outreach that strengthens partnerships with school staff, families, Elders, and local leaders. Through culturally responsive workshops, participants will explore leadership development, postsecondary preparation, and workforce pathways available within their regions.	Alaska EXCEL will design and implement a framework for sustained community collaboration to promote postsecondary training and career readiness for high school students and young adults in the communities it serves. This approach centers local leadership, mentorship, and partnerships with schools, families, and community members. The framework will be implemented through the following process: Training and Launch: Alaska EXCEL will train a designated school-site advisor at the annual Village Convening at the start of the funding cycle. Advisors will receive resources and tools to support outreach and workshop implementation. Monthly check-ins with Alaska EXCEL staff will provide technical assistance. Community Cohort Formation: During the Convening, two community members will join the Site Advisor to form a local cohort responsible for planning and implementing workshops. Local Action Planning: Each cohort will develop a yearly action plan outlining workshop topics, outreach strategies, and participant support. Workshops will focus on leadership development, postsecondary preparation, and workforce readiness. Ongoing Collaboration: Site cohorts will meet monthly with Alaska EXCEL staff to monitor progress, share updates, and address challenges. Community Support: A stipend will be provided to cohort members to support planning, outreach, and workshop facilitation. Participant Evaluation: Pre- and post-workshop surveys will assess knowledge gained, program relevance, and participant experience. Continuous Improvement: A Plus/Delta debrief will be conducted with Alaska EXCEL staff and site cohorts after each workshop to identify successes and improvements. Through hands-on learning, mentorship, and leadership development, students strengthen communication, teamwork, problem-solving, and self-advocacy skills. Outreach builds community trust and creates pathways of support for youth and young adults. This approach positions Alaska EXCEL as a collaborative partner working with rural communities to promote educational success and workforce readiness across rural Alaska. The goal of the outreach program is to increase participation from rural school districts and strengthen referral systems with educators, school personnel, and community leaders. These partnerships create pathways for rural youth to access EXCEL intensives, leadership development, and workforce training, strengthening local talent pipelines and supporting long-term economic resilience.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; North Slope Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska EXCEL	Alaska EXCEL Rural Native Youth Career Pathways: Education, Careers, and Whole-Person Support	AK	Rural Alaska Native youth face significant barriers to postsecondary education, entering the workforce, and achieving long-term stability. Geographic isolation, limited career exposure, housing instability during transitions, and intergenerational trauma contribute to gaps in leadership development, educational achievement, and employment. Many students lack consistent mentorship, practical training, and clear pathways linking high school to trade schools, apprenticeships, college, or careers. Youth moving from rural to urban communities often encounter additional challenges with housing, financial literacy, transportation, and navigating unfamiliar systems, including healthcare. EXCEL addresses these barriers through leadership development, employability skills training, and culturally responsive mentorship that support rural workforce pathways and long-term well-being. Through hands-on Foundational, Mini Bridging, and Specialty Sessions, as well as postsecondary preparation intensives, EXCEL equips youth with practical skills for postsecondary readiness, employment, resilience, and confidence. Optional wraparound case management and supportive services help address mental health needs, stability, and transition planning. By connecting rural youth with education, training, and employment opportunities, EXCEL enhances rural workforce development, promotes health equity, and builds healthier, more resilient communities across rural Alaska.	Alaska EXCEL addresses barriers facing rural Alaska Native youth through a relationship-centered, community-embedded model that integrates leadership development, workforce training, educational support, and wraparound services. The core component of our model is short-term, high-impact intensives hosted at the Alaska EXCEL campus in Wasilla. Rural students travel to EXCEL for structured residential sessions lasting 4 to 30 days, depending on age and training. These intensives immerse participants in leadership development, employability skills, and hands-on career exploration aligned with Alaska’s high-demand workforce needs in a safe, supportive environment. Students begin with hands-on Foundational Sessions focused on healthy living, employability skills, and emotional wellness. All EXCEL coursework is tied to high school credit, ensuring participants make academic progress while engaging in experiential learning. Students then progress to Specialty Sessions introducing multiple career pathways, including a medical pathway that exposes youth to healthcare professions and strengthens the rural healthcare workforce pipeline. Both Foundational and Specialty Sessions also provide opportunities to earn industry-recognized entry-level certifications, creating pathways from entry-level training to healthcare and other high-demand careers. Throughout these sessions, students build essential life and workplace skills—communication, teamwork, accountability, resilience, and problem-solving—preparing them for postsecondary education, training, and employment. EXCEL also supports postsecondary preparation and transition planning, including credit recovery in math, language arts, and science for students needing additional academic support. Staff assists youth with career exploration, applications, resume development, and planning for employment, apprenticeships, or further education. For youth relocating from rural to urban communities, EXCEL helps address barriers such as housing navigation, financial literacy, healthcare access, and workplace readiness. Optional wraparound clinical and case management services help youth address trauma, mental health challenges, family instability, and other barriers to persistence. Through coordinated outreach, campus-based intensives, transition support, and follow-up services, EXCEL creates pathways from rural high school to postsecondary success while strengthening Alaska Native leadership and a grow-your-own rural workforce.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; North Slope Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Farmers Market Association	Locally Grown Food; Alaskans feeding Alaska for the Health of People and Place	AK	Alaska has the opportunity to invest in the local food production and distribution momentum underway as a mechanism to address the health of our people and this uniquely special place. Local food production momentum includes the growing number of Alaska farmers, 48% of whom are women, largely growing on less than 10 acres, and including the nations’ largest proportion of new and beginning farmers (supported by AFMA). Local food distribution momentum includes the quadrupling of farmers markets (65 markets up from 13 in 2005), the success of AFMA's food access program pilots (SNAP Market Match and Local Food Purchasing Assistance- both ending this year without new investment), and the rise of Food is Medicine approaches including prescription produce programs (that Alaska’s farmers operating community-supported-agriculture subscription programs are well positioned to support). The momentum of Alaska’s local food production and distribution presents good news for easing pressure on the precarious supply chain that imports 95% of Alaska’s food at the price of \$2B/year and for addressing the rising burden of chronic disease including the only 8% of Alaskans getting recommended daily servings of fruits and vegetables. AFMA, founded in 2009 and led by a public health practitioner with a Board of Directors of engaged farmers and market managers statewide, stands ready to partner with Alaska’s organizations seeking to increase fresh food in the diet of Alaskans.	Our proposed approach, to continue the momentum of local food production and distribution, is to invest in Local Food First as opportunities expand for Alaskans feeding Alaska. RHTP funding is an opportunity to bring AFMA, and the farmers and markets it represents, to the table as partners in designing Alaska’s food future to meet the needs of everyone. Investing in Local Food First looks like... Alaska’s produce prescription boxes filled first with locally grown food and then with what must still be imported. Alaska's current growers, 1173 at last USDA count, can offer what they have this coming season as a pilot, plan growing seasons to meet increased demand, and mentor new growers to enter farming as a profession. The CSA model (community supported agriculture) lays the groundwork for produce prescription programs from managing distribution logistics, to utilizing technology (such as Farmingo for customizing produce boxes), to growing culturally preferred foods. As current members of the Food is Medicine and Alaska Food Coalition, we propose our farmers as partners to health organizations bringing produce prescriptions into their approach. Investing in Local Food First looks like.... Expanding upon AFMA’s successful food access programs to ensure all of Alaska’s current and new farmers markets offer nutrition incentives. Direct to consumer markets are the best way for new and small growers to make a viable living from farming, offer nourishing connections between community members and farmers, connect kids to their foodways, and bring communities together. AFMA’s 2024 market data presents an estimated \$3.1M in sales, from 180 farmers, and 316,000 visitors. Our food access programs welcome all-comers and remove the burden of potential overharvest for farmers through supported community donations. AFMA’s Power of Produce program offers \$5 to every child who shows up at farmers market to direct their families spending and engage in food choices. AFMA’s SNAP Market Match saw a 272% in SNAP redemptions across 8 farmers markets in the 2023-2025 pilot (2025 redemptions surpassed \$67,000 with pre-program data reporting \$18,000 annually). AFMA’s Local Food Purchasing Assistance 2023-2025 pilot supported \$314,000 in local food purchases from 39 farmers at 10 farmers markets donated to 22 anti-hunger organizations in local communities statewide. We propose continuing this work with AFMA as a key partner to expand nutrition incentive programs statewide.	\$50,000-\$250,000	Statewide	Anchorage (Municipality); Bethel Census Area; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Food Policy Council	Alaska Cold Chain Infrastructure Framework: A Foundational Roadmap for Rural Health and Food Supply	AK	Rural Alaska’s medical and food supply chains are compromised by a critical last-mile bottleneck: the lack of reliable temperature-controlled storage at rural airports. Research from the University of Alaska Anchorage shows nearly 60% of rural weather stations experience outages triggering aviation delays, leaving perishable cargo, including medicines, vaccines, and fresh foods, sitting for days. These disruptions have measurable consequences: 360,000 servings of fresh produce were lost in 2022 alone, and pharmaceutical deliveries face similar risks. Spoilage rates for air routes are triple those of barge routes, yet Alaska lacks a coordinated framework to guide cold-chain infrastructure investment, technical standards, or workforce readiness. With growing cross-sector awareness of this vulnerability, there is a timely opportunity to establish an Alaska Cold Chain Transformation Framework. This one-year project will map critical gaps across the rural aviation network, develop practical standards for resilient, low-tech temperature-controlled storage, and design community-based workforce pathways to prepare local operators to maintain these systems. By producing a strategic roadmap for coordinated investment, the Alaska Food Policy Council will help ensure future cold-chain infrastructure is durable and aligned across health, aviation, and distribution systems—transforming a persistent supply chain failure into a reliable health and fresh food lifeline for rural communities.	This one-year project establishes planning frameworks and decision tools to strengthen Alaska’s rural cold chain - the temperature-controlled transportation network that allows medicines and fresh foods to reach rural communities safely. Statewide Supply Chain Gap Analysis & Asset Mapping: Using existing research and datasets, we will integrate aviation reliability data, community health indicators, and the Alaska Food Systems Atlas to map critical cold-chain gaps. This analysis will identify where temperature-controlled storage is most urgently needed to prevent medication and food spoilage and will produce a Priority Investment Roadmap aligning public and private sector investment. Arctic Cold Chain Technical Toolkit: Drawing on existing research, case studies, and feedback from the Food Value Chain Coordination Council, we will develop a standardized framework for selecting appropriate technology for temperature-controlled storage at rural airports. The toolkit will include site-selection standards addressing permafrost conditions, energy requirement estimates, guidance on modular and low-cost infrastructure, integration with existing logistics assets, and coordination opportunities with industries such as seafood distribution. Community Workforce Framework: In alignment with Alaska’s Strengthening Workforce initiative, we will design a workforce roadmap outlining technical standards and local-hire pathways for village-based logistics monitors responsible for equipment oversight, temperature monitoring, and basic maintenance. This planning will ensure communities are prepared to operate and maintain systems when infrastructure investments occur. This planning phase supports Alaska’s RHTP goals—including Building Sustainable Systems and Healthy Communities—by creating a coordinated, community-led strategy to address a critical gap in the state’s rural transportation network for medicines and fresh foods.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Food Policy Council	Farm to Tray, Fish to Fork: Expanding Wellness Through Local Nutrition for Rural Alaskan Students	AK	Food security and behavioral health share a profound, scientifically established relationship. Through investments that enhance local food utilization in school lunches and nutrition education, this project seeks to influence positive behavioral and nutritional health outcomes in communities throughout 1200 miles of rural Alaska coastline. Alaska’s food systems are shaped by geographic isolation, cultural diversity, and economic challenges, all of which contribute to widespread food insecurity. Statewide, 14.6% of Alaskans experience food insecurity, including 20% of children, according to the Food Bank of AK. The problem is even more severe among Alaska Native communities, where approximately 28% of households face food insecurity, compared to 12% of non-Native households. Despite the challenges of high transportation costs and limited access to fresh produce, Alaska’s school nutrition programs demonstrate significant resourcefulness in addressing food insecurity for children. Efforts to integrate Alaska-grown and culturally relevant foods into school nutrition programs are gaining momentum. This project works with School Food Authorities (SFAs) representing diverse regions, each with its own food system dynamics. Many districts already partner with local food producers and seek innovative solutions to improve food sourcing and logistics; dedicated RHTP funding for infrastructure and resources supporting food security has potential for measurable generational health effects.	This project aligns with RHTP’s Healthy Beginnings and Healthy Communities initiative areas by using local food systems as a platform for prevention-focused health improvement among youth in rural AK. The Alaska Food Policy Council and its partners have storied histories transforming Alaska food systems through relationship-rooted work. This proposal creates alignment between needs assessments, grassroots and governmental support, and community resources to positively influence the physical and behavioral health of Alaska’s youth. RHTP funding will expand a network of food producers, School Food Authorities and other partners to develop culturally and locally relevant nutritional education, through enhancement of local food procurement and consumption within schools, in a wide swath of rural Alaska with scalable outputs and results. Despite the challenges to health and food security in rural Alaska, there has been tremendous interest and creativity across Alaska’s schools in improving school meal programs. Over the years, individual districts have piloted farm-to-school initiatives, integrated traditional foods, and experimented with scratch cooking and similar projects. These efforts have demonstrated the potential for innovation and sustainability but often lacked systemic support to scale statewide. At the same time, there has been tremendous growth in Alaska’s agricultural industry, with large increases in new and beginning farmers across the state. Alaska, from the grassroots up to the Governor, has identified and prioritized food security as a top concern, and there is significant interest in Alaska Grown/ Harvested/ Made foods, including seafood, entering institutional markets and supporting Alaska's schools. In fact, a legislative food security task force identified the establishment of co-op purchasing for school foods as a top recommendation earlier this year. Building on these insights through a best-practices local and regional food procurement toolkit, targeted training for child nutrition program staff and food producers, and deeper engagement through our statewide School Nutrition Working Group, this project will help shift Alaska’s farm-to-school landscape from isolation toward collaboration. Pass-through funding will be made available to program participants for infrastructure that supports locally-relevant production and purchasing, ensuring that such collaboration is effective by making long-term implementation tangible with resources.	\$1M-\$5M	Statewide	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Genetic Counseling Services	AKUA Sobriety Outreach Alaska - preformation LOI via AGCS	AK	Anchorage's behavioral health and recovery ecosystem is dense, well-established, and genuinely capable. Catholic Social Services, Cook Inlet Tribal Council Recovery, Providence Breakthrough, Clitheroe Center, Akeela House, Four Directions, Dena'ina Coy, Cornerstone Recovery, Alaska Wisdom Recovery, Aeon Counseling, the Narcotic Drug Treatment Center of Alaska, Rational Recovery, the VA, and ADAPT represent a remarkable concentration of recovery resources in a single city. The problem is not the absence of services. The problem is that the people who need them most cannot reliably get between them. AGCS is submitting this Concept Formation LOI on behalf of AKUA Alaska Sobriety Outreach, a recovery transportation ministry in formation as a religious nonprofit under Alaska law. AGCS is providing pro-bono administrative and organizational development assistance to AKUA to support this application — a service consistent with AGCS's broader commitment to strengthening Alaska's recovery and rural health ecosystem. AKUA's founding vision is specific and actionable: a peer-operated, recovery-dedicated transportation service connecting rural Alaskans in Anchorage to the shelters, detox facilities, inpatient programs, sober living homes, and peer recovery meetings that constitute the ecosystem of sobriety. This 12-month concept formation grant completes the organizational foundation and service design required to launch that service sustainably.	This LOI suggests 3 formation workstreams. AGCS provides pro-bono organizational support throughout, drawing on its principal's expertise in program development and delivery. 1 - Administrative Readiness: AKUA's articles of organization have been submitted to the Alaska DCED. We are in process obtaining the entity ID and business license, and will pursue 501(c)(3) federal tax-exempt status. As required, we may also form a board, adopt bylaws and conflict of interest policies, and document administrative infrastructure — accounting, reporting, insurance — required to manage grant funds and vehicle operations. 2 — Service Concept Refinement and Partner Formalization: Early conversations with more than fifteen Anchorage recovery, shelter, and behavioral health organizations have produced strong expressed interest, and Catholic Social Services has already provided a supportive memo of understanding. We will convert expressed interest into operational structure: more MOUs with priority partners; service design conversations to map transport routes, timing, volumes, and populations; and driver recruitment and documented vetting protocols. Vehicle fleet planning, including insurance, storage, maintenance, and liability frameworks, will be completed during this workstream. Simultaneously, AKUA will conduct early outreach to rural village airline service offices and airport law enforcement partners to begin scoping the aspirational rural-to-Anchorage intake transport network that represents AKUA's long-term vision for serving communities at the point of crisis. 3 — Sustainability and Funding Architecture: As detailed in the sustainability, this workstream produces the financial modeling and sustainability narrative required to take this work to the appropriate next RHTP funding application and program delivery stage. AKUA's founding operational leader — William Broad, a recovery advocate and sober living house owner/operator with lived experience of addiction and recovery in Alaska — has the community credibility, peer network access, and operational grounding required to deliver on this program's potential.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Chugach Census Area; Copper River Census Area; Dillingham Census Area; Kenai Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Genetic Counseling Services	The Alaska Genomics Partnership	AK	Alaska has no board-certified genetic counselor or medical geneticist practicing within the state. This single fact defines the problem. When Alaska Native women are referred for BRCA counseling following a hereditary cancer diagnosis, there is no in-state provider to see them. When a rural pediatrician suspects a congenital genetic syndrome in a village child, there is no specialist to consult. When a cardiologist identifies familial hypercholesterolemia, the standard cascade genetic testing pathway simply does not exist here. This absence could be accurately called a void. Alaska Native populations carry elevated risk for multiple hereditary conditions documented in medical literature, yet benefit from none of the clinical genetics infrastructure available in every other state. Primary care providers navigate genetic results without specialist support, increasing misinterpretation risk and delaying treatment. Out-of-state referrals are cost-prohibitive for rural patients and frequently abandoned. Direct-to-consumer testing reaches patients without counseling infrastructure to interpret results meaningfully. AGCS was established specifically to address this absence, but has not gone beyond planning. A grant would fund the missing pre-implementation work needed to predict real impact— needs assessment, tribal partnership formalization, workforce recruitment activities. These will ensure future work is done sustainably and with full community alignment.	AGCS proposes four interdependent planning workstreams over one year to prepare for a fully-specified Implementation-stage grant application. 1 — Community and Clinical Needs Assessment: A structured needs assessment engaging rural primary care providers, tribal health directors, Alaska Native community health workers, and patient communities across at least three geographic regions. Assessment tools will be adapted for Alaska Native cultural contexts, drawing on the AGCS principal's doctoral expertise in adult learning and community-based education. Findings will quantify unmet demand, document provider referral practices, and identify community-specific barriers to genetic services uptake, producing the evidence base for service design decisions. 2 — Tribal and Clinical Partnership Formalization: AGCS has identified as SCF and CITC as primary tribal health system partners, and inroads to established Anchorage medical practices for initial clinical collaboration. We will convert identified partner interest into executed MOUs establishing roles, data governance expectations, referral protocols, aommunity education planning, and co-design processes for implementation-phase service delivery. We hope to explore genuine co-ownership of the design with tribal partners. 3 - Workforce Recruitment Design and Candidate Pipeline: AGCS will develop and execute a national recruitment strategy targeting board-certified genetic counselors (CGC) and/or medical geneticists from accredited programs willing to commit to Alaska service. Recruitment materials will emphasize Alaska's professional opportunity, NHSC loan repayment eligibility, and the rare chance to establish a clinical field from the ground up. Notably, Alaska's absence of a state genetic counselor licensure requirement means a credentialed CGC can begin practicing immediately upon relocation — a meaningful competitive advantage in a national market where multi-month licensure queues are the norm. The planning period will result in at least one qualified candidate in active recruitment. 4 — Implementation Workplan and Budget: All planning outputs — needs assessment findings, partnership MOUs, recruitment pipeline data, validated delivery model — will be merged into a detailed implementation workplan with milestones, evaluation metrics, staffing plan, and 3-year budget projection positioning AGCS for a competitive Implementation-stage application, should that lign with ACF guidance.	\$50,000-\$250,000	Statewide	Anchorage (Municipality)	Deferred or Not Advanced

Alaska Genetic Counseling Services	Transformation program management and advisory - Technical assistance provider	AK	RHTP grantees face a consistent structural challenge: the funding to transform rural healthcare is available, but the organizational capacity to execute transformation is not evenly distributed. A Readiness-stage grantee that cannot scope a project clearly will never reach Planning. A Planning-stage grantee that cannot build a credible implementation workplan will not compete for Implementation funding. An Implementation-stage grantee that underestimates organizational change complexity will absorb resources without producing durable outcomes. These are predictable patterns in every large-scale grant portfolio serving community-based organizations in frontier environments. More guidance documents are not the answer though ACF has excelled so far in knowledge management. It is access to an experienced practitioner who can work alongside grantee teams, diagnose where work is breaking down, and provide hands-on support tailored and aligned to each organization's stage, capacity, and context. I approach this with validated relevant expertise and an ethos of service. How ACF structures TA within RHTP — services, delivery model, resources, governance — are genuine open questions that this concept formation grant hopes to answer in concert with other potential TA partners. An architecture to maximize the impact of RHTP requires early coordination, stakeholder engagement, and concept refinement. This proposed TA formation grant proposes to be part of those holistic supports.	This grant funding idea is for concept development, not service delivery. AGCS proposes three workstreams to transform an early-stage idea into a fully specified, partner-validated project concept ready for a Planning or Implementation-stage application. 1 — ACF Partnership Exploration: The foundational question is where ACF, as RHTP's administering agent, sees value in a dedicated grantee TA function and what role it envisions for an external partner in that work. AGCS will seek to understand the ACF current view of grantee capacity challenges, existing TA touchpoints, and the forms of partnership — if any — that would complement a TA service mission. ACF's ownership of the concept remains primary. To avert conflict of interest, ACF retains sole authority over grantee TA assignments, and that AGCS formally recuses from any engagement involving projects in which it holds a direct funding interest. 2 — Grantee Needs Exploration: In parallel, AGCS will conduct early-stage outreach to a small sample of RHTP grantees across readiness stages — with ACF's facilitation and endorsement — to develop a preliminary picture of where TA is most needed, what forms would be most useful, and what barriers to TA uptake exist in the rural Alaska context. This is preliminary listening, not a formal assessment — sufficient to determine whether a formal needs assessment is warranted and what it should ask. It is assumed ACF has already established some scope and direction for TA that may preclude this need. 3 — Concept Refinement and Administrative Readiness: Drawing on available data and initial findings, AGCS will refine the project concept with ACF guidance and to ACF requirements. The concept formation period concludes with a fully developed project narrative, partnership documentation, and budget ready for submission as a Planning or Implementation-stage LOI as preferred. Dr. Havelock's doctoral expertise in adult learning and organizational change, applied in over 20 years of healthcare systems improvement, is operationally relevant throughout. How rural healthcare professionals absorb new frameworks, change existing workflows, and sustain new organizational behaviors under resource constraint is a design challenge he is uniquely skilled to address. Technical assistance that ignores the learning dimension produces plans that exist on paper and die in practice. AGCS will apply systems knowledge and learning science to ensure TA is internalized, not borrowed.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Health Collaborative	Haw'áa - Health and Wellness Across Alaska	AK	1.) Lack of access to care which prevents early detection (especially colon cancer), mitigation and longitudinal care of illness 2.) Cost prohibitive or interpersonal impediment to reach primary care services 3.) Isolation from MAT services for those experiencing SUD 4.) Opportunity to enrich and sustain cultural values surrounding whole person wellness 5.) Opportunity to support and empower youth in skill development and early healthy decisions	1.) Once invited by community leaders, anticipate 2-3 days travel with care team via charter, commercial or local transport to the area of need with Piccolo or similar for point of care real time laboratory testing for screening and diagnostic purposes. Pathology samples (i.e. pap, skin lesion excision) will be collected preserved and submitted to commercial lab upon return to hub. Age appropriate health and safety surveys. Follow up can be arranged with regional medical center if appropriate and desired or continued with Alaska Health Collaborative. Full spectrum care for all those interested regardless of ability to pay. Colon Cancer specific screening: offer fecal immunoglobulin testing if appropriate and or schedule colonoscopy upon our return with General Surgeon, CRNA and RN offering to volunteer time and expertise. 2.) Example: in 2018 North Slope Borough School District advised me of a \$25,000 price tag to charter flights for students in just one outlying community to Utqiagvik and back for sports physicals where as my travel expense was \$1,600 and I was sometimes able to visit 2 villages in 1 day not leaving any students out. The fiscal logic of sending an MD to people as opposed to people out to MD is undeniable. Offer assistance with MCD/MCR application navigation. Interpersonal and privacy concerns often prevent people in smaller communities from seeking care when the Health Aid is a cousin or in-law and having an outside provider offer services has enabled confidential care of STIs, substance misuse and domestic safety issues on multiple occasions. 3.) I helped design and was the Medical Director for the first fully CARF accredited wrap around MAT program in the State and have subsequently worked with 2 additional agencies. A Psychiatric Nurse Practitioner and assessment specialist are part of my team willing to travel as well as offer telehealth. 4.) Traditional healing and connection to culture are central to a wellness that extends beyond what medication can offer. Gathering for storytelling, food, song and dance. Gathering reminds us that we are connected and rely upon one another. 5.) Ensuring every school child has a sports physical and is eligible to learn the power of their bodies, the strength of a team working toward a goal, the wisdom earned in failure. Host Science Power Camp/events to share the wonder of STEM. Mentor students interested in learning about allied health professions or trades. Assist in scholarship applications.	\$50,000-\$250,000	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Health Link LLC	Alaska Rural Value-Based Care Transformation Collaborative	AK	Rural health providers across Alaska face significant financial and operational challenges due to low patient volumes, workforce shortages, geographic isolation, and the high cost of delivering care in remote communities. In many rural settings, fee-for-service reimbursement has historically been preferred because it provides predictable revenue in environments where the cost of providing care is exceptionally high. Recent policy changes, including the repeal of Alaska’s long-standing 80th percentile reimbursement standard for out-of-network services, have increased financial uncertainty for many providers. At the same time, many rural hospitals, clinics, and behavioral health providers lack the administrative capacity, billing systems, data infrastructure, and technical expertise needed to evaluate emerging value-based care and alternative payment models. Without targeted support, rural providers may struggle to adapt to evolving reimbursement structures while maintaining essential health services. This project addresses the opportunity to support rural providers during this transition by building the operational capacity, collaborative partnerships, and shared learning networks needed to strengthen the long-term sustainability of rural health systems across Alaska.	Alaska Health Link will implement a regional, multi-community initiative that helps rural providers build the operational systems and partnerships needed to evaluate and participate in value-based care and alternative payment models. The project will establish a regional collaborative that brings together rural hospitals, primary care clinics, behavioral health providers, and Tribal health partners to share knowledge, strengthen partnerships, and explore sustainable care delivery strategies. Through this collaborative structure, participating communities will engage in shared learning, peer exchange, and coordinated planning that supports stronger regional health systems and improved care coordination across providers. Alaska Health Link will provide targeted technical assistance, planning support, and training to help participating providers develop the capabilities required to participate in evolving reimbursement models. This support will include financial modeling, contract evaluation, and planning for alternative payment models that incentivize care coordination, chronic disease management, and improved patient outcomes. Consistent with RHTP guidelines, the project will support capacity-building activities directly tied to project implementation. This may include strengthening billing and revenue cycle management systems, improving administrative workflows that support value-based care participation, and implementing population health and quality reporting tools needed to track outcomes and coordinate care across providers. The initiative will also support providers in assessing and preparing for provider payment opportunities within value-based care arrangements, including shared savings models, performance-based payments, and other payment structures that reward improved quality and coordinated care delivery. Training will be provided for clinical and administrative staff to build competencies in care coordination, quality reporting, and population health management. Alaska Health Link will also facilitate collaboration among participating communities to identify practical strategies that improve financial sustainability while maintaining access to essential health services. This initiative aligns with RHTP priorities by strengthening provider capacity, supporting chronic disease management, advancing value-based care readiness, supporting sustainable provider payment models, and fostering regional collaboration among rural health providers.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Health Link LLC	Community-Led Water Security and Health Protection Network	AK	Many rural Alaskans rely on community-managed water and sanitation systems that face increasing pressure from aging infrastructure, permafrost thaw, and weather events. When systems become unreliable, households may lose access to water needed for hygiene and sanitation, increasing risks of respiratory, skin, and gastrointestinal infections. Water insecurity can also affect maternal, family, and mental health by limiting practices that support healthy pregnancies, infant care, and daily well-being. Despite these risks, coordination between water system management and public health systems is often limited, leaving communities without the information or technical resources needed to identify emerging water-related health threats. This project addresses that gap by supporting community-led adaptation that connects environmental monitoring, water system awareness, and public health knowledge. Using a Two-Eyed Seeing approach that combines Indigenous knowledge and community experience with scientific expertise, the initiative will generate actionable environmental health data and support locally tailored solutions that strengthen water security and health protection in rural Alaska communities. The initiative will also establish a replicable model for community-based environmental health surveillance that can inform water security planning and public health prevention strategies across rural Alaska.	The project will implement a community-led adaptation model that strengthens the connection between water system management and public health protection in rural Alaska. The initiative will coordinate with participating communities, Tribal health organizations, public health partners, and local water system operators to identify water-related health risks and implement locally tailored solutions. First, the project team will conduct water and sanitation health risk assessments with participating communities. These assessments will evaluate infrastructure vulnerabilities, environmental conditions, and household-level water security challenges. Environmental water testing will identify contamination risks and establish baseline water quality data. Second, the initiative will deploy a multidisciplinary team of scientists and technical specialists to support environmental monitoring and risk analysis. Using a Two-Eyed Seeing approach, the team will integrate Indigenous knowledge and community experience with scientific expertise to interpret testing results and develop mitigation strategies suited to each community’s environmental and infrastructure conditions. Third, the program will provide training and technical assistance to community residents and local partners to strengthen their ability to monitor and respond to water-related health risks. Training will focus on water quality monitoring practices, proactive monitoring methodologies for weather-related impacts and infrastructure stress, sanitation risk mitigation, and coordination between water system management and community health programs. Fourth, the project will establish community-based environmental health surveillance systems integrating environmental water testing, infrastructure monitoring, and local health indicators. These systems will generate actionable environmental health data to identify emerging risks and guide prevention strategies. Participating communities will also develop locally tailored water security and health protection plans outlining adaptation strategies and monitoring practices. The initiative will establish a replicable model for community-based environmental health surveillance that connects water monitoring, environmental testing, and public health response to prevent water-related health risks in rural communities. The project will strengthen water security and health protection, improve community resilience and capacity to respond to water insecurity events.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Health Link LLC	Emergency Response Readiness and Community Preparedness Program	AK	Many rural and remote communities in Alaska face significant challenges responding effectively to medical emergencies and public health crises. Geographic isolation, severe weather, limited health infrastructure, and workforce shortages can make it difficult for communities to rapidly assess and manage emergency situations before advanced care becomes available. These challenges became especially apparent during events such as the COVID-19 pandemic, when communities were required to respond quickly to evolving public health threats with limited local resources. Emergency medical services and community health systems often operate with small teams and limited access to specialized clinical guidance, training, and coordinated response planning. Without structured emergency preparedness strategies, communities may struggle to rapidly assess emerging threats, coordinate response efforts, and deliver effective care during large-scale events. This project addresses the opportunity to strengthen community emergency response readiness by providing clinical expertise, training, and planning support to help communities evaluate and improve their emergency response capabilities. By strengthening coordination between EMS providers, health systems, and community partners, the project will help communities better prepare for and respond to emergency events and public health crises across Alaska.	The project will strengthen community emergency response readiness through assessment, training, and coordinated response planning. Alaska Health Link will partner with Juneau Emergency Medical Associates to provide clinical expertise in emergency medicine and EMS response planning while working with communities to evaluate and improve their emergency preparedness capabilities. First, the project will conduct assessments with participating communities, EMS providers, and healthcare facilities to evaluate existing emergency response capacity. These assessments will examine current response protocols, communication systems, workforce capabilities, and coordination between EMS, healthcare facilities, and community leadership during emergency events or public health crises. Second, the initiative will support development of community-specific emergency response improvement plans based on the findings of these assessments. These plans will identify opportunities to strengthen response coordination, improve clinical decision-making during emergency events, and clarify roles and responsibilities across local response partners. Third, the project will provide training and technical assistance for EMS providers, healthcare personnel, and community partners to strengthen emergency response practices. Training will focus on improving patient assessment, emergency triage, response coordination, and preparedness for large-scale events such as pandemics or other public health emergencies. Finally, the initiative will support development of practical guidance and response protocols that communities can use to improve readiness for future emergency events. Lessons learned through the project will inform a replicable framework that other communities can use to strengthen emergency preparedness and response capacity across Alaska. By combining clinical expertise, training, and coordinated planning, the project will help communities improve their ability to respond to emergencies and protect the health and safety of residents in rural and remote regions.	Under \$50,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Health Link LLC	Rapid Maternal Infection Detection and Clinical Decision Support	AK	Timely detection of maternal infections is critical to protecting both maternal and neonatal health. In many Alaska communities, particularly those serving rural and remote populations, access to rapid diagnostic testing during labor and delivery can be limited. Pregnant patients may arrive in labor without documented screening results for infections such as Group B Streptococcus (GBS), leaving providers without confirmed diagnostic information at the time clinical decisions must be made. When infection status is unknown, providers often administer prophylactic antibiotics to prevent neonatal infection. While this approach protects infants, it can also result in unnecessary antibiotic exposure for mothers and newborns when infection is not present. Overuse of antibiotics can contribute to antimicrobial resistance and may affect maternal and neonatal microbiome health. This project addresses an opportunity to improve maternal infection detection by supporting rapid diagnostic screening and clinical decision support during labor and delivery. Strengthening infection detection capacity will help providers make more informed treatment decisions, improve maternal and neonatal care quality, and support responsible antibiotic stewardship in health facilities serving communities across Alaska.	The project will strengthen maternal infection detection by combining gap analysis, clinical protocol development, and rapid diagnostic decision support. The initiative will work with participating hospitals and healthcare facilities to evaluate current maternal infection screening practices, particularly for patients who arrive in labor without documented prenatal screening results. First, the project will conduct an assessment of prenatal screening gaps and labor and delivery practices related to maternal infection detection. This assessment will examine the frequency of undocumented infection screening at the time of delivery, identify barriers that limit access to prenatal screening in rural and remote communities, and evaluate current clinical practices used when infection status is unknown. Factors such as limited prenatal care access, travel barriers, and care coordination challenges will be analyzed to better understand drivers of missed screening opportunities. Second, the project will support implementation of rapid maternal infection detection approaches that allow providers to obtain diagnostic information during labor when prior screening results are unavailable. Clinical decision support protocols will be developed to help providers interpret rapid diagnostic results and guide evidence-based treatment decisions. Third, the initiative will provide technical assistance and training for participating facilities to strengthen infection detection practices during labor and delivery. Training will focus on integrating rapid diagnostic testing into clinical workflows, improving documentation of infection screening status, and supporting responsible antibiotic stewardship. By strengthening infection detection capacity and improving clinical decision-making during labor, the project will help facilities provide safer maternal care, reduce unnecessary antibiotic exposure, and improve maternal and neonatal health outcomes across Alaska.	Under \$50,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Health Link LLC	Recovery Housing and Workforce Support Initiative	AK	Many Alaska communities face housing shortages that directly affect health care access and patient recovery. Patients who are medically stable may remain hospitalized longer than necessary when safe recovery environments are unavailable. Some individuals cannot safely return home due to housing conditions, lack of support services, or the need for short-term recovery space following hospitalization or treatment. At the same time, health care systems in rural and remote communities often struggle to recruit and retain traveling providers because safe and reliable housing options are limited. When providers cannot secure stable housing, staffing shortages can occur, reducing access to essential services and placing additional strain on local health systems. This project addresses these challenges by developing a coordinated model for recovery housing and workforce lodging that supports patient recovery and health system stability. By working with housing providers, health entities, and community partners, the initiative will identify existing housing resources and develop locally appropriate strategies that support safe recovery environments and stable housing options for health care workers. The project will also establish a replicable model that can improve care transitions, strengthen workforce stability, and expand access to health services in communities across Alaska.	The project will develop a coordinated approach to strengthen post-acute recovery support and workforce stability by connecting housing resources with health care delivery systems. The initiative will work with hospitals, healthcare facilities, housing providers, recruiters, and health entities to identify housing barriers that affect patient discharge, recovery, and provider availability. First, the project will conduct assessments with participating health care facilities and housing partners to identify gaps in recovery housing and workforce lodging. These assessments will examine discharge challenges, availability of temporary recovery environments, and housing needs for traveling providers that affect health system capacity and continuity of care. Second, the initiative will coordinate partnerships between housing providers, health care facilities, and community organizations to identify existing housing resources that can support post-acute recovery and provider lodging. Where appropriate, the project may support planning and adaptation of existing facilities that could serve as recovery housing environments for patients who require short-term stabilization after hospitalization. Third, the program will provide technical assistance and coordination support to help health systems and housing partners develop locally appropriate recovery housing strategies. This may include guidance on operational models, referral pathways for discharge planning, and coordination mechanisms between health care facilities and housing providers to support safe care transitions. Fourth, the initiative will support planning for post-discharge recovery programs that allow patients to stabilize in safe environments while continuing follow-up care. These approaches may include coordination with telehealth services, remote monitoring, and home-based recovery supports that help reduce readmissions and improve recovery outcomes. Through these activities, the project will strengthen care transitions, improve post-acute recovery support, and enhance workforce stability in communities with limited housing infrastructure. The initiative will also establish a replicable model for recovery housing coordination and post-acute care transitions that can inform health care access strategies across Alaska.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Alaska Heart Institute	Alaska Independent Cyclotron Initiative: Bringing Reliable Next-Gen Imaging Home for All Alaskans	AK	Currently Alaska's nuclear imaging infrastructure suffers from a critical vulnerability: 100% of short-lived radiopharmaceuticals required for PET/CT scans are manufactured in the Pacific Northwest and flown into the state daily. This "air bridge" creates a severe crisis governed by physics. Fluorine-18, the primary isotope for PET imaging, has a half-life of 110 minutes. Because door-to-door transit time often exceeds six hours, nearly 90% of the usable dose decays before reaching the patient. Alaskan providers must pay an exorbitant and wasteful "decay penalty" to secure viable doses, raising costs and threatening our financial independence. Furthermore, minor flight delays break this fragile supply chain, resulting in wasted batches and abruptly canceled procedures. For rural Alaskans, this is devastating. Patients spend significant amounts of their financial resources and days traveling for critical cancer staging or cardiac scans; a last-minute cancellation inflicts immense clinical and financial strain. The solution is to build Alaska's first medical cyclotron. Local manufacturing will stabilize this supply chain, ensuring reliable care for rural patients without delay. It will also unlock access to next-generation, ultra-short half-life tracers—like Carbon-11 and Gallium-68—bringing advanced precision oncology to Alaska. This project establishes true healthcare resilience, workforce expansion, and financial sustainability for the entire state.	We propose a multi-phase, staged grant strategy. This systematic approach mitigates risk, ensures RHTP compliance, and enables creation of vital healthcare infrastructure that would be impossible without RHTP funding. Stage 1: Feasibility, Market Validation, & Partnership Structuring. This phase utilizes seed funding to execute a feasibility study via an independent, nationally recognized consultant, producing a data-driven "Go/No-Go" analysis. • Timeline: 3–4 Months • Funding Requested: \$350,000 • Deliverables: Independent validation of use case volumes; logistics modeling for regional air-transit of isotopes; high-level financial pro-forma for the standalone facility; and the formal execution of Memorandums of Understanding (MOUs) with third-party partners (e.g., hospitals, oncology practices, universities, and possibly industrial clients). Stage 2: Seismic Engineering & Regulatory Licensing. If the Stage 1 report is positive, a follow-on grant application would request the funds necessary to navigate the stringent state and federal regulatory landscapes, alongside Alaska's unique seismic building requirements. • Timeline: 12–18 Months • Future Funding Range: \$1,500,000 – \$3,500,000 • Deliverables: Acquisition of a state-level Certificate of Need; geotechnical soil audits and structural shielding design for a Seismic Design Category D/E vault; submission of the Radioactive Materials License application to the Nuclear Regulatory Commission; cGMP facility design schematics for FDA compliance; and formal RFP execution for the cyclotron hardware manufacturer. Stage 3: Equipment Acquisition, Retrofitting, & Commissioning. After successful completion of Stage 2, a final grant would request the core implementation funds. This would be strictly framed around procuring advanced medical manufacturing equipment and retrofitting an existing clinical or industrial footprint. This ensures full compliance with the federal RHTP guidelines prohibiting new facility construction. • Timeline: 24–36 Months • Future Funding Range: \$15,000,000 – \$30,000,000 • Deliverables: Procurement, shipping, and specialized rigging of a cyclotron and radiopharmacy "hot cells"; facility retrofitting (pouring the high-density concrete vault and upgrading high-voltage/cooling utilities); beam tuning, physics commissioning, and FDA Abbreviated New Drug Application validation batches; and facility launch with the first commercial sale of short-lived isotopes.	\$250K-\$1M	Specialist	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Alaska Hospital & Healthcare Association	Find your Fit - Recruiting for Alaska's Healthcare Workforce	AK	Workforce shortages persist across Alaska’s healthcare industry. Vacancies are high and filling positions takes months. Nearly 10,000 new healthcare workers must be hired across Alaska every year to keep up with staffing needs, including more than 1,100 registered nursing (RN) recruits annually. Driven by high turnover, an aging population, and pandemic-related burnout, healthcare providers are facing severe staffing gaps, with RN vacancies averaging 20% and taking nearly five months to fill. Although our hospitals and clinics have raised wages substantially, recruitment remains highly competitive and Alaska must contend with nationwide pressures while also facing higher living costs and housing shortages that can deter relocation.	In 2024, AHHA launched the "Find Your Fit" microsite, funded by a federal US Economic Development Administration Good Jobs Challenge (GJC) grant. As a centralized digital hub, the site connects students and jobseekers with diverse roles across Alaska’s hospitals and Long-Term Care (LTC) facilities. The platform is supported by an integrated multi-channel campaign designed to: • Increase Awareness: Highlight the breadth of healthcare career paths available in Alaska. The site features photos, videos, and testimonials sharing stories and perspectives of healthcare workers at facilities across the state. • Drive Engagement: Direct traffic toward Alaska’s hospitals and long-term care providers and professional training opportunities across the state. • Support Recruitment: Bridge the gap between talent and the state's healthcare infrastructure through ongoing multimedia promotion. While the GJC funding period has ended, the site was intentionally designed to be sustained through in-house management by AHHA staff and a smaller, reduced budget has been allocated from AHHA operating funds to continue to support the promotional campaign, although at a largely reduced rate from its initial budget and scope. The requested funding from RHTP would allow us to enhance our promotional campaign so that we are able to boost and extend its impact, reach new audiences, and drive further engagement. Funding would also give us the opportunity to refresh and build on content for the site and campaign, including a new component based on People Worth Caring About – an award-winning docuseries that has showcased caregivers transforming lives in long-term care communities across Nebraska, Ohio, and New Mexico. By highlighting the dedication and humanity of frontline staff, the series challenges stereotypes, inspires career interest, and elevates public perception of caregiving. The first season is now airing on national television, and the latest season alone has garnered more than 310,000 views, with nearly 50% of viewers under the age of 35, demonstrating its resonance with younger generations and its potential to attract new talent to the field. This spring, Florida, Kentucky, and North Dakota will join the project. Funds from RHTP would make it possible for Alaska to adopt and tailor the series to complement Find Your Fit by developing segments highlighting healthcare workers and facilities across the state.	\$50,000- \$250,000	Statewide	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Sitka (City and Borough); Wrangell (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

Alaska Hospital & Healthcare Association	The Alaska Sepsis Safety Net: Standardizing Early Detection and Treatment Across the Continuum	AK	Sepsis is a leading cause of preventable mortality in Alaska. Geographic isolation and limited specialty care can turn clinical delays into life-threatening crises. Sepsis requires aggressive early intervention to prevent organ failure and death. According to the 2024 Alaska Health Facilities Data Reporting (HFDR), septicemia is the #2 cause of hospitalizations statewide, with a \$77,978 median charge per stay, the highest among top diagnoses. With mortality risk increasing 4–9% for every hour treatment is delayed, early recognition is paramount[EK1.1]. This is especially true for Alaska Native populations who face sepsis mortality rates 1.6 times higher than the national average. Current data reveals systemic failures in Alaska's sepsis chain of survival. In 2024, Alaska's SEP-1 Bundle Compliance was 59%, trailing the national 64% average. This gap is now a financial risk, as CMS integrated SEP-1 into the Pay-for-Performance Value-Based Purchasing Program for FY 2026. Furthermore, Alaska's SNF-to-hospital readmission rate is 18.5%, exceeding national benchmarks and driven largely by acute infections. This 18-month IHI Breakthrough Series collaborative will unite Alaska hospitals and LTCs to standardize early detection, treatment, and clinical handoffs. By closing the compliance gap and improving early intervention in nursing facilities, we aim to reduce avoidable admissions, optimize hospital reimbursement, and decrease sepsis mortality for all Alaskans.	Our approach utilizes the IHI Breakthrough Series (BTS) model, a proven framework designed to close the gap between clinical evidence and bedside practice. This 18-month initiative is structured as a "High-Intensity Learning Network" tailored to Alaska's unique geography. 1. The Collaborative Framework The project consists of three integrated phases to move participants from learning to rapid implementation: • Planning: We will assemble a faculty of Alaska-based sepsis experts and QI advisors to develop a change package. This is a toolkit of evidence-based interventions (e.g., NEWS2 screening, standardized SBAR transfer forms) optimized for rural and low-resource settings. • Learning Sessions (LS): Three in-person, "All Teach, All Learn" sessions held over 18 months. Teams from hospitals and nursing homes will gather to share data, troubleshoot barriers, and adapt best practices to their local contexts. • Action Periods (AP): Between sessions, teams return to their facilities to test small-scale changes using PDSA (Plan-Do-Study-Act) cycles. This ensures that improvements are practical and sustainable before being scaled. 2. Clinical Strategy: The Sepsis Safety Net We will focus on the chain of survival through three primary drivers: • Standardized Detection: Hospitals and Nursing homes will implement standardized sepsis screening, utilizing EHR optimization tools if appropriate. • Seamless Communication: We will standardize communication for transfers to ensure critical clinical data is not lost during transit. • Bundle Compliance: We will work to increase adherence to the CMS 3-hour Sepsis Bundle (part of the SEP-1 measure), focusing on the golden hour of antibiotic administration and fluid resuscitation for management of sepsis. 3. Implementation Support To bridge the distance between in-person sessions, the collaborative provides: • Monthly Facility Team Meetings: Technical assistance to help teams overcome local staffing or resource barriers and for shared learning. • Shared Data Dashboard: A de-identified portal where facilities can track their progress against statewide benchmarks and peer performance. • Regional Integration: Strengthening the hub and spoke relationship between regional hospitals and their referring facilities and nursing homes and receiving hospitals. By aligning protocols across the continuum of care, we transform fragmented responses into a unified system that catches sepsis earlier and treats it more effectively.	\$50,000-\$250,000	Statewide	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Sitka (City and Borough); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Hospital & Healthcare Association	Development of an Alaska Nursing Workforce Center	AK	Alaska faces persistent nursing workforce shortages that threaten access to care across the state. These challenges are especially acute in rural and frontier communities, where workforce shortages directly limit access to essential health services. Despite these challenges, Alaska is one of only four states without a nursing workforce center to support research based long-term workforce planning strategy. The state lacks a centralized entity responsible for collecting, analyzing, and translating workforce data into coordinated strategies to strengthen the nursing pipeline and support retention. As a result, workforce solutions are often reactive and fragmented rather than guided by a shared understanding of statewide needs. Establishing the Alaska Nursing Workforce Center represents a critical opportunity to create the infrastructure needed for coordinated, data-driven workforce planning. The Center would serve as a hub for research, collaboration, and strategic action to ensure a stable and sustainable nursing workforce across Alaska’s healthcare system. By utilizing RHTP funding, this project will support the development of the Alaska Nursing Workforce Center as an initiative housed within the Alaska Hospital & Healthcare Association (AHHA), with the goal of transitioning to a fully functional, sustainable independent entity.	Our approach focuses on the formal incubation and eventual independence of the Alaska Nursing Workforce Center. The project will establish the organizational, operational, and research infrastructure needed to support long-term nursing workforce planning across the state. The project will move through the following strategic phases: • Finalizing the Foundational Blueprint: While a mission statement exists, the project will define specific short- and long-term objectives and develop a comprehensive three-year strategic plan. This plan will identify priority workforce issues, establish measurable outcomes and ensure alignment with Alaska’s unique needs, particularly in rural and frontier communities. • Strengthening Governance and Organizational Structure: The original steering committee has transitioned into a formal Board of Directors. During the project period, the Board will establish clear decision-making structures and reporting lines to our fiscal sponsor. These structures will support effective leadership and prepare the organization for long-term independence. • Establishing Operational and Financial Infrastructure: The project will develop the operational systems necessary to support a sustainable workforce center. This includes creating a dedicated budget, outlining fundraising mechanisms, and establishing rigorous accounting processes in partnership with the host organization. • Building a Data-Driven Workforce Strategy: The Center will act as Alaska’s primary hub for nursing workforce data collection, analysis. This research will focus on the nursing pipeline, education pathways, including LPN, RN, and APRN, as well as workforce demand for nursing care in Alaska’s unique healthcare environment. Regular reports and data briefs will provide employers, legislators, educators, and policymakers with the information needed to guide workforce investments and policy decisions. • Collaborative Policy Development: As a member of the National Forum of State Nursing Workforce Centers, the Center can leverage a network of 46 workforce centers to share research, tools, and proven strategies. This collaboration will accelerate the implementation of evidence-based solutions for upskilling the nursing workforce, addressing retention, and improving nurse well-being. Through these activities, the project will create the organizational and analytical foundation needed to guide Alaska’s nursing workforce strategy for years to come	\$50,000- \$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Planning

Alaska Hospital & Healthcare Association	Rural Health Clinic (RHC) Transformation & Financial Sustainability Project	AK	Alaska’s rural hospitals operate in one of the most challenging healthcare environments in the country. Low volumes, high fixed costs, and predominantly Fee-for-Service (FFS) payment models mean that Alaskan hospitals operate on very narrow margins. A small commercial insurance market, heavy reliance on Medicaid and Tribal health systems, fragmented payment structures, and limited local public health authority further strain coordination and sustainability. The upcoming changes to Medicaid including implementing work requirements and the reduction in enhanced health coverage subsidies will further strain facilities. Aging infrastructure and heavy dependence on federal and state funding underscore the fragile financial footing of Alaska’s rural healthcare system. This creates an environment in which rural hospitals must continually strive for greater efficiency and leverage every opportunity to increase payment for services so that they can continue to provide consistent, high-quality care for their communities. We propose to address the challenges of fragile financial conditions and outdated payment models, system modernization and transformation needs, high operating costs and low patient volumes, reliance on Medicaid and Tribal care systems, and limited adoption of managed care or value-based models.	Alaska has the opportunity to strengthen our rural healthcare system’s financial position through in-depth financial and operational analysis. AHHA partnered with Stroudwater Associates to begin Phase 1 of the project, evaluating the financial and operational feasibility of the Rural Health Clinic (RHC) designation to expand primary care and stabilize service area revenue for Alaska’s 3 independent CAHs and 1 Sole Community Hospital. Phase 2 of the project would expand to include an in-depth Strategic, Financial, and Operational Assessment (SOFA) to identify improvement opportunities for Petersburg Medical Center, Cordova Community Medical Center, and South Peninsula Hospital. In addition to the SFOAs, assistance will be provided to these four hospitals with implementation of the RHC designation as needed based upon the analysis completed in a previous project. To build on that project, each hospital will receive implementation assistance should they choose to proceed with this designation. During the first year of this project we will identify other rural facilities that would benefit from the opportunity evaluate alternative payment structures in their facility, such as a RHC. Activity 1: Operational Assessment Conduct a comprehensive yet focused evaluation of key performance drivers, targeting the following areas: Market & Environmental Analysis, Physician & Provider Assessment, Clinical Service Lines, Physician Practice Operations, Volume-Based Departmental Staffing, Financial Performance, Strategic & Capital Planning, Quality & Governance. Deliverables: Executive-level report summarizing findings and opportunities based upon comparison to rural hospital best practices; identification of prioritized, high-impact initiatives; Preliminary improvement targets. Activity 2: Action Planning Translate priority recommendations into a structured implementation roadmap including; presentation of findings to leadership and department directors, facilitated prioritization of initiatives, and collaborative development of: a timeframe for objectives including: defined tactical steps, assigned accountabilities, measurable performance metrics, clear timelines and resource requirements, and financial impact estimates. Deliverables: A comprehensive work plan designed to serve as a roadmap for execution. Activity 3: Implementation Assistance Continued support post-action plan development to promote follow-through on identified high-impact initiatives.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Petersburg Borough	Advance to Planning

Alaska Hospital & Healthcare Association	Healthy Communities: Cognitive and Physical Wellness via Interactive Senior Activity Consoles	AK	The project addresses the critical need to improve the quality of life for residents in skilled nursing facilities (SNFs) and Assisted Living Homes (ALH) by deploying research-backed Interactive Senior Activity Consoles. Specifically, the project targets the widespread issues of social isolation, loneliness, reduced mobility, and cognitive decline among seniors. There is a significant opportunity to use interactive technology to engage residents in meaningful play and foster stronger relationships between them. This project provides an opportunity for AHHA SNF and ALH members to deploy non-pharmacological interventions that use interactive activities to combat apathy and reduce challenging behaviors like agitation and wandering.	We will offer participating AHHA member SNFs and ALHs a choice of high-quality interactive projection systems to best fit their specific facility layout and resident needs: Obie for Seniors: A mobile-cart-based system that projects onto any surface (floors, walls, or tables), ideal for moving between resident rooms or communal areas. Lucynt Magic Table: Offers ceiling-mounted, shelf-mounted, or mobile options with a library of over 160 research-based games tailored for specific stages of dementia (Early, Middle, and Late). Shared Methodology: Both systems utilize motion-detection sensors to encourage active play, sensory stimulation (sound/light), and social interaction without requiring seniors to learn complex digital interfaces.	\$250K-\$1M	Statewide	Anchorage (Municipality); Bethel Census Area; Chugach Census Area; Copper River Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; Petersburg Borough; Sitka (City and Borough); Wrangell (City and Borough)	Deferred or Not Advanced

Alaska Housing Finance Corporation	Healthcare Workforce Housing Catalyst	AK	The Healthcare Workforce Housing Catalyst will address the acute housing needs of healthcare workers with a flexible model that adapts to the individual worker’s housing needs and the resources available to the underlying community. Healthcare workers need a place to live, and many have families. If employers expect them to stay for any length of time, their homes need to be safe, within budget and welcoming enough to put down roots in the community. Outside of Alaska’s urban hubs, finding housing of any type is increasingly hard. But finding quality, affordable housing that families feel comfortable calling home for years to come is even harder. Operationally, the housing challenges faced by healthcare workers in rural communities have resulted in extended vacancies, expensive recruitments, and high turnover. The consequences for the Alaskans our remote healthcare providers serve are disrupted access to health services, frequent turnover in healthcare providers, and an increased need for expensive travel for health services. In some communities, the housing crisis is so severe that healthcare providers have resorted to building and / or buying properties of their own to house their workers. In addition to being prohibitively expensive for some providers, this approach further dilutes our healthcare provider capacity by directing scarce staffing and financial resources to support housing operations that are not part of their primary mission.	The Healthcare Workforce Housing Catalyst (HWHC) aims to optimize the overlapping incentives across stakeholders and their respective resources in the healthcare workforce to help workers find safe, quality and lasting housing in rural Alaska. Our proposed solution starts with the underlying healthcare workers by empowering them to pursue the housing option that best fits their family’s needs and goals. The goal is to reduce the financial stress in their first year as a new healthcare worker in the community by leveraging the resources they’re bringing to the table. Workers can receive monthly housing assistance that covers a portion of their mortgage or rental costs. The assistance would be available for up to 60% of their monthly housing costs or \$1,000 per month (whichever is less) for one year and be paid to their lender or landlord. If a renter chooses to become a homeowner before month 12 of their assistance, remaining HWHC assistance can be converted to mortgage assistance. This flexibility empowers workers with choice in the housing they pursue and the ability to adapt to the new housing opportunities that may become available to them during their term of assistance. Underpinning the HWHC assistance is a durable link between ongoing healthcare services and the underlying worker’s buy-in to the community. The HWHC assistance will provide funds that help lower, rather than eliminate, the cost of housing during the first year of employment. In addition to employee funds that match HWHC assistance, the assistance itself requires continued employment with a healthcare provider. The ability to serve prospective renters and homeowners with a single model allows the HWHC funds to meet communities and prospective workers where they are. Not all communities have robust rental or for-sale housing markets, and those that do often face a housing stock that is disparately accessible for healthcare workers based on their relative income or time entering the community. The HWHC can adapt to communities and workforce needs to match what housing is actually available with the prospective workers in the moment. The flexibility to adapt the HWHC assistance from rent to homeowner assistance during the term of service represents an innovative dynamic that incentivizes further integration into the community for the healthcare worker(s).	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kuskilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Housing Finance Corporation	Healthy and Housed	AK	Recognizing housing as a critical factor for an individual’s overall health creates opportunity for an innovative project approach. Improving patient outcomes through housing interventions is not only proven, but cost-effective. An inability to complete treatment plans, improper medication storage, missing follow-ups, or returning to the source of the health issue can not only become expensive, but create a cycle of symptom management without end. Housing is a public health intervention that has the potential to be uniquely effective in rural Alaska due to the specific challenges faced. Unexpected medical events, and even expected ones, can destabilize a household to the point that homelessness becomes possible. Being homeless comes with further health challenges that become much harder to address. A cascade effect leads to chronic conditions, an inability to manage those conditions or aftercare, and ultimately, more hospital visits and longer stays. The remoteness of some communities can leave people stranded in unfamiliar places after discharge, another path to housing instability. For those who do return home, the environment may not be conducive to recovery without some form of minor home improvement. Having to return for a follow-up appointment can put a strain on a household, and even be unnecessary if Telehealth options can be made available. Most importantly, short-term housing interventions can improve a patient’s overall health and thus their quality of life.	Alaska Housing Finance Corporation (AHFC) is requesting \$2,000,000.00 in funding to subaward to nonprofit partners for the purpose of providing Housing Interventions for those in rural Alaska interacting with the health care system. AHFC would focus on communities with Critical Access Hospitals, several of which have agencies administering AHFC-funded housing programs already. Partners will receive subawards with the following program parameters: • \$8,000.00 per household budget • 10% of total award for administrative expenses • AHFC will provide grant compliance and reporting infrastructure, technical assistance, access to data systems, and partnerships • Dynamic budgeting by which unused funds are rolled over to support new households • Uses include: - o Medical Respite Transitional Housing § Short-term housing for individuals needing safe and sanitary housing to recover or with follow-up appointments - o Eviction Prevention § Assistance to prevent eviction as a result of medical events - o Emergency Discharge Housing § Housing for individuals who would otherwise be discharged into homelessness - o Travel § Travel costs to get individuals back to home community after hospital stay - o Rental Assistance § Up to six months of rent for those escaping violent living situations such as victims of domestic violence § Unhoused populations with more extensive medical needs such as medication storage, multiple follow-ups, or health issues directly tied to housing situation - o Minor Home Upgrades/Repairs § Small, health-related home improvements such as air purifiers, grab bars, ventilation, or other minor items directly related to improving health § Potential Telehealth technology AHFC expects to serve 225 households minimum. Dynamic Budgeting will allow partners to use only the amount of budget necessary per household, which will likely lead to a larger total served, up to 30% more, as was seen in other AHFC housing programs. Subawardees will use AHFC’s data system as a condition of awards in order to track households served and outcomes. AHFC will leverage partnerships with local stakeholders to establish a community referral system to connect individuals being discharged with the local housing resources. AHFC’s pandemic-era programs fostered new, innovative approaches to addressing housing instability with great success. The experience, partnerships, and proven housing methods will be leveraged to achieve a rural health transformation rooted in housing as health care.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Housing Finance Corporation	Healthy Families Playground for Mutual Renewal Initiative	AK	With a large, deferred maintenance need, it is hard to direct resources to playgrounds and site improvements. AHFC must prioritize safety upgrades first. With the better part of a thousand units, with common spaces, parking lots, boiler rooms, and other critical facets of Public Housing, the beneficial but unfortunately not comparatively urgent need of playground renewal falls further down on the list of projects. The effect is that most playground equipment on Public Housing sites are decades old. When the equipment reaches a point of dereliction, there may be a need to remove the potentially hazardous equipment, but not enough resources to replace and update the equipment to ensure it complies with ADA and other requirements. The result is an exponential rate of deterioration for playground equipment in areas that are often the only place nearby for families to play.	In 2021, AHFC employed Design Alaska, INC to create a Site Improvement and Amenity Standard to help create an easy way to identify replacement needs based upon specific details, like useable area and median age of the resident children. The agency has successfully utilized the standard for the replacement of two of our community play areas, the first in Kodiak and the second in Ketchikan. There are three shovel ready locations, two in Juneau and one in Anchorage. The Facilities team have developed design and construction Rough Order of Magnitude (ROM) for seven other sites. Alaska Housing Finance Corporation, Public Housing Department is requesting consideration for a grant in the amount of \$4,296,000.00 for the completion of our vision to replace outdated equipment and play areas around the State.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Nome Census Area; Sitka (City and Borough)	Deferred or Not Advanced

Alaska Humanities Forum	Story Works Rural Readiness: Planning to Build Protective Factors for Rural Alaskan Youth	AK	The need to strengthen protective factors among Alaska's youth is clear. The 2023 Alaska YRBS found 23% of high schoolers seriously considered suicide, 43% have poor mental health, and 65% lack three or more trusted adults they could turn to for help. Rates are even higher for Alaska Native youth. The 2024 School Climate and Connectedness Survey finds only 26% of students report peers are respectful and helpful. These challenges are amplified in rural communities, where behavioral health providers are scarce, geographic isolation limits programming, and schools are often the only consistent institutional presence. Story Works addresses this gap through trauma-informed classroom storytelling workshops that build protective factors, including connection to trusted adults, peer support, self-regulation, and belonging, that research shows prevent and mitigate the impact of ACEs. The program has served over 6,000 students, and 88% of participants reported increases in protective factors. A Bering Strait School District pilot demonstrated that local teachers can be trained to deliver the program independently, creating a sustainable path to scale. The opportunity is to plan expansion into three rural regions where AKHF has existing relationships but Story Works has not yet been delivered. This readiness grant will fund partnership development, curriculum adaptation, and planning needed to prepare for implementation.	AKHF will use this readiness grant to plan the expansion of Story Works, a proven model for strengthening protective factors, into three rural regions: the Yukon Kuskokwim Delta, the Northwest Arctic Borough, and Interior Alaska. The planning year will build the partnerships, adapt the curriculum, and develop the implementation infrastructure needed to launch a teacher training model in each region. The project has four core components: Partnership Development. AKHF will travel to each region to formalize partnerships with school districts, tribal organizations, and behavioral health providers. In the Yukon-Kuskokwim Delta, AKHF will partner with LKSD and Calista Education and Culture. In the Northwest Arctic, AKHF will build on an existing grant partnership with the school district and develop a formal relationship with Maniilaq Association. In Interior Alaska, AKHF will formalize its relationship with Tanana Chiefs Conference and engage the local school district. In all three regions, AKHF will identify and begin partnerships with regional mental health providers to ensure the program connects students to appropriate clinical support. Curriculum Adaptation. AKHF will engage curriculum consultants to adapt Story Works for each region, ensuring cultural responsiveness across Yup'ik, Iñupiaq, and Athabascan communities. The successful Bering Strait pilot provides a strong starting point. A key focus will be aligning Story Works with state educational standards so that teachers can count the workshop toward their curriculum requirements, making adoption seamless and sustainable. Mental Health Consultation. AKHF will engage mental health consultants to review the adapted program model for each region, ensuring it meets the specific behavioral health needs of the communities served. The Story Works model has been reviewed by mental health clinicians multiple times and is grounded in SAMHSA's Six Guiding Principles for a Trauma-Informed Approach. This consultation is a targeted review to ensure the model fits each community context. Implementation Planning. AKHF will develop a detailed implementation plan for each region, including teacher recruitment and training timelines, logistics, data collection procedures, and a budget for a future RHTP implementation grant application. This plan will position AKHF to move from readiness to launch.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Fairbanks North Star Borough; Kusilvak Census Area; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Imaging Associates, LLC	Nurse Navigator	AK	Patients in Alaska face significant barriers to accessing specialty diagnostic and preventive healthcare services. Long travel distances, limited specialty providers, and complex referral processes often delay care and can result in missed screenings or incomplete follow-up. Mammography and lung cancer screening programs require consistent patient follow-up and coordination to ensure early detection and timely intervention. Rural patients may experience delays in scheduling, difficulty understanding follow-up requirements, and challenges coordinating travel and appointments. Without dedicated coordination, abnormal screening results may not receive timely follow-up, increasing the risk of delayed diagnosis. Rural providers often have limited administrative resources to manage screening programs, track abnormal results, and coordinate specialty referrals and follow-up care. As a result, patients may experience fragmented care and delays in diagnosis or treatment. The addition of a Nurse Navigator will address these barriers by providing centralized coordination and patient support for mammography and lung cancer screening services. The Nurse Navigator will assist with referral management, patient education, scheduling, and follow-up tracking and receive timely follow-up when abnormalities are identified. This coordinated approach will improve continuity of care and strengthen access to preventive and diagnostic services for rural communities across Alaska.	This project will establish a dedicated Nurse Navigator position responsible for coordinating mammography and lung cancer screening services for rural patients and referring providers. The Nurse Navigator will serve as a central point of contact for rural providers and patients and will assist with referral coordination, scheduling, patient education, and follow-up care. Responsibilities will include: • Coordinating mammography and lung cancer screening referrals • Tracking abnormal screening results and ensuring timely follow-up care • Supporting communication between rural providers and specialty teams • Assisting patients with appointment scheduling and preparation • Coordinating imaging and consultation requirements • Monitoring patient progress through the care pathway The Nurse Navigator will work closely with referring providers and specialty teams to ensure efficient coordination and timely care.	\$50,000-\$250,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Matanuska-Susitna Borough; North Slope Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Imaging Associates, LLC	Radiology workflow and care coordination platform	AK	Rural healthcare providers in Alaska face significant challenges in coordinating diagnostic imaging services due to geographic isolation, limited staffing, and fragmented communication workflows. Many rural facilities rely on manual tracking, phone calls, and disconnected systems to coordinate imaging studies and report delivery. These processes limit visibility into exam status and increase the risk of delays in communication and care coordination. Diagnostic imaging plays a critical role in guiding clinical decision-making in rural and frontier communities where specialty care is limited. When imaging interpretation is delayed, diagnosis and treatment decisions may be slowed, and patients may be transferred unnecessarily to regional medical centers. Rural providers often have limited tools to monitor imaging study status or identify urgent cases requiring priority review. Implementation of the New Vue platform, including the Radiologist Cockpit, will create an integrated workflow management system that centralizes imaging coordination across rural facilities. Radiologists will manage studies from multiple sites through a single interface with real-time visibility into exam status, priority cases, and report completion. By replacing fragmented workflows with a technology-enabled system, this project will strengthen care coordination, improve report turnaround times, and expand rural capacity to deliver timely diagnostic imaging services across Alaska’s rural communities.	This project will implement the New Vue platform using a structured, phased approach designed to support successful adoption across rural partner facilities while minimizing disruption to patient care. The implementation will include system configuration, workflow design, integration into existing radiology operations, and phased deployment across rural sites. Initial deployment will focus on core facilities, followed by expansion to additional rural partners once workflows are optimized. Comprehensive training will be provided for radiologists, administrative staff, and rural healthcare providers. Training will focus on standardized workflows, exam tracking, and communication processes to ensure consistent and effective system use. Implementation will include ongoing technical support and workflow monitoring to ensure that the system continues to meet the needs of rural providers. Continuous improvement processes will be used to refine workflows and address emerging needs. Recruitment and staffing resources will be allocated to support implementation and ensure long-term operational success. Targeted implementation will ensure that rural and frontier facilities with the greatest coordination challenges receive priority support.	\$50,000-\$250,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Matanuska-Susitna Borough; North Slope Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Imaging Associates, LLC	Recruitment & Retention of a Teleradiologist	AK	Rural and frontier communities in Alaska face significant barriers to accessing specialty diagnostic services due to geographic isolation and limited specialty workforce availability. As a result, many rural healthcare facilities depend on teleradiology to obtain timely diagnostic imaging interpretation. Alaska Imaging Associates (AIA) provides radiology services to healthcare facilities across the state through a structured teleradiology model. However, increasing imaging volumes across CT, MRI, ultrasound, mammography, and X-ray, combined with national radiologist workforce shortages, have placed substantial strain on the current workforce. AIA radiologists are currently operating near full capacity, limiting the organization’s ability to accept additional rural facilities seeking radiology coverage. Recruiting a dedicated teleradiologist will expand workforce capacity, improve report turnaround times, and strengthen diagnostic imaging support for rural healthcare providers. This project will improve access to timely diagnostic services, support clinical decision-making, and strengthen the sustainability of healthcare delivery in Alaska’s rural and frontier communities.	This project will recruit a board-certified teleradiologist to provide diagnostic imaging interpretation services for rural partner facilities across Alaska. Again, the recruitment of a dedicated teleradiologist will directly address these capacity limitations by expanding Alaska Imaging Associates' ability to support existing rural partners while allowing the practice to onboard additional Alaska facilities currently seeking coverage. This workforce expansion will help stabilize report turnaround times, reduce radiologist workload strain, and ensure reliable radiology support for rural and frontier communities across the state. Recruitment efforts will include: • Competitive compensation aligned with national market benchmarks • Flexible remote work structure • Comprehensive benefits package • Malpractice coverage • Targeted outreach through national radiology job boards and specialty organizations • Engagement with residency and fellowship programs Upon recruitment, the teleradiologist will undergo credentialing, licensing, and onboarding processes to support coverage for rural facilities. Coverage schedules will be expanded strategically to prioritize high-need rural partners and urgent case coverage. This structured recruitment approach will ensure efficient integration into rural service operations with minimal disruption.	\$1M-\$5M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Matanuska-Susitna Borough; North Slope Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Impact Alliance	907 Navigation App Expansion Project	AK	Residents of rural and remote communities in Alaska face significant barriers to accessing health care and related social services. Geographic isolation, limited transportation, workforce shortages, and fragmented information systems make it difficult for individuals and families to identify available services and complete referrals. Many communities lack centralized, easy-to-use tools that connect residents to local providers, statewide programs, and essential benefits that support health and well-being. Many service providers and agencies operate independently, which can lead to duplicated efforts, communication gaps, and missed opportunities to connect people with needed care. Rural residents often rely on word-of-mouth or outdated resource lists to navigate complex systems such as Medicaid, SNAP, behavioral health services, and other supports. The 907 Navigation Expansion Project addresses this challenge by expanding a coordinated navigation system that connects residents, providers, and agencies through a shared platform. By improving service directories, referral pathways, and navigation tools—including phone and text-based assistance—the project will make it easier for residents to find services and for organizations to coordinate care. This project represents an opportunity to strengthen Alaska’s health and social service infrastructure by improving access to accurate information, simplifying referrals, and helping rural communities connect people to care.	The 907 Navigation Expansion Project will address barriers to accessing health and social services in rural and remote Alaska by expanding and enhancing a coordinated community navigation platform that connects residents, providers, and agencies to critical resources. The project will strengthen the existing, but not yet launched, Community Alert platform by improving service directories, referral pathways, and communication tools that allow communities to share timely information about available services, programs, and supports. These improvements will make it easier for residents to identify local resources and for organizations to coordinate care across health, social service, and community systems. A key component of the project will be researching and planning the integration of navigation services that provide real-time assistance to residents through phone and text-based support. Both live navigator models and AI-supported navigation options will be explored to determine the most effective and sustainable approach for rural Alaska, where internet connectivity and service availability vary widely. The project will also explore opportunities to integrate the platform with statewide benefit programs such as Medicaid, SNAP, TANF, and the Permanent Fund Dividend (PFD). Improving awareness and navigation of these programs can help address social determinants of health and improve stability for individuals and families. To strengthen coordination among organizations, the project will research and plan for open and closed-loop referral integration with resource platforms such as FindHelp, Pear Suite and healthEConnect Alaska. This will allow agencies to more effectively connect individuals to services and track whether referrals are completed. The project will also support rural and frontier communities in adopting the platform by providing subsidies for implementation costs, including technical setup, API integrations, training, and outreach. Community convenings and marketing efforts will help ensure local organizations understand how to use the system and residents are aware of available tools. By improving navigation, strengthening referrals, and expanding access to reliable information about services, the 907 Navigation Expansion Project will build a more connected and sustainable system that helps rural Alaskans access the care and supports they need.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Impact Alliance	Alaska 100% Communities: Community-Led Systems for Access to Care	AK	Rural Alaskans face barriers to obtaining and maintaining health care not only because of provider shortages and geography, but because the systems that help people access care are fragmented and difficult to navigate. Many residents miss appointments or delay care due to transportation, childcare, housing, food access, and limited awareness of available services. Although services often exist, communities frequently lack a shared inventory of services, systems, and resources, making it difficult for residents and providers to connect people to appropriate supports. Referrals commonly depend on informal staff relationships. When turnover occurs — a frequent challenge in rural Alaska — knowledge of services is lost, and individuals must again navigate complex systems alone. This fragmentation contributes to delayed care, avoidable emergency department use, and increased strain on rural providers. The 100% Communities model addresses this problem by helping communities map services, organize partnerships, and distinguish between availability and accessibility issues. The model creates coordinated referral pathways and strengthens partnerships that leverage and braid resources. By improving navigation and prevention, the project supports timely access to care and builds sustainable, community-owned systems that help residents access the right services at the right time.	The project begins with capacity building and community outreach to prepare communities for implementing the 100% Communities framework. AIA will introduce the model through discussions with coalition leaders, healthcare providers, tribal partners, local governments, and community organizations. AIA will provide training, technical assistance, tools, and coaching, while local community leads engage partners to ensure the effort remains community driven. Partners will inventory existing coalitions, services, programs, and community resources. This process will identify services for inclusion in the 907 Navigation app platform, highlight successful efforts already operating locally, and identify gaps, duplication, and opportunities for improved coordination across health and social service systems. The Community Access Assessment was developed by AIA with a consultant team as a standardized survey tool to measure barriers to accessing healthcare and vital services. While communities may make limited local adaptations, the core survey will remain consistent to allow comparable statewide data. A deployment plan will be developed and the survey administered to residents to better understand barriers to healthcare, behavioral health, and social support services. AIA will provide technical assistance while local partners lead community engagement. After deployment, results will be shared through community presentations and discussions to guide next steps. Communities will recruit cross-sector action teams aligned with the ten vital service areas. These teams will include providers, community organizations, individuals with lived experience, and decision-makers who will use assessment data to identify practical projects that strengthen access to care and improve coordination. Communities will also develop a community navigator role to strengthen care coordination across agencies. The navigator will serve as a cross-sector systems integrator, supporting targeted case management coordination for individuals with complex needs and helping ensure warm handoffs between providers. The navigator will utilize the 907 Navigation platform to identify services, support eligibility navigation, and coordinate referrals among partners. Together, shared data, coordinated partnerships, and navigation technology support locally led solutions that improve access to care in rural communities.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Ketchikan Gateway Borough	Advance to Planning

Alaska Impact Alliance	AIA Medicaid Support Hub	AK	Many small and rural family serving organizations in Alaska provide essential behavioral health, substance use disorder, and family support services to Medicaid eligible children and families but cannot access Medicaid reimbursement. Through the Alaska FRC Network and the AIA, providers consistently report that the administrative and workforce infrastructure required to participate in Medicaid is beyond their capacity. Barriers include navigating Medicaid provider enrollment, meeting licensing and credentialing requirements, managing billing and claims systems, and providing clinical supervision for behavioral health providers pursuing licensure. Small community based organizations often lack billing staff, electronic health record systems, and licensed supervisory clinicians. As a result, many agencies either limit the services they provide or deliver services without reimbursement, restricting sustainability and reducing access to care in rural communities. We will create a centralized Medicaid Support Hub that transforms how small agencies access Medicaid participation. The hub will provide Medicaid enrollment concierge services, shared billing and documentation infrastructure, claims and denial management, and access to contracted clinical supervisors. By removing administrative and workforce barriers, we will enable rural providers to sustainably deliver Medicaid covered behavioral health and family support services and expand access to care for families.	Our approach is to establish a centralized Medicaid Support Hub that provides the infrastructure, technical assistance, and clinical oversight needed for small and rural family serving organizations to participate in Alaska’s Medicaid system. Rather than requiring each agency to independently build billing capacity and clinical supervision infrastructure, the hub will provide shared services that reduce administrative burden and make Medicaid participation feasible for community based providers. The project will support agencies through several coordinated service components. First, the hub will provide Medicaid readiness and enrollment concierge services. This includes conducting readiness assessments, identifying licensing and credentialing requirements, and guiding agencies through provider enrollment with Alaska Medicaid, the Division of Behavioral Health, and Gainwell Technologies. Agencies will receive individualized roadmaps outlining the steps required to become eligible to bill Medicaid and technical assistance to address barriers during the enrollment process. Second, the hub will operate a centralized billing and documentation infrastructure. Participating agencies will gain access to electronic health record and referral management technology, standardized documentation templates aligned with Medicaid requirements, and operational support for claims submission, denial management, resubmissions, and reporting. The hub will also provide training and compliance support to ensure documentation meets Medicaid standards and audit expectations. Third, the hub will expand workforce capacity by providing access to licensed clinical supervisors. Many rural agencies employ clinicians working toward licensure but lack supervisory staff required for Medicaid service delivery. Contracted supervisors will provide clinical oversight, review treatment plans and documentation, and support clinicians in meeting licensing and Medicaid requirements. The project will launch with a pilot cohort of three to five family serving organizations, prioritizing rural and under resourced communities. Lessons learned from the pilot will inform refinements before scaling to additional agencies statewide.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Impact Alliance	Alaska OCS Health Information Integration Project	AK	The Alaska Office of Children’s Services serves nearly 2,500 children in state custody and is responsible for coordinating their medical, behavioral health, and therapeutic services across Alaska’s rural and frontier communities. Currently, the referral process is fragmented and time intensive. Providers use different referral forms, communication often relies on fax due to privacy constraints, and there is no standardized system for tracking whether referrals are accepted or services are initiated. As a result, referrals may be duplicated, delayed, or lost, creating gaps in care for some of Alaska’s most vulnerable children. Additionally, OCS staff must manually request medical records from multiple providers to compile health histories for intake decisions, court proceedings, and foster placements. This process delays access to critical information and increases administrative burden on an already stretched workforce. The opportunity is to integrate OCS into Alaska’s Health Information Exchange to create a standardized, secure referral and medical data system that improves care coordination, reduces delays, and strengthens rural health access for children in state custody.	The proposed approach is to integrate the Alaska Office of Children’s Services into the Alaska Health Information Exchange to establish a standardized, HIPAA compliant referral and medical data access system for children in state custody. This will be implemented as a phased, multi year initiative coordinated by the Alaska Impact Alliance in partnership with OCS, the Health Information Exchange, and referred providers statewide. In year one, the project team will convene OCS leadership and frontline staff, HIE technical staff, and frequently referred medical, behavioral health, and therapeutic foster care providers to design a standardized referral process and uniform referral forms within the HIE. The team will map current workflows, identify barriers, and develop clear referral status tracking protocols to ensure confirmation of acceptance, denial, or service initiation. During year one, the project will also coordinate with OCS information technology staff to develop requirements for secure APIs between the ORCA child welfare case management system and the Health Information Exchange. This integration planning will allow relevant child information to flow securely into referral forms while maintaining compliance with federal child welfare and health privacy requirements. In year two, the API connection would be established and OCS will begin sending referrals through the HIE using the standardized systems. Caseworkers and providers will receive training and ongoing technical assistance. The project will monitor referral turnaround times, acceptance rates, and system usability, using continuous quality improvement methods to refine workflows and address challenges. Over years three through five, the system will be scaled and optimized statewide, embedding referral coordination and medical data access into routine OCS operations and strengthening rural health access, workforce efficiency, and continuity of care.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Impact Alliance	Alaska OCS Parent Orientation Initiative	AK	Families involved with OCS, particularly in rural, remote, and frontier communities, often enter the child welfare system with little understanding of their rights, court processes, case plan requirements, visitation expectations, or the roles of attorneys, tribes, and OCS staff. This lack of accessible, culturally responsive information contributes to confusion, missed appointments, delayed compliance, prolonged foster care placements, increased trauma, and poorer reunification outcomes. The need for a clear, standardized parent training curriculum has been identified as a top request of the OCS Parent Advisory Committee. Parents with lived experience consistently report they did not receive clear guidance at the start of their case and were left to navigate a complex legal and child welfare system on their own. Rural families face additional barriers including geographic isolation, limited access to legal guidance, workforce shortages, language barriers, and limited broadband. While OCS and community partners provide services, there is no standardized, statewide, ADA-compliant training designed to equip OCS-involved parents with clear guidance on navigating the system successfully.	The Alaska OCS Parent Orientation Initiative will develop and deploy a statewide, ADA compliant, multilingual training curriculum designed specifically for parents involved with OCS. This initiative directly responds to one of the top priorities identified by the OCS Parent Advisory Committee, whose members have consistently requested clearer guidance for parents navigating OCS involvement. Over a one year period, Alaska Impact Alliance will convene key stakeholders including the OCS Parent Advisory Committee, OCS leadership and case managers, tribal representatives, legal experts from the Office of Public Advocacy and the District Attorney’s Office, guardians ad litem, and community based service providers. Through structured design sessions, we will co create a curriculum grounded in lived experience, legal accuracy, and culturally responsive practice. The training will consist of modular, video and audio based content that covers navigating OCS, understanding Child in Need of Aid proceedings, parents’ rights and responsibilities, court protocol, filing motions and appeals, case plan compliance, visitation expectations, permanency pathways, and the Indian Child Welfare Act including the role of tribes. Scenario based vignettes with embedded learning reinforcement will strengthen understanding and practical application. Lived experience parents will be compensated as content experts and featured in training videos alongside OCS staff, legal professionals, and tribal partners. This ensures credibility, relatability, and shared understanding across systems. The curriculum will be housed within the existing OCS Learning Management System and designed for mobile access. A dedicated Child Welfare Training page will be built within the 907 Navigation App to ensure families statewide can easily access the modules. Alaska Impact Alliance will also create a Child Welfare Training page on its website linking to the curriculum and will distribute access through 150 partner agencies and the Alaska Center for Resource Families. The training will also be used to educate OCS staff, foster parents, and kinship caregivers, creating shared foundational knowledge and improving cross system alignment. By leveraging existing infrastructure and statewide partnerships, this approach ensures equitable access for rural and frontier communities while building a sustainable, scalable education platform that strengthens families and improves child welfare outcomes across Alaska.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Impact Alliance	Relative Caregiver Learning and Navigation System	AK	Across Alaska, many children are raised by relatives such as grandparents, aunts, uncles, extended family members, or caregivers connected through Tribal custom when parents cannot safely care for them. These caregivers often step in during crises to keep children connected to family, culture, and community. Many assume responsibility suddenly and without preparation, financial assistance, or access to training. Unlike licensed foster parents, most relative caregivers are not licensed through the Office of Children’s Services (OCS) and do not receive foster care stipends or structured support, despite carrying full responsibility for the child’s health, education, and wellbeing. Nationally, for every one child in foster care, approximately nineteen children are being raised by relatives outside the formal child welfare system. Alaska places about half of children in OCS custody with relatives, while many more families provide care informally to prevent entry into stranger foster care. Relative caregivers must navigate complex systems including medical care, Medicaid enrollment, school enrollment, guardianship and custody processes, court proceedings, and child welfare policies such as Child in Need of Aid (CINA) cases and the Indian Child Welfare Act (ICWA). Without clear guidance, many struggle to access services. This project addresses this gap by developing training and navigation support to help relative caregivers care for children and access essential services.	This project will develop a Relative Caregiver Learning and Navigation System designed to equip relatives caring for children both within and outside the Office of Children’s Services (OCS) system with the knowledge, tools, and support needed to navigate complex health, legal, and education systems. The project will create an interactive training program delivered through the OCS Learning Management System, a publicly accessible web platform, and the 907 Navigation App so caregivers can access training regardless of system involvement or location, including those living in rural and remote communities. The training will use video instruction, audio narration, AI assisted learning features, and interactive scenarios using branching logic to help caregivers understand real life situations and system navigation. Content will be developed with guidance from relative caregivers with lived experience raising kinship children, including participants in the UReCares program, along with attorneys specializing in child welfare and family law to ensure the training reflects real challenges and provides accurate legal guidance. The project will be developed in collaboration with Volunteers of America Alaska and the Kin Support Program, the Alaska Center for Resource Families, the Office of Children’s Services, Guardians ad Litem, and representatives from Alaska’s court system to support consistent guidance across agencies that work with kinship families. Training topics will include understanding OCS and Child in Need of Aid cases, the Indian Child Welfare Act, guardianship and powers of attorney, enrolling children in school, accessing medical care and Medicaid, navigating court processes, supporting children who have experienced trauma, and connecting to peer and community supports. The project will also add a Relative Caregiver Navigator to support families participating in the Alaska Impact Alliance’s Unlicensed Relative Caregiver Stipend and Respite Program funded by the Alaska Mental Health Trust Authority. The navigator will assist caregivers with legal documentation, health coverage, school enrollment, and connections to services and support.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Institute for Justice	Bridging Language, Strengthening Care: Expanding Language Access Services in Rural Alaska	AK	Approximately 34.1% of Alaskans age 5 and older speak English less than “very well,” reflecting significant linguistic diversity across both urban and rural communities in the state (U.S. Census Bureau). Language access is critical for providing care to limited English proficient (LEP) patients. National research shows that LEP patients are less likely to have a regular source of care, less likely to receive preventive screenings, and more likely to delay or forgo needed services. Language barriers are also linked to higher rates of medical errors, misunderstanding of diagnoses and treatment plans, difficulty navigating insurance and referral systems, reduced medication adherence, lower patient satisfaction, decreased trust in providers, and increased use of emergency services. LEP patients are more likely to experience longer hospital stays and higher rates of hospital readmission when communication is inadequate. These challenges compound existing rural health disparities related to workforce shortages, transportation barriers, geographic isolation, limited broadband for telehealth, and reliance on critical access hospitals. Our project addresses these intersecting inequities by providing reliable, culturally responsive interpretation services that improve equitable access, enhance patient safety, strengthen provider–patient communication, support continuity of care across telehealth and in-person settings, and improve overall community health outcomes in rural Alaska.	The Language Interpreter Center (LIC) at the Alaska Institute for Justice operates a well-established platform for professional interpretation services, the only one of its kind in Alaska. The platform connects organizations, businesses, and individuals with qualified interpreters—either in-person or virtually—for critical meetings such as court hearings, doctor visits, social services appointments, and more. To date, the LIC has provided services in many of the languages spoken across Alaska, including Alaska Native languages, reflecting the state’s rich linguistic diversity. This project will leverage that platform to expand high-quality interpretation to rural communities where language access is limited and health disparities are pronounced, particularly in geographically isolated regions with limited provider access. Our multi-pronged approach includes: 1. Strengthen staff capacity to support rural service delivery, including telehealth and onsite interpretation, ensuring rapid response and coordinated scheduling. 2. Engage and mobilize interpreters by communicating remote and rural interpreting opportunities and offering flexible participation pathways. 3. Provide advanced medical interpretation training to ensure accuracy, confidentiality, and cultural responsiveness in clinical settings. 4. Develop rural-focused digital training materials to create sustainable professional development pathways tailored to community contexts and logistical realities. 5. Recruit speakers of priority languages from within rural communities, strengthening local capacity, continuity, and trust. 6. Provide orientation resources for healthcare providers to increase awareness and effective utilization of interpretation services, improving patient access, follow-up care, and overall outcomes. Together, these strategies will strengthen Alaska’s language access infrastructure, connect rural communities to essential providers, and advance the quality, equity, and long-term sustainability of healthcare delivery.	\$50,000- \$250,000	Multi- Community or Participating in Regional Hub-and- Spoke	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Kusilvak Census Area; North Slope Borough	Deferred or Not Advanced

Alaska Jewish Campus	Alaska Friendship Circle All-Inclusive Early Childhood Play Center & Programming	AK	We aim to strengthen maternal and child health as a foundation for healthy families. Alaska Jewish Campus’s (AJC) creation of our Play Center is in response to the need for accessible, inclusive and developmentally appropriate play space for young children, (ages 15 mo - 9 years) especially those with disabilities. Families have voiced a need for an inclusive play space, where children can engage in play that fosters physical growth, emotional well-being, and social connection. To ensure our project meets current needs, we hosted meetings with service providers to gather input on: Existing services available Current gaps and unmet needs Ideas and possibilities for a new, all-inclusive Play Center Ways to partner together to best serve the needs of Anchorage’s children. The Play Center will provide developmentally appropriate play opportunities and programs that welcome children, regardless of ability. For children with disabilities, who already face barriers to inclusion, peer interaction and support, this space will offer something vital: a place to connect, belong and thrive. At the same time, it allows children to build friendships with peers of all abilities—encouraging empathy, curiosity and community values. This Play Center is more than a playground; it removes barriers, fosters inclusivity and creates a place where children grow together through joy and friendship. It will be a safe, fully accessible environment that supports year-round play and connection.	With 30+ years of serving children, AJC identified special needs as an underserved group. In response, we recently completed the outdoor space of the Play Center, designed to bring children and families together with joy, fun, connection and community. Open to the public and free of charge, the Center focuses on young children —especially those with disabilities—offering inclusive access for all. Our program is the first in Alaska to join the global Friendship Circle program—today’s fastest-growing organization dedicated to children with special needs. This proven and innovative model connects teen volunteers with children in purposeful, joyful experiences that build confidence while transforming the lives of the volunteers. Friendship Circle is a movement united by a shared mission: to ensure that no child with special needs feels isolated. Our program advances the mission through programming supported by trained staff who oversee teen volunteer coordination, family engagement, program implementation and safety. In partnership with child and disability service providers, the Center ensures equitable access to play, learning and developmental growth through accessible and sensory-friendly design. Outdoor play center (completed) Performance stage and musical zones Fort-building, playhouse and turf hills Climbing walls, sensory panels Garden, lighting, ADA parking and parent seating Indoor play center & programs (the focus of this grant): Art, dance and story areas Play areas, adaptive toys and sports equipment ADA restrooms, kitchen and coat/equipment storage Sensory and quiet spaces According to KOMPAN Play Institute, “children with disabilities participate far less in active play and physical activity than their peers. Since active play is one of the main contributors to child health, the accessibility to and usability of public playgrounds for children of all abilities is fundamental for their physical and social-emotional well-being and health. And children’s physical, social-emotional, cognitive, and creative development is not only supported by play, it is developed through play. There is evidence that play, apart from being great fun, is fundamental for all areas of child development. The social connectedness of playing together in public playgrounds is an asset in equity and inclusion agendas.”	\$1M-\$5M	Single Community	Anchorage (Municipality)	Advance to Implementation Application

Alaska Legal Services Corp.	Promoting Healthy Rural Communities through Medical Legal Partnerships Project	AK	Public health and preventative services are especially challenging in Alaska due to its rurality, high transportation costs, and limited local infrastructure. Healthy Alaskans 2030 State Health Assessment. Health is determined by complex and interdependent factors like behavior, biology, genetics, and the person’s physical and social environment. The combined impact of these factors drive health outcomes. Id. Social determinants of health (SDOH) are non-medical factors, like physical environment, income, education, family stability, employment, and safety, that influence a person’s health. SDOH, perhaps surprisingly, account for roughly 60% of a person's health—carrying more weight than genetics or healthcare services themselves. “AMA Code of Ethics’ Opinions Related to Medical-Legal Partnerships.” AMA Journal of Ethics, Vol. 26 (issue 8), 622 (2024). Additionally, some Alaska populations “suffer from disparities in health caused by systematic and avoidable social and economic circumstances that create barriers for achieving full health potential and lead to poor health outcomes.” Healthy Alaskans 2030. MLPs address SDOH and health inequities by integrating legal service providers directly into the clinical setting to address the root causes of illness that medicine cannot touch. The MLPs will collaborate with rural medical providers to shift from solely treating symptoms to solving structural problems affecting health.	This project will embed CJWs into hospitals and healthcare centers serving rural Alaskans, thereby making legal aid readily available to advise healthcare teams and provide direct legal assistance to patients and their families. CJWs will be fully supported by ALSC staff and infrastructure. CJWs will: - Assist eligible clients with legal services, including Medicaid and Medicare denials, reductions, or terminations; public benefit denials or delays; wills, powers of attorney, and advanced health care directives; domestic violence protective orders; housing matters; and family stability issues, such as minor and adult guardianships and custody needs. - Provide on-site accessibility for consultations with hospital staff to identify if a patient has health harming or other legal needs. - Provide education and training to hospital staff regarding health harming legal needs and the most common and effective legal interventions. The Project design will overcome potential recruitment and retention challenges, often typical in rural communities, by staffing positions with CJWs. Under ALSC’s CJW program, community members are trained to become legal practitioners providing specific targeted legal interventions addressing routine legal issues. The scope of the CJW program includes community outreach and information; brief legal services; and direct client representation in court for some legal matters under Alaska Bar Rule 43.5. CJWs’ areas of practice align with legal issues directly affecting SDOH. Alaska’s CJWs have proven to provide effective and impactful services. Between 2021 and March 2025, CJW cases resulted in \$23.6M in SNAP benefits recovery for clients and their families, with a \$14.5M additional economic benefit during the same time period. CJWs have a very high return on investment. A study conducted on the effectiveness of CJWs in Alaska found that CJWs generated \$25 of public benefit for every federal grant dollar invested in the program. (“Research Brief: Analysis of the Social and Economic Impact of the Alaska Community Justice Worker Program (2021-2025).” American Bar Foundation Access to Justice Research Initiative.)	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Northwest Arctic Borough	Deferred or Not Advanced

Alaska Library Network	Alaska Health Information Portal (AkHIP). --Trusted information for better health	AK	While the internet is ubiquitous it is not necessarily reliable or easy to understand for the general public. Search results can be based on unreliable health information sources or sponsored by suspicious companies or health organizations. The amount of information retrieved can be overwhelming to the general public. Too often the best reliable health information is unavailable because it is located behind pay walls. RHTP offers the opportunity for the Alaska Library Network to establish a comprehensive health information portal. This portal can transform the delivery of health information by using a single web site to offer a range of health resources not available on the open internet. As a single health information portal, the search results will be retrieved from trustworthy sources with more manageable results to review. The licensed resources will be supplemented with selective government and non-profit websites of particular interest to Alaskans.	The Alaska Library Network has decades of experience in delivering statewide high-quality vetted information to the residents, researchers, and students of Alaska. ALN has negotiated with vendors licensing agreements for statewide resources for academic, health, and school programs. The Alaska Health Information Portal (AkHIP) will approach the health information challenge by offering two windows to high quality vetted information. From the AkHIP webpage individuals would be directed to consumer health information while health care providers and medical students would be offered an additional path to health information resources produced for doctors, nurses, health sciences students, and mental health counselors. AkHIP can also help with workforce development by providing online training and testing materials for health care providers such as nurses or counselors. The consumer health resources will be readily accessible to all residents and students in Alaska and will help individuals gain an overall understanding of key topics across the health care environment from mainstream medicine to complementary, holistic and integrated medicine. Teen health and wellness will be a particular focus. Resources for health care providers and university medical students will be evidence based and up to date providing access to a range of resources. In addition to providing high quality vetted health information, the AkHIP project will transform the retrieval of health information by employing as appropriate AI, API, and discovery search services.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Library Network	Ensuring Long Term Access to Health Information and Research for Alaska's Rural Communities	AK	This project supports the curriculum needs of health science students including access to evidence-based research materials. Expanding access by adding additional journal titles focused on rural health topics will directly support students as they enter the healthcare field in Alaska and work with rural patient care.	In the first two years, ALN will acquire additional online health science journals while supporting existing health science database subscriptions over the next five years. The project also includes hiring two temporary staff members to manage the purchase and processing of the health science collections.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Literacy Program Inc	Community Health Worker Network	AK	In Alaska’s rural and frontier communities, the majority of factors influencing health outcomes occur outside clinical settings. While medical care addresses only a portion of health needs, social drivers such as housing stability, food access, transportation, cultural trust, and care coordination significantly impact maternal and child health, chronic disease management, and preventive care utilization. Community Health Workers (CHWs) are uniquely positioned to address these gaps by building trust, bridging cultural and geographic divides, and connecting families to clinical and community-based resources. When effectively integrated into health systems, CHWs reduce avoidable emergency department visits, improve care continuity, and lower long-term costs by shifting health systems toward earlier, lower-cost prevention rather than expensive crisis care. However, Alaska lacks coordinated statewide infrastructure to identify, support, and sustainably integrate the CHW workforce. Inconsistent role clarity, limited professional development pathways, and underdeveloped payment mechanisms hinder full integration across the Continuum of Care. Without dedicated capacity to implement a strategic workforce plan and strengthen statewide coordination, Alaska cannot fully leverage CHWs to advance rural health transformation, strengthen workforce resilience, and improve fiscal sustainability.	This project will build statewide infrastructure to strengthen and integrate Alaska’s Community Health Worker (CHW) workforce as a core strategy for Rural Health Transformation. In Year One, we will establish dedicated capacity through a full-time Coordinator and Administrative position, supported by an Advisory Council and targeted subcontractors for program design. This structure will implement our strategic plan and align CHW workforce development with State priorities. Key activities include expanding statewide CHW membership; strengthening partnerships with Tribal Health Organizations, community-based organizations, clinical providers, and state agencies; and developing regional CHW hubs by identifying local champions and conducting outreach in rural and frontier communities. These hubs will reduce workforce isolation, strengthen interdisciplinary collaboration, and support culturally responsive service delivery. We will provide professional development, monthly network meetings, and statewide training aligned with clear workforce pathways. Training will improve role clarity, care coordination, shared outcomes, and integration across the Continuum of Care. Shared infrastructure across partners will be critical to this effort. The Network will utilize Pear Suite to increase access to social care resources and standardize documentation, referral tracking, and shared outcome reporting across participating organizations. This will help community-based organizations demonstrate measurable impact, improve care coordination, and bridge trusted community-rooted work with emerging reimbursement pathways for CHW services in Alaska. The project aligns with Rural Health Transformation initiatives by strengthening the rural health workforce; expanding access to preventive, maternal-child, and behavioral health supports; advancing Healthy Communities through community-based care; supporting Pay for Value through quality metrics and reimbursement alignment; and partnering with the Departments of Health and Labor on workforce development and evaluation. Rural, remote, and frontier communities will benefit from improved care navigation, stronger trust between providers and communities, and reduced unnecessary emergency utilization. Populations served include pregnant and parenting families, individuals managing chronic conditions, Elders, youth, and communities facing social and geographic barriers to care.	\$50,000- \$250,000	Multi- Community or Participating in Regional Hub-and- Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

Alaska Literacy Program Inc	Pre-apprenticeship Healthcare Training Academy and Health Education and Support Services	AK	The State of Alaska faces significant healthcare workforce shortages. Existing healthcare professionals are stretched thin, and health systems across the state need sustainable strategies to train Alaskans for healthcare jobs within their own communities. According to the 2024 Alaska Healthcare Workforce Analysis, Alaska needs roughly 1,400 new registered nurses and over 9,400 new healthcare workers annually to keep up with patient demands. Additionally, a lack of health literacy, or understanding appropriate and timely access to healthcare, strains Emergency Rooms and professionals providing care. Alaska Literacy Program (ALP) addresses these challenges by developing targeted educational pathways that prepare Alaskans for entry-level healthcare careers while improving overall health literacy. Many ALP students are under-employed or hold healthcare credentials that are not transferable to the U.S. workforce. Through our Pre-Apprenticeship Training in Healthcare (PATH) Academy in partnership with the Area Health Education Center, participants earn certifications such as CPR and Mental Health First Aid while building workplace readiness skills to enter or Certified Nursing Assistant and similar entry level programs. Additionally, ALP leads our Peer Leader Navigator program, training multilingual community members in healthcare topics and systems navigation to strengthen preventive care awareness, appropriate utilization, and patient advocacy within their communities.	ALP is uniquely positioned to support workforce training that strengthens both individual economic mobility and community health outcomes. Our programming will strengthen Alaska’s healthcare workforce pipeline and alleviate strain on healthcare systems by increasing health literacy to create healthy communities. RHTP funds will be used to build organizational capacity to serve more Alaskans across our state. We are requesting funding for key personnel to expand programming, including a Distance Education Coordinator, a Healthcare Training Coordinator, and an Administrative Assistant to support our Peer Leader Navigator Program. Additionally, funding would go towards trained PLNs to provide health education and health/social resource navigation and services. We also plan to develop Healthcare Career Guides in partnership with Alaska Department of Labor, which would outline training steps, credentials, and advancement pathways, strengthening recruitment and long-term workforce retention. This increase in capacity allows for essential activities in our healthcare training academy as well as increased reach for our PLNs. Allowing for distance-delivered instruction means learners in communities across the state can access high-quality training without relocating and filling personnel gaps in their own communities. Providing Alaskans with strong foundational education in healthcare concepts, digital literacy, and workforce readiness prepares them for additional credentialed training such as CNA and Community Health Worker certificate programs and supports long-term career advancement. Alaska Literacy Program is dedicated to removing barriers to education by providing flexible hours through online and in-person learning options that support adult learners balancing work, family, language access, and transportation challenges in rural Alaska. By providing Alaskans with accessible, high quality education to prepare for additional healthcare certification, we are recruiting strong candidates for full time healthcare careers and decreasing the number of underemployed highly-skilled Alaskans. Expanding our Peer Leader Navigator program’s capacity will increase culturally responsive health education and system navigation support, helping community members access appropriate care and empower individuals in accessing services.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Marine Safety Education Association	Rural Youth Marine Safety Education for Drowning and Injury Prevention Across Alaska	AK	Rural Alaskan youth face a disproportionately high risk of drowning and cold-water injuries due to reliance on boats for subsistence, transportation, and daily life, combined with limited local access to marine safety education. Many schools lack the resources or trained personnel to provide culturally relevant, hands-on drowning prevention and water survival training. This project addresses a critical gap in Alaska’s Healthy Beginnings and Healthy Communities initiatives by providing youth with life-saving skills, including safe boating practices, cold-water survival techniques, and emergency response training. By integrating a train-the-trainer model, local educators gain certification to deliver ongoing marine safety education, ensuring sustainable, community-led programming. These interventions directly advance lifelong health and well-being, strengthen preventive care infrastructure, and align with Alaska’s Rural Health Transformation Plan goals by improving access, building workforce capacity, and reducing preventable injuries and deaths among youth in rural, remote, and frontier communities.	This project strengthens AMSEA’s rural youth marine safety program through four coordinated strategies designed to reduce drowning and cold-water injuries among Alaska’s youth: 1. Dedicated Youth Program Staffing: We will hire and retain trained staff focused on youth outreach and program delivery in rural and frontier communities. Staff will support local schools, community centers, and Tribal organizations to deliver hands-on, high-quality marine safety education. This strategy aligns with RHTP Goal 3 by building workforce capacity to meet rural needs. 2. Expanded Rural Training Access: Programming will ensure youth in off-road and remote communities can participate in hands-on marine safety training. Students will gain skills in cold-water survival, safe boating practices, and emergency response. This improves access to preventive health interventions and supports lifelong well-being, in line with RHTP Goals 1 and 2. 3. Train-the-Trainer Workshops and Peer-to-Peer Instruction: Community instructors, including teachers, health aides, and local youth leaders, will be trained to deliver culturally relevant marine safety curricula. Peer-to-peer instruction will reinforce skills and encourage local engagement, creating a sustainable training program. This builds local capacity, strengthens community partnerships, and ensures long-term program continuity. 4. Curriculum Modernization and Cultural Relevance Updates: We will update the program curriculum to incorporate current best practices in drowning prevention, cold-water survival, and emergency response, while integrating Alaska Native knowledge, and local community practices. Updated lessons will be interactive, hands-on, and designed for multiple learning levels to maximize retention and real-world application. 5. Updated Youth Program Equipment and Supplies: Students and instructors will receive modern, safe, and durable equipment to support experiential learning, including immersion suits, life jackets, training aids, and simulation tools. This ensures effective, safe, and engaging training across rural and frontier settings. By combining workforce development, expanded access, culturally tailored curriculum, and modern training equipment, this approach directly addresses the high risk of drowning among rural Alaskan youth, strengthens preventive health infrastructure, and provides measurable improvements in youth safety and preparedness.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

ALASKA MARITIME PHYSICIAN S	Remote Monitoring and Pre-Employment Screening for Alaska Maritime Crews	AK	Alaska's maritime industry operate for extended periods in remote waters where distance and weather delay medical assessment. Clinical decline may go undetected until symptoms become obvious enough to force diversion to port or late presentation at already-strained coastal facilities. This pattern drives avoidable medical evacuations, unnecessary vessel returns, and operational disruption across fleets ranging from large sophisticated operators to small seasonal co-ops with limited onboard medical capability. Many vessels lack meaningful physiologic monitoring at the point of first concern. Without better data, escalation thresholds trend conservative — generating costly disruption and avoidable burden on rural receiving sites. Some mariners also board vessels with unmanaged health risks that could have been identified and addressed before departure. The solution links two pathways: pre-deployment screening to identify and manage higher-risk individuals before leaving port, and onboard remote monitoring using wearable biosensors, cloud analytics, and exception-based workflows to give clinicians real-time physiologic data at sea. This enables more informed triage, supports safer care in place when appropriate, and drives timelier intervention when escalation is warranted — reducing avoidable medevacs, unnecessary diversions, and pressure on remote facilities while building a more proactive model of maritime care for Alaska.	We will implement an Alaska-rooted Maritime Remote Monitoring Program designed to support care delivery across the maritime industry operating in remote and frontier settings. The program will be operated through a hub-and-spoke model utilizing Alaska Maritime’s physician-led clinical team, with centralized monitoring supported by cloud-based analytics and scalable exception management. This enables limited clinical staff to oversee a large and geographically dispersed maritime population more effectively, while maintaining clear escalation pathways based on operational realities, local protocols, and the availability of transport or port access. The proposed model includes two parallel pathways. Pathway I is pre-employment screening and early risk stratification. Before deployment, mariners can be assessed using structured monitoring workflows to identify elevated risk, support more informed fitness-for-duty decisions, and establish defined treatment or management plans where needed. This creates an opportunity to avoid sending individuals with unmanaged or unstable conditions into prolonged remote maritime settings where reassessment is difficult and intervention options are constrained. In some cases, the pathway may also support ongoing monitoring plans that continue once the mariner is onboard. Pathway II is onboard remote monitoring for mariners working on vessels. This pathway is intended to support earlier detection, more informed triage, and more timely intervention when clinical concerns arise at sea. It will allow Alaska Maritime’s on-call physicians and care team to review physiologic trends and related data, use exception-based workflows to prioritize attention, and determine the appropriate level of response. The model is particularly relevant for vessels without robust onboard medical capability and in situations where early warning could prevent avoidable deterioration or unnecessary use of remote healthcare resources. The program will launch with a beta period, followed by broader operational rollout aligned to the maritime industry timing and vessel operator decision cycles. Year 1 will focus on establishing the maritime operating model, implementation workflows, training, device deployment, and early use cases across both screening and onboard monitoring. Over time, the program can scale across Alaska Maritime’s contracted vessels and become a core part of a more proactive maritime health and risk management strategy for Alaska.	\$1M-\$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah- Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska- Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

ALASKA MARITIME PHYSICIAN S	Opioid Education, Addiction/Overdose Prevention, Monitoring for Alaska Maritime Industry/Communities	AK	Diversion of prescribed controlled medications continues at epidemic proportions in our maritime communities. Residents and workers in these areas face extraordinary barriers to health care. This project directly addresses access to opioid education, overdose prevention tools, and controlled substance monitoring in communities where traditional health infrastructure is limited or nonexistent.	Proposed Approach Alaska's rural maritime communities and industry workers face compounding barriers to opioid prevention and care — geographic isolation, limited health infrastructure, occupational injury risk, and cultural mistrust of outside health systems. This project addresses those barriers through three integrated strategies delivered where people live and work. Education and Training — Culturally responsive opioid education will be delivered through tribal health organizations, canneries, harbormaster offices, and maritime worksites. A maritime-specific curriculum will address pain management risks following occupational injury, recognition of substance misuse, and employer responsibilities. Community Health Aides and local providers will receive targeted clinical training in addiction screening and evidence-based prescribing. Overdose Prevention — Naloxone will be distributed and training provided across remote coastal and river communities and maritime worksites. We will advocate for naloxone as standard equipment aboard commercial vessels, normalizing overdose preparedness within marine safety culture alongside existing emergency protocols. Monitoring and Care Coordination — We will expand provider participation in Alaska's Prescription Drug Monitoring Program and establish telehealth-based pathways connecting at-risk individuals to medication-assisted treatment. A care coordination model will specifically address the mobility of seasonal maritime workers, ensuring treatment continuity across geographic range. A Community Advisory Board of tribal leaders, maritime stakeholders, and individuals with lived experience will guide all program decisions. Local community members will be prioritized as project staff and peer navigators, ensuring trusted, sustainable delivery. This approach meets Alaska's maritime communities on their own terms — practical, culturally grounded, and built to last.	\$1M-\$5M	Family or primary care	Other	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Copper River Census Area; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kuskilvak Census Area; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Marriage & Family Therapy Associates	Peer Support Professional Program Transformation	AK	Alaska's Peer Support Professional (PSP) program is a critical behavioral health resource, yet over the years it has produced only about 150 Peer Support Professionals---far fewer than rural communities need. The primary barrier is the Alaska Commission for Behavioral Health requirement that non-degreed applicants complete 1000 hours of employment or volunteer training with a licensed behavioral health facility prior to certification. This is a necessary requirement for PSPs to obtain the experience needed. However, for rural residents, meeting this requirement is extremely difficult. Completing this required employment/training typically requires leaving one's home community to live and work wherever the behavioral health facility is located for six months, disrupting family, cultural, and subsistence responsibilities, and creating significant financial strain. Additionally, behavioral health facilities face their own challenge with this model: they must hire and pay trainees for six months of largely training-focused work without any assurance the trainee will remain after certification. This financial risk limits behavioral health facilities participating. Together, these obstacles sharply restrict participation in the PSP program and prevent rural communities from developing a stable, locally grounded behavioral health workforce. Addressing these opportunities is essential to expanding access to Peer Support Professionals behavioral health support across Alaska.	Our proposed approach integrates the Alaska Commission for Behavioral Health (ACBH) Peer Support Professional (PSP) certification with 1000 hours of structured, humanistic counseling training into a single virtual volunteer training and educational framework. This model directly addresses the problems/opportunities previously identified by streamlining both the required volunteer training and PSP certification into a single virtual process. Alaska Marriage & Family Therapy Associates (AKMFTA) will recruit PSP trainees as remote, work-from-home trainees, with the Rural Health Transformation Program (RHTP) funding supporting all training costs. Over a one-year period, each trainee will complete 1000 hours of virtual, supervised training consisting of entirely skill-building in humanistic counseling, substance abuse recovery support, along with all coursework and supervision required for ACBH certification. By transforming the mandatory 1000 hours of volunteer work into a high-quality, competency-based training experience, this model produces culturally responsive, community-grounded providers who are prepared to meet rural Alaska's behavioral health needs. The virtual structure removes geographic and logistical barriers, enabling rapid training and deployment of 500 PSPs statewide within 5 years. AKMFTA is well positioned to implement this initiative. As a behavioral health training and supervision clinic for more than a decade, we have successfully prepared numerous psychotherapists who have gone on to licensure and meaningful careers across Alaska's behavioral health system. Our existing curriculum, supervisory capacity, and virtual infrastructure provide a strong foundation for delivering this innovative Peer Support Training and employment model.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Mobility Coalition	Rural Health Flexible Transportation Fund (FTF)	AK	The RHTP aims to expand access to healthcare and wellness services for thousands of Alaskans. The scope of the program is immense, and the state is likely to see hundreds of new initiatives or expansion of services from across the state. However, the Alaska Mobility Coalition is uniquely aware of the challenges that Alaskans face, especially seniors and people with disabilities, in accessing healthcare, wellness and nutrition services. Plus, we hope that many other RHTP projects will create pipelines of workers and volunteers into a variety of healthcare related positions, many of whom will need transportation support to participate in those opportunities. While some applicants will anticipate and budget for public and community transportation needs of their clients, consumers, patients, trainees, volunteers and employees, many will not. The FTF will be available to fill in the gaps and ensure transportation is not the barrier to improved health or a job or volunteer opportunity in a health-related field.	This FTF project proposes to be a “catch all”, or broker, for unforeseen, but necessary community transportation services. It is also meant to be a “payor of last resort” to ensure that we are not supplanting other federal funds, be they Medicaid for NEMT, or federal training dollars already provided through Department of Labor and Workforce Development, and other entities that typically pay for transportation services for their clients and/or employees. The FTF will utilize every available option to purchase ground or marine transportation services including but not limited to the following: • Purchase of rides through existing community public transportation providers such as bus and paratransit services, ferry service and tribal transportation providers. • Utilization of taxicab and rideshare vouchers and agreements. • Volunteer programs that pay federal mileage reimbursement or fuel support to neighbors, friends or family members swilling to drive one or more persons to healthy recreational activities, wellness classes, employment training, volunteering and accessing nutritious foods from markets and subsistence opportunities. • Provide stipends for companions if necessary for ground and marine travel purposes. What FTF will not do in the first year of service but may in the future after some assessment and planning: • Provide airline travel purchases for consumers and/or companions in state or out of state. • Provide funds for vehicle purchases, repairs, maintenance or modifications. The purchase of services described above will be done primarily through sponsoring agencies, and not directly to individuals. This is like the concept of mini grants provided through the Alaska Mental Health Trust Authority, whereby a sponsoring agency helps an individual with an application, and a stipend is provided to them if successful. However, some of these purchases could be small, or one time, so we will explore the option for a congregant monthly reports/invoices for multiple trips and persons from partnering entities. AMC will take individual applications as well but then direct them to a partner for processing purchase of services.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Municipal League	Emergency Services Equipment Bundle	AK	Rural EMS agencies face fundamental equipment gaps that limit their ability to provide timely, safe, and reliable emergency response. Many communities lack functional EMS vehicles, specialty rescue equipment, or modern communications systems necessary to stabilize patients, coordinate care, or transport individuals across long distances and difficult terrain. These gaps reflect systemic underinvestment in the EMS equipment modernization required for basic emergency care. Modern EMS vehicles, rescue units, diagnostic tools, and interoperable communications form the backbone of rural mobile healthcare, where stabilization often occurs in the field and communities are hours from definitive care. Without reliable equipment, agencies cannot reach patients, conduct assessments, or communicate effectively, resulting in longer response times, higher medevac reliance, and poorer outcomes. This project provides targeted EMS equipment modernization to address structural barriers and allow communities to: • Reach patients more quickly and safely. • Deliver higher quality on scene care with reliable diagnostic equipment. • Reduce preventable delays caused by outdated or failing vehicles. • Improve coordination via communications that function in rural terrain. • Support treat in place and telehealth-supported decision-making. By addressing long standing deficits, this project advances RHTP goals of improving access, modernizing technology, and enhancing rural emergency care.	This project advances a strategic, community-driven approach to EMS equipment modernization across six rural and frontier boroughs/census areas. The project focuses on acquiring essential EMS equipment that communities currently lack and that is critical for safe, timely, and coordinated emergency care. Each EMS agency identified specific gaps that prevent them from meeting modern emergency response standards. The project will procure and deploy fit for purpose EMS equipment modernization assets, including: • Modern EMS vehicles and specialty response units capable of navigating remote, off road, or weather impacted environments. • Rescue and transport equipment that restores capabilities—such as Denali’s medium rescue truck or Saint Paul’s off road medical response unit. • Interoperable radio/communications systems supporting multi village and corridor-based coordination. • Clinic-based emergency transport and diagnostic tools where no functional unit exists. A centralized procurement structure ensures cost-efficiency, specification alignment, and rapid deployment, supported by AML’s extensive experience managing heavy equipment procurement for Alaska communities. Equipment will be selected to support telehealth-enabled decision-making, hub and spoke coordination, and modern emergency stabilization practices. By modernizing essential EMS equipment rather than conducting routine fleet renewal, this project advances RHTP priorities of expanded access, technology innovation, strengthened mobile care delivery, and improved safety. The approach ensures agencies can reach patients reliably, deliver effective on scene care, and reduce preventable delays tied to outdated or non-functional equipment.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Denali Borough; Kenai Peninsula Borough; Prince of Wales-Hyder Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Municipal League	Alaska Municipal Health Trust Rural Prevention & Care Navigation Initiative	AK	The Alaska Municipal League (AML) is a nonprofit member organization of 165 cities, boroughs, and unified municipalities. In 2020, to meet the health and wellness needs of its members, AML formed the Alaska Municipal Health Trust (AMHT). AMHT allows AML members to provide a flexible health plan for employees, elected/appointed officials, and associated entities. AMHT pools participating municipalities to strengthen purchasing power, stabilize risk, and promote long-term affordability in a challenging health care environment. Municipalities face sustained and accelerating health care costs. Limited primary care availability, fragmented referral pathways, and system complexity lead members to rely on episodic or crisis-based care rather than early intervention. For AMHT, these structural barriers translate into claims volatility, pressure on contribution rates, and long-term actuarial instability. At the same time, this challenge presents a clear opportunity to realign care utilization through preventive incentives and coordinated navigation support. By encouraging early engagement in primary and behavioral health care and proactively guiding members toward appropriate, lower-cost care pathways, AMHT can reduce avoidable utilization while improving outcomes. This strengthens rural health system sustainability without expanding brick-and-mortar capacity, positioning AMHT as both a fiscal steward for municipalities and a strategic partner in broader health transformation efforts.	AML, through AMHT, proposes a scalable rural health initiative focused on incentivized preventive and primary care utilization, supported by a targeted care navigation and early intervention infrastructure. The project is designed to reduce preventable health care utilization[GU3.1], improve health management, expand behavioral health access, and strengthen long-term cost stability for municipal employers across Alaska, particularly communities where access barriers drive higher downstream costs. The project will implement a dual-strategy approach: 1) Incentivizing preventive and primary care engagement: AMHT will design financial and benefit incentives that nudge members toward early, preventive, and primary care—especially via telehealth. Incentives may include, but are not limited to, wellness participation incentives (health assessments, screenings, fitness activities, preventive care visits, etc.), wellness marketplace discounts (gym memberships, nutrition programs, fitness gear, etc.), shared services/participation dividends for employers that meet participation thresholds, telehealth-first incentives, or preventive care credits. 2) Providing centralized care navigation support for high-risk members: To ensure incentives translate into measurable outcomes, the initiative will integrate a care navigation and early intervention component focused on proactive outreach to high-risk members. This support will help members understand their benefits, access appropriate services, and navigate behavioral health and post-acute care pathways. These strategies aim to reduce emergency utilization, stabilize claims experience, improve health outcomes, and strengthen long-term actuarial sustainability for municipal employers. In the first year, AML will focus outreach efforts on AMHT members. In subsequent years (dependent on funding), AML will conduct broader outreach and engagement efforts with all AML members.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Municipal League	Alaska Rural Health Infrastructure Fund (RHIF)	AK	The Alaska Municipal League (AML) is a nonprofit membership organization of 165 cities, boroughs, and unified municipalities. AML seeks to fill a critical gap in funding availability for municipalities to plan and support public infrastructure for health and community wellness. Alaska’s rural municipalities face significant infrastructure gaps that directly affect community health, safety, and overall wellness. Many communities rely on aging or undersized facilities and systems that were not designed for current population needs, climate conditions, or modern service delivery. Priority needs commonly include: • Health care facilities such as clinics, EMS stations, behavioral health spaces, and telehealth-enabled care sites that allow residents to access services locally. • Housing for health professionals is a critical barrier to sustaining essential services, as many rural areas struggle to recruit and retain workforce due to limited housing availability. • Community wellness infrastructure, such as multi-use community centers, recreation facilities, public safety buildings, and spaces that support youth programs, elder services, and behavioral health outreach. Addressing these infrastructure gaps is essential to strengthening rural health systems, supporting workforce stability, improving preventive care access, and ensuring that Alaska’s rural communities remain viable and healthy places to live.	AML proposes to launch the Rural Health Infrastructure Fund (RHIF) to strengthen municipal infrastructure that supports health access, EMS readiness, workforce stability, and community resilience. RHIF is a two-tier system designed to help rural municipalities make sustainable, long-term investments. Tier 1 – Asset Management & Pre-Development Support Infrastructure decisions shape operating costs, resilience, and service reliability for decades. Establishing a shared understanding of asset management is essential to ensure decisions are informed, coordinated, and sustainable. Tier 1 focuses on building foundational capacity through capital asset inventories, facility condition assessments, GIS mapping, lifecycle planning, and revenue modeling. This work creates a disciplined project pipeline and reduces infrastructure and operational risk for rural communities. Tier 2 – Revolving Loan Fund After Tier 1 is completed, eligible projects move into a revolving loan fund. RHIF will use a simple, transparent fee structure to ensure affordability and long-term viability. Modeled after AML’s existing water and wastewater fund, loans will have a 2% fixed rate and a 1% origination fee. Eligible projects include EMS quarters or ambulance bays; modular or renovated workforce housing; retrofits for clinic leases or telehealth; HVAC/air quality/energy systems; and water/sewer systems serving clinics or EMS. Repayment sources include EMS billing, lease payments, user fees, borough support, and energy savings. Integration with RHTP Priorities The project aligns with RHTP by strengthening access, stabilizing health workforce capacity, improving EMS readiness, enabling telehealth and broadband-supported care, and modernizing essential public infrastructure. It supports statewide goals to expand remote care, reduce chronic disease risks, and build community-led resilience. AML will convene an advisory bench—including municipal, tribal, EMS, finance, engineering, and health system partners—to standardize underwriting, documentation, and monitoring. AML will also provide application support, financial analysis, project planning, data collection, reporting, and performance-improvement technical assistance to municipal borrowers.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Municipal League	Municipal EMS Financial Sustainability & Alternative Payment Model Pilot	AK	The Alaska Municipal League (AML) is a nonprofit membership organization of 165 cities, boroughs, and unified municipalities, many of which operate small municipal emergency medical service (EMS) systems that are critical to maintaining healthcare access in rural communities. These systems often operate on thin financial margins, face volunteer workforce strain, and lack the administrative capacity to engage in value based models. Revenue is often left unclaimed due to documentation and coding gaps, and agencies lack infrastructure for reimbursable treat in place or community paramedicine, despite potential system savings and quality gains. Without targeted support, these challenges threaten the financial stability of rural EMS agencies and increase the risk of service reductions or closures Under RHTP, AML will deliver a 3-year, phased project to strengthen the financial sustainability of municipal-owned EMS systems. The project will provide statewide billing and revenue training, individualized financial sustainability assessments for participating municipalities, and technical assistance to build readiness for alternative EMS payment models. The initiative will also support pilot communities in implementing treat-in-place and community paramedicine reimbursement pathways, enabling EMS systems to deliver appropriate care in lower-cost settings while maintaining essential emergency response capacity.	AML proposes a three-year, phased approach designed to strengthen the financial sustainability and operational capacity of municipal EMS agencies while preparing rural systems to participate in value-based care models. The project combines statewide training, individualized financial sustainability assessments, alternative payment model (APM) readiness, and data infrastructure development to help municipalities improve reimbursement capture and expand care delivery models. Core activities include: 1) Training & Technical Assistance: Quarterly virtual trainings and an annual EMS billing summit; recorded modules; toolkits for documentation, coding, denial management, compliance, cost per run, and workflow templates. Objective: increase accurate reimbursement and reduce denials. 2) Agency Level Financial Sustainability Assessments: revenue capture analysis, payer mix, run volume, cost per run modeling, gap analysis, and a sustainability plan. Objective: tangible revenue improvements and days cash on hand gains. 3) APM Readiness & Pilot Implementation: • Education & Design: Overview of EMS APMs, Emergency Triage, Treat, and Transport model lessons, community paramedicine pathways, and compliance. • Infrastructure: Documentation/protocol upgrades, legal review, partner MOUs (hospitals/clinics/tribal health organizations). • Pilot Cohort (5–8 communities): Launch treat in place and alternate destination protocols, shared savings constructs, and cost avoidance tracking. Objective: demonstrate quality, cost, and access gains consistent with RHTP’s voluntary model testing. 4) Data & Reporting: Use standardized dashboards for financial and quality metrics; coordinate with healthEconnect for measure reporting to support value based arrangements and statewide learning.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Municipal League	Volunteer Fire Department Recruitment and Retention	AK	In rural Alaska, Volunteer Fire Departments (VFDs) serve as critical, often sole, first responders to medical emergencies. VFDs face numerous challenges when recruiting new volunteer firefighters. Increasing work demands and urban migration reduce the pool of potential volunteers, especially in rural Alaska. The number of volunteer firefighters across the state has plummeted by 45% since 2014, and Alaska has been experiencing a period of net outmigration for over 10 years, especially with young adults. Adding to the geographic isolation of many communities across Alaska, the recruitment and retention of volunteer firefighters is a significant hurdle for VFDs. Departments in rural and remote areas (including the seven targeted areas for Year 1) cover all emergencies, including medical, fire, rescue, and utility hazards, with small rosters, causing extended response times, unsafe crew sizes, and increased turnover. Current recruitment is ad hoc and under-resourced. The opportunity is to implement a coordinated, multi region recruitment and retention model that: (1) recruits new volunteers with locally tailored outreach; (2) retains members via a Length of Service Award Program (LOSAP) and peer support; and (3) improves readiness through NFPA 1720 compliance planning, regional training access, and community engagement—thereby stabilizing the volunteer workforce that underpins rural emergency access.	1) Recruitment & Marketing. Launch localized “Make Me a Firefighter” campaigns across the seven boroughs; produce region specific stories, social content, and event kits to reach youth, working adults, and culture bearer volunteers. Coordinate earned media and school/college outreach, consistent with RHTP’s emphasis on community based partnerships and workforce pathways. 2) Retention & Incentives. Stand up a multijurisdictional LOSAP that enrolls VFDs in phases and rewards tenure, certifications, and high need shift coverage—evidence based retention aligned with RHTP priorities to stabilize rural workforce via structured incentives and 5 year service commitments where applicable. 3) Training & Compliance. Provide technical assistance to help departments plan toward NFPA 1720 staffing/response objectives; coordinate regional trainings (including community paramedicine, treat in place, and alternate destination workflows) and facilitate shared equipment where feasible—reflecting RHTP’s EMS modernization aims. 4) Regional Coordination. Leverage AML’s statewide municipal network to convene VFDs, Tribal health organizations, regional EMS offices, and clinics/hospitals to integrate dispatch, telehealth consults, and post incident navigation—mirroring RHTP’s hub and spoke and regional planning framework. 5) Measurement & CQI. Track volunteer recruitment, retention, LOSAP participation, compliance gains, and outreach reach; use feedback cycles to refine tactics. Metrics align with RHTP’s statewide evaluation approach.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Haines Borough; Hoonah-Angoon Census Area; Kusilvak Census Area; Lake and Peninsula Borough; Petersburg Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Native Arts Foundation	Alaska Native Arts: A Cornerstone of Community Health and Economic Vitality	AK	The role of Alaska Native arts in rural communities is foundational to health, resilience, and thriving local economies. In many rural areas, Alaska Native peoples comprise a substantial portion of the population, and in some villages nearly 100% of residents participate in or benefit from culturally grounded arts. Recognizing this, arts and culture function as a preventative public health strategy, supporting mental health, physical wellness, and social cohesion, while also sustaining cash flow and local livelihoods. Strengthening arts ecosystems thus strengthens the communities that sustain them. Rural health can be strengthened through Alaska Native arts in the following ways: -Embed arts-based health education within the Alaska Native Artist Directory, linking artists to health agencies, clinics, and schools. -Create community storytelling and intergenerational programs that address behavioral health, nutrition, physical activity, and chronic disease prevention in culturally resonant ways. -Build local capacity by supporting artist-led workshops, signage, and materials that reflect village realities and languages. -Foster partnerships between health providers and artists to co-create outreach campaigns, patient navigation tools, and aftercare support rooted in cultural practices. -Use data-informed approaches to track engagement, outcomes, and community-level well-being, adapting programs to village needs.	The Alaska Native Artist Directory (launched in 2025) and our 2026 outreach tour provide a ‘warm’ entry point into homes and communities where formal health systems often struggle to gain traction. We view this project as an adaptable foundation that can help build community resilience. • Behavioral Health Integration: Our outreach photographers and coordinators can be trained to facilitate ‘Art as Healing’ workshops or distribute health literacy materials alongside artist registration. • Digital Health Navigation: We can expand the Directory’s technical architecture to include features for Social Prescribing, where providers can ‘prescribe’ cultural engagement as a clinical intervention for loneliness or depression. • Data Sharing & Interoperability: Our database of over 1,000 rural Alaskans offers a unique opportunity to test new delivery modalities for health messaging using emerging mobile technologies. ANAF has already demonstrated the technical capacity to manage complex statewide projects, evidenced by our transition to a community-focused model and the successful launch of our digital infrastructure. With the RHTP’s support, we can pivot our 2026–2027 work plan to explicitly measure health-related outcomes, such as increased social connectivity and community-level resilience metrics.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Native Birthworkers Community	Alaska Native Birthworkers Community Training	AK	Our organizing and our commitment to providing this peer support since 2017 stems directly from the expressed needs and wishes of our community - our young women want aunties to guide them through their transition into womanhood, our mothers want support to navigate pregnancy and childbirth, our sisters want someone to sit beside them while learning to care for a newborn and grow their families. For millennia, our social and community structures demanded ceremonial rites of passage, that a new mother be cared for by everyone surrounding her, and that care was offered locally by community members whose wisdom and medicine passed on from generation to generation. This has changed, and we are finding our way back. The care taken during pregnancy and early childhood impacts life-long health for both the child and the birthing parent. Pregnancy is an opportune time to work with families because a pregnant person can be especially motivated and open to healing and positive healthy choices for the benefit of their child. Protective factors identified against negative outcomes are connection to community and to healthy role models. Peer group support, such as the doula model, build upon those protective factors and have demonstrated positive maternal child health outcomes, especially for Alaska Native peoples who have been systemically underserved, and who experience the highest rates of maternal and infant mortality.	We come from the communities we serve, and we approach our work through a three sisters model where each sister focuses on a specific layer of support to uplift sovereignty from first breath. First Sister provides free direct and indirect services to Native birthing families in Alaska. Second Sister is growing a cohort of trained Indigenous birthworkers to serve Native birthing families in Alaska. Third Sister supports systemic change for improved maternal health outcomes and positive birthing experiences for Native birthing families in Alaska. Specific activities related to the role of the second sister include, but are not limited to: Grow a cohort of trained Indigenous birthworkers to serve Native birthing families in Alaska. - We currently have 15 people on our team, 10 of whom were hired after completing one of our trainings, so we are creating a direct pipeline from training to employment, and collectively we have served more than 500 families from across 100 Alaskan communities with our care. Our vision is to keep growing a statewide network to serve even more rural Alaskans. We will continue our individual and collective learning and growth to continuously improve the care we provide to the families we serve. - Build community and call upon the 80+ birthworkers who completed any of our six trainings so far (the Indigenous Full Spectrum Doula training, the Indigenous Breastfeeding Counselor training, the Indigenous Childbirth Educator training, the Sitnasuaq Indigenous Birth Support Gathering, the Indigenous Birth Helper Gathering, and Landback: Lactation Education for Indigenous Birth Helpers) to match them with families requesting support across Alaska. -Commit to hosting at least one free training each year for the statewide community. - Host gatherings for Indigenous birthworkers to meet each other, share knowledge and resources, ask questions, and debrief experiences. This includes peer skill share sessions where birthworkers volunteer to host 2-4 hour workshops to share knowledge and skills with our cohort of birthworkers for continued learning and growth. We do extensive fundraising each year to raise money across diverse funding sources and partners to support these trainings, and receiving RHTP (potential multi-year) funds designated for this purpose would help ensure the security of our training opportunities available to the community.	\$250K-\$1M	Maternal health	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Native Medical Center	ANTHC-UW Emergency Medicine Residency and Faculty Strengthening Program	AK	Alaska is a medical desert for emergency services in many rural areas, where hospital emergency departments and urgent care clinics are often not staffed by residency-trained Emergency Medicine physicians. This results in known disparities in patient health outcomes, particularly in trauma care, and challenges in emergency stabilization and difficult transfer decisions. ● Workforce Shortage: Alaska has a chronic shortage of EM specialists and significantly lacks GME programs to train and retain doctors locally. ● Healthcare Access Disparity: Emergency visits are increasing annually in Anchorage, and the state's rural population lacks consistent access to residency-trained EM expertise, which is essential given ANMC's role as the tertiary care referral hospital for the entire state. The current ANTHC-UW Global Emergency Medicine and Rural Health Fellowship has a near 100% retention rate for fellows who stay in Alaska, demonstrating that early exposure to rural Alaskan practice is a powerful recruitment tool. Expanding this educational pipeline is the most direct solution to strengthen the workforce.	1. Emergency Medicine Resident Physician Elective Rotation ● Objective: To expand resident exposure to rural emergency medicine practice in Alaska, focusing on the care of primarily Indigenous Alaska Native (AN) patients. ● Details: The one-month elective will be offered to senior EM residents (R3 and R4) from the University of Washington (UW) and Oregon Health and Science University (OHSU), as well as EM/FM dual-training residents. Rotations will occur at ANMC under attending physician supervision, with optional travel to critical access hospitals (e.g., Bethel and Kotzebue) and potential support for training community health aides. ● Benefit: Provides residents with unique training in administering remote emergency care and managing complex transfers, honing skills for high-volume, high-acuity care. 2. Emergency Medicine Faculty Exchange Program ● Objective: To strengthen the bilateral partnership through a reciprocal attending physician learning exchange to address clinical gaps and share expertise. ● Details: The exchange will facilitate upskilling of ANMC clinicians in advanced topics (e.g., stroke care, trauma care, ECMO indications, critical care delivery) via educational exchanges and clinical observerships at UW. In return, UW faculty will gain vital experience and knowledge regarding rural EM challenges, the care of Alaska Native patients, and disease processes prevalent in Alaska. ● Benefit: ANTHC faculty supervising and training resident clinicians will receive access to UW Center for Learning Initiatives and Education courses and a stipend for supervision.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Native Tribal Education Consortium	Alaska Tribal Language Rooted Holistic Student Wellness and Behavioral Health Network	AK	Alaska Native students in rural, remote, and frontier communities experience high rates of trauma exposure, suicide risk, and substance misuse, yet access to culturally responsive behavioral health services remains limited. Geographic isolation, provider shortages, fragmented education systems, and inconsistent access to student data create barriers to prevention, early identification, and coordinated care. At the same time, Tribal Education Departments are strengthening governance capacity under 25 USC 2020 to coordinate educational programming better and assert tribal control over matters affecting student success. This project addresses the opportunity to integrate holistic, culturally responsive mental and behavioral health supports within tribally governed education systems. By grounding social and emotional learning, prevention strategies, and referral pathways in each Tribe’s language, cultural teachings, and educational codes, the initiative strengthens protective factors while improving access to care. Rather than relying solely on external providers, the project builds coordinated systems that align education, family engagement, and health partners to improve student well-being and long-term community resilience.	ANTEC will lead a tribally governed, statewide network of Tribal Education Departments to integrate wholistic, culturally responsive mental and behavioral health supports within Alaska education systems. The approach builds on Tribal Education Department capacity under 25 USC 2020 and aligns education governance with coordinated health access. First, participating Tribal Education Departments will embed culturally grounded social and emotional learning frameworks within their educational systems. SEL practices will be rooted in each Tribe’s language, values, and relational teachings, reinforcing identity, belonging, and community responsibility as core protective factors. Language instructors, cultural mentors, and educators will work together to ensure wellness practices reflect local knowledge systems rather than externally imposed models. Second, the project will expand access to school-based and tele-behavioral health services through coordinated partnerships with tribal health programs and regional providers. Clear referral pathways and shared protocols will reduce fragmentation and improve continuity of care, particularly in communities with limited local providers. Third, the initiative will strengthen behavioral health prevention and early intervention strategies addressing suicide risk, substance misuse, and behavioral escalation. Restorative and culturally responsive approaches will replace punitive responses and focus on balance, connection, and healing. Fourth, the project will build rural workforce capacity by training local paraprofessionals, school support staff, and community wellness navigators under appropriate supervision. This creates a pipeline of community-rooted support providers and increases sustainability in areas facing chronic workforce shortages. Finally, ANTEC will coordinate shared learning and data practices across participating Tribal Education Departments while respecting tribal data governance. Outcome tracking will focus on increased access, reduced crisis events, improved school engagement, and strengthened protective factors. Together, this integrated model strengthens access, improves quality through cultural alignment, and builds sustainable infrastructure within tribally governed education systems to support long-term rural health transformation.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Matanuska-Susitna Borough; Nome Census Area	Deferred or Not Advanced

Alaska Native Tribal Health Consortium	Alaska Native Tribal Health Consortium Pharmacy Expansion	AK	The six ANTHC pharmacies are significantly undersized relative to clinical demand, national benchmarks, and the statewide role they serve. Current space limitations hinder workflow efficiency, sterile compounding capacity, storage stability, and the ability to maintain essential medication inventories. The ANMC Inpatient Pharmacy has only 14 DGSF per bed, far below the industry benchmark of 22–25 DGSF per bed, resulting in congestion, delayed medication turnaround, and the need for frequent work around processes. Across all locations, insufficient workspace contributes to delayed medication administration, increased error risk, constrained cold chain capacity, and reduced ability to prepare critical sterile products such as IV antibiotics, chemotherapy, and parenteral nutrition. These limits affect not only ANMC patients but also remote THO facilities that rely on ANTHC for specialty medications, after hours order verification, telepharmacy support, medication review, and statewide vaccine and procurement infrastructure. A comprehensive Pharmacy Needs Assessment is required to determine facility, workflow, and storage enhancements that align with regulatory standards and meet statewide demand. The effort will evaluate functional requirements, map workflows, identify bottlenecks, and define minor renovations or equipment improvements needed to ensure efficient operations. Without this assessment, pharmacy capacity constraints risk safety, reliability and continuity.	ANTHC will complete a structured, multi-phase Pharmacy Needs Assessment to identify the space, workflow, storage, and regulatory upgrades required across all six ANTHC pharmacies. The assessment will evaluate compounding capacity, cold chain infrastructure, inventory management, clinical workflow alignment, medication safety requirements, and statewide telepharmacy support. Findings will guide a prioritized plan for targeted, allowable renovations and equipment upgrades that directly enhance rural access and safety. A dedicated Project Manager will lead the assessment, coordinate stakeholder input, and ensure alignment with ANTHC’s strategic priorities, regulatory requirements, and available space. The project team will partner closely with pharmacy leadership, Facilities, Infection Prevention, Environmental Services, Information Technology, and statewide THO pharmacy teams to document functional requirements and validate recommendations. Key activities include: • pharmacy by pharmacy workflow mapping; • assessment of sterile compounding, hazardous drug handling, and storage standards; • evaluation of medication distribution pathways supporting rural facilities; • analysis of current versus required DGSF benchmarks; • identification of bottlenecks, safety risks, and environmental constraints; • modeling of minor renovations required for safety, capacity, and compliance; • development of a phased plan to implement improvements without disrupting essential operations. In parallel, ANTHC will execute a small, compliance driven renovation within the inpatient pharmacy to address urgent space and compounding constraints. This work will occur without interrupting pharmacy operations and will not duplicate the broader assessment. The outcome of this approach will be a clear, actionable roadmap for right sizing pharmacy services, guiding future investment, and strengthening statewide medication access and safety for rural Alaska.	\$1M-\$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

Alaska Native Tribal Health Consortium	Capacity and Bed Management to Improve Access to Care, Patient Flow, and Care Coordination	AK	Patient transfers and admissions into ANTHC’s tertiary care facility are frequently delayed due to limited real-time visibility into bed availability, unit readiness, staffing constraints, and downstream placement options. These challenges directly impact access to timely, appropriate care for rural and Alaska Native patients, particularly when coordinating medevacs, urgent travel, and scheduled specialty referrals from regional partners. In 2025, more than 60% of patient diversions were attributed to bed availability limitations, driven in part by fragmented, manual processes. Current transfer center and bed management workflows rely on phone calls, multiple messaging platforms, and locally managed tracking tools, limiting systemwide coordination and increasing risk during periods of high demand, weather disruptions, and transportation constraints. This project addresses these gaps by implementing Oracle Health’s Capacity Management tool within the shared EHR, establishing a standardized, enterprise-wide source of truth for capacity, placement, and transfer workflows across the tertiary facility, three rural tribal critical access hospitals, and ambulatory clinics. The solution will streamline patient flow from emergency department arrival through inpatient care and discharge, strengthening care coordination, reducing avoidable delays, and advancing RHTP goals for access, efficiency, and system sustainability.	This project will implement Oracle Health’s Capacity Management tool within the existing shared Electronic Health Record (EHR) used by ANTHC to strengthen access, coordination, and appropriate care availability across Alaska’s tribal health system. The solution will provide a near real-time, enterprise-wide view of inpatient capacity, including beds, unit readiness, isolation status, staffing, and demand such as pending transfers, emergency department boarding, and scheduled admissions. Constraints impacting patient movement, such as transportation availability, weather, and travel disruptions, will be documented within a single system, replacing fragmented, manual tracking processes. The approach enables proactive, data-informed decision-making rather than reactive coordination, improving timeliness, safety, and the patient experience, particularly for rural and Alaska Native patients requiring specialty or higher-acuity care. Standard operating procedures will be updated, governance established, and roles clearly defined across the tertiary facility and referring partners to support consistent use and long-term sustainability. Standardized workflows will be implemented across the full transfer lifecycle, including referral intake, clinical triage and acceptance, bed request and assignment, transport coordination, arrival management, and post-arrival placement updates. Within the shared EHR, three rural tribal critical access hospitals and ambulatory clinics will use consistent workflows, structured documentation, and status updates, reduce back-and-forth communication and eliminating parallel tracking. For referring facilities outside the shared EHR, a standardized external intake process will ensure transfers are entered and tracked end-to-end within the same capacity management workflow. The project includes configuration of beds, locations, service lines, and operational statuses; development of dashboards and alerts for key workflows such as ED boarding, transfer delays, and discharge barriers; and implementation of reporting to support continuous improvement. A phased rollout will begin with internal bed management at the tertiary facility, followed by transfer center workflows with the three CAHs and high-volume clinics. Training, change management, and defined KPIs, such as time-to-accept, time-to-bed, boarding time, transfer delays, and diversion events, will ensure adoption, measurability, and sustained impact aligned with RHTP goals.	\$1M-\$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Native Tribal Health Consortium	Compatibility Assessment for Wireless Wearable Technology for Continuous Vital Sign Monitoring	AK	Alaska's rural and frontier health care facilities rely on intermittent vital sign collection, typically every four to eight hours through manual nursing rounds. This creates blind spots during which clinically meaningful changes in heart rate, respiratory rate, oxygen saturation, or temperature go undetected until symptoms escalate to require emergency intervention. Chronic nursing shortages, high staff turnover, and minimal personnel across isolated sites compound this challenge. When deterioration is missed, consequences include unplanned ICU transfers, preventable adverse events, extended lengths of stay, and patient mortality. Beyond inpatient settings, patients discharged to remote communities lack follow-up monitoring, and pregnant and postpartum women face gaps in continuous blood pressure monitoring between visits. Wireless wearable monitoring technology has potential to close these gaps, but no systematic assessment has determined which solutions are compatible with Alaska's rural health infrastructure, workforce constraints, connectivity limitations, and Tribal Health Organization operating environments. The opportunity is to conduct a comprehensive compatibility assessment of wireless wearable vital sign monitoring technologies, evaluating feasibility across inpatient, home-based, and maternal health use cases and generating evidence-based recommendations for statewide adoption across the Alaska Tribal Health System.	The project conducts a statewide compatibility assessment of wireless wearable monitoring technologies for Alaska's rural health system, completing by September 2027. The pilot phase is conditional on assessment findings. Phase 1, Compatibility Assessment (Months 1-10): Conduct a market scan of available wireless wearable monitoring technologies evaluating capabilities, interoperability, connectivity requirements, regulatory status, and vendor viability. Define clinical, technical, and operational requirements specific to Alaska including intermittent connectivity, extreme climate, workforce constraints, and Tribal Health Organization (THO) governance. Engage THOs to evaluate receptivity, document site-specific infrastructure and EHR systems, and assess readiness for wearable monitoring. Conduct a data flow analysis mapping how patient data moves from device to platform to clinical systems, identifying storage, transmission, and processing points. Evaluate data sovereignty implications, determining whether vendor architectures comply with ANTHC and THO requirements for patient data to remain within controlled environments. Assess total cost of ownership, supply chain reliability, and vendor support for remote environments. Deliver an options analysis report with ranked recommendations, a data sovereignty determination, and a go or no-go recommendation for pilot. Phase 2, Limited-Scale Pilot (Conditional, Months 11-15): Proceed only if Phase 1 confirms data sovereignty requirements can be met and THO receptivity supports continued evaluation. Deploy recommended technology in a limited-scale pilot, focused within the Alaska Native Medical Center (ANMC), to validate performance across inpatient monitoring, post-discharge home monitoring, and maternal blood pressure monitoring pathways. Pilot scope and site selection defined based on Phase 1 findings. Collect data on clinical detection rates, alarm accuracy, staff workflow integration, patient compliance, connectivity reliability, and costs. Compile pilot data into a feasibility report with evidence-based recommendations, including a full cost projection distinguishing assessment investment from statewide rollout.	\$50,000-\$250,000	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Native Tribal Health Consortium	Network Modernization to Increase Capacity and Reliability for Statewide Tribal Connectivity	AK	Across Alaska’s statewide tribal health system, high-value clinical services depend on reliable, secure network connectivity delivered through ANTHC’s Wide Area Network (WAN). These services include telehealth, remote specialty consults, a shared tribal EHR, radiology and imaging workflows, and care coordination. The current infrastructure has the following constraints: A lack of redundancy makes it difficult to manage and update the WAN without causing outages and downtime. This impacts patient care, with network-induced downtime requiring manual workarounds by clinicians and care delivery teams. Legacy network devices do not support modern functionality such as “Out of Band Management.” Without this capability, ANTHC must rely on technicians physically accessing network equipment in the data centers during incidents, creating delays as staff travel on-site to connect to devices and restore service. Decades of budget-constrained growth resulted in a wide variety of systems being deployed over time. This inconsistent architecture makes updates and reconfiguration slower and higher risk; moving to a single platform will make network management more consistent and reliable. All network traffic coming to ANTHC from remote locations across Alaska must traverse a single data center located at the ANTHC campus. This has served Alaskans well, but as the WAN grows we need a redundant, high-availability data center model to increase throughput and provide failover in emergencies.	ANTHC will implement a phased Network Infrastructure Expansion program that provides immediate improvements to system reliability and organizational cybersecurity posture, while establishing the necessary foundation for a “High Availability” network architecture to be implemented in future years. This project modernizes and standardizes key elements of the core campus and datacenter network, enabling statewide partners to safely scale digital health capabilities that depend on ANTHC’s Wide Area Networking (WAN) systems. The work directly supports RHTP Initiative #6 (Spark Technology & Innovation) by strengthening the infrastructure resiliency needed for secure data exchange, modern clinical operations, and expansion of technology-enabled care. Year one funding will focus on establishing a resiliency-focused HA data center and campus switching topology, implementing platforms that enable more supportable, automation-centric network operations that reduce “configuration drift” and software currency. Out of Band network management systems will be implemented, enabling predictable telemetry, platform support and agile recovery during outages and major incidents. HA firewall platforms with scaled processing and throughput capacity will be implemented to support the growth demands of on-campus systems and ANTHC’s rural tribal partners. During this period, ANTHC is committed to using its own capital funding to perform additional networking platform improvements in parallel, including implementation of a resilient fiber optic (FO) interconnect between campus data centers, a redundant FO access layer topology tied to the secondary datacenter, implementation of HA SD-WAN for off campus corporate buildings, and installation of a second HA pair of wireless LAN controllers to support ANMC clinical operations. When combined, this use of ANTHC and RHTP funding to develop a robust network infrastructure supports the development of a truly resilient HA network. Future years will focus on implementing the data center interconnection and aggregation solutions to allow both proactive and (automated) reactive failover and load balancing between data centers on the ANTHC campus.	\$1M-\$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Native Tribal Health Consortium	Ophthalmology Expansion	AK	The ANMC Ophthalmology Clinic has experienced rapid growth, with patient volume increasing by more than 20% in FY24 and staffing expanding to nine board-certified ophthalmologists supported by subspecialty and technical staff. The clinic faces a significant capacity shortfall driven by rising referrals and increasing clinical complexity. Healthcare planning standards require 16 exam rooms to support current provider capacity, yet only 10 are available, resulting in reduced appointment availability and long delays. As of early 2026, more than 2,000 patients are awaiting ophthalmology appointments, with average wait times exceeding seven months. These delays disproportionately affect rural and frontier patients who must coordinate complex travel and may experience worsening of vision-threatening conditions such as diabetic retinopathy, glaucoma, and macular degeneration. Reconfiguring adjacent space to increase exam room capacity offers a timely, cost-effective solution that aligns physical space with provider availability, reduces the backlog, and improves access to specialized eye care for rural Alaskans. This project will enhance care quality, safety, and long term sustainability across the statewide Tribal health system.	To address the clinic’s exam room deficit and restore timely access to specialty eye care, ANTHC completes an enhancement project that modifies and reconfigures existing clinic space and space adjacent to the current Ophthalmology Clinic. This approach does not involve new construction; rather, it focuses on optimizing and upgrading available clinical space to support increased patient volume, improved workflow efficiency, and enhanced patient experience. Space planning and design are underway, optimizing the clinic layout for additional exam rooms with corresponding staff workstations and support areas. The design prioritizes efficient patient throughput and alignment with ophthalmology-specific requirements such as darkening capability, slit lamp placement, and accessibility for elders and mobility-limited patients. A dedicated Project Manager leads the effort, coordinating with Ophthalmology leadership, Facilities, Infection Prevention, Environmental Services, IT, and other stakeholders. The team ensures the project reflects clinical priorities, meets regulatory requirements, and is implemented with minimal disruption to ongoing patient care. Renovation activities implementing the design are planned for fall 2026, with sequencing strategies that allow clinic operations to continue safely during space modifications. In addition to physical space enhancements, the project evaluates opportunities to improve operational efficiency. Scheduling data indicate that current 45-minute visit times contribute to exam-room bottlenecks. The assessment identifies workflow redesign opportunities that reduce visit times to approximately 35 minutes. When combined with additional exam rooms, these improvements significantly increase throughput and reduce appointment delays. Staffing adjustments are minimal. One additional Medical Assistant FTE supports expanded patient flow and maintains efficient provider movement between rooms. All other staffing levels are sufficient to support increased capacity once space limitations are resolved. The project results in an optimized clinic layout, additional exam rooms, upgraded clinical infrastructure, and improved workflows that together allow the clinic to meet current demand, support continued growth, and better serve rural patients who depend on ANMC for specialty eye care unavailable in their home communities.	\$1M-\$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

Alaska Native Tribal Health Consortium	Planning for Patient Lodging Systems Modernization	AK	Each year, thousands of Alaska Native patients and caregivers travel, often on multiple flights to Anchorage, for specialty, diagnostic, surgical, and inpatient care not available in rural communities. Lodging is a critical part of this journey, offering a safe, stable place to rest and prepare for appointments. From 2017–2025, ANTHC lodging supported over 107,000 patients and 320,000 caregivers, underscoring its essential role in the statewide care continuum. Current operations rely on manual processes, spreadsheets, emails, and disconnected systems. These gaps slow room confirmations, create inconsistent communication, and increase data errors. For rural travelers, particularly Elders, pregnant patients, and those with chronic or complex conditions, lodging delays can disrupt travel plans, appointments, and discharge timing. Staff also spend significant time reconciling information rather than directly supporting patients. This project modernizes lodging through an integrated digital platform that streamlines coordination, improves workflow reliability, and enhances the patient experience. It will increase data accuracy, standardize communication, expand visibility into room availability, reduce inefficiencies, and better support staff in meeting patient needs. These improvements advance RHTP goals by strengthening timely access to care, reducing administrative burden, and promoting a more coordinated, accessible system for rural Alaska Native people.	The Patient Housing Modernization project represents the initial phase of a multi-year effort to implement a modern, integrated platform that benefits the tens of thousands of patients who need housing when traveling to the Alaska Native Health Campus to receive care each year. It will improve operational reliability, strengthen coordination across patient care and navigation services, and enhance the patient and caregiver experience. ANTHC has already evaluated the technologies, workflows, and pain points within the existing lodging process and systems. This analysis identified 447 unique steps required to fulfill patient housing requests, including 251 decision points across 13 separate applications. This project will develop a plan to simplify the process, reduce the number of tools required, and automate manual steps. The complexity identified in the initial assessment led ANTHC to determine that a deliberate, well-scoped planning project will increase success of this tool and workflow implementation. This project aims to complete formal planning and scoping efforts to evaluate a modern Property Management System (PMS), identify data integration points and system refinements, and select an implementation service provider that can integrate the PMS with existing medical records systems and travel coordination tools. This planning project includes several key activities. ANTHC will review existing process documentation to ensure accuracy and completeness, prioritizing key pain points in the patient journey to define desired outcomes from new technology and processes. Requirements analyses will be updated to create a comprehensive product assessment and selection guide, incorporating feedback from clinicians, patients, technical experts, and contracting teams to ensure the right system is identified and implemented. System integration points will be identified, looking specifically at ways to streamline the provider experience by integrating with the EHR, improve the patient experience by integrating with existing communications platforms, and reduce “swivel chair integrations” for end users who currently switch between disconnected systems to perform core job functions. Future phases of the Patient Housing Modernization project will result in the purchase, implementation, and integration of a new Property Management System. Proper planning and scoping now will help ensure the success of the larger implementation project in the future.	\$250K-\$1M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Native Tribal Health Consortium	Statewide Tribal Pharmacy Development	AK	Medication access across the Alaska Tribal Health Care System remains a structural barrier to timely, reliable care, particularly for rural and remote communities. Geographic isolation, fragmented pharmacy operations, workforce shortages, and outdated ambulatory pharmacy technology contribute to delays in prescription fulfillment, gaps in therapy, inconsistent follow-up after tertiary or specialty visits, and avoidable emergency department utilization. Pharmacy services rely heavily on manual, disconnected workflows, especially for high-cost and specialty medications. An aging retail pharmacy platform increases claim rejects, reversals, and manual intervention, delaying medication release and reducing efficiency. At the same time, persistent pharmacist and technician shortages, most acute in rural communities, limit access to medication management, chronic disease support, and immunizations, while increasing strain on existing staff. These combined challenges create an opportunity to redesign pharmacy services as a coordinated, statewide access-to-care strategy. By modernizing ambulatory pharmacy infrastructure, standardizing workflows, and investing in workforce development through expanded training and residency pathways, ANTHC can strengthen care transitions, reduce avoidable utilization, expand the clinical role of pharmacists, and build a stable, highly trained workforce capable of sustaining high-quality pharmacy services across rural Alaska.	This initiative redesigns pharmacy services as a coordinated, technology-enabled statewide system that improves medication access, strengthens workforce capacity, and modernizes ambulatory infrastructure. First, patient-centered pharmacy support will follow individuals across hospital, clinic, and home settings. Pharmacists will provide medication reconciliation, education, and follow-up after transitions of care, while a central coordination team will manage high-cost and specialty medications to reduce delays and confusion. Automated multi-dose packaging and structured refill support will simplify complex regimens and reduce travel burden for rural patients. Standardized workflows and shared operating procedures will ensure consistent service delivery across sites, supported by dedicated project management and performance monitoring. Second, the initiative builds a sustainable, Alaska-grown pharmacy workforce pipeline. Training capacity will expand through increased student rotations, residency positions, rural learning experiences, and strengthened technician training programs. Advanced skill development, including board certification, telehealth, and remote verification, will prepare pharmacists and technicians for rural practice. A statewide Tribal workforce consortium will support shared rotations, centralized technician training, and float coverage to stabilize staffing in underserved regions. Technology will be leveraged as a workforce multiplier to extend clinical reach and reduce strain on local teams. Third, ambulatory pharmacy infrastructure will be modernized by replacing the aging retail platform with Liberty Software, beginning with implementation at ANTHC’s tertiary facility and Southcentral Foundation. The project will include structured workflow redesign, claims optimization, EHR integration, data migration, and phased pilot-to-scale deployment. Standardized workflows, rejection management processes, training, and embedded KPIs will support operational stability and measurable improvements in prescription fulfillment reliability. Together, these coordinated strategies create an integrated pharmacy model that improves continuity of care, reduces avoidable utilization, and strengthens long-term sustainability across rural Alaska.	\$1M-\$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

Alaska Native Tribal Health Consortium	Alaska Native Medical Center Nurse Call Modernization and Retrofit	AK	The Alaska Native Medical Center’s nurse call system, installed more than 25 years ago, is experiencing rapidly increasing failures that impact clinical response times, contribute to patient safety events, and create regulatory compliance risks. This aging infrastructure now poses a significant threat to safe, reliable care delivery, particularly as ANMC serves as the statewide referral center for Alaska Native people and rural communities. Modernizing this system directly supports the Rural Health Transformation Project by strengthening the clinical infrastructure that rural patients depend on when receiving higher acuity care in Anchorage. Replacing the obsolete platform with a modern, fully integrated communication system will restore reliability, reduce preventable harm, and enhance coordination between rural referring providers and ANMC clinical teams. This upgrade not only improves immediate patient safety but also advances RHTP’s broader objectives of building resilient health systems, improving access to high quality care for rural residents, and ensuring long term operational sustainability across the statewide tribal health network.	The project will engage a specialty nurse call system contractor to develop detailed shop drawings, furnish modern nurse call equipment, and perform a full-system installation throughout the Alaska Native Medical Center. The contractor will coordinate closely with clinical stakeholders and the Facilities team to ensure system design aligns with patient care needs and current regulatory standards. Following installation, the Facilities team will lead commissioning activities, including system testing, staff training, and integration with existing hospital infrastructure to ensure a seamless transition from the aging legacy system to the new, reliable, fully operational platform.	\$1M-\$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Native Tribal Health Consortium	Central Logistics Loading Dock and Warehouse Modernization — Design and Renovation Planning	AK	ANMC’s central logistics dock and warehouse no longer meet the demands of a growing hospital system. Built for a much smaller operation, the current infrastructure has reached its capacity limit and cannot support existing supply volumes or projected future growth. Dock operations present an immediate deficiency. During peak deliveries, limited staging space forces vehicles to queue in areas that conflict with pedestrian movement and restrict emergency access. The lack of a drive through bay further slows throughput and increases congestion. Warehouse storage is similarly inadequate, preventing ANTHC from maintaining adequate inventory reserves. For sites dependent on barge, air cargo, or seasonal roads, where weather and transport disruptions are common insufficient storage directly increases clinical supply risks. Additional infrastructure systems are also failing to meet needs. The hospital’s San I Pak waste sterilization and compaction unit cannot keep up with demand, creating compliance risks. Safety and security features, including lighting, access control, and vehicle pedestrian separation do not meet current standards. Before investing in renovation, ANTHC requires a comprehensive design effort to define project scope, assess feasibility, provide Alaska specific cost estimates, and develop a phased plan that maintains full logistics operations during construction.	This project delivers complete pre-design planning for the expansion and modernization of ANTHC's central logistics loading dock and warehouse. It will establish the factual and functional foundation for all subsequent design work. The team will conduct a comprehensive site survey covering existing utilities, drainage, structural conditions, vehicle traffic patterns, and geotechnical conditions to inform foundation design at the site. Concurrently, current operational workflows will be formally documented in coordination with ANTHC Logistics, Safety and other affected departments to define validated functional requirements before design begins. With site conditions and requirements established, programming and schematic design options will be developed for expanded dock capacity, solutions for hazardous waste treatment capacity and improved climate-controlled warehouse storage. Each option will be evaluated against operational requirements, applicable code, site constraints, and cost parameters. Program and schematic alternatives will be presented to ANTHC stakeholders and evaluated for feasibility. Pre-application consultations with the Municipality of Anchorage and the Alaska State Fire Marshal will be initiated during this phase to identify permitting requirements early and prevent downstream design revisions.	\$250K-\$1M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Native Tribal Health Consortium	Elevator Modernization & Refurbishment	AK	The elevators in many buildings on the ANMC campus are aging, unreliable, and frequently out of service due to obsolete components. These failures disrupt patient flow, create safety and accessibility risks, and increase staff workload as teams reroute patients or provide manual transport. These impacts are especially significant for rural Alaska Native patients who travel long distances for specialty care and often require mobility assistance and coordinated scheduling. Modernizing this critical infrastructure presents an opportunity to strengthen access, improve care coordination, and support a more efficient statewide health system. Upgraded elevator systems will restore reliability, improve ADA access, reduce downtime, and lower maintenance costs, enabling safe, efficient movement across clinics, inpatient services, and lodging. These improvements will reduce missed or delayed appointments, ease workforce strain, and strengthen ANMC’s operational continuity, ensuring rural patients can access timely, high quality care on each visit.	To advance reliable access and operational continuity at Alaska Native Medical Center (ANMC), this project will apply a structured, multidisciplinary approach that prioritizes patient safety, care coordination, and system sustainability. ANMC will engage a qualified elevator consultant to evaluate existing conditions, document performance and safety deficiencies, and develop modernization recommendations aligned with current codes, ADA standards, and campus operational requirements. This assessment will ensure that proposed upgrades support the needs of patients traveling from rural and remote communities and align with ANMC’s role as the statewide referral hub. The consultant’s findings will inform a coordinated design effort led by architects, engineers, and facilities project managers to develop detailed specifications and phased implementation plans that minimize disruption to patient care. This planning approach emphasizes continuity of access, allowing clinical services, inpatient care, and patient lodging to remain functional throughout the modernization process. Following design, ANMC’s Facilities Project Management team will engage certified and licensed elevator contractors to implement system upgrades, including replacement of obsolete controls, motors, safety equipment, door operators, and communication systems with modern, reliable components. All modernization activities will be closely coordinated with facility operations to maintain safe patient access and continuous service through carefully sequenced phasing. This approach reduces avoidable delays, limits workforce strain associated with manual transport and rerouting, and supports efficient patient movement across the campus. By combining expert assessment, thoughtful planning, and specialized technical execution, the project will deliver a reliable, compliant, and durable elevator system that strengthens ADA accessibility, improves operational efficiency, and supports long-term resilience of the statewide Tribal health system.	Over \$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Native Tribal Health Consortium	Healthcare Furniture Upgrades	AK	ANTHC’s rapid growth over the past three decades has left many patient and staff spaces no longer meeting current standards for ergonomic design, safety, and functionality. Outdated furniture contributes to patient discomfort and increases the risk of strain and repetitive stress injuries for staff, negatively affecting care delivery, workforce wellbeing, and patient experience. Advances in modern, ergonomic, medical-grade furniture present a timely opportunity to address these challenges in alignment with the RHTP’s goals of strengthening health care access, quality, and sustainability, particularly for Alaska Native people who travel long distances to Anchorage for care. ANTHC’s holistic approach to health and safety recognizes that supportive physical environments are essential to delivering high-quality, culturally responsive care while protecting staff health and wellbeing. This project will modernize high-use patient-facing areas and staff workspaces with durable, ergonomic furniture designed to improve comfort, accessibility, and safe movement throughout the campus. These upgrades will reduce physical barriers within clinical spaces, enhance patient comfort and satisfaction, and better support patients and families navigating complex care journeys. For staff, improved ergonomic workstations will reduce injury risk, support retention, and allow employees to focus fully on providing safe, effective care for Alaska Native people and communities statewide	ANTHC will implement a two-part, campuswide furniture modernization initiative that addresses both patient facing areas and employee workstations across the Alaska Native Medical Center. The project will focus on upgrading furniture in waiting rooms, consult rooms, inpatient units, grieving spaces, and other high-use common areas where patients and their families spend extended time, particularly individuals traveling from rural communities who may have limited alternative locations to rest between appointments. Furniture will be selected based on durability, cleanability, comfort, and medical grade performance to support high daily usage, infection control requirements, and frequent turnover. These upgrades will enhance patient comfort, safety, and accessibility while supporting culturally responsive care environments that recognize the importance of family presence, escorts, and community connection throughout the healing journey. Comfortable, functional furnishings will allow patients and their support networks to remain engaged and present without added physical strain, reinforcing ANMC’s role as a home away from home for many Alaska Native people receiving care in Anchorage. In parallel, the project will replace outdated desks, chairs, and workstation components, many more than 20 years old, with ergonomic, adjustable furniture that meets current best practice standards. This approach aligns with ongoing assessments conducted by ANTHC’s ergonomics team and provides long-term, organization-wide solutions rather than addressing only the most urgent individual needs. Improved ergonomics will reduce injury risk, fatigue, and strain for staff, supporting workforce health, retention, and the delivery of safe, high-quality care. Funding will be used to specify, procure, and install furniture that meets safety, infection control, and ergonomic requirements. Upgrades will be prioritized based on demonstrated need, usage levels, and alignment with patient and staff health and safety goals. Through this coordinated approach, ANTHC will advance Rural Healthcare Transformation Program priorities by strengthening access, improving care quality, supporting workforce sustainability, and creating a more durable and efficient care environment for Alaska Native people and communities statewide.	\$1M-\$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Native Tribal Health Consortium	Patient Communication Digital Displays	AK	Across the ANTHC campus, current physical signage is largely static, often outdated, and unable to support rapid updates related to construction changes, parking adjustments, clinic relocations, or emergency incidents. This can create challenges for patients needing to navigate ANMC’s large campus. Expanding ANTHC’s digital signage network will replace these static signs with remotely managed, real-time communication tools that improve patient navigation and enable timely dissemination of critical information. These upgrades will significantly improve communication with patients traveling from rural communities when they arrive at ANTHC Lodging facilities, where they stay while receiving care in Anchorage. Current technology does not allow staff to deliver timely, relevant information on in-room screens upon arrival, limiting the ability to guide patients through appointments, preparation requirements, and campus navigation. This project addresses that gap by modernizing the lodging technology infrastructure and expanding digital signage across high-traffic patient areas. These improvements will strengthen patient communication, reduce confusion, and enhance coordination of care for rural patients for treatment. The project also aligns with Alaska’s Rural Health Transformation Project by improving access to care, strengthening technology-enabled patient communication, and supporting a more responsive and patient-centered health system.	ANTHC will rapidly implement this initiative by procuring commercially available, widely supported display technology and software to ensure timely deployment and long-term supply reliability. Selecting industry-standard hardware and software reduces procurement delays, supports maintenance continuity, and ensures replacement units can be easily sourced in the future. Over the past two years, ANTHC successfully executed a proof-of-concept demonstrating our ability to deploy, manage, and remotely update digital screens across patient and employee environments. This established internal capability confirms both technical readiness and organizational capacity. By leveraging our experienced Marketing and Health Information Technology (HIT) teams, we will integrate new devices with updated software. Content can be centrally updated, multilingual messaging deployed efficiently, and time-sensitive information distributed instantly across lodging rooms and high-traffic campus areas. This approach minimizes implementation risk, reduces project timelines, and delivers immediate benefits to rural patients traveling up to 1,200 miles for care. Patients will receive clear appointment logistics, navigation guidance, and culturally responsive messaging in real time. Using our experience across all communities in Alaska, ANTHC ensures sustainability, scalability, and rapid return on investment while strengthening patient access, communication reliability, and overall care coordination.	\$250K-\$1M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Native Tribal Health Consortium	Surgical Services Capacity Expansion	AK	Demand for surgical services at ANMC continues to outpace the current inpatient, Ambulatory Surgery Center (ASC), and operating room (OR) capacity. This gap significantly limits access to timely care for both acute patients and those traveling from rural communities for scheduled procedures. Although the ASC has strong potential for growth, it remains underutilized, operating at only ~53% during primetime, due to high cancellation rates, block scheduling inefficiencies, equipment limitations, and infrastructure constraints. Without targeted operational and facility interventions, access barriers and system strain will continue to increase. This project presents a strategic opportunity to enhance surgical capacity and performance by optimizing the ASC layout, adding an additional procedure room, and investing in end-of-life medical equipment replacements across Surgical Services at ANMC. Coupled with selective infrastructure upgrades, these improvements will expand access, reduce delays in care, and strengthen the overall surgical service delivery model.	The project will expand the Alaska Native Medical Center (ANMC) surgical services capacity through three coordinated strategies: creating new procedure space, modernizing infrastructure, and replacing end of life equipment to ensure staff have the tools needed to deliver high quality care. These improvements directly benefit rural, remote, and frontier Alaska Native and American Indian patients who often travel hundreds of miles, and sometimes days, to access surgical care in Anchorage. First, the project will reconfigure the ambulatory surgery clinic by relocating the breakroom and changing rooms, allowing construction of a dedicated procedure room with support spaces. This increases capacity from four operating rooms to four operating rooms plus one procedure room. Shifting lower acuity procedures (such as pain management and endoscopy) into the new room frees operating room time for higher complexity cases. This directly improves access for patients traveling from rural villages, who frequently have only one opportunity to receive surgical care during a single, time-limited visit to Anchorage due to weather, travel costs, and caregiver responsibilities. Second, the project will replace end-of-life medical equipment and purchase additional devices needed to support the increased surgical volume. Updated imaging, sterilizers, scopes, monitors, and surgical instruments ensure reliable, efficient operations. For rural and frontier patients who face long delays if procedures are canceled or rescheduled, reliable equipment reduces the risk of missed care, complications, and avoidable emergency visits. Third, the project will complete retro commissioning of the air handling unit system to ensure safe, consistent surgical air quality and regulatory compliance. Modern, reliable environmental controls reduce cancellations and prevent downtime caused by equipment failure. This is particularly important for rural patients who cannot easily return for rescheduled procedures due to transportation barriers, limited flight availability, and weather-related travel disruptions. Together, these improvements expand surgical access, reduce delays, and ensure that rural, remote, and frontier Alaska Native patients receive timely, high-quality procedures during the limited windows when they can reach Anchorage.	Over \$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Native Tribal Health Consortium	Women & Children’s Services Modernization - Planning and Design	AK	ANTHC has identified a critical opportunity to modernize and expand family birthing services at the ANMC through development of a new Family Birthing Services Tower. ANMC is the primary statewide referral center for specialized maternal, neonatal, and pediatric care for Alaska Native and American Indian patients, including services not available in most rural or remote communities. Accessing care often requires families to travel and remain in Anchorage for extended periods, separating them from home, cultural support, and family during pregnancy, childbirth, and pediatric care. These challenges create significant emotional, financial, and logistical strain. At the same time, existing facilities, built to 1980s healthcare standards, limit privacy, family presence, and culturally responsive care, and constrain ANMC’s ability to meet growing demand. This project advances an opportunity to translate years of analysis and community-informed planning into a comprehensive design and operational plan for a modern Family Birthing Services Center. The proposed tower would expand capacity for labor and delivery, NICU, PICU, and surgical services while aligning facilities with modern, family-centered, and culturally responsive standards of care. This planning effort lays the foundation for long-term improvements in access, quality, and sustainability of maternal and pediatric health care for Alaska Native families and rural communities statewide, directly supporting RHTP goals.	The design work for the Women’s and Children’s Tower is anticipated to span approximately three years and will be implemented through a deliberate, two phased approach that ensures readiness, cultural responsiveness, and long term sustainability. In the first year, ANTHC will engage an experienced healthcare design team to complete pre design planning and concept development for the tower at ANMC. This phase establishes the clinical, operational, and technical requirements needed to support high quality maternal, neonatal, and pediatric care for Alaska Native/American Indian (AN/AI) families traveling from rural and remote communities. Pre design activities will include a comprehensive site survey addressing topography, traffic, utilities, geotechnical conditions, and environmental factors. Concurrently, the project team will develop an owner’s program of requirements, a basis of design, and preliminary operational plans reflecting projected demand, family centered care models, and culturally responsive practices. Concept development will include site layout and massing studies, adjacency and functional diagrams, building access planning, life safety analysis, space comparisons, and preliminary cost estimates. Designs will be evaluated against operational needs, code requirements, site constraints, and cost parameters, with a focus on minimizing barriers for families who spend extended periods in Anchorage. Years two and three will advance the preferred concept through design development and completion of design and operational documents, with milestones at 35%, 65%, and 100% design completion. This phased approach builds on more than three years of ANTHC analysis and benchmarking and will position ANMC to meet maternal and pediatric care needs for the next 20 years, supporting future funding, contractor selection, and a smooth transition into construction while advancing RHTP goals.	Over \$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Native Unity	Alaska Native Workforce Development and Training Center	AK	Tribal health organizations in Alaska administer complex federal and state health programs through the Indian Health Service Alaska Tribal Self-Governance Compact and other funding agreements. However, there is a shortage of trained administrative staff who understand how to manage funding agreements, ensure compliance, and support program implementation. This administrative workforce gap creates challenges for Tribal health organizations working to sustain and expand health programs. The Alaska Native Workforce Development and Training Center will address this opportunity by developing administrative workforce capacity to support Tribal health program administration and strengthen the long-term sustainability of Alaska’s Tribal health system.	The Alaska Native Workforce Development and Training Center will provide workforce training focused on Tribal health compact and program administration. The Center will deliver training that prepares workforce participants to support Tribal health program operations, including funding agreement administration, compliance responsibilities, program coordination, and implementation of federal and state health programs. Training will be offered through in-person and hybrid formats from the Anchorage-based center to serve Tribal health organizations statewide. By building administrative workforce capacity, the project will help Tribal health organizations more effectively manage health programs and sustain long-term system operations.	\$250K-\$1M	Statewide	Anchorage (Municipality)	Deferred or Not Advanced
Alaska Natural Resource and Outdoor Education Association	Alaska Rural Outdoor Learning & Health Network	AK	Youth in rural Alaska face significant mental and physical health challenges, including limited access to preventive health resources and growing behavioral health concerns. Research consistently shows that time spent outdoors supports mental health, physical activity, resilience, and overall wellbeing among young people. While rural Alaska communities often have abundant access to natural landscapes, there are fewer structured opportunities for youth to engage in meaningful outdoor learning experiences supported by trained educators and community leaders. Many educators and youth program providers across Alaska are interested in implementing outdoor learning and place based education but lack access to coordinated training, shared resources, and statewide collaboration that would allow these programs to expand. At present, Alaska does not have a coordinated statewide system that connects educators, communities, and organizations working to deliver outdoor and place based education programs that support youth wellbeing. This project seeks to address that opportunity by developing a statewide network that supports outdoor learning as a preventive health strategy for rural youth.	The Alaska Natural Resource and Outdoor Education Association (ANROE) proposes to develop the Alaska Rural Outdoor Learning & Health Network, a collaborative initiative designed to strengthen outdoor and natural resource education as a strategy for improving youth wellbeing and supporting healthy communities across rural Alaska. This project would focus on building the foundational infrastructure needed to coordinate partnerships, develop shared resources, and expand outdoor learning opportunities statewide. The proposed approach includes several key components: Network Development and Partnership Building ANROE will convene educators, tribal organizations, school districts, youth-serving organizations, and land management agencies to develop a statewide collaborative network focused on youth health and outdoor learning. Statewide Needs Assessment The project will conduct outreach and engagement with rural educators and community partners to better understand existing outdoor education efforts, barriers to implementation, and opportunities for collaboration. Professional Training and Resource Development The network will explore opportunities to develop professional training and shared resources that help educators implement outdoor learning programs that support youth mental and physical health. Strategic Planning for Rural Health Impact The project will develop a long-term strategic framework for expanding outdoor learning programs that support healthy communities and youth resilience across rural Alaska. Funding would support ANROE in establishing its first paid leadership position—an Executive Director responsible for organizational development, partnership building, and resource development. This role would provide the capacity necessary to coordinate statewide	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway	Deferred or Not Advanced

collaboration and position the network for future program implementation		(Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area

Alaska Network on Domestic Violence and Sexual Assault	Addressing Strangulation and Traumatic Brain Injury as a result of domestic and sexual violence.	AK	In Alaska we have some of the highest mortality rates in the US due to traumatic brain injury (TBI) with Alaska Native People having death rates of up to 2 times higher than the national average. According to Alaska Dept of Health the most frequent cause of TBI includes assaults. In Alaska we also rank #1 in Sexual Assaults, #1 in Deaths of Women and our rates of domestic violence are some of the highest in the nation. These rankings are just the crimes that are reported. According to the AVS survey 8.1% of adult women in Alaska had experienced domestic violence and/or sexual assault in the past 12 months meaning that many of these crimes in Alaska go unreported. Most Alaskans who have experienced domestic or sexual violence do call crisis hot-lines and reach out to local organizations for assistance. Many victim's report being strangled or beaten in a way that caused an injury to their head. Often times, while the victim may talk about what has happened to them, they may be working with an organization whose staff may not be aware of the health consequences of these types of injuries. Strangulation is often-times overlooked due to there being no visible external injuries. Sometimes the victim does not remember the head injury due to the trauma that they experienced during the assault. These are just a few reasons why strangulation and traumatic brain injury is often times overlooked. This project is designed to address these two issues.	We would like to address this issue by: 1) Enhancing the knowledge of professionals working with victims of domestic and sexual violence about how to enroll in Medicaid or access insurance on the marketplace and could identify signs of strangulation and traumatic brain injury. a. ANDVSA would partner with a health practitioner to develop training for professionals using existing trainings when available and developing training content that is missing. This training would be created as an on-line training and also one that can be done in person. 2) Improve policy and practice, including building screening tools or incorporating in existing screening tools for all victims who engage with professionals working with victims of domestic and sexual violence who may have experienced strangulation or a head injury. a. ANDVSA would write sample policy and procedure for professionals; would work with statewide partners to review current Traumatic Brain Injury and Strangulation screening tools; would work with statewide partners to develop new or revise existing screening tools; and would train on how to use the screening tool. 3) ANDVSA would build partnerships between advocacy organizations and medical providers to ensure proper follow-up care is provided to victims experiencing strangulation or a head injury, including access to a specialist as needed. a. ANDSA would work to form a network of providers throughout Alaska or other states who could be available to work with victims experiencing head injuries and strangulation even when the victim had no ability to pay. This would include payment of medical fees, payment of behavioral health fees, and travel costs as necessary to access a specialist if none is available in Alaska. We would also explore the use of tele-health in rural areas to ensure access to these services in a confidential location.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Network on Domestic Violence and Sexual Assault	Building a Medicaid/Insurance Billing Hub	AK	Becoming a Medicaid billable agency is a heavy lift and it is not something that organizations serving victims of domestic violence and sexual assault in Alaska have the capacity to do, however, being able to bill Medicaid for the services provided would greatly increase their ability to provide services. This would create a centralized billing hub through the Alaska Network on Domestic Violence and Sexual Assault as a shared service to the 21 agencies who would engage in providing the services.	This would be a hub and spoke model with the Hub being ANDVSA who would obtain a National Provider Identifier and would enroll as a state Medicaid provider – defining our services to be case management and peer support under the current 1115 waivers for clients who qualify; and to provide behavioral health services. We would employ individuals with the necessary credentials to become a certified behavioral health organization. After becoming a Medicaid billable hub, ANDVSA would employ case managers/social workers, peer support specialists and licensed mental health counselors who would be available in rural Alaska to victims of domestic and sexual violence through their work with rural regional organization specializing in serving domestic and sexual violence victims. These services would be provided using an in-person method for professionals hired in a rural community; a telehealth option for professionals hired in an Alaska location other than where they will provide services; and an in-person plus telehealth option to allow for in person connections at least quarterly for all participants. ANDVSA would work with an IT specialist to ensure proper connections between the 21 member programs to keep all records confidential and to adequately document all services as necessary for billing Medicaid and insurance. ANDVSA would provide training to their 21 member organizations on how to enroll participants in Medicaid, how to help participants stay eligible for Medicaid, and how to provide referrals.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Orthopedic Specialists	Cordova Musculoskeletal Access & Recovery (CMAR)	AK	Our goal is to provide subspecialty care with regularly scheduled in-person clinics, on site enhanced training for local providers, telehealth workflows and addition of diagnostic technologies for remote the remote community of Cordova, Alaska as a geographically isolated, off-road frontier community accessible only by air or marine transport. This will help reduce and potentially eliminate barriers to residents requiring orthopedic or musculoskeletal specialty care including but not limited to: High travel costs Weather-related delays Time away from work and family Delays in diagnosis and treatment Fragmented postoperative follow-up care	This project is a scalable rural specialty care model designed to improve access, quality, and continuity of orthopedic services in Cordova, and expand in-person outreach clinics with telehealth-enabled care pathways and advanced imaging technology to support both real-time and asynchronous specialty consultation. Core Components 1. Expanded In-Person Orthopedic Clinics Regularly scheduled outreach clinics in Cordova Evaluation and management of acute and chronic musculoskeletal conditions Fracture care, joint injections, sports injury management, and preoperative planning 2. Tele-Orthopedic Consultation Pathway Real-time telehealth consultations between Cordova providers and AOS specialists Remote review of imaging and clinical findings 3. Standardized Injury & Postoperative Care Pathways Evidence-based protocols with structured postoperative telehealth follow-up model 4. Ultrasound Technology Integration AOS is requesting RHTP support for acquisition of a ultrasound system to enhance musculoskeletal imaging capacity in the rural setting. This system will: Improve diagnostic accuracy at the point of care Support ultrasound-guided injections and procedures Enable remote specialist visualization during telehealth consultations Strengthen local provider skill development Reduce unnecessary travel for diagnostic clarification The ultrasound unit is central to the project’s technology innovation strategy leveraging advanced tools to expand rural access. 5. Workforce Training & Capacity Building On-site training for local clinical staff Telehealth workflow training Imaging protocol standardization 6. Data Tracking & Performance Reporting Access metrics (clinic days, wait times, telehealth utilization) Quality metrics (postoperative follow-up completion, complication-related ED visits) Utilization metrics (travel avoided, referral patterns) Technology adoption and imaging workflow metrics	\$50,000- \$250,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area	Deferred or Not Advanced

Alaska Pacific University	Alaska Pacific University Place-based Workforce Development Initiative	AK	People in rural Alaska want jobs in healthcare. Tuition can be a large concern, but this is often offset by expected salaries upon program completion. A larger concern, for many people living in rural Alaska, is leaving their communities to move to urban areas for healthcare education. In addition to expense, this kind of move creates stress on relational ties, decreases opportunities to participate in traditional subsistence lifestyles, and isolates individuals from cultural practices that have been shown to be beneficial for the health and wellness of rural Alaskan communities. It is also very expensive. Housing and other living costs can be as expensive as tuition. This initiative leverages a highly successful, scalable model to solve Alaska's rural health crisis. Over the past five years, the APU nursing program has demonstrated a unique capacity for growth, expanding from 20 to over 100 students and from a single campus to four active sites across the state. The proposal builds on that momentum to create a permanent, multi-faceted healthcare workforce ladder, specifically designed for frontier practice, and to support rural Alaskans living and working in their home communities. Programs in nursing will be expanded to the graduate level, programs in behavioral health will be reconfigured, and programs in allied health professions will be added to the curriculum. Alaskan communities and local professional groups will be partners in this effort.	APU's experience in successfully delivering high quality nursing programs to rural communities provides a clear model for expansion of additional sites and additional pathways. APU can boast the highest NCLEX pass rates in the state for program graduates over the last 2 years. Current Strengths to be Scaled Up • Instruction includes a combination of on-line, in-person support, and embedded industry instruction that is hands-on. • Partnerships include agreements with clearly understood roles and responsibilities. • Students are allowed to continue to earn-while-they-learn; maintaining employment within the industry helps to fill needed roles while also providing learning experiences. • An industry-assigned instructor or mentor for students is co-selected by APU and the industry partner, ensuring a high-quality in-work learning experience and positive student outcomes. • Training and professional growth opportunities for instructors/mentors creates successful learning that is sustainable. • Curriculum delivery model that utilizes the work environment as an extended classroom- including work embedded projects and enhanced learning through mentors. • Online delivery of didactic instruction that creates relationships and builds cohorts through in-person intensives and/or instructional visits to remote sites. • Online delivery of support services to help students access financial aid, tutoring, registration, cultural connections, etc. – providing a sense of support and connectedness. Strong connections with community partners are at the heart of what we do. New programming will be created based upon industry gold-standards and professional accreditation requirements. Several professional groups and healthcare facilities have been in touch and are ready to move forward with this concept. Creating educational pathways, the initial start-up of a remote site, and quality implementation that leads to high success requires investment. This includes staff and faculty time to dedicate to articulation and accreditation needs, time for partnership agreements and setting up co-instructors from within the industry, creating remote learning spaces with technology set-up, and providing travel and training for on-going excellence. It also includes some campus enhancements to provide suitable housing for intensive learning sessions, technology enhancements, and up to date laboratory and simulation equipment to be used by multiple certificate and degree programs.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Pacific University	APU Connect: Healthy Communities	AK	According to the USDA Natural Resources Conservation Service, approximately 95% of the food consumed in Alaska is imported. For rural Alaska communities—especially those off the road system—this reliance on shipped food means high costs and limited access to fresh, nutritious options. Store-bought foods are often packaged and highly processed to withstand long transport, contributing to diets linked to diabetes, heart disease, and obesity. At the same time, Alaska has strong local food traditions and seasonal abundance. Salmon, berries, potatoes, carrots, and other locally grown or harvested foods are widely available in summer months. However, many families lack hands-on training to grow, prepare, and safely preserve these foods for year-round use. As a result, valuable local foods are underutilized or wasted. Food waste has been identified as a statewide concern. Rural Alaskans want to learn how to grow their own food, preserve seasonal harvests, cook nutritious meals, and pass these skills on to their children. Providing community-based education in farming, food preservation, and healthy cooking increases access to local foods while directly addressing chronic disease prevention. When families can safely dry salmon, freeze berries, store root vegetables, and prepare balanced meals, they reduce dependence on costly processed foods and improve long-term health outcomes. Introducing children to these concepts early creates healthy lifestyle habits that prevent disease.	APU Connect Healthy Communities is grounded in a clear belief: education drives sustainable, community-led health change. Our mission is to partner with rural Alaska communities to co-develop practical, culturally relevant programs that increase access to healthy local foods, strengthen nutrition knowledge, and reduce chronic disease risk statewide. Because each community has distinct strengths and challenges, we work collaboratively to identify local goals and build solutions that are locally owned, sustainable, and replicable across rural Alaska. A key model is our participation in the Alaska Resilience Farms network, in partnership with local Tribal organizations and Alaska Seeds of Change. Through this collaboration, we provide technical assistance in sustainable food production and strengthen regional food systems. Expanded staffing will allow us to deepen on-site support in rural communities, improve agricultural education programming for youth, and implement a train-the-trainer model. Our Alaska Tilth program, in partnership with Mat-Su Health Foundation, rescues surplus produce, distributes it to schools and shelters, and pairs food access with hands-on nutrition and cooking education. Renovations on the Kellogg campus will include a commercial kitchen, classroom and office space, and a cold storage facility, enabling year-round programming and reducing seasonal food gaps. Hybrid technology will connect rural learners statewide in real time. Over time, Alaska Tilth will develop accredited certificate or degree pathways in nutrition and health sciences, strengthening Alaska’s rural healthcare workforce and advancing prevention-focused care. F.I.E.L.D. School and Camp Kellogg further reinforce this ecosystem. With consistent waitlists, these programs provide place-based, experiential education during the school year and summer, fostering lifelong healthy habits tied to nutrition, agriculture, and outdoor learning. Expanded facilities will increase access and support new family learning workshops and camps that engage entire households in behavior change. The campus also serves as a training laboratory for graduate students preparing to lead community health initiatives across the state. Together, these integrated efforts create a scalable, community-driven model that improves food security, builds local capacity, strengthens Alaska’s health workforce, and measurably advances public health—especially in rural communities.	\$1M-\$5M	Statewide	Matanuska-Susitna Borough	Deferred or Not Advanced

Alaska Pediatric Specialties	Alaska Pediatric Specialties Expansion	AK	Alaska Pediatric Specialties (APS) is a private practice with over 10 years of experience providing subspecialty care in Alaska, APS is the sole provider of pediatric surgery, pediatric hematology and oncology, and pediatric gastroenterology in the State of Alaska. By delivering essential services locally, children and their families receive high-quality care in Alaska, reducing the burden and medical expenses for out-of-state travel. To better serve the needs of Alaskan children APS is actively expanding its services, but currently lacks the resources required to sustain and scale this effort to simultaneously meet the increasing demand and stabilize the needs of our current service lines. With additional funding our growth will include renovating our clinic space to increase patient capacity and optimize patient care, conducting a state-wide needs assessment for pediatric specialty services, and recruiting additional specialists and support staff to ensure comprehensive, coordinated care for the children and families of Alaska who have are dependent upon us.	Alaska Pediatric Specialties (APS) is committed to expanding access to high-quality care for children across Alaska. Serving a geographically vast and often underserved population requires thoughtful planning, efficient systems, and innovative strategies to ensure families can access timely pediatric specialty care. APS focuses on increasing patient access, strengthening operational efficiency, improving care coordination, and creating an environment where every child receives compassionate and effective treatment. APS is pursuing a remodeling initiative designed to enhance the clinical environment and improve patient flow. The redesign will create a more functional, adaptable, and patient-centered space by reconfiguring examination rooms, intake stations, and provider workspaces. A streamlined layout will reduce bottlenecks, improve scheduling flexibility, and support coordinated interdisciplinary care. An optimized clinical environment is essential for delivering safe and effective pediatric services. Improved circulation patterns, quiet spaces, and accessible exam areas will help reduce stress for families and allow providers to focus on delivering high-quality care. The updated design will also strengthen APS’s ability to deliver multidisciplinary care for children with complex medical or developmental conditions. By enabling concurrent evaluations, interdisciplinary consultations, and therapy sessions within a single visit, APS can reduce wait times and provide families with more comprehensive, coordinated guidance. Efficiency in provider and patient time is a key priority. Streamlined workflows and improved room utilization will allow clinicians to spend more time in direct patient care and less time navigating operational barriers. For families who often travel long distances for appointments, improved efficiency will reduce wait times and help consolidate services into fewer visits. Expanded telehealth capabilities will further support rural communities by providing access to care without requiring extensive travel. A modern, well-designed clinical environment supports collaboration, improves workflow, and will also help attract top-tier providers. Through strategic facility improvements and continued recruitment of specialized clinicians, APS is building a sustainable model of pediatric care to ensure that children and families across Alaska have access to coordinated, high-quality services that support their health and long-term well-being.	\$250K-\$1M	Private practitioner	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Alaska Peer LWC, LLC	Reclaim Your Roots - Healing Starts at Home	AK	Rural Alaskan communities face critical behavioral health challenges exacerbated by historical colonization, generational trauma, and cultural loss among Alaska Native and American Indian tribes. These factors disrupt traditional healing and contribute to cycles of addiction, overdose, and youth suicide. Geographic isolation and limited resources further restrict access to culturally relevant recovery services. Programs like Alaska Peer LWC, LLC’s Reclaim Your Roots address these unmet needs by building local capacity through peer support training, community engagement, and culturally informed interventions. Emphasizing education and language revitalization, the initiative fosters resilience and sustainable recovery supportive infrastructures, empowering communities to reclaim cultural identity and improve behavioral health outcomes in these underserved rural areas.	The Reclaim Your Roots program offers a comprehensive framework for addressing the behavioral health and wellness challenges faced by Alaska Native and American Indian (AN/AI) communities in rural Alaska. Implementation begins with Community Engagement, inviting key stakeholders, including community leaders, health professionals, and families, to form a diverse coalition aimed at fostering an inclusive approach to community wellness. The Amplifying Voices phase includes interactive events, such as Community Wellness Nights, which facilitate discussions on resource needs and prioritize unique community characteristics to enhance recovery and healing. A critical component is the Peer Support Professional training, which aims to equip a diverse group of community members—including adolescents, Community Health Aides, Elders, and caregivers—with the skills necessary to support behavioral wellness according to established standards. Following data collection and analysis, the program will host hub events designed to engage stakeholders in effective discussions and action planning, ensuring that community members actively participate in shaping their wellness initiatives. The program culminates in collaborative workshops to create tailored implementation strategies, establishing accountability structures to sustain positive change. This holistic approach not only empowers individuals but also strengthens community ties, ultimately enhancing the health and wellness landscape within these challenging environments. Lastly, working alongside and supporting a one year implementation plan to bring change to fruition through the people for the people.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Prehospital Education Consortium	Alaska Rural Healthcare Workforce Continuum Initiative	AK	Many rural and frontier communities in Alaska face persistent healthcare workforce shortages, long transport times, and limited access to training opportunities for local residents who want to enter healthcare professions. EMS agencies, rural clinics, and Tribal health organizations frequently struggle to recruit and retain qualified providers, while geographic isolation and travel costs make traditional education pathways difficult for rural learners to access. At the same time, Alaska has an opportunity to strengthen rural healthcare delivery by expanding locally based workforce training and creating clearer pathways for rural residents to enter and advance within healthcare careers. Hybrid education models, distributed learning technology, and partnerships with local healthcare agencies now make it possible to deliver high-quality training across large geographic areas while allowing students to remain in their home communities. This project addresses these challenges by expanding rural EMS education, strengthening workforce pathways connecting Community Health Aide and EMS training, and creating scalable systems for distributed healthcare education. By building on existing programs and partnerships, the initiative will increase the number of trained providers in rural communities and support long-term workforce sustainability across Alaska.	APEC and Alaska Pacific University propose a collaborative approach that expands rural healthcare workforce training while creating new pathways for rural residents to enter and advance within healthcare professions. The project will expand APEC’s existing hybrid Emergency Medical Technician (EMT), Advanced EMT (AEMT), and Paramedic education programs, which combine virtual instruction with locally supported skills training and clinical experiences. This distributed learning model allows rural students to complete much of their training while remaining in their home communities, reducing travel barriers and improving workforce retention. To support this expansion, APEC and APU will establish a Rural Health Training Center in Anchorage that serves as a statewide hub for distributed healthcare education. The center will support simulation-based training, hybrid classrooms, virtual skills instruction, and digital learning production that enables consistent training delivery across Alaska. The project will also explore development of integrated workforce pathways connecting Community Health Aide training and EMS education. In collaboration with Community Health Aide training centers, Tribal health partners, and APU faculty, the project will develop curriculum that merges EMS and Community Health Aide competencies into an expanded Community Health Worker training pathway. This model supports a continuum of healthcare education extending from Community Health Aide and EMS training through nursing and nurse practitioner programs. Additional project components include development of an Alaska-focused Rural Austere and Wilderness Medicine manual and the creation of two statewide training convenings: a Rural Health Providers Conference focused on integrated rural healthcare delivery and workforce pathways, and a Remote Austere and Wilderness Medicine Basecamp Conference focused on healthcare delivery in remote and austere environments. Together, these strategies expand training access, strengthen rural healthcare workforce pathways, and create scalable systems that support long-term healthcare workforce development across Alaska’s rural and frontier communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Press Club	Building skills for high-caliber rural health news	AK	Journalists throughout the state of Alaska are often working in one or two person newsrooms. Alaska Press Club plays a vital role in building community for these reporters through professional development, networking and other support. It is widely known that newsrooms in Alaska, and around the world, are struggling. Changes in where advertising dollars are spent, legislation and expectations around individual support for news and information are a huge upset to the industry. While newsrooms explore new business models and modes of sustainability, Press Club supports journalists who are working daily for the public good under less than ideal circumstances. In a 2024, Alaska Press Club workforce study, 53 percent of respondents indicated that their journalism work did not offer enough money to cover living expenses. And most respondents indicate a household income lower than the state median. Nationwide solutions to these struggles are being identified and implemented, resources for journalists covering health and other topics are sitting, waiting. Newsrooms and individuals don't have the resources and capacity to take advantage of opportunities that will enhance their abilities to serve their communities. Alaska Press Club would like to do more to help.	We would like to offer opportunities for professional development in the area of strengthening best practices for health reporting. We'd do this through our annual journalism training conference, lunch & learn sessions, internships, community events, and development of the resources hub on our Alaska Press Club website. In order for this to be successful, we'd develop ways for community members and health providers to weigh in about what local health news is lacking as well as where it is working, collaborate with local and national partners (including health professionals) to leverage existing resources and explore barriers to continuing education in the field of journalism. Professional development topic areas may include but are not limited to: Understanding Alaska health data, rural health challenges, language use when covering health topics, ethical reporting on mental health, health investigations, countering misinformation and more.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Chugach Census Area; Copper River Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; Petersburg Borough; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

Alaska Primary Care Association	Alaska Health Center Shared Services Hub	AK	Alaska’s community health centers operate in some of the most challenging environments in the nation. Geographic isolation, workforce shortages, regulatory complexity, fragmented technology systems, and thin operating margins create structural and operational challenges across the network. These pressures limit health centers’ ability to: Recruit and retain clinical and administrative workforce Scale innovations equitably across regions Fully implement integrated primary and behavioral health models Participate effectively in value-based payment arrangements Individual centers often lack sufficient scale and administrative and financial capacity to independently build advanced infrastructure. Without shared investment, transformation efforts remain fragmented and uneven. Health centers have for years requested the types of services APCA proposes to offer under this project. RHTP presents a historic opportunity to build statewide infrastructure that reduces duplication, increases efficiency, and creates long-term sustainability across Alaska’s health center system.	APCA proposes to establish the Alaska Health Center Shared Services Hub to add requested capacity and reduce costs for Alaska’s health center network. The project would include an assessment to prioritize needs across health centers, development of business plans, including sustainability plans, and phased implementation for 1-3 of the prioritized services in Year 1. APCA would offer services at a discount but would plan to include user fees from the start to ensure that services are valuable enough to health centers to sustain them in the future. The Hub will include three domains: 1. Group Purchasing & Strategic Vendor Partnerships APCA will act as a statewide group purchasing entity, identifying qualified contractors, negotiating preferred pricing and shared contracts, reducing both cost and administrative burden for health centers. Some examples of group purchased services may be billing and coding, interpretation, credentialing or IT managed services. 2. Health Center Services Network This domain leverages expertise already present in Alaska’s community health center network to build a system of shared training, technical assistance, and service delivery. APCA would facilitate a system that allows experienced health centers to offer and bill other community health centers for services such as behavioral health integration training, and revenue cycle management consultation. Several health centers have already expressed interest in expanding their capacity to deliver these services through RHTP funding independent of APCA. 3. Health Center Systems Support APCA will engage staff to provide system-wide guidance, infrastructure modernization support, technical assistance, and subject-matter expertise. Potential roles may include a Chief IT Strategist, a financial consultant, and/or a human resources specialist. Additionally, staff could support technical assistance to specific health center RHTP projects such as a proposed project on emergency or urgent care in health center settings. While APCA has funding through its HRSA Primary Care Association Cooperative Agreement to provide general support in some of these areas, RHTP funding would support in depth individual support that HRSA funds are not sufficient to provide.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Primary Care Association	Community Health Led Medicaid Value Initiative	AK	The opportunity is to launch a rural, primary-care led value-based care demonstration that proves how strengthened primary care, coordinated navigation, and improved access can measurably reduce avoidable utilization and total Medicaid spend. This initiative will be led by the Alaska Community Health Network (ACHN), a clinically integrated network of five Federally Qualified Health Centers located in Anchorage, Kodiak, Mat-su, Talkeetna and Seward. This project provides the opportunity to launch a transformative care model across Alaska that serves 8,589 Medicaid members, creating a system-level transformation. Medicaid beneficiaries in Alaska experience high chronic disease burden, fragmented care, and preventable emergency department and hospital use, often worsened by social drivers such as unstable housing, food insecurity, and transportation barriers. Many high-risk and rising-risk members rely on specialty practices rather than comprehensive primary care, leading to missed preventive services and higher per-member-per-month spending. Current Medicaid reimbursement does not support the non-visit-based services required to manage chronic disease, coordinate care, or conduct proactive outreach—services essential to reducing utilization. This demonstration provides a structured, statewide test of how a primary-care-led model can deliver better outcomes at lower cost and generate the evidence needed to drive long-term Medicaid payment reform and system sustainability.	ACHN proposes the Community Health Led Medicaid Value Initiative, a primary-care–led value-based model designed to reduce preventable utilization and improve outcomes through comprehensive, team-based care. The model leverages ACHN’s experience in population-based arrangements (e.g., Medicare Shared Savings Program) and adapts those capabilities to the Medicaid environment. Core elements of the approach include: Comprehensive, team-based primary care: Each patient is aligned with a primary care provider supported by interdisciplinary staff operating at the top of their roles. Enhanced access: Same-day care, telehealth, and flexible visit modalities reduce low-acuity emergency department use. Care coordination and navigation: Targeted support for high-risk and rising-risk members, coordination after emergency department/hospital use, and facilitation of specialist and community referrals. Proactive, data-driven population management: Risk stratification and utilization analyses guide targeted outreach and care planning. Evidence-based quality and performance management: Measures aligned to chronic disease control, follow-up after acute events, and preventive care. Network infrastructure and analytic approach: ACHN will a shared cost and utilization analytics module to integrate Medicaid claims with clinical data, enabling accurate risk stratification and performance tracking. All participating health centers already share common data platforms, enabling rapid deployment. Phased implementation: Planning & infrastructure – data integration, baseline measurement, readiness activities. Rapid testing & targeted capacity building – small tests of change for high-risk populations; staffing adjustments based on data. Scaling & evaluation – expanding successful interventions; assessing impact on utilization and cost. This model is deliberately structured to be both rigorous and scalable, with flexibility for each health center to tailor services such as integrated behavioral health or clinical pharmacy to meet community needs.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Denali Borough; Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Advance to Implementation Application

Alaska Primary Care Association	Rural FQHC Transformation for Alaska Medicare	AK	Alaska’s aging population is driving rising demand for primary care across rural and frontier communities. Resolute Health Alliance of Alaska—an FQHC led, community governed Accountable Care Organization (ACO) and subsidiary of the Alaska Primary Care Association (APCA)—began participating in the Medicare Shared Savings Program (MSSP) on January 1, 2026. This project strengthens capacity at the four FQHCs to support the core components of MSSP that matter most for seniors and for Medicare’s bottom line: • Chronic care management (risk stratified outreach, medication management, care management) • Preventive screenings (Medicare Annual Wellness Visits and closing care gaps for cancer, cardiovascular disease, and diabetes) • Care coordination (data supported pre-visit planning, team huddles, transitions of care, and referrals) By increasing the role of primary care in day-to-day management, MSSP ACOs have demonstrated the ability to improve quality and reduce total cost of care for seniors nationally. RHTP funding will enhance these MSSP foundations and accelerate positive impact for 6,000+ attributed Medicare beneficiaries by supporting rural practice facilitation and coaching, travel for convenings, learning collaboratives, and population health analytics. Pairing MSSP’s accountability with RHTP’s rural capacity building strengthens access, quality, continuity, and fiscal sustainability for Alaska’s seniors.	Resolute Health Alliance of Alaska is a low-revenue Accountable Care Organization (ACO) in the Medicare Shared Savings Program (MSSP). Advance Investment Program (AIP) funds cover essential start-up needs—staffing, compliance, basic analytics, required deliverables—but are not enough for the enhanced staffing, hands-on support, and population-health tools needed for Alaska’s first FQHC-focused MSSP. Rural Health Transformation Program (RHTP) funding will augment, not duplicate, AIP by enabling rural-tailored implementation of MSSP core functions across four Federally Qualified Health Centers (FQHCs): chronic care management, preventive screening, and care coordination. Shared platform, smarter analytics. All four FQHCs use a common population-health platform. RHTP will add non-duplicative functionality—registries, improved risk stratification, Medicare claims integration, payer reporting, and dashboards—to help teams identify rising-risk seniors, close gaps, and improve follow-up. Turning MSSP data into action. MSSP provides robust Medicare data (attribution, utilization, transitions, quality). Resolute will convert these into practical tools: rising-risk lists, post-discharge queues, Annual Wellness Visit and screening lists, and views that show where rural seniors need support. Staff will use these insights in huddles and pre-visit planning. Five integrated components: (1) Practice facilitation & workflow redesign (hybrid onsite/virtual) to activate MSSP workflows. (2) Workforce capability-building: short micro-trainings on VBC, AWW workflows, chronic disease management, and data literacy. (3) Rural travel & cross-organization learning: supported travel for remote site visits and structured sessions that spread effective approaches. (4) Population-health analytics: added platform capabilities—registries, risk stratification, payer reporting, follow-up tracking, run-chart monitoring—right-sized for rural capacity. (5) Accountability & evaluation: quarterly dashboards and run-charts aligned with MSSP measures, an independent evaluator, and feedback loops to guide course corrections. Result: Earlier identification of rising-risk seniors, stronger chronic care management, higher screening completion, smoother care transitions, and fewer avoidable ED visits/hospitalizations. In this budget period, funds focus on practice facilitation, workflow redesign, workforce training, travel, enhanced analytics on the shared platform, and evaluation.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kodiak Island Borough; Matanuska-Susitna Borough	Advance to Implementation Application

Alaska Primary Care Association	Statewide School Based Health Network	AK	School-based health centers provide health and mental health care to children and teens in or near school settings to improve access to timely health care while supporting academic success. School-based health services are more established in other parts of the US, and are a cost-effective way to increase health care access. Research has shown that school-based health supports academic success, and overall well-being of students and families. Providing care in these environments presents unique challenges, and many states have statewide school-based health networks to support program development, share best practices, and coordinate training opportunities. Alaska has an emerging network, without dedicated funding or staff, which has made it more difficult for school-based health centers to establish and to sustain themselves. More Alaska organizations are likely to start or expand school-based health services with Rural Health Transformation Program funds, and a statewide network would facilitate and coordinate their development.	APCA would develop a statewide school-based health network to support emerging or existing school-based health centers in the areas of program development, dissemination of proven or promising practices, and training. An Alaska School Based Health Network would also develop a strategic plan for school-based health in Alaska, and include an annual convening of school-based health centers. Existing school-based health services exist in Juneau, Anchorage, Naknek, Bethel, Sitka, Soldotna, Kenai, Nikiski, Petersburg and other communities. APCA’s mission is to Advance Alaska’s Wellness and its vision is to the ally for all Alaskans to live their healthiest lives. APCA focuses on community based primary care, and many of the organizations engaging in school-based health center services are APCA’s members, Alaska’s community health centers. APCA began a similar project in late 2024 with federal funds passed through the Alaska Department of Health and the national School Based Health Alliance. Unfortunately, those funds were discontinued in Spring 2025, before the project got off the ground, as part of a series of federal funding cuts during that time. But APCA developed a concept and partnerships that are still relevant to this project.	\$50,000- \$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

Alaska Primary Care Association	APCA Healthcare Workforce Pipeline Expansion	AK	Alaska community health centers and other healthcare employers experience gaps between their workforce needs and available training pipelines for the occupations they want to hire. Rural healthcare providers are often challenged to find training resources that allow staff to learn without leaving their jobs or communities. Smaller health care organizations without specialized training or HR staff can also find it administratively burdensome and expensive to identify training resources and track participation. Similarly, rural Alaska residents can find it difficult to find jobs and training that lead to livable wages and healthcare careers without leaving their home communities and regions.	APCA would expand or continue existing distance-delivered occupational training for paraprofessional roles such as Clinical Medical Assistant, Pharmacy Technician, Surgical Technician, Medical Administrative Assistant, and others, through Registered Apprenticeship Programs and other types of on-the-job learning opportunities. APCA would deliver training directly, or offer it through vetted training programs at no- or low-cost to Alaska employers. Training is distance-delivered so that participants do not need to leave their workplaces or communities to earn new credentials, increasing retention for rural employers. Employers enter into agreements with APCA to agree to identify new or incumbent employees for training, support their training participation, and report data on their job progression. APCA has established these training programs under funding from the US Department of Labor and US Department of Commerce, and has trained and tracked job placement or wage increases for over 900 participants over the past 3 years. The last of these funding sources will sunset by June 2027. This project will continue programs that would otherwise lose funding, and it will also expand the types of training APCA offers to meet Alaska employer and workforce needs.	\$250K-\$1M	Federally qualified health center	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Psychiatric Experts	Mental Health Access and readiness	AK	Currently, hospital outpatient behavioral health services in the region reportedly face waiting lists approaching four months, leaving many residents without timely care. By expanding his model, the project would provide additional outpatient behavioral health capacity, helping reduce waitlists and improving access to treatment. Also, there is mental health crisis care that provides consultation to an inpatient population, or provides therapeutic treatment in a reasonable amount of time. We will also be looking to see patient suffering from substance use disorders.	Provide 24 hour 7 day a week crisis coverage, and consultation to inpatient facilities. Be available and make space for people to have routine follow up, or emergent access to a mental health provider and prescriber.	\$250K-\$1M	Behavioral health/su bstance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Public Health Association	Rural Policy & Implementation Readiness Infrastructure - Phase 1	AK	Public health professionals often receive legislative and regulatory information late or in fragmented form. Rural providers lack a neutral, centralized way to understand how emerging policy may affect local implementation. Delayed awareness increases compliance risk, slows program adaptation, and reduces rural readiness to implement policy-linked funding opportunities. Rural communities frequently experience structural information gaps due to staffing constraints, geographic isolation, and limited capacity to monitor rapidly evolving policy landscapes. Without structured policy translation infrastructure, rural communities face uneven implementation readiness, delayed response to regulatory change, and reduced ability to capture and manage funding opportunities tied to legislative action. Local data at the borough or census area level is essential to understanding health disparities and improving population health statewide. Healthy Alaskans, led through a state and tribal partnership, provides a roadmap for addressing Alaska’s most significant health challenges. However, a persistent barrier is translating statewide public health data into actionable local insight that supports policy change and community-level health improvement. Strengthening rural partners’ ability to interpret and apply local data will improve participation in statewide health initiatives and inform the development of Healthy Alaskans 2040.	ALPHA proposes to establish and operate a Rural Policy & Implementation Readiness Infrastructure aligned with the Spark Technology & Innovation initiative and supportive of healthy communities coordination goals. The focus is on translation, implementation clarity, funding readiness, and structured feedback. Year One (Design & Launch): • Implement a legislative and regulatory tracking platform • Develop standardized implementation-focused policy summary templates • Launch biweekly Policy Intelligence Briefs during legislative session • Transition to monthly regulatory and funding updates outside session • Integrate funding opportunity alerts tied to policy developments • Host monthly statewide virtual Policy Update sessions • Establish a structured rural feedback and barrier-identification loop • Integrate a formal policy alignment and synthesis session into the ALPHA Annual Health Summit To strengthen local decision-making capacity, ALPHA will partner with Healthy Alaskans and the University of Wisconsin Population Health Institute (UW-PHI) to support borough-level data interpretation and application. UW-PHI will maintain curated borough-level datasets, including descriptive trends, interactive website tools, and downloadable summaries that help communities understand local health conditions and connect those insights to evidence-based policies and interventions. Through this partnership, rural partners and care coordination grantees will have access to data-informed summaries and responsive technical assistance to support evidence-based decisions. ALPHA will serve as the coordination hub linking rural partners, Healthy Alaskans leadership, and UW-PHI technical expertise. Over time, this infrastructure will also function as a rural policy early warning system, linking legislative monitoring, local data insights, and rural partner feedback to identify emerging implementation barriers and improve statewide coordination. The goal is not to replicate existing surveillance systems, but to connect policy intelligence with data-informed decision making, helping rural providers, Tribal health organizations, and public health leaders anticipate implementation challenges and respond more effectively to policy and funding changes.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Public Health Association	Rural Public Health Fellowship & Workforce Accelerator - Phase 1	AK	Alaska has strong clinical delivery systems and regional health leadership. However, workforce pathways into rural public health roles are episodic rather than structured. Rural providers and community leaders consistently report recruitment and retention challenges, particularly in frontier communities. As multi-year transformation initiatives are implemented across the state, workforce instability creates operational risk. Vacancies delay implementation, disrupt partnerships, and reduce continuity across funding cycles. High turnover diminishes institutional knowledge and weakens the ability of rural communities to sustain complex funding and reporting requirements. Students and early-career professionals often lack structured entry pathways into rural public health practice, and host organizations lack coordinated support for mentorship and long-term workforce planning. There is no shared, sustained infrastructure dedicated to building a structured rural public health pipeline aligned with statewide transformation efforts. This gap directly affects rural implementation capacity, funding absorption, and long-term system stability. A structured workforce accelerator is necessary to stabilize rural implementation capacity and strengthen workforce continuity during a period of accelerated transformation.	ALPHA proposes to pilot and scale a structured Rural Public Health Fellowship & Workforce Accelerator aligned with the Strengthen Workforce initiative and designed to stabilize rural implementation capacity. Rather than functioning solely as a training program, this initiative will serve as a workforce stabilization and implementation support strategy embedded within transformation efforts. Year One (Planning & Pilot Phase): • Finalize fellowship governance structure • Formalize partnership agreement with Alaska AHEC • Identify and secure 5–8 rural and Tribal host sites • Develop standardized placement and mentorship agreements • Recruit and place first cohort of 3–5 fellows • Establish outcome tracking system including placement completion, host satisfaction, vacancy duration indicators, retention tracking, and implementation support metrics. By the end of Year One, ALPHA will have an operational fellowship model with formalized host agreements, a documented mentorship framework, a defined evaluation structure, and the first cohort placed in rural and Tribal communities. Fellows will: • Support host-site public health and RHTP-aligned initiatives • Provide short-term implementation capacity in settings experiencing workforce gaps • Participate in structured mentorship and peer learning • Contribute to continuity across grant and program cycles Years Two–Five: • Maintain 3–5 annual placements • Expand host site participation across rural and Tribal regions as readiness allows • Track post-fellowship employment in rural Alaska • Explore multi-year rural service commitments where feasible • Initiate graduated host co-investment discussions by Year Three	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Public Media KSKA KAKM	Using Public Media's Digital and Broadcast Reach to Connect Alaskans to Transformative Healthcare	AK	For decades, KYUK and AKPM have worked in partnership with local organizations to raise awareness about community health, wellness, and safety across the Yukon-Kuskokwim (Y-K) Delta and throughout the entire state of Alaska. KYUK maintains strong partnerships with groups such as Tundra Women's Coalition, Yukon-Kuskokwim Health Corporation, Teens Acting Against Violence (TAAV), Yukon Kuskokwim Fitness Center, and Bethel Family Clinic, KYUK has helped connect residents with important resources and vital public health messaging. These collaborations have included public service announcements, interviews with health professionals, community education campaigns, and locally produced programming focused on topics such as domestic violence prevention, behavioral health, youth wellness, cancer screenings, oral health, and access to medical care. AKPM produces and broadcasts "Line One: Your Health Connection," heard live on public radio statewide. "Line One" features Alaskan physicians and national subject experts from the fields of childcare, mental health, nutrition, pharmacology, surgery, and more. Listeners who call in can talk one-on-one with each week's guests or email their questions during the live broadcasts. "Line One" health video tips, featuring show hosts, appear on statewide television. Building on these long-standing relationships and community trust, KYUK seeks to expand its capacity to provide reliable health communication through broadcast and digital media.	This proof of concept public media communications partnership approach would improve and expand rural Alaskans' access to the transformative healthcare services and outcomes that regionally based medical and social services organizations will develop, test, and refine over the next five years. KYUK and AKPM will leverage current partnerships, local programs, and messaging to develop stronger, more collaborative educational programming and messaging. KYUK proposes to strengthen rural health communication and improve access to reliable health information across the Yukon-Kuskokwim Delta through culturally relevant radio, television, and digital content. Y-K Delta communities experience significant health disparities, including higher rates of chronic disease, barriers to preventative care, and limited access to healthcare providers. Geographic isolation, language differences, and infrastructure challenges can limit access to health information and services. Trusted local media can play a critical role in closing these information gaps and supporting healthier communities. Serving a vast and geographically isolated region of western Alaska, KYUK reaches dozens of rural communities where broadband access is inconsistent and travel to medical care can require costly air transportation. In this context, broadcast remains one of the most trusted, universally available, and the only free platform for delivering timely public health information. Current examples of programming and messaging created and distributed by KYUK and AKPM include: Wellness Wednesday Series, What to know about Tuberculosis in the Y-K Delta - Chris O'Hara, Public Health Nurse with the State of Alaska in Bethel, speaks with MaryCait Dolan on the prevalence of tuberculosis in communities across the Y-K Delta and how we can treat and prevent the disease. Wellness Wednesdays Series, Excellent Health with YKHC – Host Nikolai Joekay is joined by YKHC's Chief of Staff, Dr. Ellen Hodges, Exercise Physiologist, Simon Cone, and Manager of Therapy Services, Eliza Ellsworth. Together they take a look at the heart, what it does, how to keep it health, what things to look out for to make sure the heart stay healthy, and exercise. Wellness Wednesdays Series, Mind Over M.A.Y.O.: How Teens Manage Stress – Bethel Regional High School students talk about different ways they manage stress AKPM produces and broadcasts "Line One: Your Health Connection," heard live on public radio statewide.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Alaska Quality Care	Alaska Quality Care (AQC) I & II Modernization	AK	Alaska Quality Care I & II currently need to upgrade the fire protection system in both homes in order to insure continued operations in Anchorage. The homes provide assisted living housing to 31 residents. Annual occupancy exceeds 95%. Therefore, the purpose of this project is to remove a barrier to continuing operating these homes.	When approved, Alaska Quality Care I & II will immediately contract to install a fire protection system meeting or exceeding the Municipality of Anchorage requirements. In order to do installation, AQC will make necessary arrangements for temporary housing for any resident disrupted due to the physical installation of the system.	\$50,000-\$250,000	Home- and community-based services provider	Statewide	Anchorage (Municipality)	Deferred or Not Advanced
Alaska Regional Hospital	Step-Down Services for Expanded Care Access	AK	Alaska healthcare providers face ongoing challenges in safely transitioning patients from acute hospital care to home or long-term care. Limited access to primary care, long wait times for follow-up, workforce shortages, and geographic barriers contribute to preventable readmissions, emergency department use, and costly transfers to Anchorage-area hospitals. These gaps disproportionately affect older adults, patients with complex chronic conditions, and those without reliable home or community support. A significant additional barrier is the lack of an onsite outpatient pharmacy at discharge. Without timely access to prescribed medications, patients often experience delays, incomplete fills, or confusion about medication changes—substantially increasing the risk of post-discharge complications and readmissions. Alaska currently lacks a hospital-operated transitional care clinic to address this high-risk recovery period. This project proposes establishing a Transitional Care Clinic (TCC) operated by Alaska Regional Hospital to provide coordinated, multidisciplinary follow-up care within seven days of discharge. By integrating clinical follow-up, care coordination, medication management, and telehealth-enabled specialty access, the TCC will improve continuity of care, reduce avoidable utilization, lower total cost of care, and strengthen services to Alaskans – all in support of the rural health transformation goals.	The concept approach of this project is to retrofit a dedicated outpatient clinic (former Senior Care Clinic) on the hospital campus designed for comprehensive post-hospital discharge follow up care. The project will also retrofit an onsite pharmacy, which will target providing patients with medications and needed support to provide full outpatient services upon discharge. The space already exists and no construction will be needed to build out the facility. This project is to outfit the outpatient clinic to be able to deliver sustainable services that will significantly improve access for Alaskans. Services Offered: -comprehensive discharge planning and follow-up coordination. -immediate Prescription dispensing. -medication management and patient education. -physical, occupational, speech, and behavioral therapy. -social work/case management services. -telehealth access to specialists not locally available. -stress tests for cardiovascular patients. There is currently one major cardiovascular practice in town with limited availability for access. Stress testing is time-sensitive and specifically targets those with other major co-morbidities such as diabetes and mental health issues. It typically includes monitored exercise, nutritional counseling, and stress reduction to improve cardiovascular health, reduce the risk of future events, and enhance quality of life. These services are critical for the senior care population. The targeted population includes patients that have recently been discharged from acute care settings (emergency department, inpatient unit) who require a follow-up visit within 7 days for medical management and coordination of specialty services. The staff will be a multidisciplinary team including a physician, nurse practitioner and/or physician assistant, behavioral health therapist, a registered nurse, a medical assistant, and front desk staff. We currently measure that 7,000 patients are provided with general primary care provider (PCP) referrals with another 228 that are not established with a PCP. Based on these numbers as well as readmissions, we estimate that we could see an average of 33 complex patients a day, significantly decreasing the time from discharge to the first follow up visit and	\$1M-\$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

providing an avenue to establish care with existing PCPs in their community.

Alaska Remote Medical Staffing	Growing the CHA/P Workforce By Empowering Advanced Practice Practitioners	AK	1 The staffing model in many Alaska Native (AN) village clinics places responsibility on Community Health Aides/Practitioners (CHA/Ps), often without adequate clinical support. The stress placed on CHA/Ps is highly visible within their communities. Potential applicants see the workload, the lack of backup, and the level of responsibility, which discourages people from entering the role. 2 Progression opportunities for CHA/Ps reduce turnover and make recruitment more attractive by showing (potential) staff clear development opportunities. More CHA-IV providers could be empowered to advance to Community Health Practitioner (CHP). However, progression often slows due to inconsistent access to in-village mentorship from APPs and advanced clinical training. 3 Unfortunately, attracting and keeping APPs in remote villages is difficult. Roles are often presented by Tribal Corporations without clearly preparing clinicians for village clinic realities, including limited resources, cultural context, and Cerner EMR systems. High workloads and limited mentorship time further reduce APP capacity to supervise and train CHAs. Rural Health Impact Without strengthening the APP supervisory workforce, the system cannot expand CHA/P training or work conditions. When clinics lack sufficient CHA/P capacity, more patients must be referred or medevacked to regional hubs. Preventable transfers place financial strain on an already fragile rural health system and disrupt continuity of care.	1: Prepare APPs for Village Clinic Practice Through Realistic Orientation and Training We will establish a Village Clinic Practice Preparation Technical Assistance Program. It will provide online training modules, a centralized website, and practical toolkits that prepare APPs for the realities of practicing in village clinics before arrival. Topics will include: --Understanding the medications and equipment available in village clinics --Managing common high-acuity patients --Navigating limited public safety and community resources. --Logistical realities of village life, including access to food, supplies, and housing in remote communities. --Structured guidance on the use of the Cerner electronic medical record system to improve clinical documentation and workflow for new staff. --Advertising campaigns will drive traffic to the site, targeting APPs where they are, and increasing awareness and interest in APP careers within AN villages. By ensuring APPs are aware of AN village openings, and arrive with realistic expectations and practical skills, the program will reduce early turnover, improve provider satisfaction, and stabilize clinical staffing in village clinics. Location: Available online statewide. 2: Strengthen Village-Based Training and Advancement for Community Health Aides We will implement a village-based training support model that expands mentorship and education opportunities for CHA-IV providers within their own communities. The model will support 1 itinerant APP preceptor to deliver structured on-site or remote training focused on strengthening clinical reasoning, critical thinking, and effective use of the Community Health Aide Manual (CHAM). Remote learning tools and virtual mentorship will complement itinerant in-person training to increase access to instruction across rural communities. We hire 1 FTE APP preceptor with expertise in the AN clinics; 1 Office Manager for administration, billing, and scheduling; and engage Applichat, a consulting and recruiting firm, for project management, workforce, and communications support. This approach aligns with RHTP’s workforce strategy to expand training pathways and strengthen the workforce. Recognizing that authority for preceptor designation resides with Tribal and federal oversight bodies, the program will work collaboratively with Tribal partners to ensure alignment with CHAPCB standards and Tribal governance structures. Location: Year 1: Kenai Peninsula Borough AN villages	\$250K-\$1M	Clinic	Statewide	Kenai Peninsula Borough	Deferred or Not Advanced

Alaska Remote Medical Staffing	Recruit quality "Alaska Prepared" RN's, APP's and Physicians for urban and rural Alaska facilities.	AK	Alaska faces significant shortages of physicians, advanced practice providers, and nurses, contributing to heavy reliance on temporary clinicians from the Lower 48 to sustain essential services. We have approximately 24% nursing vacancy rates, and projections estimate a shortage of around 5,000 registered nurses by 2030. At the same time, we train only about 346 nurses each year, while the health system requires approximately 1,400 new nurses annually, forcing providers to rely on expensive temporary staffing. A number of health systems and Tribal organizations have developed national recruitment pipelines, but most rural providers lack the resources to recruit nationally. Relocating staff are unfairly distributed to the wealthiest systems that can afford to source them. Unlike jurisdictions such as British Columbia, which used marketing to relocate more than 1,000 American nurses in 2025, compared to 127 in 2024, Alaska does not operate a coordinated statewide “destination recruitment” campaign promoting the state as a long-term career destination for healthcare professionals. Retention challenges compound the problem. Clinicians recruited from outside Alaska often arrive without sufficient preparation for frontier practice, rural living conditions, or Alaska Native cultural contexts. Without structured preparation and integration support, some clinicians decline offers before arrival or leave shortly after starting, reinforcing the cycle of turnover.	We propose a coordinated recruitment marketing, integration, and retention program designed to attract RN's, APP's and Physicians from the Lower 48 to build long-term careers in Alaska. The initiative supports RHTP goals of strengthening the healthcare workforce, improving access to care, and reducing reliance on temporary staffing in rural and frontier communities. Component 1: Recruitment Marketing Campaign We will create a brand highlighting Alaska’s unique clinical and lifestyle opportunities, including the geographic scale of the state, rural healthcare delivery models, and opportunities to practice within the Tribal Health System. Applicants will be shown the chance to practice in frontier settings, support Alaska Native communities, and experience a unique professional environment. Activities will include development of a recruitment website showcasing statewide opportunities, creation of digital and video content featuring clinicians working in Alaska, and targeted advertising through social media and healthcare job boards to reach nurses, APPs, and physicians in the Lower 48. The campaign will promote relocation incentives and structured five-year service commitments. Priority areas include urban centers of Florida, California, Texas, Oregon and Washington. Component 2: Triage and Employer Connection A centralized triage system will connect interested clinicians with participating Alaska healthcare employers. ARM’s Recruiters and Integration Consultants will work with health systems to list open positions online, and engage applicants generated. Candidates will receive initial screening and guidance before being connected with recruiters and health systems who have signed up to the platform. Participating employers may offer relocation bonuses, signing incentives, and structured five-year service agreements designed to encourage clinicians to relocate permanently and build careers in Alaska. Component 3: Integration and Retention To improve retention, ARMS will lead on supporting incoming clinicians through integration resources and community-building tools. These include pre-arrival guidance on relocating to Alaska, peer mentorship from clinicians already practicing in the state, and online communities where new arrivals can ask questions and build connections.	\$250K-\$1M	Clinic	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Rural Health Deployment & Modernization Network, Division of Apex Auctions LLC	Alaska Rural Health Deployment & Modernization Network	AK	Rural and frontier communities across Alaska face persistent structural barriers that limit their ability to modernize health infrastructure and sustain efficient care delivery. Aging equipment, deferred facility upgrades, limited project management capacity, procurement challenges, and compressed funding timelines make it difficult for rural providers to translate available capital into measurable system improvements. While the Rural Health Transformation Program represents a historic opportunity, many rural entities lack the administrative bandwidth, coordinated logistics, and deployment infrastructure necessary to rapidly scope, procure, and implement modernization projects within federal time constraints. This gap risks slowing equitable transformation across high-need regions. There is a clear opportunity to establish a structured regional deployment backbone that accelerates facility modernization, reduces administrative burden on rural providers, and ensures disciplined, compliant capital deployment. By combining on-the-ground regional coordination with centralized procurement, compliance oversight, and performance tracking, Alaska can convert transformation funding into tangible access, quality, and sustainability improvements during Year One while building a scalable framework for future expansion.	Apex Auctions LLC will launch the Alaska Rural Health Deployment & Modernization Network (ARHDMN), a structured six-region hub-and-spoke model designed to accelerate rural health infrastructure modernization during Year One of RHTP. The project combines two integrated components: 1. Regional Modernization Deployments In collaboration with participating rural health entities across the Bethel, Nome, Northwest Arctic, Dillingham, Kodiak, and Kenai regions, ARHDMN will conduct rapid needs assessments and implement prioritized renovation-lite upgrades within existing facilities. Activities include equipment replacement and standardization, workflow optimization, targeted technology enhancements, and facility improvements that improve operational efficiency and reliability. All work will comply with federal restrictions and avoid new facility construction. 2. Centralized Deployment Backbone A centralized Program Management Office (PMO) will provide procurement coordination, vendor pre-qualification, compliance oversight, segregated accounting, cost tracking, and performance reporting aligned with CMS requirements. A structured online intake and tracking portal will allow rural entities to document infrastructure gaps, submit project requests, and monitor progress, promoting transparency and equitable regional access. Year One will follow a phased 12-month plan: • Months 1–3: Establish Rural Health Division, onboard CPA and compliance systems, launch intake portal, conduct regional needs assessments, pre-qualify vendors. • Months 3–9: Implement prioritized modernization deployments across six hubs. • Months 9–12: Evaluate outcomes, refine standardized deployment model, and prepare scalable framework for subsequent years. The majority of funds will support direct rural modernization activities, with administrative infrastructure maintained within disciplined thresholds. This approach delivers immediate impact while establishing a replicable, performance-driven deployment model capable of supporting long-term rural health transformation.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Dillingham Census Area; Kodiak Island Borough; Nome Census Area; Northwest Arctic Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Alaska School Nurse Association	Alaska School Nurses Annual Spring Conference Grant Funding	AK	The ASNA Annual School Nurses Spring Conference represents a singular opportunity to bridge the professional gap for school nurses across Alaska’s vast and fragmented geography. As the only statewide, in-person forum dedicated to school nursing, this event transforms professional isolation into a collaborative learning environment. By providing specialized CNEs and evidence-based 'take-home' clinical strategies, ASNA ensures that whether a nurse is in an urban center or a remote village, they possess the standardized knowledge necessary to directly improve student health outcomes and academic readiness.	Our approach centers on removing the financial barriers that prevent school nurses from accessing essential, in-person continuing education. We will utilize grant funding in two primary ways: Registration Offsets: We will provide registration grants to school nurses throughout Alaska, ensuring that professional development is affordable and accessible to all, regardless of their personal finances or school district's budget for professional development. Rural Travel Stipends: To ensure geographic equity, we will offer travel stipends specifically for nurses practicing in rural and remote "off-road" communities. These stipends will help cover a portion of the high costs of airfare and lodging, allowing these often-isolated healthcare providers (school nurses) to join the statewide community for hands-on training. By streamlining the application process through ASNA, we will ensure these funds are distributed efficiently to those with the greatest need, directly bringing relevant clinical knowledge back to students in every corner of the state.	Under \$50,000	Statewide	Anchorage (Municipality); Bethel Census Area; Chugach Census Area; Denali Borough; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Search and Rescue Association	Alaska Search and Rescue Association - Incident Command Trailer	AK	Search and Rescue teams in Alaska have limited tools and equipment for remote incident management capability. The current option with limited success has been to request a fully supported State Emergency Operations Center tractor trailer command center. This semi-trailer is not able to be located at most remote command posts that ASARA teams operate out of. This unit also requires State of Alaska DHS&EM Staff to transport, manage and operate the unit. Utilizing individual SAR team member owned Travel trailers, RVs and cargo trailers has become more common and inappropriate for the scope and need of the service.	Having a custom built incident command trailer for ASARA Affiliated teams to operate, train and function out of during emergency response incidents not only increases the effectiveness of the assignments, safety of the personnel in the field and increase capability of locating, accessing, stabilizing and transporting an injured or loss patient in the remote and rural areas of Alaska to safety. Having the ability to coordinate, communication, document, and direct resources efficiently via an established command post, that can be deployed to the remote areas of the Alaska wilderness increases the safety of all involved. With the increase in technology and mapping capability currently deployed in Alaska having a remote site that can provide updated situational awareness, internet and cellular data uplink along with secondary communication options only enhances the capability and support we can bring to the patients in need of further care and transport out of the wilderness.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Denali Borough; Fairbanks North Star Borough; Haines Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Alaska Search and Rescue Association	Alaska Search and Rescue Association - Patient Transport Equipment Standardization	AK	Search and Rescue teams in Alaska have a wide variety of patient transport and packaging equipment. From the 1980 wire stokes baskets to the upgraded fiberglass litters. The patient packaging can range from foam sleeping mats and responders personal sleeping bags to newer hyperthermia bags that support in the advanced rewarming and critical care in the austere conditions of remote Alaska. With the recent development of a litter wheel allowing patients to be rolled along a trail, road or boardwalk which increases the safety of the patient and the responders during transport. Most teams have limited splinting supplies such as full body vacuum mattress and extremity options to properly support broken extremities. Very few to any of the teams have the same equipment for the stabilizing, packaging and transporting of patients in these remote areas.	The recommendation from ASARA is to provide each affiliated team with the below standardized equipment cache for safe and effective patient transport: Cascade Rescue Two piece fiberglass litter Cascade Rescue Terra Tamer Litter Wheel w/Handles Cascade litter rigging kit MedTech VBS Vacuum full body mattress MedTech Extremity Split set Doctor Down Rescue Wrap Guardian Litter Shield	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Search and Rescue Association	Alaska Search and Rescue Association - Radio Communication Replacement	AK	We have approximately 450 portable radio units, 40 mobiles and 5 repeaters that are in need of replacement. All the current units do not meet the P25 Phase 2 TDMA compliance mandate from the Alaska Mobile Radio Network, are not able to be encrypted for secure radio transmissions with patient medical information, and are not able to communicate with a local Public Safety Dispatch Center. The ability for teams to communicate and have updated information while in route to the location, while accessing the patient, provide direct hospital consult via radio updates and coordinate the most appropriate ground or air transport would significantly increase the survivability and positive outcomes of Alaska’s that are injured or in need of rescue in remote areas of Alaska.	Replacing team assigned radios with current recommendations for interoperability and forward planning for long-term operation capability. Working with Motorola Solutions as the continued recommended vendor and Alaska Public Safety Communication Services along with Municipality of Anchorage Communications Shop to support the implementation, programing and continued services required to ensure longevity and operational capability. The equipment will be interoperable with any other agency approved on the Alaska Land Mobile Radio Network, shared user agreements are in place to create talk groups and continue emergency medical services in the rural and remote areas of Alaska.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Speech- Language Hearing Association (AKSHA)	Feeding and Swallowing Supports for School Aged Children Across Alaska	AK	Bridging the Gap for Pediatric Feeding Disorders in Alaskan Schools: A Critical Gap in Post-Diagnostic Support Despite Pediatric Feeding Disorder (PFD) receiving its own formal ICD-10 code in 2021, a significant disconnect remains between clinical recognition and the delivery of safe, localized care in Alaska. Many families have struggled with a systemic lack of support, particularly when navigating the transition from urban medical centers to their home environments. Currently, the Alaskan landscape creates a "geographic tax" on health: - Centralized Diagnostics: Many families travel to larger urban areas, such as Anchorage, to access specialized care including access to a pediatric Speech-Language Pathologists (SLPs), medical equipment, and instrumental testing. - Post-Travel Isolation: Upon returning home, many of these families rely frequently on teletherapy, often without local supports to manage daily feeding risks. - Educational Voids: The Alaska Department of Education and Early Development (DEED) currently offers no formal guidance on supporting students with PFD. This lack of recognition in the school setting leaves staff under-supported and students at high risk for medical emergencies, such as choking and/or aspiration. In previous communications with DEED, they indicated they are open to the development of resources that can support both rural and urban schools.	Our approach focuses on building a sustainable link between clinical diagnosis in urban hubs and school-based safety measures. By aligning medical standards with educational supports, and consideration of cultural practices, this project transforms Pediatric Feeding Disorder (PFD) management from a medical model to a school based model similar to procedures emerging in the Lower 48. Phase I: Statewide Interdisciplinary Conference The project will initiate with a statewide interdisciplinary conference, hosted in Anchorage and broadcasted virtually to ensure equitable access for remote providers. - Workforce Collaboration: CEUs will be offered to those attending the conference with a common goal to establish improved awareness of PFD. - Available Digital Resources: Following the conference, a suite of free digital resources will be developed and posted (modeled after successful initiatives like the Wisconsin Department of Public Instruction (DPI) publications and webinars) ensuring access is available to every village and school district. Phase II: Culturally Attuned Clinical Resources (IDDSI) To ensure sustainability and safety, clinical standards must reflect the reality of Alaskan life. We will collaborate directly with clinical service providers that are familiar with the Alaskan Native culture to localize the International Dysphagia Diet Standardisation Initiative (IDDSI). - The "Alaskan IDDSI" Guide: We will create a specialized resource guide and "cheat sheet" for families on modified diets. This guide will translate standard diet levels into the context of Alaska Native subsistence foods and traditional diets, ensuring that "Level 4 Pureed" or "Level 2 Mildly Thick" reflects the actual foods found in a rural Alaskan home. Phase III: Institutional Integration (DEED Guidance) To address the current regulatory void, our goal is to collaborate with the Alaska Department of Education and Early Development (DEED) to draft and implement the formal guide: "Pediatric Feeding Disorders in Alaskan Schools." - Bridging the Gap: Similar to frameworks used in other states, this guide will provide the first official roadmap for both urban and rural schools to support students with PFD. - Operational Safety: It will include basic procedural templates that each district can modify, ensuring that when a student returns from an urban medical facility to their home school, the staff has recommended procedures to decrease the risk of choking and aspiration.	\$50,000- \$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Stroke Coalition	RAPID-AK Phase II: Completing Alaska’s Statewide Rural Stroke Network	AK	ASC’s Phase I RAPID-AK rollout, funded by a prior grant source that is no longer available, brought RAPID.AI advanced stroke imaging to six Alaska hospitals beginning in 2023 and has demonstrated improved image transfer, quicker transfer decisions, improved thrombectomy access, and shorter door-to-procedure times. These original 6 sites have changed stroke protocols and all aim to maintain this advanced stroke imaging RAPID.AI platform. ASC now seeks RHTP support to expand this proven model to six additional hospitals—Mt. Edgecumbe, Norton Sound, Maniilaq, PeaceHealth Ketchikan, JBER, and Wrangell—so patients can access advanced stroke imaging and faster triage times across the state. In Alaska, where geography, weather, limited specialty coverage, and the cost and risk of medevac delay stroke care, this is a rural access strategy, not ongoing software support. The proposal uses time-limited transformation funding to address implementation barriers while building a durable statewide stroke network. Participating sites would also join the statewide Get With The Guidelines SuperUser registry, helping complete Alaska’s currently incomplete epidemiologic and public health picture of inpatient stroke admissions, etiologies, care, and access.	ASC proposes a five-year rural stroke transformation project built around six additional hospital sites: Mt. Edgecumbe, Norton Sound, Maniilaq, PeaceHealth Ketchikan, JBER, and Wrangell. The project would provide RAPID.AI advanced stroke imaging access, one-time installation/optimization/training, CT server hardware at each site, startup support for participation in the AHA Get With The Guidelines Rural Health Care Outcomes Accelerator, and structured work with local teams to update stroke imaging protocols, transfer workflows, and site-specific stroke response plans. To address the way RHTP funding is awarded annually, ASC proposes that the initial project period include enough funding to secure the first three years of RAPID.AI coverage up front through a multi-year vendor commitment, subject to state and CMS allowability. This would lock in rates, reduce future price volatility, and give hospitals a stable implementation runway while they complete system updates, build local proficiency, align imaging protocols, and normalize new stroke workflows. The project is intentionally framed as time-limited implementation and transition support, not indefinite payment for software operations. ASC would coordinate implementation with RapidAI/IschemaView, hospital administration, IT, radiology, ED, and stroke teams. The five rural critical access hospitals would gain local access to advanced imaging and automated decision support. JBER is included because it can strengthen statewide referral pathways and protocol consistency for rural Alaskans who move through military and veteran systems and because its participation improves coordination across Alaska's broader stroke network. Years 1-3 would provide full grant support for technology access and adoption. Years 4 and 5 would use a transition model in which the grant covers 60% and then 30% of recurring software cost, allowing hospitals to absorb increasing responsibility before assuming full cost in Year 6. If Alaska prefers annualized disbursement instead of an upfront three-year vendor commitment, ASC can rephase the same project without changing site scope or sustainability goals.	\$250K-\$1M	Statewide	Anchorage (Municipality); Ketchikan Gateway Borough; Nome Census Area; Northwest Arctic Borough; Sitka (City and Borough); Wrangell (City and Borough)	Advance to Implementation Application

Alaska Stroke Coalition	Statewide Deployment of Clinical AI Decision Support Across Alaska Hospitals	AK	In Alaska, the absence of on-site subspecialty coverage means that for time-critical conditions—stroke, intracranial hemorrhage, pulmonary embolism, and traumatic brain injury—patient outcomes depend on how quickly a scan becomes a decision. Delays of minutes determine survival, disability, and whether a patient ever returns home. Half of Alaska’s hospitals currently use AI for stroke triage; the other half have no AI capability. Even hospitals with stroke AI lack automated triage for other lethal CT findings, leaving these cases in standard radiology queues. The result is uneven access to timely diagnosis across the state, with the greatest burden falling on rural and Alaska Native communities. AIDOC addresses this gap with a single automated, multi-pathology platform that flags critical findings across CT and X-ray studies in real time. Deploying AIDOC statewide completes Alaska’s AI triage network, extending proven technology beyond stroke to the full spectrum of life-threatening conditions where diagnostic delay drives harm.	AIDOC is deployed as a cloud hosted orchestrator providing a resilient, low-impact infrastructure that bypasses rural hardware logistics while supporting all 23 sites through a centralized framework. Implementation requires no new imaging hardware and typically completes within eight to ten weeks per site. Year 1: Deployment. Hospitals are assessed and onboarded by readiness, with priority given to sites already operating AI workflows. The initial hospitals have already invested in AI triage independently; RHTP support completes and standardizes this validated capability statewide. PACS integrations are completed, staff are trained, and baseline performance metrics are established. Year 2: Operations. AIDOC operates statewide. Clinical and transport data are collected through AIDOC platform analytics, hospital transport records, the Alaska Trauma Registry, and mandatory grantee participation in two national quality AHA registries: GWTG-Stroke and GWTG-CAD available free through 2028 via the AHA Rural Accelerator. Site-specific medevac cost avoidance is documented and shared with hospital finance teams. Year 3: Outcomes and Handoff. A statewide outcomes analysis is completed, and each hospital receives a sustainability plan supported by two years of auditable cost avoidance data. RHTP funding concludes with a clean exit, transitioning AIDOC & national outcomes registry subscriptions to hospital operational budgets.	Over \$5M	Other	Statewide	Aleutians East Borough; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Sitka (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Alaska Sustainable Fisheries Trust	Local Food Production and Healthy Eating Through Micro Processing Facilities in Rural SE Alaska	AK	Access to healthy local seafood in rural Southeast Alaska communities is limited due to lack of equipment and facilities for small-scale local fishermen to deliver, process, and distribute or sell their catch in ways that meet regulatory requirements. Abundant fish populations live throughout the waters of the region, but most commercially caught fish is landed and/or sold in bigger communities with more infrastructure. For commercial fishermen to legally sell fish to a consumer, they must land the fish at a facility that meets regulatory requirements. To process whole fish into consumer-ready products such as fillets, the facility must meet additional state requirements. ASFT is working with two rural Southeast Alaska communities, Kasaan and Yakutat, on improving access to local fish. Kasaan does not have a fish processing plant or publicly accessible commercial kitchen. Yakutat has a fish processing plant that sells fresh and frozen whole fish that are transported by barge and plane for wholesale markets, but it is not able to process fish into consumer-ready products or provide local direct-to-consumer sales. For local residents without boats, this makes them reliant on either expensive store-bought protein that has traveled long distances over lengthy times or other community members’ ability to share their harvest. Micro processing units would address these hurdles in a manner scaled for rural communities and serve as pilot projects to disseminate further.	ASFT proposes to work with Kasaan and Yakutat to install portable micro processing units for accepting, processing, distributing, and teaching about locally caught fish and other wild local foods. Increasing access to locally harvested seafood and traditional foods supports improved nutrition and can contribute to prevention of diet-related chronic diseases, including heart disease and diabetes, which disproportionately affect rural communities. Micro processing units are self-contained converted container units that include certified commercial kitchen space, blast freezer space, and storage freezer space. These units are facilities that can meet state commercial fishing and health regulatory requirements for accepting and processing fish. We will purchase insulated container units and renovate them to contain tables, drains, and equipment for processing and teaching about fish in ways that meet regulatory requirements. Each community will install container units to accommodate the space and equipment needs for commercial kitchen, blast freezing, and storage freezing. Rural resident access to healthy food includes learning how to process and prepare the food. Fishermen land whole fish, but someone (commercial or consumer) needs to process the fish into a product form ready for consumer use. The commercial kitchen portion of the micro processing units allows a space for both commercial processing before distribution to consumers as well as expert-led classes for rural residents to develop their own skills in processing fish and other wild local foods into healthy meals. Locally harvested fish and other wild local foods provide nutrient-dense, heart-healthy protein sources that can help replace highly processed foods that are often the most accessible (but expensive) options in remote communities. ASFT will work with local food preparation and nutrition experts to offer community nutrition education classes in these spaces so rural residents can reap the chronic disease prevention benefits of consuming local wild protein. These classes can also be delivered in additional rural Southeast Alaska communities to increase their residents’ access to healthy food. ASFT is working with Kasaan and Yakutat to expand access to local food and has begun outreach to additional rural Southeast Alaska communities. ASFT will develop and disseminate lessons learned from microprocessor units in Kasaan and Yakutat to other communities facing similar food access challenges.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Prince of Wales-Hyder Census Area; Yakutat (City and Borough)	Deferred or Not Advanced

Alaska Telepsychol ogy	Empowering Rural Educators & Students: Behavioral Health Continuing Education in Rural Alaska	AK	In rural Alaska, geographic isolation and workforce shortages limit access to behavioral health professionals and continuing education, leaving educators without the support they need to respond effectively to students’ behavioral and mental health needs. By investing in continuing education that strengthens the skills of Alaska’s educators, this project will build a stronger rural workforce, improve student mental health and school engagement, and promote healthier, more resilient communities across Alaska.	Alaska Telepsychology has served over 1,942 individuals and families in 97 Alaska communities and has provided behavioral support to the Lower Yukon School District for two years. Building on this experience, this project will provide continuing education that equips educators in rural Alaska with practical tools to address student behavioral and learning challenges. Our project offers continuing education that helps educators respond to conditions that interfere with student conduct and learning while introducing practical strategies that can be implemented immediately in the classroom. Continuing education will be delivered in three settings: 1) Project staff will participate in regional in-service training events, such as the Lower Yukon School District’s annual in-service week, to introduce the program, build relationships with educators and community members, and identify priority topics. 2) During the academic year we will offer weekly virtual group consultations combining short didactic presentations with collaborative discussion. These sessions will address common student challenges and how they present across developmental stages and cultural contexts. Educators will participate in case-based discussion and collaborative problem-solving focused on practical classroom responses. 3) We also will provide weekly virtual office hours for individual consultation, allowing educators to seek guidance on specific student concerns. In addition to clinical expertise and instruction, we will emphasize three practical areas that strengthen educators’ ability to support student growth. Educators will learn informal classroom accommodations for students experiencing trauma, executive dysfunction, developmental, anxiety or mood disorders. Teachers will also learn simple mindfulness and regulation strategies that help students calm down physiologically and become ready to learn. Finally, an art therapist and veteran educator will develop an art and writing program that promotes students’ verbal and nonverbal communication skills. Teachers will receive training and materials to implement these activities locally. By equipping educators with practical tools and support, this project positions Alaska’s teachers as frontline partners in prevention, strengthening student well-being and community resilience across the state.	\$250K-\$1M	Behavioral health/su bstance use disorder treatment	Multi- Community or Participating in Regional Hub-and- Spoke	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Kusilvak Census Area; Nome Census Area; Northwest Arctic Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Alaska Therapy Alliance	Telehealth-Enabled Rapid Access Physical Therapy (PT) & Musculoskeletal (MSK) Care	AK	In Alaska, distance and limited appointment availability often make the emergency department (ED) and rural health clinics the only option, including for non-emergent musculoskeletal (MSK) injuries. While EDs can rule out life-threatening conditions, they rarely provide function-restoring care, leaving patients to wait weeks before accessing physical therapy. This delay drives a high-cost care pathway with avoidable downstream utilization, unnecessary imaging, delayed recovery, and increased medication use (including opioids). Military health systems and HMO models already demonstrate a more effective approach. In these systems, physical therapists serve as first-contact providers for MSK conditions within primary care teams. Patients are evaluated immediately by a PT trained to screen for serious pathology, initiate treatment, and coordinate referral when a physician is required. These models are shown to safely reduce imaging, specialty referrals, medication use, and overall healthcare costs while improving access and recovery. Alaska Therapy Alliance (ATA) will expand this proven model to rural Alaska. We will create a statewide network that connects patients to PTs as the first point of contact for MSK care at clinics, urgent care settings, and via telehealth. By placing the right provider at the first point of care, we will reduce unnecessary ED and primary care utilization while improving recovery, access, and health system efficiency across rural communities.	Over the next 36 months, we will design, pilot and scale a “hub and spoke” Rapid Access Physical Therapy (RAPT) model to provide timely, first-contact musculoskeletal (MSK) care across Alaska. Participating clinics in hub communities will reserve same- or next-day RAPT appointments (telehealth or in-person) for initial MSK evaluation, education, self-management planning, and short-course treatment. All encounters will follow standardized red-flag screening and escalation pathways to ensure safe identification and referral of serious and non-MSK pathology. Rural “spoke” communities will connect to hub-based PTs via synchronous telehealth, including low-bandwidth options where needed. Community health partners will assist with patient navigation, technology setup, and care coordination. A centralized access portal and hotline (“Second Door”) will serve as a single entry point for EDs, urgent care, primary care, employers, community partners, and patients—routing MSK conditions quickly to the appropriate in-person or telehealth PT. All participating therapists will complete standardized training through Redefine Health Education to support safe primary access practice. Training includes differential diagnosis, red-flag screening, triage and referral decision-making, imaging considerations, and telehealth examination workflows. This ensures consistent, evidence-informed care delivery across sites. Ongoing episodes of care will incorporate Remote Therapeutic Monitoring (RTM) to track adherence, symptoms, and functional progress between visits. RTM will support patient engagement, early identification of non-response, and optimization of outcomes while reducing unnecessary utilization. Implementation will occur in four phases: Phase 1 (Months 0–6): Finalize hub site selection, execute MOUs, establish data infrastructure, and configure portal and referral workflows. Phase 2: Train clinicians, launch pilot hubs, and activate spoke telehealth services. Phase 3: Scale regionally, refine workflows using utilization and outcome data, and strengthen payer/employer partnerships. Phase 4: Conduct formal evaluation (access, utilization, cost, patient-reported outcomes), develop ROI and sustainability strategy, and produce a replication toolkit for statewide dissemination. This model improves access, reduces downstream imaging and opioid exposure, strengthens rural workforce capacity, and creates a financially sustainable pathway for PT-led primary MSK care.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Urgent Care	Strengthening Work Force by Supporting New Graduates	AK	The problem that we would like to address with this project is lack of access to healthcare in Alaska due to a shortage of Providers. Currently, we have a lack of Providers in Alaska. This is putting a strain on accessibility for all Alaskans. We believe that providing a New Graduate program for Providers would incentivize Providers to stay and get relevant experience to help them be better prepared to serve Alaskan communities.	Our approach is to this problem is to increase the support for our New Graduate Providers in Alaska, thus incentivizing more to stay in Alaska and serve all of Alaska. We would do that by Providing a peer-supported New Graduate Program. New Graduates would have one-on-one support from more experienced Providers for a minimum of one year. This would increase competency and confidence in New Graduates. This would also familiarize New Graduates more with serving Alaska specifically. New Graduates who complete the program would be more qualified and comfortable serving Alaska communities in more rural settings.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Advance to Implementation Application
Alaska Urgent Care	Equipment to Increase Quality Care and Urgent Need Access	AK	We are two locally owned and operated Urgent Cares who also provide Primary Care services. We have been serving the Anchorage and Mat-Su communities for over 25 years. We operate at break-even because we provide low-cost services to patients. Our priority is that patients receive kind, caring, and compassionate medical care. We do not have excess funding to update our equipment or buy new equipment. This has limited some of the services that we can provide for patients. It has impacted individuals, especially on nights and weekends when we are the only clinics who are open in these areas. We are requesting funding to purchase new equipment and update equipment.	Our approach to the above problem is to request funding for a new and updated equipment for our facilities. We would be able to provide more and prompt care. This would keep patients out of the ER, provide better outcomes, provide timely care, and decrease the financial burden on our healthcare system and on patients.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced
Alaska Urgent Care	Expanding Access for Uninsured	AK	We would like to bridge the gap for healthcare accessibility for those without insurance. So many cannot afford healthcare and will avoid going to the doctor if they get sick. Many will opt to go the Emergency Rooms instead of out-patient clinics because they do not have to pay at the time they are seen and they hope that the hospitals will write-off or give more assistance for their ER trips, but often they do not receive relief and end up in debt. For those who avoid care because they cannot afford it, they are at risk for worsening conditions that require much more intensive care and workups than they would have if the had been able to receive timely care.	We offer a Medical Membership program for individuals who do not qualify for Medicaid or Medicare and are without insurance. It is offered at \$50 (five visits per year) or \$100 per month (12 visits per year) and allows patients to receive primary care services, including labs and x-rays, injury, illness, and preventative care seven days a week. We would like to expand this program to be able to make it more widely known to individuals in our communities as well as expand what services can be included in this program. We see patients seven days a week and believe that we can make a large and meaningful impact on those without insurance or without access.	Under \$50,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Alaska Vein Care, LLC	Rural Vein & Interventional Radiology	AK	Rural Alaskans face significant barriers to accessing vascular and interventional radiology services due to geographic isolation, workforce shortages, and the recent closure of several specialty vein practices in Alaska due to declining reimbursement and the high cost of operating in Alaska. Many patients have already lost access to services they previously relied on, creating an urgent risk that rural Alaskans will have even fewer options for diagnosis and treatment of vascular disease. Without access to timely screening and treatment, conditions such as deep vein thrombosis, peripheral arterial disease, uterine fibroids, chronic venous insufficiency, May-Thurner syndrome, and pelvic venous disorders can go undiagnosed or untreated, leading to serious complications, hospitalizations, or preventable deaths. Many rural patients must already travel long distances by air to regional hubs or even outside Alaska for care. This project addresses both a critical gap and an opportunity to stabilize and expand specialty care access. By leveraging Alaska Vein Care’s existing clinics and physician expertise, the project will expand vascular screening, minimally invasive interventional procedures, and telehealth-supported specialty services. This will help preserve access to care that is disappearing in Alaska while improving early detection, reducing travel burdens, and increasing the availability of high-quality specialty care for rural and frontier communities.	Alaska Vein Care (AVC) will address the growing loss of vascular specialty services in Alaska by expanding access to vascular screening, minimally invasive interventional radiology procedures, and specialty care coordination across its existing clinic network in Mat-Su Valley, Kenai Peninsula, Fairbanks, Juneau, and Anchorage. These locations serve as regional hubs where rural patients already travel for care. The project will expand access through three primary strategies. First, AVC will recruit and train vascular ultrasound technologists who can provide vascular imaging services both in AVC clinics and through scheduled outreach visits to additional rural communities. These technologists will help expand screening for conditions such as deep vein thrombosis, peripheral arterial disease, and chronic venous disease, among other conditions. Imaging studies will be interpreted by AVC physicians, with telehealth consultation used to coordinate care with referring providers and ensure rapid diagnosis and treatment planning. Second, AVC will expand minimally invasive interventional radiology procedures that treat vascular disease and women’s health conditions that frequently go untreated in rural areas. These include treatments for uterine fibroids, pelvic congestion syndrome, May-Thurner syndrome, and other vascular disorders. These procedures can often be performed in outpatient settings, providing effective alternatives to surgery while reducing hospital utilization and patient travel. Third, AVC will expand additional interventional radiology services that support early diagnosis and treatment of disease, including biopsies, vascular procedures, and image-guided treatments that help prevent more serious complications and hospitalizations. Because AVC already operates clinics across multiple regions of Alaska and has completed many preparatory steps for expanding interventional radiology services—including clinic infrastructure, physician staffing, vendor relationships, and (legal) referral networks—these services can be implemented quickly. By building on existing infrastructure and workforce capacity, this project will preserve and expand access to specialty vascular care that is currently disappearing in Alaska while improving early detection, reducing travel burdens, and strengthening rural health care delivery.	\$250K-\$1M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Weight Managemen t and Diabetes Counseling, LLC	Measure What Matters: InBody Community Screening for Metabolic Health Education	AK	Most people lack a fundamental understanding of what drives chronic disease. The focus on scale weight and BMI has obscured true drivers of risk: low lean body mass and high visceral fat. Body composition analysis provides precise data on skeletal muscle mass and visceral fat. Health psychology shows people act on personal data. When individuals see their numbers, they work harder to gain lean mass and reduce visceral fat — numbers transform abstract concepts into concrete personal understanding. A sustainable health system cannot be built through clinical intervention alone; it requires informed communities making better daily decisions. Personal body composition data creates exactly this kind of engaged, health-literate population. One in eight U.S. adults now takes a GLP-1 medication, and most expect to discontinue, facing weight rebound compounded by muscle loss. Most are unaware that up to 40% of weight lost on GLP-1s can be lean mass. Without monitoring, this muscle loss goes undetected by patients and providers alike. This project requests one-time funding to purchase an InBody 380. By offering free community access, the project will provide the personal data that motivates people at risk for diabetes to take action. We will also make them aware of preventive nutrition counseling available at no cost to people with metabolic risk. If even a handful of diabetes cases are prevented, this investment in health system sustainability will pay for itself many times over.	AWMDC will purchase an InBody 380 body composition analyzer with carrying case and will conduct body composition screening and education during normal business hours. The InBody 380 provides clinical-grade bioelectrical impedance analysis measuring skeletal muscle mass, body fat mass, percent body fat, visceral fat area, and basal metabolic rate. The approach includes three core components. Free walk-in body composition assessments will be available on an ongoing basis at the AWMDC office, requiring no appointment. This ensures consistent, convenient access for any Mat-Su resident who wants to understand their metabolic health beyond scale weight. AWMDC will publicize the service through outreach to local medical offices and signage in front of the office in the high-traffic Koslosky building. Participants pursuing weight loss or taking or considering GLP-1 medications will be encouraged to return for monthly follow-up assessments to monitor lean mass preservation. This data will empower patients and their providers to make informed decisions about resistance exercise, protein intake, and nutrition strategies that protect muscle mass during weight loss. Every participant will receive immediate nutrition education based on their analysis and will be made aware of preventive nutrition counseling available for patients with obesity at no out-of-pocket cost. Participants without insurance coverage will be referred to the State of Alaska Fresh Start program, which provides free nutrition and lifestyle support. Each participant will receive a printed results sheet and a brief one-on-one consultation explaining the significance of muscle mass versus fat mass and the importance of visceral fat as a metabolic risk marker. The device portability allows AWMDC to participate in community health fairs and wellness events as opportunities arise. Simply making this assessment available has the power to inspire lasting changes in food choices and physical activity. When people see their own skeletal muscle mass and visceral fat data, they are no longer relying on an abstract understanding of risk — they are looking at a personal picture of their true vulnerability to diabetes, cardiovascular disease, and other chronic conditions. That moment of clarity moves people from awareness to action. It is the cumulative effect of these personal changes that builds a sustainable health care system.	Under \$50,000	Private practition er	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Alaska Weight Management and Diabetes Counseling, LLC	Prevention Over Placement: Telehealth Lifestyle, Nutrition & Clinical Help to Stop Cognitive Decline	AK	A breakthrough is underway in Alzheimer’s research that has not yet reached clinical practice. Peer-reviewed studies — including a soon-to-be-published randomized controlled trial — show that personalized, multi-factorial lifestyle interventions can slow or even reverse cognitive decline in patients with mild cognitive impairment and early-stage Alzheimer’s. Across several published case series and open-label trials (N≈10, 100, 255), a precision-medicine/ReCODE-style protocol has shown cognitive stabilization or improvement in most patients with MCI or early Alzheimer’s disease. Nothing in the history of dementia treatment has produced results like these. Yet virtually no one in clinical practice is aware that these interventions even exist. Research takes an average of 17 years to move from publication to clinical implementation. Rural Alaska, where specialist access is the scarcest in the nation, will be the last place this science arrives — unless we take this opportunity to act. This project will bring personalized metabolic and lifestyle interventions for cognitive decline to rural Alaskan seniors via telehealth, delivered by licensed nutrition professionals ideally skilled to deliver this care. The economic case is clear: one year of institutional dementia care in Alaska exceeds \$100,000. If this project prevents even one person-year of institutionalization, the investment pays for itself — and every additional patient reached multiplies that return.	This project is designed to move breakthrough research into real clinical delivery for rural Alaskan seniors. While stunning cognitive improvements have been demonstrated in research settings - where participant selection, caregiver support, and clinical resources were ideal — delivering this care across rural Alaska will present unique challenges that this project is built to navigate. The program will begin by training two licensed nutrition professionals in the ReCODE precision-medicine protocol for cognitive decline, building Alaska’s first clinical capacity to deliver these interventions. This training will establish the foundation for every patient interaction that follows. We will prioritize patients based on their level of cognitive decline, in consultation with their caregivers and medical providers. We will coordinate with each patient’s healthcare providers to request labs, recommend medication adjustments, and align care plans. For patients with tribal health benefits, we will work directly with their tribal health dietitian to discuss protocol implementation. All personalized medical nutrition therapy will be delivered via telehealth at no cost to patients. Each consultation will address the metabolic, inflammatory, and nutritional contributors specific to that patient’s cognitive decline — including physical activity, cognitive exercises, dietary frameworks, targeted micronutrient protocols, and insulin resistance management. We will develop standardized clinical workflows adapted for Alaska, and coordinate with primary care providers and Community Health Aides/Practitioners to facilitate the lab testing and metabolic assessments that drive personalized treatment. We will collect cognitive scores, metabolic biomarkers, functional status, and utilization data to the greatest extent possible. This multi-year dataset will build the evidence base needed to advocate for Medicaid State Plan Amendments and value-based payment models that could establish reimbursement pathways beyond the grant period. We will also collaborate with ANTHC to introduce this research and present findings at the annual diabetes conference, reaching Community Health Aides/Practitioners, dietitians, and rural healthcare providers statewide - accelerating awareness across Alaska’s provider network. We will also publish the ReCODE protocol information on the Alaska-focused NutriScape subdomains, making services easily discoverable by clinicians and consumers.	\$50,000-\$250,000	Private practitioner	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Wellness Group, LLC	Integrated Preventive Health Access and Multidisciplinary Care Hub for Alaska	AK	Alaska continues to face rising rates of preventable chronic disease, metabolic dysfunction, obesity, cardiovascular risk, chronic pain syndromes, nervous system dysregulation, and delayed intervention caused by fragmented access across disconnected care settings. Many patients currently navigate separate systems for primary care, rehabilitation, metabolic support, recovery services, and chronic disease prevention, often without coordinated care until conditions progress into higher-cost disease states. Our long-term goal is to develop an integrated preventive health model that brings proactive medical care, recovery therapies, movement, education, and lifestyle support into one coordinated environment, allowing patients to address root causes earlier, improve health outcomes, and reduce avoidable chronic illness. As part of this program, we also intend to develop an internal access pathway for individuals with chronic illness or complex metabolic conditions who face financial barriers to preventive care. This would allow qualifying patients to receive subsidized consultations, telehealth follow-up, and individualized metabolic support when earlier intervention may help prevent further decline. The project is built on the principle that preventive care is most effective when metabolic, musculoskeletal, nervous system, lifestyle, and primary medical care are delivered collaboratively rather than in isolation.	Our proposed approach begins by expanding services that are already operational or actively being developed, including direct primary care, telehealth, individualized metabolic programming, and multidisciplinary preventive care designed to address chronic disease drivers earlier and more collaboratively than traditional fragmented models allow. The project follows a phased development strategy that prioritizes immediate healthcare access first while building toward a larger integrated preventive care environment. In Phase 1, direct primary care and telehealth are used to improve continuity, expand statewide access, and support patients who need metabolic guidance, chronic disease prevention, diagnostics interpretation, treatment planning, and follow-up care without repeated travel. This phase also includes continued development of individualized metabolic programs, strategic staffing expansion, and strengthening rural reach through coordinated care for Alaska Native patients and individuals traveling from rural communities. In Phase 2, expansion into adjacent clinic space will allow gradual growth of service capacity while maintaining current operations. Planned additions include additional offices for primary care and collaborative provider consultations, expanded lab and diagnostic capacity, a small movement studio for guided mobility and rehabilitation-based programming, a larger public contrast therapy room, and additional treatment space for therapies that support metabolic recovery, nervous system regulation, and chronic disease prevention. Phase 3 includes the long-term development of an integrated preventive health facility where medical care, movement, recovery therapies, education, diagnostics, and lifestyle support operate under one coordinated model. This future facility is designed to house multidisciplinary provider collaboration, preventive medicine, recovery infrastructure, and community-centered health education while allowing future expansion as demand grows. Across all phases, the project maintains a hub-and-spoke model in which an Anchorage-based health hub extends care outward through telehealth, selective in-person services, and a limited subsidized access pathway for individuals with chronic illness who face financial barriers to preventive care.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Workforce Alliance/Alaska Safety Alliance	Alaska Health Workforce Convening & Development of Alaska Health Workforce Development Plan	AK	Alaska's healthcare workforce shortages - particularly in rural and behavioral health - are well-documented, yet efforts remain scattered across agencies, education providers, employers, and regional initiatives. Valuable reports and convenings have happened, but the state still lacks a current, coordinated Health Workforce Development Plan that connects investments, identifies priority occupations, and sets shared goals. Without that kind of plan tied to Rural Health Transformation funding cycles, workforce strategies risk staying on paper rather than driving real change. The reestablished Alaska Health Workforce Coalition offers a natural home for statewide alignment - but getting there requires structured facilitation and solid data. Bringing the right people into the same room matters. In-person convenings create the conditions for relationship-building and unexpected connections that virtual meetings rarely replicate - and those moments of trust and serendipity are often what turn fragmented efforts into genuine collaboration across healthcare stakeholders. This project is an opportunity to bring cross-sector healthcare leaders together in fall 2026 and turn emerging workforce research and findings into a practical, coordinated Alaska Health Workforce Development Plan, one aligned with the Alaska Workforce Investment Board and Rural Health Transformation priorities.	This project will facilitate a structured, action-oriented statewide convening and produce an Alaska Health Workforce Plan aligned with Rural Health Transformation priorities and the Alaska Workforce Investment Board. The work will occur in three coordinated phases. Phase 1: Preparation & Data Synthesis (Months 1–2) The project team will synthesize existing workforce intelligence, including findings from the Health Workforce Data Visualization Tool, behavioral health workforce assessments, employer insights, and labor market data. Priority occupations, regional shortages, pipeline gaps, and projected demand trends will be translated into concise briefing materials designed to support informed decision-making. Stakeholder mapping will ensure representation from rural providers, Tribal health organizations, education institutions, employers, state agencies, and Workforce Investment Board leadership. Clear objectives, decision points, and expected outputs for the convening will be defined during this phase to ensure the event produces actionable outcomes. Phase 2: Statewide Convening (Month 3) A professionally facilitated fall convening will bring cross-sector leaders together to align around workforce priorities. Structured facilitation methods - regional breakouts, small group discussions, live polling, and consensus-building exercises - will move participants beyond dialogue toward defined commitments. Participants will: • Identify priority healthcare occupations for coordinated investment • Clarify regional distinctions and shared statewide strategies • Align on measurable three- to five-year workforce goals • Identify policy, funding, and operational barriers Phase 3: Plan Development & Alignment (Months 4–6) Convening outcomes will be synthesized into a formal Alaska Health Workforce Plan. The plan will include: • Priority occupation targets • Recommended training capacity adjustments • Employer engagement strategies • Regional considerations • Performance metrics for tracking progress • Assigned lead entities responsible for advancing each strategic priority • A proposed annual public progress review mechanism through the Alaska Health Workforce Coalition The draft plan will be reviewed with the Alaska Workforce Investment Board and key partners to ensure policy and funding alignment before final release. The result will be an implementation-ready workforce roadmap grounded in shared data and collective commitment.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Workforce Alliance/Alaska Safety Alliance	Alaska Post-Secondary Education Non-Completers Survey	AK	Alaska faces persistent healthcare workforce shortages, particularly in rural communities. Alaska has the highest dropout-to-undergraduate ratio in the country, with dropouts outnumbering currently enrolled undergraduates by more than 4-to-1. Health systems rely heavily on out-of-state recruitment, traveling staff, and short-term contracts, driving high costs, turnover, and reduced continuity of care. Many Alaskans, especially rural residents, Alaska Native community members, and working-age adults, do not complete postsecondary credentials and remain underrepresented in healthcare training pathways. Growing the in-state healthcare workforce from this population represents one of the most sustainable long-term rural health stabilization strategies under RHTP. However, we lack actionable data on what would enable these Alaskans to enter and complete healthcare training. Barriers may include childcare, financial constraints, geographic isolation, scheduling rigidity, cultural misalignment, or lack of career navigation. Without understanding these barriers, workforce investments risk reinforcing inequities and failing to stabilize the rural healthcare system. This project grows and retains an Alaska-based healthcare workforce by identifying and redesigning training pathways to meet the realities of rural Alaskans' lives. By building a data-driven understanding of untapped local talent, Alaska can shift from reactive recruitment to sustainable, homegrown workforce development.	This project will use structured, statewide market research to identify what would motivate Alaskans who have not completed postsecondary credentials to enter high-need healthcare careers, particularly in rural and frontier communities. Phase 1: Statewide Polling & Targeted Market Research We will conduct statistically valid polling of working-age Alaskans who have not completed postsecondary education, with intentional oversampling in rural, frontier, and Alaska Native communities to ensure representative and equity-centered findings. The research will: • Assess barriers to healthcare training participation, including financial constraints, childcare, transportation, geographic isolation, housing instability, technology access, and cultural alignment • Evaluate perceptions of healthcare careers (wages, stability, advancement, community impact) • Test specific motivators such as stipends, paid training models, hybrid or tele-education delivery, employer-sponsored pathways, guaranteed job placement, local cohort models, and modular credentialing • Segment responses by region, age, employment status, community type, and prior education experience to identify distinct participation profiles Phase 2: Recommendation Development & Implementation Strategy Findings will be translated into actionable, evidence-based pathway redesign recommendations tailored to Alaska’s healthcare labor market. This phase will: • Identify training delivery adjustments such as flexible scheduling, distributed learning hubs, paid clinical placements, stackable credentials, and rural-aligned cohort models • Prioritize high-shortage healthcare roles with strong return on investment for rural system stabilization • Develop an implementation roadmap for piloting redesigned pathways in 1–2 regions • Align recommendations with existing workforce, Tribal health, and education investments to ensure feasibility and sustainability Deliverables will include a market research report, segmentation analysis, and an implementation-ready pilot roadmap. By grounding workforce strategy in direct input from untapped Alaska residents, this project ensures healthcare training investments align with lived experience, rural realities, and long-term workforce retention goals.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Workforce Alliance/Alaska Safety Alliance	Evaluation of Non-Degree Behavioral Health Educational Programs ROI & Statewide BH Workforce Survey	AK	Alaska faces persistent behavioral health workforce shortages, particularly in rural communities. Behavioral health paraprofessionals play a critical role in service delivery, yet training pathways, costs, supervision capacity, and retention outcomes vary significantly across regions. Given the high cost of contracted behavioral health staffing and the financial strain of prolonged vacancies, optimizing paraprofessional workforce training represents a direct cost-containment and fiscal sustainability strategy under Rural Health Transformation. If the state wants to invest in greater behavioral health services, the State should know more about the return on investment and the effectiveness of different types of its training programs. This should include an understanding of the cost of training by role, major cost drivers, how many individuals move from recruitment to training to employment, where and why candidates exit the pipeline, or how training output compares to statewide workforce demand. Additionally, employer experience in recruiting, preparing, supervising, and retaining paraprofessionals is not systematically documented. Without this analysis, investments to expand behavioral health services risk fragmentation, inefficiency, or misalignment with workforce realities. This project presents an opportunity to optimize training investments, strengthen rural workforce capacity, and ensure behavioral health workforce expansion is both cost-effective and sustainable.	This project will conduct a structured, statewide Behavioral Health Paraprofessional Workforce Assessment that integrates financial analysis, pipeline evaluation, employer voice, and external benchmarking to strengthen Alaska’s behavioral health workforce. Phase 1: Internal Training & ROI Assessment This phase will conduct a detailed financial and operational review of behavioral health paraprofessional training programs across regions. The assessment will: • Analyze training costs, including cost per trainee, completer and successful hire • Identify major cost drivers such as instructional delivery models, supervision requirements, travel, stipends, and administrative overhead • Map the full workforce pipeline from recruitment → enrollment → completion → hiring → early retention • Quantify completion-to-hire conversion rates and identify where candidates exit the pipeline • Assess regional variation in costs and outcomes to determine relative return on investment This analysis will establish a clear baseline for cost-effectiveness and system efficiency. Phase 2: Employer & Workforce Voice Recognizing that labor data alone cannot explain workforce instability, this phase will engage behavioral health employers across rural and urban communities through structured surveys. The engagement will: • Identify recruitment challenges and persistent vacancy drivers • Assess job readiness gaps among new hires • Evaluate supervision capacity and workload constraints • Document retention barriers and turnover patterns • Capture how paraprofessional responsibilities are embedded within broader roles (e.g., schools, clinics, community health centers, public safety settings) Findings will clarify how training aligns or fails to align with real-world workforce demands. Phase 3: External Benchmarking & Best Practices To provide a comparative perspective, the project will develop 2–3 case studies from peer rural or frontier states. These case studies will examine training cost structures, credential pathways, supervision models, and measurable ROI outcomes. Lessons learned will inform the identification of scalable practices adaptable to Alaska’s geographic and workforce context. Deliverables will include a comprehensive ROI and cost driver analysis, a pipeline gap assessment, an employer insights report, and a prioritized, implementation-ready roadmap for optimizing behavioral health paraprofessional training statewide.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Workforce Alliance/Alaska Safety Alliance	Fall 2026 AHCW Steering Committee Strategic Planning Meeting & Special Topics Sprints	AK	Many challenges within Alaska’s healthcare education and training system are too complex for any single institution or organization to solve alone. While AHCW broadly engages healthcare stakeholders across the state, it has intentionally brought together 13 regional, institutional, and organizational leaders to co-develop the priorities and foundation of the newly relaunched Coalition. By coordinating efforts to address structural barriers, AHCW gives Steering Committee members the opportunity to speak with a unified voice - and the collective ability to drive meaningful improvements that benefit the entire healthcare system, including future healthcare workers, employers, communities, and individual Alaskans. The same principle applies to specific shared challenges that no single institution or trainer can easily tackle alone. These might include improving the Peer Support Specialist training and certification process, developing articulation and affiliation agreements between educational institutions, or streamlining professional licensing. To address these issues, AHCW proposes working with AHCW steering committee members to first identify challenges, priorities, or barriers and then following the strategic planning session, host 3 individual Special Topic sprints using an entrepreneurial sprint framework - a structured approach that guides participants through identifying, developing, and testing practical solutions to real-world problems - to build testable solutions.	AHCW is brand new and has intentionally tapped 13 healthcare-connected community leaders to assist with overall health workforce strategic planning and to help guide the development of the newly re-established organization. These leaders represent a broad cross-section of Alaska's healthcare community and now form the Steering Committee: 1. Terissia Bell - University of Alaska Southeast 2. Gloria Burnett - University of Alaska Anchorage 3. Lisa Cauble - University of Alaska Anchorage 4. Kim Champney - Alaska Association of Developmental Disabilities 5. Dr. Travis Hedwig - University of Alaska Anchorage 6. Vandana Ingle - Mat-Su Health Foundation 7. Elizabeth King - Alaska Hospital and Healthcare Association 8. Dr. Victoria Kildal - Alaska Behavioral Health Association 9. Mike Kruzinski - State of Alaska, Division of Public Health 10. Dr. Eric Murphy - University of Alaska Anchorage 11. Katharine Pagani - Alaska Pacific University 12. Samantha Ponts - Alaska Mental Health Trust Authority 13. Keja Whiteman - Nokomis Strategies While some of these leaders know and work with one another professionally, many do not, and three members live outside Southcentral Alaska. At present, AHCW has no resources to bring everyone together for a full-day in-person planning session - one that would allow the group to discuss and commit to long-term, ambitious strategic goals and priorities, including identifying the Special Topics that will drive the second phase of this initiative. This project has two distinct components. The first is a full-day strategic planning session bringing together the 13 community leaders to establish a shared vision, set long-term priorities, and identify the specific Special Topics to be addressed. The second is a series of three separate Special Topic sprints, each focused on one of the topics identified during the planning session. These convenings will use a design framework to guide participants through developing and testing practical solutions for each identified problem. Alaska has good community networks and professional connections: bringing people together is one of the most effective ways to further build relationships and forge a shared identity that can move beyond individual and organizational interests to collectively address common challenges. Working together also means faster results. Participants will leave with concrete next steps, not just good intentions. Use of project management will ensure solutions move forward	Under \$50,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Workforce Alliance/Alaska Safety Alliance	Health Workforce Data Visualization Tool	AK	Alaska’s ability to “grow its own” healthcare workforce is central to stabilizing rural health access and reducing reliance on out-of-state recruitment and temporary staffing. However, Alaska currently lacks a centralized, shared system for collecting, integrating, and translating healthcare workforce education and training data into actionable insights. Enrollment, completion, credentialing, and training pipeline data are dispersed across institutions, state agencies, industry groups, and employers, often using inconsistent metrics. As a result, RHTP workforce investments risk being made without visibility into cumulative impact, duplication of effort, or alignment with high-cost vacancy areas. Without a unified view of workforce supply, pipeline progression, and regional variation, policymakers and industry leaders cannot determine whether investments are aligned with workforce demand, where shortages persist, or whether training programs are producing sustainable workforce growth. This fragmentation limits strategic decision-making and risks inefficient allocation of public and private resources. This project presents an opportunity to establish a neutral, statewide Health Workforce Data Visualization Tool that transforms fragmented data into clear, comparable, and actionable workforce intelligence to guide workforce investment and support long-term rural system stabilization under RHTP.	This project will develop and launch the Alaska Health Workforce Data Visualization Tool - a centralized workforce intelligence platform operated by the Alaska Health Workforce Coalition (AHWC) under the Alaska Workforce Alliance. Alaska's ability to "grow its own" healthcare workforce is central to stabilizing rural health access and reducing reliance on out-of-state recruitment and temporary staffing. Yet Alaska lacks a shared system for collecting and translating workforce education and training data into actionable insights. Enrollment, completion, credentialing, and pipeline data are dispersed across institutions, agencies, and employers using inconsistent metrics. A February 2026 Department of Labor report found one in four Alaska workers is a nonresident and that healthcare employs fewer nonresidents than other industries - yet it excluded traveling positions, a critical workforce segment. When workforce data is scattered, policymakers lack the visibility needed to assess whether investments match demand, where shortages are growing, or whether training programs are delivering results. This makes it difficult to use public and private resources as effectively as possible. This project will establish a neutral, statewide tool that transforms fragmented data into clear, actionable workforce intelligence to guide RHTP investment and support long-term rural stabilization. Phase 1: Data Mapping & Standardization The project will take stock of existing data sources - including enrollment, completion, credentialing, labor market projections, and wage data - and develop standardized templates so that information can be meaningfully compared across sources. Phase 2: Dashboard Development An interactive platform will bring this data to life, displaying enrollment and graduation trends, regional workforce comparisons, and how training output aligns with labor market demand. The tool will be designed with policymakers, employers, and educators in mind, keeping usability front and center. Phase 3: Validation, Testing & Training Before launch, the tool will be tested with stakeholders and refined based on their feedback. Training will be provided to ensure that agencies and coalition members feel confident using the platform to inform strategic planning and RHTP implementation. The result will be a durable workforce intelligence infrastructure that enables data-driven decision-making across Alaska’s healthcare system.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska Works Partnership, In.	Rural Healthcare Industry Building Maintenance Technician Outreach and Training Project	AK	Alaska has a large challenge for operating and modernizing rural healthcare infrastructure today. Currently healthcare providers are trapped in a costly cycle of Building Maintenance Technician (BMT) vacancies and emergency repairs that places patient safety and infrastructure investments at risk. Alaska’s healthcare infrastructure is valued at \$4.8B, with an estimated \$32B replacement cost. Persistent BMT labor shortages threaten these investments. These workers support and maintain facilities and operate essential life-support systems. Without BMTs, facilities face high risks of system failure and costly emergency repairs. Healthcare employs >1,600 BMTs today. A survey of twelve major healthcare employers on March 1, 2026, shows >200 BMT job openings. In rural Alaska it takes an average of 145 days to fill a BMT position, 3 times longer than nursing vacancies (45 days). Statewide, > 4,000 general maintenance workers are employed across all industries. Occupational growth is expected to be 8.6% by 2032 with 413 openings annually. About 90% of future demand is due to retirement as 65% of BMTs are over the age 45 and 20% 60 years or older. BMTs have a 36% turnover rate for many reasons besides retirement and the ability to move into higher pay construction, oil, mining and other facility maintenance jobs. These factors make it clear the healthcare industry needs a dedicated BMT career outreach, training and upskill pathway program. RHTP offers that opportunity.	AWP has successfully recruited and trained entry-level Building Maintenance Technicians (BMTs), and provided ongoing incumbent BMTs upskill training for 25 years. Our BMT training has led several hundred rural residents into jobs and careers as BMTs with a variety of industry employers including AVCP Regional Housing Authority (RHA), Bristol Bay RHA, Bering Straits RHA, and the North Slope Borough Public Works Department and Alaska Housing Finance Corporation contractors. The main goal of this project is to narrow and ultimately close the healthcare BMT labor gap. With RHTP resources AWP can serve as a healthcare workforce intermediary and create an industry specific BMT training program and career path in partnership with employers and industry associations. Applying a pilot and demonstration approach will ensure measurable inputs and outputs, results and performance of the project can be assessed and evaluated. Utilizing AWP’s existing BMT training platform and a hub-and-spoke training delivery system like other proven rural healthcare workforce programs will offer an efficient and cost-effective means for recruiting and training new BMTs and incumbent BMTs. By working closely with employers, the program’s design will meet real industry needs and allow for single- and multi-employer participation. AWP can quickly pivot current BMT training into a healthcare industry specific program to build the BMT talent pipeline and training track. BMT training combines classroom and hands-on learning in 40-hour stackable modules in essential areas such as carpentry, drywall, basic electricity, plumbing, HVAC, and occupational health and safety certification courses. The RHTP project will use our existing training centers and mobile training modules. Employers will be informed about upskill and cross-skill training opportunities for their employees and can choose additional training to meet their needs. AWP will assign a current BMT instructor and hire an additional instructor to coordinate and conduct training sessions. Our experienced case managers are ready to provide individual needs assessments and help recruits create an Individual Career Plan (ICP) to support participants during and after training. This RHTP workforce project will quickly expand the pool of healthcare BMTs, reduce vacancies, improve retention, and strengthen facility maintenance capacity.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alaska's Midnight Sun Therapy Services, LLC	Marine-Based Mobile Therapeutic Services for Remote Coastal Alaskan Communities	AK	Remote coastal regions often face limited access to specialized therapy services due to geographic isolation, workforce shortages, and inconsistent healthcare infrastructure. This project aims to address the lack of accessible and consistent speech, occupational, physical, and emotional/substance abuse therapy for individuals living in these areas. By developing a scalable delivery model—using mobile clinics, the project seeks to improve continuity of care, reduce travel barriers, and ensure residents receive timely, high-quality therapeutic support regardless of location.	Weather conditions in coastal Alaska frequently prevent aircraft from accessing rural communities for extended periods of time. Whether relying on wheel planes or float planes, low ceilings, high winds, fog, and severe coastal storms regularly ground flights, sometimes for days or even weeks at a time. When flights are delayed or canceled, scheduled visits must often be postponed, creating a backlog of communities needing services. This frequently results in a cascading effect that disrupts the entire service schedule and limits our ability to provide consistent and timely support. Consistency is critical for effective service delivery in rural communities. When providers are unable to return regularly, care may be delayed, continuity of services is disrupted, and additional strain is placed on already limited local healthcare resources. Over time, these interruptions make it difficult to establish dependable service models that communities can rely on for ongoing care and support. To address these challenges, we propose utilizing a marine-based vessel that will serve not only as transportation but also as a fully functional floating clinic, while providing accommodations for visiting specialists in four private staterooms. Many of the communities we serve are located along Alaska’s extensive coastline and are naturally accessible by water. A marine-based service model offers greater flexibility and reliability compared to aviation alone, particularly during periods when aircraft cannot safely operate due to weather conditions. The vessel we plan to use was custom built by one of the most respected commercial fishing boat builders in the world and was specifically designed for the demanding marine environments of Alaska. It has a proven track record of operating safely in challenging coastal conditions from Kodiak to Southeast Alaska. Its size, durability, and seaworthiness make it well suited for extended travel and operations in remote coastal regions. By utilizing this vessel as a mobile clinic, we can bring both transportation and clinical space directly to the communities we serve. Most importantly, this model will allow us to establish a more predictable and consistent service schedule. By reducing dependence on aircraft availability and narrow aviation weather windows, we can improve reliability, expand access to care, and ensure that rural coastal communities receive regular, dependable services.	\$1M-\$5M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Chugach Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Kodiak Island Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Aleutian Pribilof Islands Association, Inc.	APIA Facility Renovation and Community Wellness Enhancement (Anchorage and Unalaska)	AK	Our remote communities in the Aleutians and Pribilof Islands face limited access to integrated primary care, behavioral health, and wellness services due to small, under-optimized facilities and geographic isolation. The Anchorage office lacks fully functional, HIPAA-compliant workspaces, while the Unalaska office has insufficient space for community outreach, wellness programming, and elder food box preparation, including limited freezer/refrigeration capacity. This project will renovate and reconfigure existing facility to improve staff workflow, expand preventive health programming, and strengthen rural food security and diabetes prevention for underserved communities, elders, and individuals at risk for or living with diabetes.	To address limited access and facility constraints in Anchorage and Unalaska, the Aleutian Pribilof Islands Association (APIA) will renovate / reconfigure existing offices to improve integrated health services. In Anchorage, workspace will be reorganized to create a more functional, efficient, and HIPAA-compliant environment for primary care, behavioral health, and community health staff, enhancing workflow, collaboration, and patient privacy allowing for increased services to clients through victim services, behavioral health, Elder case management and Veteran suicide prevention services with clients. In Unalaska, renovations will expand space for community outreach, wellness programming, diabetes prevention, and elder food box supply storage, supported by chest freezer and refrigerator capacity to strengthen rural food security and safe distribution of perishable items. With no freezer or cooler space within the airlines or airport in Unalaska, it requires a large logistical effort to ensure Elder Food Box supplies shipped from Anchorage make it to outlying communities while still frozen. The approach maximizes existing infrastructure to improve access, quality, and sustainability of care. Dedicated clinical and programming areas, along with shared spaces for confidential telehealth visits and virtual trainings, will allow staff to deliver coordinated services efficiently. Wellness and outreach spaces will host small group programs, preventive health education, and culturally responsive services, enhancing community engagement. By targeting both offices, the project ensures rural residents and elders have reliable access to integrated primary care, behavioral health, and preventive services, while strengthening operational efficiency and the long-term sustainability of health and wellness programs in remote communities. These two projects will allow for increased capacity to serve more clients.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality)	Advance to Implementation Application

Aleutian Pribilof Islands Association, Inc.	Strengthening APIA Rural Diagnostic Capacity through Laboratory Expansion	AK	Current lab services within APIA PCS clinics are limited to CLIA-waived testing. Patients who present with symptoms that require additional laboratory testing may need to be transported off island or experience delays while samples are sent to more advanced laboratories in Anchorage, AK. These delays can impact patient outcomes and increase clinical risk in emergency situations. Having additional point of care labs such as the ability to test for troponin will help us identify cardiac arrest and potentially eliminate the need for a medevac.	RHTP funding will support the expansion of laboratory capacity within the APIA primary care system. The project will include the expansion of laboratory capability at the regional hub clinic, the Oonalaska Wellness Center (OWC) and deployment of point-of-care diagnostic equipment in rural clinic. APIA will strengthen laboratory services at the subregional hub clinic OWC by expanding diagnostic capacity in our CLIA Waived labs. This will allow providers to perform a broader range of diagnostic tests locally and support clinical decision-making for patients throughout the region. Key equipment investments will include: • Piccolo Chemistry Analyzer for the Nikolski health center to support testing capabilities • Point-of-care diagnostic systems capable of measuring troponin to support evaluation of potential cardiac events across APIA clinic sites • Additional laboratory equipment and training needed to support expanded diagnostic services at the regional hub clinic, OWC. These upgrades will strengthen the ability to diagnose and manage conditions locally, reducing the need to travel and reducing delays in treatment.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality)	Advance to Implementation Application

Aleutian Pribilof Islands Association, Inc.	Strengthening Rural Care Coordination through Expansion of Community Health and Social Work Services	AK	Communities served by APIA PCS experience significant health disparities driven by geographic isolation, workforce shortages, and barriers to accessing health and social services. Patients often require assistance navigating referrals, specialty care coordination, and eligibility for insurance programs such as Medicaid. Many patients often first present to APIA’s health system through our primary care clinics. Without dedicated staff embedded within the interdisciplinary clinical care team to support outreach, patient navigation, and care coordination, providers end up absorbing these responsibilities in addition to their clinical duties. Current staffing levels limit our ability to provide comprehensive outreach, care coordination, and assistance navigating complex health and social service systems. This limits the health system’s ability to proactively address social determinants of health, connect patients with available services, and support individuals who have not recently accessed care. Expanding workforce capacity within the primary care team will allow APIA to better coordinate services across departments, strengthen connections between health care and social supports, and improve patient engagement in care across the region.	RHTP funding will support the recruitment of one Social Worker and two Community Health Workers within APIA Primary Care Services. These positions will function as part of the interdisciplinary care team supporting providers and case management staff. The Social Worker will focus on clinical care coordination and patient support including assisting patients in navigating social services and behavioral health resources, and focusing on interdepartmental collaboration to ensure continuity of services across programs. The CHW will focus on outreach and enrollment activities including: • Conducting outreach to individuals not recently seen by primary care • Providing culturally appropriate health education and prevention activities • Assisting with Medicaid and insurance enrollment • Supporting screening for social determinants of health and connecting patients identified as having a need with the Social Worker to connect patients to available resources The CHW will also support community health awareness efforts and participate in local events to improve awareness of available health resources. These roles will strengthen coordination between primary care, behavioral health and social service programs while expanding the health workforce serving APIA PCS communities. As part of this initiative, APIA commits to maintaining these positions for a minimum of five years, ensuring long-term workforce stability and sustained impact in the communities of Atka, Nikolski, St George and Unalaska.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality)	Advance to Implementation Application

Aleutian Pribilof Islands Association, Inc.	Creating Cultural Connections to Promote Healthy Communities	AK	Our project proposes to build resilience and create positive social connections through cultural gatherings. These gatherings will foster the health and well-being of community members by providing a safe gathering place and a healing space that brings our people together to learn and share traditional knowledge, create traditional art pieces, and make healthy, meaningful connections within an intergenerational community. The program aims to improve health by fostering social connections that promote a healthy mind and body through the following RHTP goal and initiatives: Goal 1: Promote Lifelong Health and Wellbeing ~Healthy Beginnings: our project will offer wellness activities that can help youth build healthy habits. ~Healthy Communities: our project aligns with evidence-based approaches to support a healthy lifestyle by providing opportunities for community members to make positive social connections, encourage family engagement, and strengthen mental health resilience.	The project will be administered by APIA’s Cultural Heritage Department (CHD). APIA’s Cultural Heritage Director and Cultural Heritage Coordinator will plan and implement program activities. CHD staff are ready to execute the project immediately upon receipt of award. Six cultural instructors will be hired to share traditional knowledge. One cultural instructor will travel from our tribal community of Akutan to teach afternoon sessions in traditional foods preparation during a week-long gathering for children and youth. Project staff will also assist the Qawalangin Tribe with planning and implementation of community gatherings in Unalaska. CHD has a long history of implementing culturally relevant community projects and events. The department has historically managed grants and provided implementation support for initiatives aimed at strengthening the community. Formed in 1998, APIA’s Cultural Heritage Department promotes Unangaġ (Aleut) heritage through preservation and education programs, including teaching cultural values to new generations. It supports cultural healing practices, art, and language, and facilitating projects that ensure the Unangaġ people and culture flourish. Weekly events will be held at APIA’s headquarters in Anchorage where a large meeting space is available to host the event in collaboration with mutual support groups. We will hire elders and culture bearers who will teach/share traditional knowledge such as drum making, drumming, dancing, sewing, beading, language, carving, and more. This unique combination offers mutual support in a multifaceted dynamic approach where people have a shared cultural identity. Peer support by Unangaġ people for Unangaġ people: results from an APIA 2022 Community Needs Assessment, demonstrate the profound need to provide access to healing modalities that have a foundation in cultural relevance and are facilitated by Unangaġ people. This is also echoed through the ongoing communications with our board of directors, comprised of representatives from each tribe in our Region. The need to increase access to cultural healing activities facilitated by Unangaġ people for participants seeking support is urgent. Part of that urgency stems from the fact that the Aleutian Pribilof Islands Region is comprised of thirteen tribal entities spread across ten remote geographical locations, separated by great distances and the hindering cost of travel.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality)	Deferred or Not Advanced

Aleutian Pribilof Islands Association, Inc.	Expanding Access to APIA Behavioral Health Services	AK	The remote nature of APIA’s service area is the primary problem we face. Travel is difficult and unpredictable, there is a lack of a workforce pool, and costs can be prohibitive. By hiring dedicated telehealth providers to serve our region, APIA Behavioral Health Services sees opportunity to improve access to culturally appropriate behavioral health services, help ensure continuity of care for rural residents, and provide evidence-based and cost-effective services to our region.	Remote clinicians will be incorporated into current outpatient workflows, including centralized scheduling with the APIA Registration Team, standardized virtual intake appointments, and EHR-based documentation. Collaboration between onsite and remote staff will ensure continuity of care, coordinated referrals, and clear escalation pathways if in-person services are required. Since our office-based clinicians are already remote one day per week, using existing workflows will be seamless for clinicians who would be remote full-time. Technology Infrastructure Remote services will utilize HIPAA-compliant telehealth platforms with end-to-end encryption, supported by secure broadband connectivity. Clinicians will access fully integrated EHR Cerner systems to maintain documentation standards, scheduling efficiency, and care coordination. Remote Workspace Requirements All remote staff will maintain private, secure, and professional home office environments, meeting standards for confidentiality, device security, and patient privacy. Remote clinicians would provide a detailed description of their home office, with approval from both APIA IT Support and BH Department Managers regarding space approval standards. Clinical Roles & Competencies Remote Outpatient Therapist (LCSW/LPC/PsyD/ PhD) Remote therapists will conduct virtual assessments, develop individualized treatment plans, provide evidence-based therapy, and collaborate with onsite teams and community resources. Core Virtual Competencies Clinicians must demonstrate proficiency in digital professionalism, virtual rapport building, recognizing non-verbal cues in video sessions, and adapting therapeutic techniques for remote delivery. Crisis Management Remote Crisis Protocols will be established, including documented safety plans, identification of local emergency resources near each client, and structured communication pathways with onsite leadership. Clinicians will receive training in remote risk assessment and escalation procedures. By integrating up to three remote clinicians into existing workflows, this project supports patient access, employee retention, and operational efficiency while maintaining clinical quality and regulatory compliance.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality)	Deferred or Not Advanced

Aleutian Pribilof Islands Association, Inc.	Improving Emergency Medical Transport Capacity in Nikolski by Acquisition of a Dedicated EMS Vehicle	AK	Nikolski, AK is an isolated rural community in the Aleutian region with limited transportation infrastructure and severe weather conditions that frequently delay emergency response. The local clinic currently does not have a dedicated Emergency Medical Services transport vehicle. In medical emergencies, clinic staff and responders must rely on improvised or shared vehicles to move patients between the clinic, airstrip, and other transfer points. These limitations can delay stabilization and transport for patients requiring urgent medical care, particularly during events when alternative vehicles are unavailable. The lack of appropriate transport capacity increases clinical risk and complicates coordination of transporting patients from the clinic to the airfield where medevac flights land. This project addresses a critical infrastructure gap by strengthening emergency medical response capacity in Nikolski and improving the reliability, safety and timeliness of patient transport.	RHTP funding will support the acquisition and deployment of a dedicated EMS transport vehicle for the Nikolski Health Center operated by Aleutian Pribilof Islands Association. The project will procure a reliable all-terrain EMS transport vehicle suitable for the severe weather and rural road conditions common in the Aleutian region. The vehicle will be equipped to safely transport patients and allow trained responders to move individuals experiencing medical emergencies between the clinic, community locations, and the airstrip where patients are transferred to higher levels of care. The vehicle will also support emergency preparedness activities and community response. Implementation activities will include: • Procurement of a reliable EMS transport vehicle suitable for rural terrain and weather conditions • Outfitting the vehicle with essential patient transport equipment and safety features • Integration of the vehicle into existing clinic and community EMS response protocols • Training clinic staff and local ETT responders on vehicle operation and emergency transport procedures This project will strengthen emergency preparedness and response capacity while improving coordination between clinic staff, local responders, and regional medevac services.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality)	Deferred or Not Advanced

Aleutian Pribilof Islands Association, Inc.	Rural Health Facility Safety and Technology Infrastructure Enhancement	AK	APIA operates a network of health and behavioral health facilities serving communities across the Aleutian region. Many of these locations are remote and rely on small clinical teams working in isolated environments to deliver essential health services. In rural clinic settings, staff frequently provide care independently while responding to a wide range of medical and behavioral health needs, including patients experiencing behavioral health or substance use related crises. Limited facility monitoring infrastructure can reduce situational awareness within clinical environments and make it more difficult to quickly identify and respond to safety concerns involving patients, visitors, or facility access. This project will strengthen the safety and operational resilience of APIA facilities by implementing standardized CCTV monitoring systems across regional clinics and behavioral health facilities while expanding monitoring coverage at the Anchorage headquarters. Improving situational awareness will support staff working in remote locations and enhance the ability to respond to safety incidents when they occur. This project strengthens the infrastructure supporting rural health care delivery by improving safety, situational awareness, and operational coordination in facilities where essential health and behavioral health services are provided.	This project will deploy standardized CCTV monitoring systems across APIA regional clinics and behavioral health facilities while expanding monitoring coverage at APIA’s Anchorage headquarters. The systems will consist of secure network-based cameras positioned at building entrances, hallways, exterior access points, and other public operational areas to improve situational awareness and support facility safety. These systems will improve situational awareness within clinical environments, support facility safety monitoring, and provide documentation of incidents when needed. Each clinic location will receive a system scaled appropriately to the size and operational needs of the facility. Systems will allow secure access for authorized clinic staff as well as designated personnel at APIA headquarters. This approach will support operational awareness across facilities and improve coordination between rural clinics and administrative teams. Expansion of the Anchorage headquarters monitoring system will strengthen oversight of entrances, public spaces, and operational areas where staff and clients interact. All systems will utilize secure video management technology compatible with APIA’s existing IT infrastructure and selected for reliability in remote environments.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality)	Deferred or Not Advanced

Aleutian Pribilof Islands Association, Inc.	St George Health Center Facility Exterior Repair Project	AK	APIA operates the St George Health Center, which provides primary care, emergency stabilization, and public health services to residents of St George Island in the Pribilof Islands. The facility is exposed to extreme maritime weather conditions including extremely high winds, salt exposure, and prolonged moisture that accelerate deterioration of exterior building materials. The facility’s roof and siding have experienced significant wear due to these environmental factors. Without timely replacement, the building is at increased risk of water intrusion, structural damage, and deterioration that could disrupt healthcare operations. Because St. George Island is a remote community only accessible by air, maintaining resilient healthcare infrastructure is critical in ensuring residents have access to healthcare. Damage to the facility could interrupt access to essential medical care and emergency stabilization services for local residents. This project will replace the aging roof and exterior siding of the St George Health Center to restore the integrity of the building, improve resilience against severe weather, and ensure continued delivery of healthcare services in this rural Alaskan community.	This project will focus on rehabilitation of the St George Health Center exterior structure through replacement of the facility’s roof and siding with durable materials designed for harsh maritime climates. The project will include: • Removal and replacement of the existing roof • Removal and replacement of deteriorating exterior siding • Installation of weather-resistant materials designed to withstand high winds and moisture exposure common in the Pribilof Islands • Transportation of construction materials and equipment to St George Island • Coordination with qualified contractors experienced in rural Alaska construction The work will restore the building envelope and protect the interior clinical spaces, medical equipment, and patient care areas from environmental damage. This project supports the long-term sustainability of healthcare services in the community by ensuring the facility remains structurally sound and capable of supporting ongoing clinical operations.	\$250K-\$1M	Other	Single Community	Aleutians West Census Area; Anchorage (Municipality)	Deferred or Not Advanced

Aleutian Pribilof Islands Association, Inc.	Supporting Atka Island Health Services with Reliable Fuel Supply	AK	Healthcare facilities in remote communities like Atka Island rely on consistent fuel deliveries for heat and power. Weather, shipping delays, or limited supply can disrupt clinic operations and housing for medical staff. This project aims to improve health system reliability by establishing a community-managed fuel transport and delivery system, ensuring timely fuel access for both the clinic and provider housing. Reliable fuel access enables: • Continuous clinic operations • Safe, comfortable housing for healthcare providers • Enhanced emergency preparedness • Reduced risk of service interruptions	The project will establish a local fuel transport solution to support healthcare infrastructure in Atka. Key activities include: 1. Acquisition of a small fuel transport truck or tanker trailer - o Suitable for local road conditions - o Equipped with safety features and pump system 2. Fuel delivery system setup - o Transport fuel from bulk storage to the clinic and provider housing - o Maintain consistent delivery schedules 3. Operator training and safety compliance - o Safe fuel handling and transport - o Spill prevention and response - o Equipment maintenance 4. Operational planning - o Designate trained local operators - o Develop fuel inventory monitoring and delivery schedules	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area	Deferred or Not Advanced

Aleutian Pribilof Islands Association, Inc.	Supporting Unangan Elders at Home	AK	Elders living in Aleutian communities face significant barriers to health and social services. Geographic isolation, limited transportation, workforce shortages, and complex administrative requirements for Social Security, Medicare, and Medicaid make it difficult for elders to access preventive care, chronic disease management, and supportive services. Many older adults in these communities' experience falls, mobility challenges, and social isolation, yet local resources to address these issues are limited. By improving the health, safety, and quality of life for older adults through hiring local Elder Care Services staff to deliver evidence-based programs, including Bingocize and Stepping On for chronic disease prevention and exercise. Staff will provide case management, assist with benefits paperwork, and connect elders to home and community-based supports such as congregate meals and transportation. By embedding trained staff within the community, this initiative strengthens local capacity, ensures culturally and geographically appropriate services, and reduces barriers to care. By leveraging community networks to deliver preventive programs and supportive services directly where elders live it addresses both health and social needs. This approach improves access, enhances quality of care, and builds sustainable local systems to support older adults, ultimately reducing risks associated with falls, chronic disease, and social isolation in rural and frontier communities.	The proposed approach focuses on hiring additional Elder Care Services staff from local communities to expand access to preventive health programs and supportive services for older adults in rural and frontier areas. Hiring locally ensures staff have cultural knowledge, community trust, and an understanding of geographic and logistical challenges, which improves engagement and sustainability. With the lack of funding for additional staff, this fills a large gap within serving Elders in the Aleutian communities. Staff will implement evidence-based programs to address key health risks: Bingocize, a fall prevention program, and Stepping On, a chronic disease prevention and exercise program. Programs will be offered in community settings and adapted for home-based or small-group delivery when transportation or isolation limits access. Staff will be trained in program delivery, outcome tracking, and trauma-informed engagement with older adults. In addition to program facilitation, staff will serve as a central point of contact for elders, assisting with Social Security, Medicare, and Medicaid paperwork, case management, and connecting participants to home and community-based supports such as congregate meals, transportation, and other local resources. This integrated approach ensures that both preventive health and social support needs are addressed in a coordinated manner. Ongoing training, supervision, and technical assistance will support staff retention and program fidelity. By embedding these positions within the community, the project strengthens local capacity, increases access to health and social services, and creates a sustainable framework for ongoing elder care, preventive programming, and support services in frontier communities.	\$250K-\$1M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality)	Deferred or Not Advanced

Aleutian Pribilof Islands Association, Inc.	Supporting Victims through Widespread Training and a Home Visiting Program	AK	Aleutian communities face significant barriers to identifying and responding to domestic violence and its related health impacts. Victims often have limited access to healthcare and victim advocacy due to geographic isolation, transportation challenges, provider shortages, and concerns about confidentiality in small communities. As a result, many survivors do not receive timely screening, support, or referrals for the physical and emotional effects of abuse, including traumatic brain injury, mental health challenges, and parenting difficulties following violence. This project addresses these gaps by strengthening early identification and support through trauma-informed training and screening programs. Implementing Confidential, Universal Education and Support (CUES), H.E.L.P. screening for domestic violence–related traumatic brain injury, and the B.A.S.K.E.T.S. advocate-driven screening model will help healthcare providers and advocates recognize signs of abuse, provide universal education, and connect victims to appropriate resources. In addition, many families affected by domestic violence in rural communities lack access to parenting support and home-based services. Implementing the Hearts and Hope: Parenting After Domestic Violence program and the Family Spirit home visiting model will provide trauma-informed parenting education and family support directly in the home, helping reduce barriers to care while promoting safety, resilience, and healthy child development.	This project will build local capacity by training healthcare providers, community health aides, and victim advocates to implement trauma-informed screening, education, and response strategies within the services already available in each community. Training in Confidential, Universal Education and Support (CUES), H.E.L.P. screening for domestic violence–related traumatic brain injury, and the B.A.S.K.E.T.S. advocate-driven screening model will equip local professionals to recognize signs of abuse, provide universal education, and connect survivors to confidential support and resources. The project will also strengthen the work through the APIA Victim Services team, who will provide direct advocacy, coordination of services, and ongoing technical assistance to local partners. These staff will help ensure survivors have access to confidential support, safety planning, and referrals, while also helping sustain training efforts and strengthen collaboration among healthcare providers, advocates, and community organizations. To overcome transportation and access barriers, the project will expand home-based services through the Hearts and Hope: Parenting After Domestic Violence program and the Family Spirit home visiting model. These programs allow trained advocates or home visitors to provide parenting education, safety planning, and family support directly in the home or through telehealth when travel is not possible. By strengthening local skills, expanding advocacy support, and integrating services within existing systems, this approach will improve access to care and promote long-term health and safety for survivors and families in the Aleutian and Pribilof Islands region.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality)	Deferred or Not Advanced

All Alaska Pediatric Partnership	All Alaska Pediatric Partnership: Readiness for a Coordinated Pediatric System of Care	AK	Since launching HMG-AK in 2018, we have seen increased demand for the program’s care coordination and resource navigation services. This trend aligns with the persistent barriers facing families seeking coordinated pediatric health and behavioral health care, including geographic isolation, limited provider capacity, and fragmented referral systems across health, education and community services. In the Behavioral Health Roadmap Project for Alaska Youth, DOH recommends expanding awareness and utilization of HMG-AK to increase support for parents and guardians navigating the system and identifies HMG-AK as a strategy to optimize utilization of existing resources. In response, A2P2 proposed a multi-phase initiative to develop new service tracks and referral pathways that will strengthen Alaska’s pediatric system of care by improving referral coordination, expanding service mapping, and supporting earlier identification and connection to services. This grant is needed to strengthen A2P2’s organizational readiness to implement the work proposed in the initiative and successfully meet anticipated rising demands for our services. Through targeted internal planning, organizational development activities and technical assistance, A2P2 will design implementation strategies, develop staffing and operational models and strengthen internal leadership, governance and funding structures needed to support expanded statewide coordination and to further sustain these system improvements.	This project seeks Administrative Readiness funding to prepare A2P2 for the anticipated implementation of a multi-phase expansion of Help Me Grow Alaska’s service tracks and referral pathways in service of a more coordinated system of care for children and families across Alaska’s rural communities. The readiness effort will support two complementary activities: 1. Project Design and Implementation Planning A2P2 will engage a contractor to further develop and operationalize Phases 1–3 of the proposed Coordinated System-of-Care initiative. This work will include refining referral pathways, defining implementation milestones, strengthening data infrastructure requirements and aligning project activities with state systems, priorities and partners. Planning will also focus on structural enhancements to HMG-AK’s Centralized Access Point (CAP) and resource directory to better identify service gaps, increase coordinated referrals, and provide actionable data to the State and health system partners. This work will also support development of infrastructure needed for enhanced data integration and interoperability with existing systems such as Alaska’s Health Information Exchange, enabling better coordination among providers and agencies. 2. Organizational Readiness and Workforce Planning To successfully implement this initiative at scale, A2P2 must expand its organizational capacity. A second contractor will support leadership development, organizational planning and staff expansion strategies to prepare A2P2 for overall program growth. Activities will include defining future staffing models, strengthening internal systems and governance structures, supporting leadership development and establishing operational processes needed to sustain expanded services. Together, these readiness activities will position A2P2 to launch a more coordinated and sustainable system of care that improves early identification of needs, strengthens provider partnerships, and ensures families, especially those in rural and remote communities, can access the services and supports necessary to keep children healthy and thriving as close to home as possible.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Planning

All Alaska Pediatric Partnership	Alaska Family Journey Mapping: Visualizing Access to Early Childhood Services	AK	In 2024, All Alaska Pediatric Partnership (A2P2) launched The Early Childhood Partnership (ECP) coalition to promote a coordinated and unified early childhood system for Alaska’s young children, prenatal to age eight, by advancing cross-sector leadership and providing trusted information on the early childhood system and the programs within it. Throughout the first year of planning, ECP members recognized a transformative opportunity to bridge the gap between service provider data and the actual lived experiences of Alaskan families as they utilize available services. While there is substantial information available from service providers about needs and gaps in the systems of care, similar information from families on the barriers they encounter is anecdotal and indirectly reported by programs. State leadership, policymakers and funders lack access to concrete data showing precisely where parents experience gaps and barriers as they navigate specific processes, as well as which factors facilitate their successful movement through complex health care delivery systems and public assistance programs with specific eligibility criteria. Through a proposed process of Family Journey Mapping, the ECP will reveal and visualize the hidden work families and providers who serve them perform to navigate eligibility criteria and service delivery and the nuances of the barriers that stand in their way.	The ECP proposes to lead parent journey mapping activities in collaboration with members of the Early Childhood Network (ECN) - a network of early childhood coalitions and advocates across the state, co-hosted by A2P2 and the Alaska Department of Health. These activities will be co-designed to provide information on the processes involved in accessing various family needs. • We will contract with an Alaska-based research and consulting agency to complete 18–25 Family Journey Maps across 5-7 participating public health regions, prioritizing rural areas most impacted by system barriers. • At least 50 percent of the mapping will be conducted with families who are living in off-road communities, and 75 percent with Medicaid-reliant families. Most families will have multiple needs. • Participation stipends will be provided to community members to recognize the value of their input and expertise and to compensate them for their time and effort. Maps will be analyzed by thematic area, and we will create graphic representations of each of the core topic areas explored to visually represent the unique journeys of parents and/or caregivers across several critical areas: • Developmental Milestones: Navigating the path from initial concern to accessing early intervention services. • Remote Maternal Health: Accessing consistent prenatal and postpartum care for high-risk pregnancies in off-road communities. • Family Recovery: Seeking treatment for substance use as a single parent. • Economic Resilience: Accessing the child care necessary to maintain employment or return to work. • Complex Care Coordination: Managing care for a child with complex health care needs. Once completed, the ECP will utilize the maps to propose and support additional projects and initiatives that address needs and gaps in the systems of care and are aligned with the key initiative areas of the RHTP and recommendations in documents such as the Early Childhood Alaska Strategic Direction for 2025-2030 and Alaska’s Comprehensive Integrated Mental Health Program Plan. The maps will help translate statewide goals embedded in these plans into clear understanding of how families actually experience the system of care. Finally, the maps will also be made widely available to other program partners and state agencies to support their own work of transforming care for Alaskans.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

All Alaska Pediatric Partnership	All Alaska Pediatric Symposium - strengthening Alaska's Pediatric Workforce	AK	This project addresses the unique challenges of pediatric care in Alaska by using the All Alaska Pediatric Symposium as a central platform to strengthen collaboration, readiness, and coordination among pediatric providers and partners while delivering Alaska-specific education. Many providers now choose online CMEs or conferences outside Alaska, which often lack content relevant to Alaska’s healthcare realities and opportunities for peer collaboration. The symposium offers a valuable opportunity for providers to network and build relationships, improving care continuity as children often receive care from multiple providers across regions. The symposium features high-quality presentations on rural healthcare delivery, care coordination, and emerging technologies. This project will support development of a dedicated technology vendor track to encourage dialogue between Alaskan providers and technology vendors seeking a footprint in Alaska with the goal of increasing coordination and to offer education and assistance on decisions around appropriate use of technology. Participation stipends will help reduce financial barriers and support attendance from key partners across the pediatric care continuum, ensuring diverse perspectives are represented. By strengthening networks, promoting Alaska-focused education, and supporting statewide collaboration, this project will help build a more connected and specialized pediatric workforce to meet the needs of Alaska’s children.	This project will leverage the All Alaska Pediatric Symposium as a platform to strengthen the pediatric workforce, enhance collaboration, and introduce technology-focused education tailored to Alaska’s care environment. Re-branding The symposium’s messaging will be refreshed to emphasize the value of Alaska-specific training and collaboration. This will highlight how the conference addresses the realities of pediatric care in Alaska, including geographic isolation, limited access to pediatric sub-specialists, and the need for coordination across a widely dispersed workforce. Messaging will also emphasize peer-to-peer networking among providers caring for children across the state. The symposium supports Alaska’s itinerant model of care, where specialty providers are often based in Anchorage but serve multiple regions, by promoting coordination across the statewide pediatric care network. Targeted Outreach and Communication Expanded outreach will increase participation from providers across Alaska, particularly those serving rural and remote communities. Efforts will focus on engaging providers from tribal health organizations, rural clinics, regional hospitals, and urban systems to ensure broad statewide representation. Communications will highlight the symposium’s Alaska-specific training and the opportunities it collaboration and shared learning. Participation stipends will help reduce financial barrier for those who may otherwise be unable to attend. Ensuring important voices and roles within the pediatric care system are represented. Technology-Focused Sessions The symposium will introduce a technology-focused component to help providers better utilize digital health tools in Alaska’s unique care environment. A session will be provided that addresses things like responsible and effective use of telehealth, digital communication platforms, and remote consultation technologies that support pediatric care across long distances. Opportunities for partners and stakeholders to coordinate around technology engagement and discuss practical strategies for implementation in rural and resource-limited settings will be provided. Through these efforts, focused messaging, targeted outreach, and technology education, the project will expand participation in the symposium, strengthen connections across Alaska’s pediatric workforce, and support collaboration and innovation in pediatric care delivery statewide.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alpenglow Women's Health	The Alpenglow Initiative: Bridging critical gaps in Alaska rural maternity care.	AK	The Mat-Su Borough and other surrounding Alaskan rural communities, faces significant barriers to maternal and child health, including high rates of morbidity and mortality among women and children due to limited access to prenatal care, education, and ongoing support. . Alaska's RHTP allocates \$272 million annually to states like ours to transform rural health systems, emphasizing initiatives such as Healthy Beginnings under Goal 1: Promote Lifelong Health and Wellbeing for Rural, Remote, and Frontier Alaskans. Our project aligns precisely with this priority by providing comprehensive pregnancy and parenting education, which evidence shows can reduce adverse outcomes like preterm births, low birth weights, and maternal complications—critical needs in Alaska's interconnected health system where hub communities like Mat-Su serve remote populations.	We propose the The Alpenglow Initiative: Bridging critical gaps in Alaska rural maternity care., a scalable initiative ready for the Project Implementation funding pathway, with potential to advance to Targeted Innovation as it evolves. Key components include: • Hiring a Full-Time Registered Nurse: The RN will serve as a dedicated case manager, conducting home visits, coordinating care with local clinics, and linking clients to telemedicine for rural residents, stabilizing the workforce in line with RHTP's Strengthen Workforce initiative. • Pregnancy and Women's Health Education: Weekly group sessions and one-on-one counseling on prenatal nutrition, mental health, substance avoidance, and postpartum recovery, tailored to Alaska Native and rural families, fostering Healthy Communities. • Comprehensive Case Management: Holistic support from preconception through early childhood, including transportation assistance, family planning, and parenting classes to prevent morbidity and mortality, directly supporting Health Care Access and reducing costly medevacs. This project supports RHTP's statewide application by addressing geographic challenges in Mat-Su, a hub for rural Alaskans, and avoids duplication of existing services by focusing on integrated education and navigation not currently scaled in the borough. Our clinic also serves many communities outside of the Mat-Su Borough as far as Ketchikan and Fairbanks. Initial rollout targets up 1000 high-risk women in Year 1, expanding based on outcomes like reduced emergency visits (tracked via metrics aligned with RHTP reporting).	\$250K-\$1M	Maternal health	Statewide	Copper River Census Area; Dillingham Census Area; Ketchikan Gateway Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; Petersburg Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced
Alpine Physical Therapy LLC	Bringing and keeping specialized physical therapy services to SEAK	AK	- New parents do not get the support they need on many fronts. I can provider the movement, mobility, strength and ergonomic side to pregnancy and being a new parent. Any support for new parents and families can assist in improving early childhood outcomes and decrease PPD risks. I also work a little for Early Learning and can help screen clients to get into early learning - Movement and strength screens: prevention of injury and movement limitations. Just like getting dental cleanings we should have a movement screen by a PT every 6-12 months to learn what we need to do for our body and our movement. To get folks active, moving, exercising and health. For all ages and to prevent the frequent mid and low back pain that occurs in new parents. - Avoid high cost of out of state travel for specialized PT care for pelvic health and vestibular health	- Offer 1:1 movement and mobility screens for all ages get people moving and active. Teaching for and technique specific to them for exercise and strength. - Offer coming to the home of new parents to look at ergonomics, movement, mobility and initial post partum exercise. Screen for other medical conditions PPD, HTN etc that can occur early post partum. - Keep up date with specialized education and course work and board certification to bring the highest quality PT care to SEAK and any community via telehealth.	Under \$50,000	Other	Other	Sitka (City and Borough)	Deferred or Not Advanced

Altair Community Health, Inc	Alaska Rural Tele-Rehabilitation Access Network (ATRAN)	AK	Alaska continues to face significant health challenges that underscore the need for expanded access to rehabilitation and preventive health services, particularly in rural and remote communities. According to the Healthy Alaskans 2030 Scorecards, the state’s unintentional injury mortality rate remains extremely high, measured at 92.9 deaths per 100,000 in 2023 and 90.6 per 100,000 in 2024, far above the state target of 56.5. Drug-induced mortality remains a major concern as well, rising from 51.0 per 100,000 in 2023 to 47.1 per 100,000 in 2024, still more than triple the Healthy Alaskans target of 14.2. Mental health indicators show similar strain, with adults reporting an average of 4.9–5.0 mentally unhealthy days per month. At the same time, access barriers persist: 11.5% of adults in 2023 and 12.9% in 2024 reported they could not afford to see a doctor within the past year. These data highlight a growing need for accessible rehabilitation, injury recovery support, and preventive wellness programs. Rural Alaskans face additional barriers due to limited provider availability, high travel costs, and geographic isolation. Expanding tele-rehabilitation and digital wellness services can help close these gaps by providing guided exercise, rehabilitation programs, and health coaching directly to individuals in their communities, helping reduce long-term disability, support recovery after injury, and strengthen health outcomes statewide.	Altair Community Health proposes a statewide online rehabilitation and wellness program designed to address the high burden of injury, substance misuse, and mental health challenges across Alaska, particularly in rural and frontier communities where access to care is limited. The program will provide residents with remote access to personalized rehabilitation plans, guided exercise programming, nutrition education, and ongoing coaching from trained rehabilitation professionals through a secure online platform. Participants will begin with a virtual assessment to identify injury history, functional limitations, and wellness goals. Based on this assessment, each individual will receive a customized rehabilitation and strengthening program delivered through a mobile and web-based platform. Programs will include guided exercises focused on improving strength, mobility, balance, and injury prevention, along with nutritional guidance and lifestyle strategies that support healing and long-term health. A key component of the program is ongoing support from a dedicated rehabilitation coach who will monitor progress, provide accountability, and adjust programs as needed. This coaching model is particularly valuable for rural communities where individuals often lack consistent access to rehabilitation providers and may struggle with isolation or limited follow-up care after injury. Beyond injury recovery, the program also addresses broader health challenges linked to Alaska’s high rates of injury, substance misuse, and mental health concerns. Regular physical activity, structured coaching, and improved nutrition are proven to support mental health, reduce stress, and improve resilience. By helping individuals rebuild strength, restore physical function, and regain confidence in their health, the program can reduce long-term disability and support healthier lifestyles. For rural communities, this digital model removes barriers related to travel distance, cost, and provider shortages by delivering rehabilitation support directly to individuals in their homes. By combining rehabilitation care, nutrition education, and coaching through an accessible online platform, the project creates a scalable solution that improves recovery from injuries, supports mental well-being, and strengthens long-term health outcomes for Alaskans statewide.	\$50,000-\$250,000	Clinic	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Altair Community Health, Inc	Mat-Su Traumatic Brain Injury Recovery & Rehabilitation Program	AK	The Matanuska-Susitna Borough faces a significant burden of injuries and preventable deaths closely associated with traumatic brain injury (TBI), including accidents, overdoses, and suicide. In 2024, leading causes of death in the Borough included accidents (112 deaths), drug-induced deaths (58), and suicide (35). Drug-induced deaths reached 53.6 per 100,000 residents and overdose deaths 52.6 per 100,000. Injury-related hospitalizations remain high, with 693 cases reported in 2023, including 333 from falls and 103 from motor-vehicle occupant injuries. Local TBI hospitalizations are rising rapidly, increasing from 83 cases in 2022 to 136 in 2023. Statewide data reflects an even broader crisis: Alaska has the highest traumatic brain injury mortality rate in the United States, more than double the national average. Despite this urgent need, many Alaskans with concussion or brain injury cannot access coordinated assessment and rehabilitation. Patients frequently lose insurance coverage after injury, face denied claims, or encounter therapies that are not reimbursed. This gap is particularly severe for working-age adults. Alaska Medicaid generally does not cover chiropractic services for individuals ages 21–65 unless they are also Medicare recipients. As a result, the population most likely to be working, supporting families, and attempting to return to duty or employment after brain injury often cannot obtain the comprehensive neurological rehabilitation necessary for recovery.	This project expands traumatic brain injury (TBI) treatment capacity in the Mat-Su Valley through an access-first clinical model designed to begin care immediately rather than delaying treatment while patients wait for insurance authorization or referrals. The program will launch a Rapid Access TBI Clinic supported by a Coverage Gap Fund so patients can receive timely evaluation and rehabilitation even when insurance coverage is absent, delayed, or incomplete. Within the first 30–60 days, the Rapid Access TBI Clinic will establish a single referral pathway and standardized intake process serving emergency departments, urgent care clinics, primary care providers, schools and sports programs, first responder agencies, VA and veteran networks, workers’ compensation referrals, and self-referrals. Patients will receive clinical triage appointment and a comprehensive TBI evaluation within seven days, with expedited evaluation available for urgent neurological concerns. This rapid-access approach allows patients to begin treatment during the critical early recovery window following concussion or brain injury. All patients—regardless of insurance status—will follow the same evidence-informed care pathway. Initial assessments will include injury history, symptom inventories, vestibular and ocular screening, cervical and neuromusculoskeletal evaluation, autonomic regulation indicators, cognitive and behavioral health screening, and return-to-work or school readiness assessment. Based on these findings, patients will enter an individualized 6–12 week episode-of-care plan integrating vestibular and vision rehabilitation, cognitive therapy, graded exertion progression, cervical and musculoskeletal care, sleep and pain regulation strategies, and behavioral health support when indicated. Care coordination will support return-to-work or return-to-learn planning, family education, and transition to community providers when appropriate. When insurance coverage is unavailable or essential services are not reimbursed—including limitations affecting adult Medicaid beneficiaries—the Coverage Gap Fund allows treatment to proceed. The project will also develop standardized care pathways, documentation templates, and outcome tracking to demonstrate functional recovery, reduced downstream healthcare utilization, and improved long-term access to TBI rehabilitation in Alaska.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Alterity	Alterity Solutions Managed Learning Services -Consulting & Continued Workforce Training	TX	Alaska’s Rural Health Transformation initiative prioritizes strengthening the workforce by growing local talent, improving retention, and expanding access to training across rural and frontier communities. Alterity Solutions’ Managed Learning Services (MLS) directly supports this goal by helping health organizations train, and retain a skilled, resilient workforce. Alterity MLS enables scalable, technology-enabled learning that overcomes geographic barriers through virtual onboarding, role-based clinical and non-clinical training, and continuous upskilling aligned to rural care models. By building structured career pathways, competency-based learning, and leadership development programs, Alterity helps organizations grow local pipelines and reduce reliance on costly temporary staffing. With data-driven learning analytics and change management support, Alterity ensures training investments improve performance, engagement, and retention which will help with outcomes of Alaska’s Strengthen Workforce initiative. This approach supports culturally responsive care, accelerates readiness for new models of care, and builds a sustainable workforce that can deliver high-quality care close to home. MLS will help create a culture of learning and help reduce the gaps in management and leadership training to help retain top talent.	Alterity proposes addressing this challenge through its Managed Learning program, a scalable workforce training solution designed specifically for rural, remote, and resource-constrained healthcare organizations. The program strengthens the workforce by embedding continuous, role-based learning directly into daily operations, allowing staff to build skills without disrupting patient care. Managed Learning provides end-to-end learning management, including program design, delivery, administration, reporting, and ongoing optimization. Training pathways are aligned to specific workforce roles—clinical and non-clinical—supporting faster onboarding, cross-training, and skill development tailored to local operational needs. This approach is particularly well-suited to rural settings where staff often perform multiple functions and workforce flexibility is essential. The program uses a remote-first delivery model, offering self-paced digital learning, virtual instructor-led sessions, and on-demand content that accommodates shift-based schedules and eliminates the need for travel. Continuous learning replaces one-time training events, supporting sustained competency, adaptability, and confidence across the workforce. By removing the administrative burden of managing training internally, Alterity enables rural healthcare organizations to access high-quality workforce development without adding staff or diverting clinical leaders from care delivery. Managed Learning also supports workforce retention by connecting training to professional growth and career pathways. Through this approach, Alterity’s Managed Learning program directly advances Rural Health Transformation Program goals by expanding access to training, strengthening recruitment and retention, and building a resilient, adaptable healthcare workforce capable of supporting long-term care transformation in rural and remote communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alzheimer's Association - Alaska	Dementia Capable Communities in Rural and Frontier Alaska	AK	As of 2020, 8,400 people aged 65 or older have Alzheimer's disease in Alaska. There are 25,000 caregivers across the state who dedicate a total of 39 million hours of unpaid care valued at \$887 million annually; 53.7% of them have chronic health conditions. Rural communities face a disproportionate burden of Alzheimer's disease and related dementias (ADRD), yet remain critically underserved in terms of awareness, early detection, and access to care. Geographic isolation, limited healthcare infrastructure, and workforce shortages create significant barriers for rural residents at every stage of the cognitive health continuum — from prevention and risk reduction to diagnosis, care, and end-of-life support. Community health workers (CHWs) and rural healthcare professionals, who are often the first and only point of contact for these individuals, lack the dementia-specific training and resources needed to identify risk factors, provide guidance, and connect people to appropriate dementia services. Meanwhile, rural employers, public health agencies, and community organizations have limited access to brain health education tools tailored to their populations. Without targeted investment, rural residents living with dementia, their caregivers, at-risk, and other individuals will continue to fall through the gaps of an already strained system.	This project seeks to address that gap by building a comprehensive, community-centered approach to cognitive health that spans awareness, access to resources, and workforce development across rural communities with three primary activities. 1. Brain Health Awareness and Community Mobilization: The Association will develop and launch a targeted Brain Health public awareness campaign tailored to rural and frontier audiences. Campaign messaging and collateral will promote risk-reduction strategies for healthy aging. The program will also convene rural community members and train public health leaders through structured learning collaboratives with local Health Departments. Additionally, the Brain Health At Work program will be expanded to rural employers, equipping them with tools and resources to support employees' cognitive wellness. 2. Empowering Rural and Frontier Community Members: The Association will promote its suite of consumer-facing tools, including ALZNavigator, My ALZ Journey mobile application, the Community Resource Finder (CRF), Brain Health Habit Builder, and the Association's 24/7 Helpline — to rural residents and caregivers. The Association will ensure these tools are current and accessible, reflecting all the relevant resources. 3. Building a Dementia-Capable Rural Workforce: ALZPro, the Association's central training hub for professionals, will be promoted and serve community health workers, primary care providers, hospital staff, long-term care workers, and other rural health professionals. Tailored training pathways, new courses and microlearnings, and expanded Project ECHO programs for community health workers and primary care providers will be leveraged to support Alaska's rural and frontier workforce. The Association will build on and integrate with the existing Alaska ECHO network, using these established programs to strengthen the workforce and fill identified gaps where opportunities exist. Lastly, the Provider Direct Referral Program will be established, allowing providers to refer patients directly to the Association's Helpline and telehealth partners for clinical care navigation, creating a seamless, coordinated care experience for rural patients. Together, these strategies form a continuum of support, from building awareness and self-empowerment to strengthening the clinical and community workforce, designed specifically for the realities of rural health systems.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alzheimers Resource of Alaska	Statewide Client Management System for ADRD, Care Coordination, and Reimbursement Infrastructure	AK	ARA does not currently have an integrated client management system (CMS) or dedicated data management capacity to support statewide ADRD services, Medicaid waiver care coordination billing, mini grants, and CCH based Medicare reimbursement. Referrals, intakes, care coordination notes, education contacts, support group participation, mini grant administration, and billing documentation are tracked across multiple tools and paper-based processes. This fragmentation creates staff inefficiencies, inconsistent reporting across all programs, and heavy manual grant reporting and billing burdens. In rural and frontier communities, where continuity depends on timely handoffs and limited staff capacity, these gaps directly affect access, service quality, and financial sustainability. Partnering with a consulting firm like Gartner will help ARA to better assess these challenges, identify an integrated CMS capable of supporting Medicaid and Medicare billing, eliminate manual and time-consuming grant reporting, implement dashboards and measurable KPIs, mitigate migration risk, and compensate for the lack of internal CIO-level technology leadership. This project is not a software upgrade; it is a statewide infrastructure redesign that will give ARA the operational backbone to deliver coordinated ADRD services, generate actionable data, and participate in sustainable reimbursement models across Alaska.	ARA will implement a CMS that supports Medicaid waiver care coordination, mini grant administration, and CCH workflows and billing statewide. Core functions will include intake and consent, standardized assessment and care planning, scheduling and follow up, documentation of education and support activities, referral tracking with closed loop status updates, outcomes reporting, and improved workflows. Selection will prioritize ease of use for dispersed teams, strong reporting capacity, privacy and security, low bandwidth practicality, and interoperability with systems including HIE. This is not a hospital EMR replacement. It is community based care coordination, navigation, and reimbursement supporting infrastructure designed to strengthen rural access, referral accountability, and sustainability across multiple programs. ARA will onboard a Data Manager and engage implementation support for workflow mapping, vendor selection, data governance design, and system deployment. ARA also plans to leverage Gartner as a strategic advisory partner for executive guidance, migration planning, KPI and dashboard design, change management, and technology decision support. A key design principle will be using a single platform across ADRD services, Medicaid waiver care coordination, mini grant administration, and CCH participation so staff are not maintaining parallel systems. ARA is the pilot project partner with Envoy Health for the CCH. This work creates an opportunity to support Medicare billing through the hub for eligible services that can appropriately move from medical providers to community based organizations, increasing access to care while helping reduce system costs. Implementation will include configuration of documentation standards, care coordination workflows, referral tracking, and billing related functions, followed by phased staff training supported by peer leads, management data review, and structured feedback. The platform will expand reporting, dashboards, and partner coordination while strengthening shared referral pathways and data exchange with HIE and CCH partners. Ongoing optimization, refresher training, and data quality management will support consistent statewide use and long term sustainability.	\$250K-\$1M	Home- and communit y-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Planning

Alzheimers Resource of Alaska	ADRD Workforce and Caregiver Training and Support	AK	This training is an on demand, statewide platform, combining workforce development, caregiver education, and simulation-based learning. Alaska also has a time-sensitive opportunity to deploy this ADRD curriculum that was developed with support from Alaska Senior Disability Service funding. Currently proposed legislation, SB 103 and HB 244, may require ADRD training for CNAs. This project improves access to quality, culturally relevant training for rural Alaska. Replacing episodic travel-dependent training with an online Learning Management System (LMS) that delivers standardized, Alaska-specific ADRD education statewide. The LMS will support mobile access, asynchronous participation, completion tracking, and certificate of completion. It will also provide immediate, on-demand tools for providers and caregivers, including Teepa Snow Positive Approach to Care (PAC) training videos. Making ADRD training available at no cost through an online statewide platform strengthens rural health system capacity by equipping providers, frontline workers, and caregivers with skills to recognize symptoms and deescalate crises, helping people with ADRD remain safely in their homes and communities longer. By reducing the need for costly travel across Alaska for training, the program lowers expenses, reduces workforce and caregiver burnout, and decreases reliance on crisis driven interventions while improving outcomes.	ARA will lead this project in partnership with the University of Alaska Anchorage Center for Human Development (UAA CHD). Building on 18 months of SDS funded development, the partnership will implement the ADRD core-competency framework, complete modular course content, deploy a scalable LMS optimized for mobile access, and launch a pilot within 45 days followed by rapid statewide rollout with priority outreach to rural and frontier providers, tribal partners, and caregivers. Courses will be organized as short, stackable modules aligned to key caregiving tasks across home and community-based care, assisted living, and facility settings. The LMS will support asynchronous participation, knowledge checks, completion tracking, certificate issuance, and hosted on-demand content so learners can access practical ADRD tools when challenges arise rather than waiting for scheduled instruction. Before launch, the LMS and associated training content will be reviewed with input from key stakeholders, including the Alaska Board of Nursing, Alaska Commission on Aging, assisted living homes and tribal healthcare providers to strengthen relevance, usability, and alignment with culturally relevant workforce and community needs. ARA will serve as applicant and will lead the caregiver engagement, provider outreach, in-person training options, implementation support, and statewide coordination. The UAA CDH will partner with ARA on in-person training, curriculum alignment, evaluation design, and outcome review. For professional providers seeking deeper skill development, the project will offer optional two-day in-person advanced training centered on Mental Health First Aid for Older Adults and PAC. The training will focus on practical provider and caregiving skills in ADRD communication, stress response, safety, caregiver partnership, and person-centered support strategies that can be applied across care settings. It will also include an in-person immersive experience, including Dementia Live, to deepen empathy and reinforce the training. Dementia Live may also be used separately for community outreach sessions that build understanding among family caregivers, community partners, and the broader public. Quarterly reviews of participant survey findings will inform content refinement, strengthen rural uptake, and guide course correction.	\$50,000-\$250,000	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alzheimers Resource of Alaska	Innovating ADRD Consumer Directed Supports for Aging in Place	AK	Alaska’s long-term care system depends heavily on family caregivers, especially in rural and frontier communities where ADRD capable respite, direct care workers, and home safety services are limited. When families cannot get timely relief or basic support, preventable crises follow: falls, wandering incidents, caregiver burnout, emergency transport, hospitalization, and earlier institutional placement. For 20+ years, ARA has successfully operated the AMHTA ADRD mini grant program. The data collected by the program has proven the ROI of these grants in helping Alaskans with ADRD to age in place for as long as possible. The opportunity is not simply to add more dollars to an existing program, it is to redesign a proven 20+-year platform, so it better reflects current costs, rural realities, and RHTP priorities. The project shifts the model to a strategic rural support platform with tiered awards tied to documented need and return on investment, technology enabled workflow and reporting through the client management system, low tech access for rural families, and stronger outcome data to guide future investment. By supporting practical home-based services, the model helps people age in place longer, improves quality of life, and reduces long term care costs. This redesign creates a more responsive and evidence-driven ADRD support model that advances health care access, healthy communities, fiscal sustainability, and spark technology and innovation.	ARA will redesign and expand its existing statewide mini grant program by supplementing the current annual AMHTA per-person cap of \$2,500 with additional tiered awards of \$5,000 to \$10,000 based on documented need, safety risk, and rural cost factors such as travel, contractor availability, and remote pricing. Eligibility will continue to require an Alzheimer’s disease or dementia diagnosis. Funds will support practical, prevention-focused needs that help a person remain safely at home and improve quality of life, including ADRD capable respite, adaptive or durable equipment, technology-enabled and safety supports, supplies, and small home modifications that reduce falls, wandering risk, and bathing or mobility barriers. Because this is a consumer-directed model, families can use local providers, vendors, and contractors, or purchase through hub communities when local options are limited. The redesign is also operational and technological. ARA will integrate online applications with clear eligibility requirements, eligibility review, approvals, payments, reporting, and outcome tracking into the proposed client management system and online portal, while maintaining paper applications, phone support, and staff-assisted submission so rural households are not excluded by limited broadband or digital literacy. In Year 1, ARA will finalize tiering criteria, update guidance, strengthen internal controls, build technical support, and implement the new workflow. In Years 2 through 5, ARA will operate continuous award cycles with quarterly review of timeliness, spending by geography and category, rural reach, caregiver stability, crisis prevention, delayed placement, and ROI indicators. Findings will be used for course correction, stronger reporting, and sustainability planning.	\$1M-\$5M	Hospital	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alzheimers Resource of Alaska	Statewide ADRD Data Collection	AK	Alaska lacks a consistent, statewide data picture of ADRD. Current estimates vary across sources and are often based on different definitions, timeframes, or datasets, leaving state agencies, providers, tribal organizations, and community partners without a shared baseline. This fragmentation is a foundational obstacle to resource allocation, policy development, workforce planning, and coordinated care across Alaska’s geographically dispersed health system. The gap is especially urgent because rural communities face persistent barriers to diagnosis and follow-up. Without reliable information on how many Alaskans are diagnosed versus likely living with undiagnosed ADRD, stakeholders cannot accurately project costs, identify where caregiver burden is concentrated, anticipate safety and guardianship needs, or evaluate whether current ADRD supports are reaching the people they are intended to serve. A shared data infrastructure is the necessary first step to align investments with need, strengthen rural access, and support fiscal sustainability through evidence-based decision-making.	ARA is willing to serve as lead applicant or as a partner with another stakeholder to develop a collaboration with a data collection and research organization, selected in coordination with the State of Alaska, to build a rigorous and sustainable statewide ADRD data infrastructure. The data partner will provide research design, data governance, and analytic capacity; ARA will provide statewide ADRD subject-matter expertise, trusted community relationships, and rural outreach capacity through its network of caregivers, providers, tribal health systems, and community-based organizations. The partnership will standardize ADRD definitions, select defensible data sources, and implement a repeatable methodology to produce consistent prevalence estimates, regional distribution analyses, demographic breakdowns, and patterns of service utilization and unmet need. The approach will be designed for feasibility in rural and tribal settings by combining administrative data with practical field methods, including structured surveys distributed through clinics, tribal health programs, and caregiver support networks that will be supported by validated estimation methods including undercount adjustment. Privacy protections, appropriate aggregation for small communities, and culturally responsive engagement practices will be built into the governance framework from the outset. The project will also explore secure integration and interoperability opportunities with existing statewide systems, including the HIE, using a phased, pilot-first approach before any broader scaling. Deliverables will include a shared baseline dataset, a documented and repeatable collection protocol, and regular reporting products that can be used by state agencies, health systems, tribal organizations, and community-based planners to plan services and evaluate impact.	\$50,000-\$250,000	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alzheimers Resource of Alaska	Statewide Alzheimer’s and Dementia Anti-Stigma Awareness Campaign for Rural Alaska	AK	ADRD is one of the most expensive and rapidly growing public health challenges in Alaska. Despite the growing prevalence, stigma remains a barrier to prevention, early diagnosis, seeking caregiver support, and planning. In the Alaska Mental Health Trust Authority’s (AMHTA) 2025 statewide stigma survey, ADRD had a stigma score of 6.49, almost as high as alcohol misuse (6.99) and drug misuse (6.74) and higher than mental illness (4.89), traumatic brain injury (3.36), or developmental disability (2.75). Stigma has worsened over time: 8 of 12 attitude measures moved in a more negative direction from 2023 to 2025, 79% believed a person with ADRD would act in unpredictable ways, and 63% believed the person would pose a danger to self or others. Research shows stigma delays help seeking, reduces participation in education and prevention programs, and increases social isolation. In rural communities, where services are limited and informal networks are essential, delays result in crises requiring emergency response or sudden relocation from home communities. Addressing stigma encourages earlier intervention, stronger prevention engagement, and improved readiness among families and communities to support aging populations. A statewide public education campaign allows Alaska to address these challenges at the population level by improving dementia health literacy, encouraging brain health screening and planning, and normalizing conversations about cognitive change before crises occur.	ARA will partner with an Alaska-based communications firm to design and implement a statewide anti-stigma awareness campaign grounded in Alaska-specific data and best practices in public health communication. Campaign development will be guided by findings from the AMHTA stigma survey so messaging responds directly to the beliefs and concerns that drive stigma in Alaska. The campaign will combine stigma-reduction messaging with clear pathways to prevention, support, and services. Outreach will highlight the evidence-based “10 Keys to Dementia Risk Reduction,” an educational program shown to improve brain health, and will connect audiences to ARA support and referral services. The strategy includes several coordinated components: • Message strategy and creative development informed by stigma research and audience segmentation • Cultural adaptation of messaging for rural and Alaska Native audiences • Multi-channel dissemination including radio, print, digital media, social platforms, and community events • Continuous monitoring using media analytics, community feedback, and engagement metrics Campaign activities will include production of promotional and collateral material, broadcast radio placements, digital advertising, social media storytelling, educational materials, tradeshow and conference displays, and participation in community events. Messaging will evolve over time from general awareness toward encouraging cognitive screening, early detection, and proactive care and financial planning. Because Alaska’s communications environment varies widely across regions, the campaign will intentionally combine high-reach broadcast channels with targeted digital strategies. Radio remains one of the most reliable communication tools in rural Alaska, while digital advertising allows the campaign to reach individuals privately when they search for information about memory changes or caregiver support.	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Alzheimers Resource of Alaska	Transforming Rural ADRD Access Through Regional Navigation and Case Management	AK	Across Alaska, ADRD care and caregiver support are fragmented across primary care, hospitals, behavioral health, long-term services and supports, and community programs. In rural and frontier communities, distance, weather, transportation barriers, limited provider availability, and workforce turnover make that fragmentation more severe. Families often become the default coordinators of diagnosis follow-up, safety planning, respite, benefits, and long-term care decisions with little ADRD capable guidance. Concerns about cognitive change may go unaddressed too long, referrals stall, and practical barriers such as respite, transportation, or in-home supports can push families into crisis. ARA has demonstrated demand for Resource Specialist and Care Navigator support, but the current staffing model is a structural mismatch for Alaska’s geography. It does not allow ARA to build dependable regional referral relationships or consistent local follow-through. The opportunity is to transform that test-piloted model into a multi-region rural access and case management system that supports earlier identification of concerns, stronger referral pathways to primary care and community supports, connection to mini grants when appropriate, and sustained follow-up that helps Alaskans remain safely at home longer while reducing unnecessary travel, crisis-driven care, and premature placement outside their communities.	ARA will implement a region-based ADRD access and case management model built around two complementary functions in each region. Resource Specialists will serve as the front door by completing intake, urgency and safety screening, offering non-diagnostic cognitive screening when appropriate, and connecting individuals back to primary care providers or other qualified clinicians for further evaluation when concerns are identified. Care Navigators will function as case managers and provide ongoing support for Alaskans through care planning, referrals, caregiver coaching, follow-up, and coordination across systems. This is a redesign of how services are delivered, not simply an expansion of current staffing. The project will translate what ARA has learned from its Anchorage test pilot into a statewide multi-region model with standardized intake and triage workflows, consent-based information sharing, shared documentation, and closed-loop referral tracking so families do not have to repeat their story and referrals do not stall. Each region will maintain a living resource map, providing connections to tribal and local health care, respite, transportation, benefits, housing, legal planning, and other supports relevant to ADRD. Resource Specialists and Care Navigators will connect families to mini grants when modest flexible assistance can address immediate barriers such as respite, transportation, or in-home safety needs.	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Amahealth LLC	NewDate - Bringing Personalized Maternal Care with AI and Wearables	AZ	Predicting when natural labor will begin remains one of the most significant unmet needs in obstetric care. Only 5% of women deliver on their expected due date. Term pregnancy spans 37–42 weeks and is associated with better maternal and neonatal outcomes than preterm or post-term birth. However, clinicians currently have no reliable way to predict spontaneous labor onset. As a result, providers and families must make decisions under uncertainty, balancing potential complications—like hypertensive disorders, abnormal fetal growth, or stillbirth—against the unknown timing of labor. This uncertainty often leads to conservative clinical decisions such as precautionary relocation closer to hospitals, increased monitoring, or medically induced labor. These approaches can increase healthcare costs, place strain on hospital resources, and create logistical and emotional burdens for families. The problem is amplified in regions with limited maternity care access, like in rural communities. In Alaska 30.1% of births occur among women living in rural census areas while only 14% of maternity care providers practice in those regions. Improving prediction of labor timing could reduce uncertainty in care planning, help avoid unnecessary interventions, and support better maternal health outcomes while lowering logistical and healthcare burdens.	Research has shown that a woman's body prepares for labor well before physical symptoms commonly associated with labor (e.g., contractions, cervical dilation, water breaking, etc.). Notably, the estrogen dominance during pregnancy and functional withdrawal of progesterone are reflected in the underlying physiologic signals of body temperature and heart rate variability (HRV), and could be used to infer accurate timing of labor onset. During pregnancy, progesterone increases respiratory drive and ventilation, estrogen causes upper airway vascular congestion, and mechanical changes such as diaphragmatic elevation and relaxin-mediated rib cage expansion alter thoracic mechanics—physiological changes that can be reflected in measurable signals such as respiratory rate, heart rate, and cardiorespiratory variability. Recent advances in wearable sensors and artificial intelligence create an opportunity to identify subtle physiological shifts and address this challenge. Physiological signals such as skin temperature, HRV, heart rate, respiratory rate, sleep patterns, and activity change during late pregnancy and contain predictive information about labor onset. Amahealth has developed NewDate, an AI-driven platform that analyzes wearable physiological data to predict when labor is likely to begin. In an initial clinical study of 119 pregnant women, the system demonstrated promising ability to detect patterns associated with labor onset. NewDate showed a 79% accuracy with a 5-day labor prediction window. The proposed approach of this project is to collect physiological data collection from 100 pregnant women in rural Alaska using additional smart wearables (E.g., wrist watches) to further train, validate, and test NewDate. Amahealth will conduct at least 15 usability interviews and at least 15 ethnographic interviews to identify user and product requirements to ensure NewDate fits in existing care pathways within rural communities.	\$250K-\$1M	Statewide	Kenai Peninsula Borough	Deferred or Not Advanced

AMC Health Alaska Inc.	Alaska Remote Monitoring Partnership: Caring for Communities at Home	AK	Alaska’s RHTP highlights the urgent need to expand access to high-quality care across rural and remote communities where long distances, weather, workforce shortages, and fragmented services contribute to preventable emergencies and rising Medicaid and Medicare costs. The six initiatives point to major gaps in chronic disease management, maternal health, behavioral health, workforce stabilization, and technology modernization, areas where virtual care and remote monitoring can deliver immediate value. AMC Health can help Alaska close these gaps by scaling proven RPM models that reduce travel burdens, support early intervention, and bring care as close to home as possible. With eight years of Alaska-tested experience supporting Veterans through the VA Home Telehealth Program, AMC Health has demonstrated that remote monitoring can reliably serve patients even in areas with limited broadband. Our project will help reduce avoidable medevacs and hospitalizations, improve maternal and chronic disease outcomes, and support rural and Tribal care teams through low-burden digital workflows. By combining cellular-enabled devices, satellite-capable connectivity, interoperable data exchange (FHIR/HL7), automated triage, and rapid deployment capability, AMC Health can help Alaska advance all six RHTP initiatives with a scalable, community-aligned, and financially sustainable RPM model.	AMC Health proposes a phased, Alaska-tailored approach to expand access, reduce avoidable emergency utilization, strengthen rural and Tribal workforce capacity, and deliver measurable outcomes aligned with Alaska’s RHTP goals. Our model emphasizes rapid deployment, community partnership, and technology readiness to support care “as close to home as possible”. Phase I: Readiness & Co-Design Collaborate with Tribal Health Organizations, FQHCs, Critical Access Hospitals, rural hospitals, and village clinics to assess connectivity, workforce capacity, priority populations, and current workflows. Alaska’s focus on community-led design guides our culturally aligned approach. Rural-ready solutions including cellular, satellite, and multi-connectivity devices, modems, and app-free workflows are configured for remote regions. FHIR/HL7 interoperability supports secure data exchange across Tribal and non-Tribal systems. Phase II: Rapid Deployment & Hub-and-Spoke Monitoring Deploy statewide hub-and-spoke RPM network anchored by CAHs and regional hospitals. Hubs manage vitals review, escalations, and post-acute follow-up. Spoke sites (Tribal and village clinics, FQHC satellites) enroll patients using CHW-friendly tools that route alerts back to hub clinicians. This model draws on AMC Health’s eight years supporting the VA Home Telehealth Program in Alaska’s frontier communities, demonstrating reliability in limited-bandwidth and weather-impacted environments. Priority groups include patients with heart failure, hypertension, diabetes, COPD, behavioral health needs, and high-risk pregnancies. Phase III: Workforce Extension & Capacity Building Automation supports symptom detection, triage, and follow-up, reducing burden on CHWs, Tribal providers, and rural clinicians in alignment with RHTP workforce goals. AMC Health’s Virtual Medical Group provides backup triage and complex-care support to extend clinical reach without adding staff. Phase IV: Value-Based Performance & Sustainability Our platform captures outcomes tied to Alaska’s focus on fiscal sustainability - reductions in medevacs and hospitalizations, improved maternal stability, and better chronic disease control. CMS-aligned RPM reimbursement models establish a durable funding pathway beyond RHTP grants. Phase V: Statewide Scaling With early success, RPM expands to other specialties. AMC Health increases Alaska-based staffing and strengthens local partnerships to build a long-term infrastructure.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

American Cancer Society Alaska, Inc	American Cancer Society: Cancer Prevention & Screening Technical Assistance for RHTP Grantees	AK	Cancer has dominated Alaska's mortality statistics since 1993. This is despite significant national progress, with 70% of people surviving at least five years after a cancer diagnosis (2015 – 2021). Despite oncology advances over the past 30 years, new research requires roughly 17 years to clinical implementation. Alaska faces the compounding challenge of geographic distance from oncology research hubs and limited access to local training opportunities. Improved outcomes for Alaskans relies on cancer prevention and screening serving as a core feature of rural transformation, not an optional add-on. The American Cancer Society (ACS) partners with clinics to bring research more quickly into practice, implementing proven strategies across the health care ecosystem to improve outcomes and accelerate innovation. Our Alaska-based staff hold statewide relationships through our participation in the Alaska Cancer Partnership (facilitated by DOH) and the Alaska Tribal Cancer Advisory Network (facilitated by ANTHC). Cancer prevention and screening align directly with RHTP's Health Care Access initiative and supports Healthy Communities through education on lowering cancer risk. We propose a cancer prevention and screening technical assistance (TA) program to help grantees design, implement, and sustain cancer screening interventions that will help drive progress toward the RHTP outcome of improving age-appropriate cancer screening rates across the health care spectrum.	This LOI seeks funding for ACS staff capacity to deliver scalable cancer prevention and screening TA within the RHTP grantee cohort. Early investment in cancer TA supports implementation, reduces duplication, and aims to produce measurable improvements in Alaska's cancer screening rates. TA will be structured around three activities. 1)Quality Improvement: “Quality improvement (QI) is the framework used to systematically improve care. QI seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations" (CMS). ACS Alaska is trained to support health systems in QI. Grantees and ACS will use evidence-informed tools, training, and the latest research for improving cancer screening outcomes. TA will be delivered virtually to grantee sites, with an emphasis on serving grantees in remote boroughs that may lack dedicated resources or staff for cancer QI programming. At minimum, QI sessions will take place at grantees’ project kick-off, at the midpoint, and at the end of the annual grant cycle. Pending the volume of relevant project partners, ACS staff bring experience in both group learning collaboratives and clinic support coaching models. 2)Workforce Training: ACS will facilitate at least two educational activities in grant year one focused on increasing colorectal, breast, cervical, and/or lung cancer screening strategies. Attendees should include any grantee with projects tailored to cancer or projects that could benefit from the integration of cancer screening. Unlike the clinic QI TA activity, cancer screening workforce training will take place in virtual statewide webinars for all relevant grantees. This could include presenting cancer screening strategies at RHTP grantee convenings or other relevant meetings. We cannot guarantee availability of Continuing Medical Education (CME) credits but will strive to make CMEs available at workforce trainings as an incentive for attendance. 3)Data Support: A crucial part of TA is coaching partners to make data-informed decisions about their cancer screenings. ACS will prompt grantees to revisit their cancer screening data and assess if their interventions are impacting patient outcomes. Typically, this includes a baseline, mid-point, and year-end data review. We will also collaborate with DOH to increase awareness of statewide and regional cancer screening benchmark data available through the BRFSS Data Center.	Under \$50,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

American Cancer Society Alaska, Inc	American Cancer Society: Readiness to Address the Alaska Native Cancer Disparity	AK	Cancer is the leading cause of death in Alaska and does not affect all people equally. For Alaska Native people, the disparity is profound: compared to White people in Alaska, Alaska Native people have incidence rates at 1.5x higher for lung cancer, 2.5x higher for colorectal cancer and 4x higher for stomach cancer. The American Cancer Society is preparing to stand up an Alaska Native Cancer Fund to meet this urgent need. By funding culturally and geographically relevant research projects that advance cancer prevention, screening, treatment and survivorship outcomes for Alaska Native people, the Fund will directly address the unique genetic, environmental, and socioeconomic factors driving these inequities. As a nationwide leader both in cancer research and in philanthropic fundraising, the American Cancer Society has the experience to implement and sustain population-specific cancer research. What we need support for is the planning and project design phase to ensure the Alaska Native Cancer Fund will meet Alaska’s unique needs and realities. This LOI seeks funding to support payroll expenses for American Cancer Society staff time spent building out the project design and implementation plan for the Fund. Short-term funding support now will act as a catalyst to ensure the viability and sustainability of the project and move us all towards longer-term outcomes of reducing the cancer burden in Alaska.	The first aim of the Alaska Native Cancer Fund is to establish a Cancer Health Research Center (CHeRC) specifically focused on addressing the Alaska Native cancer disparity. The CHeRC model currently exists in eight sites around the country with research focused on other populations facing a cancer disparity. We believe this model is needed to address the profound burden of cancer experienced by Alaska Native people. A Cancer Health Research Center is not a building; it is a \$1.65 million, 4-year grant to support community-led research. This research grant mechanism is designed to bring multidisciplinary teams together to co-develop actionable solutions to improve health outcomes, ensuring that innovations reflect local culture, needs and values. CHeRCs are implemented by an academic or non-profit institution with a strong track record in community engagement and health equity research. This CHeRC will undergo Tribal review and a competitive peer review process within the American Cancer Society’s well-respected framework, to include national coordination, best practice sharing and scientific oversight. To adapt this innovative model to Alaska, investment in readiness and planning is needed to build capacity and establish a framework for assessment, implementation and evaluation with partners. Having this solid framework will ensure sustainable health innovation through the CHeRC grant period and beyond. Readiness includes deeper integration with Tribal and community health partners to assess evolving barriers to cancer screening, treatment and care, and adapting the American Cancer Society’s nationwide model to fit the unique types of entities that may be part of the CHeRC’s community-focused hub framework in Alaska. Developing procedures for the coordination between local Tribal review and nationwide peer review is also necessary to prepare for implementation. Once the Cancer Health Research Center is launched, the second aim of the Alaska Native Cancer Fund is to create an endowment with raised funds to ensure Alaska Native voices and experiences are sustainably represented in cancer research now and for generations to come. The endowment will allow the most promising concepts from Alaska Native-focused CHeRCs - and innovative ideas from new investigators – to receive continued or new funding and drive progress.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

American College of Lifestyle Medicine	Strengthening Alaska’s Health Workforce Through Statewide Lifestyle Medicine Training	MO	Chronic disease is a leading driver of poor health outcomes and healthcare costs across Alaska, with rural and frontier communities disproportionately affected. Type 2 diabetes, cardiovascular disease, and obesity are compounded by geographic isolation, limited specialty access, workforce shortages, and the time and cost of travel for care. Too often, care focuses on managing progression rather than addressing the lifestyle and behavioral drivers of these conditions. verse and geographically dispersed populations. This project strengthens Alaska’s healthcare workforce by expanding access to evidence-based lifestyle medicine training for clinicians and care teams statewide. Lifestyle medicine provides practical clinical tools to treat root causes of chronic disease through therapeutic lifestyle interventions (nutrition, physical activity, sleep, stress management, social connection, and avoiding risky substances). By providing scalable training and practical implementation resources to teams serving rural and frontier communities, the project builds local capacity to deliver more effective prevention-oriented chronic disease care within existing clinical settings. Over time, this workforce investment can help reduce avoidable disease escalation and support a more sustainable healthcare system for Alaska’s diverse and geographically dispersed populations.	This project will expand the capacity of Alaska’s healthcare workforce to prevent, treat, and reverse chronic disease by delivering statewide training and practical implementation resources in evidence-based lifestyle medicine. The approach equips clinicians and care teams serving rural, remote, and frontier communities with actionable tools to address key drivers of cardiometabolic disease within existing care settings, helping reduce reliance on travel and hard-to-access specialty services. A central component is establishing a shared clinical language and framework across Alaska’s diverse health systems. Standardized, evidence-based training improves consistency in how chronic disease is understood and treated and strengthens interdisciplinary collaboration. The scalable format is designed for geographically dispersed teams, combining flexible virtual learning, connection to a national peer network, and ready-to-use tools. Participants build practical skills in therapeutic lifestyle interventions (nutrition, physical activity, sleep, stress management, social connection, and avoiding risky substances) and can tailor approaches to local strengths, cultural traditions, and food systems across Alaska’s diverse populations, including Alaska Native communities and subsistence-based lifestyles. Participating organizations also receive guidance and planning resources to integrate lifestyle medicine into workflows and team-based care models, including Lifestyle Medicine Shared Medical Appointments (LMSMAs). These approaches can help teams reach more patients efficiently while reinforcing social support and sustained behavior change. By building a statewide network of clinicians trained in a shared, culturally adaptable model of care, the project strengthens the sustainability of chronic disease care delivery in rural and frontier communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

American Lung Association	Alaska Lung Cancer Screening Project	AK	Lung cancer is the leading cause of cancer death, yet screening rates remain low among eligible populations in Alaska. Many individuals at high risk are not referred for screening due to limited awareness of screening guidelines, lack of provider engagement, and barriers to accessing culturally and community-appropriate information. Although Alaska Medicaid began covering lung cancer screening in 2023, many eligible patients and providers are still unaware of this benefit, creating a missed opportunity to increase early detection. This project aims to address these gaps by increasing awareness, strengthening referral pathways, and improving systems that support quality lung cancer screening. The Lung Association will work with healthcare systems and community organizations to develop and disseminate culturally appropriate education materials, promote implementation of evidence-based lung cancer screening guidelines, and build stronger partnerships within target communities. The project seeks to reduce barriers to care and increase the number of high-risk individuals who are referred to and receive screening. Increasing lung cancer screening can lead to earlier detection, improved treatment outcomes, and reduced cancer disparities. This initiative presents an opportunity to leverage recent Medicaid coverage changes, strengthen community partnerships, and implement best practices that will improve lung cancer prevention and early detection efforts across Alaska.	The American Lung Association will implement a multi-pronged strategy to expand access to lung cancer screening for high-risk populations in Alaska, with a focus on rural and remote communities where access to preventive care is often limited. This effort will strengthen referral pathways, increase provider engagement, and improve health system practices to ensure more eligible patients receive recommended screening. The Lung Association will leverage partnerships with health systems serving rural and underserved communities to improve identification and referral of patients eligible for low-dose CT (LDCT) lung cancer screening. By strengthening coordination between primary care providers and screening facilities, the project will help ensure eligible patients—particularly those living in geographically isolated areas—are identified and referred for screening. Health systems participating in this project will receive technical assistance and financial support to implement quality improvement initiatives that strengthen screening referral workflows and improve patient follow-through. These efforts will support sustainable systems changes that increase screening referrals beyond the project period. To further reduce barriers faced by patients in rural communities, the project will establish a referral pathway connecting health systems with the Lung Association’s Lung Health Navigators. Navigators will provide one-on-one education and support to help patients overcome barriers related to screening, follow-up care, and treatment, including challenges related to travel, awareness, and access to services. The project will also address tobacco use by supporting health systems in implementing the Ask–Advise–Refer (AAR) model. This evidence-based approach encourages providers to assess tobacco use, advise patients to quit, and refer those interested in quitting to evidence-based cessation services. A similar model implemented by the Lung Association in Illinois integrated lung cancer screening referrals into the state Quitline, increasing both screening awareness and completed referrals. Patients may also be referred to the American Lung Association’s Freedom From Smoking® program or cessation services within participating health systems. Together, these strategies will strengthen rural health system practices, reduce barriers to lung cancer screening, and increase early detection among high-risk Alaskans.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Anchorage (Municipality); Bethel Census Area; Copper River Census Area; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Sitka (City and Borough)	Deferred or Not Advanced

Amerita Inc.	Improve and expand access to pharmacy services by investing in workforce and facility improvements	AK	Rural and frontier communities in Alaska face significant barriers to accessing medication therapy and home infusion services. Geographic isolation, limited healthcare infrastructure, and shortages of qualified nursing and pharmacy staff contribute to delays in treatment initiation, extended hospital stays, and frequent patient transfers to distant facilities. These challenges affect both patients served locally at our branch and those in remote communities statewide. Patients in isolated areas often experience limited access to specialized care, including timely medication administration and home infusion training. Staffing shortages create bottlenecks in service delivery, increasing the risk of delayed therapy and higher reliance on hospital-based care. Telehealth and remote care services are inconsistently available or underutilized, leaving patients in remote communities without adequate support for managing therapy at home. Collectively, these factors create inequities in access to safe, timely, and high-quality care, highlighting a critical need for interventions to improve medication therapy and home infusion services in Alaska’s rural and frontier communities.	Our approach focuses on strengthening workforce capacity, modernizing pharmacy infrastructure, and implementing telehealth-enabled care to expand access to medication therapy and home infusion services for patients in rural and frontier communities across Alaska. A primary component of this project is workforce development. To address regional healthcare staffing shortages, we will recruit, train, and retain qualified pharmacy and clinical staff who can support patient education, therapy initiation, and ongoing care coordination. Offering competitive compensation and professional development opportunities will help us attract and retain skilled staff who are essential to supporting home-based therapies. Increasing staffing capacity will allow for more timely initiation of therapy, enabling patients to begin treatment sooner and facilitating earlier discharge from hospitals when appropriate. Expanded staffing will also allow our team to provide comprehensive patient education and support for individuals managing complex therapies in the home setting. Staff will be available to guide patients and caregivers through medication administration, therapy management, and safety protocols, helping ensure treatments are delivered correctly and confidently. The project will also include improvements to our sterile compounding area to enhance environmental controls and ensure proper temperature stability for medications. Upgrading compounding infrastructure will help maintain the highest standards for sterility and medication quality, ensuring that patients receive safe and effective therapies. To further expand access for patients in remote communities, we will implement telehealth resources that allow pharmacists and clinical staff to provide virtual training, education, and follow-up support. Telehealth tools will enable patients and caregivers to receive guidance on medication administration and therapy management without the need for extensive travel. Remote monitoring and virtual check-ins will also allow care teams to track patient progress, address questions, and intervene early if concerns arise.	\$50,000-\$250,000	Pharmacy	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Anchor Point Safe Water Corporation	Rural Water Infrastructure Data & Control System (SCADA) Upgrade	AK	Anchor Point Safe Water operates an aging rural water treatment plant that currently relies on manual monitoring and control. This limits the ability to detect system issues quickly and creates operational challenges for a small utility with limited staff. Upgrading the plant with a SCADA system would allow for real-time monitoring of water quality, system performance, and equipment status. This modernization would improve reliability, support regulatory compliance, and strengthen the sustainability of safe drinking water infrastructure that supports the health of the rural Anchor Point community and local health providers such as SVT Health & Wellness.	Anchor Point Safe Water proposes to modernize its rural water treatment plant by installing a SCADA (Supervisory Control and Data Acquisition) system to enable real-time monitoring and automated system alerts. The project will include installing sensors and controllers to track key indicators such as water levels, pressure, flow, and chlorine residual, along with a secure communications system that allows operators to monitor the plant remotely. Using a hub-and-spoke approach consistent with RHTP goals, the system could connect to regional technical support partners who can assist with monitoring, troubleshooting, and data management. This approach will strengthen system reliability, reduce response time to operational issues, and support long-term sustainability of safe drinking water infrastructure serving the rural Anchor Point community.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Anchorage Community Land Trust	Investing in Mountain View's Nonprofit Hub	AK	Anchorage Community Land Trust (ACLT) seeks funding to complete critical structural repairs to the roof of the Mountain View Service Center, ensuring long-term safety and sustainable operations for tenants. During the winter of 2023–2024, record snowfall in Southcentral Alaska exposed structural vulnerabilities in many buildings constructed in the 1980s using a “gang-nail” truss system. As snow accumulated, roofs of buildings with these trusses began collapsing across Anchorage, particularly in older neighborhoods and warehouse districts, including Mountain View. The Municipality identified structures requiring heightened monitoring due to potential roof failure; the Mountain View Service Center was among them. Structural engineers have determined that repair and redesign of the building’s truss system are necessary to ensure long-term safety and stability. The estimated cost for design and construction is \$1.5 million. Until ACLT secures funding, we must pay to clear the facility's 10,000-square-foot roof whenever it snows to avoid a hazard. The average cost per winter is \$150,000, and the building must shut down for 10-12 days each winter for emergency snow removal, disrupting important beneficiary services. These improvements are necessary to eliminate safety risks and ensure operational stability for tenant partners and the thousands of clients and beneficiaries they serve across Alaska.	With the proposed funding, ACLT will finalize engineering design for truss repair and reinforcement, complete roof reconstruction and structural improvements to ensure long-term safety, coordinate temporary tenant relocation if needed to avoid service disruptions, and absorb short-term rental income loss during construction. If funded, repairs are anticipated during winter 2026–2027, with completion in spring 2027. The project will eliminate the need for ongoing emergency snow mitigation and prevent catastrophic structural failure, securing the building for decades of continued service. The project has already secured significant investment, including \$750,000 in federal support championed by Senator Lisa Murkowski. This funding would help leverage these public investments and ensure timely completion. Completing the roof repair will produce three key outcomes: 1. Preservation of Affordable Space for Behavioral Health and Early Intervention Organizations For more than 20 years, ACLT has invested in Mountain View’s commercial corridor through a rent stabilization strategy that provides below-market space to nonprofit tenants. The Mountain View Service Center leases space to 5 organizations at approximately \$1.70 per square foot—20–25 cents below market rate. Without grant support, repair costs or ongoing snow mitigation could force rent increases. By preventing cost escalation and preserving affordability, ACLT effectively acts as a downstream funder of behavioral health & early intervention services—reducing tenants’ overhead costs so they can direct more resources to direct services to beneficiaries. 2. Long-Term Tenant Stability The Service Center has operated as a nonprofit hub for nearly two decades, with long-term tenants including The Foraker Group, Camp Fire Alaska, and Programs for Infants & Children. Maintaining the facility ensures continued stability for these organizations and protects decades of community investment. 3. Strengthened System of Care Infrastructure The building functions as a centralized nonprofit hub where hundreds of clients access services daily and hundreds of staff work. Stabilizing the facility ensures uninterrupted early intervention services, supports youth and families experiencing developmental disabilities and mental illness, strengthens nonprofit capacity statewide, and protects a vital piece of Alaska’s behavioral health infrastructure.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Anchorage Fire Department	AFD Training Center: Neonatal Advanced Life Support (NALS) Rural Training Initiative	AK	This letter expresses the Anchorage Fire Department Training Center’s intent to develop a regional Neonatal Advanced Life Support (NALS through American Red Cross) education initiative to strengthen neonatal emergency response capacity for rural and remote communities across Alaska. Alaska’s geography, limited specialty care access, and extended transport times create significant challenges for neonatal stabilization in rural settings. Community health aides, rural clinic providers, and EMS personnel are frequently required to manage high-risk neonatal emergencies with limited resources. Improving neonatal resuscitation and stabilization capacity is critical to supporting safe maternal and newborn care across the State of Alaska. This project aligns with Alaska’s Rural Health Transformation goals to promote lifelong health, build sustainable systems, and strengthen the rural healthcare workforce. It advances the “Healthy Beginnings,” “Strengthen Workforce,” and “Spark Technology and Innovation” priorities by ensuring frontline providers have the training, simulation experience, and clinical decision-making skills to manage neonatal emergencies until definitive care is available.	The project will establish a coordinated training partnership between healthcare and EMS agencies in the Anchorage Bowl, the Matanuska–Susitna Borough, statewide EMS providers, and nonprofit EMS education organizations to support providers serving rural Alaskan families. The initiative will leverage existing training infrastructure and regional expertise to extend neonatal emergency education to road-accessible and off-road communities. The program will focus on three core components: • Regional Neonatal Emergency Training Network: Create a collaborative training network with EMS organizations, including Alaska Prehospital Education Consortium, Chugiak Volunteer Fire Department, Girdwood Fire Department, Mat-Su Borough EMS, Alaska Medical Transport and other EMS training organizations throughout the State. • Simulation-Based Neonatal Stabilization Education: Deliver NALS training in a hybrid format. Initial online instruction followed by high-fidelity simulation and scenario-based learning tailored to rural environments and long-distance transport challenges, informed by established neonatal resuscitation education models. • Sustainable Rural Instructor Development: Train rural clinicians and EMS personnel as certified instructors to expand long-term capacity and ensure continued access to neonatal emergency education beyond the grant period. Through these strategies, the project will increase provider readiness, strengthen regional coordination of neonatal care, and improve early stabilization of newborns prior to transport to higher levels of care. By leveraging partnerships with established EMS education organizations and regional healthcare systems, the program will create a scalable, hub-and-spoke model capable of serving providers across Alaska.	\$1M-\$5M	Statewide	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Anchorage Fracture and Orthopaedic Clinic	Improving Access to Orthopedic Trauma and Microvascular Reimplantation in Alaska	AK	Alaska currently faces a critical shortage of highly specialized orthopedic trauma services. Specifically, there is only one orthopedic trauma surgeon in the state and no surgeons trained in microvascular limb or digit reimplantation. Consequently, patients with severe injuries such as pelvic fractures or traumatic amputations must often be transported to hospitals in the Lower 48 for definitive treatment. These transfers can result in prolonged transport times, increased medical risk, higher healthcare costs, and poorer clinical outcomes. In cases of pelvic fractures, patients may experience fatal hemorrhagic shock before reaching definitive care. In cases of finger or limb amputations, the delay in surgical intervention often eliminates the possibility of successful reimplantation. This project presents an opportunity to close a major gap in Alaska’s trauma care system by recruiting two highly specialized surgeons and establishing the infrastructure necessary to deliver these services locally.	AFOC proposes a multi-phase approach to address this critical need: Recruitment and Retention 1. Recruit and provide competitive compensation packages for: - A fellowship-trained Orthopedic Trauma Surgeon with expertise in acute and pelvic trauma. - A fellowship-trained Orthopedic Microsurgeon capable of performing complex limb and digit reimplantation. 2. Infrastructure Development Utilize RHTP funding to support tenant improvements and necessary equipment purchases for clinical and surgical facilities in the U-Med District in Anchorage. 3. Operational Support - Recruit and train the clinical support staff necessary to support these surgeons, including surgical assistants, nursing staff, and administrative personnel. 4. Integration with Alaska’s Trauma System - Collaborate with regional hospitals, medivac providers, and rural health systems to ensure rapid triage and transfer protocols so patients can receive definitive care in Anchorage.	\$1M-\$5M	Specialist	Statewide	Matanuska-Susitna Borough	Deferred or Not Advanced

Anchorage Neighborhood Health Center	Clinical Equipment Modernization	AK	The Clinical Equipment Modernization project is a one-time capital investment designed to transform rural health care delivery by equipping ANHC with reliable, modern clinical tools and diagnostics. Upgrading essential medical, dental, pharmacy, laboratory, and digital equipment will strengthen ANHC’s ability to provide safe, efficient, and integrated care for Alaska’s most medically vulnerable residents. This investment ensures all clinical spaces meet ADA standards, creating a more inclusive environment while supporting whole-person care. Many of ANHC’s core tools, including dental surgical units, microscopes, vitals monitors, lab analyzers, ultrasound devices, and point-of-care testing systems, are outdated, unreliable, or at end-of-life. Replacing this equipment is critical for maintaining essential services, meeting current patient demand, and adapting to emerging payment models and care-team redesign. By stabilizing clinical operations and supporting modern data and diagnostic requirements, this project establishes a durable foundation for long-term sustainability and future program improvements, ultimately advancing high-quality health care.	ANHC has completed a comprehensive inventory and condition assessment of all medical, dental, laboratory, diagnostic, and digital equipment across the organization. This assessment identified end-of-life items, current operational gaps, and the infrastructure requirements needed to support modernized systems. With this groundwork complete, ANHC is prepared to implement a structured procurement and deployment process for the full equipment modernization effort. This project aligns with goals 1, 2, and 3 of RHTP. During the first year of the project, ANHC will work directly with established medical, dental, laboratory, and IT vendors to finalize specifications, execute contracts, and place orders for all required equipment and technology. The organization has existing vendor relationships and purchasing workflows that allow for timely obligation of funds. Ordering equipment in the first year also ensures alignment with supply-chain lead times for specialized diagnostic tools, associated EHR integration and clinical devices. Once procurement is underway, ANHC will begin phased installation, configuration, and onboarding. This approach allows clinical areas, dental suites, laboratory services, and IT infrastructure to be upgraded without disrupting ongoing patient care. Equipment requiring facility modifications, integration with Epic, or network configuration will be scheduled in coordination with biomedical technicians, IT staff, and departmental leads. All equipment will be fully operational by the end of the project period. To support this work, the project funding for a dedicated project manager to oversee timelines, procurement coordination, vendor communication, and cross-departmental implementation. The project also includes funding for an additional biomedical technician to support equipment installation, testing, preventive maintenance planning, and long-term asset management. These roles ensure that the modernization process is implemented efficiently, and that new equipment is properly deployed, tracked, and supported throughout the project period.	\$1M-\$5M	Federally qualified health center	Multi- Community or Participating in Regional Hub-and- Spoke	Anchorage (Municipality)	Advance to Implementati on Application

Anchorage Neighborhood Health Center	Digital Infrastructure and Systems Transformation	AK	Alaska’s rural, remote, and frontier communities rely heavily on Anchorage-based providers for specialty services, after-hours support, and coordinated care. Anchorage Neighborhood Health Center (ANHC) is a key part of this network, but its digital infrastructure has not kept pace with increasing care complexity across long distances. Although ANHC shares an Electronic Health Record with Providence, tools needed to integrate workflows, streamline communication, and support advanced care management remain limited. Opportunities exist to expand interoperability, add integrated modules, and align Dental and Pharmacy on the same platform. Additional auditing, compliance, and AI-enabled documentation tools would improve accuracy, efficiency, and patient safety—critical for rural residents who depend on ANHC for coordinated, time-sensitive care. Aging hardware, limited telehealth capacity, and outdated audiovisual systems also restrict ANHC’s ability to collaborate with rural FQHC partners, including those supporting obstetric care coordination. These gaps delay information exchange and hinder workflows needed to manage patients across distance. Lack of modern disaster-recovery infrastructure also creates risk during earthquakes, severe weather, or outages. By modernizing ANHC’s digital backbone, this project will strengthen care coordination and support earlier intervention—aligning with Goal 3 of the Rural Health Transformation Project to improve health outcomes for Alaskans.	ANHC will implement this project over 18 months using a phased, vendor-supported deployment strategy that strengthens digital systems, expands interoperability, and increases operational resilience. Work will be coordinated among ANHC staff, external vendors, Providence, and ANHC’s managed services provider (MSP). Staffing may be temporarily adjusted to support implementation, testing, and training while maintaining continuity of care. The project begins with enhancements to the shared Electronic Health Record (EHR) with Providence. ANHC will work with Providence and the vendor to configure integrated tools, expand care-management functionality, and improve information exchange. ANHC will also evaluate integrating Dental and Pharmacy into the same EHR platform. Additional auditing, compliance, and AI-enabled documentation tools will improve workflow accuracy and efficiency. Vendor-led design sessions, testing cycles, and training will support a smooth rollout. Next, ANHC will upgrade aging hardware and endpoint devices across clinical and administrative areas. The MSP will manage procurement, imaging, deployment, and security configuration. Replacements will occur in waves, beginning with departments that rely on high-performance devices for telehealth, care coordination, and daily operations. Conference room audiovisual systems will also be modernized. ANHC will work with AV integrators to install updated equipment, improve connectivity, and configure rooms for multi-site communication, with scheduling designed to minimize disruption. To strengthen resilience, ANHC will establish a new disaster-recovery co-location with real-time failover. Working with the MSP and hosting vendors, ANHC will build secondary infrastructure, implement data replication, configure automated failover, and conduct testing to ensure continuity during earthquakes, severe weather, or outages. ANHC will also upgrade its accounting platform and administrative tools through vendor-guided configuration, workflow redesign, and structured staff training. Throughout implementation, ANHC will use a formal project-management framework with clear timelines, vendor coordination, risk mitigation, and ongoing monitoring. Staffing roles may be adjusted or supplemented to support change management and system stabilization. This phased approach ensures effective implementation with minimal disruption to patient care.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Advance to Implementation Application

Anchorage Neighborhood Health Center	Integrated Primary Care Expansion	AK	Demand for integrated primary care in Alaska has outpaced ANHC’s current facility capacity, creating an urgent opportunity to expand and meet the state’s growing need for accessible, comprehensive and integrated services. ANHC has experienced a 34% increase in unique patients since 2021, driven by rising demand for chronic disease management, behavioral health integration, pharmacy support, and team-based care. Space limitations restrict co-located care teams, delay timely consultations, and contribute to gaps in follow-up for medication management, behavioral health, and patient education. Anchorage’s critical shortage of Medicare-accepting and primary care providers further intensifies pressure on ANHC, which serves as a key access point for both urban and rural residents. By converting the existing third-floor medical shell into a full medical pod with integrated team spaces, ANHC can expand primary care capacity, strengthen behavioral health and pharmacy services, and modernize IT systems to support scalable telehealth and population-health management. This redesign closes critical access gaps, improves continuity for rural patients, shortens wait times, reduces avoidable emergency visits, enhances chronic disease management, and increases ANHC’s capacity to accept referrals and provide integrated whole-person care—positioning the organization to meet the current and future primary care needs of Alaska’s rapidly growing and aging population.	Today, physical space is the primary limitation preventing Anchorage Neighborhood Health Center (ANHC) from meeting growing demand for primary care, behavioral health, and chronic disease management services. ANHC will convert the fully built but undeveloped third-floor medical shell—currently used as administrative space and therefore unavailable for clinical care—into a comprehensive medical pod that directly increases patient capacity. To enable this transition, administrative staff will relocate to leased off-site office space so the main facility can be prioritized for patient care. By transforming this administrative area into clinical space, ANHC will add exam rooms, shared care-team workspaces, co-located behavioral health offices, medication education rooms, group visit and care-transition areas, and dedicated telehealth rooms. This redesign supports integrated, team-based care and allows same-day chronic disease co-management, improved workflows, and expanded access for patients with complex conditions such as diabetes, hypertension, cardiovascular disease, and behavioral health disorders. Expanded clinical space will allow providers, behavioral health clinicians, and care coordinators to work together more effectively, improving care coordination, patient engagement, and long-term disease management. Group education and care-transition areas will support patient self-management programs and medication counseling that help reduce preventable complications and hospitalizations. In parallel, ANHC will undertake targeted IT modernization to support reliable clinical operations and care coordination. Improvements include expanded Virtual Desktop Infrastructure, increased network capacity, stronger cybersecurity protections, and improved EHR interoperability. Redeveloping the third floor and relocating administrative offices will allow ANHC to significantly expand clinical capacity while optimizing the facility for patient care, directly supporting goals 1, 2, and 3 of the Rural Health Transformation Project. With existing architectural test fits, phased procurement, and established project governance, ANHC is positioned to move efficiently into design, permitting, and construction while maintaining uninterrupted services.	Over \$5M	Federally qualified health center	Multi- Community or Participating in Regional Hub-and- Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Anchorage Neighborhood Health Center	Patient Environment Modernization	AK	Anchorage Neighborhood Health Center (ANHC) serves as a critical healthcare access point for both urban and rural populations across Alaska. While most patients live within the Municipality of Anchorage, about 7% travel from rural communities including Eagle River, Girdwood, Wasilla, Palmer, Kodiak, Kenai, and Utqiagvik (Barrow). ANHC also maintains service agreements with the Girdwood, Talkeetna, Glenallen, and Seward health centers, making the facility environment especially important for patients who travel long distances for care. Many patient-facing areas are aging and no longer aligned with modern infection-control, safety, trauma-informed, and accessibility standards. Worn flooring, outdated seating and finishes, limited antimicrobial surfaces, unclear wayfinding, and insufficient translation resources create barriers to comfort, safety, and efficient patient flow—particularly for rural patients who may not easily return for follow-up visits. Aging staff breakrooms also contribute to fatigue that can affect patient experience and care delivery. This project will modernize patient and staff spaces by improving infection control, safety, accessibility, trauma-informed design, communication systems, and staff wellness areas. These improvements align with the first goal of the Rural Health Transformation Project by strengthening access to safe, coordinated care for Alaskans who rely on ANHC as a key access point within the state’s health system.	ANHC will implement the Patient Environment Modernization Project over a 18 month period using a coordinated, phased approach designed to minimize disruption to patient care while modernizing the physical environment for long-term safety, accessibility, and sustainability. The project will be completed through close coordination with facilities contractors, infection-control specialists, design consultants, safety experts, and ANHC’s internal operations team. The first phase will focus on planning, design, sequencing, and procurement. ANHC will engage architectural and environmental design partners to finalize specifications for flooring, paint, wall coverings, antimicrobial materials, seating, safety glass, trauma-informed elements, and other surface upgrades. Wayfinding, translation signage, and digital check-in kiosk placement will also be identified during this stage. Safety enhancements—including duress buttons, grab bars, and overhead paging improvements—will be designed in collaboration with security and workflow experts. During this phase, ANHC will develop staff-impact mitigation plans and determine when night or weekend work is necessary to maintain clinical operations. Construction and installation activities will occur in phased zones the second half of the proposed period. Patient-facing areas such as waiting rooms, hallways, dental and medical pods, and behavioral health spaces will be renovated in a staggered schedule to ensure continuous access for patients, including those traveling from rural and remote communities. Infection-controlled construction protocols will be used to isolate work areas, reduce dust and noise, and maintain safe circulation routes. Environmental upgrades will be followed by technology enhancements, including installation of digital check-in kiosks, updated overhead paging equipment, and refreshed wayfinding systems. Multilingual signage and trauma-informed visual design updates will be rolled out concurrently. Staff breakroom renewal will be scheduled during lower-impact operational periods to support workforce wellness without service disruptions. Throughout the project, ANHC will coordinate timelines with contractors, communicate updates to staff and patients, and continuously evaluate workflow impacts. Adjustments will be made as needed to ensure patient safety, efficient movement, and uninterrupted access to care.	\$1M-\$5M	Federally qualified health center	Multi- Community or Participating in Regional Hub-and- Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Anchorage School District	Anchorage School District – Integrated Systems Stabilization & Sustainability Project	AK	Alaska faces persistent statewide behavioral health capacity gaps that limit access, weaken outcomes, and strain system sustainability. Schools increasingly serve as the primary entry point for youth mental health support, identifying crises, stabilizing students, and coordinating referrals, yet education funding is not designed to sustain health service delivery. This structural mismatch leaves districts responsible for services essential to learning without durable financing to embed clinicians and infrastructure that ensure student safety and readiness. Since 2022, ASD has partnered with community mental health providers to implement an interconnected, tiered system of care embedding clinicians within school teams. Through screening and referral pathways, more than 1,200 students across 20 schools have been identified as needing behavioral health services, and over 600 have received early intervention through integrated school-based clinicians. ASD now includes 20 full-time embedded clinicians in 2026. Integration into school teams and governance structures has strengthened triage, referral coordination, prevention, and crisis response. However, core components, including clinician funding, mental health promotion, and data infrastructure, remain largely dependent on short-term grants. This grant period provides a structured runway to transition time-limited positions into a financially sustainable model.	ASD will focus on systems stabilization and sustainability rather than expansion of headcount. The project will transition and fully integrate 25 grant-supported Integrated Clinicians whose current funding ends 9/30/26 into a durable district-aligned structure. During this period, ASD will strengthen the systems that enable clinician effectiveness and long-term viability. Districtwide universal screening (SAEBRS) will serve approximately 30,000 students annually, strengthening early identification and progress monitoring. Threat assessment systems will be reinforced to ensure consistent crisis response. An Integrated Mental Health Supervisor and dedicated Data Coordinator will support fidelity, clinician oversight, and integrated outcome tracking. ISF technical assistance will deepen Tier I–III implementation quality across participating schools. In parallel, the project will build the financial and governance infrastructure necessary for sustainability. Year 1 will emphasize reimbursement pathway development, clinician-to-school staffing standards, integrated dashboards linking behavioral and academic indicators, and formalized cross-sector agreements. The purpose of this runway is to convert short-term grant-supported roles into sustainable, braided funding structures aligned with district and healthcare financing mechanisms. With clinicians already embedded and governance systems operational, ASD can immediately execute this transition without launching a new pilot. Together, these efforts position the project to focus on operationalizing a durable district-community aligned system through: Hiring key infrastructure, including an Integrated Mental Health Supervisor to provide integration oversight and fidelity monitoring and a Data Coordinator to support integrated data management and outcome tracking. Add 5 clinicians across all high school sites with the greatest need to ensure appropriate coverage across secondary settings while funding all 25 positions for prevention and early intervention support. Establish clear outcome criteria to measure program effectiveness, including indicators related to student mental health, attendance, disciplinary events, and academic engagement. Secure comprehensive technology infrastructure to provide integrated tools for supporting student success with data, workflow, and reporting automation.	Over \$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Anchorage School District	From Classroom to Care: Project Alaska Health Pathways (AHP)	AK	Alaska's Rural Health Transformation Program identifies workforce shortages as a central barrier to access, service stability, and system sustainability. Alaska's 2024 Healthcare Workforce Analysis estimates 9,430 additional healthcare workers are needed annually, with healthcare support occupations projected to grow most rapidly. While 76% of the nation's healthcare workforce holds at least a bachelor's degree, Alaska's most persistent vacancies are in credentialed, entry-level roles that are essential to stabilizing care teams and reducing burnout. The education pipeline is not meeting this demand. Only 33% of Alaska graduates enrolled in postsecondary education in 2024–2025. Yet 83.7% of ASD students completing two or more years of CTE transitioned to postsecondary education, advanced training, or employment demonstrating that structured, credential-aligned pathways significantly improve persistence and workforce readiness. Alaska does not lack expertise; it lacks sustained investment to scale proven local models. ASD, serving 40,000 students and operating established industry councils and statewide virtual delivery systems, is uniquely positioned to expand credential-aligned health pathways at scale. By moving workforce preparation upstream, integrating simulation, paid internships, employer alignment, and dual credit ASD can increase the annual flow of credentialed entry-level workers statewide, strengthen staffing stability, and reduce reliance on external recruitment.	The Anchorage School District proposes From Classroom to Care: Project Alaska Health Pathways (AHP), a statewide workforce development initiative expanding credential-aligned health and behavioral health pathways across six ASD high schools, with virtual and summer access. Project AHP builds on ASD's established Academies of Anchorage (AOA) model, now in Year 2 of districtwide implementation. Under AoA, students begin career exploration in Grade 9 through College and Career Exploration coursework, career expos, industry engagement, and early work-based learning. Project AHP advances into Phase 2 by launching Grades 10–12 Health and Behavioral Health Career Academies with a sequenced progression: Grade 10: Applied health sciences (Anatomy & Physiology, biomedical science) with workplace readiness. Grade 11: Credential preparation in pathways (Pharmacy Technician, CCMA, Dental Assisting, or EMT) supported by simulation. Grade 12: Credential completion (e.g., Pharmacy Tech, EMT-1, CCMA, NOCTI, RBT preparation, Teen Mental Health First Aid) with paid internships and postsecondary articulation. Delivery is intentionally multi-modal to maximize statewide access: • In-person academies • Dual credit alignment with postsecondary institutions • Virtual pathways through AKChoice for rural students • CTE Summer Healthcare Intensives: Students complete a coherent sequence integrating credentials, simulation-based training, paid internships, structured work-based learning, and stackable advancement options. This is a proven model. In 2024–2025, 83.7% of ASD students completing two or more years of CTE transitioned to postsecondary education, advanced training, or employment. Industry-recognized credential attainment increased from 1,392 to 1,555 in one year, with strong growth in Healthcare pathways. Ninth-grade on-track rates have also improved. Project AHP scales this Alaska-developed framework while removing structural funding barriers that have limited cross-district collaboration. By supporting instructional capacity directly rather than relying solely on enrollment-based thresholds, ASD functions as a shared statewide workforce asset. Anchorage houses approximately 64% of Alaska's healthcare workforce, enabling direct alignment with employer demand. Through established industry councils, simulation infrastructure, and cross-sector partnerships, ASD is uniquely positioned to deliver both immediate local impact and scalable statewide workforce capacity.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kusilvak Census Area	Deferred or Not Advanced

Anesthesia Care Associates	From Locum Dependence to Strong Workforce Sustainability: Strengthening Local Anesthesia Services	AK	The Mat-Su represents one of Alaska’s fastest-growing regions. While procedural demand continues to rise, our practice faces: • Recruitment competition with Anchorage health systems • Increasing call intensity with limited staffing depth • High locum tenens utilization to cover workforce gaps • Early-career attrition within 1–3 years • Housing and childcare barriers for relocating providers • Revenue volatility tied to workforce instability Locum anesthesia rates in Alaska commonly range between \$2,500–\$3,000 per day, excluding travel and housing expenses. A practice utilizing 3-4 locum providers per month may incur annual costs exceeding \$1,750,000. This financial volatility limits reinvestment in workforce development and increases burnout among core providers. The opportunity is to use time-limited grant support to transition from reactive locum dependence to a stable, multi-year workforce model aligned with the Mat-Su’s long-term surgical growth.	This project will stabilize anesthesia services in the Mat-Su through targeted recruitment, structured retention incentives, flexible workforce scheduling, and scope of practice optimization. 1) Targeted Anesthesia Recruitment Grant funds will support national recruitment efforts for anesthesiologists and CRNAs, emphasizing independent practice, lifestyle advantages, and scheduling flexibility in the Mat-Su. Recruitment will align with projected procedural growth and support staffing for a flexible 6-, 8-, and 10-hour shift model that matches anesthesia coverage to daily and seasonal surgical demand. The strategy will also address rising healthcare, housing, and cost of living pressures by incorporating targeted stipends and relocation support to improve long term recruitment success. 2) Structured Five-Year Retention Incentives To support long-term workforce stability, incentives will include signing bonuses tied to five-year service commitments, repayment provisions for early departure, and incentive payments weighted toward Years 3–5. Time limited housing, childcare, and healthcare stipends during the first three years will help offset relocation and family costs while supporting long term retention. 3) Flexible and Seasonal Workforce Model Our practice uses a structured scheduling system that includes 6-, 8-, and 10-hour shifts and seasonal workforce scaling. Recruitment supported by this project will expand the provider pool, distribute call responsibilities more equitably, improve schedule predictability, and reduce reliance on high-cost locum coverage. 4) Scope of Practice Optimization The project will support advanced regional anesthesia training, expanded CRNA clinical competencies, Enhanced Recovery After Surgery (ERAS) protocols, and collaborative care team models. Enabling providers to practice at the top of licensure will improve operating room efficiency, patient throughput, and quality outcomes without increasing provider workload.	\$1M-\$5M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Angoon Community Association	Healthy Food = Healthy People: Promoting Healthy Lifestyles in Culturally Relevant Ways	AK	For the past several decades, many in Angoon have believed that the unusually high incidents of cancers in our community might be related to heavy metals and toxins that concentrate in the tissues of the plants and animals that every household consumes. Greens Creek Mine, located 30 miles from Angoon has been in operation since 1989 and as of December, 2023 has created over 11 million tons of fine tailings stacked adjacent to Hawk Inlet, a traditional food gathering area for the people of Angoon. The U.S. Forest Service estimates over 100 tons of tailings blow from the stack into Admiralty Island and Hawk Inlet annually as fugitive dust. The tailings are high in heavy metals especially lead. Local waters around Angoon also risk contamination from passing cruise ship discharge, as well from the Angoon landfill's burn-box, and the boat harbor that may be leeching chemicals into the air and watershed. The people of Angoon and specifically those who are hunting, fishing, and gathering to fill their freezers and smokehouses do not have reliable information on whether the food they are eating and the areas where they have traditionally gathered this food, is free from contamination. Baseline and ongoing food chain data needs to be collected. And it is the responsibility of the people in Angoon to gather this data, send it out to laboratories for analysis, and then make decisions on what they should be feeding their families, and where they should be gathering their food.	The approach to addressing the problem of determining whether the way-of-life food that is being consumed in Angoon is healthy and free of cancer causing toxins and heavy metals, will be to support the development of a local crew of youth and adults who are trained by SE Alaska scientists to properly gather, label, store, and transport plant and animal specimens and tissues to a certified laboratory for analysis. Test results will be compiled, interpreted and reported to the community and to the U.S. Forest Service so that decisions can be made about where subsistence foods should and should not be gathered in the future. This project will create baseline data in year one - 2026, and then repeat data collection efforts over the remaining four years to measure changes and trends, and to test additional gathering sites. List steps for year 1: - Work with SE Alaska scientists and the community of Angoon to identify what plant and animal tissue will be gathered, and collection locations. - Design data collection protocols and methods - Recruit and hire a field crew of at least three local youth and three local adults - Coordinate with Angoon's Alaska Youth Stewards program coordinator to schedule two, 5-day gathering events in Hawk Inlet - Provide field training on data specimen handling, labeling, storage, and chain of custody - Schedule up to 15 collection events around Angoon - Purchase all needed supplies and materials - Conduct field events and send specimens to selected laboratory for analysis - Work with scientist team to interpret lab results - Schedule one or more community events to share findings from Year One field season. Future year activities will include repeating the data collection efforts to track any changes over time, and identifying new subsistence gathering sites that could be used in the future, and conduct testing at these sites as well.	\$50,000-\$250,000	Single Community	Hoonah-Angoon Census Area	Deferred or Not Advanced

Ankau Billing Services Inc	Rural Healthcare Reimbursement Program	AK	The most persistent financial challenge Rural Clinics, providers and vendors face has been timely reimbursements for services rendered. Many RCM companies operate on a high-volume, low-time model, where only a limited number of labor hours are allowed to each claim. Their practice of offshoring the billing process creates communication barriers and reduces accountability when complex reimbursement issues arise. Close coordination between the billing team and Rural Clinics is necessary. Once RCMs see a diminishing return-claims that require additional follow-up, such as appeals, payer clarification, or documentation corrections receive minimal attention or are abandoned. As a result, claims could remain unresolved or written off prematurely. Rural clinics struggle with medical billing and coding. 1. Shortage of Trained Billing & Coding Staff. 2. High Claim Denial Rates. Denials create cash flow problems. 3. Complex Government Program Billing. Many rural facilities have unique billing rules, cost reporting requirements, and reimbursement models that can be confusing without specialized knowledge. 4. Outdated Technology or EHR Systems increases the likelihood of mistakes and rejected claims. 5. Cash Flow Delays. With small patient volumes, a few denied or delayed claims can impact operations. 6. Limited Compliance Knowledge, Healthcare billing must follow compliance. 7. Lack of Denial Management. Many rural clinics submit claims but don't actively manage denials.	To address billing and coding challenges faced by rural clinics, Ankau Billing proposes launching a pilot revenue cycle support program serving one rural clinic initially. The program will leverage the expertise of our current experienced billing and coding specialist to improve claim accuracy, reduce denials, and stabilize the clinic's cash flow. The program will be led by an experienced billing and coding specialist with extensive knowledge of healthcare reimbursement processes. That person will work directly with the clinic to manage billing operations and ensure accurate medical coding. Responsibilities will include: • Reviewing provider documentation • Assigning accurate codes • Submitting insurance claims • Monitoring claim status and payments This dedicated expertise helps compensate for the clinic's lack of trained in-house billing staff. We will implement a pre-submission review process to ensure claims are complete and accurate before they are sent to insurers. This process will focus on: • Verifying patient eligibility • Confirming documentation supports the coded services • Identifying common coding errors This approach is expected to reduce denial rates and improve first-pass claim acceptance. Because rural clinics often rely heavily on reimbursement from programs such as Medicare and Medicaid, a specialist will ensure that claims meet the specific requirements for these programs. They will also assist with documentation and reporting requirements related to rural healthcare reimbursement models, helping the clinic avoid billing errors and compliance risks. Instead of allowing denied claims to go unresolved, we will implement a denial tracking and follow-up process. This includes: • Identifying reasons for denied claims • Correcting and resubmitting claims • Appealing denied reimbursements when appropriate This process can recover revenue that might otherwise be lost. To reduce compliance risks, we will help ensure billing practices follow healthcare regulations, including the requirements of the Health Insurance Portability and Accountability Act. We will also provide guidance to clinic staff on improving documentation so that medical services are properly supported for billing purposes. This program will allow the team to evaluate the effectiveness of dedicated billing support in a rural clinic environment.	\$250K-\$1M	Other	Anchorage (Municipality); Yakutat (City and Borough)	Deferred or Not Advanced

If successful, the model could later expand to support additional rural clinics using the same structure.



Aprexis, LLC	Aprexis - Medication Management, Optimization & Risk Reduction Program	VT	Adverse drug events are now the third leading cause of death in the US. This includes prescribing errors, prescription drug overdoses, drug-drug interactions, allergic reactions, and adverse drug reactions. RHT presents an opportunity for Alaska Medicaid to address one of the most common—and costly—clinical challenges in routine care: improper medication use. Comprehensive medication management remains underutilized, particularly outside traditional clinical settings. As Alaska experiences accelerating pharmacy closures and consolidation, the downstream effects include a reduction in community access to the professional guidance historically provided at the point of care and distribution. Aprexis is seeing a widening of this gap in care which, in turn, is driving up Pharmacy and overall Medical costs unnecessarily. Medicaid costs in Alaska are predicted to rise by an average of 4.7% per year and over \$7M in new annual pharmacy costs. Medication Optimization reduces overall medical costs significantly. As medication complexity increases, especially among the Medicaid population (who are diagnosed with chronic conditions at a significantly higher per capita rate than the commercial population), the absence of consistent medication oversight elevates preventable risk, avoidable utilization, and total cost of care exposure for the state. Proactive, data-driven, pharmacy care for aging and rural communities is an innovation that will yield ROI and save lives.	Aprexis proposes a statewide, pharmacist-led Medication Optimization & Risk Reduction Program for Alaska Medicaid designed to advance rural health transformation goals. The program will: Target high-impact medication risk. Leverage daily pharmacy claims and advanced clinical algorithms to proactively identify members with hazardous polypharmacy, poor adherence, and unmet therapy needs (gaps in care). Extend primary care through licensed pharmacists and clinicians. Conduct comprehensive medication reviews (CMRs), develop collaborative care plans with prescribers, and deliver personalized patient engagement via telehealth and community-based channels. Strengthen Alaska’s healthcare workforce. Establish structured clinical roles for Alaska-licensed pharmacists, supporting rural economic development, expanding in-state career pathways, and reducing reliance on out-of-state vendors. Provide real-time insight and accountability. Deliver actionable reporting that enables state oversight, performance measurement, demonstrated cost avoidance, and measurable clinical impact. This model is purpose-built to scale statewide, overcoming geographic isolation and ensuring access to pharmacist-led care even in communities where traditional facilities or pharmacies are limited, closing, or geographically inaccessible. As program administrator, Aprexis provides the full infrastructure required to operationalize and sustain the initiative, including: A comprehensive technology platform for member identification, gap-in-care analytics, clinical workflows, provider communication, and robust reporting. Development of a local clinical care network of Alaska-licensed pharmacists and nurses to conduct outreach and consultations with training and career advancement to perform at the top of their license. Centralized billing administration and payment management for all participating providers. The result is a fully-integrated, locally-anchored model that delivers measurable clinical improvement for Medicaid Members, as well as cost containment, and sustainable return on investment for Alaska Medicaid.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Arctic Access Inc	Environmental Modifications, non waiver persons not only a legal obligation, but a human obligation	AK	Environmental modifications for those who are not on waivers and don't have access to basic services allotted to able bodied humans. Physical adaptations to individuals homes are necessary to an individuals health and selves, keeping humans from becoming dependent on the State of Alaska via Assisted Living homes and staying on the homes and villages of their choice. Creating an environment which enables functioning with greater independence. Modifications including but not limited to are widening doors for access, modifications to bathrooms, installations of specialized electrical and plumbing systems that are necessary for an individual who may live alone or with others who are not in the home 24/7, giving full independence to those who choose to live in their own home and not in assisted living facilities, costing a much greater cost not only in daily obligations of funding but the cost to the human and their civil rights.	Environmental modifications will be provided in the least expensive manner possible required by the individual yet providing long term supports needed to stay in the home of ones choice, creating independence and access to both health care and social constructs. Arctic Access visits 33 villages including Nome and Kotzebue. Within our weekly visits and in home evaluations we have determined there is more of a need for people in the rural of Alaska than the over tasked waiver programs can provide. We will work with contractors and legal businesses to provided modifications for those in need. There will be a priority process for those most threatened by placement or by those needing modifications to divert from going to Assisted Living facilities. We are working with providers who have previously made environmental modifications, whose work has been completed satisfactorily in order to ensure adequate construction. Documentation by recommendation of a professional will be required, I.E Assessment Professionals, Occupation therapists, aging in place specialists, accessibility specialists and physical therapists. A recommendation for cost effective options to meet the persons accessibility needs, Assess the project to determine the bid and assess if the bid meets the persons accessibility needs and project requirements. Assessing that the request meets the persons modification needs and makes the persons home sage and accessible, ensure the bid covers the entire cost of need, and includes all items needed to include all items needed to ensure the bid meets the entire need of the human and will complete and ensure the upgrade meets the entire need for the project requested. This will ensure that all projects requested do not need future funding and will be completed and access will be ensured at end of project.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area; Northwest Arctic Borough	Advance to Implementation Application

Arctic Access Inc	Keeping The Norton Sound and Arctic North Communities/Villages Living Healthy and Safe	AK	The problem is the disposal of human waste. The lack of disposal for those not having in home infrastructure, complete waste disposal process preformed and not preformed by communities for those not having running water. During the winter months as well as non winter months the disposal of human waste for many villages is a major problem. No running water and lacking of infrastructure causes waste disposal detrimental to human health, community health and environmental health, both wild and domestic animals. Therefore we are proposing to provide incinerating toilets with solar power and battery backup systems. Power for the incinerator toilets will be subsidized with solar panels and back up batteries that will be used 10 or more months of the year. The only time The incinerators might be used from the power grid will be during the darkest days of winter. The back up batteries will improve usage from the already taxed community power systems, generators and grids, as well as keeping the power bills at a minimum for the home owners. Currently human waste builds up around the communities, both inside the homes and outside the homes. When and if it is collected the paper products are incinerated (if one is available for community) and the human waste is left for the environment to dispose of naturally. This system over time has started to take a toll on the community and its inhabitants.	Arctic Access has lists of consumers who are dealing with lack of running water and infrastructure adequate to deal with human waste. Communities dumping their human waste in the ocean, landscape and airborne is affecting the sea life, hunting and gathering sites, which they then eat. Human waste littering the landscape, filling the landfills and being spread across the landscape by both domestic and wild animals, environmental natural processes and lack of human intervention to solve the problem. Arctic Access has been gathering this information for years trying to find ways to deal with the issues, finding small funding sources to make very minimal impacts. The RHTP funding will give the region an opportunity to make a larger impact on this issue. We will focus on 20 toilets to start use those 20 systems as examples to help convince and show improvement for the home owners and the communities overall. We have been working with a solar panel company, an incinerator toilet company and a back up battery system that will set the home owner up with a complete system that will consist of being mindful of waste, power and health factors. The target communities are on the Nome Road system making the project available to train staff and home owners on use and make sure they are being used properly, as well as system functionality.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area; Northwest Arctic Borough	Deferred or Not Advanced

Arctic Angels, LLC	Arctic Angels Nursing Services - Home Health Skilled Nursing	AK	The Kenai Peninsula Borough (KPB) spans 16,017 square miles and is the fourth largest borough in Alaska, with an estimated population of approximately 60,413 residents. The Borough’s population over age 65 continues to grow, increasing demand for skilled nursing, chronic disease management, and end-of-life support delivered in the home. Older adults, including those dually eligible for Medicare and Medicaid, face higher rates of hospitalization, chronic disease burden, and difficulty accessing coordinated care. Existing home health agencies report limited capacity in outlying communities such as Seward, Cooper Landing, Seldovia, Nikiski, and other rural areas. In addition, direct referrals from patient’s Primary Care Providers may help avoid unnecessary or preventable hospitalizations. Arctic Angels Nursing Services proposes a nurse-led, team-based care model to expand skilled nursing access in the home, improve continuity of care, reduce preventable utilization, and support aging in place across the Kenai Peninsula Borough. In addition, we will plan to partner with local Tribal entities, including the Kenaitze Indian Tribe, to help transform parts of rural healthcare.	Implementation of a technology-enabled transitional and chronic care management model aligned with RHTP initiatives: • Skilled nursing visits within 48 hours of hospital discharge • Medication reconciliation and chronic disease stabilization • Remote patient monitoring (RPM) for high-risk seniors • Individualized nursing care plans shared with primary care providers • Telehealth consult capability • Workforce pipeline partnership with Kenai Peninsula College, additional partnerships with local PCP offices from all areas, and tribal affiliations.	\$250K-\$1M	Home-and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced
Arctic Chiropractic	Bethel Community Musculoskeletal Care Access Initiative	AK	Musculoskeletal pain and injury are among the most common reasons people seek medical care. In rural Alaska, access to timely treatment for these conditions is often limited due to geographic isolation, workforce shortages, and long wait times for specialty care. In the Bethel region and surrounding Yukon-Kuskokwim Delta communities, many residents rely on physically demanding work and subsistence activities such as fishing, hunting, and gathering. When musculoskeletal injuries or chronic pain are not treated early, they can significantly impact mobility, quality of life, and the ability to work or participate in subsistence activities. Expanding access to conservative musculoskeletal care represents an opportunity to improve health outcomes and support the daily functioning of rural Alaskans.	This project would explore ways to strengthen access to musculoskeletal care in Bethel and the surrounding Yukon-Kuskokwim Delta region. Arctic Chiropractic currently provides chiropractic care, therapeutic massage, and rehabilitation support for patients experiencing musculoskeletal conditions. The proposed project may include expanding clinic capacity, strengthening workforce availability, and improving coordination with other healthcare providers in the region. By increasing access to conservative musculoskeletal care, the project aims to help patients receive earlier treatment for pain and injury, improve mobility and function, and reduce the need for more costly or complex medical interventions.	\$50,000-\$250,000	Clinic	Single Community	Bethel Census Area	Deferred or Not Advanced

Arctic Chiropractic and Physical Medicine Ketchikan	Housing and office repairs	AK	We would like to make improvements and repairs to our office and to our employee housing including a leaking ceiling in the office and windows at the employee housing.	We need to hire contractors to make the repairs as noted above.	\$50,000- \$250,000	Clinic	Multi- Community or Participating in Regional Hub-and- Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Deferred or Not Advanced
Arctic Chiropractic and Physical Medicine Kodiak	Building Resilient Communities: Establishing multi- disciplinary physical medicine on Unalaska Island	AK	As a frontier Alaskan location, residents have limited availability to access specialized care in physical medicine. Many residents work in physically-demanding vocations which are more prone to injuries of various types and are often times treated off island at physical rehabilitation facilities in Anchorage after medical procedures. Many times for more minor injuries people return home with no specialized follow up care often leading to more time off work, longer recovery times, and increased financial hardship.	Provide specialty services allowing for faster evaluation and treatment of injuries while also decreasing the need for prolonged rehabilitative stays in Anchorage. Establishing specialized physical medicine care locally will allow all members of the community to have access to treatments allowing many with injuries that did not need to be addressed by clinicians in Anchorage to work while receiving care and avoiding unnecessary financial hardships. We will also be providing continued preventative care for acute and chronic physical medical conditions allowing community members to have a better quality of life and the ability to enjoy the island in which they live and work.	\$50,000- \$250,000	Specialist	Multi- Community or Participating in Regional Hub-and- Spoke	Aleutians West Census Area	Deferred or Not Advanced

Arctic Chiropractic Barrow	Strengthening Rural healthcare by equipping our clinic with enhanced equipment	AK	Rural communities in Alaska face significant barriers to accessing healthcare due to geographic isolation, harsh weather conditions, and limited transportation infrastructure. Many villages are only reachable by small plane or boat, making routine medical visits time-consuming, costly, and sometimes impossible during adverse conditions. These challenges are compounded by a chronic shortage of healthcare professionals, meaning residents often wait weeks or months for appointments with primary care providers or specialists. As a result, many individuals in these communities struggle to manage chronic pain, inflammation, and mobility issues, which can limit their ability to work, care for family members, or participate in daily activities. Without timely intervention, these conditions can worsen over time, leading to decreased independence, higher rates of disability, and increased reliance on emergency care. The lack of accessible treatment options contributes to a cycle of poor health outcomes and diminished quality of life for rural Alaskans.	To address the significant healthcare barriers faced by rural Alaskan communities, this project will combine hands-on treatment with education to improve mobility, reduce chronic pain, and enhance overall wellbeing. We provide regular chiropractic care and massage therapy sessions tailored to residents’ needs, focusing on relieving inflammation, improving joint function, and supporting musculoskeletal health. The funding requested for new equipment will play a critical role in delivering these services safely, efficiently, and effectively. Advanced treatment tables, therapeutic devices, and massage tools will enable providers to administer care at a higher standard, expanding both the range and quality of services available locally. In addition to treatment, we will increase educational opportunities for community members on self-care strategies, healthy lifestyle choices, and techniques to maintain mobility and reduce pain between sessions. By combining treatment and education with state-of-the-art equipment, this approach empowers residents to take a proactive role in their health, mitigates the effects of limited access to traditional healthcare, and fosters stronger, healthier rural communities.	\$50,000- \$250,000	Specialist	Single Community	North Slope Borough	Deferred or Not Advanced

Arctic Chiropractic Dillingham	Strengthening rural healthcare through updated equipment and community health education	AK	Rural communities in Alaska face significant barriers to accessing healthcare due to geographic isolation, harsh weather conditions, and limited transportation infrastructure. Many villages are only reachable by small plane or boat, making routine medical visits time-consuming, costly, and sometimes impossible during adverse conditions. These challenges are compounded by a chronic shortage of healthcare professionals, meaning residents often wait weeks or months for appointments with primary care providers or specialists. As a result, many individuals in these communities struggle to manage chronic pain, inflammation, and mobility issues, which can limit their ability to work, care for family members, or participate in daily activities. Without timely intervention, these conditions can worsen over time, leading to decreased independence, higher rates of disability, and increased reliance on emergency care. The lack of accessible treatment options contributes to a cycle of poor health outcomes and diminished quality of life for rural Alaskans.	To address the significant healthcare barriers faced by rural Alaskan communities, this project will combine hands-on treatment with education to improve mobility, reduce chronic pain, and enhance overall wellbeing. We provide regular chiropractic care and massage therapy sessions tailored to residents’ needs, focusing on relieving inflammation, improving joint function, and supporting musculoskeletal health. The funding requested for new equipment will play a critical role in delivering these services safely, efficiently, and effectively. Advanced treatment tables, therapeutic devices, and massage tools will enable providers to administer care at a higher standard, expanding both the range and quality of services available locally. In addition to treatment, we will increase educational opportunities for community members on self-care strategies, healthy lifestyle choices, and techniques to maintain mobility and reduce pain between sessions. By combining treatment and education with state-of-the-art equipment, this approach empowers residents to take a proactive role in their health, mitigates the effects of limited access to traditional healthcare, and fosters stronger, healthier rural communities.	\$50,000- \$250,000	Specialist	Single Community	Dillingham Census Area	Deferred or Not Advanced

Arctic Chiropractic Haines	Enhancing Rural Healthcare by upgrading equipment and educating the community on healthy living.	AK	Rural communities in Alaska face significant barriers to accessing healthcare due to geographic isolation, harsh weather conditions, and limited transportation infrastructure. Many villages are only reachable by small plane or boat, making routine medical visits time-consuming, costly, and sometimes impossible during adverse conditions. These challenges are compounded by a chronic shortage of healthcare professionals, meaning residents often wait weeks or months for appointments with primary care providers or specialists. As a result, many individuals in these communities struggle to manage chronic pain, inflammation, and mobility issues, which can limit their ability to work, care for family members, or participate in daily activities. Without timely intervention, these conditions can worsen over time, leading to decreased independence, higher rates of disability, and increased reliance on emergency care. The lack of accessible treatment options contributes to a cycle of poor health outcomes and diminished quality of life for rural Alaskans.	To address the significant healthcare barriers faced by rural Alaskan communities, this project will combine hands-on treatment with education to improve mobility, reduce chronic pain, and enhance overall wellbeing. We provide regular chiropractic care and massage therapy sessions tailored to residents’ needs, focusing on relieving inflammation, improving joint function, and supporting musculoskeletal health. The funding requested for new equipment will play a critical role in delivering these services safely, efficiently, and effectively. Advanced treatment tables, therapeutic devices, and massage tools will enable providers to administer care at a higher standard, expanding both the range and quality of services available locally. In addition to treatment, we will increase educational opportunities for community members on self-care strategies, healthy lifestyle choices, and techniques to maintain mobility and reduce pain between sessions. By combining treatment and education with state-of-the-art equipment, this approach empowers residents to take a proactive role in their health, mitigates the effects of limited access to traditional healthcare, and fosters stronger, healthier rural communities.	\$50,000- \$250,000	Specialist	Single Community	Haines Borough	Deferred or Not Advanced

Arctic Chiropractic Homer	Supporting rural healthcare with modernized equipment and increased community health awareness.	AK	Rural communities in Alaska face significant barriers to accessing healthcare due to geographic isolation, harsh weather conditions, and limited transportation infrastructure. Many villages are only reachable by small plane or boat, making routine medical visits time-consuming, costly, and sometimes impossible during adverse conditions. These challenges are compounded by a chronic shortage of healthcare professionals, meaning residents often wait weeks or months for appointments with primary care providers or specialists. As a result, many individuals in these communities struggle to manage chronic pain, inflammation, and mobility issues, which can limit their ability to work, care for family members, or participate in daily activities. Without timely intervention, these conditions can worsen over time, leading to decreased independence, higher rates of disability, and increased reliance on emergency care. The lack of accessible treatment options contributes to a cycle of poor health outcomes and diminished quality of life for rural Alaskans.	To address the significant healthcare barriers faced by rural Alaskan communities, this project will combine hands-on treatment with education to improve mobility, reduce chronic pain, and enhance overall wellbeing. We provide regular chiropractic care and massage therapy sessions tailored to residents’ needs, focusing on relieving inflammation, improving joint function, and supporting musculoskeletal health. The funding requested for new equipment will play a critical role in delivering these services safely, efficiently, and effectively. Advanced treatment tables, therapeutic devices, and massage tools will enable providers to administer care at a higher standard, expanding both the range and quality of services available locally. In addition to treatment, we will increase educational opportunities for community members on self-care strategies, healthy lifestyle choices, and techniques to maintain mobility and reduce pain between sessions. By combining treatment and education with state-of-the-art equipment, this approach empowers residents to take a proactive role in their health, mitigates the effects of limited access to traditional healthcare, and fosters stronger, healthier rural communities.	\$50,000-\$250,000	Specialist	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced
Arctic Chiropractic Juneau LLC	Business infrastructure repair project	AK	Currently we are in need of replacing the roof on one of our facilities. This is a major project we need help with. We are also still making repairs as funds allow to previous damages to one of our buildings from water damage sustained last winter.	We are currently working with local contracting companies to get a bid on the repair costs of the roof. Once that has been attained we would have a better idea of the budget required to move forward. We estimate the cost to range from 30-50K. Repairs from the recent water damage to the clinic are underway and total costs are expected to approach 10K.	\$50,000-\$250,000	Clinic	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Arctic Chiropractic Petersburg	Improving rural healthcare by upgrading medical equipment and educating the community on health.	AK	Rural communities in Alaska face significant barriers to accessing healthcare due to geographic isolation, harsh weather conditions, and limited transportation infrastructure. Many villages are only reachable by small plane or boat, making routine medical visits time-consuming, costly, and sometimes impossible during adverse conditions. These challenges are compounded by a chronic shortage of healthcare professionals, meaning residents often wait weeks or months for appointments with primary care providers or specialists. As a result, many individuals in these communities struggle to manage chronic pain, inflammation, and mobility issues, which can limit their ability to work, care for family members, or participate in daily activities. Without timely intervention, these conditions can worsen over time, leading to decreased independence, higher rates of disability, and increased reliance on emergency care. The lack of accessible treatment options contributes to a cycle of poor health outcomes and diminished quality of life for rural Alaskans.	To address the significant healthcare barriers faced by rural Alaskan communities, this project will combine hands-on treatment with education to improve mobility, reduce chronic pain, and enhance overall wellbeing. We provide regular chiropractic care and massage therapy sessions tailored to residents’ needs, focusing on relieving inflammation, improving joint function, and supporting musculoskeletal health. The funding requested for new equipment will play a critical role in delivering these services safely, efficiently, and effectively. Advanced treatment tables, therapeutic devices, and massage tools will enable providers to administer care at a higher standard, expanding both the range and quality of services available locally. In addition to treatment, we will increase educational opportunities for community members on self-care strategies, healthy lifestyle choices, and techniques to maintain mobility and reduce pain between sessions. By combining treatment and education with state-of-the-art equipment, this approach empowers residents to take a proactive role in their health, mitigates the effects of limited access to traditional healthcare, and fosters stronger, healthier rural communities.	\$50,000- \$250,000	Specialist	Single Community	Petersburg Borough	Deferred or Not Advanced

Arctic Chiropractic Valdez	Advancing rural healthcare with improved clinical tools and healthier living initiatives.	AK	Rural communities in Alaska face significant barriers to accessing healthcare due to geographic isolation, harsh weather conditions, and limited transportation infrastructure. Many villages are only reachable by small plane or boat, making routine medical visits time-consuming, costly, and sometimes impossible during adverse conditions. These challenges are compounded by a chronic shortage of healthcare professionals, meaning residents often wait weeks or months for appointments with primary care providers or specialists. As a result, many individuals in these communities struggle to manage chronic pain, inflammation, and mobility issues, which can limit their ability to work, care for family members, or participate in daily activities. Without timely intervention, these conditions can worsen over time, leading to decreased independence, higher rates of disability, and increased reliance on emergency care. The lack of accessible treatment options contributes to a cycle of poor health outcomes and diminished quality of life for rural Alaskans.	To address the significant healthcare barriers faced by rural Alaskan communities, this project will combine hands-on treatment with education to improve mobility, reduce chronic pain, and enhance overall wellbeing. We provide regular chiropractic care and massage therapy sessions tailored to residents’ needs, focusing on relieving inflammation, improving joint function, and supporting musculoskeletal health. The funding requested for new equipment will play a critical role in delivering these services safely, efficiently, and effectively. Advanced treatment tables, therapeutic devices, and massage tools will enable providers to administer care at a higher standard, expanding both the range and quality of services available locally. In addition to treatment, we will increase educational opportunities for community members on self-care strategies, healthy lifestyle choices, and techniques to maintain mobility and reduce pain between sessions. By combining treatment and education with state-of-the-art equipment, this approach empowers residents to take a proactive role in their health, mitigates the effects of limited access to traditional healthcare, and fosters stronger, healthier rural communities.	\$50,000- \$250,000	Specialist	Single Community	Chugach Census Area	Deferred or Not Advanced

Arctic Chiropractic Wrangell	Strengthening rural healthcare through improved clinical equipment and lifestyle education.	AK	Rural communities in Alaska face significant barriers to accessing healthcare due to geographic isolation, harsh weather conditions, and limited transportation infrastructure. Many villages are only reachable by small plane or boat, making routine medical visits time-consuming, costly, and sometimes impossible during adverse conditions. These challenges are compounded by a chronic shortage of healthcare professionals, meaning residents often wait weeks or months for appointments with primary care providers or specialists. As a result, many individuals in these communities struggle to manage chronic pain, inflammation, and mobility issues, which can limit their ability to work, care for family members, or participate in daily activities. Without timely intervention, these conditions can worsen over time, leading to decreased independence, higher rates of disability, and increased reliance on emergency care. The lack of accessible treatment options contributes to a cycle of poor health outcomes and diminished quality of life for rural Alaskans.	To address the significant healthcare barriers faced by rural Alaskan communities, this project will combine hands-on treatment with education to improve mobility, reduce chronic pain, and enhance overall wellbeing. We provide regular chiropractic care and massage therapy sessions tailored to residents’ needs, focusing on relieving inflammation, improving joint function, and supporting musculoskeletal health. The funding requested for new equipment will play a critical role in delivering these services safely, efficiently, and effectively. Advanced treatment tables, therapeutic devices, and massage tools will enable providers to administer care at a higher standard, expanding both the range and quality of services available locally. In addition to treatment, we will increase educational opportunities for community members on self-care strategies, healthy lifestyle choices, and techniques to maintain mobility and reduce pain between sessions. By combining treatment and education with state-of-the-art equipment, this approach empowers residents to take a proactive role in their health, mitigates the effects of limited access to traditional healthcare, and fosters stronger, healthier rural communities.	\$50,000-\$250,000	Specialist	Single Community	Wrangell (City and Borough)	Deferred or Not Advanced
Arctic Circle Hot Springs Health & Wellness	Creating an Alaskan experience for mental health and recovery at Circle Hot Springs	AK	Alaska has a disproportionately high number of individuals suffering from PTSD and substance abuse disorders. Our project seeks to create a treatment and recovery center at Circle Hot Springs.	We intend to improve the current facilities there, build new ones, and staff said facility with healthcare professionals.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced

Arctic Encounter	Arctic Encounter: Rural Health Solutions Convening & Policy Acceleration Initiative	AK	Rural Alaska faces a persistent and compounding crisis in health care access, workforce sustainability, and system coordination. Geographic isolation, infrastructure gaps, workforce shortages, and fragmented policy frameworks leave communities without adequate care — and leave the professionals who serve them without the peer networks, technical resources, or policy leverage to drive change at scale. Despite the urgency, the mechanisms for structured, cross-sector dialogue on rural health solutions remain underdeveloped. Critical stakeholders — tribal health directors, rural providers, state and federal health officials, community leaders, and innovators — rarely occupy the same room with enough time, structure, and follow-through to move from conversation to commitment. Arctic Encounter exists to close that gap. As North America's largest Arctic policy convening organization, we have spent over a decade mastering the art of bringing the right people to the table around the North's most complex challenges. The Rural Health Transformation Program represents a timely opportunity to focus that infrastructure directly on rural Alaska's health system — convening experts, moderating high-stakes professional debates, facilitating intensive working sessions, and producing impact reports that translate dialogue into durable, implementable policy and partnership outcomes.	Arctic Encounter proposes a targeted convening and facilitation program in direct support of RHTP goals. Our approach has three integrated components. First, we will convene dedicated rural health intensives — structured, invitation-only working sessions that bring together rural health professionals, tribal health entities, state and federal health officials, technology innovators, and community stakeholders to tackle defined problem sets within RHTP's six initiative areas. These are not passive conferences; they are professionally moderated, outcome-oriented sessions designed to produce specific deliverables. Second, we will facilitate cross-sector network building — connecting rural providers with peer organizations, subject matter experts, funding partners, and implementation resources they cannot easily access from remote communities. Third, we will produce and disseminate impact reports that synthesize session outcomes into clear policy recommendations, implementation frameworks, and decision-support tools for state and federal health leadership. Arctic Encounter's platform is uniquely suited to this work: we have established trust with Indigenous leaders, federal agencies, state government, academic institutions, the private sector, and international partners operating across the circumpolar North. We operate as a neutral convener with the credibility to bring competing interests into productive alignment — and the discipline to move from dialogue to documented outcomes within compressed timelines.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Nome Census Area; North Slope Borough; Northwest Arctic Borough	Deferred or Not Advanced

Arctic Slope Community Foundation	Payanaigsaigvik, A Place to Build Support for Motherhood	AK	The Payanaigsaigvik project addresses the critical need to improve maternal and child health care access, quality, and sustainability in the eight remote communities of Alaska's North Slope. These communities face significant barriers, including geographic isolation, limited local health services, and the emotional and financial strain of requiring pregnant women to leave their villages for care. This initiative leverages a regional approach to build local capacity and provide culturally connected, family-centered support for new and expecting parents. The project will use the Circle of Security training, an evidence-based intervention that helps new parents build secure, nurturing relationships with their children. By embedding trained facilitators within the communities, the program ensures long-term sustainability and cultural relevance. Additionally, the initiative will expand access to essential prenatal services, such as local sonograms, and provide culturally aligned support for new and expecting mothers. Through partnerships with medical service providers, the project will ensure seamless care and continuity before and after childbirth, empowering families to prepare for the best day of their lives. This initiative not only addresses immediate health care gaps but also builds a foundation for sustainable, community-led maternal and child health care, ensuring that families in the North Slope have access to high-quality, culturally appropriate care close to home.	The Circles of Security, Mothers Helping Mothers program aims to create a culturally responsive, community-based support network for new and expecting mothers across Alaska’s North Slope. The Arctic Slope Community Foundation (ASCF) will recruit and train 15 local facilitators in the Circle of Security Parenting (COSP) curriculum, maternal nutrition, and sonogram operation. These facilitators will be trained in culturally grounded practices to ensure services align with the traditions and values of North Slope communities. Training will be conducted in Anchorage in collaboration with regional health providers, including the Samuel Simmonds Memorial Hospital (ASNA), Maniilaq Association, and Chief Isaac Andrew Health Center. Once certified, facilitators will return to the eight North Slope villages to provide direct support to participants. In the first year, 24 new mothers will be enrolled, with an additional 24 participants added annually in subsequent years. Services will include localized care, regular sonograms, resource navigation, appointment scheduling, and travel coordination to address the challenges of geographic isolation. The program will provide comprehensive maternal and child health services from pregnancy through the first two years of the child’s life, ensuring continuity of care during this critical developmental period. ASCF will work with partners and analyze HIPPA-compliant data to monitor program performance and improve outcomes. This approach ensures that mothers in remote Alaskan communities receive culturally attuned, continuous support while building local capacity and fostering long-term family well-being. Program Highlights: Facilitator Recruitment: 15 facilitators trained in COSP, nutrition, and sonogram operation. Training Location: Centralized in Anchorage with regional health partners. Deployment: Facilitators return to eight North Slope villages. Participant Enrollment: 24 mothers in Year 1, and 24 annually thereafter. Support Services: Localized care, Circle of Security classes, sonograms, resource navigation, family visits, and travel support. Service Duration: Pregnancy through the child’s first two years. Data Collection: Ongoing tracking of performance and family well-being. This program builds a sustainable, culturally aligned maternal health network to improve outcomes for mothers and children across the North Slope of Alaska.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Advance to Implementation Application

Arctic Slope Native Association	Center for Supporting Healthy Families Project	AK	Because a patient’s earliest life events and experiences have the greatest impact on their long-term health and overall wellbeing Arctic Slope Native Association (ASNA) will make a strategic investment in improving service delivery and coordination for children and their parents. ASNA has the opportunity to expand health and social services to families with children, as well as to young people that may become parents in the near future. By repurposing underutilized space at the ASNA West Campus, we have an opportunity to develop a dedicated service center for teaching proactive positive health strategies, parenting classes, early childhood nutrition, and providing other health care and social services supports that are not readily available at the main hospital campus. This center will also serve as a springboard for future delivery of these services into the surrounding communities of Atkasuk, Kaktovik, Nuiqsut, Point Lay, and Wainwright.	We will develop a master planning document to comprehensively update the West Campus facility and create appropriate spaces for delivering health care education, parenting classes, and other foundational training for helping children and families live healthy lifestyles. Using the campus master planning document we will remodel space at the West Campus to provide additional training and supervised parenting space, offices for social services workers and case managers to serve patients from Utqiagvik and the surrounding villages, and appropriate storage for resources. As space becomes available, we will collaborate with our community partners to identify families with the greatest need for services and begin a targeted outreach campaign. The campaign will encourage them to utilize the space as “VIP guests” and take advantage of the classes and trainings available. Each family will be connected case managers that can address their specific needs and make referrals to the necessary medical or social services provider. The ultimate objective is to connect a symptom or a problem in the child’s life to an underlying health issue and treat the health issue rather than just addressing the immediate symptom (i.e. lack of attention in school may be due to poor vision/inability to see the course material rather than a “bad attitude”). Parents will be trained and equipped with appropriate education to recognize common childhood medical needs and current information for accessing resources that can help their child. ASNA staff will be available at the center to deliver services and assist parents in identifying and accessing additional community resources to help them and their children. This approach will create a single, integrated point of contact for parents and families that are seeking services from ASNA. It will also reduce the risk of families “falling through the cracks” when making referrals or connecting people with resources. We are requesting \$1,000,000 in financial support to complete the space planning, including architectural and engineering support, and complete the remodeling of the space. The project will be completed in phases, with the master planning completed by September 2026 and the remodeling efforts completed by June 2027. We will order all of the materials and have all of the funds encumbered by September 30, 2026 and will fully liquidate the encumbrances within the performance period.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Advance to Implementation Application

Arctic Slope Native Association	Pre-maternal Care Project	AK	On the Arctic Slope, as with many rural location, lack of access to on-going pre-maternal care is a significant issue. Studies indicate that babies born in the rural communities are more likely to be pre-mature and suffer from numerous health problems. Many mothers do not have adequate pre-maternal care. One of the causes is the amount of travel that is required when the mothers are in communities which are only connected to the hub communities by daily small aircraft flights. Instead of a few hours spent for a pre-maternal visit, the mothers in these communities must spend two days traveling to and from their pre-maternal appointments. Approximately 40% of the mothers in rural communities are advised to give birth in Anchorage, at least partly due to lack of pre-natal care increasing their chances of being high risk pregnancies. This has led individuals in these communities to believe that this is their only and best option. This increases the cost on the patient, the community, and the state via Medicaid funded travel. Specialty care in the villages is limited to rotating providers and frequently the appointment slots are full. Pre-natal visits, nutrition counseling and pre-maternal care are lacking due to the rural and remote nature of our communities.	ASNA will double the number of village clinic trips by our OBGYN, Women’s Health, Diabetes Educators and other specialty providers and expanding the days and hours of the clinics, to include weekends, to allow expectant and new mothers to see their providers on a more routine basis. In addition, should these visits not be possible, trips to the hub community could be paid for to encourage the on-going relationship with their providers. In addition to nurses and OBYN providers, we would schedule regular community visits by nutrition staff and others so we can offer wrap around services to all mothers, including those simply planning to become mothers. This will also help us provide additional training to the Community Health Aides so that even when our providers are not present, the community has someone to answer questions and provide referrals. Addressing the lack of pre-natal care in the outlying and remote communities in our region begins with nurses and providers developing relationships with the mothers in their communities. Offering pre-natal visits in their community and having nurses performing home visits has been shown to increase compliance with pre-natal care plans and the comfort of the mothers in giving birth closer to home. Encouraging routine and regular contact between the nurses, OBGYN providers and others on the care team will enable the patients to increase their trust in their team, provide them with the pre-maternal and post-partum care they need and encourage them to give birth closer to home. All these efforts will lead to better outcomes for both the mothers and babies.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Advance to Implementation Application
Arctic Slope Native Association	Pre-maternal Equipment and Training	AK	Pre-maternal and post-partum care in the region suffers from several disconnects in the way services are provided. Mothers in the outlying villages often do not receive adequate pre-maternal care despite the efforts of our providers to be in the outlying communities. The lack of ultra-sound equipment and other equipment in the community clinics often requires that expectant mother travel to Utqiagvik to be seen by their providers. As the pregnancy progresses, these trips away from their family and support systems become more and more difficult. The CHAPS in the villages are unable to provide the required services as both the equipment in the community and the required training for the CHAPS is inadequate.	ASNA, in partnership with the North Slope Borough Health and Social Services Department, is proposing a multi-phase approach to addressing this issue. The first step would be the purchase of ultrasound equipment for each of the 5 village clinics in the North Slope. The ultra-sound equipment would be purchased, certified, and maintained by ASNA. The second step which could occur concurrently would be the training of the NSB CHAPs to work with the SSMH medical providers on helping conduct ultrasound exams and providing follow up care. Patients who need Samuel Simmonds Memorial Hospital (SSMH) services will have travel cost for village to Barrow paid for.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Advance to Implementation Application

Arctic Slope Native Association	Surgical Suite Renovation	AK	As noted in a 2025 Study by University Alaska Anchorage, “Rural women with more high-risk pregnancies may be directed to travel to cities or hub communities to give birth. ”This project, the surgical suite renovation at Samuel Simmonds Memorial Hospital, will provide the option for higher risk pregnant parents to remain closer to home by providing them with the necessary supports and options should complication arise during their pregnancy up to and including c-section deliveries in an advanced medical suite. The lack of the ability to perform even routine surgeries on patients means that patients requiring even procedures that would be considered routine, such as a simple tonsillectomy, orthopedic interventions, or even placement of tubes in their ears, need to be transported to Anchorage for these very routine surgical interventions. SSMH is designated as a Level IV trauma center and is equipped to stabilize and transfer patients with severe injuries or critical illness to tertiary care facilities in Anchorage or Fairbanks. Depending upon aircraft availability, this can require 4 to 6 hours of standby and travel time before a patient can have surgery. In poor weather conditions, medevac operations may be suspended, which jeopardizes the health and life of the patient. This time constraint places pressure on patients and providers to make quick care decisions and lowers quality of care.	ASNA will renovate existing conference room and office space into two fully equipped medical suites capable of addressing the needs of high risk pregnant mothers while they remain in our region as well as trauma patients. The surgical suite will also allow us to provide care to other patients including orthopedics, cardiac, and other trauma and emergency situations without having to transport the mother, child, or patient to Anchorage, increasing access to services avoids aggravating injuries. In a emergency care situation, a hand injury to a young child, the delay in care to the patient resulted in a much longer recovery time and a much worse outcome. This projects timeline is very aggressive with 35% design completed in March of 2026 and construction beginning in Fall of 2026, Completion is currently scheduled in the Summer of 2027.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Advance to Implementati on Application

Arctic Slope Native Association	Virtual Intensive Care Unit Project	AK	Samuel Simmonds Memorial Hospital (SSMH) does not have the infrastructure needed to provide intensive care (ICU) level services for patients. This limitation requires medically fragile or unstable patients to be transferred to Anchorage facilities, which can delay their care. This limitation also prevents delivery of specialty care services such as dialysis or oncology where a patient may have an adverse reaction and need immediate access to ICU care. We will partner with the larger hospitals (Alaska Native Tribal Health Consortium, Providence, and/or Alaska Regional) to develop a virtual intensive care unit. Three existing inpatient rooms can be retrofitted with telehealth equipment and appropriate monitoring devices to allow intensive care providers at the urban hospitals to monitor patients in real time at SSMH. The doctors and nurses at SSMH will collaborate with the ICU staff at the partner hospitals to respond to any patient needs and deliver care on site. Patients that recover can be moved to the regular inpatient facilities at SSMH. If higher levels of care are needed, the patients can be safely held and monitored in the virtual ICU while waiting for transfer. We are requesting \$500,000 in financial support to purchase and install the equipment and \$100,000 in financial support for training the clinical, facilities, and IT teams on implementing and maintaining the new virtual ICU. The equipment will be ordered immediately with a target for installation in June 2026. Training will be implemented concurrently, with a goal of starting virtual ICU operations in September 2026. Full accreditation and commissioning of the virtual ICU will be completed within 12 months of the equipment installation.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Advance to Implementation Application

Arctic Slope Native Association	Community AODA Health Assessment/planning	AK	The North Slope Borough is a rural and remote region of Alaska roughly the size of the state of Wyoming. In our region, Alcohol & Other Drug Abuse (AODA) is a serious issue with 42% of households reporting being impacted by alcohol or drug use. The North Slope Borough operates an Integrated Behavioral Health program which offers outpatient treatment and recovery services for AODA issues, however inpatient treatment is only available at facilities that are out of Alaska. Lack of a stable, alcohol and drug free living environment can be a serious obstacle to sustained abstinence, especially when the environment is the only environment choice available due to the chronic lack of housing in the region. Additionally, there is no available detox environment in the region. Currently individuals who are in need of this service are medically cleared at the Emergency Room at Samuel Simmonds Memorial Hospital before being transported to the North Slope Borough Police Department jail facility to complete their detox. The North Slope Borough operates an Integrated Behavioral Health program which offers outpatient treatment and recovery services for AODA issues, however inpatient treatment is only available at facilities that are out of Alaska. Lack of alternative housing, due to the overall lack of housing in the region, often requires that the individual who has achieved sobriety in an inpatient facility be returned to the same home and environment that contributed to their AODA issue.	The Arctic Slope Native Association, in partnership with the North Slope Borough's Health and Social Services Department, will complete a study for the feasibility of building and operating a sober living environment and potentially a detox arrangement. This study would assist in determining if such environments are feasible in the area and if they would be able to be sustained with future funding under this program. Sober living environments have been studied and found beneficial by the National Institute of Health and been found to be beneficial in maintaining sobriety, especially for individuals who are newly sober. Though these environments are often funded by the individuals who reside in them, that is likely not an option in the North Slope Borough due to the high cost and general lack of housing. It is hoped that such an assessment will assist the region in determining what solutions might be available and what a self-sustaining model would require. This information would not only assist our region but potentially provide a model for the other regions of the state to increase the effectiveness of existing AODA treatment. Detox services in urban areas of Alaska are typically handled in medically supervised environment such as the Anchorage Recovery Center. These services are simply not available in rural areas of the state. There are many barriers that must be overcome in providing these types of services including the volume of patients, the physical location, accreditation, and cost. A study of these issue will help fully identify what the barriers are, what additional services might be offered and how to overcome any barriers in the system. This project will also be shared with the NSB Police Department and the Alaska Court System to see how to best mitigate the impacts to the corrections system. Access to this resource will also support therapeutic courts and their services. This project is estimated at \$500,000 for a planning and feasibility study as well as architectural concepts and renderings.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Advance to Planning

Arctic Slope Native Association	ADA Accessibility Needs for West Campus Project	AK	Frequently patients that need to travel for a higher level of care have specialized or complex medical needs (i.e. cancer treatment, orthopedic surgeries, etc.) and need a lot of support to successfully travel. The best outcomes happen when these patients are able to meet in person with travel staff, review their appointment schedules, and carefully plan their trips. Due to the growth in medical services at Samuel Simmonds Memorial Hospital, patient travel services have relocated to new workspace at the West Campus. The work area has been updated to create a modern, comfortable area for patients and staff, but due to the age of the building there are very few accessible entrances for patients. This creates a negative feedback loop where patients that have the greatest complexity and need the most staff support to successfully travel may be the least able to access ASNA resources to help them. Because of the specialized nature of the needed medical care, appointments at Anchorage and Fairbanks facilities can be hard to get and any travel mishap that leads to a broken appointment has a very high cost. This does not account for the potential for the underlying medical condition to deteriorate because of the delay in rearranging the new appointment and the associated increase in medical costs. Arctic Slope Native Association (ASNA) proposes to directly address this obstacle by creating a new ADA accessible entrance to help patients access services.	ASNA carpenters will work with a qualified building contractor to create a new wheelchair access ramp with appropriate lighting and safety features to remove barriers for patients with mobility challenges. Separate from the interior improvements, ASNA electricians will install additional exterior lighting and an intercom system to allow patients to safely access services from the parking lot if patients prefer not to come in the building. We are requesting \$200,000 in financial support to remodel the building entrance and make it easier for patients to access the space. The project has a narrow scope and can be fully completed by September 30, 2026.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Arctic Slope Native Association	Community Medical Provider Housing for RHCTP	AK	Due to isolation and other obstacles rural Alaska has significant challenges to recruit and retain qualified staff. The North Slope has had a housing shortage since the 1980s, with the growth in families vastly exceeding the rate of new housing construction. A community survey conducted by TNHA in 2015 indicated a shortage of 400 housing units and the deficit has expanded since that time. The Housing Authority has an existing inventory of apartments and rental homes across the North Slope, but due to funding constraints, has been unable to invest in the upkeep and modernization of these units. The ASNA as well as the North Slope Borough Health Department are very reliant on TNHA for housing key personnel: approximately 80 units are occupied by North Slope Borough Health Department staff, medevac/EMS personnel, community health aides, and other essential medical and support staff. The current housing shortage creates pressure on all of the stakeholders in the region and it can turn into a self-reinforcing “downward spiral”: lack of housing funds limits TNHA’s ability to complete maintenance and upkeep, lack of maintenance creates higher facility operating costs, and poor housing quality increases ASNA and North Slope Borough Health Department staff turn-over and program staffing costs. Staffing instability makes it harder to complete other health care quality improvement initiatives and increases the burnout levels of the remaining staff.	ASNA will partner with TNHA to create a comprehensive plan to address deferred maintenance needs, energy efficiency improvements, and an interior upgrade (floor/wall coverings, ventilation and lighting upgrades, etc.) to create 25 updated and attractive units for use by health care staff. We are requesting \$1,500,000 in financial support to conduct the planning project and fund the modernization of the rental units. TNHA will perform the modernization work and prioritize healthcare workers for future occupancy of the updated units. Depending upon the community healthcare needs, units could be occupied by North Slope Borough Health Department employees (community health aides, behavioral health counselors, etc.) or ASNA medical staff. The planning work can be completed and all funds fully obligated by September 30, 2026. The modernization work is expected to take place in phases with the project taking 16-24 months to complete.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Arctic Slope Native Association	Healthcare Provider Retention Project	AK	Hospital labor costs are the single highest expense category at our facility. Each provider is difficult to recruit, must be relocated to the community, and is a highly valued resource for the organization. Isolation, darkness, extreme weather conditions, and the regular stresses of healthcare delivery create frequent provider burnout and increase staff turnover at the hospital. Each time this happens the hospital goes through a costly cycle of recruiting, orienting, and training replacement staff and the patient continuity of care is interrupted, which makes positive clinical outcomes harder to achieve. Departing staff share concerns around lack of recreational activities, inability to go outside during winter months, and a lack of opportunities to socialize or interact outside of the clinical environment. Because the hospital is in a very small community, there is a high likelihood that using the high school gym or city basketball court will involve interactions with patients or their family members. In these settings, staff are frequently interrupted during their off time with questions about medications, medical concerns, etc. This makes it very difficult for staff to fully relax and disconnect from the stresses of hospital operations. Similar barriers exist if staff go out to eat in local restaurants or attend community events. The community perceives them as “always on duty” and there is no place available for them to completely disengage from their work.	We will remodel and update two existing spaces (Main Campus & West Campus) to create a modern, attractive, and inviting work out area for staff to utilize when not on their work shifts. All of the equipment and amenities will be fully compliant with hospital infection control and safety standards. We will also create three dedicated spaces in the staff quarters where staff can exercise on weekends, holidays, and other non-work periods. The Facilities maintenance team will take responsibility for maintaining the equipment, oversee cleaning, and overall operations of the exercise spaces which will ensure that the space is available 24 hours a day without creating any additional burdens on staff for upkeep. These areas will be secured and exclusively used by staff, so people can exercise and socialize in a comfortable environment. We are requesting \$600,000 in financial support to purchase and install exercise equipment and upgrade the existing space (lighting, paint, floor coverings, etc.) to create five employee exercise areas for staff use. A portion of these funds will also be used to purchase spare parts and training resources for the Facilities maintenance team, so all of the equipment can be serviced in house. The project will be completed in phases, with two areas completed by September 2026 and three areas completed March 2027. We will order all of the materials and have all of the funds encumbered by September 30, 2026 and will fully liquidate the encumbrances within the performance period.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Arctic Slope Native Association	Sim-Lab equipment refresh	AK	This project is seeking to improve and refresh the simulation lab that ASNA utilized during the training of “home grown” nurses who are participating the APU Associate in Nursing program. A cohort of that program is based at our facilities. The sim lab also is utilized to provide training to the nursing staff at SSMH reducing the amount of time our nursing staff need to spend traveling to urban communities to receive the training they require. The sim lab was originally equipped in 2020 and has been very successful, however, the equipment has a limited lifespan and requires replacement. The equipment is of an age that the simulations can no longer be shared with the APU campus or other training programs as it is no longer supported. Students who can not use the same equipment as that found in other state of the art facilities may be less equipped and less able to fulfill the requirements of the program.	ASMA will develop a replacement plan will Ilisagvik College and APU to upgrade the entire lab. Refreshing the technology in the simulation lab will encourage students to remain in our communities and thereby develop our nursing workforce. The refresh will allow ASNA and APU to continue to provide state of the art training opportunities in our community which will in turn encourage more individuals to remain in the community once they graduate. This project is expected to coms \$1,000,000 including the purchase of new equipment, set-up, and instructor training.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Arctic Slope Native Association	Surgical Suite Equipment	AK	As noted in a 2025 Study by University Alaska Anchorage, “Rural women with more high-risk pregnancies may be directed to travel to cities or hub communities to give birth.” This creates hardships for the patient, distances them from family supports, and creates increases the overall cost of care. We propose adding surgical equipment as part of an integrated surgical suite renovation project at Samuel Simmonds Memorial Hospital to support higher risk deliveries closer to home. This project leverages the earlier Labor and Delivery Procedure room expansion and the growth in prematernal services by creating the capability for emergency surgeries at the hospital. The hospital is currently designated as a Level IV trauma center and is primarily equipped to stabilize and transfer patients in need of higher levels of care to Anchorage or Fairbanks. Depending upon emergency aircraft availability, this can require 4 to 6 hours of standby and travel time before a patient can have surgery. In poor weather conditions, medevac operations may be suspended, which jeopardizes the health and life of the patient. The surgical equipment we propose to utilize for supporting complex deliveries can also be deployed for handling emergency surgeries and trauma response for all SSMH patients. Having the capability immediately available reduces the potential for crisis level events and reduces the pressure on medical providers to make immediate treatment decisions.	ASNA will renovate existing conference room and office space into two fully equipped medical suites capable of addressing the needs of high-risk pregnant mothers while they remain in our region as well as trauma patients. The RHCTP would invest \$1,000,000 to purchasing the equipment for the Surgical Suite including but not limited to headwalls, medical gas connections, anesthesia equipment, lighting, gurneys, sterilization equipment, and surgical equipment. The project construction costs will be funded separately. The hospital has already completed upgrades to the medical gas and oxygen generation systems to support adding services. Current hospital staff include OB/GYN, Cardiology, and other specialty doctors with surgery qualifications. The hospital currently employees support staff including anesthesiologists, CRNAs, surgical nurses, and sterile processing technicians. The staff would complete the credentialing process to add surgery privileges and then begin providing care in the newly renovated space. Because the scope is limited, we expect to rapidly address the need. The 35% design will be completed by the end of March 2026 and with construction beginning in Fall of 2026. The project is expected to be completed, fully commissioned, and placed in service by September 30, 2027. All RHCTP funds will be fully obligated by September 30, 2026 and fully spent within the performance period.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Arctic Slope Native Association	Technology Refresh at SSMH	AK	Medical Care, especially in rural areas, continues to move towards technological solutions to address the vast distances involved. This technology including telehealth and wearable technology, to be effective, needs to have a knowledgeable and trained provider at it’s end point to analyze the information and provide effective care as the devices themselves only provide the metrics or information. Providers that direct the actual care need to have access to the information and metrics in an equal or/in some cases more detailed manner requiring equally advanced equipment. In rural Alaska, where hub and spoke health care is prevalent, the need for the hub of that care to have the advanced technology to support the spokes is critical as is the ability to deal with the issues at the local or regional hubs instead of having all the information flow to state or out of state sources which makes them more difficult to access. New standards of care including providing CT scans for head injuries, Cardiac CT scans for diagnostics, halter monitors for cardiac health monitoring, tele neurology for stroke response, and AI enabled interpretations of MRI requiring substantially more capacity than when the hospital was built. Each solution implemented at SSMH requires more advanced technology and connectivity and have strained our IT infrastructure impacting our ability to fully implement these solutions.	ASNA proposes a technological refresh hospital infrastructure to support new service delivery . This would begin with the development of a Technology plan that allows for the exponential growth in the need for IT infrastructure with an estimate of \$100,000 The plan combined with an existing electrical engineering study would will give the facility the necessary electrical capacity to support the upgrades. This is estimated at \$250,000 The implementation of communication upgrades and upgrades to the routing, and switching hardware is estimated at \$650,000 The long term goal is the implementation of a “rack of the future” which we are currently studying and piloting that will allow for the replacement of physical servers with virtualized environments and cloud based systems with local backups for essential systems. These upgrades will allow us to fully adopt CT scans for head injuries, Cardiac CT scans for diagnostics, halter monitors for cardiac health monitoring, tele neurology for stroke response, and AI enabled interpretations of MRI in a more comprehensive manner with faster results and better patient outcomes.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Arctic Slope Native Association	Trauma Bay Equipment	AK	This year, Samuel Simmonds Memorial Hospital (SSMH) has utilized trauma services 98 times, with 18 individuals requiring medi-vac services for additional care and two fatalities. We expect the demand for services to increase as the community grows and more vehicles, subsistence activities and travel occur. We have the staffing in place to operate the expanded space and expect it will be financially self-sufficient and not require ongoing financial support from the State. Depending upon the nature of the trauma cases this project may create cost savings by reducing some of the demand for medevac services and potential charges to Medicaid. In urban areas, there is seldom a concern that the space needed to provide care is available when there is an emergency or trauma. In rural settings such as ours, the design of the spaces was often done based on statistical analysis with little regard to how life is lived in our region. In this case, one trauma bay that has been divided into two extremely small trauma bays was designed into the facility disregarding that in rural areas, there is higher occurrence of multi-occupant car accidents, that ATV accidents are also seldom single occupant occurrences and that a single boating accident could result in multiple traumas at a time. Due to the design of the current space, two traumas occurring at the same time results in very cramped conditions where equipment must be moved around to accommodate the treatment of trauma patients.	This project will purchase the medical equipment needed to complete the trauma bay that will be constructed and completed in 2027. The new trauma bay is a remodel of underutilized space to perform trauma care. The morgue space at SSMH has been moved to west campus and the space is ready for the mechanical and construction work that will begin this year and which is being funded from other sources. The equipment for the space including the headwall, lighting, trauma, and other equipment for the space is not part of the existing package. The addition of a third larger trauma bay will address the deficiencies in the current two trauma bay set up at SSMH. The space, the former morgue, has been identified as the space that will be renovated into the new trauma space. The equipment for this space would include the headwall (medical gas connections, monitoring equipment, and lighting), Trauma lighting, gurneys, specialized monitoring equipment, and trauma equipment such as trauma carts. This project will result in the completion of a third trauma bay at SSMH, providing additional trauma capacity and an increased ability to deliver emergency medical care.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Arctic Slope Native Association	Village Medical Provider Housing - Nuiqsut Demonstration Project	AK	Due to isolation, extreme weather conditions, limited amenities, and other obstacles rural Alaska has significant challenges to recruit and retain qualified staff. The North Slope has had a housing shortage since the 1980s, with the growth in families vastly exceeding the rate of new housing construction. A community survey conducted by Tagiugmiullu Nunamiullu Housing Authority (TNHA) in 2015 indicated a shortage of 400 housing units and the deficit has expanded since that time. Lack of quality housing for families is the number one factor that recruiting efforts fail or staff choose to leave employment. ASNA has been very successful in attracting specialty doctors to care for patients on the North Slope, but the lack of quality housing contributes to high turnover. It is very difficult to persuade a cardiologist or other highly trained medical professional to sleep on the floor in the village clinics. In the village of Nuiqsut, Kuukpik Corporation has developed a “house in a box” concept, where the entire building package can be purchased and delivered to Nuiqsut at a relatively low cost. The North Slope Borough also has limited cash subsidies to reduce the freight costs associated with shipping materials for home building. Each resource is valuable, but there is no coordinated effort to mobilize all the resources to address the community need.	ASNA will work with a professional planning firm to identify the community stakeholders and develop a master planning document to capture all of the resources and requirements for building provider housing in the village of Nuiqsut. Using the master planning document, ASNA will partner with Kuukpik Corporation to build a demonstration house. The building will be used as housing for medical providers working in Nuiqsut and serve as a template for future projects in different communities. Arctic Slope Native Association (ASNA) proposes to directly address this problem by creating a coordinated community plan for all of the Nuiqsut stakeholders to pool resources and construct a housing unit as a demonstration project. The success of the demonstration project is intended to serve as a catalyst for future adoption in surrounding communities. We are requesting \$700,000 in financial support to complete the planning project, purchase the materials for the demonstration phase, and pay for the initial leasing and operating costs for the demonstration project. Kuukpik is expected to own the property and the finished home and provide ASNA a long-term lease for occupancy by medical providers. RHCTP funding would be utilized for materials purchases, furnishing the house, setting up utility services, and providing lease payments for the initial term. The actual construction costs would be funded separately from RHCTP. Depending upon the community healthcare needs, ASNA would sublease the new unit to a provider or the North Slope Borough Health Department would sublease the new unit to a community health aide as part of their employment agreement. This structure limits reserves the use of the unit for health care workers and their family members, while still allowing for Kuukpik to handle the maintenance needs. The planning work can be completed and all funds fully obligated by September 30, 2026. The demonstration unit can be fully assembled and placed in service by September 30, 2027.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

ArcticEdge Innovations LLC	Project RuralConnect: Resilient IT Infrastructure for Frontier Health	AK	Rural Alaska health clinics face a "tech gap": intermittent connectivity, aging hardware, and a total lack of dedicated on-site IT personnel. Cybersecurity threats are also rising, targeting smaller facilities that lack enterprise-grade protection. Without a professional managed services partner, these clinics operate on "break-fix" cycles that lead to costly downtime and data vulnerabilities.	We will implement a centralized "Managed IT Ecosystem" for rural healthcare partners. This includes: 1) Proactive 24/7 network monitoring to prevent outages; 2) Deployment of hardened, HIPAA-compliant hardware; 3) Secure cloud-backups for patient data; and 4) A "Human-in-the-Loop" help desk designed for rural staff. We are specifically targeting a partnership with the Eastern Aleutian Tribes to stabilize their multi-site clinic networks.	\$250K-\$1M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

Arete Family Care, LLC	Direct Primary Care Program Refinement and Community Outreach Initiative	AK	Direct Primary Care removes the insurance intermediary from routine primary care, enabling physicians to offer comprehensive services at dramatically lower cost. For a predictable monthly membership fee, DPC patients typically receive: • Unlimited office visits with no copays or per-visit charges. • Same-day or next-day appointments with their personal physician. • Extended visit times allowing thorough, relationship-based care. • Direct phone, text, and telehealth access to their provider. • Significantly discounted labs, imaging, and medications through direct vendor agreements. Research consistently demonstrates that DPC reduces emergency department utilization, improves management of chronic conditions, increases patient satisfaction, and lowers total healthcare costs. For uninsured and underinsured populations, DPC paired with a low-cost catastrophic insurance plan provides comprehensive coverage at a fraction of the cost of traditional insurance. Arete Family Care currently operates a DPC model and has demonstrated the viability of this approach in Alaska. This grant will strengthen that foundation and dramatically expand its reach to the Alaskans who need it most.	Funds will support a systematic review and improvement of Arete Family Care’s existing DPC program across the following areas: • Membership structure and pricing: Review and optimize membership tiers to ensure affordability for uninsured and underinsured Alaskans, including a reduced-rate options for low-income patients. • Service scope expansion: Assess and expand the range of services included in DPC membership, potentially adding chronic disease management protocols, preventive care bundles, behavioral health coordination, and telehealth services. • Operational workflows: Streamline scheduling, patient communication, care coordination, and documentation workflows to improve efficiency, reduce administrative burden, and maximize time available for patient care. • Technology infrastructure: Evaluate and upgrade patient-facing technology including the patient portal, telehealth platform, and direct messaging systems to improve accessibility and engagement. • Care gap identification: Implement systems to proactively identify and address care gaps among existing DPC members, particularly those with chronic conditions. • Policy and procedure documentation: Develop or update comprehensive policies and procedures to support program scalability and consistency as membership grows. Component 2: Community Outreach & Marketing Campaign A well-designed, accessible DPC program is only impactful if the people who need it most know it exists. Grant funds will support a targeted, multi-channel outreach and marketing campaign focused on reaching uninsured and underinsured Alaskans statewide. Campaign activities will include: • Digital marketing: Website refresh, search engine optimization (SEO), social media campaigns (Facebook, Instagram, community groups), and targeted digital advertising reaching working-age adults in Alaska. • Community outreach: Presentations and informational sessions at community centers, libraries, Alaska Native organizations, workforce development programs, and small business associations. • Employer outreach: Direct engagement with small and mid-size Alaska employers to promote DPC as a low-cost employee health benefit alternative to traditional group insurance. • Printed materials: Patient-friendly brochures, flyers, and FAQ sheets explaining DPC in plain language — distributed through community partners, clinics, pharmacies, and community health aides. • Earned media: Press outreach to Alaska media to build public awareness of the DPC model	\$50,000-\$250,000	Family or primary care	Statewide	Anchorage (Municipality)	Advance to Implementation Application

Arete Family Care, LLC	Point-of-Care Ultrasound & PACS System Acquisition	AK	Without on-site ultrasound, Arete Family Care faces the following documented challenges: • Delayed diagnosis: Patients with time-sensitive conditions such as suspected DVT, appendicitis, or ovarian pathology must wait for external appointments rather than receiving same-visit evaluation. • Referral attrition: A meaningful proportion of patients referred for external imaging do not complete the study due to transportation barriers, cost, or scheduling difficulties, resulting in unresolved clinical questions. • Fragmented care: Results from external facilities arrive through separate systems, creating documentation gaps and communication delays between imaging and treating providers. • Patient burden: Patients bear additional costs and time demands associated with traveling to separate facilities, which is particularly burdensome in Alaska's climate and geography.	Arete Family Care proposes to acquire two integrated systems: (1) a high-quality diagnostic ultrasound unit capable of performing the full range of point-of-care imaging studies needed in a primary care setting, and (2) a cloud-based or on-premise Picture Archiving and Communication System (PACS) to store, manage, retrieve, and share all diagnostic images generated at our clinic. Together, these systems will create a complete on-site imaging infrastructure — from image capture through long-term archival and provider access. Key ultrasound equipment specifications will include: • Multi-frequency transducer array supporting linear, curvilinear, and phased array imaging modes. • High-resolution digital imaging with DICOM compatibility for PACS and EHR integration. • Doppler capability for vascular assessment including color flow and spectral analysis. • Portable or cart-based design suitable for use across clinic exam rooms. • Vendor-provided training, warranty, and technical support. Key PACS specifications will include: • DICOM-compliant image storage with support for ultrasound and future imaging modalities. • Secure, HIPAA-compliant storage with role-based provider access from clinic workstations. • Integration with our electronic health record (EHR) system for seamless image linking to patient records. • Remote viewing capability to support telehealth consultations and specialist image sharing. • Scalable storage architecture to accommodate growing image volume over time.	\$50,000-\$250,000	Family or primary care	Single Community	Anchorage (Municipality)	Advance to Implementation Application

Arete Family Care, LLC	Portable Digital Radiography Acquisition for Point-of-Care Diagnostic Imaging at Arete Family Care	AK	Despite being Alaska's largest city, Anchorage faces significant gaps in healthcare access. Many residents — including low-income families, uninsured and underinsured individuals, elderly patients, and those without reliable transportation — face substantial barriers to obtaining timely diagnostic services. When primary care providers must refer patients elsewhere for basic imaging, a meaningful percentage never complete those referrals, leaving conditions undiagnosed and untreated. Arete Family Care currently serves a diverse patient population in Anchorage, providing comprehensive primary and family care services. However, the clinic lacks on-site radiological imaging capability. This gap creates the following problems: • Patients with suspected fractures, pulmonary conditions, or other imaging-indicated presentations must be sent to external facilities, adding days or weeks to the diagnostic timeline. • Referral fragmentation increases the likelihood of lost follow-up and patient non-compliance, particularly among vulnerable populations. • Clinical staff must make treatment decisions with incomplete information or wait for outside imaging reports, reducing care quality. • External imaging referrals increase overall healthcare costs for patients and payers, including Medicaid and Medicare.	Arete Family Care proposes to acquire one portable digital radiography (DR) system, including a wireless flat-panel detector, mobile X-ray generator, and integrated imaging software compatible with the clinic's existing electronic health record (EHR) and picture archiving system (PACS). The unit will be housed within the clinic and operated by trained clinical staff under the supervision of a licensed provider. Once operational, the portable X-ray system will enable Arete Family Care to provide: • Musculoskeletal imaging (fractures, joint assessments, injury follow-up) • Chest X-rays (pneumonia, TB screening, COPD monitoring, cardiac assessment) • Abdominal imaging (obstruction, foreign body, acute abdomen evaluation) • Pediatric imaging for common conditions managed in a family care setting • Occupational health imaging for workers' compensation and DOT physicals	\$50,000-\$250,000	Family or primary care	Single Community	Anchorage (Municipality)	Advance to Implementation Application

Arete Family Care, LLC	Adult Weight Management Program with Body Composition & Bone Density Screening	AK	Obesity is among the most significant and costly public health challenges facing Alaska today, contributing to diabetes, cardiovascular disease, joint disease, and diminished quality of life. Yet access to structured, medically supervised weight management programs remains limited — particularly outside major urban centers. By combining clinical-grade body composition measurement with a comprehensive weight loss program, Arete Family Care will deliver a level of care rarely available in community-based settings, with outcomes that are measurable, meaningful, and sustainable.	The AFC Adult Weight Management Program will be a structured, medically supervised program for adults with obesity, delivered at our clinic with telehealth support for patients unable to attend in person. The program will integrate body composition scanning, individualized medical assessment, evidence-based nutrition and behavioral counseling, and exercise guidance into a cohesive, clinician-led experience. The program will be grounded in evidence-based frameworks including the American Academy of Obesity Medicine (AAOM) guidelines, the Obesity Medicine Association clinical protocols, and applicable CDC chronic disease prevention models. Equipment: Body Composition & Bone Density Scanner Grant funds will support the acquisition of a clinical-grade body composition and bone density scanner — most likely a DEXA (Dual-Energy X-ray Absorptiometry) system. Key specifications will include: • Full-body and regional body composition analysis: fat mass, lean mass, visceral adipose tissue, and fat percentage by region. • Bone mineral density assessment: lumbar spine, hip, and whole-body measurements with fracture risk scoring. • DICOM compatibility for EHR integration and image archiving. • Automated reporting with normative comparisons for patient-friendly result interpretation. • Vendor-provided training, warranty, and technical support. Program Components The weight management program will include the following core components: • Initial comprehensive assessment: Medical history, physical exam, laboratory workup, and baseline body composition and bone density scan. • Individualized treatment plan: Clinician-developed plan incorporating nutrition goals, physical activity recommendations, behavioral strategies, and medication management where appropriate. • Structured group and individual sessions: Weekly or biweekly sessions covering nutrition education, behavioral change techniques, physical activity, stress management, and long-term maintenance strategies. • Telehealth follow-up: Virtual check-ins between in-person visits for accountability, symptom monitoring, and plan adjustments. • Progress scanning: Repeat body composition scans at regular intervals (e.g., 3, 6, and 12 months) to objectively track fat loss, muscle preservation, and bone health changes. • Behavioral health integration: Referral pathways or embedded counseling support for participants with emotional eating, depression, or anxiety contributing to weight challenges.	\$250K-\$1M	Family or primary care	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Arete Family Care, LLC	Statewide Nutritional and Diabetes Education Program — Program Development Grant	AK	To develop a complete, evidence-based, launch-ready Statewide Nutritional and Diabetes Education Program that is accredited, reimbursable, and sustainable — delivering accessible education to all Alaskans through multiple modalities upon grant completion. Measurable Development Objectives • Complete full curriculum development across all content areas within 12 months of award. • Develop and produce printed educational materials suitable for statewide distribution within 12 months of award. • Establish functioning telehealth and video conferencing infrastructure within 6 months of award. • Hire or contract a credentialed diabetes educator (CDE) and/or registered dietitian (RD) within 90 days of award. • Complete a pilot cohort of participants across all five delivery modalities by Month 12. • Submit applications for DSMES accreditation and CDC DPP recognition by Month 12. • Achieve a pilot participant satisfaction score of 80% or higher to validate program readiness for full launch.	The program will reach participants through five complementary delivery channels: • In-person classes: Structured group education sessions held at Arete Family Care and partner community locations, covering nutrition fundamentals, blood sugar management, medication adherence, physical activity, and self-monitoring skills. • Teleconference sessions: Audio-based group education for participants in remote communities without reliable video access, enabling real-time interaction with educators without requiring travel. • Video conferencing: Live interactive group and individual sessions via secure video platform, supporting visual demonstrations, Q&A, and small-group learning for participants statewide. • Telehealth consultations: One-on-one virtual appointments with Arete Family Care clinicians and diabetes educators for individualized assessment, goal setting, and follow-up support. • Printed educational materials: Plain-language, culturally informed materials covering nutrition, diabetes self-management, healthy cooking, label reading, and local food resources — mailed to participants and distributed through community partners. Core curriculum topics will include: • Understanding diabetes: types, causes, risk factors, and progression. • Nutrition fundamentals: macronutrients, portion control, carbohydrate awareness, and meal planning. • Healthy eating in Alaska: incorporating traditional and subsistence foods, reading nutrition labels, and navigating food access in rural communities. • Blood glucose monitoring: interpretation, targets, and self-management strategies. • Physical activity: safe exercise recommendations tailored to varying ability levels and Alaska seasons. • Medication management: understanding prescriptions, adherence strategies, and recognizing side effects. • Preventing complications: foot care, eye health, kidney protection, and cardiovascular risk reduction. • Mental health and diabetes: stress management, motivational support, and preventing burnout.	\$50,000-\$250,000	Family or primary care	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

AscendRural	De-Risking Tech Solutions for Alaska’s Spark Tech & Infrastructure Initiative via AscendRural	MN	Rural, remote, and frontier communities in Alaska face persistent barriers to accessing high-quality health care, including geographic isolation, workforce shortages, limited broadband infrastructure, and high travel and service delivery costs. Providers, community-based organizations, and public agencies often lack the technical capacity to evaluate and implement emerging technologies. The Spark Technology and Infrastructure Initiative presents an opportunity to invest in telehealth expansion, consumer-facing digital tools, interoperable platforms, analytics, and value-based care infrastructure. However, without structured support, these investments can carry significant financial and operational risk. AscendRural bridges the gap between Spark Technology and Infrastructure Initiative investments and sustainable implementation. Through structured technology sourcing and selection, pilot scoping and planning, hands-on facilitation, and rigorous outcome evaluation, AscendRural systematically de-risks adoption. Solutions are aligned with local infrastructure, workforce capacity, reimbursement pathways, and community context to ensure feasibility and long-term viability. By validating effectiveness before scaling, AscendRural strengthens sustainability and ensures the Spark Technology and Infrastructure Initiative investments translate into resilient and sustainable opportunities across rural Alaska.	Our approach is to ensure investments under the Spark Technology and Infrastructure Initiative translate into sustainable, effective implementation across rural, remote, and frontier Alaska. AscendRural systematically de-risks technology adoption for health providers, community-based organizations, and public agencies through structured evaluation, pilot implementation, and measurable validation. Rather than introducing stand-alone tools, we apply a proven methodology to source and select credible, scalable solutions aligned with Alaska’s infrastructure realities, workforce capacity, reimbursement environment, and community context. We begin with technology sourcing and selection support, helping partners assess readiness, evaluate vendors, and identify solutions—such as telehealth platforms, interoperable systems, and digital tools—that are financially and operationally sustainable. Structured pilot scoping and planning follow, defining clear objectives, participant criteria, engagement strategies, timelines, and measurable success indicators aligned with Spark Technology and Infrastructure Initiative priorities and rural health transformation goals. AscendRural provides hands-on pilot facilitation, coordinating logistics, maintaining consistent communication, and ensuring strong stakeholder alignment. Community onboarding, paired with locally grounded curriculum and tools, prepares partners to integrate technology directly into clinical workflows and operational processes—strengthening care coordination, data exchange, and value-based care readiness. To support scaling and long-term sustainability, we conduct rigorous quantitative and qualitative evaluation of pilot outcomes, including utilization, cost implications, provider experience, and patient impact. Findings are synthesized into actionable reports to inform future Spark Technology and Infrastructure Initiative investments. By validating effectiveness before broader deployment, AscendRural reduces financial and operational risk while building a replicable model for resilient, technology-enabled health systems across rural Alaska.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Assets Inc.	I/DD Remote Monitoring Feasibility Study	AK	Assets Inc is a 501(c)(3) community-based agency with a 45-year history of consistently improving employment opportunities, home environments, and community connections for its target population of individuals with intellectual and developmental disabilities (I/DD), mental illness, or a dual diagnosis of both conditions. These individuals require substantial support to live independently, especially in rural Alaska. I/DD individuals often lack the freedom to choose where they live with service options limited to urban congregate facilities. However, the federal government’s investment in Alaska’s rural broadband offers an opportunity to optimize telehealth for remote, in-home monitoring and support for rural consumers, thereby increasing their independence, outcomes, quality of life, and reducing the cost of care. Assets, Inc., requests RHTP funding to conduct a feasibility study to determine if remote monitoring of I/DD consumers in rural communities could provide cost-effective services that do not rely on institutional care and keep Alaskans in their homes. The study would analyze connectivity with rural communities and calculate the cost of equipment, technology, staffing, and training against potential savings. Assets, Inc., is well qualified by experience and expertise to develop a study that defines the needs of rural consumers; evaluates connectivity; ensures data security; and identifies vendors who offer the most sophisticated devices and competitive pricing.	Assets’ feasibility study for remote support of I/DD Alaskans residing in distant communities would include an assessment of rural connectivity, staff capacity, and equipment that is user-friendly for the target population. Regulatory compliance would be assessed to ensure that implementation is safe, effective, and HIPAA-compliant. A successful study would determine if technology can reduce caregiver turnover and improve independence without compromising safety. Assets’ study would be structured to determine rural consumer needs; availability of high-speed internet; and data collection for specific outcomes. Assessing connectivity would require selection of a pilot project location to ensure consistent cellular or Wi-Fi connectivity in each home to be served. Consumer-facing technology would be evaluated to ensure ease of use with non-intrusive sensors, wearables, or environmental monitors (e.g., door sensors, motion sensors). The study would also review 24/7 response plans to ensure the best fit for rural areas of Alaska. During the study, staff would visit the selected rural area to conduct interviews with potential users to measure comfort, trust, and perceived invasion of privacy, as well as digital literacy and potential training requirements. The eligibility of prospective users would be assessed to determine if Medicaid waivers or other reimbursement sources cover remote support. DSPs (Direct Support Professionals) would be interviewed to determine if they are open to adopting new technology. At the end of the feasibility study, Assets would apply for funding to conduct a 3-month pilot project followed by full implementation during the second project year.	\$50,000-\$250,000	Single Community	Anchorage (Municipality)	Advance to Planning

Association for Professional s in Infection Control and Epidemiolog y - Midnight Sun Chapter	Training To Increase Certification of Healthcare Environmental Services Staff throughout Alaska	AK	The Midnight Sun Chapter of The Association for Professionals in Infection Control and Epidemiology (APIC) wants to establish and sustain a training program for Environmental Services (EVS, previously called Housekeeping) and Infection Prevention (IP) workers throughout the state of Alaska. EVS is often described as an entry-level job and seen as low-skill, however EVS workers are crucial to the success of any healthcare system’s Infection Prevention program as they are the staff cleaning rooms, disinfecting surfaces, and handling laundry and biohazardous waste. Any degree of failure while performing the tasks required of an EVS job increases infection risk to staff, patients, and visitors, which can impact the health of entire communities. The day-to-day work of an EVS employee requires integrity, specificity, and technical knowledge. This project would address the lack of subject matter experts (SMEs) on EVS knowledge in Alaska, and the certification that comes with it will increase job satisfaction and fulfillment for staff in a field that often has low satisfaction and high turnover. The training will reflect current evidence-based best practices for cleaning and disinfecting the environment of care and standardize training for EVS technicians across Alaska. Our proposed project will increase job satisfaction and employee retention and will demonstrate the value of EVS workers in health care settings by improving patient outcomes.	Our chapter will use RHTP funding to initially contract with the Association for the Health Care Environment (AHE) so their team can travel to Alaska and host an initial train-the trainer program, called Certified Health Care Environmental Services Technician Train-the-Trainer Program (T-CHEST). This initial event will train 15 Environmental Services (EVS) or Infection Prevention (IP) workers in Alaska to become trainers in the Certified Health Care Environmental Services Technician (CHEST) program, and will build the foundation for a sustainable training program in our state. Following the initial training event, the program can snowball and the initial group of T-CHEST trainers can disperse to their communities throughout AK and train others. The training can be blended into our pre-existing Alaska Infection Prevention conference, held annually in Anchorage and supported by the Alaska Department of Health and the Alaska Hospital and Healthcare Association (AHHA). The structure of a learning conference is already in place and scheduled for October 2026, and usually brings around 50 Infection Preventionists from around Alaska to one location for training. Adding EVS workers to the conference will allow them to participate in this T-CHEST program and will expand the scope of our conference in a positive manner.	Under \$50,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Association of Alaska School Boards	Busy Hands, Big Conversations: A Collaborative Approach to Health and Nutrition	AK	In recent decades, many students have become disconnected from the subsistence activities and traditional activities that once provided both physical exertion and stress regulation. This shift has led to: Sedentary Lifestyles: A move away from functional, land-based movement toward more stationary routines. Nutritional Insecurity: Increased reliance on expensive, processed imported foods rather than nutrient-dense traditional diets. Erosion of Agency: A school system that often operates independently of family expertise, overlooking the historical role of parents and Elders as the primary architects of a child’s wellbeing. This project presents a unique opportunity for restorative planning. By hosting Busy Hands, Big Conversations, AASB will facilitate a partnership where schools and families co-design a wellness framework. This is not only about adding more gym time; it is about: Aligning school PE, health curriculum, afterschool programs, and science with the community’s seasonal subsistence cycle, Restoring the traditional decision-making authority of families in determining what health looks like for their children and Using local activities (from sled building to fish processing) as high-quality, sustainable PE and nutrition interventions that carry intergenerational significance.	Our approach restores the traditional role of families as health architects through a structured, community conversation and planning process. With oversight from the Alaska Family Engagement Center's Family Advisory Board, convened by AASB, this project will meet state requirements and incorporate a community approach to planning. 1. We begin by identifying and developing bright spot examples of existing Alaskan programs where subsistence, movement, and traditional values are already successfully integrated into the school day. To ensure these models can be replicated. 2. We will train school staff, students, and family members as Co-Hosts using our "Big Conversations, Busy Hands" training sessions. This is a train, collaborate, maintain model. Where family members, advisory school board members, and school staff will get host-trained and then co-host with AASB staff or experienced conversation hosts. "Big Conversations, Busy Hands" sessions are low-stress, culturally safe spaces where the community can provide genuine input on values, nutrition and movement. 3. Once trained, these teams will host 3-5 local conversations to inform district health and nutrition planning. By centering these dialogues around busy hands activities like traditional crafts or food processing we lower barriers to participation and ensure the resulting health plans are rooted in local reality. 4.AASB will act as the bridge between family input and systemic change with their school and district leadership, creating platforms to represent family input. 5. Whenever possible, Tribal Health entities will be invited to be involved and at the very least family input will be shared with Tribal Health entities to align school wellness with broader community health goals. 6. Policy Reform: AASB will analyze and adjust policy recommendations, including supporting food program waivers that allow for the inclusion of traditional, locally harvested foods in school meals. There are several examples in the state. We will also work with school boards and administrators to formalize Family-School Health Teams within existing or emerging family decision-making bodies. 7. Finally, we will identify ways to adapt key curricula or identify opportunities that support these expanded definitions of health education that can be through the Alaska Family Engagement Center training, website, and resources.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Association of Alaska School Boards	Project UpLift Alaska: School-Based Youth Mental Health Prevention and Early Intervention	AK	Alaska has one of the highest suicide rates in the U.S., with approximately 28.1 to 28.2 deaths per 100,000 people as of 2023, nearly double the national average of 14.7. The rate is particularly high among Alaska Native populations, in rural areas, and among teens, with the highest teen suicide rate in the nation. For four consecutive years, student participants of AASB’s annual Youth Leadership Institute have strongly raised the need for more support for youth mental health. Specifically, they have requested more training, supports, and skill-building for the caring adults in their life, especially the adults they interact with every day at their school. Alaskan youth are also reporting that schools, rather than serving as positive, supportive environments, have become stressors that negatively impact their mental well-being and sense of connectedness. This recurring feedback highlights an opportunity for intervention that can have lasting impacts on generations of Alaskans. AASB will develop and test a replicable, scalable model to serve as a proof of concept of school-based training to support youth mental health. Through partnership with at least 3 school districts including the remote districts of North Slope and Lower Yukon and rural Southeast district Annette Island (Metlakatla), AASB can compile the lessons learned and develop tools and support all school districts in Alaska to address youth mental health needs with limited resources.	Our youth have issued a clear call to action: they do not just need more clinicians; they need the caring adults already present in their lives to be better equipped. This project serves to create systems of support, school environments of care and connection, and youth empowerment and skills for mental health. Key activities: Training for school staff and after school providers (“caring adults”): This training equips non-clinical school-based staff to create "Healing-Centered Environments." It prioritizes the development of high-quality student-teacher relationships, which research identifies as a core protective factor against adverse long-term health outcomes. The training is built on a curriculum currently being used with school staff in a randomized control trial, “Project Transform.” Ongoing support and coaching for school staff and after school providers: Monthly virtual coaching sessions and at least 1 in-person site visit per school year. Coaching is designed to build long-term educator practice changes. Mental Health and Leadership Training for Youth: AASB will pilot a meaningful two-day intensive workshop at each site for students utilizing AASB’s youth institute’s tools and an adapted curriculum based on lessons learned and best practices from Project Transform. AASB has successfully integrated highly engaging tools and strategies over two decades of hosting youth institutes. Project UpLift will blend these engagement strategies with a youth companion training of Project Transform and test this model in new settings. Peer Educator and Student-Led Safety Projects: Students will plan and carry out school safety projects that support mental health. A smaller cohort of students will be supported to inform curriculum adaptation, school climate building tools to improve mental health habits, and referral processes within each school. Family Wellness Circles: These sessions will create continuity between the home and school. Using Project Transform’s new family-facing workshops, we will build meaningful conversations, shared language and tools for stress management and emotional regulation that can be used at home and school. Early Intervention and Referral Structures: Work with each participating school site to identify and establish written mental health intervention and referral protocols that align with the resources available in each region. Evaluation: A program evaluation will identify replicable best practices to inform scale up.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Prince of Wales-Hyder Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Association of Alaska School Boards	Strong Start: A Strong Start to Kindergarten and Beyond	AK	Supporting children through the early years requires a team approach. Strong Start supports schools, families, and other service providers to make sure that each child is ready to be fully present, engaged, and ready to learn. Because the school is often the most consistent and well-resourced institution in remote Alaska, it presents a unique opportunity to serve as a gateway for holistic wellness. The project captures this opportunity by:creating a warm-hand off and moving away form one-day orientation to a year-long relationship building process between families, key school staff, and service providers. AASB has piloted this work in a few sites, within a Full Service Community School grant, and has built a range of tools, events, opportunities, discussion prompts, and protocols to support this early support structure. This would allow an opportunity to expand the reach and impact of a Strong Start Kinder program. Strong Start relies on universal kinder transition strategies, early intervention and wrap around supports. Using the kindergarten window, families and schools can coordinate several key behavioral/social emotional, health, academic, and basic need support. This can include a medical point of contact, basic needs support to address housing or food security, and academic and social emotional team support.	Strong Start is the foundation for building relationships between schools and families. Stong Start Families are invited to initial transition family and student events, families get one on one time with key staff, school staff serve as a liaison between the school, student needs, and community/tribal/or tele-health or local services. All transition grade staff (enter and exiting elementary school) participate in trauma informed training, and Strong Start training that builds on the efforts of nationally recognized programs such as City Connects and Building Assets and Reducing Risks. Over the course of this pilot, partners will help to develop forms, data systems, relationship-building practices, coordination tools, and referral protocols. A Strong Start Coordinator, who is focused solely on this early childhood transition, serves as a support to transitioning students. They work closely with the teachers and other school personnel to serve the whole student and family. Each school will have a Strong Start Coordinator, A Strong Start or Comprehensive Multi-tiered Systems of Support Team (school and community team), and Strong Start activities that works with a cohort of students and families. Phase I: Asset Mapping: Before the first student walks in, the Strong Start Coordinator maps community assets, from tribal elders and local clinics to the nearest reliable internet hub.Customized Training: Staff undergo training that blends the BARR (Building Assets, Reducing Risks) model, City Connects model, with local rural realities and statewide support. Phase II: The Warm Welcome this can include a range of fun family transition activities and personalized supports with some examples developed through a Full Service Community Schools grant. This also includes Individual Family Meetings: Instead of a generic orientation, one-on-one meetings are held in locations comfortable for families (the school, a community center, or via mobile-friendly video). Phase III: The Multidisciplinary huddle: The Strong Start Team (Teachers, Coordinator, Community Partners) meets bi-monthly to review the cohort, referral forms, and data. They don't just look at grades; they look at food security, behavioral issues, attendance and emotional well-being. The Coordinator acts as a Single Point of Contact. If a student needs tele-health or tribal services, the Coordinator handles the logistics so the family doesn't have to navigate a complex bureaucracy alone.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Ketchikan Gateway Borough; North Slope Borough; Sitka (City and Borough)	Deferred or Not Advanced

Association of Alaska School Boards	Transforming Schools A Health-Centered Approach to School Safety	AK	The Problem: Fragmented Safety in Rural Alaska Currently, school safety in rural Alaska is in silos. Physical security audits, behavioral health, and trauma-informed initiatives operate independently, creating a check-the-box culture that fails to address the root causes of risk. In many remote communities, safety is viewed through a lens of "hardening" (locks and cameras), which does little to mitigate the impact of the high rates of Adverse Childhood Experiences (ACEs) , establish strong emotional regulation, or reduce the bullying, absenteeism, and long-term health disparities. This fragmentation means that at-risk students, particularly those with internalizing behaviors, often fall through the cracks until a crisis occurs. The crisis becomes evident when we look at Alaska's high rates of suicide, substance misuse, intimate partner violence, chronic disease, and unmet mental health needs. Many of these health issues are preventable within a comprehensive approach to safety and well-being in the schools. AASB's proposed Transforming Schools model bridges the gap between trauma-informed approaches, healthy habits, strong connections, early interventions and physical security. This project addresses the social determinants of health directly within the educational landscape, turning fragmented protocols into a unified, culturally responsive system that improves attendance, staff retention, connection, referrals and student well-being across rural Alaska.	Using a three-year cohort structure, Alaskan schools will integrate a comprehensive safety and well-being framework. This project addresses risk at the root through four strategic pillars. Pillar 1: Expanding the Relational Foundation: Building on the success of the trauma-informed tools and resources developed in Alaska we can help schools to Incorporate a) Neuro-sequential classroom: Staff training in Tier 1 approaches to regulation includes breathing, movement, sensory corners, cultural practices into the classroom and the school day. This lowers cortisol for students. b) Attachment-Based Instruction: Prioritizing student-staff bonds to foster emotional co-regulation and mitigate external stressors. Pillar 2: Establish multidisciplinary Behavioral Assessment and Management (BAM) teams using an "Observe, Connect, Refer" Framework a) Holistic Review: Administrators, counselors, and tribal liaisons review student data through a non-punitive lens. b) Behavioral Decoding: Teams shift from "threat" to decoding withdrawal, bullying or grade drops as early health signals for trauma or suicidality. c) Referral Pathways: Formalizing "warm hand-offs" to health providers before crises escalate. Pillar 3: Climate & Student-Led Prevention Data Utilization: Analyze peer climate and risk data with districts. Peer-Led Initiatives: Empower students to define and lead culturally grounded safety projects. Pillar 4: Systemic Integration & Policy a) Codification: Provide AASB recommended board policies to institutionalize exclusion reduction and long-term policy alignment. b) Resource Development: Develop self-guided learning and data-tracking tools that can be shared through existing and new channels within the state, districts and by AASB. c) Capacity Building: School staff, board members and out-of-school providers to ensure local expertise survives staff turnover. Year One Activities: 1) The Assessment Matrix: Develop an Integrated Assessment Matrix mapping safety , well-being and climate data 2) Finalize the Observe, Connect, Refer Playbook; draft policies, and audit templates. 3) Expert Input: Host design sprints at statewide summits (MTSS, AASB's); and input circles (students through the Youth Institute and youth leadership events to define safe and healthy schools). 4) Core Team Training: Pilot intensive coaching, focusing on BAM transitions in 4 schools. Refine and finalize training and coaching protocols with statewide trainers.	\$250K-\$1M	Statewide	Aleutians East Borough; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Association of Village Council Presidents (AVCP)	Elluarrluteng Ilakutellriit Healthy Families	AK	Elluarrluteng Ilakutellriit works because its regional origins make it understandable to our residents. Families referred to the program often get so much out of the workshops that they voluntarily attend again, wanting to continue to do better by their children. But we need capacity to report data meaningfully to partners and funders. Year 1 RHTP funding can help AVCP accomplish two immediate needs: (1) funding what other federal funding does not, allowing us to implement the full model while we work toward a long-term sustainability plan; and (2) plan for building data collection capacity, which will help us better track and communicate outcomes that measurably demonstrate the model’s success. We have built a crucial model for improving health outcomes for the children and families of our region. The 48 communities served by AVCP are predominantly Alaska Native/American Indian (AN/AI), the population with the highest rate of child maltreatment. In 2023 in Alaska, more than half of victims were AN/AI, making them vastly overrepresented (Child Maltreatment 2023, US DHHS). Compounding the problem, prevention and early intervention resources are scarce and especially difficult to access in rural Alaska. Statewide, only half of child victims in Alaska received post-response services, a situation that Elluarrluteng Ilakutellriit works directly to improve. These efforts will have a ripple effect across physical and behavioral health outcomes and social indicators of health.	Per the CDC, prevention of ACEs could also reduce other health risk factors, including smoking by 33%, heavy drinking by 24%, dropout by 5%, and unemployment by 15% (https://www.cdc.gov/vitalsigns/aces). Health conditions impacted by prevention of ACEs range widely, from reduction in depression (by as much as 78% for adults) and suicide attempts (up to 89% for youth) to heart disease up to 22% and misuse of prescription pain medication up to 84% (https://www.cdc.gov/aces). Families and children fare better if they retain a connection to their culture, community, and identity. Removing families from their home communities, even to access services, is harmful, and Tribal families have been particularly subject to this kind of trauma. All families deserve to be able to access services where they live. We also cannot overstate the importance of Elder involvement, key to our workshops; they are the bearers of traditional Yup’ik knowledge. Time with Elders guarantees absorption of traditional teachings, which improves outcomes for families. Elluarrluteng Ilakutellriit acknowledges and incorporates all of these truths, providing a framework for improving family and child well-being and health outcomes. In Year 1, AVCP will: • conduct five Elluarrluteng Ilakutellriit workshops: one per month, except in July when subsistence activities are at the peak, for at-risk families and assess the results using existing workshop evaluation tools. • hire a project manager for this next technology and data capacity phase rather than use existing staff, which we did for Phase 1 and has proven to spread staff thin with their other ongoing duties. The project manager will assess the new system, identify gaps needed for Elluarrluteng Ilakutellriit, and develop solutions that improve capacity to collect, track, and share data. This will allow us to better measure outcomes and also allow Elluarrluteng Ilakutellriit to better collaborate and share data with Tribal Child Welfare and the Alaska Office of Children’s Services to improve targeted services and outcomes for children and families. AVCP is requesting funding for the components of this project that are not federally funded. For instance, a key aspect of the Elluarrluteng Ilakutellriit model are Qasgiqs, gatherings with Elders and AVCP staff to offer ongoing guidance in the adaptation of the model for prevention work with at-risk families; these are currently federally funded and are not part of the RHTP budget request.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area	Advance to Implementation Application

AstraDx	Alaska Against Sepsis: Saving Lives with the AstraDx Atawa Rapid Diagnostics System	MA	The problem we address is sepsis: specifically, the sepsis-related morbidity and mortality that can be prevented through rapid diagnosis and antibiotic testing (“antimicrobial susceptibility testing” AST). Sepsis is the second-leading cause of hospitalization in Alaska behind childbirth and the leading cause of hospital death nationwide. Sepsis is directly responsible for an estimated 200-300 deaths in the state each year. Sepsis is also an economic problem for Alaskans, costing \$150-250 million annually. The median charge per hospitalization in Alaska is \$49,000—substantially higher than the nationwide average of \$29,000 due to remoteness and transport costs. Neonatal cases are proportionally more expensive. The main obstacle is the time it takes to diagnose the patient, identify the pathogen, and determine the appropriate antibiotics. Together, these take days, even with state-of-the-art diagnostic equipment at well financed, fully staffed medical centers. Our technology reduces this to hours—the first in the industry to provide all three of detection, ID, and AST so rapidly—via a compact benchtop instrument, the AstraDx Atawa, that is affordable and simple to operate. Consequently, the opportunity is to place Atawas in every clinic and medical center in the state, including those of the Alaska Native Tribal Health Consortium and the Alaskan Native Medical Center. This would largely eliminate the wait for sepsis diagnosis, enabling appropriate treatment as soon as possible.	We will progress the AstraDx Atawa system from its current technology-readiness level to a field-validated, deployable diagnostic instrument in three phases that fit the RHTP timeline. In Phase 1: Initial Production, we will produce a limited run of instruments and establish regulatory readiness with an ISO 13485-compliant quality system and a draft FDA 510(k) package. Deliverables will be updated drawings, a bill of materials, a production-test report showing ≥95% repeatability, detection limit, ≤8 hour assay time (with positive results sooner), and the regulatory documents. In Phase 2: Multi-Site Clinical Evaluation, we will conduct a prospective, multi-site clinical evaluation at rural Alaska clinics—including ones associated with the Alaska Native Tribal Health Consortium (ANTHC)—as well as the Alaska Native Medical Center (ANMC; a leading tertiary care center) comparing Atawa results to reference methods for sepsis diagnosis (blood culture, ID, AST) to demonstrate agreement and a reduction in time to appropriate therapy. We will submit the approved protocol, IRB approvals, an interim safety report, a final validation report meeting the statistical endpoints, and an updated 510(k) filing. Phase 3: Rollout, will roll out Atawa to priority clinics and hospitals in two waves, providing hardware, SOPs, a train-the-trainer curriculum, warranty, remote technical support and EHR integration. Acceptance will be documented with a test report for each site, and the Contractor will deliver a sustainability plan covering consumable supply, local maintenance contracts and reimbursement pathways, followed by a final report quantifying mortality reduction and cost avoidance. A Project Director at AstraDx will submit reports to the appropriate RHTP oversight body and other in-state partners on an agreed-upon schedule, and independent clinicians will review quarterly progress and authorize phase transitions. Risks such as component supply disruption, regulatory delays, and weather-related site access will be mitigated with inventories, early regulatory meetings, and travel and transportation timed to seasonal forecasts. This phased, deliverable-oriented approach ensures verifiable progress and positions Atawa to markedly improve access, quality and sustainability of sepsis care for Alaska’s rural, remote, and frontier communities.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Attending AI	ATTENDING AI: AI-Powered Clinical Decision Support for Rural, Remote, and Frontier Alaska	CO	Rural Alaska providers face a structural clinical workflow problem that limits care quality, drives burnout, and threatens health system sustainability. Physicians spend approximately 80% of each encounter gathering information—histories, labs, imaging review, documentation—and only 20% on clinical reasoning that determines outcomes. In Alaska this is amplified: providers often work alone, without specialist backup, managing complex presentations across vast distances. The consequences are measurable—preventable emergency transfers, diagnostic uncertainty, documentation burden driving providers out of rural practice, and care quality varying widely across facilities. Alaska's 160+ RFI respondents identified technology modernization as a top priority. The Spark Technology and Innovation initiative calls for fostering appropriate AI use, improving interoperability, and deploying consumer-facing digital health tools. Yet most rural facilities lack the resources to evaluate, procure, and implement AI clinical tools independently. ATTENDING AI was built by a practicing physician specifically to solve this problem—not as a generic tech product, but as a clinical intelligence platform designed from the exam room out.	ATTENDING AI deploys a physician-designed, two-component platform that automates clinical information gathering so providers focus on decision-making: 1. COMPASS (Patient AI Assessment): Before or at visit start, patients complete an AI-guided symptom assessment using voice input. The 18-phase workflow captures presenting complaint, history, review of systems, medications, allergies, and social/family history. It detects 14+ emergency red flags in real-time with 911 integration and GPS facility finding. Structured data flows directly to the provider—no redundant intake. 2. ATTENDING (Provider CDS Portal): Providers receive pre-organized patient data with AI-generated differential diagnoses, evidence-based treatment recommendations, integrated ordering for labs/imaging/medications/referrals, real-time drug interaction checking, and auto-generated SOAP notes. Deployment follows a 90-day, 5-phase model: - Weeks 1-3: Site assessment, EHR mapping, stakeholder alignment - Weeks 4-6: FHIR R4 adapter deployment, clinical catalog customization for Alaska-specific protocols - Weeks 7-9: Provider training (4 hours), staff training, super-user certification - Weeks 10-12: Supervised go-live with remote or on-site support - Months 4-6: Performance optimization, outcomes reporting, expansion planning The platform integrates with existing EHR systems (Epic, Oracle Health, Athena) through FHIR R4 APIs—no rip-and-replace. Cloud-native Azure infrastructure means no on-site hardware needed. Year 1 pilot: 10-15 facilities across 2-3 regions, expanding statewide in subsequent years. We are actively seeking Alaska-based clinical partners to co-deploy and validate.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Audacious Inquiry, PointClickCare	GrantOps & Performance Hub to Support Awardee Oversight & Accountability	UT	Alaska’s RHTP is a significant statewide investment delivered through subrecipient awards. To ensure measurable impact, the Alaska Community Foundation (ACF) needs strong fiscal oversight, standardized KPI monitoring, and consistent reporting across all awardees. The gap is the absence of a unified operating and reporting backbone to support ACF’s responsibilities at the portfolio scale. Without a centralized system, fragmented submissions, inconsistent definitions, and manual reconciliation can reduce transparency and make it harder to link funding allocations to measurable improvements in access, quality, and sustainability. The opportunity is to implement an RHTP GrantOps & Performance Hub that integrates funding tracking, activity reporting, and KPI monitoring in a single governed framework. This enables consistent KPI definitions, standardized templates, automated validation, and dashboards that improve data quality, reduce administrative burden, and support targeted technical assistance where rural access challenges are most acute.	The RHTP GrantOps & Performance Hub will be delivered through a phased approach that provides rapid operational value while supporting continuous improvement. The strategy prioritizes establishing a core capability quickly and refining it through structured feedback from awardees and ACF administrators until steady-state operations are achieved. Phase 1 (Months 1–6): Minimum Viable Product (MVP) Goal: Enable ACF to administer award workflows, collect standardized KPI submissions, and monitor program performance through centralized dashboards. Scope includes: • Structured award and funding workflow management with status tracking and audit trails • KPI template library aligned to RHTP initiatives with standardized definitions and reporting formats • Automated validation rules to improve submission completeness and reduce reconciliation effort • Role-based access controls for awardees and ACF administrators • Portfolio dashboards providing visibility into reporting status, performance summaries, and operational monitoring • Audit-ready documentation for funding allocations and reported performance data Phase 1 emphasizes configuration over custom development so workflows and reporting templates can evolve as program needs mature. Short configuration cycles allow ACF to review and refine templates early, reducing rework. Phase 2 (Months 7–12): Operational Maturation Goal: Transition the Hub to steady-state operations through structured feedback and incremental improvements. Activities include: • Expanded validation rules and data quality checks based on early reporting cycles • Enhanced dashboards supporting deeper portfolio insight and targeted technical assistance • Structured onboarding and training to reinforce consistent usage across awardees • Managed reporting cycles, including submission windows, reminders, exception handling, and completeness monitoring The Hub is technology-agnostic and can be implemented using configurable cloud platforms or existing systems, depending on ACF preferences. The design emphasizes configurable workflows, standardized templates, governed access, and reporting dashboards rather than custom software development. By linking funding transparency to measurable outcomes, ACF will	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

gain clear visibility into how RHTP investments advance technology modernization, fiscal sustainability, and rural health care access.

Audiology Associates	Expanding Health Access: Medical Treatment of Hearing Loss of Rural Medicare Beneficiaries in Alaska	AK	The proposed project seeks to address this critical gap by expanding access to medical treatment for hearing loss and tinnitus among Medicare beneficiaries living in rural Alaska. By providing accessible diagnostic services, evidence-based treatment, and longitudinal cognitive monitoring, this program aims to improve communication, enhance quality of life, and reduce risk factors associated with cognitive decline among older adults living in underserved rural communities. By intervening early with accessible hearing healthcare, this project has the potential not only to improve individual health outcomes but also to generate substantial long-term cost savings for the healthcare sytem through reduced demand for institutional care and dementia-related services.	The proposed project will establish a scalable rural hearing healthcare delivery model designed to reach Medicare beneficiaries living in rural communities across Alaska. The program will utilize a hybrid model of community-based outreach, portable diagnostic technology, and telehealth-enabled care. The initiative will focus on identifying and medically treating hearing loss and tinnitus among underserved rural Medicare beneficiaries. Patients will be identified through community outreach, primary care referrals, and partnerships with regional healthcare organizations serving rural populations. Once enrolled, participants will undergo a comprehesive audiologic examination using portable diagnostic equipment suitable for remote environments. Individuals diagnosed with hearing loss or tinnitus will receive evidence-based treatment, including prescriptive hearing technology and tinnitus management interventions. Participants will also undergo baseline and follow-up screening, using FDA-cleared computerized cognitive assessment tools. These screenings will allow the project team to measure potential risks of cognitive decline, while measuring potential improvements in cognitive function associated with improved auditory input and reduced neural strain. The project aims to treat approximately 300 medicare beneficiaries per year over a 5 year period, resulting in treatment for approximately 1500 individuals. Telehealth audiology services will be incorporated to provide follow-up care and ongoing support for participants living in geographically isolated areas. Portable diagnostic equipment and telehealth infrastructure will allow the program to deliver services directly within rural communities without requiring patients to travel long distances for care. This approach combines clinical treatment and community-based service delivery to create a sustainable model for improving hearing healthcare access across rural Alaska.	\$1M-\$5M	Clinic	Statewide	Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Kenai Peninsula Borough; Kodiak Island Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; Yukon-Koyukuk Census Area	Advance to Implementati on Application

Aunt Bertha, a Public Benefit Corporation dba Findhelp	Better Care for Rural Alaska with an Integrated CLRS	TX	Rural Health Transformation funding offers AK a timely opportunity to address rural health challenges like delivering care across vast geographies, isolated communities, and diverse populations. The State’s rural and frontier areas face persistent barriers including limited clinical access, fragmented referral processes, and significant gaps in transportation, behavioral health and care coordination. A rural health Closed-Loop Referral System (CLRS) powered by Findhelp will be a forward-thinking, innovative, and maximally effective solution that will result in fast, measurable improvements to rural health outcomes in AK and put the State on a fast track to achieving its goals. The foundation for an integrated rural health network in AK already exists. Findhelp’s public portal has long been a trusted resource for 104,000+ residents, who have used Findhelp to conduct 334,800+ searches for support, helping them receive enhanced and easier access to hospitals, other health care providers, and health care items and services furnished to rural residents. This network provides a launchpad for implementation, reducing risk and accelerating impact. Findhelp’s proven CLRS technology, deep rural health initiative experience, and collaborative approach will integrate existing elements into a unified health and social care ecosystem that is responsive to AK’s unique needs, and that supports long-term sustainability, community empowerment, and measurable impact across the State.	AK’s RHTP application identifies a core goal of developing community-based system navigation applications and investing in applications that connect rural and frontier community members with nearby clinical and social services. The plan also emphasizes in-person support and scheduling assistance, care navigation, care coordination, and digital support. Findhelp’s closed-loop referral platform directly aligns with this strategy. Our tools empower care teams and community navigators to seamlessly connect individuals to trusted nearby services, whether through digital self-navigation or in-person support. We also maintain robust accessibility features to ensure usability across populations and geographies. Findhelp will provide Alaska with a closed-loop referral system that complements the Statewide HIE, tailored to AK’s unique geography, populations, and health delivery ecosystem. Findhelp’s platform includes the following: CLRS infrastructure bridges the gap between clinics, tribal organizations, care navigators, community-based organizations and frontier providers, providing closed-loop tracking for care and social service referrals. Mobile-enabled public portal allows residents to find and self-refer to services, even in low bandwidth areas, using any device. Provider access and analytics enable care navigators to coordinate services and track outcomes across programs, supporting real-time reporting and referral engagement insights. In-person supports and care scheduling workflows help Alaska meet its goal of reaching residents with digital and on-the-ground care navigation, and enhances in-person care navigation with digital documentation and outcomes tracking. Agency-branded sites offer consistent trusted access points for State departments and local health entities. Benefits and eligibility enrollment with Findhelp’s new benefits enrollment engine, rural residents can more easily access programs and aid they are already eligible for, providing a boost to help them get back on their feet. The system intelligently screens individuals for state and federal benefits programs (like SNAP, WIC, or Medicaid) and simplifies the complex application process. Our platform is designed for standards-based data exchange, including SMART on FHIR APIs, making it an ideal companion to Alaska’s efforts to advance interoperability. Findhelp’s flexible integration framework is designed to complement Alaska’s existing health IT infrastructure including HealthEConnect AK.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Aurora Holistic Arts LLC	Coaching and guiding for a healthier tomorrow.	AK	Many people have the need to connect with a life coach that can guide, mentor, and help promote health that is non drug based and will work with the whole being. Weather this is a spiritual need, physical need such as deep breathing work, emotional need where the client can talk through the area of concern and can have the help to resolve issues that need to be addressed to reduce stress. This type of work with an individual or a group can have a profound impact on quality of life for all of those involved.	With a one on one approach the client can reveal and work toward resolution of an issue with ease and simplicity of integration as they process the concern with love, support and breathing or stress reduction techniques that can be done. As a group this has a great impact with breathing techniques or processing therapies, and with stress reduction techniques that will meet and assist with the overall health of the peoples that are treated with respect. This process will be fact based and allowed to be integrated at a pace that will meet the clients needs.	\$1M-\$5M			Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced
Aurora Integrated Oncology Foundation	Evidenced Based Quality Cancer Survivorship for All Alaskans	AK	Much of the current attention of cancer care focuses on the 3,401 annual newly diagnosed cases each year in Alaska. For most, quality cancer services to treat their primary tumors are available. Yet the group at greatest risk of developing cancer are those 38,000 Alaskans as reported by the Alaskan Department of Health, who are living with a history of cancer. The risk includes recurrent local disease, metastatic disease, and a twice likely of developing a new primary tumor elsewhere. By development of a survivorship/OMD type service, we can provide Alaskans with evidence-based care to monitor and catch disease early, when still treatable. We would do so by providing technology with mid-level providers who work independently of centers and serve any Alaskan with a history of cancer. Community partners like the Alaska Men’s Run can help facilitate messaging in combination of the awareness campaign to the wider medical community to refer. Telemedicine would be utilized to consult and monitor enrolled Alaskans. Equicare Health would provide the necessary technology platform to autonomously organize the data from medical records and self-reports to create a summary of care and care plan is defined by the IOM to provide the patient and primary care provider, so each party is aware of the prescribed follow up for lab, imaging, and physician follow ups. Short term and long-term side effects of both disease and treatments are managed while monitoring new OMD tumors.	The evidence is clear on what a person diagnosed with cancer should receive following active cancer treatment & is supported by ASCO, NCCN, American College of Surgeons, and the IOM. Yet, much of cancer care is focused only on the active acute care treatment phase, ignoring the ongoing chronic care management. It is the intent of this proposal to change that model and provide structured services in a way that recognizes cancer as a chronic care illness; assuring side effects of disease & treatment as well regular labs & imaging are followed. Funding will provide the launch of a regional footprint that will develop into a wider model. A mid-level Physician’s Assistant or Nurse Practitioner will be recruited and supported by a dedicated administration support staff member. Equicare software tool will be implemented & integrated with partner organizations. eHealth will serve as the underlying software architecture that provides connectivity to various 3rd party EMR’s that reside in clinics or hospital. These two products will automate much of the process by developing a comprehensive summary of care and ongoing care plan. The treatment summary & care plan will be provided to the patient, but also the primary care provider, if there is one. This provides all participants equal & evidenced based information. Recognizing cultural elements, Equicare was selected in part to their ability to convert all patient facing information into preferred language. This will greatly help address the barriers and acceptance to care in reaching Alaskan Native Tribes (ANT). In addition, the tech platform allows most consultations to be conducted via telemedicine & includes the means to message their care team electronically while also providing care team a means to monitor patients remotely. AIOF will allocate the space & support needs. Anchorage Neighborhood Health Center (ANHC) is a Federally Qualified Health Center that provides primary health care services for everyone in their community, with a special focus on those who face extra barriers to care. ANHC is a partner organization that will be the first to integrate services for purposes of assuring this proposal reaches a wide range of Alaskans to include those that may be socially	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and	Advance to Implementati on Application	

	economically disadvantaged. ANHC provides a remarkable service, & it is our intent that we provide ANHC patients with a level of service currently only found in the largest urban-based cancer-focused facilities in the lower-48.	Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area

Aurora Integrated Oncology Foundation	Paying for Value in Radiation Oncology	AK	Radiation Oncology is a key modality in the treatment of many cancers. It is a rapidly changing field with the emergence of new technologies and treatment options. At present, Radiation Oncology Services in Alaska are paid fee-for-service based on the number of treatments a patient receives. This method of payment theoretically creates a disincentive to adopt newer technologies and treatment approaches which utilize fewer treatments. This phase of the project is intended to develop and assess the feasibility of an alternative pay-for-value payment methodology that will shift payment away from fee-for-service. Implementation would occur in a second phase to be proposed in 2027. When implemented, the result will be more rapid adoption of new technologies and shorter treatment protocols. Shorter treatment protocols mean Alaskans living in rural areas who travel to receive daily treatment will spend less time away from home. Fewer treatments result in reduced travel expenses, family disruption and time away from work without sacrificing quality of care! A second aspect of the project will be to assess the needs and opportunities for new technologies which can either shorten treatment duration and/or expand services to more rural locations. Aurora Integrated Oncology Foundation, the submitter of this proposal, owns or provides professional staff to five of the eight Radiation Oncology Centers in Alaska and shares a common billing company with the sixth.	To develop and test a pay-for-value model we will convene a project “Core Group” comprised of expert radiation oncologists from Alaska and elsewhere led by healthcare consultants and AIOF staff with intimate knowledge of Alaska and radiation oncology. The Core Group will be supplemented by an array of additional experts, including physicians, actuaries, attorneys, claim payment and revenue cycle management experts and others as identified through the project. As a first step, this group will research pay-for-value models in use or in development elsewhere, tapping into national resources such as ASTRO, (American Association of Radiation Oncology) and others. Existing models will be analyzed for their applicability in Alaska and consistency with the goals of this project. From there the group will determine the most promising options for further development and begin to develop the required detail sufficient to account for the variety of diagnoses and treatments which radiation oncology encompasses. A critical component of this project will be developing consensus/agreement amongst the stakeholders, so they are willing to agree to change from fee-for service to pay-for value. Building consensus will require all parties to understand the model and how it was developed along with the pros and cons of the transition to value-based payment. They must be willing to accept the inevitable tradeoffs to achieve the benefits. Another crucial factor for success is to build the model in a way that can be administered by claim payers without prohibitively costly modifications to their systems, perhaps by changing how services are billed. Building out the detailed clinical payment model, achieving consensus amongst the stakeholders and making the approach administratively feasible will be much of the work and time required for this project.	\$250K-\$1M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Aurora Integrated Oncology Foundation	Address Cultural and Acceptance Barriers to Life-Saving Cancer Services	AK	Alaska’s cancer burden falls most heavily on the communities least served by existing cancer education and communication systems. Alaska Native people experience cancer incidence and mortality rates significantly above state averages; cultural mistrust, language barriers, and unfamiliarity with the health system drive delayed screening, late-stage diagnosis, and lower treatment engagement. Currently, cancer information available to patients is fragmented, inconsistent, and predominantly available only in English. A patient diagnosed with cancer in a rural Alaska community receives different information from their clinic, their oncology provider, their navigator, and whatever they find independently, none of it in their preferred language, none organized around their actual questions. Community services exist, including navigation assistance, lodging support, and financial aid, but patients are left to piece together their own understanding from sources never designed for their language or culture. The result is confusion, mistrust, and disengagement at the moment when clear information is most critical. This project consolidates that scattered landscape into a single, authoritative, multi-format educational campaign in preferred languages across Alaska Native and immigrant communities, establishing one source of truth for Alaskans diagnosed with cancer and the providers and navigators who serve them.	AIOF will partner with C3 — Crystal Clear Creative to develop, produce, and distribute a comprehensive, multilingual cancer education campaign that addresses cultural and acceptance barriers to life-saving cancer services across Alaska. C3 brings existing relationships with Alaska Native communities and cultural liaisons, making community-informed development not just translation central to the project model. The campaign will be developed in multi-format: print materials for clinical and community distribution, digital assets for web and mobile access, and video content in preferred languages that can be shared through community networks and deployed at CAPS events and screening sites statewide. Languages will include Alaska Native languages (including Yup’ik, Inupia̋q, and Athabascan) and immigrant community languages, prioritized based on C3’s community needs assessment conducted during the development phase. Content will cover two parallel tracks. The clinical track curates and adapts existing oncology education materials covering diagnosis, treatment options, surveillance, and survivorship into culturally grounded, language-accessible formats. The community services track consolidates existing but fragmented resources navigation assistance, transportation programs, financial support, lodging options, and community-based services into a single, organized reference that AIOF Patient Navigation, CAPS, and the survivorship clinic can deploy as a standard patient-facing tool. Community review panels will validate all materials before distribution, ensuring cultural accuracy, language appropriateness, and community trust. AIOF will own the campaign and maintain it as a living resource updating content as services, programs, and community needs evolve. Upon completion, the campaign will be distributed through AIOF’s statewide program network and made available to any Alaska health organization, clinic, or community partner at no cost.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Aurora Integrated Oncology Foundation	Bringing Rural Patients and Providers Together for Cures - Peninsula & Valley OncoWheels, (POW/VOW)	AK	The intent of this proposal is to provide any Alaskan who requires transportation for cancer related appointments, be assured reliable ADA compliant transportation will be provided at no cost. To understand the challenge, in 2024, Alaska rated 46th in the USA for adherence to eligible mammography. Poor screening rates contribute to late-stage diagnosis and higher mortality. Access is a significant barrier but only addresses the problem if it provides for screening, treatment, and follow-up. In the most recent reported year, the Nation Cancer Institute reported that 352 people were newly diagnosed cancer cases in Kenai and 485 Alaskans in MatSu Valley regions. Of those in the Kenai Peninsula, 47% are defined as more rural, while 42.4% in MatSu Valley. In many cases transportation is being arranged for these patients which may cause issues with reliability, especially for treatments that are prescribed on a regular schedule of days as part of the protocol. Unfortunately, there are limited resources available for those individuals who need ADA compliant transportation. Public transportation is not conducive to cancer patient’s needs. Oncology patients typically have compromised immune systems where they shouldn’t be exposed to large crowds or are managing side effects such as nausea or diarrhea, both not desirable to have on public transit. This would address a common barrier to allow easy, convenient scheduling, ADA compliant ride, by a known driver.	The RHTP funds would allow for two ADA compliant, winter capable vehicles to be purchased and staffed to serve patients of the Kenai Peninsula and MatSu Valley. From Homer to Cooper Landing and Sutton to Talkeetna this would serve patients needing rides for cancer screening, daily cancer treatments (chemotherapy or radiation), and important follow-up visits with their cancer team. The drivers would be CPR certified, and the van would be outfitted to support cancer patients’ needs. The funds would also allow schedulers to assist the drivers with scheduling patients for their cancer screenings or cancer related appointments. Dispatcher services would include augmenting with local transportation if services are available. ‘POW’ and ‘VOW’ ‘OncoWheels’ vehicles will also be available for any residents who wish to attend health fair screening events in their regions. To generate awareness, a promotional campaign will be developed that targets both the community, local communities, and area clinical providers. A coordinated campaign would be executed in the Kenai Peninsula and MatSu Valley through appropriate media outlets to reach the right audiences. From advertising in print to a boosted Facebook messaging that this service is at no cost to patients and open to all providers Alaskans may be receiving treatment. Along with a media campaign the van would be wrapped for visibility and to raise awareness about the importance of cancer screening.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Aurora Integrated Oncology Foundation	Cancer Patient House for Access to Screening, Testing, and Cures in SE Alaska	AK	This project aims to address the critical shortage of temporary housing for patients traveling to Juneau for cancer-related care, including long-term treatment, short-term procedures, diagnostic testing, and preventive screenings. In recent years, Juneau has become an important regional hub for medical services, providing specialized care for patients from surrounding and remote communities. However, access to these services is often limited not by the availability of care itself, but by patients’ ability to secure safe, reliable, and affordable lodging while they undergo treatment or testing. Currently, there are no dedicated short-term housing options in Juneau designed specifically for individuals seeking cancer screenings, diagnostic procedures, and options for treatment housing are limited. Patients must rely on hotels or short-term rentals, which can be costly and unpredictable in availability. Because these options operate largely on a first-come, first-served basis, patients often face uncertainty about whether housing will be available when they arrive for scheduled medical appointments. Establishing a reliable and affordable patient housing option would reduce these barriers, alleviate stress for patients and families, and help ensure equitable access to the cancer care services available in the region.	The proposed cancer house will serve as a centralized, patient-centered facility providing temporary housing for individuals traveling to Juneau for cancer treatment, diagnostic testing, screening, or follow-up care. By consolidating support services in a single, accessible location, the facility will reduce geographic, financial, and logistical barriers that often prevent patients from seeking timely care. Phase One of the project, scheduled to begin in 2026, will focus on planning, community engagement, partnership development, preliminary site selection, and establishing the operational framework for the facility. This foundational work will ensure that construction in 2027 and operational launch in 2028 are guided by evidence-based practices, community input, and sustainable operational models. The cancer house will be designed to serve multiple patient groups, including individuals undergoing active treatment, those traveling for screening or diagnostic testing, and those attending follow-up appointments. By providing dedicated spaces for each group, the facility will ensure privacy, accessibility, and comfort while accommodating the unique needs of patients and families. Shared areas will allow families to stay together, facilitate community engagement, and provide access to on-site resources such as counseling, nutritional support, and social services. The centralized nature of the facility will make it easier for patients to attend appointments on time, access support services, and engage in preventive care, directly addressing barriers that often delay early detection and treatment. By improving access to housing and supportive services, the cancer house will play a critical role in promoting early screening and timely interventions, which are essential for improving outcomes in cancer care. Removing the burdens of travel, lodging, and logistical challenges allows patients to prioritize preventive screenings and follow-up care, increasing the likelihood of early detection and effective treatment. The facility’s patient-centered design, combined with strong community partnerships, will not only enhance the patient experience but also strengthen the overall healthcare system in Southeast Alaska. By addressing these barriers early, the cancer house aims to improve survival rates, reduce complications, and ensure that patients and families have the resources and support needed to navigate the cancer care continuum successfully.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Aurora Integrated Oncology Foundation	Gaining Access to Cancer Cures through Navigation	AK	Rural, remote, and frontier Alaskans face significant non-clinical barriers to timely cancer screening follow-up and specialty care. Travel distance, limited transportation, financial strain, and fragmented referral pathways often delay movement from abnormal screening findings to specialty consultation. Many rural residents postpone or forgo evaluation because distance, cost, and logistical complexity create substantial obstacles to care engagement. Cancer incidence in Alaska is 432.6 per 100,000, and cancer remains the leading cause of death for Alaska Native people, who experience significantly higher rates (588.4 per 100,000). Despite this burden, rural communities frequently experience extended delays between abnormal findings and confirmed specialty connection. While elements of patient coordination exist within the network, there is no centralized, structured navigation model dedicated to reducing barriers statewide. Without coordinated navigation support, patients may struggle to move efficiently from screening to consultation and treatment. With a mission of ‘Improving the quality of and access to cancer prevention, treatment and supportive care for all Alaskans’ this project addresses that gap by formalizing AIOF Patient Navigation as a statewide, resource-centered coordination model designed to strengthen referral continuity, improve care engagement, and reduce logistical barriers for rural Alaskans facing cancer.	AIOF Patient Navigation will implement a structured, statewide coordination model embedded within AIOF’s existing oncology network. The project centralizes navigation responsibilities currently dispersed across staff into a dedicated role focused on referral coordination, barrier assessment, and resource linkage. By centralizing navigation within an established oncology network, the project leverages existing clinical infrastructure through an innovative system-integration model rather than creating a parallel service line. Upon referral from screening partners or providers, the navigator will conduct timely outreach, facilitate connection to appropriate specialty providers, and support appointment coordination as needed. A core component of the approach is resource navigation, including coordination of travel logistics, lodging arrangements, and linkage to approved financial assistance mechanisms and community-based services. Direct cash payments or gift cards are not part of this model; instead, assistance will be coordinated through structured partnerships and established support systems. Standardized referral protocols will be developed with Alaska Health Fair, regional hospitals, and additional community partners to ensure consistent communication and follow-up processes statewide. The project also incorporates rural awareness and partner education efforts managed by C3 to increase understanding of navigation services and strengthen referral engagement.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Aurora Integrated Oncology Foundation	Greater Alaska Exercise Oncology & Lifespan Wellness Initiative	AK	Obesity rates in Alaska have more than doubled in the past 25 years. Approximately 35% of adults are classified as having obesity, with more than two-thirds of adults and one-third of children exceeding a healthy weight. Excess weight is not only linked to diabetes and cardiovascular disease—it is a well-established risk factor for more than 12 types of cancer and is associated with poorer cancer outcomes, increased treatment complications, higher recurrence risk, and reduced survival. Each year, approximately 3,400 Alaskans are diagnosed with cancer. Many would benefit from evidence-based, oncology-specific exercise and lifestyle support to improve treatment tolerance, maintain functional independence, and enhance long-term survivorship outcomes. For rural Alaskans, these risks are compounded by geography. Patients often travel hundreds of miles for diagnosis and treatment, then return home without structured rehabilitation support. Without supervised exercise oncology services, many experience preventable physical decline, worsening fatigue, depression, and diminished quality of life. Geographic isolation, workforce shortages, limited oncology-specialized rehabilitation services, inconsistent referral pathways, and gaps in culturally responsive resources create an urgent opportunity to redesign cancer prevention and rehabilitation delivery across Alaska.	This initiative will implement a coordinated, statewide transformation strategy to build long-term healthcare capacity in Alaska’s rural and frontier communities. At its core is workforce development. The project will expand the proven outcomes achieved at the AIOF center in Anchorage by scaling access to Maple Tree Cancer Alliance’s nationally recognized Exercise Oncology Instructor (EOI) and CancerFit certifications. Alaska’s approximately 130 registered Athletic Trainers represent a highly skilled but underutilized pipeline for specialized oncology training. Scholarships will also support rural fitness professionals, Community Health Aides, and physical education teachers. By training Alaskans to serve Alaskans, the initiative strengthens trust, builds local ownership, and creates durable in-state expertise that persists beyond the grant period. To overcome geographic barriers, the project will expand a hybrid model of supervised virtual exercise oncology delivery. Individualized, supervised sessions will increase statewide, and live tumor-specific group classes—for breast, colorectal, prostate, hematologic, and other cancers—will be launched. Referral pathways with hospital partners will be standardized so cancer rehabilitation becomes an expected component of survivorship care rather than an optional service. To ensure cultural relevance and equitable access, Maple Tree On Demand will be adapted for Alaska communities. Core materials will be translated into four principal tribal languages, and a dedicated Alaska-focused website and centralized education portal will provide culturally responsive survivorship resources and workforce training materials optimized for low-bandwidth environments. Community playground signage promoting healthy eating and physical activity will feature QR codes linking families to free, downloadable wellness resources, extending prevention messaging directly into neighborhoods. A school-based wellness initiative will reinforce prevention early by teaching age-appropriate cancer risk reduction principles and promoting lifelong physical activity. Physical education teachers will receive CancerFit training to ensure programming is safe, evidence-based, and sustainable. Finally, a coordinated statewide marketing and education campaign will normalize cancer rehabilitation as a standard of care, improving awareness, referral consistency, and engagement across rural Alaska.	\$1M-\$5M	Clinic	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Aurora Integrated Oncology Foundation	Screen. Connect. Care. An Alaska Cancer Awareness & Navigation Initiative	AK	The intent of this proposal is to provide any Alaskan easy access within their own communities while bridging cultural & language barriers to provide evidenced based screenings & vaccines. To understand the challenge, in 2024, Alaska ranked 44th in the nation for adherence to eligible colorectal screenings. Poor screening rates contribute to late-stage diagnosis and higher mortality. For Prostate-specific antigen (PSA) screening prevalence within the past year, Male ages 55-69 perfumed poorly with Anchorage, Nome, and the Aleutians all ranking at the bottom with under 26.3% adherence. As a result, Alaska mortality for prostate cancer ranks 47th in the nation. At root of the poor outcomes are Access, Acceptance, and Availability, with each creating its own significant barriers and independent solutions. We believe screening addresses the first half the problem. To address, we must build upon the existing success AHF has had to include wider community partners & more culturally specific events to gain acceptance. The second half we well addressed within our pilot through navigating those found to have a suspicious finding through both informed & coordinated clinical work up. If necessary, navigating access to patients at their chosen location for treatment. Addressing the high mortality rate across Alaska can only address the problem if it provides for screening, treatment, follow-up.	RHTP is a remarkable opportunity to fund the resources necessary to scale a successful model that contributes towards addresses poor health outcomes across Alaska. For over 45 years AHF has made an impact & with additional resources, can make the difference. By adding 2 purpose vehicles, 3 employees, culturally developed content & awareness, AHF can reach more Alaskans. Having best in market software available in larger lower-48 locations, we will support care coordination from village to hospitals for continuity & standard of care principles. Vaccines will be provided when appropriate to foster prevention as well as smoking cessation services. AIOF will recruit a dedicated Navigator to provide care coordination & facilitate appointment to patient preferred locations, providing measured follow through & expert guidance rather than making Alaskan responsible to manage unassisted access to care. Tiered Mobile Screening Infrastructure: To overcome Alaska’s geographic barriers, AHF will deploy a dual-model mobile delivery strategy: 1) Regional Hub Mobile Clinic (Modular Truck): A fully equipped mobile clinic capable of supporting high-volume screening events in regional hubs & larger rural communities 2) Rapid-Deployment Medical Van: A smaller, flexible mobile unit designed for road-system communities, blood draws, & targeted outreach in hard-to-reach areas 3) Flyable Mobile Screening Kits: Compact screening systems that can be transported by small aircraft or standard vehicles to off-road-system villages. Both vehicles will be visibly branded to increase awareness & normalize preventive screening across Alaska. Community-Embedded Outreach: AHF will model a proactive rural engagement by 1) Hiring 3 rural outreach coordinators (preferable tribal) 2) Partnering with tribal health organizations, local health centers, & local leaders 3) Aligning events with seasonal & community schedules Closed-Loop Navigation & Data Integration: Screening alone is insufficient. Suspicious findings will trigger rapid AIOF navigation through 1) A dedicated patient navigator responsible for appointment scheduling, referral management, & follow-up 2) Deployment of a care coordination platform (Equicare) integrated into mobile screening vehicles with ability to connect with provider EMR’s for seamless integrated care 3) Remote connectivity solutions (ie: Starlink) for off-grid communities 4) Closed-loop tracking with local health centers, tribal health partners, & specialist groups	\$1M-\$5M	Clinic	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Aurora Maternal Fetal Medicine	Expanding access to Maternal-Fetal Medicine subspecialists in Alaska for high-risk pregnancy care	AK	The objective of the project includes addition of ambulatory outpatient clinics around hub cities in Alaska equipped to perform specialty ultrasound services, MFM consultative services and high-risk pregnancy care via telemedicine for underserved communities and patients in Alaska. The mission will be to improve maternal and neonatal outcomes by providing continuity of care for patients with known fetal abnormalities or maternal conditions that require close monitoring that can be done close to home while not requiring substantial patient travel in the right clinical situations. Patient travel time to the proposed hub locations will be significantly less and the opportunity for expert care to be available in areas of maternity deserts will be life-changing for rural Alaskans. Grant funding would be used to lease state of the art ultrasound machines, payroll for employees of Aurora MFM, provide 1FTE physician to see patients remotely (provided by Obtelectcare), LilyLink remote diabetes management, lease of office space in proposed hub cities and telemedicine technology to perform remote consultation and management of high-risk pregnant patients.	Ambulatory clinic locations will be created in Fairbanks, Soldotna and Juneau. Existing clinics in Wasilla and Anchorage will expand with new ultrasound equipment and Teladoc stations for remote physician consultation. Aurora MFM will partner with Obtelectcare to provide physician telemedicine MFM services. Obtelectcare will supply one full time MFM physician to see patients remotely with their pool of physicians who are licensed to practice in Alaska. These subspecialty services provided will include diabetes management (remote LilyLink support staffed by MFM specialists), review and interpretation of specialty ultrasound, consultation and co-management of high risk pregnancy conditions by remote MFM physicians via Teladoc stations provided by Obtelectcare. Tricefy is an ultrasound image storage program (cloud based) that will be purchased and used to upload images from the ultrasound for remote physician review and interpretation. PNC IT will continue to be the internet technology company that will help to provide support of technology in Alaska sites. As research has shown, Maternity deserts tend to be associated with poor outcomes in pregnancy, including increased maternal mortality, increased risk for low birthweight and increased neonatal mortality. Providing care remotely via Teladoc connection, use of state of the art GE ultrasound equipment and expert involvement of skilled MFM teams via telehealth will likely lead to improved outcomes and management of high-risk conditions in pregnancy for Rural Alaskans that may not have been discovered until it is too late due to patient inability to seek care with MFM physicians early in pregnancy to manage complications. • Lease of 5 GE Voluson Expert 22 ultrasound machines x 60 months with Verisound Collab program and ongoing technical support from GE = \$924,704.00 • Teladoc telemedicine stations x 5 clinic sites = \$18K for the equipment, shipping and configuration (per device) and another \$9K per year in recurring annual fees = \$135,000 for the first year • Upgrade of computer equipment and IT support from PNC IT = \$30,000 • AMFM payroll (1 year) to support outreach ambulatory clinics = \$1,059,790.81 • One full time Obtelectcare MFM physician to provide telemedicine coverage of clinic sites for one year = \$1,000,000	\$1M-\$5M	Clinic	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Austin's Compassionate Enterprise	Southcentral Alaska Rural Medical Equipment & Access Hub	AK	Rural Alaskans discharged from Anchorage-based hospitals, including Alaska Native Medical Center and Southcentral Foundation facilities, frequently experience delays accessing medically necessary durable medical equipment (DME) and reliable transportation for follow-up care. The absence of centralized equipment redistribution infrastructure and coordinated mobility support creates gaps between hospital discharge and safe recovery in rural communities. Currently, Austin’s Compassionate Enterprise (ACE) operates a statewide medical equipment redistribution program from temporary storage containers without permanent infrastructure. This limits processing capacity, data tracking, hospital integration, and coordinated expansion. The opportunity is to strengthen Alaska’s rural health system by establishing a centralized Rural Medical Equipment & Mobility Access Hub that integrates equipment redistribution with transportation coordination. This project addresses structural barriers to discharge stabilization, continuity of care, and rural health sustainability.	Austin’s Compassionate Enterprise will establish a centralized Rural Medical Equipment & Mobility Access Hub integrating medical equipment redistribution (ACE Lending Closet) with coordinated transportation access (Guardian Patient Services). The approach includes: • Securing and developing centralized infrastructure to safely store, sanitize, repair, and inventory durable medical equipment • Formalizing discharge coordination pathways with hospital and tribal health partners to streamline referrals • Expanding rural redistribution logistics for wheelchairs, hospital beds, respiratory equipment, and assistive devices • Integrating transportation coordination to ensure patients can obtain equipment and attend follow-up appointments • Implementing inventory tracking and referral monitoring systems to improve efficiency, transparency, and accountability The hub-and-spoke model positions Anchorage and the Matanuska-Susitna Borough as the central coordination site, with rural communities connected through structured referral pathways. By aligning hospital discharge planning with community-based equipment and mobility access, the project strengthens care transitions, reduces avoidable delays, and enhances continuity of care for rural and Alaska Native patients. This approach advances rural health transformation by building infrastructure that improves access, coordination, and fiscal sustainability within Alaska’s health system.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Avel eCare	Avel eCare Crisis Care	SD	Despite impactful investments in crisis care, gaps in community-based behavioral health crisis response have been identified as an area of opportunity across Alaska (Milliman Report, 2024). As a result of this lack of access, state can experience an over-reliance on law enforcement, emergency medical services, and hospital emergency departments to manage behavioral health emergencies, particularly in rural and frontier communities. Alaska’s behavioral health crisis response system relies heavily on these community resources in responding to individuals experiencing acute mental health or substance-related crises, particularly in rural and frontier geographies where clinical crisis resources are limited or unavailable. In many communities, officers are frequently called to situations that fall outside traditional public safety roles because alternative crisis response options do not exist locally. Limited access to appropriate stabilization settings often results in default transport to emergency departments or involvement with the criminal justice system—outcomes that can be traumatic for individuals, inefficient for public safety agencies, and costly for the healthcare system.	Avel’s Virtual Crisis Care program addresses gaps in community-based behavioral health crisis response by providing law enforcement officers with real-time, virtual access to behavioral health clinicians who can assist with assessment, de-escalation, stabilization, and safety planning at the point of contact. This model supports officers in determining when hospitalization or involuntary holds are not clinically necessary, helping divert individuals from emergency departments and correctional settings toward more appropriate care pathways. By enhancing existing public safety responses with clinical expertise—rather than replacing them—Virtual Crisis Care aligns with Alaska’s stated goal of strengthening its behavioral health crisis continuum through telehealth-enabled solutions that reduce unnecessary emergency utilization, minimize trauma, and better meet individuals’ emotional and physical needs during a crisis. Over time, this approach supports both cost containment and system sustainability by reducing avoidable ED visits and preserving law enforcement resources for core public safety functions. Our care program utilizes HIPAA-compliant, video-enabled telehealth, and staff trained in the use of evidence-based practices. Additionally, funds would be used to deploy portable audio/visual equipment, along with the costs associated with training and management of equipment. Avel will collaborate with the State of Alaska and law enforcement agencies across the state, and work with local community providers to ensure appropriate referrals and promote coordination and safety. Virtual Crisis Care directly supports Alaska’s stated goals to strengthen the behavioral health crisis continuum, reduce reliance on law enforcement and emergency departments, improve safety and outcomes during crisis response, and expand access to appropriate behavioral health care in rural and frontier communities through telehealth-enabled solutions.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Avel eCare	Avel eCare Emergency Medicine and Emergency Medical Services	SD	In medical emergencies such as trauma, heart attack, and stroke, rapid access to definitive care is critical to survival and recovery. However, residents of rural and frontier communities-- particularly in Alaska-- face significant disparities in emergency response and outcomes. These populations are often located hours from Level I or II trauma centers or cardiac catheterization labs, and local facilities frequently lack on-site emergency physicians. Further, EMS agencies are commonly staffed by volunteers or limited scope providers, leaving them as the primary point of care during life-threatening events. While recent investments in telehealth, data systems, and communication tools have improved access, these resources alone do not reduce unnecessary emergency transports or improve outcomes. The core challenge is not a lack of information, but a lack of delegated clinical authority and real-time medical direction that allows EMS personnel to safely treat patients in place or pursue other care pathways when appropriate. Without physician ownership of field decisions, EMS providers default to transport-based risk mitigation, increasing strain on patients, health systems, and transport resources. This dynamic contributes to higher mortality rates in rural trauma cases, as well as provider burnout and ongoing recruitment challenges. Avel's Emergency and EMS solutions provide the opportunity to close this gap by enabling timely, supported clinical decision-making in the field.	Avel eCare proposes a scalable, technology-enabled emergency care model designed to improve outcomes, reduce unnecessary transports, and support frontline clinicians in rural and frontier communities. Building on more than 30 years of experience delivering virtual care in underserved settings, this project will deploy ready-to-launch emergency programs: Avel eCare Emergency for rural emergency departments and Avel eCare Emergency Medical Services (EMS) for field-based providers. Through high-definition audio/video technology activated at the push of a button, local clinicians and EMS personnel gain immediate access to a virtual team consisting of a board-certified emergency physician, an experienced emergency nurse, and a paramedic. This team provides real-time medical direction, diagnostic support, clinical decision-making, and assistance with transfer coordination. The approach ensures faster access to definitive emergency expertise during time-sensitive events while reinforcing, rather than replacing, local care teams. For EMS agencies, Avel eCare will equip ambulances with in-rig telemedicine capabilities, enabling peer-to-peer support in the field and during transport. This model not only improves clinical confidence and supports volunteer and limited-scope providers, but it also enhances patient safety in high-acuity situations. By providing physician-led guidance at the point of care, our model reduces reliance on transport-based risk mitigation and improves system efficiency. As a second phase, Avel will address the root cause of unnecessary transports in frontier settings: the lack of delegated clinical authority. We will extend established EMS protocols to allow personnel to participate in treat-in-place and alternate destination pathways through real-time physician delegation and oversight (without permanent scope-of-practice expansion). Physicians retain clinical authority and decision ownership, while technology supports immediate consultation, documentation, and escalation. Together, these approaches extend established EMS medical principles through modern telehealth infrastructure, improving access to timely emergency care for high- and moderate-acuity patients; strengthening rural workforce support; and advancing safer, more appropriate care pathways for rural and frontier populations.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Avel eCare	Avel eCare Senior Care Services	SD	Alaska is experiencing a significant demographic shift that is placing increasing strain on its long-term care system. The number of Alaskans aged 65 and older continues to grow, while the working age population is shrinking, exacerbating long standing workforce shortages across health care and long-term care settings. This imbalance limits the availability of trained staff needed to support older adults with increasingly complex medical, cognitive, and behavioral health needs. At the same time, Alaska’s long term care capacity is constrained by a small number of licensed nursing home beds and a highly fragmented network of assisted living homes, many of which are small and geographically isolated. As a result, hospitals are frequently used as a default setting for individuals who no longer require acute medical care but cannot be safely discharged due to the lack of appropriate continuing care options. Collectively, these pressures (an aging population, a declining workforce, and limited long term care capacity) create challenges in timely clinical assessment, care coordination, and treatment in place. The resulting delays in discharge, avoidable hospital utilization, and strain on both hospital and long-term care staff underscore the urgent need for scalable solutions that extend clinical capacity, support the workforce, and strengthen Alaska’s long term care continuum.	Avel eCare Senior Care addresses these challenges by connecting long term care and assisted living facilities to geriatric trained clinicians through 24/7, two-way audio and visual telehealth. Avel’s virtual care model provides just in time access to physicians, nurse practitioners, nurses, and psychiatric nurse practitioners who support urgent evaluations, chronic condition management, medication and laboratory review, behavioral health services, RN assessments, and admission and documentation support. By extending local clinical capacity regardless of geography, the model strengthens Alaska’s long term care system, improves quality and safety, reduces unnecessary hospitalizations, stabilizes the workforce, and improves hospital bed availability. This approach is designed for Alaska’s highly dispersed long term care landscape, including rural, frontier, hub based, and off-road system communities. Participating sites will include licensed nursing homes, assisted living and memory care communities, and small residential care homes serving residents with increasing medical and behavioral complexity. Avel’s model integrates into existing workflows, supporting on site staff as capacity extenders rather than replacing local providers. Through real time consultation and collaboration, Avel clinicians assist with urgent assessments, chronic disease management, medication and laboratory review, behavioral health evaluation, and admission and documentation support, enabling facilities of all sizes to access specialized expertise at any time. The project will primarily serve adults aged 65 and older, as well as younger residents with aging related complexity, multiple chronic conditions, dementia, behavioral symptoms, or advanced illness. Designed to support treatment in place when clinically appropriate, Avel eCare Senior Care helps facilities manage acute issues on site while improving resident comfort and continuity of care. Beyond resident outcomes, the model directly supports Alaska’s long term care workforce. Avel clinicians provide decision support and clinical partnership to on-site medical directors, nurses, administrators, and providers. By reducing after hours call burden and providing immediate access to geriatric expertise, the model improves clinical confidence and supports recruitment and retention across long term care settings.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Avel eCare	Avel eCare Specialty Clinic	SD	Due to low patient volume and workforce shortages, most specialists do not serve rural communities, requiring patients to travel long distances (often across challenging geography and weather conditions) to access specialty care in more populated areas. As a result, patients experience significant delays in diagnosis and treatment or forgo care altogether, leading to exacerbation of chronic and complex conditions that could have been managed with timely specialty intervention. These access barriers also place additional strain on rural primary care teams, who are asked to manage conditions beyond their scope without specialist support. In many cases, rural facilities lose patients not only for specialty services and associated diagnostics, but also for ongoing primary care, diverting care and revenue out of the local community and further weakening the sustainability of local health systems.	Avel’s Specialty Clinic enables patients to receive scheduled specialty services and treatment at their local clinic, reducing scheduling delays and costs associated with patient and family travel while strengthening coordination between local primary care providers and specialists. Leveraging Rural Health Transformation funding, Avel will partner with participating Alaska clinics to implement specialty telehealth services aligned with local community needs and existing workflows, Our Specialty Clinic model includes scheduled telehealth visits using secure, two-way audio and visual technology within the originating clinic. First, clinics schedule appointments through Avel’s centralized scheduling platform, enabling access to specialty providers while maintaining local control over patient flow and follow-up care. Then, Avel eCare’s board-certified physicians and advanced practice providers conduct specialty consultations, document in the EMR, and coordinate care recommendations directly with on-site teams. Avel’s Specialty Clinic solution offers a wide range of services and is customizable to each community’s priorities. To date, behavioral health has been the most in-demand specialty, and Avel has responded by providing access to adult and child/adolescent psychiatrists, behavioral-health-certified advanced practice providers, and master’s-prepared social workers for assessment, medication management, and ongoing therapeutic support. Additional specialties may include rheumatology, endocrinology, dermatology, cardiology, gastroenterology, pulmonology, oncology, neurology, and nephrology, allowing clinics to address high-need conditions without requiring patients to leave their communities.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Avvento Consulting Inc.	Alaska Rural Health Transformation: Program Management and Oversight	CA	Rural healthcare systems in Alaska operate across vast geographic distances and rely on a combination of small clinics, tribal health organizations, regional hospitals, telehealth platforms, and state systems to deliver care. Many transformation initiatives therefore require coordination across multiple organizations, technology platforms, and vendors. Without strong program governance and independent oversight, complex health technology initiatives can become fragmented, difficult to manage, and challenging to sustain. The Rural Health Transformation Program presents an opportunity to strengthen the planning, coordination, and implementation of technology and operational initiatives that support rural healthcare delivery. This includes the need for independent program management, vendor oversight, and technical validation to ensure that projects meet performance, security, and interoperability expectations. Many large technology initiatives rely heavily on vendors to manage implementation, test system performance, and validate security controls. Establishing an independent oversight capability allows the state and participating organizations to conduct objective project monitoring, security and privacy reviews, and independent quality testing when internal resources are limited. This approach strengthens accountability, reduces risk, and helps ensure that technology investments deliver reliable and sustainable benefits for rural communities.	Our proposed approach establishes an independent program management and governance capability to support rural health transformation initiatives across Alaska. Rural health systems operate across small clinics, tribal health organizations, regional hospitals, and telehealth networks, which creates significant challenges for coordinated implementation of technology, data interoperability, and operational initiatives. Without structured oversight, projects can become fragmented, difficult to manage, or unsustainable. Our approach strengthens planning, coordination, and independent oversight to ensure initiatives are implemented effectively, securely, and sustainably, maximizing benefits for rural communities. The project begins with establishing governance frameworks, reporting structures, and decision-making processes that align initiatives with statewide priorities. We would facilitate coordination among state agencies, providers, tribal health organizations, and vendors to ensure consistent standards, timely delivery, and clear accountability. Key services include independent monitoring of vendor deliverables, software quality testing, privacy and security reviews aligned with HIPAA, CJIS, NIST, and FedRAMP, and validation of technical and operational performance when internal resources are limited. This independent oversight ensures vendors cannot self-certify their work, reduces risk, and strengthens accountability across initiatives. Additional support includes program and project planning, risk tracking, stakeholder engagement, continuity of operations planning, disaster recovery planning, and development or review of policies, procedures, and standards. By providing independent oversight and structured program management, our approach improves interoperability, care coordination, and the reliability of health systems. It also reduces reliance on vendors, mitigates technical debt, and supports sustainable, high-quality healthcare delivery and access for Alaska’s rural, remote, and frontier communities. Through clear oversight, measurable performance tracking, and alignment with statewide goals, this project ensures technology investments deliver long-term impact and build capacity for ongoing transformation.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

AWARE, Inc	Behavioral Health Support for Vulnerable Youth	AK	Behavioral health supports for youth are in short supply in Juneau, and nearly non-existent for remote communities in northern SE Alaska. While several agencies provide these services (Bartlett Outpatient Services, SEARHC, JAMHI Family), they are unable to maintain a qualified staff to meet demand, and their waitlists are long- some over 8 months. As emergency shelter providers, AWARE and ZGYC see families in acute crisis, often experiencing violence, homelessness, food insecurity, and extreme poverty. As a result of acute and generational trauma, many families and young people experience substance use disorders, and/or mental illness. All of the youth we see likely have substantial ACEs scores, and many have or will develop PTSD as a result of their repeated early traumas. Shelter can be a reprieve from the dangers of the street or violent homes, however, staying in a congregate shelter, even when the youth or family really want assistance, is often very challenging. The staff at both shelters is experienced and caring, however, the magnitude of challenges facing these children and young people rightfully call for clinical supports. When children or youth use violence against themselves or others, we have very few options, outside of the emergency room, to access care that can help keep them safely sheltered. And leaving shelter, either because they are a danger to others or they cannot cope with the environment, increases their risk of harm dramatically.	AWARE and ZGYC propose funding and sharing a clinical provider who can provide behavioral health support in a acute and medium-term situations for children and youth utilizing our shelter services. We believe that one clinical position could serve the needs of both shelters, and also be available for assistance with families who are housed but are utilizing AWARE's victim services or ZGYC support services. We envision a Behavioral Health Consultant (BHC) model, with the clinician located in our shelters, that can provide brief, solution-focused, sessions aimed at functional improvement, often utilizing cognitive-behavioral therapy (CBT), relaxation techniques, and psychoeducation. We are looking for a BHC who has experience with individual, group, and family interventions. We believe this program could grow to include a range of options based on the unique child/youth need. It is essential that safe family members are included in the youth's care, and can learn to be that person's support as they transition out of crisis care. We also believe that a small but extremely vulnerable population of youth would benefit from accessing behavioral/substance abuse assessments to access longer term care. If these assessments are available within their shelter/care environment, the chance that the youth will cooperate and finish the assessment increases greatly. Access can mean the difference between receiving needed treatment as a teen vs living with a lifelong substance use disorder. Also, our BHC would assist with staff development, helping to increase successful interactions between youth and non-clinical staff. Staff, particularly at AWARE, often struggle with 18-21 year olds, as they present often with adult challenges, but have yet not developed adult coping capacities. AWARE would also require additional funding to hire part-time childcare providers, as staffing ratios often cannot accommodate childcare on top of necessary advocate duties, such as answering our 24 hour careline and monitoring the shelter. Finally, both programs would benefit from assistance from a nutrition specialist, as the families and youth who enter our programs often experience food insecurity, and have developed unhealthy habits around food consumption. Youth in ZGYC programming demonstrate often demonstrate confusing beliefs about food and nutrition, that may not fit the definition of a clinical eating disorder, but are clearly negatively impacting their health.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

AWARE, Inc	Ensuring Access for Low Income Alaskans in SE Alaska	AK	There are two "elements" to this problem- the significant need for low-income Alaskans, particularly those served by social service agencies in Juneau, to obtain functioning computers/laptops to attend remote appointments for medical and behavioral health appointments. AWARE serves many remote clients who have been impacted by domestic and sexual violence, are seeking assistance, and are asked to access telemedicine options in Juneau. Many of these folks lack the financial resources to buy and maintain a home computer. Some are able to access telemedicine from their phones, but even for those individuals/families may have difficulty operating the software or even seeing the provider due to the limited screen and functionality. Laptops would enable better remote access, as well as other collateral benefits, including the ability to fill out on-line applications for services, medical releases, job search and resumes materials, etc. The need is the first element of this problem; the second element is the waste that is generated by laptop turn-over at agencies served by Hansen Gress. Their clients replace hardware as needed and also according to funding/service schedules. This means that older, but functional, laptops are often surrendered for wiping and end up not being used. Hansen Gress would like to see these resources being used by low-income Alaskans who really need technology to access care, rather than surrendered for parts or disposal.	Our project envisions Hansen Gress providing these recycled laptops to AWARE for distribution to AWARE's existing clients, as well as other low-income Alaskans who need assistance. AWARE sees such a benefit to this program for our participants that they are happy to serve as the distribution hub, and expand that distribution beyond survivors,. because access to healthcare and services is an essential element of violence prevention. This project would use funding to ensure Hansen Gress could wipe and restore functionality to laptops surrendered by their clients as well as any hardware-related expenses to ensure security compliance standards are met. They would provide those machines to AWARE, who would use the remaining funding to distribute the laptops to survivors and low income Alaskans who apply to the program.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Skagway (Municipality); Yakutat (City and Borough)	Deferred or Not Advanced

A-Z Speech Therapy, Inc	Alaska Rural Therapy Project: A-Z Mentorship Collective	AK	Rural Alaska students and families experience uneven access to speech-language services. Many districts fill vacancies by contracting with large, out-of-state staffing companies whose itinerant providers fly up for short assignments. This approach: Increases travel time and cost, Sends a significant share of public funds Outside, Contributes to provider burnout when “Alaska adventure” travel is layered on top of clinical work, and Leaves little lasting connection to community priorities or local mission. Because funding for in-person services varies widely, some districts can afford regular on-site SLP weeks while others must rely heavily on teletherapy. This creates inequities in service intensity, opportunities for coaching, and IEP/IFSP compliance across regions. The opportunity is to use Rural Health Transformation support to build an Alaska-based itinerant and mentorship collective that: Hires clinicians who live in Anchorage and travel out to rural communities, Keeps funding and expertise in Alaska, and creates a structured pathway for therapists to serve rural students, experience rural communities, and enhance service delivery given a hybrid approach to speech therapy services. By building relationships with the communities, the ART Project aims to mentor therapists over multiple years rather than as brief visitors.	A-Z Speech Therapy will launch the Alaska Rural Therapy (ART) Project as an Anchorage-based itinerant SLP and mentorship program dedicated to rural communities as a resource pool for first school districts, and eventually ILPs and/or Native Corporations. Key elements of the approach include: Anchorage-based itinerant team: Recruit 2 SLPs who live in Anchorage and commit to 2-3 years of blended work that includes regular hub-and-spoke rural travel with remaining time focused on Anchorage-based services and project activities. Services in Anchorage may be delivered as part of a hybrid model with contracted partners when specified in agreements, or as private speech therapy services through A-Z Speech. Provide approximately 6-12 service weeks per school year across one to two partner districts and/or associated ILPs/Native corporations (depending on expressed need of district or entity). Service model During rural weeks: conduct evaluations, direct intervention, IEP/IFSP participation, screenings, staff and caregiver coaching, and planning so strategies continue after the team leaves. Between trips: offer teletherapy and consultation where contracts support it; otherwise, clinicians participate in mentorship, complete follow up documentation and report writing, while maintaining skills and employment through Anchorage-based intensives during weeks not providing rural services. Mentorship and workforce development Implement a staged mentorship program (Foundations, Growing Clinician, Senior Clinician, Mentor) with IECMH-informed reflective supervision and Alaska-specific training. Recruit therapists into a defined “Alaskan abroad” experience, with an option to progress into mentor roles by year four, acknowledging and planning around expected workforce mobility. Partnership and design Conduct at least one owner-led, Rural Health Transformation-funded site visit to partner communities in Year 1 to co-design schedules, workflows, and communication practices. Formalize contracts and MOUs where districts pay for billable services and lodging, while grant funds support recruitment, mentorship, planning, and infrastructure. Infrastructure and data	\$50,000-\$250,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area	Deferred or Not Advanced

Build telehealth capacity as needed, documentation templates, and simple data systems to track students served, sessions delivered, and outcomes, supporting continuous improvement and reporting.



Bamboo Health, Inc.	Transforming Rural Care Through Real-Time Connectivity and Coordination	KY	Alaska’s vast geography, dispersed population, and current behavioral health infrastructure create unique challenges for rural and village communities. Even though providers collaborate well, they often operate in isolation, with limited visibility into available treatment capacity across regions. As a result, individuals in crisis may face long wait times, unnecessary emergency department boarding, out-of-state placements, or gaps in follow-up care. Workforce shortages and constrained financial resources further strain the system. Transforming rural care through real-time connectivity and coordination is essential to overcoming these barriers. Bamboo Health’s approach connects hospitals, crisis teams, behavioral health providers, and other stakeholders through shared, real-time data infrastructure. This visibility enables faster placement into appropriate levels of care, reduces duplication and delays, and strengthens care transitions at pivotal moments such as crisis events or hospital discharge. By unifying fragmented data streams and embedding coordination into daily workflows, Alaska can better preserve scarce rural capacity, support providers with limited staff, and intervene earlier to prevent costly escalation. Real-time connectivity ensures that geography no longer determines access to timely, appropriate care—creating a more equitable, efficient, and sustainable system for Alaska’s rural and village communities.	Bamboo approach to transforming rural care in Alaska centers on building shared, real-time infrastructure that connects providers, improves visibility, and embeds coordination into workflows. Bamboo creates a unified ecosystem that enables providers to act quickly and confidently at pivotal moments in care. At the foundation of this approach is the Bamboo Intelligence Hub® (BIH®), a statewide platform that integrates data across hospitals, behavioral health providers, crisis, and other key partners. BIH® delivers longitudinal, real-time insight into an individual’s interactions across the care continuum, ensuring that providers in rural communities no longer operate in isolation. As an initial step, Bamboo proposes implementation of Open Beds®, our real-time behavioral health availability with embedded closed-loop referrals. Open Beds® gives providers immediate visibility into treatment capacity across regions, replacing time-consuming phone calls and manual processes with streamlined digital referrals. This accelerates placement into appropriate levels of care, reduces boarding and delays, and helps retain patients locally whenever clinically appropriate. Beyond improving placement, Bamboo’s approach strengthens care transitions. BIH® surfaces pivotal care moments, such as crisis encounters, hospital admissions, or discharges, and flags individuals at elevated risk of repeat utilization. This real-time intelligence allows providers to intervene earlier, coordinate follow-up, and reduce preventable escalation to higher-acuity, higher-cost settings. In future phases, BIH® can expand to integrate additional data sources, including PDMP access, Justice-Involved data, ADT feeds, and Bamboo Bridge®, an AI-enabled care navigation model with human-in-the-loop support. By unifying these data streams within a single secure hub, Alaska can move from reactive care to proactive, coordinated intervention. Importantly, Bamboo’s approach is provider-centered and locally informed. We engage stakeholders through listening sessions, workflow alignment, and role-based training to ensure the platform supports, not burdens, rural teams with limited capacity. Through real-time connectivity, closed-loop accountability, and cross-sector collaboration, Bamboo’s approach addresses geographic barriers, workforce constraints, and fragmented systems, creating a more coordinated, efficient, and sustainable model of care for Alaska’s rural and village communities.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Bartlett Regional Hospital	Bartlett EHR Conversion - Technological Infrastructure Update	AK	Bartlett Regional Hospital currently uses five different software platforms for Electronic Health Records (EHRs). Our main hospital, skilled nursing facility, Home Health and Hospice, pediatric clinic and other clinics each use separate EHR systems which are not connected. Some of these are older and outdated, and several came to us with clinics or facilities we have absorbed while expanding our community services. These software platforms are not designed to integrate, and advanced AI healthcare applications cannot gather information from our wide array of patient health information platforms. For our clinical staff, accessing patient information in so many ways, from so many sources, is challenging and can create gaps that impact care. In addition, older technology limits our access to opportunities to improve healthcare outcomes by not accessing the most modern technological advances in healthcare data and insight.	This project involves the purchase of and conversion to a single EHR platform (EPIC) that will integrate all the data systems of our hospital and specialty clinics and facilities. Consolidating patient information and providing smooth and contiguous access across our departments and clinics will prevent gaps that can negatively impact patient care. With this cutting-edge software, we would be able to access new and emerging AI healthcare applications that would provide a world of insight and pertinent information for each individual healthcare interaction. A patient at Bartlett would benefit from the same world-class assistive technology as would a patient in a higher density community. Bartlett Regional Hospital will purchase cutting-edge EHR software and conversion services to integrate information from existing hospital software and provide AI and other assistive technology for improved clinical usage and enhanced patient experience and outcomes. Bartlett leadership has approved this project and will manage implementation. Institutional staff, including Information Systems department and executive steering committee are experienced at managing systems upgrade and conversion projects.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

Bartlett Regional Hospital	Bartlett New Cardiology Clinic	AK	Juneau's healthcare system lacks local cardiology services; this represents a longstanding gap in access to care for our region. Patients requiring cardiology or ongoing management of cardiac issues must travel by airplane out of the region to either Anchorage or Seattle. This can result in delayed diagnosis of cardiac disease, increased medevac flights for consultation of cardiology, and poor cardiology management, as travel can place financial and emotional stressors on the patient as well as their family. Sometimes, it means that patients simply don't get the care they need, because the barrier to access is just too high. Cardiovascular disease remains a leading cause of morbidity and mortality in Alaska. As Juneau is geographically isolated and has an aging in place population, Juneau's lack of cardiology services creates significant access barriers and inequities in care. Currently Juneau has approximately 5,500 seniors over 65; projections for 2030 rise to 6,200 seniors over 65. That is a 13.7 % increase in the next 4 years. This request seeks to close the gap in access to cardiac services that will be felt far into the future. Having local cardiology services will help Alaskan seniors age in place and remain in their home state, getting the care they need throughout their lives.	Bartlett has been talking with a cardiology practice in Anchorage that has expressed interest in working with our hospital to provide services in Juneau. Bartlett also has an available space that is already set up to provide clinical services. The cost of starting up a new cardiology clinic in Juneau is prohibitive, as it will take up to a year to establish a patient roster sufficient to self-sustain. For this reason, private cardiology groups are hesitant to commit to coverage in Juneau without a guarantee of income. RHTP funding would support the startup cost of contracting with the cardiology group to bring services to Juneau during the first year of establishing the clinical practice. The bridge funding would ensure that the specialists were paid while Bartlett stands up and advertises the new services, building a sufficient patient load for sustainability.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

Bartlett Regional Hospital	Bartlett Secure Communication Expansion	AK	Bartlett Regional Hospital currently relies on TigerConnect for secure HIPAA compliant, clinical communication, care coordination, and operational messaging. However, our clinical workflows, physician scheduling processes, and patient engagement functions remain fragmented across multiple unrelated platforms. This results in delayed communication, inefficiencies in provider scheduling, difficulty coordinating care teams, and limited patient-to-clinician communication pathways. The opportunity is to expand and stabilize the hospital’s communication infrastructure by renewing TigerConnect under a multi year unified platform model, adding modules that improve patient engagement and experience and ease staff burden. This will allow Bartlett to strengthen role based communication, integrate scheduling directly into care team messaging, and introduce standardized patient engagement tools that operate inside a single, HIPAA compliant system. Consolidating these functions improves reliability, reduces paging and manual outreach burdens, and enhances the speed and safety of clinical decision-making.	This project renews Bartlett’s TigerConnect contract for a 3-year term and strategically expands its capabilities to strengthen secure communication and care coordination. Offering a secure avenue for communicating with patients will equally benefit our workforce and our patients by enhancing their security and increasing access and promoting the flow of communication. The approach includes: 1. Unified Communication Platform Continue providing 700 Clinical Collaboration + Archiving licenses to ensure all care team members—including nursing, physicians, ancillary departments, and support services—operate in a single, secure messaging environment. 2. Integrated Physician Scheduling (250 users) Implement the TigerConnect scheduling module to centralize call schedules, automate fair-shift assignments, and sync role-based communication assignments. This removes reliance on manual spreadsheets and third-party scheduling tools, reducing errors and delays when identifying the correct on-call provider. 3. Patient Engagement Module (50 licenses) Adopt Patient Engagement Pro to allow secure patient texting, virtual visits, and care follow-up without requiring patients to download an app. This creates a consistent pathway for nurses and clinicians to communicate with patients during pre-admission, post-discharge, and ongoing care. 4. Multi-year cost stabilization A 3-year agreement provides predictable annual expenses, mitigates price volatility, and reduces staff turnover associated with repeated re-contracting. 5. Implementation & Training TigerConnect will conduct implementation work included in the agreement, ensuring configuration of scheduling rules, role-based assignments, and integration with existing systems where applicable. Staff education will be delivered through BRH’s Clinical Informatics and IS departments. This approach strengthens clinical operations, enhances patient experience, and builds a sustainable communication infrastructure.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

Bartlett Regional Hospital	Bartlett Clinical Mobility & Point of Care Infrastructure Upgrade	AK	Bartlett Regional Hospital is an aging but still very useful facility that benefits from the use of modern mobile technology solutions instead of purpose-built spaces with hardwired tech devices. The workstations on wheels (WOWs), for example, work well for bringing patient charts and records to the bedside -- as long as they are charged and ready to use. Unfortunately, our fleet of WOWs is aging, and specifically, they rely on aging, short-use batteries that often don't hold a charge long enough to complete patient care services. In addition, the different WOWs work differently. Some have locking storage for prescription distribution and various accessories, but others do not. Lack of standardization and decreasing reliability makes it increasingly difficult to rely on these WOWs for bedside patient care. Bartlett Regional Hospital's clinical mobility equipment is aging, inconsistent, and increasingly unreliable across Med/Surg and other patient-care areas. This leads to workflow delays, reduced documentation efficiency, inconsistent infection-control practices, and increased maintenance burden on IT.	Workstations on Wheels (WOW) are an excellent solution to the problems of aging facilities and infrastructure and allow hospitals to provide excellent, modern care at the patient's bedside in buildings that were built under a paper chart model. Rather than attempting to fund large-scale construction or remodel projects, utilizing updated, ergonomic and efficient WOWs allows hospitals to provide excellent care with a sustainable investment. This project seeks to replace aging WOWs with standardized, AC-powered Mosaic LCD carts (with and without drawers) and associated accessories such as slotted shelves, scanner mounts, and wipes holders. These devices ensure improved ergonomics, availability, and workflow reliability for frontline staff. Bartlett will acquire 15 Mosaic AC carts with drawers and 15 Mosaic AC carts without drawers, each with standardized accessories to support clinical operations. The project will proceed as a coordinated clinical-infrastructure upgrade. IT will procure and deploy 30 standardized Mosaic WOWs (15 with drawers, 15 without) along with their accessories. These include slotted shelves, rear T-slot mounts, adjustable wipes holders, and other workflow equipment designed for point-of-care reliability. Deployment would occur in stages: 1. Procurement & Inventory Validation – Finalize order quantities and receive hardware. 2. Configuration & Imaging – Install BRH standard clinical workstation images and security tools. 3. Accessory Mounting & Testing – Attach scanner holders, wipes holders, and mounts; confirm power and mobility readiness. 4. Clinical Rollout – Introduce units into Med/Surg and associated units, removing failed/aging carts. 5. Training & Change Management – Provide short, targeted orientation for nurse super-users. 6. Retirement of Old Units – Decommission outdated carts to reduce support demands.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Bartlett Regional Hospital	Bartlett Computer Replacement Project	AK	Bartlett Regional Hospital has 800 employees serving a regional population of 70,000 Alaskans -- and every service we provide involves the use of a computer and monitor. Currently, staff are using outdated devices that are slow, harder to support, and don't always work well with newer systems like Windows 11, Wi-Fi 6E, or modern clinical applications. As we adopt newer technological solutions and software, updated computers and monitors are essential to the success of these innovations. As it is, our IT department is stretched very thin meeting the ongoing requests for tech support to solve problems caused by incompatible or outdated equipment. Existing equipment at the hospital is hard pressed to meet the daily needs of our clinical tasks, and plans for additional regional telehealth services will stretch this even thinner.	Bartlett proposes to upgrade all older computers and monitors with compatible equipment (approximately 200 laptops, 300 desktop computers, and 1,000 27 inch monitors, some with docking hubs). These devices will make workstations faster, more reliable, and easier for staff to use. Moreover, it will be easier to train clinical and IT staff in their use and repair, as devices will be consistent across the hospital. The upgrade will also support expanding telehealth, Hospice, day-to-day clinical tasks, and remote work. The project plan is as follows: 1. Buy identified equipment (quote already obtained): - o 200 laptops (Dell Pro 14 Plus) - o 300 desktop computers (Dell Pro Micro Plus) - o 1,000 27" 4K monitors (USB C and Thunderbolt models) 2. Prepare the devices: We will load each device with our standard Windows 11 setup, security tools, hospital software, and automatic update settings. The quote includes Windows Autopilot, which makes setup faster. 3. Deploy in phases: - o Start with clinical areas (ED, inpatient units, clinics). - o Move to registration and support staff. - o Finish with administrative departments. 4. Train users and support the rollout: We will provide simple instructions for the new single cable monitor setup and have staff available during go lives to help with questions. 5. Use the included support: Laptops and desktops include ProSupport / onsite service, and the monitors have advanced replacement service. This helps keep downtime low.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Bartlett Regional Hospital	Bartlett Data Center Conversion	AK	Bartlett Regional Hospital’s datacenter controls storage of and real-time access to patient and hospital data. More than just historical records, this data includes labs, x-rays, family histories, prescriptions -- all the information we need to access while treating patients in our hospital, nursing facility, and clinics. Unfortunately, the system is now end-of-life, and the support of its various elements has become prohibitively expensive due to skyrocketing annual contracts for each of the separate elements which no longer work well together. We now spend each year more than 25% of the original cost just to have access to the support. In addition, as the companies have all been sold to other companies, the number of people who still work on this convergent system has dwindled to just a handful, putting us in a very vulnerable position. We need to move to a cloud-based storage system that is not tied to specific vendors, giving us the flexibility to choose vendors based on costs and to access newer technology and innovation. The current datacenter infrastructure also lacks capacity and redundancy for rapid and comprehensive disaster recovery. Mean Time to Recovery (MTTR) remains well below industry-recommended Recovery Time Objectives (RTO), leaving the hospital vulnerable to service interruptions that could jeopardize patient care. We need to establish a secondary offsite data storage center to hold data concurrently for immediate access in the event of disruption.	We will replace our current data center with a more flexible system that is not tied to multiple, non-integrated vendors with expensive support contracts and limited available expertise. We will store data on the cloud, and also use an offsite data storage facility to maintain a redundant storage system that will prevent gaps in access during any disruptive event. 1. Deploy a vendor and hypervisor agnostic hybrid cloud-integrated data-center platform on Bartlett campus. 2. Deploy a one-to-one off-site disaster-recovery (DR) site, creating a real-time replication datacenter, with automatic failover to ensure continuity of care and meet the state’s emphasis on resilient health IT systems. We have identified an available data center within a City and Borough of Juneau (CBJ) facility, and we would offer our hospital data center as a redundant system for CBJ data as well. 3. Modernized infrastructure positions Bartlett to leverage zero-cost, open source, self-hosted, Large Language Models and other advanced AI data analytics tools. 4. Additional and more efficient infrastructure provides the capacity to pilot emerging technologies and develop shared service partnerships with other organizations. 5. Sustainability comes from elimination of skyrocketing vendor support costs and contracts. Extensibility of non-converged architecture and the pay-as-you-go cloud resources connections create a financially sustainable solution that can scale up or down with demand.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Bartlett Regional Hospital	Bartlett Molecular Diagnostics	AK	Bartlett's laboratory currently has an aging molecular testing system that has reached end-of-life. We currently have eight testing slots, which is insufficient to meet our testing volumes. We need to double our testing slots and increase the number of unique tests that we offer in house, in order to provide accurate diagnosis and enable appropriate interventions. As we bring in more tests, lack of slots can delay test resulting and affect care decisions and outcomes.	Bartlett needs to replace end-of-life laboratory testing equipment with newer molecular testing technology and expand the slots for testing to meet the overwhelming need. Having recently added a skilled nursing facility and primary care and pediatric clinics to our institutional umbrella, the laboratory needs to support increased in-house testing requests and provide timely results to all our departments. Replacing aging equipment with advanced molecular testing technology with expanded capacity will improve access to timely healthcare and appropriate intervention for all Bartlett patients. Modern molecular testing is more sensitive than other testing solutions and offers rapid results for many testing inquiries that determine diagnosis and treatment. Rapid molecular testing also identifies bacterial, viral and parasitic pathogens, providing accurate detection of disease and aiding in infection control by early diagnosis.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Bartlett Regional Hospital	Bartlett Staff Trauma Support System	AK	Bartlett currently lacks a structured, evidence-informed system to support staff exposed to traumatic events, critical incidents, and cumulative occupational stress. Hospital employees frequently and regularly encounter emotionally intense situations, yet responses are handled inconsistently, often relying on informal peer support or ad hoc debriefings in the absence of structured supports. This gap increases the risk of burnout, compassion fatigue, absenteeism, and long-term psychological effects. With more than 800 employees and an average of 70 open positions, worker satisfaction and retention is a critical goal that affects our ability to provide excellent care to our patients. Protecting and supporting our staff is also a humane responsibility of the organization, as our coworkers are also our community members and patients.	Bartlett will establish a coordinated Critical Incident Stress Management (CISM) trauma support program that provides timely, standardized interventions, strengthens organizational resilience, and fosters a culture where psychological safety of staff is prioritized. By implementing a proactive and comprehensive approach, the organization can reduce negative impacts of trauma exposure and improve staff wellbeing, retention, and overall functioning -- positively affecting patient care. We will create an internal response team, trained in the CISM principals and overseen by a clinician, providing appropriate supports to employees experiencing the effects of trauma exposure. The project will implement a multi-tiered Critical Incident Stress Management (CISM) program tailored to the organization’s operational environment. The approach includes: • Program Design and Policy Development: Establish protocols for activation, confidentiality, referral pathways, and integration with existing wellness and HR systems. • Team Formation and Training: Recruit a multidisciplinary CISM team composed of trained peers, supervisors, and mental health professionals. Team members will complete recognized CISM training modules (e.g., Group Crisis Intervention, Assisting Individuals in Crisis). • Core Intervention Services: Provide structured interventions such as defusing’s, debriefings, one-on-one crisis support, peer support, and follow up check-ins after critical incidents. • Preventive and Educational Components: Offer resilience building workshops, psychoeducation on stress reactions, and training for supervisors on recognizing early signs of distress. • Partnerships and Referral Networks: Collaborate with local mental health providers for higher level clinical care when needed. • Evaluation and Continuous Improvement: Track utilization, participant feedback, and organizational indicators (e.g., sick leave, turnover) to refine the program. This approach ensures a comprehensive, scalable, and culturally aligned trauma support system grounded in best practices.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Basecamp Medical, LLC	Preventive and specialty-level metabolic care across geographically isolated communities.	AK	Rural Alaska faces persistent structural barriers to timely specialty and preventive healthcare access. Extended waiting times for endocrinology, metabolic medicine, and primary care services contribute to delayed diagnosis, unmanaged cardiometabolic risk, and avoidable disease progression. System-level gaps include: • Limited rural access to metabolic and hormone-focused specialty evaluation • Inadequate early screening for insulin resistance and cardiometabolic dysfunction • Fragmented care following hospital discharge • Workforce shortages limiting service expansion • Reduced telehealth reimbursement models impacting rural care delivery • Geographic barriers that increase travel burden and delay intervention These structural barriers disproportionately affect workers in Alaska’s essential and resource-based industries. These sectors represent the backbone of Alaska’s economy and frequently operate in geographically isolated or rotational work environments where preventive healthcare access is limited. Delays in early metabolic and cardiometabolic intervention contribute to workforce absenteeism, reduced productivity, medical evacuation costs, and avoidable high-acuity utilization. Strengthening preventive access in these populations directly supports both individual health outcomes and statewide economic stability.	Basecamp Medical proposes the development of a statewide, telehealth-enabled rural metabolic optimization network designed to strengthen Alaska’s healthcare infrastructure through early detection, coordinated management, and system integration. Key components include: • Expansion of telehealth-based metabolic and endocrine screening services • Standardized rural screening protocols for metabolic syndrome and related dysfunction • Integration of remote monitoring technologies (continuous glucose monitoring, blood pressure monitoring, cardiovascular risk markers) • Deployment of mobile diagnostic and point-of-care testing capabilities • Interim specialty-level management for patients awaiting referral appointments • Workforce expansion to include additional acute/primary care providers and interdisciplinary care team members (health coaches, nutritionists, pharmacists, exercise physiologists) • Structured care coordination to reduce fragmentation and improve continuity This model shifts care upstream by addressing modifiable risk factors before progression to advanced chronic disease.	\$250K-\$1M	Private practitioner	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Be Well Counseling LLC	Expanding Access to Perinatal Mental Health Education and Support for Alaska Families	AK	Perinatal mental health conditions, including postpartum depression and anxiety, can significantly affect the wellbeing of mothers, infants, and families. In Alaska, access to mental health providers with specialized training in perinatal mental health remains limited, particularly for individuals covered by Medicaid and those living in rural or remote communities. As a result, many pregnant and postpartum mothers struggle to find providers with expertise in prevention, early intervention, and treatment of perinatal mental health conditions. Pregnancy and postpartum care providers in Alaska often include basic screening and education related to maternal mental health. However, these conversations are typically brief and may not provide mothers or families with practical tools, strategies, or guidance for recognizing and responding to mental health challenges during pregnancy and the postpartum period. Partners and family members may also have limited understanding of warning signs or ways to support maternal mental health. These gaps represent an opportunity to strengthen preventive behavioral health support for mothers and families across Alaska. Expanding access to education, early awareness, and specialized support can help healthcare providers better support maternal mental health while improving outcomes for mothers, infants, and families statewide.	A central component of the project will be the development of a Perinatal Mental Health Resource Hub, a free digital platform providing structured educational content focused exclusively on maternal mental health. The Hub will guide individuals through a mental health curriculum similar in structure to childbirth education programs, supporting mothers through different stages of pregnancy and the postpartum period. Content will focus on mental health awareness, coping strategies, emotional regulation, and practical tools that support wellbeing during pregnancy and early parenthood. While national maternal mental health resources exist, they are often designed for urban healthcare systems and do not address the geographic, cultural, and healthcare access realities of Alaska. This project will develop Alaska-specific perinatal mental health resources designed to integrate into prenatal care and support mothers, families, and providers in Alaska. The Resource Hub will include short educational videos, reflection exercises, mental health toolkits, validated screening tools as well as guided self-check resources, and practical strategies designed to help mothers recognize emotional changes and develop supportive coping skills. Educational resources for partners and family members will help them recognize warning signs and better support maternal mental health. Content will be developed in collaboration with community partners to ensure materials reflect culturally relevant perspectives and the lived experiences of families across Alaska. Healthcare providers, including obstetric care providers, midwives, behavioral health clinicians, and community health professionals, will be able to refer patients to the Resource Hub during pregnancy as part of routine care. This allows maternal mental health education to enhance remote maternal health care in Alaska. The project will also support workforce development by recruiting and training mental health therapists interested in providing perinatal mental health services in Alaska. Recruitment efforts will focus on therapists interested in providing virtual services to Alaska residents or relocating to serve Alaska communities. Together, these activities will expand access to perinatal mental health education, strengthen provider referral pathways, and increase Alaska’s capacity to support maternal mental health.	Under \$50,000	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Be Well Counseling LLC	Strengthening Neurodivergent Care Access and Workforce Capacity in Alaska	AK	Adults with ADHD and autism face significant challenges navigating employment, education, relationships, and independent living due to executive functioning difficulties, sensory regulation needs, and other impacts of neurodivergence. Access to specialized care that helps individuals develop strategies to manage these challenges is limited across Alaska. While some services exist for children and adolescents, far fewer resources are available for adults. Occupational therapy and behavioral health professionals can play a key role in helping neurodivergent adults develop strategies that support independence and wellbeing. However, Alaska currently has very few providers experienced in supporting adults with ADHD and autism. As a result, many adults rely on general healthcare or behavioral health providers who may have limited training in neurodivergent-informed care. Healthcare providers, behavioral health clinicians, case managers, and community support staff report lacking tools and training to effectively communicate with and support neurodivergent adults. Many students leave the state to pursue higher education and do not return to practice. This project presents an opportunity to strengthen Alaska’s workforce by recruiting clinicians and trainees interested in supporting neurodivergent populations and encouraging them to build careers serving Alaska communities while increasing statewide capacity to support adults with ADHD and autism.	To address the limited availability of neurodivergent-informed care and support for adults in Alaska, Be Well Counseling proposes to develop a statewide initiative focused on three pillars: provider education, public access to practical resources, and workforce development. The project will be led by a full-time Occupational Therapist with expertise in ADHD and autism who will serve as Program Director. This role will coordinate project implementation, develop training curriculum, support outreach and partnership development, establish a practicum placement program, and guide the creation of educational resources. A neurodivergent-specialized mental health clinician will also support the project by contributing clinical expertise, assisting with curriculum development, and co-facilitating trainings. A core component of the project will be the development and delivery of a statewide neurodivergent training program designed to strengthen provider capacity across Alaska. Quarterly virtual trainings will be offered to healthcare providers, behavioral health clinicians, case managers, and community support staff. Additional workshops may be delivered in collaboration with partner organizations to support staff working directly with neurodivergent adults. The project will also develop the Be Well Neurodivergent Resource Hub, a free digital platform providing practical tools and educational resources for neurodivergent adults and their families. The Hub will include short educational videos, downloadable guides, and practical strategies related to executive functioning, sensory regulation, communication skills, and daily living supports. These resources will be accessible online to individuals and families throughout Alaska. Providers will be able to utilize this resource hub when providing care. To support long-term workforce development, the project will establish a neurodivergent training pipeline by recruiting occupational therapy and mental health trainees interested in working with neurodivergent populations in Alaska. Practicum placements and mentorship opportunities will provide trainees with specialized experience supporting Alaska residents. Together, these activities will strengthen the capacity of providers across Alaska while also improving access to practical neurodivergent support resources for individuals and families statewide.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Bee Well Chiropractic	Alaska Rural Health Access & Long-Term System Sustainability Initiative	AK	Rural Alaska communities lack consistent access to preventative musculoskeletal and nervous system care. Families in Talkeetna, Glacier View, and Kodiak already travel extended distances for chiropractic services. This travel burden delays care, increases out-of-pocket costs, and limits early intervention opportunities. Chiropractic care remains concentrated in urban hubs, despite its role in chronic pain management, maternal health support, pediatric development, and nervous system regulation. There is a transformative opportunity to build a Native American veteran-led rural expansion model that integrates prevention, workforce development, technology, and regional partnerships into a long-term statewide strategy.	Year 1: Infrastructure & Pilot Expansion • Portable equipment acquisition • Telehealth platform integration • Establish Talkeetna and Glacier View outreach rotations • Partnership outreach to Kodiak providers Years 2–3: Rural Deployment & Workforce Development • Regular outreach clinics in Talkeetna, Glacier View, Kodiak • Begin collaboration with Tribal Health Organizations Year 4: Regional Integration • Expand into additional hub communities • Establish recurring service contracts or shared-care models • Recruit additional providers with rural focus Year 5: Sustainability & System Integration • Embed services into regional care networks • Reduce reliance on travel to Palmer • Develop long-term workforce pipeline The approach supports RHTP goals of innovation, prevention, workforce strengthening, and sustainable statewide health transformation.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Denali Borough; Kodiak Island Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Behave Health Corp.	Software Access For Effective Treatment (SAFE-T)	CA	A persistent barrier to behavioral health care in rural Alaska beyond limited capacity is limited visibility and coordination across fragmented provider networks. This makes it difficult for those in need to find and connect to appropriate services. This proposal advances a Core Platform Strategy through SAFE-T (Software Access For Effective Treatment), a statewide network directory with provider information and, where enabled, real-time bed availability. SAFE-T will serve as (1) a provider-facing coordination and referral tool to support timely placement and warm handoffs, and (2) a patient-facing directory that helps people identify, schedule, and engage with care across the spectrum. SAFE-T supports Alaska RHTP’s Spark Technology & Innovation priority to “develop community-based system navigation applications” and aligns with CMS Rural Health Transformation goals to promote innovative technology that improves care efficiency, strengthens data security, and expands access to digital health tools for rural providers and patients. The platform will apply privacy-by-design safeguards for workflows involving ePHI, including HIPAA Security Rule-aligned controls (45 CFR §164.312) and, where applicable, protections consistent with 42 CFR Part 2. Beyond navigation, SAFE-T strengthens cross-cutting RHTP priorities by improving access pathways, reducing administrative burden, and providing reporting that identifies service gaps and supports sustainable system planning.	Behave Health has served over 2,000 opioid use disorder treatment centers, recovery residences, and recovery community facilities for the past 11 years. We currently provide directory software for 19 states through chartered state-level National Alliance for Recovery Residences (NARR) affiliate organizations. Building on this experience, our Alaska deployment will follow a phased, stakeholder-led approach that prioritizes verified data, rapid onboarding, and continuous improvement. SAFE-T strengthens and integrates with Alaska’s broader transformation agenda. It can reinforce Alaska’s Behavioral Health 1115 Waiver service delivery (7 AAC 139) by making waiver-covered services and access pathways more visible and actionable. It aligns with statewide crisis system transformation work documented by the Alaska Department of Health, helping operationalize “no wrong door” routing. 1. Stakeholder discovery and scope definition. We will convene state and regional stakeholders to define directory scope, priority service categories, required data fields, and Alaska-specific taxonomy. The platform can accommodate listings across the full spectrum, including treatment centers, recovery residences, peer support, recovery community organizations, FQHCs, CCBHCs, and other community resources as requested. 2. Data seeding and verification. We will identify authoritative data sources (for example, state licensing datasets) to seed initial listings, then validate and refine records with stakeholders. Participating facilities can enable a bed availability widget to display real-time capacity, while clearly distinguishing real-time fields from informational listings. 3. Provider onboarding, training, and adoption. We will conduct remote structured training and awareness campaign for organizations across Alaska, with streamlined onboarding and support. Providers will be able to enhance profiles with photos and standardized tags such as populations served, modalities, levels of care, accessibility, and culturally specific supports. 4. Dissemination and integration. SAFE-T will be easily embeddable on state, regional, and partner websites to maximize public and referral-partner access. 5. Monitoring, reporting, and quality improvement. We will monitor utilization, data quality, and deliver regular reports on participation, coverage by region and service type, and directory actions. Ongoing retraining and outreach will expand adoption and strengthen statewide impact over time.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Behavior Matters, LLC	Behavior Matters: Building Rural Capacity through ABA Clinical Rotations and Community Training	AK	Rural and frontier Alaska faces a systemic "geographic gap" in behavioral health. While urban hubs are able to offer Applied Behavior Analysis (ABA) services, families in remote regions must navigate a clinical desert. For children with autism or complex developmental challenges, the absence of local Board Certified Behavior Analysts (BCBAs) leads to delayed interventions, extreme caregiver burnout, and a reliance on costly, disruptive travel to urban hubs. Behavior Matters recognizes a transformative opportunity to shift the paradigm from a "fly-in/fly-out" service model to a capacity-building residency model. By mobilizing clinical expertise directly into the community, we address immediate behavioral needs while seeding a permanent, local support ecosystem that can sustain itself long-term.	Our initiative, "The Ripple Effect," utilizes a hybrid "On-Site Residency + Telehealth-Out" framework to ensure clinical excellence is sustainable, not just episodic. The approach is built on three pillars: - Direct Clinical Mobilization: A BCBA will travel to designated rural communities on regular, scheduled intervals to conduct initial assessments, design individualized behavior plans, and provide intensive face-to-face coaching. - The "Train-the-Trainer" Framework: Every interaction is a "knowledge transfer." By training the families in ABA principles, we empower the existing client team to manage behaviors and promote skill acquisition long after the BCBA departs. - Continuous Digital Mentorship: Between physical visits, we deploy high-frequency, HIPAA-compliant telehealth. This ensures real-time data review, emergency behavioral support, and emotional "wellness checks" for families, maintaining clinical momentum regardless of weather or geography.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kuskokwim Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Behavior Matters, LLC	Behavior Matters: Empowering Alaskans to Localize Behavior Excellence	AK	Rural and frontier Alaskan communities face a critical shortage of intensive behavioral health services. Currently, families rely on infrequent telehealth or high-cost travel for care, leading to inconsistent intervention for children with complex needs. There is a significant opportunity to convert this unmet need into a workforce development engine. By providing high-quality ABA training to local providers, families, schools, and child care facilities, we can resolve the crisis of care while establishing a professional career ladder within the community.	Our approach utilizes a hybrid mentorship model. We will deploy BCBA's to rural sites at regular intervals to provide hands-on, clinical training to parents and community partners. This "in-the-trenches" coaching focuses on functional communication, emotional regulation, and reducing maladaptive behaviors. Between site visits, we maintain continuity via weekly telehealth supervision. This ensures that the science of ABA is not just taught in a classroom, but applied directly within the unique cultural and environmental context of each Alaskan community.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kuskokwim Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

BelleTorus Corporation ("Belle AI")	AlaskaSkin.ai - Statewide Skin Cancer Screening and Skin Health Assessment Powered by AI	AK	Dermatology is among the most access-limited specialties in rural Alaska. Patients routinely wait months and travel hundreds of miles (often by small plane) to see a specialist. These barriers drive delayed diagnosis of skin cancers and common skin conditions that, left untreated, significantly reduce quality of life. Alaska Native and American Indian communities bear a disproportionate share of this burden. AI/AN individuals have the second-highest melanoma incidence in the United States, with melanoma incidence among AI/AN females rising 186% from 1999 to 2017. Fewer than 21% of AI/AN individuals with skin disease have ever seen a dermatologist. Conditions like impetigo, scabies, eczema, and diabetic skin ulcers - highly prevalent in AN communities - also go undertreated due to access barriers. AlaskaSkin.ai presents an opportunity to reach every Alaskan household with a smartphone photo and create a statewide skin health safety net. By combining accessible smartphone-based image submission, AI-assisted triage, central human-in-the-loop review, and targeted BelleLens™ deployment for high-risk cases, this project turns smartphones already in people's hands into the front door of dermatologic care.	The project launches AlaskaSkin.ai - a free, HIPAA-compliant web platform accessible from any smartphone browser - enabling statewide skin triage without requiring app downloads, provider visits, or travel. Stage 1 – Smartphone photo upload and AI triage: Any Alaskan visits AlaskaSkin.ai, photographs a skin concern with their phone camera, and submits it through a guided intake form. Belle's AI analyzes the image across 2,000+ dermatologic conditions and generates an AI-assisted assessment with risk stratification. Cases are reviewed by a human-in-the-loop provider who confirms the triage and issues a structured finding. Stage 2 – BelleLens Deployment for Moles and Pigmented Lesions: When the triage identifies a mole or pigmented lesion warranting dermoscopic evaluation, Belle ships a BelleLens™ dermatoscope to the patient's home or a designated nearby clinic. The patient or a community health aide captures high-quality dermoscopic images using the BelleLens™ paired with Belle's mobile app. These images are reviewed centrally by the dermatologist for skin cancer risk assessment, with clear referral pathways for high-risk findings. This staged funnel maximizes reach while concentrating the highest-cost intervention—BelleLens™ deployment—where clinical need is greatest. The AlaskaSkin.ai platform is designed for low-bandwidth environments and minimal digital literacy, with culturally adapted content for Alaska Native communities. Importantly, AlaskaSkin.ai will have the ability to analyze images of dark-skin population, a unique and fully validated capability of the Belle AI technology. All data is stored in a HIPAA-compliant, encrypted environment. Belle has demonstrated this approach across 70+ countries and 1,000+ sites, including a \$3.5M ARPA-H deployment in the Bronx, Harlem, Queens community health centers, and also in a Defense Health Agency skin cancer screening program for all skin tones in rural Georgia. Belle AI deck for Alaska: https://docs.google.com/presentation/d/1yXj7o3Sxxo00oiqveF1U0eqsWpxDASI2JRpE3mrHEQQ/edit?usp=sharing BelleLens dermatoscope video: https://www.youtube.com/watch?v=9Szr6T47v-s	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Bering Home	Bering Home is a planned residential nursing care home in Unalaska.	AK	Presently, there is no way for ailing residents in the Aleutian region to age in place or pass away at home. Teams of licensed professional caregivers will be on-site 24 hour a day providing adult daycare, assistance with daily living activities, memory care, palliative and hospice care, and respite services in a secure, regulated setting. The program will utilize telemedicine technology between residents' primary care providers and personalized holistic healthcare teams at Bering Home. We will be located in the hub community of Unalaska which has a stable base population of approximately 5500, large enough to support a healthy labor pool. This project will encourage job growth and career stability in the caregiving field as it evolves into internships for on-the-job training and certification.	Bering Home is designed to meet the longstanding and critical need for localized elder care in the Aleutian region. Unlike other care options that require relocation to Anchorage or beyond, Bering Home provides a local solution that will provide professional service while honoring cultural values and strengthening family connections. The company goals are to offer stability by keeping elders, families, and their care-teams together in the community. This will be achieved by: - utilizing new telemedicine technology to connect with residents' primary care providers - developing community-based caregiving teams to enhance health and cultural continuity - developing career opportunities with stable employment - providing housing for staff and residents' traveling family members - creating a financially viable model for rural elder care to model for other communities Bering Home will provide essential services for ten residents on the first floor. The second floor will be reserved for level 2 assisted living residents. The top two upper floor apartments provide caregiver housing to support staff retention and service consistency as well as offering potential housing for family members traveling with their loved ones from nearby communities. This on-site employee housing will promote consistent staffing and sustainability. Our mission is to maximize the quality of life for those who choose to remain in the Aleutian region. Teamwork, confidentiality, accountability, compassion, dignity, and cultural respect are embedded in the home's operational manual. These core values ensure that resident's needs are respected and promptly attended to. Employees act with compassion in even the most difficult situations with the understanding that loss of physical and social control combined with Dementia and Alzheimer's is often the reason for some unacceptable behaviors. It's imperative to maintain dignity when presented with difficult situations. Employees work within teams to mitigate the stress. With careful monitoring and regular communication with healthcare providers via the telehealth program, symptoms of a variety of conditions can be slowed with preemptive care. Diabetes, Alzheimer's and Dementia, even cancer can be treated to minimize symptoms. Teamwork, confidentiality, accountability, compassion, dignity, and cultural respect describes who we are as a business, as a caregiver, as a resident, and as a home.	Under \$50,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Deferred or Not Advanced

Bering Strait School District	Connecting Kids to Behavioral Health Support in the Bering Strait	AK	The Bering Strait region has especially high rates of completed student/young adult suicides and attempted suicides. The percentage of students who self-report they use tobacco, alcohol and marijuana has increased steadily in the past 4 years - the biggest increase being around marijuana. We have higher rates of pregnant or parenting teens and teens being treated for STIs than the national and state averages. This list could continue on - we know this data. The needs are screaming. Despite these significant indicators of mental health struggles, we do not do a good job of connecting our young adult population to mental health supports until their need hits a nearly crisis level. And, even then, there seem to be barriers to making a good connection with village based counselors or regional clinicians. Quite often, students do not want to leave the village to get help but they also have issues with the local village based counselor so they feel stuck. We need to be able to bring the regional resources to the villages. We also need to intervene earlier with stronger prevention, before young people feel hopeless or overwhelmed by other negative feelings. We need to teach them about mental health and practice skills that will allow them to navigate sad or stressful situations successfully so they have agency	The three partners in this grant request are in the beginning stages of planning this work. Our goals are 6-fold: 1) Coordinate together so behavioral health supports are easily and seamlessly available to children and young adults in local villages. Using the school counselor at each site as a conduit between regional agencies and schools and the village based counselor as primary contact with the broader community. Developing MOU's and procedures as needed. 2) Determine where there are gaps and overlaps in our services and make necessary adjustments, if possible. 3) Create a protocol for a coordinated crisis response that works in all parts of our region and considers whole communities, not separating school and village. 4) Create coordinated prevention/education campaigns that are responsive to needs as determined by data collected by partner agencies. Initially, regional specialists could guest present in schools and eventually, school staff could take over those presentations so that regional specialists could continue to develop new trainings. 5) Support recruitment and retention of qualified staff so therapists, clinicians, health specialists and school counselors do not have to itinerate. 6) Create professional development that explores cultural ways of understanding wellness and behavioral health. Envisioning staff at Liitfik guiding this for school counselors and new therapists or clinicians.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Best Beginnings	Screen Smart Alaska: Reducing Screen Exposure to Improve Sleep, Health, and Childhood Development	AK	Alaska children are experiencing growing negative impacts to their physical and mental health due to excessive screen time and reliance on digital media. The American Academy of Pediatrics recommends that children ages birth to five be limited to no more than one hour of screen time per day, including television, videos, movies, and video games. However, Alaska data shows many young children exceed this recommendation. In 2017, more than three-quarters of Alaska mothers of three-year-olds reported their child had at least one hour of screen time per day. Recent statewide assessments reinforce these concerns. The 2024 Early Childhood Alaska Needs Assessment identifies improving child wellbeing as a priority, including decreasing screen time and increasing physical activity. Parents surveyed in both the 2020 Alaska Department of Health and Social Services Needs Assessment and the 2024 Early Childhood Public Opinion Survey reported that children are getting less physical activity and spending more time on screens. Excessive screen time is linked to increased risks of obesity, poor sleep, and cognitive, language, and social-emotional delays. 1 in 3 Alaska children are considered overweight or obese, and the 2025 Alaska Physical Activity, Nutrition and Obesity Facts Report shows declining physical fitness trends. While many recommendations focus on older children, healthy screen habits begin in early childhood and are strongly influenced by parent education and family routines.	Best Beginnings will lead a statewide initiative combining research, community engagement, workforce training, and a public awareness campaign to reduce excessive screen exposure in early childhood. The project will focus on prevention and early intervention by equipping caregivers, educators, and health providers with practical tools that support healthy sleep, physical activity, and reduced sedentary behavior. By embedding guidance on healthy media use within existing early childhood systems and rural health delivery networks, the initiative will strengthen provider and family capacity to address early risk factors associated with childhood obesity and chronic disease. The first phase will research screen use among children from birth through elementary school to better understand where and why screens are used, caregiver attitudes toward digital media, barriers to reducing screen time, and culturally meaningful alternatives to screen use. Through statewide surveys, interviews with educators and health providers, and community listening sessions, the project will analyze patterns across Alaska’s geography, seasons, and diverse communities. The second phase will translate findings into practical toolkits for professionals serving young children. Toolkits will summarize research, explain health implications of excessive screen exposure, and provide guidance on discussing screen use with families. Materials will include strategies that reduce screen time while encouraging play, sleep, and family interaction. Toolkits will also include assessment tools to help programs identify ways their services may unintentionally increase screen exposure. Resources will draw from national models while reflecting Alaska’s unique conditions and barriers identified through research. The project will also launch a statewide public awareness campaign focused on realistic behavioral changes families can adopt. Schools may participate through screen free challenges supported by small mini grants and family rewards. Community gatherings will support adoption and local adaptation. To strengthen rural health systems, the project will integrate healthy media counseling into pediatric care, community health aide programs, home visiting services, and education. Training and toolkits will help providers incorporate guidance during well child visits, developmental screenings, and caregiver education, expanding access to preventive health education and coordination between systems.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Bethel Family Clinic	Bethel Family Clinic Rural Access and Mobile Care Transformation Initiative	AK	Residents of rural communities in the Yukon-Kuskokwim Delta face significant barriers to accessing primary care and preventive health services due to geographic isolation, transportation limitations, workforce shortages, and limited local clinical infrastructure. Many patients must travel to Bethel for routine care or delay treatment until conditions worsen, leading to preventable complications, increased emergency utilization, and higher health care costs. Bethel Family Clinic seeks to address these challenges by expanding access to care through a coordinated rural service delivery model that includes a structured Village Travel Program and mobile care capacity. The program would deploy multidisciplinary clinical teams to rural communities on a scheduled basis to provide primary care, chronic disease management, preventive screenings, and behavioral health services. In addition, the initiative will strengthen the infrastructure needed to support reliable rural care delivery, including electronic health record modernization, improved IT systems, and facility resiliency investments such as backup power systems. Together, these efforts will improve access to timely care, support earlier diagnosis and management of chronic conditions, and strengthen the sustainability of health care services for rural and remote communities across the region.	Bethel Family Clinic proposes to expand access to care for rural communities in the Yukon-Kuskokwim Delta through a coordinated rural care delivery model centered on mobile service delivery, technology-enabled care coordination, and strengthened clinical infrastructure. This project is currently in the Concept Formation stage. Bethel Family Clinic has identified the need to expand access to care for rural communities through a Village Travel Program and supporting infrastructure improvements. The proposed approach includes mobile service delivery, telehealth-enabled care coordination, and technology upgrades to support rural care delivery. While the overall concept and approach are defined, key elements such as detailed scope, operational model, staffing plans, partner roles, and implementation timelines are still being developed. Funding at this stage would support refining the project design, coordinating with partners, and preparing a detailed implementation plan. A key component of the approach is the development of a Village Travel Program, in which multidisciplinary care teams travel to rural communities on a scheduled basis to deliver primary care, preventive services, chronic disease management, and behavioral health support. This model will bring care directly to communities that currently face significant barriers to accessing routine services due to distance and transportation limitations. The program will also incorporate telehealth and digital care coordination tools to ensure continuity of care between village visits and to connect patients with additional services when needed. Investments in electronic health record modernization and upgraded IT infrastructure will strengthen data sharing, improve care coordination, and support more efficient clinical operations. In addition, the project will include facility and operational resiliency improvements, such as backup power systems and upgraded technology infrastructure, to ensure reliable care delivery in a remote and environmentally challenging region. Together, these strategies will allow Bethel Family Clinic to expand access to care, strengthen preventive and chronic disease services, and build a more sustainable and resilient rural health care delivery system that better serves communities across the Yukon-Kuskokwim Delta.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area	Deferred or Not Advanced

Betty Eliason Child Care Center	Healthy Foundations through Quality Early Childhood Care	AK	Currently Sitka's demographic age is shifting with a reduction in the ages of 30-50 years. This is due highly in part to a lack of access to affordable child care. Families often find themselves unable to move to Sitka, and families with young children residing here are struggling to remain in Sitka. Businesses are affected as well both economically and with the situation they find their employees facing with the child care crisis. Sitka licensed child care centers currently do not cover the full child care needs of our community. Additionally, families would like to see options in what early learning environments are available for their children, such as a variety of philosophies applied within different programs. Our enrolled families could benefit from an opportunity for parent education and community resource networking which we'd like to share with others not enrolled in our program as well. The foundation for a healthy life starts with the family and our staff would benefit from collaborative training and education and community networking with the parents and guardians of our enrolled children. I have a Montessori certification and would like to apply more Montessori concepts within our program, offering our community another philosophical approach to their childcare options. SEARCH employees need childcare and employee recruitment efforts can be stifled by lack of childcare for potential providers and staff to move to Sitka, or remain in Sitka.	Betty Eliason Child Care Center (BECCC) has a license capacity of 99 children per day, yet we currently only provide care for 32 children per day operating at about 1/3 our license capacity. This is due highly in part to our workforce recruitment, training, and retention. Another factor is that the quality of materials available to children is outdated, and our building is aging and has maintenance needs to be upkeep. My approach to the above community problems is an opportunity to further develop the quality of care our staff can provide through additional staff training, offering adequate prep and sanitization time to their workday, offering fair compensation, and researching potential Health Benefits to offer our staff. I would seek appropriate Montessori training for our staff, giving them the opportunity to expand their skills and certifications and ultimately build their self-esteem and interest in remaining employed in our childcare facility. When adequately staffed, we can expand our infant program, increasing infant care for Sitka and increase our enrollment throughout the facility. BECCC would invest in high quality Montessori learning manipulatives, furniture, and equipment for our infant, toddler, preschool and school-age classrooms. If SEARHC were interested in working on a partnership, we could discuss priority enrollment within our facility to support long-term health care staff for Sitka. We would look at the building's needs and determine if a new roof is necessary now, or later. Additionally, we would improve our north side yard to a state where children could utilize that space safely. I would continue to design our current classrooms in our facility in a way that would allow for an adult education location on site, and we would begin to reach out to local organizations that may want to collaborate with us in providing parent & family education workshops and/or develop a family/caregiver networking system. Building stronger support systems for our staff, parents and caregivers, will improve their ability to nurture solid, healthy foundations for their children; Quality staff will support program development to increase capacity and better meet the child care needs of Sitka; more childcare access means better recruitment for Sitka employers including health care professionals.	\$50,000-\$250,000	Single Community	Sitka (City and Borough)	Deferred or Not Advanced

Big Brothers Big Sisters of Alaska	Strengthening Alaska’s Preventive Behavioral Health Infrastructure: Regional Mentoring Expansion	AK	Healthy Alaskans 2030 identifies improving youth mental health, reducing suicide, and strengthening protective factors as statewide priorities. For healthy development, children need stable, supportive relationships both within and outside their families. Yet approximately half of Alaska’s children and youth have experienced at least one Adverse Childhood Experience (ACE). ACEs, including family instability, substance misuse, abuse, neglect, and economic hardship, are strongly associated with long-term depression, suicide risk, substance use disorders, and poor physical health outcomes. Youth experiencing ACEs are also more likely to report social isolation and lack of consistent adult support, both significant risk factors for worsening mental health. In rural Alaska, access to licensed behavioral health providers is limited and workforce recruitment remains challenging. Expanding access to evidence-based mentoring represents a scalable, community-based opportunity to strengthen protective factors and improve mental health before youth require intensive behavioral health intervention. By increasing the number of youth who have consistent, supportive adult relationships across multiple regions, BBBSAK strengthens preventive behavioral health capacity and advances Alaska’s broader health system transformation goals.	BBBSAK serves children, youth, and young adults ages 6–25 who have experienced ACEs. Youth (“Littles”) are matched with trained, screened, and professionally supported adult volunteers (“Bigs”) in structured one-to-one mentoring relationships focused on strengthening social-emotional skills, resilience, and connectedness. Matches meet multiple times per month and are supported by professional Match Support Specialists (MSS) who monitor child safety, relationship quality, and youth well-being. MSS staff provide ongoing supervision through structured check-ins with youth, volunteers, and parents/guardians. This professional oversight allows for early identification of emerging behavioral health concerns and timely referral to academic, social service, or mental health resources when needed. Monthly group activities for Big/Little matches support relationship building, volunteer retention, and equitable access to positive community experiences. Across Alaska, BBBSAK consistently maintains a waitlist of 100–150 youth, reflecting significant unmet demand for supportive adult relationships among children and young people who have experienced ACEs. Prolonged wait times delay access to critical protective factors that reduce risk for depression, substance use, and social isolation. Two causes for youth wait times include inadequate staffing levels to move youth and volunteers quickly through enrollment and screening processes; and a reduction in volunteerism that makes it challenge to recruit and enroll volunteer Bigs. Through this project, BBBSAK will increase enrollment and match support staffing to reduce wait times, expand volunteer recruitment, improve match support services quality, and ultimately increase the number of youth participants. With full funding, BBBSAK will create 65 new mentoring matches and support 260 existing matches during the funding period, increasing total youth served from approximately 260 annually to approximately 325. This approach increases access to preventive behavioral health services for youth with ACEs and enhances mentoring quality by ensuring matches have access to professional supervision and evidence-based standards.	\$50,000- \$250,000	Multi- Community or Participating in Regional Hub-and- Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Matanuska-Susitna Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Big Brothers Big Sisters of Alaska	Strengthening Rural Preventive Behavioral Health Infrastructure Through AI-Enabled Workflow Redesign	AK	Big Brothers Big Sisters of Alaska (BBBSAK) delivers preventive behavioral health supports to youth experiencing Adverse Childhood Experiences (ACEs). One-to-one mentoring is an evidence-based, CDC-recognized intervention that builds protective factors for youth experiencing adversity. BBBSAK has expanded statewide mentoring in recent years. However, administrative inefficiencies within enrollment, screening, matching, and match support workflows create delays for the people we serve. Inadequate internal systems lead to longer waits for youth before being matched with a mentor; and delays in scheduling match support meetings. These inefficiencies disproportionately affect rural and frontier communities supported through BBBSAK’s centralized infrastructure, where regionally embedded staff rely on Anchorage-based systems to process enrollment, complete background checks, schedule match support, and monitor youth safety. We have achieved incremental gains through internal quality improvement efforts and an increase in volunteer recruitment; however, these improvements were labor-intensive, dependent on staff overextension, and are not sustainable without structural systems redesign. Without modernization, administrative bottlenecks will continue to limit timely access to preventive behavioral health services and increase workforce burnout risk.	BBBSAK proposes a 12-month Preventive Behavioral Health Infrastructure Modernization initiative through implementation of the McBride Method, a nationally recognized BBBS-specific operational redesign model integrating workflow automation and AI-assisted quality oversight within Big Brothers Big Sisters’ Matchforce case management system. Implementation will be led by a former BBBS practitioner who exclusively supports BBBS agencies nationwide, ensuring alignment with National Standards and reducing implementation risk. The project will deploy: • Automated youth and volunteer enrollment workflows • Automated reference and background check reminders • Automated match support scheduling • AI-assisted summaries of match support documentation • AI-enabled early warning flags to identify potential behavioral health or safety concerns • Centralized workflow redesign to eliminate bottlenecks These enhancements will reduce manual administrative burden, accelerate match formation, and strengthen real-time monitoring of youth well-being indicators. Automation is projected to reduce staff processing time by 30–40%, allowing staff, particularly those supporting rural regions, to shift time from paperwork to direct preventive behavioral health support. Because BBBSAK operates a centralized statewide infrastructure supporting regionally embedded staff in rural communities, modernization of core systems directly improves rural access. Reducing delays in match formation ensures faster delivery of protective adult relationships, strengthening Alaska’s preventive behavioral health capacity in alignment with Initiative #6: Spark Technology and Innovation.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Matanuska-Susitna Borough; Sitka (City and Borough); Southeast Fairbanks Census Area	Deferred or Not Advanced

Big Delta Rescue Inc	EMS Led Sustainable Rural Health Care (Copper River, Upper Tanana Valley, Deltana)	AK	Our area of the Alaskan Interior has been struggling to define an EMS solution that can provide a modern level of emergency response with an affordable, sustainable financial plan. Big Delta Rescue is a new community nonprofit located in Delta Junction. On February 17, 2026, Big Delta Rescue’s bid proposal won the City of Delta Junction’s two-year contract to provide ALS ambulance service to the city and the greater Deltana area (REAA 15). Big Delta Rescue’s goal is to establish a long-term community health asset, capable of growing and adapting to our community’s needs. This must involve developing specialized EMS response abilities to ensure the most effective use of personnel and resources.	BDR’s approach to the sustainable transformation of rural health care in the REAA15 region will focus on developing a workforce of cross-trained, multi-disciplinary EMS personnel available to provide Mobile Crisis response, Critical Care, community paramedicine/MIH, on-site telehealth (medical, BH, MAT), mobile MAT, local SUD treatment options, local 24 hour trauma center, transport and/or referral of patients to alternative destinations, and increasing the capacity for appropriate ground transport to the ER in order to reduce the inefficient and wasteful over-reliance on long-distance transports. BDR proposes to facilitate the expansion of a growing network of existing partnerships, identify and recruit new partners, and join other projects as supporting partners in order to implement transformative and sustainable approaches to rural healthcare in Alaska’s super-rural Copper River, Delta Junction, Tok, and surrounding service areas. BDR’s project will facilitate mutually beneficial and sustainable partnerships between willing Emergency Services organizations in the Copper River, Delta Junction, Tok and surrounding service areas. Projects that work for one of these regional services will have a high probability of transformative success and sustainability in other neighboring regions due to their many similarities. Partnerships and expanded collaboration will yield many unique, transformative and sustainable pathways for similarly challenged low-volume rural AK ambulance services to increase efficiency, expand services offered, expand access to care, share the administrative and financial burdens of under-utilized and seldom utilized resources, share technical assistance, reduce waste, increase resilience, and increase the sustainability of EMS and its expanded role in the healthcare system throughout the combined service areas of CREMS, Tok Area EMS, and Big Delta Rescue (Delta Junction) to include the many independent EMS first responder groups including Dry Creek EMS, Dot Lake EMS, Slana EMS, Rural Deltana Volunteer Fire Department, Gakona Volunteer Fire, Chitina EMS, Strelna Volunteer Fire Department and McCarthy Area EMS.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Southeast Fairbanks Census Area	Advance to Implementation Application

Big Delta Rescue Inc	Big Delta Rescue ALS Emergency Response Vehicle	AK	1) Leasing a new, fully equipped ambulance is costly. 2) At the end of a year of leasing, Big Delta Rescue still doesn't own the ambulance. Equipment ownership and eventual repair/replacement must be a major component of a sustainability plan. The lease arrangement, while convenient, requires a capital drain so that funds are no longer available to be invested back into building BDR's security and sustainability. 3) Many 911 calls are for situations that do not require state of the art ALS capabilities in the response team and its equipment. Many do not require transportation and therefore do not result in a billable service. Our community does not have the resources for the initial investment in separate vehicles and equipment suited to different levels of response. Currently, we must use our leased ALS vehicle (and personnel required to provide ALS service) to respond to all community needs. Additionally, Big Delta Rescue would like to be an onsite ambulance presence at many community events without the financial burden of paying for the full team of ALS EMTs and paramedics.	1) An RHTP-granted ambulance featuring the latest advances in workforce safety, patient care, and patient safety will ensure that a modern, reliable ALS response vehicle is permanently available to serve our community. 2) At the end of one year of NOT having to lease an ambulance, an RHTP grant will have freed up \$60,000 in budgeted funds to invest back into an equipment replacement fund, improving Big Delta Rescue's long-term sustainability. 3) An RHTP-granted ambulance would be ready to provide ALS service, 24/7. Existing older ambulances could be dedicated to serve the community in specialty situations that do not require the hundred-mile emergency transport to Fairbanks, such as SUD support and intervention programs and being an on-site presence at community and school events.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Southeast Fairbanks Census Area	Deferred or Not Advanced

bingli	AI-Supported Clinical Intake and Decision Support for Community Health Aides	MA	Many rural Alaska communities rely on village clinics staffed by CHA/Ps as their primary point of care. These frontline providers operate in remote settings where access to physicians and specialists is limited, and consultations with supervising clinicians often occur remotely. While the CHA/P Manual (CHAM) provides structured clinical protocols, documenting patient encounters, navigating guidelines, and preparing consultation notes can be time-consuming and inconsistent. This creates administrative burden for CHA/Ps and can delay consultations with regional care teams. There is an opportunity to improve the efficiency and consistency of clinical intake, documentation, and remote consultation by equipping CHA/Ps and supervising clinicians with modern, AI-supported tools that structure patient information and support protocol-based decision making.	The project will enhance clinical assessment, documentation, and consultation workflows in village clinics by deploying Bingli’s AI-enabled clinical intake and decision-support platform to CHA/Ps and their supervising clinicians. The platform will complement the existing CHAM and the hub-and-spoke care model that connects village clinics with regional care teams. Patient information can be captured through two complementary workflows. In some cases, patients may complete a digital symptom intake assessment prior to visiting the clinic or contacting a CHA/P, allowing key information to be collected before the encounter begins. When intake occurs during the clinical encounter, Bingli’s ambient listening capability can capture and structure relevant information from the conversation between the patient and CHA/P. Both methods generate a structured clinical intake that organizes symptoms, relevant history, and key clinical observations. The platform will incorporate relevant CHAM protocols, helping ensure that the information collected aligns with the protocol-driven workflows already used by CHA/Ps to assess patients and determine appropriate next steps. By mapping patient symptoms and findings to appropriate protocol pathways, the system helps CHA/Ps quickly identify recommended assessments, treatments, or consultation requirements. As information is captured, the system generates structured clinical summaries and documentation, reducing administrative burden on CHA/Ps and improving the clarity of patient records. These summaries are also available in real time to supervising physicians and regional care teams, giving them remote visibility into cases being managed in village clinics and enabling faster, more efficient consultations when needed. Implementation will begin with a preliminary deployment in a small number of village clinics, working in partnership with Tribal Health Organizations (THOs) and regional health systems. Participating CHA/Ps and supervising clinicians will receive onboarding, training, and workflow support. Lessons learned during the pilot phase will inform broader expansion across additional communities. By combining AI-enabled intake, CHAM-informed decision support, and improved consultation workflows, the project strengthens Alaska’s frontline rural workforce while improving care coordination across the state’s distributed health system.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

bingli	Alaska AI-Enabled Nurse Triage & Telehealth Access Network	MA	Many residents of Alaska’s rural, remote, and frontier communities face significant barriers to accessing timely healthcare. Geographic isolation, severe weather, limited transportation, and persistent healthcare workforce shortages make it difficult for patients to obtain prompt clinical guidance when new symptoms arise. As a result, individuals often delay seeking care, rely on local emergency departments for non-emergent conditions, or require costly medical transport to distant facilities for issues that could be safely addressed through primary care or telehealth. While some healthcare organizations operate NALs or telehealth services, these systems often function separately. NALs can provide guidance but typically cannot directly connect patients to treatment, requiring patients to schedule a separate telehealth or clinic visit, causing delays, increasing the burden on healthcare resources, and leading to unnecessary escalation of care. Additionally, legacy nurse triage processes that rely on unstructured information and lack clinical decision support are time-consuming and inconsistent. This project offers an opportunity to improve rural healthcare access by integrating AI-enabled nurse triage and telehealth services into a single coordinated system. By enabling patients to move seamlessly from triage to clinical evaluation when needed, the project helps ensure patients receive the right care when they need it while making better use of limited healthcare resources.	The Alaska AI-Enabled Nurse Triage and Telehealth Access Network would be implemented as a rural-focused care access service designed and convened by the State of Alaska, with Bingli providing the enabling technology that supports clinical intake, triage, care navigation, and telehealth clinical decision support. Rather than creating a new statewide call center, the project would focus on designing and launching a coordinated nurse triage and telehealth service specifically for rural, remote, and frontier populations where access barriers are most significant. RHTP funding would support the design, implementation, and early operational scale of the program, including deployment of the enabling technology platform. Under this model, the State of Alaska Department of Health (DoH) would assemble the operational components of the service by partnering with organizations that already provide clinical capabilities. This may include aligning the program with Alaska’s Medicaid program, which covers a large share of rural residents and has strong incentives to reduce avoidable emergency utilization and medical transport costs. The state could also partner with a large Alaskan health system with existing telehealth services, enabling rapid deployment of clinical staffing and infrastructure. Bingli would provide the AI-enabled intake, triage, and clinical decision-support platform used by both the NAL and telehealth clinicians. The system structures patient-reported symptoms, presents clinical summaries to triage nurses, and supports evidence-based care routing. When clinical evaluation is required, patients can be seamlessly transferred to a telehealth provider who will receive structured clinical information from the triage encounter, differential diagnoses, and diagnostic and treatment recommendations. The service would initially focus on rural Medicaid populations and high-need frontier communities, ensuring that RHTP investments deliver the greatest impact where access challenges are most severe. Over time, additional payers and health systems could opt into the service through a subscription or participation model, allowing the network to expand while supporting long-term financial sustainability. This approach allows Alaska to rapidly launch a rural NAL and telehealth service that leverages existing clinical partners while building a sustainable model for long-term operation.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

bingli	Alaska Rural Interoperability Gateway	MA	Rural clinics and health facilities in Alaska often face barriers to participating in interoperable health information exchange due to limited technical infrastructure, small IT teams, and the high cost of building and maintaining HL7 or FHIR integrations. As a result, many providers rely on manual data-sharing methods such as fax or scanned documents, which slows care coordination and limits the ability of regional providers to access complete patient information. This creates an opportunity to strengthen care coordination across Alaska’s geographically dispersed health system by lowering the technical barriers to interoperability. Enabling rural clinics, Tribal health facilities, and critical access hospitals to more easily share structured clinical information with the statewide HIE can improve continuity of care, reduce duplication of services, and support more efficient referrals and telehealth consultations across the state’s rural care network.	This project is designed to expand rural participation in Alaska’s statewide HIE by deploying Bingli’s Prism AI platform as a shared rural interoperability gateway for clinics and health facilities. The project will focus on communities where limited technical infrastructure and workforce capacity currently restrict participation in interoperable health information systems and coordinated care initiatives. This approach supports Alaska’s goal of advancing tech-enabled health infrastructure that improves data sharing, care coordination, and access to care across rural and frontier communities. Ideal participants include rural clinics, Tribal health facilities, and critical access hospitals that maintain electronic clinical records but lack the technical resources to implement and maintain HL7 or FHIR interfaces required to connect with the statewide HIE. These organizations often rely on manual data sharing methods such as fax, scanned documents, or limited EHR exports, which creates barriers to care coordination across Alaska’s distributed health system. A phased implementation will begin with a small group of rural clinics and facilities. During this phase, Bingli will configure the Prism AI platform to ingest clinical documents and patient data from participating clinics, automatically structure and code the information, and securely transmit it to the statewide HIE and other authorized providers using standardized APIs. Prism AI can also be configured to serve as a user-facing access point, allowing rural providers to view relevant patient information available through the HIE even if their local systems lack direct integration capabilities. The system architecture is designed for efficient statewide expansion. Rather than establishing separate integrations between each clinic and the HIE, the project will implement a single secure two-way connection between Prism and the HIE. Multiple rural facilities can then be onboarded within the same Prism environment using organization-specific access controls. This shared gateway model significantly reduces technical complexity while enabling rapid onboarding of clinics. Participating facilities will receive onboarding, training, and centralized support to integrate Prism into existing workflows. As additional clinics are added, the shared infrastructure model will allow the network to scale efficiently while maintaining consistent interoperability and support services across Alaska’s rural health system.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Birchwood Behavioral Health	Bridge to Wholeness Transitional Living Program for Young Adults	AK	Alaska lacks structured transitional residential programs for young adults ages 18–25 aging out of youth residential treatment or foster care. Without transitional support, many experience homelessness, relapse, justice involvement, or psychiatric hospitalization. This gap creates significant costs for Medicaid, hospitals, shelters, and public safety systems. A structured transitional living model provides housing stability, clinical continuity, life-skills training, workforce development, and coordinated care management. The opportunity is to reduce system cycling while building long-term self-sufficiency for high-risk young adults.	Bridge to Wholeness Transitional Living Program will establish a licensed adult residential behavioral health program aligned with Alaska Adult Mental Health Residential Services Level 1 and 2 standards and Medicaid billing requirements. Core components include: • 12–16 bed supervised residential setting • Integrated behavioral health services • Individualized treatment planning • Life skills curriculum (budgeting, cooking, employment readiness) • Educational and workforce pathway development • Peer mentorship • Case management and discharge planning • Telehealth integration for rural continuity The program will align with: • Alaska Administrative Code Chapter 50 and 135 • Medicaid documentation and service authorization standards • CARF accreditation standards • Trauma-informed and faith-integrated care practices RHTP funding will support capital preparation, workforce development, infrastructure buildout, and technology integration necessary to launch and stabilize the program.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Anchorage (Municipality)	Deferred or Not Advanced

Birchwood Camp	Challenge Accepted: Empowering at-risk Youth through Teamwork, Leadership, and Supportive Community	AK	Young people are facing larger and more serious challenges than ever before with fewer spaces to develop skills to overcome challenges in a safe and healthy way. Community is fractured, individuals are hurting, and youth lack space for safe and structured growth. A low ropes challenge course offers a unique, holistic approach to preventative mental healthcare.. Through structured physical challenges and team-based activities, participants develop mental resilience, self-confidence, critical thinking, leadership skills, and positive teamwork experiences in an outdoor, nature-centered environment. For individuals and families facing adversity, the course can be healing — a place where personal growth happens through movement, trust, and shared experience. The collaborative nature of the activities nurtures emotional well-being, problem-solving, communication, and teamwork. As a preventative healthcare measure, this course encourages the five Leading Causes of Life: Agency, Coherence, Connection, Intergenerativity/Blessing, and Hope (Gunderson and Pray, 2007). As a community space, the low ropes course brings together youth, families, schools, behavioral healthcare providers, and partner organizations under a common goal: to challenge individuals in a healthy way, to support one another, and to grow together. For youth in particular, these experiences build the foundational confidence and preventative mental healthcare that carries into classrooms, homes, and communities.	Birchwood's approach to this opportunity is rooted in a commitment to providing a safe, impactful, and sustainably managed challenge course that serves as a preventative mental healthcare model for holistic health and development. Our approach to providing an improved experience on our challenge course is threefold: 1. Physical Improvements to the Challenge Course: The foundation of this project begins with assessing and improving the physical condition of the low ropes challenge course. We will conduct a thorough inspection of all course elements to identify areas in need of repair, replacement, or enhancement. Volunteers, community partners, qualified inspectors and vendors will work collaboratively to bring the course up to the highest safety and usability standards through both fixed and portable elements. These improvements ensure that every participant — regardless of age or ability — can engage with the course in a secure and welcoming environment. 2. Leadership and Facilitation Training: A well-maintained course is only as effective as the people who lead it. Birchwood Camp will conduct a comprehensive leadership and facilitation training for local volunteers, staff, behavioral healthcare providers, and community partners. Working alongside a qualified trainer, participants will develop the skills needed to guide groups through challenge course activities with intention, safety, and a trauma-informed lens. This training builds lasting local capacity, ensuring the course continues to serve the community long after the project is complete. 3. Safety Renewal for the Course In addition to physical improvements, Birchwood will pursue formal safety renewal for the course, ensuring all elements and procedures meet current industry standards. This process includes professional inspection, documentation, and certification that affirms the course's readiness for community use. Regular safety renewal reflects Birchwood's ongoing commitment to responsible stewardship of this community resource.	Under \$50,000	Multi- Community or Participating in Regional Hub-and- Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Blood Bank of Alaska Inc.	Anchorage and Fairbanks Blood Transport Vehicles	AK	Alaska’s geography, weather conditions, and transportation constraints create unique challenges for maintaining a stable blood supply. Hospitals rely on rapid and carefully controlled transport of blood products between collection, testing, storage, and clinical facilities. Currently, blood transport in Anchorage and Fairbanks relies heavily on third-party courier services and ad hoc transportation solutions. These arrangements create several challenges: • Limited availability during nights, weekends, and emergencies • High and increasing courier costs • Reduced flexibility during urgent or weather-related transport disruptions • Lack of dedicated vehicles equipped for proper biological transport • In Fairbanks, no organizational vehicle exists to support airport or hospital transport These limitations create inefficiencies and potential delays in blood distribution that can impact patient care. The lack of dedicated vehicles particularly limits the Fairbanks operation’s ability to independently manage transport between the airport, hospitals, and other partners that serve the Interior region. At the same time, the growing need for timely transfusion services—particularly for trauma, oncology, and surgical care—creates an opportunity to strengthen the logistical backbone of Alaska’s blood system.	This project will purchase two dedicated transport vehicles to support blood distribution operations in Anchorage and Fairbanks. The vehicles will be used to: • Transport blood products between the airport and processing facilities • Deliver blood components to hospitals and healthcare partners • Retrieve blood donations and supplies when needed • Respond rapidly to urgent hospital requests • Reduce dependence on third-party courier services In Fairbanks, the new vehicle will provide the first dedicated transportation resource for the Blood Bank of Alaska’s Interior operations. It will enable direct transport between the airport and local hospitals and allow staff to manage urgent deliveries more efficiently. Vehicles will be equipped and operated according to established blood transport standards, ensuring proper temperature control and chain-of-custody procedures. This project strengthens a critical logistical component of Alaska’s blood supply system and enhances the organization’s ability to support hospitals that serve rural patients.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Blood Bank of Alaska Inc.	Equipment Upgrades, ACP 215 Cell Washer	AK	The Blood Bank of Alaska currently faces several challenges that this project will address. 1. Imminent Equipment Sunset Our existing legacy cell washer will reach its sunset date in June 2026. After this date, manufacturer support and parts availability will be limited, creating operational risk. 2. Limited Redundancy The blood bank currently relies on a single ACP 215 cell washer purchased more than ten years ago. Operating with only one unit increases vulnerability to equipment failure, maintenance downtime, or unexpected surges in demand. 3. Increasing Demand for Specialized Blood Products Advances in clinical care, including neonatal medicine, oncology treatments, and transplant support, have increased the need for specialized blood products such as washed red blood cells. 4. Statewide Responsibility Because many healthcare facilities in Alaska do not have the capacity to perform cell washing themselves, the Blood Bank of Alaska must maintain reliable centralized production for the entire state. While these challenges pose risks, they also present an opportunity to strengthen statewide blood processing infrastructure and ensure that specialized transfusion services remain available for years to come.	To address these challenges, the Blood Bank of Alaska will purchase and implement a new Haemonetics ACP 215 Cell Washer. This approach includes several key components: Equipment Acquisition Funding will be used to purchase a new ACP 215 cell washer, including installation and validation. Operational Integration Laboratory staff are already trained and experienced in operating ACP 215 systems, allowing the new unit to be integrated immediately into existing workflows. Quality and Compliance The new device will be validated according to regulatory and accreditation standards, ensuring continued compliance with transfusion medicine best practices. Statewide Distribution Washed units produced using this equipment will continue to be distributed through the Blood Bank of Alaska’s existing statewide logistics network, supporting hospitals and healthcare providers across Alaska. This strategy leverages existing expertise, infrastructure, and distribution systems, making it a highly efficient and sustainable investment.	\$50,000-\$250,000	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Blood Bank of Alaska Inc.	Equipment Upgrades, Blood Storage Units, Cold Chain	AK	The Blood Bank of Alaska seeks funding through the Rural Health Transformation Project to purchase three medical-grade blood storage refrigerators to be placed at three strategic locations: two in Anchorage and one in Wasilla. These units will store transfusable blood products and ensure that the organization can maintain safe, compliant, and accessible blood supplies across Southcentral Alaska.	Reliable storage of blood and blood components is essential to maintaining a functional transfusion network for hospitals and emergency medical services throughout the region. The requested refrigerators will provide dedicated, temperature-controlled storage for red blood cells, plasma, and other transfusable products in accordance with U.S. Food and Drug Administration (FDA) guidelines for blood product storage. Medical-grade refrigerators provide continuous temperature monitoring, alarm systems, and controlled environments necessary to maintain product integrity and patient safety.	Under \$50,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced
Blood Bank of Alaska Inc.	Equipment Upgrades, Platelet Storage	AK	The Blood Bank of Alaska is seeking funding through the Rural Health Transformation Project to purchase two PC4200 platelet incubators to replace aging equipment that is no longer supported by the manufacturer. These incubators are essential for maintaining the proper storage and monitoring conditions required for platelet products used in patient care. Replacing the current units will ensure the Blood Bank of Alaska can continue safely collecting, processing, and distributing platelet and plasma products to hospital partners across the state. These products are critical to trauma care, surgery, cancer treatment, and other lifesaving medical interventions. In addition, maintaining reliable platelet incubation capacity strengthens Alaska’s emergency preparedness infrastructure by ensuring a stable and responsive blood supply during disasters, mass casualty events, and other public health emergencies. Investment in this equipment will support the sustainability of Alaska’s only statewide blood provider and help ensure healthy, resilient communities throughout the state.	Reliable storage of plasma and platelets is essential to maintaining a. Functional transfusion network for hospitals and emergency services throughout the state. The requested incubators will provide dedicated, temperature-controlled storage for plasma and platelets in accordance with U.S. Food and Drug Administration (FDA) guidelines for blood product storage. These incubators provide continuous temperature monitoring, alarm systems, and controlled environments necessary to maintain product integrity and patient safety.	Under \$50,000	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area;	Deferred or Not Advanced

Wrangell (City and
Borough); Yakutat
(City and Borough);
Yukon-Koyukuk
Census Area

Blood Bank of Alaska Inc.	South Anchorage and Fairbanks Facility Upgrades	AK	Alaska faces unique challenges in maintaining a resilient blood supply due to geographic isolation, severe weather conditions, and limited transportation infrastructure. Two BBA facilities critical to statewide blood collection currently face infrastructure limitations: South Anchorage Blood Center: The facility experiences high donor volume but has aging flooring, outdated furnishings, and lighting systems that no longer meet the expectations of modern donor care environments. An outdated physical environment can negatively impact donor comfort and repeat donation rates. Fairbanks Blood Center: The Fairbanks facility serves Interior Alaska and plays a key role in collecting blood products for hospitals throughout northern and rural Alaska. However: • Exterior signage is outdated and no longer fully functional due to lighting components that cannot be replaced. • Lack of visible roadway signage limits community awareness of the facility. • Parking lot lighting is inadequate, creating potential safety concerns for donors and staff during long winter darkness. These limitations reduce the visibility, accessibility, and safety of the donation center and may discourage donor participation. Addressing these infrastructure gaps presents an opportunity to improve donor engagement, strengthen the blood supply, and enhance health care access for rural communities dependent on these blood products.	The Blood Bank of Alaska will implement targeted capital improvements at both facilities to address safety, accessibility, and donor experience. South Anchorage Blood Center Improvements • Replace aging flooring in donor areas • Upgrade donor seating and furniture • Install energy-efficient lighting • Update branding elements and interior environment to create a welcoming, modern donation experience Fairbanks Blood Center Improvements • Replace the exterior building sign with energy-efficient illuminated signage • Install visible roadway signage directing donors to the facility • Install upgraded parking lot lighting to improve safety and accessibility Project activities will include: 1. Facility design and vendor selection 2. Procurement of materials and services 3. Construction and Installation All improvements will be implemented with minimal disruption to blood collection operations.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough	Deferred or Not Advanced

Blood Bank of Alaska Inc.	Statewide Collections, Apheresis Trima Kits	AK	The increasing cost of apheresis collection kits has created a growing financial strain on the Blood Bank of Alaska. As a nonprofit organization responsible for maintaining the state’s blood supply, the Blood Bank must absorb rising procurement costs while continuing to provide reliable access to blood products for hospitals and patients throughout Alaska. External funding is necessary to help offset these escalating costs and to support the purchase of apheresis kits in sufficient quantities to establish and maintain a 3–4 month emergency preparedness inventory at all times. Grant funding will allow the Blood Bank of Alaska to purchase kits in bulk, helping stabilize costs while ensuring a consistent supply of the materials required to collect plasma and platelets. Investing in this inventory will also support the Rural Health Transformation Program’s goal of creating healthier communities through improved access to essential health services. By strengthening the state’s blood collection capacity, this project helps ensure that hospitals—particularly those serving rural and remote communities—have timely access to life-saving blood products without relying on costly or delayed imports from outside Alaska.	The Blood Bank of Alaska proposes to strengthen the stability and affordability of the state’s blood supply by increasing the inventory of Trima apheresis collection kits used to collect plasma, platelets, and red blood cells. These kits are required for each apheresis procedure and are essential to maintaining the statewide availability of blood products used in trauma care, cancer treatment, emergency surgery, and chronic disease management. Since 2018, the cost of Trima kits has increased by approximately 73%, with additional annual price increases of 5–10% due to global supply chain pressures, tariffs, and shipping costs associated with transporting medical supplies to Alaska. These rising costs create significant financial strain and increase the risk of supply interruptions in a state that already faces geographic and logistical challenges. To address these challenges, the Blood Bank of Alaska will implement a strategic bulk purchasing and inventory stabilization approach. Grant funding will allow the organization to purchase a larger quantity of Trima apheresis kits at one time, enabling the Blood Bank to: • Reduce the per-unit cost of kits through bulk purchasing agreements and reduced frequency of smaller orders. • Offset annual cost increases by purchasing inventory before anticipated price adjustments. • Decrease shipping and handling expenses by consolidating orders and reducing the number of deliveries required throughout the year. • Build a 3–4 month supply reserve of apheresis kits to protect operations from supply chain disruptions. This approach will ensure the Blood Bank of Alaska can maintain continuous apheresis collection capacity, which is essential to producing the more than 6,000 blood component units distributed annually to hospitals across the state. By stabilizing the supply of collection kits, the Blood Bank will also expand healthcare access statewide, particularly for rural and remote communities. Alaska’s healthcare system relies heavily on locally collected blood products because importing blood from outside the state can be expensive, time-consuming, and unreliable due to weather and transportation limitations. Maintaining a stable supply of Trima kits will allow the Blood Bank of Alaska to continue collecting and distributing blood components locally, ensuring that hospitals throughout Alaska—including those serving rural communities—have reliable access to life-saving transfusion products when they are needed.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Blood Bank of Alaska Inc.	Statewide Collections, Whole Blood Bag Collections	AK	The increasing costs of whole blood bag sets has created a growing financial strain on BBA. As a nonprofit organization responsible for maintaining the state’s blood supply, BBA must absorb rising procurement costs while continuing to provide reliable access to blood products for hospitals and patients throughout Alaska. External funding is necessary to help offset these escalating costs and to support the purchase of whole blood bag sets in sufficient quantities to establish and maintain a 3-4 month emergency preparedness inventory at all times. Grant funding will allow BBA to purchase these bag sets in bulk, helping stabilize costs while ensuring a consistent supply of the materials required to collect whole blood. Investing in this inventory will also support RHTP’s goal of creating healthier communities through improved access to essential health services. My strengthening the state’s blood collection capacitor, this project helps ensure that hospitals - particularly those serving rural and remote communities, have timely access to life-saving blood products utility relying on costly or delayed imports from outside Alaska.	BBA proposes to strengthen the stability and affordability of the state’s blood supply by increasing the inventory of whole blood bag sets used to collect whole blood. These bags are essential for each donation at all of our centers, including mobiles, and are essential to maintaining the state wide availability of blood products used in trauma care, child birthing and emergency surgery. Since 2018, BBA has increased 5%, with additional price increases to continue. Supply chain pressures, tariffs, and shipping costs associated with transporting medical supplies to Alaska has impacted these increases, too. These rising costs create significant financial strain and increase the risk of supply interruptions in a state that already faces geographic and logistical challenges. To address these challenges, BBA will implement a strategic bulk purchasing and inventory stabilization approach. Grant funding will allow BBA to purchase a larger quantity of blood bags at one time, enabling BBA to: • Reduce the per-unit cost of bags through bulk purchasing agreements and reduced frequency of smaller orders. • Offset annual cost increases by purchasing inventory before anticipated price adjustments. • Decrease shipping and handling expenses by consolidating orders and reducing the number of deliveries required throughout the year. • Build a 3-4 month supply reserve of bag sets to protect operations from supply chain disruptions. This approach will ensure that BBA will maintain continuous whole blood bag collection capacity, which is essential to producing the more than 25,000 blood units distributed annually to hospitals across the state. By stabilizing the supply of these bag sets, BBA will also expand healthcare access statewide, particularly for rural and remote communities. Alaska’s healthcare system relies heavily on locally collected blood products because importing blood from outside the state can be expensive, time-consuming, and unreliable due to weather and transportation limitations. Maintaining a stable supply of blood bags will allow BBA to continue collecting and distributing blood components locally, ensuring that hospitals throughout Alaska – including those serving rural communities, have reliable access to lifesaving transfusable products when they are needed.	\$250K-\$1M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Blue Phoenix Dental LLC	Aleutian Oral Health Transformation	AK	Aleutian residents face barriers from the extreme cost and unpredictability of air travel in the region and the lack of local healthcare providers. The costs of travel and temporary housing can easily exceed \$3,000 for a single dental emergency. Expanding clinical operations and providing care, prevention, and education directly within small communities will substantially reduce costs to patients and other 3rd party payers, such as tribal organizations or Alaska State Medicaid, and reduce the rates of emergency extractions and preventable disease. Improving local training and clinical operations will empower residents to make a positive impact on their community.	Our approach is a "Hub and Spoke" model centered in Unalaska/Dutch Harbor. The Hub: We will renovate existing clinic space to include a high-tech training operatory and simulation station. In partnership with the ANTHC ADTEP program, we will provide clinical rotations for students who commit to serving the region. Moreover, we can assist in housing with existing resources and we will be able to expand that opportunity through the time-limited housing assistance offered through the RHTP program. Housing in frontier Alaska is one of the most difficult barriers to attracting providers to the region. Hygienists and Dentists have already expressed interest in working with Aleutian Family Dentistry and this program would allow them the opportunity to serve in these communities with the mentorship of experienced staff. The Spoke: We will purchase and deploy portable dental suites and AI-enhanced intraoral cameras for teledentistry. This team will travel to villages and schools to provide preventive care, screenings, and triage, overseen by the Dutch Harbor clinical lead. According to the American Dental Association, this type of outreach can reduce emergency care by over 50%.	\$250K-\$1M	Dental	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Deferred or Not Advanced

Blueberry Pediatrics	Statewide Pediatric Access Network for Alaska Medicaid Children	CA	Access to pediatric care remains a persistent challenge across Alaska. Many families live in communities off the road system, where accessing pediatric care can require expensive and disruptive medical travel. Workforce shortages, geographic barriers, weather-related travel disruptions, and limited pediatric specialty availability often require families to travel long distances or rely on emergency departments for conditions that could otherwise be managed earlier or at home. As a result, many pediatric ED visits occur because families cannot quickly reach a pediatrician to evaluate symptoms, determine whether care can be managed at home, or initiate treatment early. This contributes to unnecessary ED utilization, higher system costs, and additional strain on rural health facilities that often operate with limited workforce capacity. This project addresses that gap by establishing a statewide pediatric access layer that complements Alaska’s existing healthcare infrastructure and supports the work of local clinics, community health centers, tribal health organizations, and rural hospitals. This is done through the combined benefit of 24/7 on-demand access to board-certified pediatricians via video, call, or text, supported by the at-home medical kit for higher diagnostic capability. The result is earlier treatment of common pediatric conditions, reduced reliance on EDs, and improved access to pediatric expertise for children across Alaska regardless of location.	Blueberry Pediatrics proposes to establish a statewide pediatric access network that allows every Alaska Medicaid child with internet or cellular connectivity to reach a pediatrician when they are sick, regardless of location, bandwidth, or internet connection speed. Families who enroll in Blueberry receive access to board-certified pediatricians available 24/7 on demand. Blueberry provides episodic pediatric care when a child becomes sick or a caregiver has an urgent concern. Pediatricians evaluate symptoms, provide treatment guidance, prescribe medications when appropriate, and help families determine whether a condition can be safely managed at home or requires in-person care. Participating families receive a pediatric diagnostic kit that includes a wireless digital otoscope, pulse oximeter, and infrared thermometer. These tools allow physicians to evaluate common childhood illnesses remotely with significantly greater clinical confidence than traditional telehealth and enable pediatricians to diagnose and treat conditions that would otherwise require in-person visits. Diagnostic kits will also be deployed to community health centers and other local access points to ensure families can enroll and access pediatric care immediately, while also providing rural providers additional pediatric expertise when caring for children in their communities. Blueberry coordinates care with local providers whenever in-person evaluation or follow-up care is needed. After each encounter, a visit summary is shared with the child’s primary care provider when one is identified, helping maintain continuity of care and supporting the child’s existing medical home. The program can be deployed rapidly following project approval. Blueberry expects to be fully licensed to operate in Alaska by March 16, enabling statewide implementation. Blueberry will collaborate with the State of Alaska to evaluate program impact using Medicaid claims data, including analysis of emergency department utilization, urgent care use, and other avoidable pediatric cost drivers. Findings will help inform long-term strategies to expand pediatric access while strengthening Alaska’s rural health system.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Boys & Girls Clubs of the Kenai Peninsula	Growing Pathways to Health Careers	AK	Across the Kenai Peninsula, many youth—especially in rural communities—have limited access to programs that support lifelong health, career awareness, and workforce development. At the same time, our region faces growing health disparities and workforce shortages in healthcare, skilled trades, and other professions critical to sustaining rural health systems. This project will expand the Boys & Girls Clubs of the Kenai Peninsula’s (BGCKP) existing youth development programs to build a foundation of lifelong health while introducing youth to careers that strengthen community wellbeing. Through Growing Pathways to Health Careers, youth will participate in hands-on activities such as gardening, harvesting, and food preservation, building practical life skills while learning about nutrition, sustainability, and healthy living. Programming will promote physical activity, nutrition education, and well-being to strengthen mental health resilience and encourage prevention-focused healthy lifestyles. To expand career awareness, BGCKP will integrate Transfr’s virtual reality–based learning, allowing youth to explore careers in healthcare, skilled trades, and environmental fields that support rural health systems. Strong partnerships with schools, Tribal organizations, local colleges, and community partners will ensure programming reaches underserved youth while creating a continuum of learning that connects healthy living, career pathways, and community health across the Peninsula.	BGCKP will implement Growing Pathways to Health Careers through a phased approach that builds foundational knowledge about healthy living while gradually introducing youth to career pathways that support community health. Programming will begin with hands-on experiences that help youth understand the connection between food systems, nutrition, environmental stewardship, and overall wellbeing. Youth will participate in activities such as gardening, harvesting, and food preservation while learning about sustainable practices and healthy food choices. These experiences build practical life skills while helping youth understand how personal health choices impact families and communities across the Kenai Peninsula. As the program becomes established, BGCKP will expand learning opportunities by integrating Transfr’s virtual reality career exploration platform. Through immersive virtual experiences, youth will explore careers in healthcare, skilled trades, environmental stewardship, and other fields that support rural health systems. This phased approach allows youth to first develop an understanding of healthy living before discovering how those concepts translate into education and career pathways. The program will strengthen prevention-focused youth development by expanding opportunities that address the root causes of chronic disease and promote lifelong wellness. Youth will participate in physical activity opportunities, including fitness challenges from National Boys & Girls Club of America evidence-based programs, while receiving nutrition education and engaging in well-being learning that strengthens mental health resilience and positive decision-making. BGCKP will prioritize youth in communities where access to health education, career exploration, and wellness programming is limited. Program spaces will be adapted for dual-purpose use supporting recreation, wellness activities, and itinerant programming to expand access. Strong partnerships with the Kenai Peninsula Borough School District, Kenaitze Indian Tribe, Salamatof Native Association, local colleges, trade schools, and community organizations will help ensure programming reflects community priorities and strengthens sustainability. Together, these partnerships will connect healthy living, career awareness, and community wellbeing for youth across the Kenai Peninsula.	\$50,000-\$250,000	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

Brave Heart Maternity Home	Brave Heart Maternity Home - Strengthening Alaska's Healthy Beginnings	AK	Alaska has no housing program for unhoused pregnant women with complex behavioral health challenges. Despite high rates of substance use during pregnancy, inadequate prenatal care, and Neonatal Abstinence Syndrome (NAS) and Fetal Alcohol Spectrum Disorder (FASD), there is no coordinated maternal system that keeps mothers and infants together while addressing medical needs and social determinants of health. Unhoused pregnant women often cycle through shelters and unsafe settings, disrupting prenatal care and increasing risk. Many are not identified until presenting in crisis settings such as the emergency room (ER), labor and delivery, or child welfare systems. Fragmented services limit early identification, coordinated discharge planning, and prevention-focused care. Systems are largely crisis-driven rather than integrated and preventive, and are not structured to address housing instability, maternal behavioral health, substance use recovery, and infant stabilization simultaneously while preserving family unity when safe. As a result, families cycle through emergency care, Neonatal Intensive Care Unit (NICU) admissions, and child welfare involvement, increasing public costs and worsening outcomes. Brave Heart Maternity Home was founded in September 2024 to create a coordinated maternal stabilization model that bridges housing, maternal health, and recovery supports, intervening early to improve outcomes, preserve families, and reduce reliance on high-cost systems.	Brave Heart will implement a three-phase approach to building maternal-child stabilization infrastructure in Alaska. Brave Heart's model was shaped through conversations and site visits with established maternity homes and infant care programs in the Lower 48, drawing from what works while adapting those approaches to fit Alaska's unique geography and systems. Phase I (July 2026) – Maternal Stabilization: Establish trauma-informed, long-term maternity housing providing prenatal, postpartum, and wraparound stabilization supports for pregnant and postpartum women experiencing substance use disorder, trauma, domestic violence, and housing instability. The program combines safe housing with coordinated prenatal care navigation, behavioral health support, recovery services, and parenting preparation in a family-centered environment that prioritizes keeping mothers and infants together when safe. Brave Heart will function as a coordination hub, strengthening care transitions between rural referral partners, tribal health organizations, medical providers, behavioral health systems, and child welfare agencies. Coordinated discharge planning, clear referral pathways, and travel coordination for rural participants will reduce geographic barriers and support consistent engagement in prenatal and behavioral health care. Phase II (2028) – Early Childhood Care: Expand to include a trauma-informed early childhood daycare that supports healthy child development while enabling maternal employment, education, and continued treatment engagement, strengthening long-term family stability and workforce participation. Phase III (2030) – Infant Recovery Care Center: Develop a family-centered, non-medical Infant Recovery Care Center serving substance-exposed infants and caregiver-infant dyads following hospital discharge, filling Alaska's non-medical stabilization gap during a critical transition period. Through this phased, scalable model, Brave Heart will build a comprehensive maternal-child stabilization continuum that shifts care from crisis response to prevention, improves birth outcomes, preserves families when safe, and reduces reliance on high-cost medical and child welfare systems.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Matanuska-Susitna Borough	Advance to Implementation Application

Braveheart Volunteers	Bridge of Hearts - a coordinated community grief support program	AK	Alaska has some of the highest rates of traumatic loss in the United States, including accidental injury, alcohol-related illness, and roughly 80% of young Alaskans have unmet mental health needs. Alaska Native people experience suicide rates 91% higher than the general population. These realities mean that many Alaska communities experience frequent trauma, creating widespread unaddressed grief. A single traumatic death affects dozens of people. In small rural communities, repeated exposure to loss can result in “multiple loss exposure,” where individuals experience numerous deaths within their social networks. This increases the risk of prolonged grief, depression, and social isolation across all ages. This is especially relevant in Sitka, where geographic isolation, limited behavioral health resources, and workforce shortages make it difficult to access grief support services. Sitka is uniquely positioned to pilot a coordinated community grief support program due to its strong traditions of collective care, including Alaska Native cultural values that emphasize shared responsibility during times of loss. Because BHV is trusted in the community with strong partnerships and a reputation for compassionate, reliable care, it is positioned to lead a program that specializes in grief, and establishes clear pathways to support during times of loss. BHV aims to create a framework that can be adapted and shared with other rural Alaska communities facing similar challenges.	BHV will address this need through a structured process to develop a community grief support program for Sitka. The planning phase will focus on designing the framework, partnership strengthening, and development of a work plan for the Grief Support Coordinator role. BHV mission is to champion people who are experiencing loneliness, loss, and end of life. Over the last 25 years our non profit has built a robust volunteer network, with 60 volunteers who serve over 100 Sitkans annually. We are a solid, trusted volunteer organization with a reputation for reliability by serving our community members at a time when they are most vulnerable. BHV will grow a network of partners, including SEARHC, the Sitka School District, Sitka Counseling, Sitka Tribe of Alaska, Youth Advocates, and other community organizations to identify current gaps in grief support services and define clear referral pathways between health care providers and community-based support programs. Creating a strong local model will allow for adaptation into other rural Alaska communities. As part of this planning process, BHV will conduct a community needs assessment survey to connect with and gather input from our local residents, caregivers, volunteers, educators, and health care partners in order to better understand where our community needs are greatest when it comes to grief support services, and barriers to care. Assessment will intentionally include voices from our local elders to ensure the program reflects cultural traditions. Feedback from the survey will allow for the best possible design of volunteer training, youth grief programming, caregiver support resources, and community education efforts. As part of phase one, we will develop the work plan for the Grief Support Coordinator who will organize volunteer engagement, coordinate referrals, raise the profile of grief and its impact in the community, and serve as a bridge between community members and available services through SEARHC. Planning will include development of volunteer training materials, identification of a grief expert who can provide training to professionals and laymen, coordination with schools, grief education, support group meetings, and program guidelines to support compassionate presence and peer support. Finally, the planning phase will establish measurable program goals, evaluation metrics, and sustainability strategies to guide long-term implementation.	\$50,000-\$250,000	Single Community	Sitka (City and Borough)	Deferred or Not Advanced

Breast Cancer Detection Center of Alaska	Envision Hope	AK	Alaska continues to face significant disparities in access to timely breast cancer screening and follow-up care, particularly in rural and frontier communities. Geographic isolation, severe weather, limited specialty infrastructure, and high travel costs create structural barriers that delay screening and prolong time to resolution. When a suspicious finding is identified, women may wait weeks or travel long distances for additional imaging. For uninsured, underinsured, and rural patients, these delays increase anxiety, financial strain, and the risk of later-stage diagnosis. In many communities, access to advanced imaging depends on travel outside the region, placing additional pressure on families and local healthcare systems. Envision Hope represents a strategic infrastructure investment to modernize breast imaging technology and strengthen in-state capacity. By upgrading both mobile and clinic-based mammography equipment, this project improves image quality, reduces repeat imaging, and enhances early detection across Alaska. Modernized systems will increase reliability, improve efficiency, and support a sustainable, statewide breast imaging program capable of serving Alaska’s geographically dispersed population.	BCDC’s approach focuses on strengthening rural breast cancer screening access by modernizing both our mobile mammography program and clinic-based infrastructure. Our mobile unit travels across Alaska to deliver screening directly to communities where access to specialty services is limited. To sustain this rural access model, we will replace our aging mammography system on the mobile mammography truck and in the clinic. The upgraded system provides higher-resolution imaging, captures more breast tissue per exam, and improves radiologist confidence in interpretation. Improved image quality at the point of service will reduce repeat imaging critical in communities where return travel may require flights, long-distance road travel, or extended time away from work and family. Modernized equipment will also improve operational reliability, reducing cancellations and service interruptions that disproportionately impact rural outreach schedules. Upgrading the Fairbanks clinic strengthens statewide capacity by increasing appointment availability and providing timely follow-up imaging within Alaska. Together, these coordinated upgrades reinforce a sustainable, Alaska-based breast imaging system designed to serve geographically dispersed populations.	\$50,000-\$250,000	Specialist	Statewide	Aleutians West Census Area; Denali Borough; Fairbanks North Star Borough; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Skagway (Municipality); Southeast Fairbanks Census Area; Yakutat (City and Borough)	Deferred or Not Advanced

Bridges Community Resource Network, Inc.	100% Recovery Responsive Communities – Kenai Peninsula	AK	By establishing a self-sustainable RCO in the central peninsula, we can remove silos by offering support to individuals enrolled in any organized recovery program as well as those who are considering recovery and those approaching sobriety through alternative paths. Trained peers have participated in outreach and support services as agencies are able to hire or contract with trained peers. However, when individual organizations with peer support only exist within the entity, the population served is limited. Such programs prevent community wide efforts and are often impossible to financially sustain without ongoing grant funding. An independent RCO will create sustainability through collaboration with multiple entities for direct peer services through a wide referral network, bridging with the proposed Alaska Impact Alliance pilot program (the Medicaid Support Hub) to utilize the Medicaid concierge services that will support Medicaid enrollment and provide clinical, billing, claims, and compliance support, building alternative financial resources and acting as a hub for community training and events, and providing sustainable space to other organizations in the community for meetings, training, and events. The RCO would act as a hub and serve the community by providing services.	We will build out an RCO through partnership and guidance with Homer’s RCO and True North Recovery in Wasilla who has successfully built a robust peer support system in their community and through national resources such as Faces and Voices of Recovery. We have approached a local group, Universal Recovery Services to build their board of directors, train members as peer supports and peer trainers, and work to meet the requirements of a Recovery Community Organization. We will work with this group up to the point where they are able to obtain RCO designation, build policy and procedures, coordinate with clinical and administrative supports or build these into the project if necessary. Initial steps will be site visits with KBRC and True North, RCO Bootcamp training, building out the board of directors to include a cross section of community recovery members, identifying and contracting with an individual to create policies and procedures and strategic plan, contracting or hiring a community navigator to begin providing services as we establish the framework, identifying appropriate lease space, outreach, and coalition building with providers, organizations, and individuals in the area.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Bridgewell Analytics	Healing the Healers: Rural Alaska year 1 clinician wellness and retention program	AK	Alaska’s rural health access challenge is compounded by workforce instability, vacancies, and reliance on traveling clinicians, reducing appointment availability, continuity, and quality of care. Burnout is higher in health care than in nearly any other profession, driving turnover, higher costs, adverse patient outcomes, and harm to providers. Clinicians experience high levels of impact of work on personal relationships (IWPR), which affects patient outcomes, clinician compassion, and clinician wellbeing. These effects are amplified in rural communities, where clinicians face psychological distress and isolation. The opportunity is not only to address burnout, but to address a system gap in rural Alaska. Most solutions either measure burnout or offer generic wellness support. Rural health systems need a non-punitive, evidence-based way to identify distress, apply interventions, and measure whether those interventions improve retention, patient care, access, and fiscal sustainability. Evidence-based interventions such as couple-oriented retreats, popular opinion leader groups, and clinical consultation groups have reduced burnout and IWPR and improved professional fulfillment, but they have not been adequately implemented or evaluated in rural communities. Their downstream effects on patient outcomes, continuity of care, workforce retention, and ROI have not been well quantified. Without these measures, securing stakeholder buy-in and lasting system change is challenging.	We propose strengthening Alaska’s workforce through improvement in health care providers’ well-being. Our primary RHTP alignment is Strengthen Workforce, with direct benefits to Health Care Access, Healthy Communities, Pay for Value/Fiscal Sustainability, and Spark Technology & Innovation. Working with ANMC to identify pilot sites, and with UAA and Stanford as partners, we will use an annual, non-punitive measurement-to-action cycle: measure, intervene, and re-measure. Year 1 will focus on a practical pilot. First, we will establish baseline measurement and data governance. Key wellness measures developed by Stanford will be collected at pilot sites, including burnout, professional fulfillment, impact of work on personal relationships (IWPR), values alignment, and wellness-centered leadership behaviors. We will pair these with patient experience measures and workforce stability measures such as attrition; if direct turnover data are not available, we will use self-reported intent to leave as a proxy. We will provide accessible, de-identified aggregate dashboards so stakeholders can track trends in a way that supports improvement while protecting trust and anonymity. While baseline measurements are established, we will implement an evidence-based Year 1 intervention focused on IWPR: a retreat for providers and their partners led by UAA and supported by Stanford. This approach is grounded in recent findings showing reduced IWPR and burnout and increased professional fulfillment. Systematic measurement, reporting of results, and use of results to inspire local organization-level improvement efforts will be an overarching intervention strategy. As the project advances, we will expand to additional evidence-based interventions, continue re-measurement across sites, and train local facilitators so organizations can implement interventions within their existing systems. In later phases, we leverage technological innovation to explore opt-in passive measures, app-based recommendations, and efficiency-of-practice improvements, including AI-enabled tools, to reduce burden and further support rural workforce sustainability.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Bristol Bay Area Health Corporation	Bristol Bay CHA Recruitment: Adventure, Service and Compassion in the Alaska Frontier	AK	BBAHC is unable to fill the Community Health Aide roles needed for the 28 villages we serve in the Bristol Bay region. We currently have at least 7 vacant villages, a problem that has persisted over a number of years. Community Health Aides/Practitioners perform vital health care services in BBAHC village clinics and are key part of our regional health care delivery system. Without these roles filled, our health care delivery system cannot function optimally. The model works best to recruit, train and retain people from local villages.	Our approach is to develop a persuasive, engaging, informative campaign focused on successful Community Health Aides working with patients in the clinic, engaged in cultural activities in the villages and chronicle their journey. The campaign would be entitled, “Community Health Aide Recruitment: Adventure, Service, and Compassion in the Alaska Frontier.” It will also emphasize the training and continuing education provided to support each CHA in their essential role, and how they interface with patients and other providers as part of a health care team. Storytelling will emphasize the challenges, benefits, and unique advantages of working as a CHA in BBAHC village clinics. Campaign goals would include: • Promoting workforce development through “grow your own” pathways • Promoting the role of CHA as an entry point into the health care field • Raising awareness of the need for CHAs, their importance, and impact in people’s lives • Increasing interest in, and application for open CHA positions	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Advance to Implementation Application
Bristol Bay Area Health Corporation	Bristol Bay Chignik Lagoon Clinic Upgrade	AK	The facility lacks in basic structural integrity as its original use was modified into a clinic. Upgrades will address life safety, structural integrity as well as functionality of the facility. The building foundation skirting is not insulated making assessable to water and waste lien freeze up, as well as higher energy costs. The facility lacks in data capabilities for all components of lab, and pharmacy needs. The exterior siding is compromised from the elements and lacks in thermal protection from the elements. Case work inside the facility is dated and worn lacking in functionality. Furniture is dated and lacks functionality. Interior walls are in need of patching and new finish.	We would have a construction crew address the by the following. *exterior cladding, metal siding *modify building interior to include a lab *insulate crawlspace *new data runs *new flooring *paint *new office furniture *new casework	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Lake and Peninsula Borough	Advance to Implementation Application

Bristol Bay Area Health Corporation	Bristol Bay Expansion of Behavioral Health Aide Program	AK	Expansion of the BHA Program by the hire of additional BHA's would support the increased demand for immediate access to certified providers for mental health, substance use disorder, and prevention services, by tribes and village communities.	The approach is to ask for funding for two additional Behavioral Health Aides. They are located in the villages. Once we identify the applicant and the village, then we look for space to rent and will need associated furnishings and IT equipment. And to augment funding for additional village travel and supplies.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Advance to Implementation Application
Bristol Bay Area Health Corporation	Bristol Bay: Supporting Communication in Our Villages	AK	Purchase devices to assist with communication and hearing for our patients. Many residents of the Bristol Bay Area have un- or under-managed hearing loss, which makes it difficult to communicate with caregivers and family members in a clinical setting.	We will provide low cost, high quality, and durable ALDs to Bristol Bay Area clinics for clinicians to use when interacting with patients in one-on-one settings.	Under \$50,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Advance to Implementation Application
Bristol Bay Area Health Corporation	Community Health Representative Program	AK	The Bristol Bay region faces significant barriers to accessing timely, coordinated, and culturally grounded health care due to its extreme remoteness, limited local staffing, and high burden of chronic and behavioral health conditions. Most communities are only accessible by air or water, and many communities have minimal, to no local health education, navigation support, or prevention services. Patients often struggle to understand referrals, manage chronic disease, navigate complex travel healthcare protocols and processes, or stay connected to care after returning home. These gaps contribute to delayed treatment, fragmented care, and preventable health complications. This project addresses the opportunity to strengthen BBAHC's healthcare system by establishing a trained, community-based CHR workforce that can provide consistent outreach, navigation, and culturally relevant support in every community, which will improve on the ability to deliver accessible, high-quality, and sustainable care.	BBAHC's proposed approach addresses the region's limited access to local health education, navigation, and prevention services by establishing a phased Community Health Representative (CHR) Program that can operate effectively despite space and staffing constraints in many communities. Because not all communities currently have the capacity to house a full-time CHR, the program will begin by hiring six positions, one CHR Coordinator and five CHRs, who will be strategically placed in subregional hub communities. From these hubs, CHRs will travel to their assigned communities on a quarterly basis to deliver prevention activities, school-based education, home visits, and culturally grounded outreach. This phased model ensures that all communities begin receiving CHR services immediately while long-term community capacity is developed. The approach also includes comprehensive training for all CHRs, including certification, higher education pathways, and ongoing continuing education, ensuring a skilled, culturally competent workforce capable of providing consistent, high-quality support across the region. As communities expand space and staffing capacity over time, CHRs can transition from subregional rotation to permanent placement, strengthening the sustainability and reach of the program.	\$1M-\$5M		Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Advance to Implementation Application

Bristol Bay Area Health Corporation	Bristol Bay Home Health	AK	There are a number of elderly, or chronic ill, or patients of various kind that struggle getting into a clinic appointment and some are home bound and may need palliative care. We often find patients staying in our small hospital for long periods of time because we do not have a place to discharge them or their family is unable to support at home. Also, by being closer to the patient and families we will be better able to make informed decisions about their care.	BBAHC is interested in a planning grant that will help us create policies and procedures that would enable us to integrate the home services into a care model, care plans and appropriate staffing even with some use of telemedicine, Community Health Aides, nurses and providers. We may need to invest in devices for the patients' home environment that enable remote monitoring, such as blood pressure and video where the village infrastructure permits and allows care in the home even when faced with weather and travel delays. This can assist with mitigating provider shortages as well. And to Identify Home Health that works in our region's infrastructure capabilities that may include digital instruments that measure, record, and transmit health data directly to providers for chronic condition management and post-operative care. Key devices include blood pressure monitors, glucometers, pulse oximeters, digital scales, and wearables.	Under \$50,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Advance to Planning
Bristol Bay Area Health Corporation	Bristol Bay Substance Misuse Awareness Campaign: Bristol Bay Recovers	AK	Almost every Alaskan has been touched by substance use disorder through an experience they or a family member has had, or they know of someone who has been affected. Efforts to address the problem have taken many forms, however information may not be easily accessible when it is needed most. Community partners struggle to provide consistent, reliable information and may lack the funding for local outreach work. Additionally, stigma is a contributing factor to the delay in seeking treatment and ultimate success in recovery.	This project addresses substance misuse by providing access to a centralized, community-based system to navigate existing programs and resources based on individualized needs. It provides community organizations resources to support their work in local communities. It addresses stigma through sharing the lived experience of those in recovery in the Bristol Bay region. Components of the project include a marketing campaign and website development, to include video storytelling and social media promotions.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Deferred or Not Advanced
Bristol Bay Area Health Corporation	Bristol Bay Workforce Recruitment and Retention Program	AK	We have a lot of difficulty recruiting and retaining critical staff in our region. This is a pilot to assist in finding the staff we need to provide comprehensive services to our communities.	Provide recruitment and retention incentives for the following hard to fill positions: Registered Nurse, Mental Health Clinician, Case managers, Pharmacists, Community Health Aides, Resident Attendants, Counselor Technicians, Patient Access Representatives, Patient Travel Coordinators and Health Benefits Specialists.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Deferred or Not Advanced

Bristol Bay Foundation	Bristol Bay Rural Health Fellowship	AK	Rural communities in the Bristol Bay region continue to experience persistent health workforce shortages across nursing, behavioral health, dental, emergency services, and primary care. Recruitment from outside Alaska has proven costly and unsustainable, with high turnover and limited long-term retention in remote settings. At the same time, Alaska Native students from the Bristol Bay region are already pursuing health related degrees and certifications through Bristol Bay Foundation’s Higher Education Scholarship Program. Health professions consistently rank among the top fields of study for BBF scholars. However, students in clinical training pathways face significant financial and logistical barriers during high intensity years, including travel for rotations, licensing fees, reduced work hours, and rural placement costs. The opportunity is to strengthen a grow our own workforce model by providing targeted fellowship support to Alaska Native students already committed to serving their communities. By enhancing BBF’s existing scholarship infrastructure with a structured Rural Health Fellowship track, this project will accelerate credential completion, increase rural clinical engagement, and build a sustainable pipeline of certified providers rooted in Bristol Bay.	The Bristol Bay Rural Health Fellowship will operate as a specialized workforce enhancement track within BBF’s existing Higher Education Scholarship Program. Rather than creating a new standalone program, the Fellowship leverages proven scholarship infrastructure, academic monitoring systems, teletherapy supports, and emergency aid resources already serving Alaska Native students. In Year One, the Fellowship will prioritize students entering their junior and senior years in health-related degree programs. This stage represents a critical transition into high intensity clinical coursework and licensure preparation, where financial strain and attrition risk are highest. An estimated 15 to 20 Health Fellows will be supported across priority fields including nursing, medicine, physician assistant studies, behavioral health, dental and DHAT programs, community health work, CHA or BHA programs, pharmacy, medical laboratory sciences, public health, and EMS or paramedicine. Simultaneously, BBF will identify first year students demonstrating strong academic performance and commitment to health careers to form a prospective second cohort. These students will receive early engagement, mentorship exposure, and workforce orientation so that when they reach junior standing, they are prepared to transition into the Fellowship track. This staged cohort model strengthens pipeline continuity and creates a rolling workforce development structure. The Fellowship includes a supplemental stipend to offset clinical travel and licensing costs, structured quarterly case management, coordination with Tribal Health Organizations for rural immersion opportunities, and continued access to integrated student supports. This approach directly aligns with Strengthen Workforce priorities by developing a rural provider pipeline and increasing retention strategies.	\$1M-\$5M	Statewide	Anchorage (Municipality); Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Advance to Implementation Application

Bristol Bay Housing Authority	Naknek Senior Housing - Public Health Infrastructure	AK	To ensure the long-term sustainability of this critical housing and health resource, we will replace the aging and unstable water filtration system serving SW Elder Home. The current filtration system is outdated. Maintenance and replacement parts are no longer available, requiring improvised and unsustainable repairs, creating ongoing risk to the reliability of safe drinking water for residents. For older adults, disruptions to safe and reliable water can directly impact health, sanitation, and the safe operation of the facility itself. The proposed project will install a new water filtration system designed to provide consistent and safe drinking water to the facility. This infrastructure investment will reduce the risk of service interruptions, decrease ongoing maintenance costs, and ensure the facility can continue operating safely for the elders who depend on it. By strengthening this core building system, the project will protect an essential piece of community health infrastructure and support continued access to stable housing located adjacent to the region’s primary healthcare provider. In rural communities infrastructure failures can have outsized impacts, maintaining reliable housing infrastructure is critical to sustaining local health systems. This project will ensure that SW Elder Home can continue to provide safe, stable housing that enables elders to age in place while maintaining access to healthcare and community support.	To address the instability of the current water filtration system at Southwest Elder Home, the project will install a new water treatment and filtration system designed specifically to address the water quality conditions present in the region, which include elevated levels of iron. The recommended system, developed in consultation with Alaska Water Tech, will provide reliable treatment of sediment and naturally occurring minerals in the local water supply while improving the overall stability and performance of the building’s water infrastructure. The proposed system is designed to remove sediment particles measuring 5 microns and larger and to effectively treat elevated levels of iron (2.1 ppm), manganese (307 µg/L), and hydrogen sulfide (up to 10 mg/L), which contributes to sulfur odor. The system will include a high-flow 2-inch sediment filter housing containing a single extra-large pleated filter cartridge that will function as a sediment pre-filter to the backwashing treatment vessel. A key advantage of the recommended system is that it does not require salt or oxidizing chemicals to operate, reducing operational complexity and long-term maintenance requirements for the facility. The treatment media within the system is expected to have a service life of approximately eight to ten years. At the end of that period, only the internal treatment media and under-bedding gravel will need to be replaced, while the mineral tank and control valve can remain in service. This approach provides a durable, low-maintenance solution that is well suited to the operational realities of a remote community. By installing a reliable water treatment system with long service intervals and minimal chemical requirements, the project will reduce maintenance demands on facility staff while ensuring consistent access to safe, reliable water for residents of Southwest Elder Home.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough	Deferred or Not Advanced

Bristol Bay Native Association	Bristol Bay Prenatal Outreach & Perinatal Support Project	AK	Pregnant women in Bristol Bay with substance use disorders face substantial barriers to early and continuous care due to remoteness, stigma, and fear of punitive responses. Limited behavioral health capacity, travel constraints, and lack of a dedicated outreach model delay treatment and prenatal care engagement. These gaps increase preventable risks including complications in pregnancy, neonatal withdrawal, and family instability. The region currently lacks a coordinated, non-punitive approach focused on initiating early contact, building trust, and connecting mothers to care in ways that are culturally grounded and locally delivered. This project seeks to create a maternal-health–centered outreach and care coordination model that meets mothers where they are, reduces stigma, improves access to treatment and prenatal care, and strengthens family wellness.	The project will implement a maternal-health focused outreach and care coordination model staffed by two Community Health Workers (CHWs) and supported by a 0.5 FTE supervisor. Outreach will occur in villages and homes, using trauma-informed, non-punitive methods to build trust with pregnant mothers who have substance use disorders . CHWs will provide culturally grounded engagement supported by the Wellness A Circle of Life and Positive Indigenous Parenting programs, partnering closely with Bristol Bay Area Health Corporation (BBAHC). Care navigation will include warm handoffs to substance use disorder treatment, medication assisted treatment, prenatal providers, and supportive programs. Each participant will receive a Perinatal Wellness Plan addressing healthy lifestyle goals, safety considerations, cultural supports, prenatal scheduling, and postpartum needs. Telehealth access and transportation support will reduce barriers. Formal referral pathways will be strengthened among BBAHC, BBNA programs, behavioral health providers, and public health nursing. Shared data processes will track outreach, linkages, engagement, and retention. Postpartum support will continue through 12 months, emphasizing parenting strength, culture, and connection to early childhood services. This approach creates a cohesive, maternal-health–anchored model that improves coordination and access for rural families.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Kodiak Island Borough; Lake and Peninsula Borough	Advance to Implementation Application

Bristol Bay Native Association	Revitalizing Marrulut Eniit Assisted Living (Grandma’s House) for Aging in Place in Bristol Bay	AK	Elders play a vital role in Bristol Bay communities, carrying language, cultural traditions and knowledge about subsistence lifeways and local history. However, many Elders face difficult choices as their health needs increase. Assisted living, daily caregiving support and coordinated medical services are limited across the region, forcing some Elders to relocate far from family, language and the subsistence lifestyle that has shaped their lives. Families who wish to keep Elders at home often take on significant caregiving responsibilities while balancing work, childcare and subsistence activities. For nearly two decades the assisted living facility known locally as “Grandma’s House” in Dillingham helped address this challenge. Opened in 2003, the small residential facility provided a home-like setting where Elders from across the Bristol Bay region could receive support with daily activities such as meals, medication management and mobility. Its model allowed Elders to age in a familiar environment rather than relocating for care. For many Bristol Bay families, it was the region’s only local assisted living option and helped Elders remain near family and community. When Grandma’s House closed in 2019 due to financial and operational challenges, the region lost its only assisted living option. The closure created a major gap in the continuum of care and underscored the need for a more durable operating model, stronger workforce supports and sustainable financing.	This project proposes revitalizing Grandma’s House as a culturally grounded, community-based model of aging-in-place care for Elders in the Bristol Bay region. Grandma’s House was originally developed and operated through a collaborative regional effort involving multiple Bristol Bay partners. Although the facility ultimately closed due to staffing and funding challenges, it demonstrated the strong community need for local assisted living services and the potential for a sustainable model when supported by clear operational strategies and stable resources. BBNA proposes to lead the planning and revitalization of Grandma’s House and establish a streamlined management structure designed to ensure long-term sustainability. The model will incorporate strategies such as workforce housing incentives to attract and retain caregivers, development of local caregiver training pathways, integration with Medicaid waiver and long-term care reimbursement programs, and diversified funding partnerships among Tribal entities, regional nonprofits, and state and federal programs. Together, these strategies will support a stable care model that enables Elders to age in place while remaining connected to their families and cultural traditions. As a long-standing regional nonprofit serving the Tribes and communities of Bristol Bay, BBNA is positioned to coordinate the Tribal, health, housing and community partners needed to plan and sustain a culturally grounded Elder care model. The initiative will, if site control can be secured, utilize the existing assisted living facility and undertake necessary renovations to create a safe, home-like residential care environment for Elders. The revitalized model will combine assisted living services, community health support and culturally relevant programming. Residents will receive help with daily living activities such as meals, medication management, mobility and transportation to health services. Partnerships with Tribal organizations, regional health providers and local workforce training programs will help ensure culturally competent care and strengthen the regional caregiving workforce. Ultimately, revitalizing Grandma’s House will restore a vital support system for Bristol Bay families. By creating a sustainable, culturally grounded model of Elder care, the project will ensure that Elders can age in place—remaining in the communities they helped build while continuing to guide and inspire future generations.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Kodiak Island Borough; Lake and Peninsula Borough	Advance to Implementation Application

Bristol Bay Native Association	Bristol Bay Reentry Transitional Housing for Rural Health and Recovery	AK	The Bristol Bay region faces a critical shortage of safe and stable housing for individuals returning to the community after incarceration. In rural communities such as Dillingham, the lack of transitional housing creates significant barriers for individuals attempting to reintegrate. Many returning individuals struggle to secure immediate housing, limiting their ability to access healthcare services, participate in outpatient substance use treatment, maintain employment, and establish stability. Without safe housing, individuals face increased risk of relapse, untreated behavioral health needs, homelessness, and recidivism. This project seeks to address this gap by establishing a transitional living facility in Dillingham that supports individuals returning to the Bristol Bay region after incarceration. The facility will provide a safe, sober environment where participants can stabilize while connecting with healthcare providers, treatment programs, and supportive services. In addition to supporting reentry clients, the facility will provide short-term emergency housing for men experiencing domestic violence in partnership with the Tribal Men’s Program, as well as temporary stabilization housing for families or children traveling with an OCS worker. By addressing multiple housing gaps affecting health and safety, this project will strengthen healthcare access, improve recovery outcomes, and support stabilization for vulnerable individuals and families in rural communities.	The BBRP proposes a phased approach to develop a transitional living facility in Dillingham, Alaska to support individuals returning to the community after incarceration while addressing critical short-term housing needs that impact health and community stability. Phase 1 (Months 1–12): Planning and Partnership Development During this phase, the project team and financial management systems will be established to ensure proper grant oversight. Reporting and monitoring procedures will be developed to support accountability and program effectiveness. Stakeholder meetings will align project goals with community partners. A 2024 regional Community Needs Assessment identified housing as a major barrier to reentry success, healthcare access, and community wellness; updates will be conducted if needed. Memorandums of Understanding will strengthen partnerships with healthcare providers, law enforcement, tribal councils, and regional service organizations. Community engagement will build awareness and support while program models are finalized. Phase 2 (Months 13–24): Facility Development and Program Preparation During this phase, contracts will be finalized to renovate the selected facility to meet program and safety standards. The facility will support transitional housing for reentry clients while reserving space for emergency housing through the Tribal Men’s Program for men experiencing domestic violence and temporary stabilization housing for families or children traveling with an OCS worker. Stakeholders will be updated on project progress while baseline data is collected to measure outcomes. Staff training, service coordination, and regional outreach will continue. Phase 3 (Months 25–36): Program Implementation and Evaluation In the final phase, the facility will begin serving individuals returning to the Bristol Bay region who need short-term housing and stabilization. Participants will be connected to healthcare services, behavioral health treatment, case management, and community resources. Program monitoring and evaluation will track outcomes using qualitative and quantitative data. By addressing three regional gaps—reentry housing, emergency housing for men experiencing domestic violence, and short-term housing for OCS families—the project will strengthen regional health infrastructure and community stability. Sustainability planning will support long-term success through partnerships and diversified funding.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Kodiak Island Borough; Lake and Peninsula Borough	Deferred or Not Advanced

Bristol Bay Native Association	Bristol Bay Regional Emergency Response Readiness Assessment	AK	Like much of Alaska, the Bristol Bay region is remote and largely inaccessible via the State’s highway system. Apart from roads connecting Dillingham–Aleknagik, King Salmon–Naknek, and Iliamna–Newhalen, the remaining 25 communities have no interconnecting road access. Residents rely on boats, personal vehicles, snow machines, ATVs, and charter aircraft for local travel, emphasizing the critical need for reliable emergency response services. The region has a year-round population of approximately 7,000, which can increase by more than 13,000 seasonal fishermen. Community populations range from uninhabited areas to several thousand residents. There is no formal regional emergency response system; each community’s capacity depends on available local resources. Dillingham hosts the regional hospital and serves as the primary healthcare hub. Twenty-one communities operate village clinics staffed by Community Health Aides (CHAPs) who coordinate with medical teams at Kanakanak Hospital. Village Public Safety Officers (VPSOs) are present in eight communities, including Dillingham, and frequently act as first responders. In communities without VPSOs or CHAPs, residents provide initial care until medevac transport arrives. Those serving in these roles often manage complex medical emergencies with limited supplies, outdated equipment and insufficient training—factors that can adversely affect patient outcomes and contribute to a high-pressure environment with increased provider burnout.	Phase I of this initiative will build the foundation for a coordinated, sustainable and culturally responsive regional emergency response system across the Bristol Bay region. Recognizing the geographic isolation, workforce limitations and infrastructure gaps that characterize many of the region’s 31 communities, this phase will focus on assessment, engagement and strategic planning to guide long-term system transformation. The project will begin with a regional needs and readiness assessment evaluating each community’s current emergency response capacity, including workforce availability, certification levels, training frequency, equipment condition, communication systems, transport logistics, and coordination with village clinics and the regional hospital. The assessment will also document informal response practices in communities without structured services to ensure existing local strengths are recognized and incorporated. A mixed-methods approach will include site visits, structured interviews with Community Health Aides, Village Public Safety Officers, tribal leaders, municipal officials and residents, along with review of response data, medevac utilization and incident trends. Particular attention will be given to barriers related to distance, weather, seasonal population fluctuations, and volunteer recruitment and retention. Findings will be synthesized into a regional gaps analysis identifying priority needs in workforce development, infrastructure, equipment standardization, governance and interagency coordination. By the conclusion of Phase I, the project team will have the assessment results needed to begin developing a data-driven regional strategic plan in Phase II (future funding need) that outlines phased investments, standardized training pathways, equipment benchmarks, communication improvements and governance recommendations. The plan will include cost projections, funding pathways and implementation timelines to guide future phases. Emphasis will be placed on building local capacity, strengthening stabilization capabilities, improving coordination with partners and reducing preventable delays in care. By the conclusion of Phase I and II, the region will have a clear, community-informed roadmap to expand into Phase III - implementation of strategies to provide timely access to emergency care, elevated service quality, enhanced sustainability of health resources, and advancement of health equity across its rural and frontier communities.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Kodiak Island Borough; Lake and Peninsula Borough	Deferred or Not Advanced

Bristol Bay Native Association	Bristol Bay Regional Workforce Development Gaps Analysis	AK	Bristol Bay communities face persistent shortages in direct care, care navigation, EMS support roles and other frontline health positions. Many communities are small and isolated, making it difficult to recruit and retain qualified staff. Limited local access to training programs, high costs for certification and continuing education, and seasonal employment patterns tied to fisheries and other industries contribute to workforce instability. As a result, communities often rely on a small number of individuals to fill multiple roles or depend on temporary or itinerant providers, which can create gaps in services and disrupt continuity of care. These workforce shortages directly affect access to care. Limited direct care staffing reduces access to Elder supports and in-home care, making it harder for Elders to age safely in their communities. Gaps in care navigation roles can delay referrals, reduce follow-up, and make it difficult for residents to access benefits, specialty care or chronic disease management services. EMS and emergency response shortages can also affect response times and community readiness during high demand, severe weather or travel disruptions. The region also lacks a comprehensive understanding of service availability and workforce distribution across communities. Without coordinated service and workforce mapping, it is difficult to identify priority gaps, prioritize investments or design training and recruitment strategies that reflect regional needs.	In order to meet the need for stable health care roles in remote communities and provide consistent access to care, BBNA will conduct a regional workforce and service gap analysis to guide development of the “Grow Our Own Workforce Hub” in Year 1. A RFP will be developed to select a partner to complete the assessment. BBNA will engage key partners—including Tribal governments, regional health providers, EMS programs, Elder services organizations, schools and training institutions—to participate through surveys, interviews and data sharing across the 31 Bristol Bay communities. The analysis will identify workforce shortages by role and location, document service gaps affecting access to care and highlight barriers to building and retaining a local workforce. Findings will identify priority occupations for the workforce hub and inform a data-driven workforce development plan outlining training pathways, partnerships and investments needed to build a sustainable regional workforce pipeline. In Year 2, BBNA will operationalize the workforce hub by developing or adapting curriculum for priority pathways identified in Year 1, aligning training with certification requirements. Regulatory considerations for operating the workforce hub will be identified. BBNA will secure trainers and training partners, establish training locations within hub communities, and procure equipment and instructional materials. Programs will utilize a mix of in-person, hybrid and online learning models. Recruitment will prioritize residents from Bristol Bay villages and hub communities, and trainee supports will be identified to reduce participation barriers. By the end of Year 2, the workforce hub will launch its first cohort of students. In Years 3–5, the workforce hub will expand training pathways and enroll additional cohorts based on regional workforce needs. As participants complete certification, the number of locally trained health care workers entering the workforce will increase. BBNA will work with regional employers and Tribal partners to support job placement and retention through mentorship and career advancement opportunities. These efforts will help stabilize the health care workforce in Bristol Bay’s remote communities, improve access to care, and expand local career opportunities while strengthening the long-term sustainability of the regional health system.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Kodiak Island Borough; Lake and Peninsula Borough	Deferred or Not Advanced

Bristol Bay Native Association	Preventing Chronic Illness Through Nutrition in Vulnerable Populations Throughout Bristol Bay	AK	Residents of the Bristol Bay region face significant barriers to accessing healthy foods, particularly fresh fruits and vegetables. None of the communities in the region are connected to the road system and are accessible only by plane, boat, or snow machine depending on the season. These transportation challenges, combined with high food costs and limited retail options, make fresh produce difficult to obtain consistently. As a result, many households rely on shelf-stable foods and have limited access to the nutritious foods needed to maintain a healthy diet. Limited access to fruits and vegetables contributes to increased risk of diet-related chronic diseases such as diabetes, cardiovascular disease, and obesity. These conditions are already prevalent in rural Alaska and place additional strain on rural health care systems that often operate with limited workforce and infrastructure. Food insecurity also remains a persistent challenge in the Bristol Bay region. Many households rely on food assistance programs to meet basic nutritional needs, yet available food resources often lack consistent access to fresh, healthy options. Improving reliable access to fruits and vegetables represents an opportunity to address a key root cause of poor health outcomes in rural communities.	To address barriers to accessing nutritious foods, Bristol Bay Native Association (BBNA) proposes to expand the Bristol Bay Regional Food Bank by providing regular produce boxes to food bank clients throughout the region. This project will increase access to fruits and vegetables for households in communities that are only accessible by plane, boat, or snow machine and where grocery options are limited and costly. BBNA will partner with Full Circle Farms, a produce distributor that already maintains a regular shipping route to Dillingham. Through this partnership, produce boxes will be delivered to Dillingham and then distributed to communities throughout the Bristol Bay region using the Food Bank’s existing logistics and air freight systems. BBNA will coordinate ordering, packing, and shipment of produce boxes through the Food Bank facility before distributing them to participating communities. Once shipments arrive in each community, produce boxes will be delivered to a central and accessible location such as a Village Council office, school, or other trusted community facility. Food Bank clients will be notified when shipments arrive and will pick up their produce boxes from these locations. This distribution model allows BBNA to reach multiple communities efficiently while working within the transportation realities of rural Alaska. During the first year of the project, BBNA anticipates distributing produce boxes approximately every two weeks to participating households. This schedule balances the goal of increasing access to fresh foods while ensuring the program remains logistically sustainable for rural transportation and distribution systems. By increasing access to fruits and vegetables through an established regional distribution network, the project will help improve diet quality and reduce chronic disease risk factors associated with limited access to healthy foods. Expanding nutritious food availability through the Food Bank strengthens community-based prevention efforts and supports healthier lifestyles for residents across rural Bristol Bay communities.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Kodiak Island Borough; Lake and Peninsula Borough	Deferred or Not Advanced

Bristol Bay Region Career and Technical Education	Classroom to Careers: Building Alaska’s Rural Health Workforce	AK	Workforce development is a multifaceted challenge in rural Alaska. Because of its vast size and isolated communities, rural Alaska faces unique challenges related to the delivery of formalized workforce training programs. Low population density creates significant barriers to sustaining local training programs, as developing workforce pathways within each community is cost-prohibitive and difficult to maintain over time. K–12 school districts represent a critical entry point into the healthcare workforce pipeline, yet most rural districts lack the infrastructure, curriculum, and trained instructors necessary to provide high-quality, career-aligned health education programs. Without early exposure to healthcare careers and accessible training pathways, many rural students are unable to pursue healthcare professions or must leave their communities to do so, reducing the likelihood they will return to work locally. This project addresses the opportunity to strengthen the rural healthcare workforce by building structured education-to-career pathways within rural schools and communities. By equipping schools with aligned curriculum, workforce partnerships, and instructor support, the program will help prepare local students for healthcare careers while creating a sustainable pipeline of homegrown healthcare professionals for rural Alaska.	Bristol Bay Region Career and Technical Education (BBRCTE) was formed as a collaborative partnership with four rural school districts in the Bristol Bay Region. The consortium was created to meet the unique needs of rural Alaskan students who have limited access to high-quality, industry-supported career training. BBRCTE believes that students should be empowered to take their place in the regional economy as leaders in their community. BBRCTE is a critical component of a regional workforce strategy that connects K–12 education, industry partners, and workforce training organizations to create sustainable healthcare career pathways for rural students. Through this project, partners will align their expertise to expand healthcare workforce exposure, training, and mentorship opportunities for students across the Bristol Bay region. BBRCTE will serve as the central convening and program delivery partner, coordinating the regional health career pathway and hosting two week-long career intensives that bring together students from 21 remote communities. BBRCTE will manage program logistics, student recruitment, and alignment with school districts to ensure participation from rural students who would otherwise have limited access to healthcare training. BBRCTE Career Guides will connect students with healthcare professionals, and introduce career pathways in fields such as nursing, behavioral health, community health, and allied health professions. Partners will provide industry expertise and curriculum aligned with healthcare workforce needs. Using hands-on instruction during the intensives. Their role ensures that programming reflects real workforce demands and exposes students to attainable career pathways within Alaska’s healthcare system. Local school districts will serve as the foundational pipeline for the program by identifying and preparing students for participation, integrating career awareness into the school year, and supporting students as they transition from exploration to postsecondary training opportunities. Together, this collaborative model addresses geographic barriers by pooling regional resources and expertise to deliver high-quality healthcare workforce training. By strengthening partnerships between education and healthcare sectors, the project creates a scalable pathway that prepares rural students for healthcare careers while building a locally rooted workforce for rural Alaska.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Deferred or Not Advanced

Brittany Gene Design Solutions, LLC	Rural Alaska Digital Care Navigation Hub	AK	Rural Alaskans, particularly Alaska Native populations in frontier regions such as the North Slope, face significant geographic and administrative barriers to healthcare. Residents often navigate a fragmented system where medical care, behavioral health services, and essential social supports—such as employment resources and cultural programs—are disconnected and difficult to access. A major bottleneck occurs in outdated administrative processes. Rural patients frequently wait five to seven weeks simply for paper intake forms to be processed before they can schedule an appointment. These delays can worsen behavioral health crises, prolong untreated conditions, and increase stress for families and caregivers. At the same time, healthcare providers often lack visibility into whether patients successfully access services after referrals are made, limiting their ability to coordinate care and monitor outcomes. Manual paperwork also places a heavy burden on the already limited rural healthcare workforce, taking time away from patient care and contributing to provider burnout. These systemic challenges highlight the need for modern, accessible tools that streamline navigation, improve coordination between services, and reduce administrative barriers for both residents and providers.	Our approach centers on community-led co-design and Indigenous human-centered design to ensure the platform reflects the realities of rural Alaska. Large healthcare systems often fail in frontier regions due to limited internet bandwidth, geographic isolation, and varying levels of technical literacy. To address this, we are developing a lightweight, customizable, low-bandwidth digital platform designed to function reliably in remote communities. This solution is being co-designed with tribal governments, cultural leaders, and strategic partners including the Arctic Slope Community Foundation, Recover Alaska, and the University of Alaska Anchorage. These collaborations help break down organizational information silos and consolidate fragmented resources into a unified, user-friendly digital entry point. By bringing clinical services, behavioral health support, and Social Determinants of Health (SDOH) resources into one system, the platform improves coordination while reducing duplicated efforts across organizations. The hub will feature a responsive AI-powered chatbot and intuitive digital intake forms designed for usability across a wide range of users. Residents will be able to navigate clinical, behavioral, and social resources through a single interface, reducing administrative barriers that currently delay care. By tracking engagement, common questions, and service needs, the platform can be continuously refined to improve responsiveness and service delivery. The platform architecture prioritizes both HIPAA compliance and Indigenous Data Sovereignty. A tiered, role-based access model ensures that public resources are widely accessible while Protected Health Information (PHI) remains strictly secured. The system also supports secure closed-loop referrals, allowing providers to coordinate care while sharing only the minimal data necessary. This protects privacy while building trust within Alaska Native communities. Development is guided by a multidisciplinary advisory team including an Iñupiaq cultural advisor and clinical psychologist, alongside experienced technology specialists. By integrating local resources, reducing duplicated efforts, and streamlining care navigation, this ecosystem helps lower operational costs across Alaska’s healthcare system while supporting the transition toward sustainable value-based care models.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Juneau (City and Borough); North Slope Borough	Deferred or Not Advanced

Brother Francis Shelter Kodiak Inc	Improving the Health of Kodiak's Homeless	AK	Brother Francis wants to better serve the homeless population by providing additional case management, addressing transportation barriers, and offering more services focused on client success, including employment, housing, and access to additional social services. We also need financial assistance with bathroom and kitchen upgrades. The bathroom upgrade will extend the life of our shelter and its ability to continue offering critical services to the community, and the kitchen upgrade will allow for clients who require accommodations to be part of the daily service team, which is shelter clients serving others. This concept helps build a sense of community here at the shelter. It improves shelter morale and individual mental health. When this population takes ownership of their well-being, they become healthier individuals and place less strain on our health systems.	We will begin by adding a case worker position to facilitate a more client-focused day service where clients can come to navigate housing applications, employment opportunities, and applications for additional services. This case worker will also schedule classes focused on budgeting, employment interviews, healthy cooking, and any subject that will lead to client success. During these day hours, we would schedule Public Health and the Kodiak Community Health Center's mobile unit to be on-site and available for blood pressure, diabetes, and COPD screening. We will also have a credentialed caseworker, Mrs. Mary Guilas-Hawver, LMSW, MAC, CDCS ADM, on call and available to clients needing evaluations, assessments, or additional in-depth case management. This access to client assessments can either eliminate the need for additional health care or streamline the process to necessary services. Providing transportation to this equation will reduce the number of emergency ambulance calls and also enable clients to attend wellness and prevention appointments. Transportation will be provided by our shelter vehicle or by passes for the local bus system. Having the plumbing issues corrected can be done intermittently. Should the shower areas be completely closed due to maintenance, we are located close to the harbor and their public bathing facilities, we will provide shower passes and transportation to and from on those days. Completing the dumbwaiter will have long-lasting benefits for the shelter. Once completed, it will allow many of our older clients to be involved in shelter services. These individuals want to be needed and appreciated; they will mentally flourish having this added responsibility. The combination of these services will reduce the demand on Kodiak's emergency healthcare systems, improve access to necessary care, encourage workforce development, and have long-lasting, positive effects on the homeless community of Kodiak. These will all be steps towards stabilizing homeless individuals, helping them obtain permanent housing, and creating a safer, healthier community.	\$50,000-\$250,000	Single Community	Kodiak Island Borough	Deferred or Not Advanced

Build Alaska's Future Education Fund	Alaska Rural Health Workforce Pathways and Community Access Initiative	AK	The Problem: Alaska’s rural health system faces a critical, persistent shortage of healthcare professionals. Remote communities rely heavily on transient, nonresident providers, leading to inconsistent care, high turnover, and a lack of cultural alignment. Compounding this crisis is the systemic disconnect between rural residents, particularly Alaska Native youth, and the training pathways required to enter the health sector. They lack the exposure, accessible entry points, and localized data needed to confidently pursue health-related careers. The Opportunity: BAFEF has an established model that can be adapted for the health care workforce. We possess an established two-way workforce engagement model that currently connects rural Alaskans to the infrastructure sector. The RHTP presents a timely opportunity to adapt this proven framework explicitly for the health care workforce. Instead of building a new program from scratch, we will leverage our existing logistical infrastructure, community trust, and local government partnerships. We will pivot our 8-community rural outreach workshops and Fairbanks-based, week-long hands-on training cohorts to focus on nursing, EMS, behavioral health, and Community Health Aide Programs (CHAP). By allowing rural residents to "try out" healthcare fields before committing to long-term programs, and utilizing our GIS mapping to highlight workforce gaps, we will build a resilient, homegrown health workforce from within.	BAFEF will execute this project by adapting our proven Alaska Native Rural Workforce Development Collaboration to specifically build Alaska’s rural health workforce. Because our logistical infrastructure and local government partnerships are already established, our approach can be rapidly deployed through four phases: Phase 1: Targeted Rural Community Outreach: We will host intensive, multi-day workshops in eight geographically isolated and economically distressed communities. BAFEF teams will convene municipal leaders, tribal representatives, and educators to identify localized workforce needs. We will use these sessions to introduce rural residents, especially Alaska Native youth, to high-demand health career pathways, including nursing, Emergency Medical Services, behavioral health, and Community Health Aide Programs. Phase 2: Hands-On Urban Training Cohorts: To bridge the gap between initial interest and long-term commitment, we will transport prospective rural apprentices to urban training hubs (Fairbanks) for week-long health sector workshops. We will host three cohorts of approximately 12 participants each. Partnering with healthcare educators and facilities, we will provide a unique opportunity for participants to try out a healthcare field before committing to a rigorous certification program. This approach significantly reduces attrition, while allowing healthcare employers to build relationships with prospective trainees to improve long-term retention. Phase 3: Data Transparency & GIS Mapping: To sustain this effort and Spark Technology, BAFEF will expand our interactive GIS mapping platform. This tool will track RHTP investments, identify regional health workforce gaps, and help communities visualize where resources and opportunities intersect. Utilizing our innovative quasi Electronic Health Management System, we will share data across regions, collaborate on training priorities driven by community engagement, provide staffing needs system-wide and ultimately support any potential crisis interventions. This empowers local governments and tribal consortiums to make data-informed decisions regarding their local health infrastructure. Phase 4: Following the cohorts, we will host a virtual statewide convening for stakeholders to share insights and solidify collaborative workforce strategies. The project will culminate in a strategic report detailing best practices and actionable recommendations for sustaining a rural health workforce ecosystem.	\$50,000-\$250,000	Statewide	Bethel Census Area; Kusilvak Census Area; Nome Census Area; Northwest Arctic Borough; Prince of Wales-Hyder Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Cadence	Scaled Statewide RPM and Remote Care Delivered Through HIE Integration	NY	Alaska's rural and frontier populations carry a disproportionate burden of chronic disease — particularly Hypertension, Type 2 Diabetes, and Congestive Heart Failure — yet face persistent barriers to the consistent monitoring these conditions require. Geographic isolation, provider shortages, and the cost of travel make routine follow-up care inaccessible for many Alaskans, allowing manageable conditions to progress into costly hospitalizations and emergency events. At the same time, outpatient clinics that want to offer Remote Patient Monitoring face a separate barrier: the complexity and cost of integrating RPM platforms into their existing workflows. Most rural clinics lack the IT resources to build and maintain these connections, leaving RPM adoption fragmented and out of reach for the communities that need it most. Cadence sees an opportunity to solve both problems simultaneously. By deploying a turnkey RPM program for CHF, T2D, and Hypertension patients — and routing all vitals data and care summaries through Alaska's existing HealthEconnect HIE — Cadence can extend continuous, clinician-supervised monitoring to patients statewide while giving providers access to RPM data through infrastructure they already use. No custom integrations required. The result: meaningful chronic disease monitoring coverage for Alaskans who need it most, and a scalable model that grows as more clinics participate in the state HIE.	Cadence proposes to operate a statewide Remote Patient Monitoring program for Alaskan patients managing Hypertension, Type 2 Diabetes, and Congestive Heart Failure. The program is built on three core components: Referral and Enrollment: Participating outpatient clinics, including rural health clinics, FQHCs, and Critical Access Hospitals — identify eligible patients and refer them to Cadence. Cadence handles all onboarding, device fulfillment, and patient activation, placing no operational burden on the referring clinic. 24/7 Clinical Monitoring: Enrolled patients transmit daily vitals from home using Cadence-provided RPM kits. Cadence's clinical team monitors all incoming data continuously, proactively contacting patients when readings indicate risk. This replaces the need for frequent in-person visits and allows early intervention before conditions escalate to emergency events. HIE-Based Data Sharing: Cadence transmits structured vitals data and monthly patient summaries from its EMR into HealthEconnect, Alaska's statewide Health Information Exchange. Participating clinic providers can access their patients' RPM data directly through HealthEconnect, the system they already use, without requiring any direct integration with Cadence. This architecture is the key innovation: it makes the program accessible to any HIE-participating clinic in the state immediately, without IT build costs or vendor procurement on their end. Cadence currently serves ~300 Alaskan patients per month through partnerships with Community Health System and Providence Health, providing an active operational foundation from which to scale.	\$50,000-\$250,000	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

CalmKey Telehealth Connection LLC	Rural Arctic Health Psychology Postdoctoral Fellowship	AK	Alaskans face a critical shortage of licensed psychologists who specialize in care for people in rural and frontier communities. Even fewer experts are supervising new clinicians towards licensure and career opportunities in Alaska. As a result, individuals seeking help often encounter long waitlists. Long waitlists reflect a broader statewide gap in workforce development support and access to timely, specialized behavioral health care, particularly for trauma-informed, telehealth-based services that can reach remote communities. By the time care is accessed, conditions are often more complex and difficult to treat. These delays also contribute to burnout among the small number of providers currently serving rural Alaskans. I wish to address the workforce development gap by establishing a fellowship position in the Arctic setting designed to mentor an early-career psychologist through supervised postdoctoral training and licensure while expanding telehealth-based behavioral health services. The fellowship will increase access to culturally responsive, trauma-informed care for individuals across Alaska and support sustainable workforce development. The “grow-our-own” workforce development model expands immediate service capacity in a sustainable supervisory space for a new psychologist to gain Arctic practice skills. This initiative aims to reduce wait times, improve access to behavioral health care, and strengthen integrated workforce development by prioritizing local hire.	The proposed solution is the Rural Arctic Health Psychology Postdoctoral Fellowship development, a structured workforce initiative and service expansion project based at CalmKey Telehealth Connection in Fairbanks, Alaska under the supervision of National Register of Health Service Psychologists provider Dr. Rebekah Burket. The fellowship addresses two interconnected barriers to behavioral health access in Alaska: a shortage of licensed psychologists and a critical lack of supervisors available to train early-career clinicians toward licensure. The program will establish a competency-based postdoctoral training position for an early-career psychologist, providing a 2,000-hour supervised training experience over 12–24 months. The fellow will deliver substance use disorder treatment, psychotherapy, psychological assessment, and telehealth-based behavioral health services while receiving intensive mentorship in rural and frontier behavioral health practice. Training will emphasize evidence-based, trauma-informed cognitive behavioral principles, telepsychology, suicide risk assessment in low-resource environments, and culturally responsive care that integrates Indigenous healing practices and community collaboration. This fellowship uses a hub-and-spoke rural service model, with Fairbanks serving as the clinical hub and telehealth technology extending specialty care to underserved communities throughout Interior Alaska and other remote regions. Through this model, the fellow will provide direct, supervised services via in-person and secure telehealth platforms, expanding access to substance use treatment, psychotherapy, diagnostic assessment, and emerging service lines such as digitally-delivered neuropsychological testing. The fellow will participate in community capacity-building activities and develop a capstone project focused on sustainable rural behavioral health programming. This component strengthens partnerships with community organizations, health systems, and Alaska Native–serving institutions while supporting prevention, education, and systems collaboration. The fellowship is intentionally designed as a workforce capacity building effort for Alaskans by Alaskans. By training psychologists within the Arctic practice environment where they are needed, the program increases the likelihood that fellows will remain to practice and supervise future clinicians. Over time, the model can scale to support additional fellows and expanded supervisory capacity.	\$50,000- \$250,000	Private practition er	Statewide	Fairbanks North Star Borough; Yukon- Koyukuk Census Area	Deferred or Not Advanced

Camai CHC	Bristol Bay Regional Specialty Care Hub Transformation Project	AK	Residents of Bristol Bay and surrounding rural communities face significant barriers to accessing specialty healthcare. Patients requiring cardiology, ENT, and vision services often must travel to Anchorage or other urban centers. Travel is expensive, weather-dependent, and disruptive to patients and families, leading to delayed care, missed appointments, and worsening chronic conditions. Cama’i Community Health Center is expanding its facilities to meet growing healthcare needs in the region. The construction of a new standalone clinic creates an opportunity to repurpose the existing clinic building to address a critical gap in rural healthcare access: the lack of locally available specialty services. The current facility was originally designed to support emergency services and traditional clinic functions. As services transition to the new facility, the building can be redesigned to support a regional specialty care model that brings visiting providers and telehealth-enabled consultations directly to rural patients. Through architectural redesign and planning, this project will create a regional specialty care hub capable of supporting visiting specialists, telehealth services, and coordinated care delivery, improving access to specialty care for rural residents across the Bristol Bay region.	Cama’i Community Health Center proposes transforming its existing clinic into a regional specialty care hub that expands access to specialty services for rural residents of Bristol Bay and surrounding communities. With the construction of a new standalone clinic facility to house core primary care and other services, the current building can be strategically redesigned to support a new model of specialty care delivery. The project will begin with architectural design and facility planning to repurpose the existing clinic space for specialty services and telehealth-enabled care. Design work will focus on converting former emergency department and clinic areas into specialty exam rooms, telehealth consultation spaces, and flexible treatment areas to support visiting specialists. The redesigned facility will accommodate visiting providers in specialties such as cardiology, ear, nose, and throat (ENT), and chiropractic care, while also housing tele-optometry services that allow patients to receive vision assessments locally with remote specialist consultation. In addition to clinical space, the project will design a flexible community meeting and training area on the lower level of the building with an attached kitchen. This space will support regional healthcare collaboration, workforce training, community health education, and coordination among local partners. Cama’i has already completed a competitive RFP process and selected an architectural design team, allowing the project to begin immediately upon award. This design phase will produce detailed plans and cost estimates needed to support a future renovation phase that will implement the specialty care model. By repurposing existing infrastructure and integrating visiting specialists with telehealth technology, this project will expand access to specialty care, reduce costly patient travel, and strengthen care coordination across the rural healthcare system serving Bristol Bay.	\$50,000-\$250,000	Federally qualified health center	Single Community	Bristol Bay Borough	Advance to Implementation Application

Camai CHC	Connected Care: Remote Monitoring for Chronic Disease and Post-Hospital Recovery in Rural Alaska	AK	Rural residents in the Bristol Bay region face significant barriers to ongoing health monitoring and follow-up care due to geographic isolation, limited transportation options, and long distances between communities and higher levels of care. In Alaska, over 60% of communities are not connected to the road system, requiring travel by air or boat for hospital services, and weather conditions can delay care for days. Chronic conditions such as cardiovascular disease, diabetes, and hypertension are leading causes of hospitalization, and nearly 40% of Alaska adults live with at least one chronic condition. Elders and patients with multiple comorbidities are particularly vulnerable when consistent monitoring and follow-up care are limited. Preventable hospitalizations and emergency transports are among the most costly aspects of rural health care delivery in Alaska. This project will improve continuity of care through remote patient monitoring using wearable health devices and portable cardiovascular tools. By enabling providers to monitor patients remotely, Cama'i Community Health Center can detect early signs of health deterioration and intervene sooner, improving outcomes while reducing avoidable high-cost care.	Cama'i Community Health Center will implement a Remote Patient Monitoring program designed to support elders, patients with multiple chronic conditions, and individuals requiring close follow-up after hospital discharge or medication changes. The program will deploy approximately 200 wearable health monitoring devices and portable cardiovascular monitoring tools to high-risk patients in the Bristol Bay region. Patients enrolled in the program will receive devices that track key biometric indicators, including heart rate, activity levels, sleep patterns, and other cardiovascular signals. Portable finger-sensor diagnostic tools will allow patients to easily collect additional cardiovascular readings when needed. This data will be securely transmitted to the clinical care team, allowing providers to monitor trends and identify potential health concerns earlier than would otherwise be possible through periodic in-person visits alone. Cama'i will establish clear clinical protocols to identify eligible patients, including those recently discharged from the hospital, individuals with multiple chronic conditions, and elders who would benefit from additional monitoring as they age in place. Care teams will review incoming patient data and respond to alerts or concerning trends through telehealth visits, medication adjustments, or in-clinic follow-up, as needed. To ensure successful implementation and ongoing monitoring, the project will fund a part-time remote nurse or clinical staff member dedicated to managing the remote monitoring program. This individual will oversee device distribution, patient onboarding and education, daily monitoring of incoming data, and coordination with providers when follow-up is required. This role will also support patient engagement and caregiver communication to ensure the technology is used effectively. Over time, the program will generate valuable data that can support quality improvement initiatives, improve chronic disease management strategies, and help reduce preventable complications and hospital readmissions. By combining wearable technology with clinical oversight, this project will expand care beyond the clinic and create a more sustainable model for monitoring high-risk patients in rural Southwest Alaska.	\$250K-\$1M	Federally qualified health center	Single Community	Bristol Bay Borough	Advance to Implementation Application

Camai CHC	ACCESS Project: Alaska Collaborative for Clinic-Based Emergent Stabilization Services	AK	Rural community health centers in Alaska often serve as the first and only point of care for patients experiencing urgent and emergent medical conditions. In remote communities such as the Bristol Bay Borough, patients frequently must be stabilized locally while awaiting medevac transport to higher levels of care. Weather delays, distance, and transportation limitations can extend the time patients remain in local clinics, requiring providers to deliver emergent stabilization and monitoring for hours or even days. Despite providing these high-acuity services, community health centers are reimbursed under primary care billing structures because they are not licensed hospitals or emergency departments. This creates a structural financing gap between the services delivered and the services that can be billed. Cama'i Community Health Center operates as an independent rural safety-net provider and is not part of a larger hospital system or provider network. As the primary source of healthcare in the Bristol Bay Borough, the clinic must absorb the financial impact of emergent care services that cannot be appropriately reimbursed. This project will stabilize emergent care capacity at Cama'i while supporting participation in the ACCESS Project, a collaborative effort to document emergent care delivery in frontier clinics and inform development of sustainable reimbursement solutions for rural Alaska.	The ACCESS Project (Alaska Collaborative for Clinic-Based Emergent Stabilization Services) is a collaborative effort among rural clinics to better understand and address the structural challenges associated with delivering emergent care in frontier communities. This request focuses on stabilizing emergent care capacity at Cama'i Community Health Center while supporting the data collection and analysis needed to inform a broader policy solution being developed through collaboration with partner clinics in Skagway and Unalaska. Funding will support two primary activities. First, the project will provide short-term stabilization support, allowing Cama'i Community Health Center to continue delivering emergent stabilization services despite the financial gap created by current reimbursement structures. As an independent rural safety-net provider, Cama'i lacks the financial backing of a larger hospital system or provider network, making short-term stabilization critical to maintaining these services while longer-term solutions are developed. Second, the project will support the engagement of a consultant with expertise in rural health policy and reimbursement systems. The consultant will work with Cama'i and partner clinics to collect and analyze data related to emergent care delivered in rural clinic settings. This work will include documenting patient acuity levels, stabilization duration, staffing requirements, and the gap between services delivered and current reimbursement mechanisms. Cama'i will coordinate closely with partner clinics in Skagway and Unalaska that are advancing the broader ACCESS initiative. Data collected through this project will contribute to the broader effort to better define the scope of emergent stabilization services provided in frontier clinics and to support the development of a sustainable reimbursement framework appropriate for rural Alaska communities. Through this approach, the project will ensure that emergent care capacity at Cama'i remains stable while contributing critical data and operational insights needed to inform long-term system improvements for rural clinics providing emergent stabilization services.	\$250K-\$1M	Federally qualified health center	Single Community	Bristol Bay Borough	Deferred or Not Advanced

Camai CHC	BRACE: Bristol Bay Rural Administrative Capacity & Enhancement Initiative	AK	Cama’i Community Health Center has experienced significant growth in services in response to increasing healthcare needs in the Bristol Bay region, including expanded behavioral health programs, substance use treatment services, and school-based healthcare. While these programs improve access to care for rural and frontier communities, they also increase regulatory requirements, reporting obligations, and operational complexity. Currently, key administrative functions related to compliance oversight, quality improvement, and grant management are concentrated within a very small senior leadership team. As the organization expands programs and manages multiple federal and state funding sources, this structure creates risk related to regulatory compliance, quality monitoring, financial accountability, and long-term sustainability. The BRACE Initiative (Bristol Bay Rural Administrative Capacity & Enhancement) addresses this challenge by strengthening the administrative infrastructure required to support expanded rural healthcare delivery. By establishing dedicated roles focused on compliance, quality improvement, and grant management, BRACE will ensure that the systems supporting healthcare services are as strong and sustainable as the services themselves. Strengthening these systems will help stabilize healthcare delivery in Bristol Bay and position the organization to responsibly manage growth while continuing to serve rural and frontier communities.	Cama’i Community Health Center will address this challenge through the BRACE Initiative (Bristol Bay Rural Administrative Capacity & Enhancement), a comprehensive effort to strengthen the administrative infrastructure necessary to support sustainable healthcare delivery in the Bristol Bay region. BRACE will establish two key positions: a Compliance and Quality Officer and a Grants Administrator. The Compliance and Quality Officer will develop and oversee a formal compliance and quality improvement program aligned with federal, state, and FQHC requirements. This role will lead the implementation of compliance policies, coordinate internal monitoring and risk management activities, oversee clinical quality performance metrics, and provide training to clinical and administrative staff on documentation standards and regulatory requirements. The position will also support data analysis and reporting systems that allow the organization to monitor outcomes and continuously improve care delivery. The Grants Administrator will strengthen the organization’s ability to manage and sustain multiple funding sources that support rural healthcare services. Working closely with the Chief Financial Officer and program leadership, this role will oversee the grant lifecycle, including monitoring reporting deadlines, tracking deliverables and outcomes, ensuring compliance with federal funding requirements, and maintaining organized documentation for audits and monitoring reviews. In addition to these positions, BRACE will implement a governance and administrative training initiative to strengthen Board and leadership oversight. This component will provide training focused on fiduciary responsibility, compliance oversight, and accountability for federally funded programs. Strengthening governance will ensure that leadership and the Board are equipped to guide the organization through continued growth and increased regulatory complexity. Together, these investments will establish the operational systems required to support expanded healthcare services in Bristol Bay. By strengthening compliance, quality monitoring, grant management, and governance, the BRACE Initiative will build the administrative foundation necessary for sustainable rural healthcare delivery and long-term system improvement.	\$250K-\$1M	Federally qualified health center	Single Community	Bristol Bay Borough	Deferred or Not Advanced

Camai CHC	Bristol Bay Rural Health Cybersecurity and Digital Infrastructure Initiative	AK	Cama’i Community Health Center is a federally qualified health center serving residents of the Bristol Bay Borough and surrounding rural communities in Southwest Alaska. As the only non-Indian Health Service provider in the region, the clinic plays a critical role in maintaining access to primary care, behavioral health services, and emergency stabilization for local residents and the large seasonal workforce that supports the Bristol Bay fishery. Like many rural health providers, Cama’i relies on limited information technology infrastructure while facing increasing cybersecurity threats targeting health care systems nationwide. Rural clinics often lack the internal expertise and resources needed to fully assess vulnerabilities and implement modern cybersecurity protections. A cyberattack or system disruption could significantly impact patient care, compromise sensitive health information, and interrupt access to essential health services in a remote region where alternative care options are limited. This project addresses the need for a comprehensive cybersecurity and digital infrastructure assessment to identify vulnerabilities, strengthen system resilience, and ensure reliable, secure technology systems that support the delivery of health care in rural Bristol Bay.	Cama’i Community Health Center will implement a phased approach to strengthen cybersecurity and modernize the digital infrastructure that supports rural health care delivery. The project will begin with a comprehensive cybersecurity and information technology assessment conducted by qualified experts with experience supporting rural health care organizations. This assessment will evaluate the clinic’s current network architecture, electronic health record systems, data storage and backup processes, endpoint devices, access controls, and overall cybersecurity posture to identify vulnerabilities and areas for improvement. Based on the assessment findings, Cama’i will develop and implement a prioritized cybersecurity and infrastructure improvement plan. Planned improvements may include strengthening network security architecture, implementing advanced threat protection and monitoring tools, enhancing data backup and disaster recovery systems, improving identity and access management, and upgrading hardware or software needed to protect clinical systems and patient data. The project will also include staff training and policy development to strengthen organizational cybersecurity practices and ensure that employees understand how to recognize and prevent common threats such as phishing and ransomware attacks. Building internal awareness and capacity is critical for maintaining long-term system resilience. Together, these activities will strengthen the reliability and security of the technology systems that support patient care, protect sensitive health information, and ensure that Cama’i can continue delivering essential services to residents of Bristol Bay and surrounding rural communities. The project will also establish the secure digital infrastructure needed to support future technology-enabled care delivery models such as expanded telehealth services and remote patient monitoring.	\$250K-\$1M	Federally qualified health center	Single Community	Bristol Bay Borough	Deferred or Not Advanced

Camai CHC	Bristol Bay School HealthLink: A Wearable Health Monitoring Network for Rural Students and Staff	AK	Rural schools in Southwest Alaska face unique challenges in responding quickly to health and safety emergencies due to geographic isolation, limited on-site medical staff, and long EMS response times. In the Bristol Bay Borough School District, approximately 100 students and 50 staff spend most of their day in a setting where rapid coordination among school personnel, health providers, and emergency responders is critical. Currently, emergency communication relies on phones or radios, which can delay response during medical incidents such as asthma attacks, allergic reactions, injuries, or behavioral health crises. This project addresses the opportunity to improve emergency response and coordination by introducing wearable health and safety devices for students and staff that enable immediate alerts and communication with designated responders. By connecting the school with local health providers and emergency services, the project strengthens safety and health response capacity in a rural Alaska school setting.	The Bristol Bay School HealthLink project will implement a wearable health and safety alert system for approximately 150 students and staff in the Bristol Bay Borough School District. Each participant will receive a wearable device capable of initiating an immediate emergency alert and transmitting location information within the school environment. When activated, the device will notify designated school personnel and trigger established response protocols involving school leadership, emergency medical services, and Cama'i Community Health Center. Project implementation will occur in three phases. First, the project team will work with school leadership, local EMS, and clinic staff to finalize device selection, develop response protocols, and establish communication pathways between the school and health partners. Second, the wearable devices and supporting infrastructure will be deployed, and staff will receive training on use, emergency procedures, and response coordination. Third, the system will be integrated into routine school safety and health protocols. This approach strengthens rural health response capacity by enabling faster identification of emergencies, improving coordination between school staff and local health providers, and ensuring that students and staff can quickly request assistance during medical or safety incidents. The project will also collect implementation data to assess response times, system use, and opportunities for expansion to other rural school settings.	\$50,000-\$250,000	Federally qualified health center	Single Community	Bristol Bay Borough	Deferred or Not Advanced

Camai CHC	Riverside Safe Haven: A Bristol Bay Survivor Shelter and Healing Project	AK	Cama’i Community Health Center, in partnership with SAFE and Riverside Chapel, seeks to address a critical gap in services for survivors of domestic and sexual violence in the Bristol Bay region of Southwest Alaska. Bristol Bay is an extremely remote region where communities are not connected by road systems, and residents often travel hundreds of miles by small aircraft to access specialized services. These geographic barriers limit access to coordinated medical care, behavioral health support, and safe shelter for survivors of violence. Cama’i recently received funding to launch Sexual Assault Response Team (SART) exam services in the Bristol Bay Borough, allowing survivors to receive forensic exams locally rather than traveling to Anchorage or other urban centers. While this expansion improves access to medical care, the region has extremely limited shelter capacity for survivors who require immediate safety and trauma-informed support after an assault. This project will renovate the Riverside Chapel building to create additional shelter space and support services for survivors. Expanding shelter capacity will strengthen the region’s coordinated response to violence and ensure survivors accessing SART services can also access safe housing, advocacy, and culturally supportive healing resources within their community.	Cama’i Community Health Center, in partnership with SAFE and Riverside Chapel, will address the region’s lack of shelter capacity by renovating the Riverside Chapel facility to serve as a safe, trauma-informed shelter and support space for survivors of domestic and sexual violence. This project expands the coordinated response to violence in the Bristol Bay region and directly supports the newly funded Sexual Assault Response Team (SART) exam services being launched at Cama’i. The project will renovate the Riverside Chapel building to ensure the facility is safe and functional for year-round shelter use in rural Alaska. Planned improvements include replacing the existing furnace, installing a supplemental Toyo heating unit in the upstairs area, installing new flooring or carpet throughout the building, interior painting, and other necessary upgrades to ensure the building can safely support shelter operations. Following renovation, the facility will provide two additional sleeping spaces for survivors and their children, a private office for advocacy and case management, and a meeting room for support groups and healing activities. SAFE advocates will utilize the space to provide crisis response, safety planning, and ongoing support for survivors accessing SART exams and other victim services. This approach strengthens the continuum of care by ensuring survivors who receive forensic medical exams locally also have immediate access to safe housing and advocacy support. The meeting space will support trauma-informed group services and culturally grounded healing activities. Supplies will be purchased for traditional activities such as beading and kuspuk-making, which help promote cultural connection, resilience, and trauma recovery among Alaska Native and rural residents. To support implementation, the project will fund a part-time project manager/handyman during the first year to coordinate renovation activities and address maintenance needs associated with the older building. After renovation, SAFE will lease the facility to operate shelter services, and rental revenue will support building operations, including utilities, insurance, and maintenance, thereby ensuring the shelter's long-term sustainability.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Deferred or Not Advanced

Camai CHC	Strengthening Rural Diagnostic, Vision, and Infusion Care Access in Bristol Bay	AK	Residents of the Bristol Bay Borough and surrounding rural communities face significant barriers to accessing diagnostic and specialty healthcare due to geographic isolation, limited transportation, and the high cost of travel to regional hubs such as Dillingham or Anchorage. Many services—including diagnostic imaging, laboratory testing, vision care, and infusion-based treatments—often require patients to leave their home community. This can delay diagnosis, interrupt treatment, and create financial and logistical burdens for rural families. Cama’i Community Health Center operates a CLIA-certified moderate-complexity laboratory and provides primary care locally, but aging and limited equipment restrict the range of diagnostics and treatments available in the community. As a result, patients are frequently referred outside the region for services that could otherwise be provided locally. This project addresses the opportunity to strengthen rural healthcare access by modernizing diagnostic equipment and expanding the clinic’s ability to provide imaging, laboratory testing, vision care, emergency cardiac response, and infusion therapy locally. Expanding these services will improve timely diagnosis, support chronic disease management, and allow some patients requiring infusion treatments to remain in their home community. These investments will reduce the need for costly medical travel and improve access to timely, high-quality care for rural residents in Bristol Bay.	Cama’i Community Health Center will address barriers to rural healthcare access by expanding diagnostic and treatment capacity within the community through targeted investment in updated clinical equipment. This project will modernize critical diagnostic infrastructure and enable the clinic to provide a broader range of local services, reducing the need for patients to travel outside the region for routine testing and treatment. The clinic operates a CLIA-certified moderate-complexity laboratory and will expand its in-house diagnostic capabilities by purchasing updated laboratory analyzers, including equipment for complete blood count (CBC) testing, comprehensive metabolic panels (CMP), and rapid chemistry analysis using a Piccolo analyzer. These tools will allow providers to conduct timely diagnostic testing onsite and improve clinical decision-making for chronic disease management, acute illness, and medication monitoring. The project will also include the purchase of a modern digital X-ray unit to improve diagnostic imaging capacity for injuries, respiratory illness, and other common medical conditions seen in a rural primary care setting. To expand access to vision care services, the clinic will establish a new optometry diagnostic suite to enable providers to conduct comprehensive eye exams and screen for conditions such as glaucoma, diabetic retinopathy, and other vision-related health concerns. Emergency response capacity will be strengthened by purchasing a new defibrillator, ensuring the clinic can respond effectively to cardiac emergencies in this remote setting. Finally, the project will introduce infusion pump capability, allowing patients who require IV therapies—including chemotherapy, antibiotics, and other medically necessary infusions—to receive treatment locally under medical supervision. Together, these equipment investments will expand the scope of services available at Cama’i Community Health Center, improve the timeliness of diagnosis and treatment, and strengthen the sustainability of healthcare services for rural residents in the Bristol Bay region.	\$50,000-\$250,000	Federally qualified health center	Single Community	Bristol Bay Borough	Deferred or Not Advanced

Camp Fire Alaska	Summer Youth Wellness Programs for Western Alaska	AK	Rural Alaskan communities face a persistent summer gap in supervised, culturally relevant services for children and teens. Limited afterschool and extracurricular resources and geographic isolation leave youth with fewer opportunities for social learning, structured activity, nutrition education, and behavioral health supports. COVID-19 exacerbated these gaps: interruptions in annual programming make re-engagement difficult and increase disparities in mental and physical health outcomes between rural and urban youth. This project addresses that disparity by restoring and expanding Camp Fire’s proven Rural Alaska Program.	We will deliver four to eight-week, summer Camp Fire sessions in target communities, combining child care/supportive services with a hands-on wellness curriculum grounded in culturally relevant methods and intergenerational connection. Core Components: • Behavioral & mental health supports: daily social learning, trauma-informed practices, partnerships with Elders and local community members, and culturally based resilience-building activities. • Nutrition education: culturally adapted lessons, traditional foods integration, and daily healthy meals/snacks in partnership with local food suppliers. • Child care and structured activities: weekly programming including physical activity, behavioral and social wellness, and community engagement. • Intergenerational engagement: Elders and adult community members integrated into programming for cultural transmission and protective-factor building. • Facility optimization: collaborate with partners to adapt multipurpose community spaces (schools, halls) for flexible, dual-use to enable itinerant programming. • Sustainability strategy: combine start-up funding for initial costs with a longer-term braided funding model including family contributions when feasible, local/regional partner support, and diverse revenue streams, to move sites toward financial viability.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area	Deferred or Not Advanced

Cancer Connection	Southeast Alaska Cancer Care Support Network	AK	Cancer patients in SE Alaska face unique challenges due to geography, travel requirements, and the limited availability of services in small and remote communities. Local nonprofit organizations provide important assistance with travel, lodging, financial support, peer connection, and/or survivorship programs, yet many patients are unaware of the full range of resources available locally or across the region, yielding missed opportunities for support. Often health care providers do not refer patients to cancer support organizations, mostly due to lack of knowledge of their existence or the range of services offered. In 2025, Cancer Connection provided travel assistance funds for 58 residents from 15 different SE Alaska communities outside of Juneau. Forty of those individuals reside in localities without any type of organized support services other than, if aware, Cancer Connection’s hybrid support group, retreats, or the Let’s Talk peer mentor program. The cancer support nonprofits throughout SE Alaska currently operate independently of one another, with little information of what is being provided in other communities. Through creation of the Network participants will collaborate to gain deep knowledge of each organization's programs and services, develop strategies to increase patient and provider knowledge and use of programs and services, and establish a formal framework that increases awareness, referrals, and use of cancer support services region-wide.	Each of the identified cancer support organizations have local insights and connections that serve to realize important impact in their respective communities. By participating in the Network, significant opportunities exist to replicate or scale successful programs region-wide, and to create new work that will lead to improved and expanded prevention and support services locally and regionally. Funding from the RHTP will support a Project Director, a role essential for coordinating the Network and facilitating collaboration among volunteer-led partner organizations. The Project Director will conduct site visits, facilitate convenings, coordinate shared initiatives and support implementation of the Network’s collective work. The Project Director will contact each partner to schedule a community site visit. During this initial trip the Project Director will learn about the local nonprofit and their goals, explain the project, solicit input regarding convening design, and collaborate to identify a representative of the local organization. Once all site visits have been completed, the Project Director will plan, organize, and facilitate the first in-person Network meeting. This will include coordinating logistics, creating agendas, and preparing background research. At the convening the partners will collectively identify the Network purpose. They will set goals for what they hope to achieve, such as shared resources or joint planning, and identify collaborative actions. There will be a focus on building long-term relationships, mapping the system, identifying mutually beneficial opportunities, and combining efforts to amplify impact. The possibility of sharing resources to increase efficiency will be explored. The group will identify what data needs to be collected to measure outcomes and inform the work of the Network. A simple governance structure, with rotating leadership, will be established. Following the convening, the Project Director will: - publish and distribute a summary report - facilitate the implementation of collaborative actions identified by project partners - schedule routine check-ins with each partner - create digital tools to support communication, collaboration and data collection - host bimonthly on-line partner meetings - author and distribute a Network Newsletter - facilitate the Network Memorandum of Agreement to include each partner’s commitment	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough)	Advance to Implementation Application

Care Solace Inc.	Active Navigation, Care Coordination, and Resource Integration for Rural Alaska	CA	In the 2026 Alaska healthcare landscape, the primary barrier to wellness in rural and frontier communities is not merely a lack of clinicians, but a systemic "Last Mile" disconnection. RHTP is expanding clinical capacity and telehealth, but the burden of navigating this complex, fragmented ecosystem remains a significant point of failure for residents and providers alike. The Problem: The "Ghost Network" and Administrative Burnout Currently, 80% of Alaskan residents rely on static outdated insurance directories. This results in "ghost networks" where listed providers are unreachable or lack the specific low-bandwidth telehealth capabilities required for remote villages. For a Rural Health Aide or school counselor, coordinating a referral can take upwards of 10 to 20 hours of phone calls and follow-ups. Without a "Warm Handoff®," many referrals are abandoned, leading to crisis escalation and costly, avoidable medevacs (averaging \$50,000+ per flight). The Opportunity: Active Navigation as Infrastructure Care Solace identifies a critical opportunity to implement Active Navigation as a core component of Alaska’s "Spark Technology" (Initiative #6). By shifting from a passive "list-based" referral model to a high-accountability, human-driven coordination system, we can ensure that every RHTP-funded resource is utilized. We bridge the gap between village "spokes" and regional "hubs," ensuring that a screening in a remote village leads to a verified, attended appointment.	The proposed approach for the Alaska Rural Health Transformation Program (RHTP) is a "Frontier-First" navigation model that bridges the gap between identification and treatment. By aligning with Initiative #2 (Health Care Access) and Initiative #6 (Spark Technology), we move beyond passive directories to provide a high-accountability, human-driven coordination system. Active Navigation: The "Human-in-the-Loop" Core Unlike static resource lists that often contain "ghost" entries or providers 400 miles away, our approach utilizes Active Navigation. When anyone - a village health aide, school counselor, first responder - identifies a need, they trigger a Warm Handoff® to Care Solace. The 24/7/365 Care Companion: A dedicated team performs the exhaustive work of matching clinical needs to providers, verifying insurance (Medicaid/ARHOME/Tribal Health), and confirming current availability. Multilingual Support: We provide support in over 200 languages and dialects, ensuring cultural and linguistic barriers do not impede access in Alaska Native communities. Technical Integration: The "Digital Bridge" Our approach treats navigation as critical infrastructure, integrating directly with Alaska's health data ecosystem. HIE Connectivity: We can integrate with healthEconnect Alaska (Contexture). When an appointment is secured, the referral data can be pushed to the HIE closing the data loop. Low-Bandwidth Architecture: Our platform is optimized for the "Alaska Reality," using browser-based, light-data architecture that ensures village-level clinicians can access the system via limited satellite or GCI connections without lag. Workforce Optimization In rural Alaska, clinicians are often bogged down by administrative scope creep. Our approach acts as a Force Multiplier: Administrative Offloading: By centralizing the search-and-schedule function, we save rural staff 10–15 hours per case. Clinical Focus: This allows Village Health Aides and BHAs to focus on direct patient care and crisis intervention rather than being on hold with insurance companies. Data-Driven Sustainability To ensure the RHTP’s five-year sustainability (Initiative #4), we provide a Transparency Dashboard: Gap Analysis: We track real-time "Care Deserts" to justify targeted workforce investments. Value-Based Outcomes: We track "Speed to Care" and "Appointment Attendance," providing the DOH with evidence to move from volume-based grants to value-based care outcomes.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Cartwheel Health Services P.C.	Youth Mental Health: School-Based, Self-Sustaining Telehealth	MA	The Problem: Alaska’s students face some of the most serious mental health challenges in the country. We rank near the top nationally for youth suicide, and 43% of Alaska students were chronically absent — nearly double the national average — with unmet mental health as a leading driver. Geography makes this crisis uniquely hard to address. Long distances, extreme weather, and a limited local clinician workforce create barriers families simply cannot overcome. Even with dedicated local providers, families in many areas wait 6–12 months for basic care. Families naturally turn to schools for help. Schools are trusted institutions in their communities and see students every day. But schools can’t keep up with the volume of need, and they weren’t designed to deliver clinical care in the first place: They often lack licensed clinicians, crisis infrastructure, and the billing capabilities needed for financial sustainability. The result is a downward spiral of student crises, family frustration, and staff burnout. The Opportunity: With the right tools, schools are uniquely effective in helping families access quality mental health care. By integrating evidence-based telehealth into the local provider ecosystem, schools can reduce wait times by up to 90%, augment their local workforce, reduce staff overwhelm, and improve follow-through in care — thanks to their trusted relationships with families. This leads to better access, earlier intervention, and less burnout.	Anchorage School District (ASD) proposes to partner with Cartwheel Care to launch a school-based behavioral telehealth initiative serving students across Alaska. Cartwheel is the nation’s largest K–12 school-based mental health telehealth provider, serving 350+ school districts across 15 states including 25 tribal nations and Indigenous communities. The SouthEast Alaska Regional Health Consortium (SEARHC) is in active discussion to serve as a Tribal Health anchor for Southeast Alaska. The initiative delivers three components: 1. Direct telehealth mental health services, reducing waitlists for care by 90%. Students access therapy, psychiatry, and family counseling via telehealth — from school or home, including evenings and weekends. Clinical protocols will be co-designed with SEARHC to reflect Alaska Native cultural values and community norms. 2. Care Coordination Platform for Schools. School staff refer students to services, collaborate on cases, and track progress over time — replacing the current patchwork of email, phone, and spreadsheets. Built with the Massachusetts Dept. of Public Health and Arizona Dept. of Education, the platform improves quality of care, reduces staff burden, and gives districts the data they need to demonstrate ROI. 3. School-Based Medicaid Billing infrastructure, enabling 100% sustainability after RHTP ends. Most districts deliver services that qualify for Medicaid reimbursement but don’t bill due to complexity. This platform automates that billing. Our goal: 100% of ongoing program costs covered by Medicaid revenue by end of the grant period. Year 1 launches at two anchor sites. ASD — enrolling roughly one-third of Alaska’s K–12 students — functions as a statewide care hub, regularly serving students from rural and remote communities for care unavailable closer to home. SEARHC will facilitate introductions to districts across its 27-community network — including Juneau, Sitka, Pelican, Klawock, and Tenakee Springs — and will provide cultural guidance and a bidirectional referral pathway with Raven’s Way Campus. Students needing higher-intensity care transition seamlessly to SEARHC; SEARHC waitlist patients are referred to Cartwheel. Year 2+ scales statewide, building on Year 1 learnings and the sustainable funding model established in Year 1.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough)	Advance to Implementation Application

CATCH Global Foundation	From Prevention to Leadership: Scaling CATCH My Breath in Rural Alaskan Schools	TX	Youth vaping remains a significant public health concern among Alaskan adolescents. According to the 2023 Alaska Youth Risk Behavior Survey, 17.3% of students reported using a vape product in the past 30 days and 37.8% reported ever using one, indicating widespread nicotine exposure. While 61% of students who used tobacco products reported trying to quit, many lack access to effective prevention education and support. Nicotine exposure during adolescence carries serious health risks. Even limited use can lead to dependence, withdrawal symptoms, and long-term changes in brain development that affect attention, learning, and primes youth for susceptibility to future addiction to more dangerous substances. Vape aerosol also contains ultrafine particles, carcinogens, and toxic chemicals linked to respiratory, cardiovascular, and oral health problems. Without accessible prevention education, youth remain vulnerable to social influences, misinformation, and targeted marketing that normalize vaping. CATCH My Breath, developed in partnership with UTHHealth, is an evidence-based, school-based youth vaping prevention program grounded in Social Cognitive Theory. Research demonstrated that the program reduces vaping initiation and current use while increasing knowledge and positive perceptions of a vape-free lifestyle. This project addresses the urgent need to ensure students receive accurate information, skills, and peer support to make healthy decisions and avoid nicotine addiction.	This project will expand access to evidence-based youth vaping prevention in rural Alaskan schools by combining local leadership, virtual curriculum access, and virtual training to ensure high-quality and sustainable implementation of CATCH My Breath (CMB). Year 1: Establish Infrastructure and Build Momentum CATCH will hire and train a full-time Alaska-based CATCH Coordinator (CC) to lead statewide outreach, recruitment, implementation, and partner engagement. Working closely with organizations like SERRC, the CC will prioritize outreach to rural and geographically isolated districts. Participating schools will receive access to CATCH’s evidence-based CMB vaping prevention curricula through a robust digital platform featuring evidence-based lessons, middle school video lessons, Parent Toolkit, embedded asynchronous training, and available usage reports by teacher, school, and district to support accountability and measurable progress. Educators will also participate in virtual CATCH My Breath training, ensuring that they are prepared to implement the full scope of the CATCH My Breath program, including the 4-lesson (per grade group) core curriculum, curriculum supplements, environmental supports, and parent education materials. To strengthen program quality and foster collaboration across remote communities, the CATCH Coordinator will facilitate regular virtual Communities of Practice (CoPs) for participating educators and school leaders. These sessions will provide a structured forum for sharing implementation experiences, troubleshooting challenges, and identifying strategies for engaging students in vaping prevention, and foster an ongoing network of peer support. Years 2–5: Scale and Sustain The CC will continue district recruitment and educator support while hosting quarterly CoPs to replicate best practices and sustain peer learning. Technical assistance, usage reporting, and access to virtual training will continue. The Students Teach Students (STS) model will empower youth leaders to reinforce prevention messages among their peers. STS strengthens program relevance, increases student engagement, and helps normalize vape-free lifestyles within school communities. By combining evidence-based curriculum, virtual access, local coordination, and student leadership, this approach will expand vaping prevention programming in rural Alaska, improve the quality of youth health education, and build sustainable local capacity to address youth vaping.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

CATCH Global Foundation	Fueling Futures: School-based Physical Activity & Nutrition Curricula, Training & Sustainable Impact	TX	Alaska’s children face significant health risks driven by poor nutrition and inadequate physical activity. Per the State of Childhood Obesity, 16.3% of Alaska youth ages 6–17 have obesity, placing them at increased risk for lifelong health challenges like heart disease, type 2 diabetes, asthma, joint problems, and certain cancers. Only 18% of Alaska students meet national physical activity guidelines, less than 8% consume the recommended daily servings of fruits and vegetables, and more than half drink at least one sugar-sweetened beverage per day. These behaviors threaten long-term health and undermine academic success. Research shows healthy students are better prepared to learn, demonstrate improved cognitive performance, attend school more regularly, and achieve higher grades and test scores. Yet many Alaska schools lack the coordinated systems and trained staff needed to effectively promote student wellness. The 2022 CDC School Health Profiles Survey highlights a critical capacity gap: only 25% of classroom teachers and 28% of PE specialists received professional development (PD) related to physical activity in the prior two years, despite more than 53% expressing a desire for such training. Similarly, nearly 60% of lead health teachers wanted more PD in nutrition and dietary behavior. This project provides schools access to high-quality curriculum and PD to address the growing health and academic consequences of poor nutrition & physical inactivity among Alaska’s youth.	CATCH will implement a phased, capacity-building approach to expand access to high-quality physical education (PE) and nutrition programming while strengthening long-term sustainability across rural Alaska. Year 1: Establish Infrastructure and Build Momentum - CATCH will hire and train a full-time Alaska-based CATCH Coordinator (CC) to lead statewide outreach, recruitment, implementation, and partner engagement. Working closely with organizations such as SERRC, the CC will prioritize outreach to rural and geographically isolated districts. Participating schools will receive access to CATCH’s evidence-based PE and nutrition curricula through a robust digital platform featuring turnkey lesson plans, pacing guides, family materials, embedded asynchronous training, and usage reports by teacher, school, and district to support accountability and measurable progress. To ensure quality implementation, the CC will deliver in-person PE trainings, traveling between communities to model lessons, build educator confidence, and support fidelity. Live nutrition trainings will be offered virtually, reducing geographic barriers and enabling broad participation. In-person and virtual technical assistance will be provided throughout the year. Schools will also be introduced to the CATCH Coordination Kit (CCK). Grounded in the CDC’s Whole School, Whole Community, Whole Child model, the CCK provides a structured framework for forming interdisciplinary wellness teams, aligning stakeholders, and embedding health-promoting practices into school culture. Quarterly virtual Communities of Practice will foster peer learning, shared problem-solving, and continuous improvement across participating districts. Years 2–5: Scale and Sustain - CATCH will expand recruitment while deepening support for existing sites. A Train-the-Trainer model, initially focused on PE, will develop regional leaders capable of independently training additional educators, reducing long-term reliance on external support and embedding expertise locally. The CC will continue virtual and in-person support, monitor curriculum utilization through platform reporting, and facilitate Communities of Practice. Adoption of the CCK will be encouraged as schools build readiness and capacity. By prioritizing accessible curriculum, high-quality training, and gradual systems integration, this approach addresses immediate educator capacity gaps while laying the groundwork for sustainable, coordinated school wellness statewide.	\$50,000- \$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

CATCH Global Foundation	Healthy Minds, Ready Learners: School- Based Mental Wellness for Every Rural Alaskan Student	TX	Alaska’s youth are experiencing alarming levels of mental distress. According to the 2023 Alaska Youth Risk Behavior Survey, 34.5% of students reported feeling so anxious, nervous, tense, or scared for two weeks or more that it interfered with their ability to function. Even more concerning, 22.6% of students reported seriously considering suicide and 19% reported attempting suicide at least once during the year preceding the study. Young people across Alaska face significant barriers to accessing mental health services such as limited availability of mental health providers, fragmented systems of care, and logistical challenges such as transportation. Students may also experience internal and social barriers, including stigma, limited mental health knowledge, and fear of judgment, that prevent them from seeking help. These challenges highlight the need for a proactive approach that improves social support for preventive mental wellness and reaches all students before concerns escalate. This Tier 1, schoolwide approach is essential in communities where clinical services may be scarce or difficult to access. By integrating mental wellness education and prevention strategies into everyday school environments, schools can increase mental health literacy, normalize help-seeking, and foster safe and supportive climates for all students. Accessible, school-based prevention efforts, provide students with the knowledge, skills, and support needed to manage stress and seek help early.	This project will expand access to Tier 1 mental wellness education for Alaska’s students by partnering with school districts and community organizations to implement evidence-informed mental wellness programming and educator training designed for school-wide prevention. Year 1: First we will focus on building awareness and recruiting schools statewide. CATCH will hire and train a full-time Alaska-based CATCH Coordinator (CC) to lead outreach, recruitment, implementation support, and partner engagement. Working with organizations such as SERRC and other local education partners, the CC will prioritize rural, remote, and geographically isolated districts. Recruitment will also leverage relationships with schools already using CATCH programs. The second major activity will provide professional development to build educators’ capacity to support student mental wellness. Training will increase awareness of youth mental health factors, strengthen educators’ ability to recognize and respond to student needs, and provide strategies for fostering supportive classroom environments. Educators will receive orientation to the K-8 CATCH Health Ed Journeys curriculum, with emphasis on the Mental Health unit (3-4 lessons per grade level). Training will also introduce trauma-informed practices and strategies for integrating mental wellness promotion throughout the school day. Additional implementation training can focus on included substance misuse and vaping prevention lessons. Schools may also use the CATCH Coordination Kit to reinforce mental wellness through coordinated, schoolwide activities that promote positive school climate and normalize help-seeking. To ensure equitable access for rural schools, training will be offered through flexible live, interactive virtual sessions. The CATCH virtual curriculum platform allows educators across Alaska to access structured lessons, implementation guidance, and classroom-ready materials aligned with evidence-informed health education standards. Evaluation activities may be incorporated to assess program implementation and outcomes. Years 2-5: The CC will continue virtual and evaluation support, monitor curriculum utilization through platform reporting, and facilitate Communities of Practice. Adoption of the CATCH Coordination Kit will be encouraged as schools build readiness and capacity. Together, these strategies will equip Alaska’s schools with practical tools to proactively promote student mental wellness.	\$50,000- \$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Catholic Social Services Brother Francis Shelter Clare House	Closing the Gap: Rural Health Care Transitions for Medically Fragile Alaskans	AK	Alaska is facing an urgent and growing gap in care for Medicaid beneficiaries who are medically stable but lack a safe place to recover following hospitalization. Hospitals across the state routinely face challenges discharging individuals experiencing homelessness, which leads to avoidable or prolonged inpatient stays, repeated emergency department utilization, increased Medicaid expenditures, and poor recovery and adverse health outcomes. Consequently, medically fragile Alaskans are often discharged into unsafe environments, or they remain in high-cost hospital beds solely because they lack stable housing. This challenge is acute in Anchorage, where individuals experiencing homelessness relocate to access healthcare services and where hospitals serve as referral centers for patients from across Alaska’s rural and frontier communities. Geographic isolation, extreme weather, and limited discharge options create additional challenges. Currently, the state lacks a Medicaid-reimbursable service designed to provide short-term recovery support in community settings, despite evidence that such services are cost-effective and clinically appropriate. There is now an opportunity to establish a community-based recuperative care benefit through a Section 1115 Waiver demonstration. By building a fiscally responsible solution tailored to rural and frontier conditions, Alaska can support Tribal health systems and improve health and housing outcomes for Alaska’s vulnerable residents.	This project strengthens the Alaska health system by creating a fiscally sustainable level of step-down care for vulnerable Alaskans experiencing homelessness, who are too medically fragile to discharge to homelessness, but not sick enough to prolong their inpatient hospital stay. Adding respite or recuperative services to the Medicaid 1115 waiver demonstration provides for Alaskans who lack safe housing for recovery, specifically by creating dependable funding to provide medical respite services at our Complex Care Shelter. In rural and frontier areas, a single patient needing long-term recovery can consume a significant portion of available bed capacity, but medical respite provides a safe alternative discharge option that frees up acute care beds for emergencies and high-acuity patients. The Medical Respite program was successfully piloted in a 10-bed space at Brother Francis Shelter that provided guests with 24-hour access to semi-private rooms, meals, and intensive case management, ensuring a safe environment for recuperation for patients discharged from medical facilities in Anchorage. By offering a monitored, warm environment that supports healing and stabilization, Medical Respite supports rural residents who must travel long distances to regional hubs for acute treatment and cannot return home immediately due to medical restrictions or weather-related travel delays. Beyond immediate clinical quality, the project significantly improves system sustainability by transitioning this established Brother Francis Shelter program from a donation-dependent model to a Medicaid fee-for-service structure. This shift allows for stable staffing, better recruitment, and the establishment of consistent clinical protocols, moving the service away from unpredictable fundraising and donation cycles and into a permanent part of the healthcare delivery system. By providing a lower-cost alternative to inpatient stays and reducing avoidable emergency department returns—saving the community an estimated \$2 million in its first year alone—the project enhances the overall fiscal resilience of the state’s emergency and rural health systems. Finally, the infrastructure at Brother Francis Shelter serves as a scalable and flexible model that can be adapted across different regional hubs through Tribal organizations or other dedicated facilities.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Advance to Implementation Application

Catholic Social Services Brother Francis Shelter Clare House	The Brother Francis Shelter Integrated Recovery Hub	AK	The primary problem is the critical shortage of accessible substance use disorder (SUD) treatment for Alaskans, particularly those who are experiencing homelessness or at risk of experiencing homelessness. Alaska has recently seen a 47% increase in drug overdose deaths, and many of these individuals are rural residents who have been referred to urban centers for specialty care only to fall through the gaps of a fragmented system while experiencing homelessness. Traditional treatment models often fail this population because they frequently lack the transitional support needed to bridge the gap between high-intensity clinical interventions and long-term community stability. By establishing an ASAM Level 3.1 program at Brother Francis Shelter, we create a vital step-down recovery environment that provides the 24-hour structure necessary for individuals to maintain sobriety while focusing on social-skills development. This model allows guests to gain the essential employment, income, and personal stability required for a successful transition into independent living, effectively closing the loop in the recovery continuum. By establishing a dedicated SUD unit within this trusted community setting, we can address the root causes of disease and chronic instability for guests who would otherwise remain disconnected from broader healthcare services.	The startup costs for the new substance use disorder program have been primarily established through a congressional appropriation secured by Senator Murkowski. These initial funds provided the essential foundation for launching the SUD treatment center within the Brother Francis Shelter campus, demonstrating strong federal support for our mission to serve Alaskans with complex needs. This grant application seeks supplemental funding to bolster and complete the program’s physical and operational infrastructure. Specifically, these resources will be directed toward critical technology and safety enhancements, including a modernized security camera system and perimeter fencing designed to meet residential program standards. Additionally, the funding will support necessary location renovations, the procurement of specialized treatment materials, and the furnishings required to transform the space into a dignified, fully equipped environment for therapy-based recovery. We will leverage existing technology and telehealth infrastructure to coordinate care with tribal health organizations and rural providers, ensuring that when a guest is ready to return to their home village, there is a seamless transition of care and data sharing through the statewide health information exchange. This model prioritizes treating in place within the shelter environment to stabilize guests before they reach a point of medical crisis, thereby right-sizing the delivery system and shifting care to a more appropriate, cost-effective setting. By integrating these services into an established emergency shelter, we create a culturally appropriate, trauma-informed environment that supports both clinical recovery and social stabilization for individuals with the most complex needs.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Catholic Social Services Brother Francis Shelter Clare House	The CSS Healthy Communities Initiative: Bridging the Gap Between Farm and Pharmacy	AK	The primary challenge addressed by this project is the severe food insecurity and limited access to fresh produce across Alaska, where 95% of food is imported and grocery supplies often last only a few days. These systemic issues are exacerbated for vulnerable populations, including shelter residents and CSS clients in areas like Delta Junction and Wasilla, who lack consistent access to nutritious food. Low-income communities in Alaska currently face a high burden of chronic disease, with 75% of adults living with or at risk for conditions such as diabetes and hypertension, which are directly exacerbated by poor dietary options and high costs. Simultaneously, there is a significant gap in accessible workforce pathways for individuals with major employment barriers, such as language differences and a lack of professional networks. This project presents a strategic opportunity to expand the existing CSS client farm model to more clients to better serve these high-need populations. By scaling the "Give Local, Grow Local" framework, Catholic Social Services can connect health, food security, and economic mobility into a single, integrated pathway. Positioning agricultural production as preventative health infrastructure allows us to strengthen local food systems while providing low-income residents with a tangible route toward health stabilization and financial self-sufficiency.	The proposed approach centers on the strategic expansion of the existing CSS client agricultural framework into a comprehensive, tiered "Food as Medicine" pathway. By broadening eligibility, CSS will create a formal referral system for shelter residents and participants in the Supportive Services for Veteran Families (SSVF) program. This integration allows case managers to incorporate farm participation directly into individualized service plans, positioning agricultural engagement as a core component of health and stability. The program utilizes a structured, three-stage progression model designed to meet participants at their current level of readiness. The entry-level stage, Fresh International Gardens (FIG), provides a low-barrier environment for individuals to gain foundational skills and experience the immediate benefits of therapeutic, outdoor work. Participants then move to the advancement stage at Grow North Farm (GNF), which focuses on high-volume commercial production and rigorous skill development. The final entrepreneurship track provides specialized training in market logistics, pricing, and cooperative business models, empowering individuals to manage their own small-scale farming operations and participate in local marketplaces. A critical operational component is the "Give Local, Grow Local" (GLGL) campaign, which will be scaled to increase the volume of fresh, culturally appropriate produce distributed through the St. Francis House Food Pantry and CSS-operated shelters. This ensures that the fruits of the program’s labor directly address the food insecurity of the broader community while providing farmers with a reliable, dignified source of income. Rather than pursuing large-scale physical expansion, the initiative focuses on systems integration and demonstration, with capital investments limited to essential greenhouse improvements and agricultural equipment. Success will be measured through clear benchmarks, including food distribution volume, the number of employment-ready classes completed, and successful transitions into the broader workforce.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Catholic Social Services Brother Francis Shelter Clare House	The Food-as-Medicine Infrastructure Initiative	AK	St. Francis House faces an urgent crisis of displacement that threatens the health of Alaska’s most vulnerable populations. For 40 years, this program—the largest food pantry in the state—has operated as a cornerstone of the public health safety net. However, we are now being forced to relocate from our long-term site without a secured, permanent destination. This sudden displacement creates a critical gap in the "Healthy Communities" framework outlined in Alaska’s RHTP. Currently, 14,000 unique individuals annually—including elders, Alaskans with disabilities, and families from rural areas—rely on St. Francis House for nutrition. Without a stable location, these individuals face acute food insecurity, which is a primary driver of hospital readmissions and the exacerbation of chronic conditions like hypertension and diabetes. By renovating our existing building to house the pantry, we can move beyond a standalone service to a "Whole-Person Health Hub." This relocation allows for the seamless integration of nutritional support with our existing behavioral health and care coordination services. We have the chance to transform an emergency response into a permanent health infrastructure that addresses the Social Determinants of Health (SDOH) at their root, ensuring no Alaskan is forced into the acute care system due to a lack of basic nutrition or conditions resulting in a lack of basic, appropriate nutrition.	Our approach centers on the strategic renovation of our existing facility to create a purpose-built, permanent home for St. Francis House. By transitioning from a tenant model to an owner-occupied model, we are securing the physical infrastructure required to sustain the state’s largest and most critical nutritional safety net. The infrastructure and capacity enhancement phase of the project will transform a segment of our current facility into a modern, high-volume distribution hub. This process includes installing commercial-grade walk-in freezers and refrigerators to increase our capacity for fresh produce, lean proteins, and dairy, which serve as the cornerstones of medically necessary nutrition. We will also optimize the floor plan to implement a choice pantry model that allows clients to select foods aligning with their specific dietary restrictions. Furthermore, the facility will undergo accessibility upgrades to exceed ADA standards, ensuring we can safely accommodate the high volume of elders and individuals with complex physical disabilities who utilize the pantry. The core of our approach is the development of a Whole-Person Health Hub that integrates clinical and social services. Because the pantry will now be located within the same building as our care coordination and behavioral health teams, we will implement a dual-entry service model. Every pantry visitor will be invited to undergo a behavioral-health screening, and when a client is identified as having unmet mental health or housing needs, we will provide a referral to the appropriate internal or external resource. This referral system removes the gap where vulnerable Alaskans often fall through the cracks between disparate service providers. We also will commit to providing educational materials in all pantry boxes that deliver health education, increase health literacy, and promote sustained behavior change to prevent and manage chronic disease by featuring the National Diabetes Prevention Program and Alaska’s Fresh Start program to support improvements in weight management, blood pressure control, and tobacco cessation. This is a one-phase capital improvement project, and we have already identified the necessary building modifications. Because our organization already provides the staffing and operational oversight for St. Francis House, these funds are strictly dedicated to the bricks-and-mortar requirements of the relocation.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Catholic Social Services Brother Francis Shelter Clare House	Transforming Rural Care Delivery through Optimized Revenue Systems	AK	Catholic Social Services (CSS) is a new Medicaid-billing behavioral health provider dedicated to reinforcing the healthcare safety net for vulnerable Alaskans in Anchorage and surrounding rural regions. While CSS has rapidly expanded programs to meet the rising needs of individuals experiencing or at risk of homelessness, the agency faces significant challenges in building the administrative and operational infrastructure required for long-term sustainability. As a new billing provider, CSS has identified critical "pain points" within its Medicaid revenue cycle, including documentation gaps, inconsistent workflows across programs, and limited integration between clinical and billing systems. These inefficiencies lead to delayed reimbursements, increased staff burden, and financial instability, which hinder the agency's ability to maintain high-quality care while expanding services. This project seeks to engage an experienced consultant to conduct a comprehensive assessment of the revenue cycle and implement standardized systems of efficiency. Beyond internal stabilization, there is a transformative opportunity to develop a framework where CSS serves as a billing support hub for smaller rural agencies. By establishing shared processes and scalable infrastructure, CSS can alleviate the administrative burden on rural providers, allowing them to focus on direct service delivery and improving behavioral health access for Alaskans statewide.	Phase 1: Comprehensive Assessment and Data Gathering CSS will engage an experienced Medicaid revenue cycle consultant to conduct a full review of existing processes. This assessment includes mapping all billing workflows, reviewing documentation practices and coding accuracy, interviewing staff, and evaluating the current Electronic Health Record (EHR) functionality to determine if optimization or a new system is required. The consultant will analyze denied claims and interview staff to identify specific pain points and revenue leakage. Phase 2: Development of a Revenue Cycle Improvement Plan Working with leadership and clinical directors, the consultant will develop a prioritized action plan. Key deliverables include standardized documentation policies, updated billing procedures aligned with Medicaid requirements, and comprehensive training plans for clinical and billing staff. This phase also establishes quality assurance (QA) audit processes and EHR configuration recommendations to ensure long-term system health. Phase 3: Implementation of System Changes CSS will execute the high-impact recommendations with technical assistance and coaching from the consultant. This includes introducing standardized intake procedures, improving communication loops between clinical and billing teams, and creating performance dashboards to monitor revenue metrics and reduce claim denials. Standardized QA checkpoints will be established to maintain ongoing compliance. Phase 4: Design of a Billing Support Hub Model In collaboration with the consultant, CSS will design a scalable shared-services model to allow smaller behavioral health providers to utilize CSS's upgraded billing infrastructure. This phase involves designing workflow pathways for partners, establishing data-sharing requirements, and drafting formal partnership agreements or MOUs. The model will be piloted with one or two partner agencies to ensure scalability for rural providers. Phase 5: Evaluation and Sustainability CSS will track improvements in billing accuracy, reimbursement timelines, and staff efficiency using pre- and post-intervention metrics. Feedback from staff and pilot partners will be used to refine the shared billing model, securing long-term sustainability through revenue gains and potential partnership fees.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

CCS Early Learning	Mental Health Supports for Early Childhood	AK	Within the Mat-Su Borough, the problem to be addressed is that there are extremely limited behavioral health therapy and mental health support services for child 0-5. There is also very limited evidenced-based training for 0-5 behavioral health paraprofessionals and support staff to meet the unique needs of early childhood.	CCS’s approach is designed to significantly expand early childhood mental health services for children ages 0–5 and their families, increasing both access and quality of care. Our strategy is two-pronged: training and service delivery. First, CCS will become a certified hub providing high-quality early childhood mental health training to providers statewide. Community paraprofessionals will receive comprehensive instruction in both early childhood development and mental health before providing classroom-based support services. By equipping behavioral health associates with these specialized skills, CCS will strengthen the workforce across the Mat-Su Borough, ensuring that children in early learning programs receive timely, developmentally appropriate support. Second, CCS will establish and grow an early childhood mental health clinic. Leveraging our existing trained providers and leadership expertise in behavioral health operations, the clinic will provide outpatient services directly within our four campuses. This expansion includes hiring licensed clinicians and support staff, including case managers and fully trained early childhood behavioral health associates, to meet the growing needs of children with behavioral and emotional challenges. Through these efforts, CCS will increase both the volume and quality of early childhood mental health services. Children will have earlier access to specialized care, families will receive coordinated support, and community providers will benefit from advanced training opportunities. Ultimately, this project will not only expand services within CCS but also enhance the capacity of other local organizations to deliver high-quality early childhood mental health supports, creating a sustainable network of care for all Alaskan communities.	\$250K-\$1M	Single Community	Matanuska-Susitna Borough	Advance to Implementation Application

CCS Early Learning	Access to Early Childhood Preventative Health and Workforce Capacity Model	AK	Head Start programs are responsible for ensuring children receive preventive health screenings, care, and follow-up. In the Mat-Su, with geographic dispersion, limited transportation, and scarce provider availability it is challenging for families to access timely preventive care. Families often face delays in completing screenings and follow-up services. CCS plays a critical role in connecting children to care, but staff often manage complex health documentation without dedicated health professionals, and without the ability to access health care funding. This limits consistent support for preventive services. Strengthening preventive health access during early childhood is recognized as a key strategy for improving long-term health outcomes and reducing avoidable costs associated with delayed diagnoses, unmanaged chronic conditions, and preventable emergency care. This project presents an opportunity to advance the RHTP priorities by expanding access to preventive and primary care, enhancing workforce capacity, and implementing innovative service delivery approaches that improve care coordination. Embedding preventive health services directly within CCS centers addresses these barriers, allowing children and families to access care in known settings. This approach strengthens care coordination, improves timely access to preventive services, and builds sustainable community-based health capacity, advancing long-term health outcomes for children and families.	CCS Early Learning proposes an Early Childhood Health & Wellness Capacity-Building Model to strengthen access to preventive care, improve compliance with health requirements, and support staff and families. Central to this model is hiring a Nurse Practitioner or Registered Nurse to serve as a rotating health consultant across CCS centers. This consultant will focus on three interconnected areas: direct health services, health compliance and oversight, and workforce and family capacity building. In the direct service role, the consultant will assist programs with required Head Start health screenings, coordinate follow-up care with local medical homes and pediatric providers, and support families in completing EPSDT-recommended preventive screenings and diagnostics. This ensures that Medicaid-eligible children receive timely, comprehensive preventive care. The consultant will also provide program-level oversight, maintaining accurate health records, strengthening tracking systems, and aligning documentation with Head Start Program Performance Standards and EPSDT expectations. They will review and update health policies to reflect current regulations and evidence-based practices, and coordinate individual child health care plans, especially for children with chronic conditions such as asthma, allergies, or seizure disorders. Workforce development is a critical component. Early childhood staff will receive training in medication administration, communicable disease prevention, chronic condition management, and general health monitoring, promoting consistent, evidence-based practices across all centers. Families will also benefit from health education workshops, informational sessions, and resources on preventive care, nutrition, common childhood illnesses, and navigating pediatric services. The model uses a flexible, itinerant structure, allowing the health consultant to rotate across sites and provide hybrid telehealth support for families and staff. This approach reduces geographic barriers, aligns with RHTP priorities for mobile health teams and technology-enabled care, and ensures sustainable improvements in access, quality, and coordination of preventive health services for rural children and families.	\$50,000-\$250,000	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

CCS Early Learning	Quality Childcare for Health Care Providers	AK	The problem that we are prepared to address is the lack of availability of childcare for the healthcare workforce.	CCS Early Learning is uniquely positioned to address the shortage of childcare available to the healthcare workforce through strategic expansion, established partnerships, and phased facility development. With more than 55 years of experience delivering federally funded Head Start, Early Head Start, and other early childhood education programs in the Mat-Su region, CCS has a proven track record of providing high-quality, compliant, and sustainable childcare services. Our proposed approach includes a phased implementation strategy. In partnership with the Mat-Su Health Foundation and Mat-Su Regional Medical Center, CCS will begin increasing our organizational capacity which will allow us to offer a limited number of childcare slots for healthcare employees. These initial services would serve children ages 0–5 (with an emphasis on infants and toddlers) in a temporary location. This phase allows us to begin ramping up our capacity and to take initial efforts that begin addressing urgent workforce needs while longer-term infrastructure is finalized. Concurrently, CCS is collaborating with community partners to develop a new, purpose-built childcare facility on land located near the Mat-Su Regional Hospital campus. The proximity to healthcare employers will improve accessibility, reduce daily logistical barriers for providers, and strengthen workforce retention. We do not anticipate requesting funds for construction however, we might determine that funds for renovation or furniture, fixtures, and equipment is needed if that is determined to be allowable. Upon completion of the permanent center, CCS will obtain State of Alaska licensure and transition services into the new facility to ensure long-term sustainability and regulatory compliance. This phased model creates immediate impact while establishing a durable childcare solution designed to stabilize and support the healthcare workforce serving rural communities.	\$250K-\$1M	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced
Center for Community	Center for Community Fire Sprinkler Repairs – Sitka, AK	AK	The sprinkler in the building needs to be repaired so it works properly and is up to the NFPA 13 code	We would have someone who is appropriately certified for the job do all repairs needed to bring the sprinkler system up to code	\$50,000-\$250,000	Single Community	Sitka (City and Borough)	Deferred or Not Advanced

Center for Community	Electronic Health Record (EHR) System for Center for Community’s Early Learning Program	AK	Our Early Learning Program currently relies on paper-based documentation for progress notes. This manual system presents operational challenges that impact efficiency, accuracy, compliance, and overall program effectiveness. Handwritten progress notes are often difficult to read, increasing the risk of data entry errors and exclusion of mandatory documentation. For example, contact notes frequently have incomplete required elements such as: ICD codes, service dates, service times, billable units, signature of therapist, and location of service. These omissions create compliance risks with Medicaid Alaska and other billed insurances, require additional administrative time to correct, and may delay billing. The absence of an electronic health record system translates to duplicate data entry for record keeping and billing. There is a clear opportunity to modernize our documentation system by implementing an electronic record-keeping solution. Implementing a digital platform would: streamline documentation processes, improve data accuracy, save time, cut the cost of carbon copies, and reduce billing delays, which would all support higher-quality service delivery for children and families.	The Early Learning Program will research a secure electronic health record software that is specifically designed to support early intervention service delivery and billing. The ideal platform will have the ability to bill all health insurances, including but not limited to: Medicaid, Tricare and private insurance companies in Alaska. The Early Learning Program will connect with other Infant Learning Program coordinators across the state to gather information and reviews of the systems they are using. ELP will research across the nation what early intervention programs are utilizing for electronic health record keeping and billing. We will choose the best platform that will meet our program needs. Next, we will work with the chosen company to modify the software exactly tailored to the requirements of Alaska's early intervention laws. Finally, we will implement the electronic health record system and billing system. Training will be necessary amongst staff. During the last phase of implementation, we will receive ongoing technical assistance from the EHR company to trouble shoot any issues that arise.	\$50,000-\$250,000	Single Community	Sitka (City and Borough)	Deferred or Not Advanced

Center for Community	Expanding Eligibility For Southeast Alaska's Early Intervention Programs	AK	Many young children with developmental delays or involvement with Office of Children's Services enter school without receiving timely, high-quality early intervention. As a result, they are more likely to be referred for special education services, particularly for speech-language and social delays, even when earlier support could have prevented special education services. The current state system of a child needing a 50% delay in one or more developmental domains leaves many children behind. Current systems lack consistent developmental progress monitoring, child-centered outcome tracking, and longitudinal data for those children who miss the eligibility percentage (50%) but still qualify as at-risk or have a delay of 25-49%. At the same time, early intervention programs face sustainability challenges due to limited insurance billing capacity and inconsistent reimbursement. This proposal creates an opportunity to strengthen developmental monitoring, improve family outcomes, and build a sustainable funding model that reduces long-term educational costs. By implementing a structured data collection system, tracking children into early elementary school, and expanding private insurance billing, the project addresses both service quality and financial sustainability. This initiative fills a critical gap by generating actionable data on developmental progress, family engagement, and special education avoidance.	This project will implement a data collection and outcomes measurement system paired with a sustainability and billing expansion strategy. First, each child will receive a baseline standardized or criterion referenced developmental assessment at enrollment. Early intervention providers will then conduct quarterly progress monitoring using criterion-referenced checklists, language samples, parent-reported functional outcomes, and observational data from home and community visits. These data will generate individualized growth curves that show each child’s rate of skill acquisition and identify children who may no longer require services. Second, the project will build a longitudinal dataset to track whether children require special education services upon kindergarten entry. Data will include the type and intensity of services, comparisons between children with developmental delays and those with no delays, but has involvement with Office of Children's Services. Finally, this project will strengthen financial sustainability by expanding insurance billing. The insurance reimbursement from children with a 25-49% delay, will be able to support most of the program's future stability.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Juneau (City and Borough); Ketchikan Gateway Borough; Sitka (City and Borough)	Deferred or Not Advanced

Center for Safe Alaskans	Alaska Rural Transportation Safety Surveillance System	AK	There is a lamentable data gap in assessing transportation safety in rural Alaska. We have good data indicating the frequency of injuries resulting from snowmachines, boats, and ATVs from the AK trauma registry. We do not have data to understand "exposure" to off-road transportation in rural Alaska. There is no data on the actual amount of time or distance these machines are used. It is therefore difficult for community leaders to determine whether their local injury rates reflect a high-risk environment or simply a high-usage one, as modes of transportation and usage rates vary by region and season. This is an opportunity to leverage our group’s years of experience in survey design, methodology, and analysis to gain insight into the missing data and generate statistically valid estimates of injury rates stratified by geography, demographics, season, etc. We propose integrating incentivized web-based surveys into existing administrative touchpoints, like when residents register boats, snowmachines, and ATVs with the State. Further insight can be achieved by applying a similar approach to applicants for hunting and fishing licenses, endeavors that often require high use of these transportation modes, and are critically important to rural Alaskans’ subsistence. This project can alleviate a substantial data blind spot by implementing sophisticated, statistically valid survey sampling to better understand, compare, and monitor rural injury and identify prevention interventions.	Our approach utilizes "logical common sense" and established digital survey tools to capture the "denominator" data required for frequency estimation and true risk assessment. 1. Incentivized Web Surveys: We will design a low-bandwidth, mobile-friendly, incentivized survey platform that captures usage metrics (e.g., average hours per week or seasonal mileage) and recent injury experiences. 2. Strategic Integration: Rather than creating a standalone survey, for which identifying target populations to recruit from and successfully recruiting participants (e.g. text message recruitment with PFD database telephone information) is inefficient, we propose partnering with state agencies to achieve improved survey recruitment (and focused on likely users of off-road transportation) via encouraging with incentives and convenient web link survey participation at the point of action, specifically during the Fish & Game licensing process or ATV/boat/snowmachine registration. Persons “touching” the State system at both of these departments are almost certainly the majority of users of these alternative modes of transportation (and if not themselves specifically, they can report family use) 3. Data Linkage: We will apply appropriate statistical modeling and weighting to link this new usage data with existing State injury registry data. This allows us to calculate, for the first time, injury rates per hour of operation across different regions/groups. 4. Targeted Oversampling: To ensure the results are representative of "truly rural" life, we will specifically oversample rural and Alaska Native populations in our survey recruitment efforts (perhaps through the use of survey “quotas”). By integrating this surveillance into existing state portals, we can minimize rudimentary mandatory reporting burden while using sampling techniques/methods to maximize the quality of the data	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Center for Safe Alaskans	Data Insights to Action: Building Rural Prevention Communication and Action Capacity in Alaska	AK	Alaska's prevention landscape is fragmented. Coalitions addressing suicide, substance misuse, violence, and family wellbeing often operate in silos — unaware of complementary efforts nearby or statewide — despite sharing common upstream drivers. Limited infrastructure exists to connect these coalitions, align messaging, or translate the state's rich surveillance data into tools communities can actually use. The result is inefficiency and missed opportunity. Prevention data sits in dashboards while frontline coalitions craft messaging without analytical support. Communities with the greatest prevention needs often have the least capacity to communicate effectively about them. Coalition leaders — frequently volunteers or multi-role staff — face significant barriers in turning data into practical action, and data professionals are stretched too thin to provide consistent community-level support. This project creates the connective tissue Alaska's prevention ecosystem is missing: linking data analysts with communicators, coalitions with each other, and surveillance systems with locally resonant community action.	The Center for Safe Alaskans will build practical, sustainable infrastructure connecting prevention data to community action through three mutually reinforcing strategies. Strategy 1: Data Translation and Asset Development Beginning in Summer 2026, graduate students will be mentored in data translation — reviewing, refining, and expanding a toolkit designed to convert Alaska OARS and other surveillance data into ready-to-use messaging assets. Coalition partners statewide will help shape these assets to reflect local priorities, cultural contexts, and community voices rather than generic statewide messaging. The Center's Health Communications Neuromarketing Lab will support message testing to ensure outreach resonates with intended audiences. Strategy 2: Coalition Alignment and Capacity Building The project will convene prevention coalitions, data professionals, and communication practitioners to strengthen collaboration across Alaska's prevention ecosystem. Prevention coalitions rarely have both data and communications skill sets in-house. By bringing these groups together, the project breaks down silos that keep good data from becoming good messaging — and creates innovation spaces where partners can respond collectively as the communication environment evolves. Strategy 3: Locally Relevant Communication Working alongside community partners, the Insights to Action Team will develop communication approaches that resonate within rural Alaska communities. Strategies include community-authored media, culturally grounded storytelling, adaptable messaging toolkits, and locally shaped outreach materials. Flexible contractual partnerships will expand reach by engaging local experts, media producers, and implementation partners as needed. Across all three strategies, the project will track outreach efficacy over time, creating a continuous feedback loop that improves both messaging quality and coalition reach — and ensures measurable, evidence-informed impact in rural Alaska communities.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Center for Safe Alaskans	Rural Injury Prevention Safety Initiative	AK	Injuries remain a significant and preventable cause of death and disability in Alaska. Rural communities face particular challenges due to limited access to prevention programs and workforce shortages, making it difficult to sustain safety initiatives locally. Over the past 25 years, Safe Alaskans has developed and implemented evidence-based transportation safety initiatives across Alaska, including child passenger safety programs, youth engagement initiatives, pedestrian safety education, and driver safety tools. While these initiatives have demonstrated success, many rural communities lack the capacity, training, and resources needed to implement them consistently. At the same time, Alaska currently lacks a structured model for delivering injury prevention programs through rural hub communities that builds lasting local capacity. Programs often operate as short-term projects rather than sustainable systems. This project addresses that gap by developing a replicable rural implementation model for safety initiatives. Through partnerships with hub communities, Safe Alaskans will adapt existing programs to local contexts, train community-based professionals to implement them, and provide the equipment and technical support necessary to sustain them. By creating a scalable framework for delivering prevention initiatives in rural settings, this project will strengthen community capacity to prevent injuries, improve health outcomes, and support safer environments across Alaska.	Safe Alaskans will establish a Rural Injury Prevention Initiative to expand access to evidence-based injury prevention programs while building long-term community capacity. The project will use a hub-community partnership model, working with regional communities to serve surrounding areas. Safe Alaskans will collaborate with local partners,such as public health nurses, school districts, tribal health organizations, and community safety advocates, to adapt and implement programs that address local transportation safety needs. Core project activities will include: Training and Workforce Development •Train and mentor community members to become Certified Child Passenger Safety Technicians and develop child passenger safety programs. • Provide training in pedestrian and bicycle safety education through traffic garden programs. • Train local staff to use virtual driving assessment technology to support safe driving skill development among youth. • Train local staff to implement fall prevention initiatives, specifically fall prevention kits (i.e. kits of materials to reduce falls in and around the home), to support fall prevention among older Alaskans. Program Implementation • Support local car seat inspection and distribution programs. • Implement youth pedestrian and bicycle safety programs. • Provide safe-driving education opportunities using virtual simulation technology. • Support youth-led community safety projects that promote protective factors and leadership. • Increase access to fall prevention education and resources among older Alaskans. Community Adaptation and Learning Programs will be adapted collaboratively with local partners to ensure alignment with community needs and cultural values. Safe Alaskans will work with communities to refine program models that can be implemented sustainably in rural contexts. Development of a Rural Implementation Model Throughout the project, Safe Alaskans will document lessons learned and develop practical tools—including training materials, implementation guides, and evaluation tools—to support future expansion of transportation safety initiatives across Alaska. This approach combines prevention programming, workforce development, and healthy community capacity building, aligning with RHTP priorities to strengthen rural health systems and improve population health outcomes.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Center for Safe Alaskans	Virtual Home Visiting: Developing a Cell-Based Model for Rural and Remote Alaska Communities	AK	Alaska's rural mothers and infants lack support that mountains of evidence indicates results in better child outcomes. Home visiting programs consistently demonstrate improved birth outcomes, reduced child abuse and neglect, better developmental trajectories, and stronger family functioning. Yet rural communities with perhaps the greatest need have the least access. No existing home visiting model sustainably in rural Alaska, given the logistic barriers of these villages. Our work builds on the “SmartMom” concept developed by Dr. Adam Zolotor at the University of North Carolina, who explored “cell-based” virtual home visiting. That early work stalled because necessary technology was not yet mature. Satellite internet through Starlink and expanding cellular coverage have been a game-changer, reaching communities that were previously disconnected. Dr. Zolotor has encouraged us to advance his foundational work within Alaska's rural context. The model concept has 3 core components. First, rural mothers gain access to professional clinical support, peer connection, and developmental screening. Second, the model extends nurse capacity dramatically, allowing a single nurse to support families across many communities, less limited by geography. Third, the approach builds in sustainability by design via lower per-family costs and a staffing model that does not require recruiting providers to relocate to remote villages.	Our approach is to develop a complete, pilot-ready, virtual home visiting program package. . The model centers on nurse-facilitated support delivered through smartphones to mothers across multiple rural villages simultaneously. Core service components include facilitated group video sessions where mothers from different communities connect with peers and a facilitating nurse, scheduled one-on-one video consultations for individualized clinical assessment, structured educational content in culturally appropriate formats, validated developmental and psychosocial screening with immediate nurse review, and warm referrals to behavioral health, substance use treatment, nutrition programs, and other services. As an incentive, each enrolled mother receives a smartphone with activated service at no cost - as long as they maintain regular program participation Development has four phases. First, we will build a mobile technology platform optimized for Alaska's connectivity realities with offline functionality for intermittent service and low-bandwidth design. This aligns with the Spark Technology and Innovation initiative by deploying consumer-facing digital health tools in frontier settings. Second, we will adapt comprehensive curriculum content in partnership with ANTHC, THOs, tribal health workers, and traditional birth workers, spanning prenatal preparation through 36-month child development. This directly advances Healthy Beginnings by expanding evidence-based home visiting to rural families. Third, we will develop clinical protocols including screening tools, referral coordination systems, and nurse training curricula. This supports Health Care Access by creating support for behavioral health, specialty care, and community services regardless of location. Fourth, we will design operational systems including enrollment workflows, data management, quality assurance, and sustainability models demonstrating long-term cost-effectiveness. We will engage diverse rural Alaska communities representing different cultural groups, geographic regions, and existing health infrastructure in the process to ensure the model respects local preferences, incorporates village health aide expertise, and builds on, rather than displaces, existing community support systems. This aligns with the Healthy Communities initiative by centering community voice in program design.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Central Area Rural Transit System, Inc. (CARTS)	Collaborative Rural Transit Development Plan for Sustainable Mobility in Seward and Homer	AK	Across the Kenai Peninsula, communities such as Homer and Seward are growing and changing, yet neither community has undertaken a comprehensive process to evaluate long term public transportation needs or identify feasible service models that reflect current population patterns, travel needs, and community priorities. Without a coordinated planning effort, communities lack the data, partnerships, and strategic direction necessary to pursue sustainable transportation solutions. This project addresses the opportunity to conduct a structured, community driven planning process that brings together local governments, service providers, health organizations, and community stakeholders to better understand mobility needs and evaluate potential transit strategies. The project will assess current transportation conditions, identify service gaps, analyze demand for transit, and explore practical options that could improve connectivity within each community and between surrounding rural areas and essential services. By developing a comprehensive transportation plan, communities will gain a clear framework for future decision making, funding opportunities, and implementation strategies. The planning effort will position Homer, Seward, and surrounding areas to pursue transportation solutions that support community mobility, strengthen access to services, and respond to the evolving needs of residents across the region.	This project will support the development of a comprehensive transportation plan for Homer, Seward, and surrounding communities on the Kenai Peninsula. Planning funds will be used to hire a qualified transportation consultant with experience in rural and community based transit planning to guide a structured and collaborative planning process. The planning process will begin with an assessment of existing transportation conditions within each community. This will include reviewing current transportation services, identifying gaps in mobility, and analyzing how residents currently travel to reach health care, employment, education, and other essential destinations. Particular attention will be given to understanding how transportation barriers affect residents living outside city centers. Community engagement will be a central component of the project. Residents, health care providers, social service organizations, employers, tribal partners, and local governments will be invited to participate through public meetings, surveys, and targeted stakeholder discussions. These activities will help ensure that the planning process reflects the experiences and priorities of the people who rely most heavily on transportation to access essential services. Using data gathered through research and community engagement, the consultant will evaluate potential service models and operational approaches that could improve mobility in Homer and Seward. This may include analysis of flexible transit options, partnerships with existing transportation providers, and other scalable solutions appropriate for rural communities. The planning process will also examine potential governance structures, operating costs, and funding strategies needed to support long term sustainability. The final outcome of this project will be a comprehensive transportation plan that outlines recommended strategies, phased implementation options, and potential funding pathways for developing public transit in Homer and Seward. This plan will provide local partners with a clear roadmap to guide future investments and support the development of transportation solutions that improve mobility, strengthen access to services, and respond to the evolving needs of the region.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Planning

Central Council Tlingit and Haida Indian Tribes of Alaska	Rooted in Wellness: Building a Sustainable Model for Tribal Behavioral Health	AK	Alaska Natives, which include many of our staff and the individuals that Tlingit & Haida serves, experience disproportional rates of mental illness, substance use disorder, incarceration, and victimization. This, coupled with a nation-wide disparity of services and providers, especially indigenous providers, speaks volumes to the problems the Tribe’s Community and Behavioral Services division attempts to address. One of the most important statistics is that among American Indian and Alaska Native people needing treatment in 2021, only 5.3% received any treatment and just 3.7% received specialty care - the largest gap of all racial/ethnic groups. Furthermore, in 2022, AI/AN people were 91% more likely to die by suicide than the U.S. population overall. Tlingit & Haida strives to improve mental health and wellbeing for our tribal citizens, to increase access to care, to reduce violence, reduce incarceration, and reduce untreated substance use disorders and mental illness. We strive to increase the number of providers available to our tribal citizens, especially Alaska Native providers.	Tlingit & Haida’s Community & Behavioral Services (CBS) division hopes to leverage these funds toward the following three goals: 1. Expand and increase access to the of spectrum of behavioral health services available to tribal citizens in Southeast Alaska communities; 2. Improve staff development and retention; 3. Ensure program fiscal sustainability. CBS consists of our CARF accredited Healing Center providing behavioral health services, our NARR Accredited Reentry & Recovery program consisting of three non-congregate homes offering reentry support services for people coming out of substance use treatment and incarceration, and the Community Advocacy Program serving tribal citizens that are victims of crime, co-located with the Healing Center. Services within our division include Individual, family and group therapy; same-day crisis response; assessments and referrals; case management; prevention and education; reentry support; victim advocacy and emergency support; postvention crisis collaboration; community healing events; psychological testing; 24/7 365 Crisis Hotline; CultureHeals.com online platform. Our mission is to empower community healing and break intergenerational cycles through the holistic embodiment of our tribal values. Our vision is to provide comprehensive, integrated behavioral health services spanning the continuum of care from prevention to postvention, easily and readily available to our tribal citizens throughout Alaska. Tribal values are the core of our work. Culture is not just something we learn about – it is the daily life of our staff, integrated into everything we do, and represented in all our day-to-day functioning. We prioritize individual and community needs, truly attempting to reduce barriers to care and healing. We value strong collaboration with other programs and community partners and ensure we are accessible and trustworthy in all our work. The foundation has been laid, and these funds would bridge us from ‘start-up programs’ that have to chase grants every year, to a fully sustained division that is billing for a spectrum of behavioral health services. We hope to explore value-based care and reduce administrative burdens from the start. These funds would ensure vital access for our tribal citizens and help expand our current offerings. Additionally, they would help strengthen our workforce, would ensure adequate training and licensure, prevent staff burn-out, and build future leaders.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

Central Council Tlingit and Haida Indian Tribes of Alaska	Indigenous Foods: A Traditional Solution to the Modern Health System	AK	Since 1935, Tlingit & Haida has watched the colonization of our food systems. Diets shifted from traditional to commodities-based, bringing health issues. The obesity rate among Alaska Native youth is 33.8%, approximately 50% higher than the rest of the U.S. (NIH, 2023), increasing risk for adult obesity, liver disease, cardiovascular disease, and diabetes. Alaska Natives are 2.5 times more likely than Caucasians to die from type 2 diabetes, 1.2 times more likely to die of heart diseases, and more than 4 times more likely to die from diseases of the liver. Reliance on food systems of the continental U.S. means importing groceries with high prices and short shelf life. More than 25% of Alaska Natives are living in poverty, a rate over double the general population (NIH). Certain tribal groups are approaching 40%. Alaska ranks 49 in average weekly grocery cost by state (BLS, 2025), with households seeing an 8.8% average annual cost increase year over year. Southeast Alaska spans more than 35,000 sq. mi. Urban communities such as Anchorage or Juneau have different food needs than the rural villages, and due to indigenous history, geographical location, and accessibility, no two rural communities share the same food needs. With encapsulating regional food data being such a difficult task, Tlingit & Haida’s Traditional Food Security program will conduct a traditional food needs assessment and transform the region’s health systems through food.	Tlingit & Haida serves 38,000 Tribal Citizens across 19 communities – including Anchorage, Juneau, and 17 rural Southeast Alaska villages and towns. Since time immemorial, our people have served as stewards of the lands and seas of the Inside Passage, ensuring balance throughout the region as we carefully harvested indigenous foods and upheld our traditional way of life. The Tlingit and Haida people’s history is spoken, not written. Culture was passed along in-person and learning opportunities involved storytelling and hands-on demonstrations. While utilizing technology typically improves data collection, technology use lags in rural areas not only due to limited connectivity, but an inherent need to adhere to traditional communication methods. For this reason, efforts to collect regional data have been ineffective. Data collection attempts by the Traditional Food Security program - including mailings lists and social media - have provided limited responses and, ultimately, unreliable data. As part of the three-year project, Traditional Food Security staff would host indigenous foods community events in 19 Alaska locations – Anchorage and 18 Southeast Alaska communities. These community events would feature hands-on demonstrations focused on the traditional methods of harvesting, processing, preserving, and preparing foods of the region. They will feature storytelling, language, and arts, as well as in-person data collection. Our program will partner with local clinics to provide education and health screenings as part of the event. Community events would typically last 1-2 days, demonstrations will feature foods with availability based on the traditional foods calendar and be open to Tribal Citizens of all ages. The Traditional Food Security program hosts community events for 1,000 participants annually. Whether hosting classes focused on the traditional harvest of fish, deer, seal, or other historical food source, these events are continually well attended and are the ideal space to not only connect people with foods and pass on traditional knowledge, but to combine with data collection. Data that will help us mold a strategic food plan for the region while addressing the unique needs of all our Tribal Citizens. For us, food is medicine. A health system built on this idea will not only address food security but decrease reliance on Tribal health systems.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Wrangell (City and Borough)	Deferred or Not Advanced

Central Council Tlingit and Haida Indian Tribes of Alaska	Transforming Rural Youth Health Through Indigenous Physical Activity and Community Leadership	AK	Rural Alaska Native youth face disproportionate challenges related to physical inactivity, mental health risk, and social isolation—factors that significantly influence long-term health outcomes. Alaska’s geography includes vast remote communities accessible only by air or water. These challenges contribute to serious health disparities. Alaska has one of the highest youth suicide rates nationally, and Alaska Native youth experience disproportionately higher suicide rates and behavioral health challenges than other populations. Research identifies physical activity, cultural identity, and mentorship, as protective factors that strengthen youth resilience and reduce suicide risk. However, many rural communities have limited opportunities for organized physical activity programs outside of school settings. The Central Council of Tlingit and Haida Indian Tribes of Alaska proposes to expand its Youth Wellness Native Youth Olympics (NYO) work, a culturally grounded approach that combines traditional athletic games with mentorship, leadership development, and mental health awareness. By expanding NYO-centered programming in rural communities, this initiative will increase youth engagement in healthy activities, strengthen community support networks, and advance culturally rooted approaches to youth wellness. The project aligns with Rural Health Transformation Program goals to improve physical activity, strengthen mental health resilience, and build healthier rural communities.	This project will implement a community-driven, four-component model that equips rural Alaska communities to establish and sustain culturally grounded youth wellness programming centered on Native Youth Olympics. 1. Local Capacity Building and Training The project will train local community members to serve as NYO coaches and youth mentors. Training will include: • NYO coaching certification and program facilitation • Youth Mental Health First Aid and suicide prevention training • “Together We Are Stronger” leadership development modules • First Aid and CPR certification to ensure safe activity environments These trainings equip trusted local adults to guide youth in culturally relevant ways while strengthening community capacity to support youth mental health and resilience. 2. Equipment and Program Resources Many rural communities lack basic recreational equipment and program materials due to limited budgets. The project will provide: • NYO equipment and physical activity supplies • materials for community events and youth programming • resources for camps, training sessions, and community gatherings Providing direct resources allows communities to begin programming immediately without financial barriers. 3. Community Site Visits and Sustainability Planning Program staff will conduct site visits to participating communities to deliver equipment, support program launch, and conduct collaborative planning with local leaders. These visits will help identify community strengths, program needs, and potential barriers while developing sustainability plans tailored to each community. 4. Regional Engagement and Youth Leadership Development Funding will support travel for youth to participate in regional and statewide NYO events and gatherings. These events foster cross-community mentorship, strengthen cultural identity, and reduce the sense of isolation experienced by many rural youth. Annual summer camps will provide immersive physical and cultural programming, followed by seasonal refresher trainings that maintain program momentum during the school year. The program anticipates serving three to four rural communities each year, prioritizing areas demonstrating both need and readiness for partnership.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Central Peninsula General Hospital	Rural Health Facility Modernization to Meet Patient Demand	AK	Central Peninsula Hospital (CPH) serves as the primary hospital for the Kenai Peninsula. As the population grows, particularly among older adults with complex medical needs, demand for inpatient care, diagnostic services, and rehabilitation increases. However, several core hospital facilities are aging or constrained, limiting the hospital’s ability to expand services and support patient volume growth. The clinical laboratory currently lacks sufficient space to install modern diagnostic analyzers and expand microbiology and hematology services, restricting CPH’s capacity to provide timely local testing. Similarly, other infrastructure, such as laundry services and clinical support spaces, was not designed for the expected 50–60% growth in inpatient and long-term care census. Without expansion and modernization, these infrastructure limitations slow diagnostic turnaround times, create operational bottlenecks, and constrain service capacity. In addition, several facilities identified through the hospital’s facility condition assessment require timely upgrades to maintain safe and reliable operations. Addressing these issues presents an opportunity to modernize critical infrastructure while preparing CPH to support future growth in patient volume and service complexity. This project will modernize and expand key hospital facilities, including the clinical laboratory, laundry services, and rehabilitation clinic, while creating additional clinical space to support growing demand.	CPH will implement a coordinated facility modernization and capacity expansion strategy focused on strengthening core infrastructure that supports inpatient care, diagnostics, and hospital operations. This project focuses on minor renovations and capacity adjustments within existing facilities that allow critical hospital systems to function efficiently and safely. Clinical Laboratory Renovation: CPH will make limited modifications to the existing laboratory footprint to accommodate updated diagnostic analyzers and additional workstations for chemistry, microbiology, and hematology. These improvements primarily involve reconfiguring existing space so new equipment can be installed. This modest renovation will allow the laboratory to maintain modern testing capability and support faster diagnostic turnaround times. Laundry Facility Modernization: The hospital will complete a minor renovation of the existing laundry department to improve workflow and increase processing capacity within the current facility. These upgrades will help the hospital keep pace with increased linen and material processing needs as patient census grows, ensuring reliable operational support for inpatient and long-term care services. Rehabilitation Clinic Priority Improvements: The project will address minor but important facility repairs identified through the hospital’s facility condition assessment. These include roof, exterior enclosure, and site improvements needed to maintain safe and reliable building operations at the rehabilitation clinic in Kenai. Addressing these issues proactively prevents larger facility failures that could disrupt patient services. Support Services Building Alterations: CPH will perform minor alterations to an existing off-site commercial space to create additional operational capacity and relieve pressure on crowded hospital departments. This renovation focuses on adaptive reuse of an existing building rather than new construction, allowing the hospital to efficiently expand functional space. These incremental infrastructure improvements allow CPH to maintain reliable hospital operations, accommodate modest growth in patient demand, and preserve essential services for rural communities without requiring large-scale capital expansion.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Central Peninsula General Hospital	Rural Healthcare Access Expansion Through Technology-Enabled Care	AK	Central Peninsula Hospital (CPH) serves as the regional health care hub for a large and geographically dispersed population across the Kenai Peninsula. Like many rural health systems, CPH faces growing challenges related to provider workforce shortages, increasing patient complexity, documentation burden, and limited access to specialty services. Clinicians spend significant time on administrative tasks, reducing time available for direct patient care and contributing to burnout. At the same time, gaps in clinical documentation and data management limit CPH’s ability to capture appropriate reimbursement, demonstrate quality outcomes, and participate effectively in emerging value-based payment models. Rural access barriers further compound these challenges, as patients often travel long distances for specialty services that could be offered via telehealth. This project addresses these challenges through a bundled investment in digital health infrastructure, including clinical documentation improvement, telehealth expansion, and cybersecurity. This expansion will reduce administrative burden on providers, improve care coordination, enhance regulatory compliance, and strengthen the hospital’s ability to deliver high-quality care locally.	To address these barriers, CPH will implement a coordinated digital health modernization strategy that integrates clinical documentation technology, telehealth expansion, data management infrastructure, cybersecurity protections, and compliance systems. The approach is designed to reduce provider administrative burden, improve documentation accuracy, strengthen data security, and expand access to specialty care for rural patients. Implementation will occur over 12 months to allow for testing, training, and gradual scaling across departments. Project components include: • Clinical Documentation Improvements: CPH will deploy ambient AI documentation technology and a structured clinical documentation improvement (CDI) program. These tools reduce administrative burden on clinicians, improve documentation quality, and strengthen reimbursement accuracy. • Rural Telehealth Expansion: CPH will expand access to telehealth services for pediatric specialty care and support for rural patients. • Data Infrastructure and Cybersecurity: CPH will deploy an upgraded data management and cybersecurity system to strengthen data governance and protect patient data. These upgrades provide the backbone required to support telehealth, AI tools, and secure patient data. • Compliance and Operational Infrastructure: CPH will deploy a Compliance Management System, a centralized platform for environment-of-care and life safety monitoring, and an environmental services software designed to digitize paper-based processes. The systems improve regulatory compliance, infection control monitoring, and operational efficiency. This initiative directly supports several Rural Health Transformation Program priorities: • Spark Technology & Innovation: Implements modern health IT infrastructure • Health Care Access: Expands rural access to specialty services through pediatric telehealth consultations • Pay for Value Fiscal Sustainability: Improves documentation accuracy and data readiness to support quality reporting, utilization management, and participation in emerging value-based and alternative payment models. • Strengthen Workforce: Reduces administrative burden through workflow redesign and technology-enabled documentation	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Central Peninsula General Hospital	Rural Specialty Care Access and Advanced Diagnostics Expansion	AK	As demand for specialty care grows, particularly among the region’s aging population, access to advanced diagnostics, surgical services, and coordinated specialty care remains limited. Rural residents must travel to Anchorage for procedures, specialty consultations, or advanced imaging when local capacity is constrained or unavailable. These transfers create financial hardship, delay treatment, and disrupt continuity of care. At the same time, several critical pieces of equipment at Central Peninsula Hospital (CPH) are outdated, creating reliability risk and limiting the ability to expand specialty services locally. Without modern surgical technology, imaging systems, and sterile processing capacity, CPH cannot safely grow procedural volume or support new specialty providers in the region. In addition to infrastructure limitations, patients with incidental findings or complex conditions often experience delays navigating specialty referrals and diagnostic follow-up. Strengthening patient navigation and utilization management capacity presents an opportunity to ensure that rural patients move efficiently through health care pathways. The project addresses these challenges through a coordinated investment in advanced surgical technology, diagnostic equipment modernization, patient navigation tools, and utilization management systems. Improvements will expand access, improve diagnostic capacity, and strengthen coordination, allowing more patients to receive care close to home.	CPH will implement a coordinated specialty care expansion strategy that combines advanced clinical technology, improved diagnostic capacity, and enhanced care coordination systems. The project focuses on expanding local procedural capability, modernizing diagnostic equipment, and strengthening systems that guide patients through specialty care pathways, allowing more rural patients to receive specialty care locally while improving clinical quality and operational efficiency. Advanced Surgical Capacity: CPH will deploy a robotic surgical system to expand minimally invasive surgical options. Robotic-assisted surgery allows more complex procedures to be performed locally with shorter recovery times, improved precision, and reduced complications. Diagnostic and Procedural Technology Modernization: The project will modernize critical diagnostic and procedural equipment needed to support expanded specialty services. A new mobile C-Arm fluoroscopy system will replace aging imaging equipment, improving image quality, reducing radiation exposure, and increasing reliability during surgical and interventional procedures. Additional diagnostic equipment will strengthen the CPH’s ability to evaluate and manage complex patient conditions locally. Sterile Processing and Surgical Support Infrastructure: To support increased surgical volume and maintain infection prevention standards, the project includes upgrades to sterile processing systems. Modern equipment will improve turnaround times, maintain compliance with current clinical standards, and allow surgical teams to perform procedures safely and efficiently. Patient Navigation and Utilization Management: CPH will implement a patient navigation platform that combines AI-supported imaging review with RN navigators to identify incidental findings and ensure patients receive timely follow-up and specialty referral. A strengthened utilization management and review program will improve care coordination and ensure patients receive the appropriate level of care while reducing delays, unnecessary transfers, and avoidable hospital utilization. Facility Support: Facility improvements, including upgrading resident beds at Heritage Place skilled nursing facility, minor renovation of the Serenity House Treatment Center to expand care, and establishment of a dedicated Mobile Crisis program space, will improve patient safety and operational readiness across care settings that serve rural residents.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Central Peninsula General Hospital	Rural Patient Safety & Clinical Infrastructure Modernization Initiative	AK	Central Peninsula Hospital (CPH) serves as the regional referral hub for residents [RBM3.1] across the central Kenai Peninsula. When core hospital infrastructure becomes unstable or outdated, rural patients must travel long distances to Anchorage for care, contributing to higher costs, delayed treatment, and growing perceptions that essential services are unavailable locally. Core clinical infrastructure is aging and capacity constrained, including laboratory systems, IV medication delivery platforms, patient safety monitoring tools, and diagnostic equipment. In a geographically isolated region, infrastructure instability does not simply create operational inconvenience; it constrains access transformation. Equipment failures or outdated systems delay diagnostics, reduce medication safety, restrict surgical throughput, and increase avoidable transfers to urban hospitals. At the same time, the Borough has one of the fastest-growing populations of residents 65 and older, increasing demand for diagnostics, medication management, and inpatient monitoring. Without reliable foundational systems, CPH cannot safely expand specialty services, support population health needs, or reduce costly care outmigration. Modernizing core clinical infrastructure is therefore a prerequisite for broader rural health transformation, enabling CPH to maintain reliable hospital services, improve patient safety, and strengthen access to care closer to home.	CPH will implement a bundled modernization strategy focused on stabilizing essential clinical infrastructure required to sustain and improve rural hospital services. The approach prioritizes replacement of outdated equipment, installation of modern patient safety systems, and targeted upgrades to diagnostic and medication management technologies. By bundling these investments into a coordinated initiative, CPH will efficiently modernize core systems that support care directly enable faster diagnostic turnaround, safe expansion of inpatient and specialty case volume, reduced transfer dependency, and support for increasing geriatric and complex patient demand. Major investments include: • Clinical and diagnostic equipment, including portable X-rays and ultrasounds, vein viewers, transport monitors, newborn hearing screening, medical imaging system, scope guide and drying cabinet, and endoscope reproprocessors. • Medication management and patient safety systems, including IV pump replacements, medication-grade refrigerators, malignant hypothermia cart, infant security system, in-code identity verification, and security cameras. • Inpatient and outpatient care equipment, including affinity birthing beds, exam tables, podiatry exam chairs, and upright cycles for physical therapy. • Facility operations and clinic improvements, including automatic door and sliding door upgrades, flooring replacement, autoscrubber, and food storage systems. This initiative directly supports several Rural Health Transformation Program priorities: • Health Care Access: Strengthens diagnostic, surgical, and inpatient infrastructure needed to maintain essential services locally. • Healthy Beginnings: Supports maternal and newborn safety. • Healthy Communities: Improves patient safety and quality of care through modern medication delivery systems, diagnostic tools, monitoring equipment, and infection-prevention infrastructure. • Strengthen Workforce: Provides clinicians with reliable equipment and safer care environments, improving staff efficiency, recruitment, and retention. • Spark Technology & Innovation: Advances modern health system capabilities through upgraded diagnostic imaging, medication management systems, and patient safety technologies that support evolving care models and regional coordination.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Central Peninsula General Hospital	Rural Workforce Stabilization and Service Line Expansion Initiative	AK	Alaska’s rural health workforce volatility has increased reliance on locum providers and created inconsistent access to specialty services. This variability drives patient transfers, raises system costs, and disrupts continuity of care, particularly as the region’s 65 and older population grows and requires more complex chronic disease management. At the same time, behavioral health crisis demand exceeds current shift coverage, and the absence of a structured palliative care pathway limits the ability to manage complex or serious illness locally. This project addresses these interconnected gaps through a bundled set of time-limited start-up investments that strengthen workforce stability and expand access to care. The initiative includes targeted specialty recruitment and retention support, expansion of Mobile Crisis shift coverage, development of a leadership and workforce development program, launch of an inpatient palliative care consult service with future outpatient expansion, and deployment of a secure workforce wellness platform to improve staff resilience and retention. Together, these investments will stabilize specialty access, improve behavioral health crisis response, and build leadership and workforce capacity necessary to sustain rural health services.	CPH will implement a coordinated strategy with two primary components to address the root causes of rural access gaps and build sustainable systems that allow care to remain close to home: 1) Expanding Health Services Capacity: CPH will expand access to critical clinical services through targeted specialty recruitment, behavioral health crisis response expansion, and the development of a palliative care program. Recruitment and retention support will be used to stabilize specialty practices in cardiology, ENT, urology, dermatology, and internal medicine/hospitalist care. CPH will also establish an inpatient palliative care consult service. The program will provide symptom management, goals-of-care conversations, and care coordination while building protocols and clinical expertise needed to support future outpatient expansion. CPH will also expand the Mobile Crisis Team shift coverage. Additional resources will allow the program to provide more consistent daily coverage and surge response during peak demand periods. Improved coordination with EMS, emergency departments, and outpatient providers will enable more patients experiencing behavioral health crises to be stabilized in the community rather than requiring emergency department care or out-of-area transfer. 2) Workforce Development and Resilience: The second component focuses on strengthening the rural health workforce through leadership development, training infrastructure, and workforce wellness initiatives. Renovation of a staff development space will provide dedicated capacity for workforce training, continuing education, and interdisciplinary collaboration. A multi-year leadership development program will build management and clinical leadership capacity across the organization. Leadership training will focus on workforce retention strategies, operational reliability, and team-based care models that improve service stability in rural settings. To further support workforce resilience, CPH will pilot a digital wellness platform to promote employee health, engagement, and burnout prevention. This platform provides structured wellness programming and behavioral health resources that help sustain staffing levels and improve workforce stability.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Central Rescue Team	Central Rescue Team Emergency Response Center	AK	Rural emergency response time is critical for the injured and sometimes survival depends on it. Our Central Response Team improves the chances of patient's survival and recovery, but we have no facility in which to attend to people's injuries or even a way to transport the injured in a safe and timely manner. We want to provide a safe place where we can administer first aid and assist with transportation when needed. Our community sits at 130 Mile on the Steese Hwy, we have potential patients who are the Alaskan families who are our residents, Steese Hwy road travelers, gold miners and moose and caribou hunters the type of injuries and illnesses we may encounter as an ETT are too many to list here but we intend to increase the patient's odds by providing a place and a way to get needed medical attention. We plan to elevate our community with much needed services while providing emergency care in a safe environment. There are currently no emergency services in our rural area and we will do our best to provide the care that we all hope will be there when we need it.	We intend to utilize the abandoned school buildings and land in Central which are now owned by the State of Alaska as an Emergency Trauma Technician Response Team center and to have a vehicle available for emergency transport when needed, there's even an old bus barn where we can store the ETT vehicle to ensure that its ready when needed. We will use the grant funding to bring these buildings up to code, furnish the center appropriately, re-establish utilities, install communications and to purchase a vehicle that will accommodate having a patient laying down on a backboard securely. We will contact the State of Alaska to facilitate the use of the buildings and the land which are currently sitting empty since the school closed in approximately 2007. By creating an Emergency Response Center we will add a much-needed service to the rural area around Central Alaska.	\$50,000-\$250,000	Other	Single Community	Yukon-Koyukuk Census Area	Deferred or Not Advanced

CFHM	Value-Based Care Readiness Service	MD	Federal value-based payment programs are creating financial exposure for Alaska providers who lack the technical support to navigate them. Two challenges are converging: CMS's mandatory Ambulatory Specialty Model (ASM) launches in 2027, imposing episode-based financial accountability on approximately 50 Alaska providers with no prior experience in bundled payments. Simultaneously, over 20% of Alaska's MIPS-eligible clinicians are already being penalized under a program that's been in place since 2017. These providers, many without dedicated quality reporting staff or data infrastructure, need education, assessment, and hands-on support to build the internal capability to succeed in value-based care on their own.	We propose a two-track technical assistance program delivered in partnership with a healthcare consulting firm with direct experience supporting providers in CMS value-based care programs including MIPS, EQIP, and ACO Programs. Track A — ASM Readiness (~50 providers currently on CMS’s ASM Participant List): A tiered engagement that moves providers from education through implementation. This includes a CME-approved education series on the ASM model, a practice-level readiness assessment identifying clinical and operational gaps, an optimization dashboard for ongoing performance visibility, and hands-on advisory support to help practices build the internal workflows and capabilities needed before the program launches. Track B — MIPS Optimization (~1,300 MIPS-Eligible clinicians): A parallel program focused on quality metric reporting and fiscal sustainability. This includes statewide education on MIPS scoring and common pitfalls delivered virtually at low cost, a preparedness assessment reviewing current scores and workflow gaps, an optimization dashboard tracking performance against benchmarks, and advisory support to help practices build sustainable reporting and quality improvement processes. Both tracks are designed to transfer knowledge and build lasting capability within the practices we serve — not to create dependency on outside consultants. All services are delivered virtually, making them accessible statewide.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

CGI Technologie s and Solutions	Child Welfare Quality Improvement and New Foster Parent, Provider and Tribal Portal	WA	Alaska’s current Child Welfare Information System was designed for a different era of service delivery and does not adequately support today’s needs for timely decision-making, cross-system coordination, workforce efficiency, or equitable service delivery—particularly in rural, Tribal, and frontier communities. Limitations include: • No self-service or portal for engaging Foster / Provider and Tribal communities • Fragmented data across child welfare, behavioral health, courts, and Medicaid • Manual, duplicative casework that increases staff burden and turnover • Limited real-time visibility into safety, permanency, and well-being outcomes • Barriers to culturally responsive and community-based service coordination These gaps directly impact children and families by delaying services, increasing placement instability, and limiting accountability. To modernize Alaska’s Child Welfare Information System into a secure, interoperable, user-centered platform that improves child safety, permanency, and well-being outcomes while strengthening the child welfare workforce and enabling cross-agency collaboration.	Phase 1: Months 1 to 12 - CGI in partnership with State of Alaska FCS OCS develop and deploy portals to Parents, Providers, base as front end to existing system Phase 2: Months 12 to 24 - the second phase of the project will focus on modernization of Intake and Investigation of OCS case load Phase 3: Months 18 to 24 - the third phase of the project will focus on introducing AI Case Mining Phase 4: Future - further incremental modernization of the child welfare case management platform (future year funding is likely required)	Over \$5M	Statewide	Anchorage (Municipality); Juneau (City and Borough)	Deferred or Not Advanced

CHADIS, Inc.	Technology for evidence-based health care to empower patients and providers to improve outcomes	MD	Rural health care has more issues with access, quality and cost than more populated areas. People living in rural areas often lack access to primary and tertiary care due to distances and clinician availability as well as preventive measures. Families have barriers of child care to make visits. Quality of healthcare is also an issue in rural areas. Even when able to travel for care, not having their issues triaged in advance may either delay appropriate care or cause visits at great effort and expense when it is not needed- both quality issues. Coordination of care over time may be impeded by changing staff and a lack of shared records, resulting in gaps in care or, at times, duplication, with associated costs. Quality of rural care may be lower when there are fewer physicians and specialists and more care by less well-trained providers. Costs for taking time off for care may be higher for lengthy travel, and this is more of a burden for low-income families who may also have jobs with limited time off. Costs may be higher when there are fewer site options for care. All of these issues can be ameliorated when previsit data is collected for triage, evidence-based care by telehealth is facilitated by previsit online data collection, choices of clinicians are possible by telehealth, and quality is assisted by easily accessed linked decision support and proven Care Pathways, as well as mental health navigation linking primary care with mental health care, as CHADIS provides.	CHADIS will help Alaskans by: Collecting data pre-visit: Questionnaires (>1000) are custom set up initially, with auto-assignment by visit type and age including for health, mental health (>200), and social drivers of health for all ages, suitable for pediatric, family, internal and OBGYN medicine and mental health. Patients are reminded by text/email to complete the questionnaires in English (or other languages) before visits, at home, or waiting room via QR code via phone or tablet; perfect for telehealth. Teachers etc. are invited by staff or parents to fill questionnaires; with results only for clinicians. CHADIS works with or without an EHR integration (9 so far). Streamlining visits, improving quality, and reducing burnout: Clinicians see results instantly, scored, graphed and linked to patient-specific decision supports, including evidence-based Care Pathways for chronic conditions, to inform care and obviate redundant questions. Patient input automates notes for every visit type, streamlining and assuring comprehensive care, earning higher billing codes, and reducing burnout. CHADIS data informs AI Scribes (CHADIS or others) for comprehensive notes. Post-visit: Patient-specific local/national resources and prevention education based on questionnaire results are offered in portals or printed. A MemoryBook created for young children, links their milestones to activities to promote parent-child interaction and relational health. Wellness is promoted by assessment of and resources for Abilities and Interests, Goals and Strengths, and Best and Hardest parts of parenting for discussion. Clinicians or algorithms can schedule follow-up monitoring and outcome questionnaires. Care coordination and improved access via CHADIS closed loop referral system: CHADIS' prefilled referral form faxed or securely emailed can share information for remote or in person care by specialists to help triage and coordinate care and return feedback to PCP. A code allows inviting other clinicians to see data without requiring an EHR and replaces/reduces a care coordinator. CHADIS Background: CHADIS, developed with \$27.4M NIH funding, is used in 48 states by >5000 PCPs, and screens 375,000 patients/month. Care Pathways are validated for asthma, autism, depression, suicide risk, substance use, and social drivers of health. Care Pathways won AAP Technology Innovation of the Year. CHADIS research validated many tools including a superior early autism and development screen.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Challenge Alaska	Challenge Alaska Keil Center Tenant Improvements	AK	Investing in the renovation of Challenge Alaska’s Keil Center in Girdwood would address significant barriers that prevent many Alaskans with disabilities from accessing outdoor recreation and adaptive sports. Individuals with disabilities often face high equipment costs, as adaptive skis, sit-skis, outriggers, handcycles, and other specialized gear can cost thousands of dollars and require proper storage, maintenance, and fitting. Financial barriers also limit participation, as travel to recreation sites, lift tickets, instruction, and specialized support can quickly become unaffordable for many families. In addition, safe participation in adaptive recreation requires trained instructors, volunteers, and therapists with specialized knowledge to match participants with appropriate equipment, teach adaptive techniques, and manage safety needs. Without facilities designed to provide adaptive equipment, train staff and volunteers, and provide accessible spaces for participants to prepare and learn, many individuals are excluded from these life-changing experiences. Improving the Keil Center would expand Challenge Alaska’s capacity to remove these barriers and strengthen the training hub that makes adaptive recreation possible for people with disabilities from across Alaska.	Originally built in 1993, the Challenge Alaska Keil Center for Adaptive Sports and Therapeutic Recreation is no longer adequate to promote the physical and mental health needs of Alaskans living with disability. Using RHTP funding, Challenge Alaska leadership will transform this state-wide hub into a world-class venue for year-round access to adaptive sports, therapeutic recreation, and education. The overall facility improvements have both an expansion of the facility planned, as well as tenant improvement throughout the existing structure. For the sake of compliance with the allowable use of the funds, only the portion of the project considered tenant improvements are included in the scope of RHTP funding. No RHTP funds will be used for the new construction portion of the total facility project. The tenant improvement budget is \$3,552,327. The expansion will be an additional \$3,033,315. This request is for the \$3,552,327 tenant improvement budget. By investing in a renovation of the Keil Center, RHTP Funding is investing in the overall health of all Alaskans living with disability. Having safe and affordable access to recreation opportunities has been proven to increase health outcomes and reduce preventable illness and negative impacts to mental health. As the only facility of it's kind in the state, Challenge Alaska will work within rural communities to promote inclusion in Challenge Alaska activities and provide a safe place to stay while doing so. Alaskans will travel to the Keil Center to participate in Challenge Alaska programing. If they are traveling by air, Challenge Alaska will assist with transport to/from the Anchorage Airport for the participant(s) and their caregiver(s). Once on-site, the facility will have all the amenities needed to participate in programming and live comfortably during their visit. During their stay, the individuals will receive instruction on the activities they are there to participate in, and given the tools to continue that activity once they travel back home, or if that community cannot support the desired activity, they will work on a plan of care that ensures that progress is continued though repeat visits supplemented with suitable cross-training.	\$1M-\$5M	Home- and communit y-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Changing Tides Therapy Services, Inc	Southcentral Alaska Pediatric Development & Community Integration Institute	AK	Children in rural Alaska face significant barriers to accessing timely developmental and behavioral health evaluations. Families across the Kenai Peninsula and surrounding rural communities often travel long distances or wait many months to access autism diagnostic assessments, pediatric behavioral health evaluations, and specialized developmental services. These delays can prevent children from receiving early identification and intervention during critical developmental periods when treatment is most effective. At the same time, rural Alaska faces persistent shortages of pediatric developmental specialists and behavioral health providers. Recruitment and retention of clinicians in rural communities remains challenging, limiting local diagnostic capacity and access to multidisciplinary care. These challenges create an opportunity to develop new models of care that expand access to early childhood developmental diagnostics while strengthening the rural pediatric workforce. This project seeks to address these gaps by creating a regional pediatric neurodevelopmental hub that improves diagnostic access, builds workforce training pathways for early-career clinicians, and introduces innovative care environments that support children’s functional participation in their communities. Together, these efforts aim to improve early identification of developmental conditions, reduce travel burdens for rural families, and build sustainable pediatric care capacity for rural Alaska.	To address limited access to pediatric neurodevelopment diagnostics and rural workforce shortages, Changing Tides Therapy Services proposes establishing the Southcentral Alaska Pediatric Development & Community Integration Institute, a regional hub designed to expand access to multidisciplinary developmental care for rural children and families. The project will introduce a rotating specialist model that brings credentialed diagnosticians, including developmental psychologists, neuropsychologists, and developmental pediatric specialists, to a regional hub location to conduct scheduled diagnostic clinics. Local clinicians will complete structured developmental assessments, caregiver interviews, and standardized testing prior to these visits, allowing visiting specialists to conduct comprehensive evaluations and provide diagnostic determinations and care recommendations. This approach reduces the need for families to travel long distances for diagnostic services while expanding diagnostic capacity within the region. In addition to expanding diagnostic access, the institute will serve as a training hub for early-career pediatric clinicians through partnerships with universities and professional training programs. Student clinicians, interns, and fellows in speech-language pathology, occupational therapy, behavioral health, and related disciplines will complete supervised rural training placements focused on neurodevelopmental diagnostics, interdisciplinary care models, and early childhood intervention. By training clinicians in rural environments early in their careers, the program aims to strengthen long-term workforce retention in Alaska. The project will also develop a community integration learning environment, or “Life Skills Lab,” where children can practice real-world social, emotional, and daily living skills in simulated community settings. These natural-environment therapy models allow children with developmental differences to practice functional skills such as social interaction, emotional regulation, school readiness, and daily routines in contexts that mirror everyday life. Together, these components create a new rural pediatric care model that expands diagnostic access, builds regional workforce capacity, and prepares children with developmental differences for meaningful participation in school and community life, strengthening long-term pediatric developmental care capacity for rural Alaska.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Chapel of the Cross Church of the Nazarene	Develop Family Health by ensuring access for people with disabilities	AK	In rural Alaska, where long winters, limited recreational infrastructure, and geographic isolation already restrict opportunities for physical activity and social engagement, accessible indoor spaces are essential to community health. Families with young children, grandparents serving as caregivers, individuals with disabilities, and those recovering from illness or injury are currently unable to fully participate in programs and services offered in our lower-level facility. This barrier limits equitable access to: • Safe indoor physical activity for children • Family-centered wellness programming • Intergenerational community connection • Mental health–supportive gathering space during winter months Installing an elevator will remove a critical structural barrier and align with the goals of the Alaska Rural Health Transformation Program by improving accessibility, reducing isolation, and strengthening protective factors for families. The project will ensure that all community members—regardless of mobility status—can safely access health-promoting programs and supportive environments. By increasing accessibility, Chapel of the Cross will expand inclusive participation, promote physical and mental well-being, and enhance community resilience in our rural setting.	Our approach is to have an elevator installed that will give access from the entry-way of the building (parking lot level) to the downstairs area where Chapel of the Cross services are provided to seniors, families and youth. Along with the installation of the elevator there will need to be some remodel of the main entry to accomodate the location and usability of the elevator.	\$250K-\$1M	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Cheesh'Na Tribal Council	Cheesh'na Healthy Community & Food Sovereignty Planning Initiative	AK	The community faces multiple interrelated health and resilience challenges due to its remote location, limited infrastructure, and vulnerability to natural disasters that can isolate the region. Food insecurity is a major concern, particularly if the Tok Cutoff Highway becomes impassable due to earthquake, wildfire, or flood. In addition, community members have expressed concern about the need for stronger support systems for young men, including mentorship, healthy relationship education, and positive pathways for leadership and cultural engagement. The Cheesh’na Tribal Council sees an opportunity to strengthen community resilience through planning focused on food sovereignty, youth mentorship, and improved health system coordination. By working with tribal health organizations and community partners, the Tribal Council aims to develop a long-term strategy that strengthens access to healthy foods, improves behavioral and chronic health outcomes, and supports healthier families and relationships.	This project will support a two-year planning and development initiative designed to gather community input and develop a comprehensive Healthy Community Plan. Activities will include community listening sessions, culturally appropriate engagement with elders and youth, coordination with regional tribal health organizations, and collaboration with local service providers. Planning efforts will focus on several key areas: • Food sovereignty and emergency food system resilience planning • Mentorship and healthy relationship programming for young men • Behavioral health and chronic disease prevention priorities • Community-driven strategies to improve quality of life and wellbeing • Strengthening partnerships among tribal government, health providers, and community organizations Mt Sanford Tribal Consortium, the local tribal health organization will partner with the Tribal Council to help guide community engagement, health system coordination, and long-term strategy development.	\$50,000-\$250,000	Single Community	Copper River Census Area	Deferred or Not Advanced

Cherokee Nation System Solutions	Developing a State-Tribal Interoperable Electronic Client Record Infrastructure for Alaska	OK	Rural and frontier communities in Alaska face persistent healthcare workforce shortages that limit access to care and strain rural health systems. Geographic isolation, limited transportation infrastructure, and small population centers make it difficult to recruit and retain physicians, nurses, behavioral health professionals, and other essential staff. Many rural facilities rely on temporary or itinerant clinicians to maintain services. While these arrangements address short-term staffing gaps, they increase costs, disrupt continuity of care, and make it difficult to sustain stable care teams. Workforce challenges are also shaped by broader community conditions. Limited housing, transportation barriers, childcare access, and social isolation can make it difficult for healthcare professionals to remain in rural communities after relocation. At the same time, Alaska has an opportunity to strengthen its rural health workforce by aligning workforce development, community support systems, and workforce planning across Tribal health organizations, healthcare providers, educational institutions, and state partners. This project addresses that opportunity by supporting a coordinated workforce ecosystem that strengthens workforce pipelines, improves workforce retention, and supports data-informed workforce planning.	Our proposed approach focuses on strengthening the systems that support the rural health workforce by implementing a coordinated workforce ecosystem that improves workforce planning, expands workforce pipelines, and supports long-term workforce retention in rural communities. The project is organized around four interconnected strategies. Workforce Intelligence and Data Integration The project will support the development of workforce intelligence tools that integrate workforce data across healthcare providers, training programs, and workforce agencies. These tools help identify workforce shortages, forecast future workforce needs, and guide workforce investments. Data-informed planning allows healthcare leaders to target workforce development strategies where they will have the greatest impact. Strengthening Rural Workforce Pipelines The project will expand pathways that connect rural residents to healthcare careers. This includes strengthening partnerships with educational institutions, supporting rural training opportunities, and expanding programs that introduce students to health professions. Evidence shows that individuals trained in rural communities are more likely to remain and practice in those communities. Workforce Stabilization and Retention Support Recruitment alone does not address workforce shortages if professionals leave soon after relocating. The project will support workforce stabilization strategies that address barriers such as housing availability, relocation logistics, transportation access, and family support. These efforts help healthcare professionals transition successfully into rural communities and remain there over time. Community and Tribal Partnership Engagement The project will be implemented in collaboration with Tribal health organizations, healthcare providers, educational institutions, and community partners. These partnerships help ensure that workforce strategies reflect the needs and priorities of the communities they serve and support culturally responsive care. Together, these strategies strengthen the entire lifecycle of the rural health workforce—from early career pathways through long-term community integration. By improving workforce planning, expanding training pipelines, and supporting workforce retention, the project helps ensure that rural and frontier communities have reliable access to healthcare services now and in the future.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Cherokee Nation System Solutions	Operationalizing the Social Determinants of Work	OK	Rural and remote communities in Alaska face persistent healthcare workforce shortages that limit access to care and strain local healthcare systems. Many communities rely on small teams of providers who must deliver a wide range of services across large geographic areas. Recruiting healthcare professionals to these locations is difficult, and retaining them is often even more challenging due to housing shortages, transportation barriers, professional isolation, and limited community support resources. These workforce challenges lead to increased reliance on temporary staffing, higher operating costs for healthcare providers, and disruptions in continuity of care for patients. At the same time, many rural residents face barriers to entering healthcare careers due to limited access to training programs and workforce development opportunities. This project addresses these challenges by strengthening workforce planning, expanding rural workforce pipelines, and supporting long-term workforce stability. By improving coordination among healthcare providers, training institutions, and community partners, the project will support sustainable workforce solutions that improve access to care and strengthen rural healthcare systems across Alaska.	This project will address rural healthcare workforce shortages by implementing a coordinated, data-driven approach that strengthens workforce planning, workforce development pipelines, and long-term workforce stability in rural and frontier communities. The project will begin by improving workforce planning through the development and use of workforce data systems that provide insight into workforce supply, demand, and regional workforce needs. These data tools will help healthcare organizations and policymakers identify workforce gaps, anticipate emerging shortages, and better align workforce development investments with community needs. The project will also support the expansion of rural healthcare workforce pipelines. Partnerships with educational institutions, healthcare providers, and workforce development organizations will help increase access to healthcare career pathways for rural residents. Activities may include early exposure to healthcare careers, rural training opportunities, and support for programs that prepare students for careers in fields such as nursing, behavioral health, and allied health professions. In addition to expanding workforce pipelines, the project will focus on improving workforce retention in rural communities. Many healthcare professionals leave rural positions due to challenges related to relocation, housing availability, and community integration. The project will support workforce stabilization strategies that address these barriers and help healthcare professionals build stable careers in rural communities. Regional collaboration will play a central role in the project. Healthcare providers, tribal health organizations, educational institutions, and community partners will work together to coordinate workforce initiatives and share resources that strengthen regional workforce capacity. By strengthening workforce planning, expanding training pathways, and supporting long-term workforce retention, this project will help improve access to care, strengthen healthcare delivery systems, and support sustainable rural healthcare workforce development across Alaska’s rural and frontier communities.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Chevak Traditional Council	Improving Access to Behavioral Health Care in Chevak’s Rural Community	AK	Rural Alaska communities face significant challenges in accessing timely and culturally appropriate mental health services. In communities such as Chevak, geographic isolation, limited behavioral health providers, transportation barriers, and long wait times for care create major gaps in mental health support. Residents often must travel to regional hubs to receive services, which can be costly, disruptive to families, and sometimes impossible during severe weather or seasonal travel limitations. At the same time, rural communities are experiencing increasing mental health needs, particularly among youth and young adults. Without consistent access to prevention, early intervention, and behavioral health support, individuals may face worsening mental health conditions, substance misuse, or crisis situations. This project seeks to expand mental health services through the Chevak Traditional Council’s Behavioral Health Program. The project will provide the Chevak community with virtual mental health resources while funding future support for local staffing and programming. By strengthening local capacity, the project will ensure that residents can access services within their own community, reducing barriers to care and improving overall community well-being. This opportunity will allow the community to build sustainable behavioral health support systems that are culturally responsive and better equipped to address the growing mental health needs of rural Alaska residents.	To address the gaps in access to mental health services in rural Alaska, this project will expand and strengthen behavioral health services through the Chevak Traditional Council’s Behavioral Health Program. The proposed approach focuses on increasing capacity, improving early intervention efforts, and providing culturally responsive support to community members. In addition to implementing virtual services for tribal members, the project will support future dedicated behavioral health staff positions responsible for prevention programming, outreach, and direct support services. These staff members will provide early intervention for individuals experiencing mental health challenges, assist community members in accessing appropriate care and referrals, and coordinate crisis response support when needed. For members needing support in the moment and virtually, through the Talkspace platform, individuals can access therapy via asynchronous messaging as well as scheduled live video sessions, allowing them to engage with care in a flexible format that accommodates varying schedules, connectivity limitations, and comfort levels. This model removes the need for long-distance travel and allows our community to receive support from the privacy of their own community. Participants will be matched with licensed therapists through the Talkspace platform, which pairs individuals with providers based on clinical needs, preferences, and therapist expertise. This process allows individuals to begin care quickly, often within 24 hours, while expanding access beyond our limited pool of local providers. Through a combination of locally delivered services, prevention programming, and coordinated partnerships, this approach will improve access to behavioral health services, support early intervention, and build a sustainable system of mental health care for rural residents.	\$50,000-\$250,000	Single Community	Kusilvak Census Area	Deferred or Not Advanced

Chickaloon Native Village	Chickaloon Village Personal Care Agency and Rural Care Coordination Initiative	AK	CVTC has identified a growing need for improved access to home-based care and coordinated healthcare navigation for community residents. Through this project, CVTC will begin developing the infrastructure needed to support a tribally led Personal Care Agency workforce and care coordination system serving Alaska Native Elders. During the first year, CVTC will focus on partnership and program development, workforce preparation, and the establishment of care coordination services. The project will support the hiring and training of a Care Coordinator, development of a Personal Care Assistant (PCA) training program aligned with Alaska Medicaid standards, and collaboration with Cook Inlet Tribal Council to explore a sustainable reimbursement model for home-based care and care coordination services. CVTC will also establish program policies, procedures, and compliance structures while recruiting potential trainees from the local community. CVTC has already identified community members who would benefit from these services and will begin with a small client base while building program capacity. This project will strengthen rural healthcare systems, expand access to culturally responsive care, and develop a local workforce capable of supporting Elders and individuals with disabilities to safely remain in their home communities.	1. Program Infrastructure Development - CVTC staff will develop the operational infrastructure necessary to support a tribally operated Personal Care Agency (PCA) program. Activities will include: • Researching Alaska Personal Care Agency program requirements and regulatory standards. • Developing culturally responsive training materials and curriculum aligned with Alaska Medicaid PCA standards. • Establishing compliance procedures and documentation systems. • Developing policies and procedures for service delivery, caregiver supervision, and quality assurance. 2. Care Coordination and PCA Capacity - CVTC will recruit and hire a full-time Care Coordinator to lead program development and service implementation. The Care Coordinator will oversee client care plans, coordinate medical appointments, assist with service referrals, and support individuals in navigating healthcare and social service systems. Existing CVTC staff will receive PCA training and as capacity grows, new recruits will be hired and trained. 3. Sustainability and Systems Alignment - CVTC will collaborate with Cook Inlet Tribal Council (CITC) to establish a framework for long-term program sustainability. Collaborative activities will include: • Designing a reimbursement model for PCA and care coordination services. • Exploring Medicaid/Medicare billing pathways for home-based services. • Contracting with CITC for shared use of segmented Electronic Health Record (EHR) systems. • Aligning care coordination practices with regional Tribal healthcare systems. • Developing shared best practices for service delivery and program administration. Goal 1: Improve continuity of care within the Chickaloon Native Village ANVSA service area. Objective: Train at least three staff members as certified Personal Care Assistants (PCAs) within 12 months. Goal 2: Enhance care coordination and improve client outcomes. Objective: Hire and onboard a full-time Care Coordinator within three months of receiving funding. Goal 3: Strengthen health information sharing and operational efficiency. Objective: Sign an MOA with CITC within the first 6 months. Goal 4: Evaluate program development and early implementation. Objective: Conduct a program development and implementation	\$1M-\$5M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

review by the end of Year 1 to guide future program expansion.

This phased approach allows CVTC to build the operational, workforce, and partnership infrastructure necessary to support a sustainable tribally led home-based care program.

Chickaloon Native Village	Ahtna Language Reading and Writing Curriculum Development Project	AK	The Ya Ne Dah Ah School has been actively engaged in Ahtna language preservation efforts and has successfully developed a Total Physical Response (TPR) curriculum focused on language comprehension and pronunciation. While this approach has strengthened students’ listening and speaking abilities, the next phase of preservation efforts must focus on developing structured reading and writing instruction to sustain this at-risk language. The Ya Ne Dah Ah School proposes to develop and pilot an Ahtna Language Reading and Writing Curriculum designed to strengthen cultural identity, literacy skills, and community wellness in the Chickaloon community. Language revitalization is widely recognized as an important cultural determinant of health for Alaska Native communities, supporting mental health, resilience, and intergenerational connection. Funding will support hiring a curriculum developer to design Ahtna reading and writing materials and a teaching assistant to support classroom implementation and pilot testing with students. The pilot program will allow educators to test lesson plans, reading passages, writing exercises, and instructional strategies that integrate language learning with traditional cultural knowledge. By developing and piloting structured literacy materials, this project will strengthen language preservation while increasing student engagement, reinforcing cultural identity, and supporting community well-being in the Chickaloon region and across Alaska.	This project will include three main phases: Curriculum Development - A qualified curriculum developer with experience in Ahtna language curriculum development and education will work with Ahtna language speakers, educators, and cultural knowledge holders to create basic age-appropriate reading and writing materials. Curriculum components will include vocabulary guides, reading passages, writing prompts, and teacher instructional guides that reflect Ahtna cultural values and traditional knowledge. Curriculum Pilot - During the first year, a teaching assistant will support classroom implementation of the pilot curriculum at the Ya Ne Dah Ah School as lessons are developed. Students will participate in structured reading and writing activities designed to strengthen both literacy skills and language familiarity. The teaching assistant will work alongside teachers to support students and help document lessons learned during the initial pilot phase. Evaluation and Refinement Teachers, students, and language experts will provide feedback on the curriculum materials and instructional methods. This feedback will be used to refine lesson plans and reading materials to improve effectiveness and usability for future instruction.	\$250K-\$1M	Home- and communit y-based services provider	Multi- Community or Participating in Regional Hub-and- Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Chickaloon Native Village	Chickaloon Village Traditional Council Community Food Security and Sustainability Project	AK	To improve access to healthy, locally grown foods, the Chickaloon Village Traditional Council (CVTC) proposes to repair and upgrade its existing community greenhouse and develop an additional greenhouse and chicken coop co-located with Ya Ne Dah Ah School. These improvements will expand local food production and increase access to fresh produce and eggs for Elders, students, and community members. To support implementation, CVTC will hire a Project Coordinator during the first year to oversee project infrastructure development and coordinate community volunteers for planting, harvesting, and food distribution activities. The Project Coordinator will support CVTC’s weekly Elders’ lunch congregate and home-delivered meals program, which has served community Elders since 2007, by providing locally grown foods to improve the nutritional quality of meals. The coordinator will also provide community education on food production, food storage, and healthy food preparation in collaboration with Health & Social Services staff. Working closely with Ya Ne Dah Ah School staff, the coordinator will support development of the school greenhouse and chicken coop, creating hands-on learning opportunities for students while contributing to the production of eggs and fresh foods for the community.	The project will be implemented through four integrated components. 1. Greenhouse Expansion/Chicken Coop Set-Up and Management - The first season will be focused on infrastructure maintenance of the existing greenhouse in Sutton, and set-up of a new prefab greenhouse and chicken coop at the Ya Ne Dah Ah School. A full-time Food Security Program Coordinator will oversee: • greenhouse modifications and setting up the new greenhouse and chicken coop at the Ya Ne Dah Ah School • planting schedules • crop rotation planning • soil health management • harvest planning • volunteer coordination Expanded greenhouse production will focus on nutrient-dense crops such as: • leafy greens • root vegetables • herbs • tomatoes Production will be structured to maximize harvest periods and extend the growing season. 2. Community Volunteer Program The coordinator will develop a structured community volunteer network including: • youth • Elders • families • community members. Volunteers will participate in: • planting • greenhouse maintenance • harvesting • chicken husbandry • produce distribution The volunteer program will support intergenerational knowledge sharing, strengthening cultural connections to food systems and land stewardship. 3. Food Distribution for Health Produce and eggs harvested through the program will support: • Elders’ Lunch Program • Fresh vegetables will be incorporated into meals to improve nutritional quality.	\$50,000-\$250,000	Home-and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

- School Meal Program

The program will provide fresh produce and eggs to Ya Ne Dah Ah School, supporting healthier meals for students and reinforcing food nutritional education.

Community Food Access

- Excess produce will also be distributed during community events and food distribution days.

4. Health Promotion and Chronic Disease Prevention

Access to fresh foods will be paired with education offered in collaboration with staff from CVTC's Health & Social Services

Department addressing:

- diabetes and chronic disease prevention
- heart health
- nutrition education
- healthy cooking practices

Activities may include:

- cooking/food preservation demonstrations
- nutrition workshops
- culturally relevant food education for youth.

These efforts will support long-term improvements in dietary behavior.

Chickaloon Native Village	Chickaloon Village Traditional Council Natural Disaster Emergency Preparedness Project	AK	Funding will support the purchase and distribution of emergency preparedness equipment to help households maintain essential services during power outages. Equipment may include generators, battery-powered medical devices, emergency heating supplies, and communication tools. These resources will prioritize vulnerable residents, including Elders, individuals with medical needs, and low-income households. Goals & Objectives • Goal 1: Improve power and heat security for individuals within CVTC's ANVSA jurisdiction. • Objective: Purchase and provide equipment to have on hand to provide temporary power to homes of vulnerable individuals on a loaner basis. • Goal 2: CVTC staff will inventory and maintain all equipment. • Objective: Readily available and well-serviced equipment will be housed at the Health & Social Services Department for distribution by CVTC emergency responders during power outages. • Goal 3: Create a preparedness group to create a sustained plan for emergency preparedness. • Objective: Integrate community knowledge and create roles and responsibilities for CVTC staff for emergency response in the event of a disaster.	CVTC’s ANVSA area includes individuals and families facing geographic isolation, limited infrastructure, and economic disadvantages. Many lack reliable transportation, access to nutritional meals, or consistent power in the event of dangerous weather conditions or natural disasters. The remoteness and sparse infrastructure create a challenge for local electrical providers to get power back on line after an event causing loss of power for many vulnerable individuals. In response to recent outages this winter, CVTC opened a shelter at the Ya Ne Dah Ah School; however, bringing vulnerable elders to the school for long periods of time was a great inconvenience to them. The ability to heat their homes on a temporary basis was a better solution; however, we only had a few units available and had to rotate them between several residences requiring significant work on behalf of our emergency responders. These challenges in securing elders in their homes safely can lead to preventable hospitalizations, safety insecurities, and increased stress for community and Tribal employees. Community Impact of Creating a Heating and Medical Equipment lending program. • Health and Safety: Ensures that medical facilities, clinics, homes of the disadvantages and emergency response systems can operate during outages. • Resilience: Supports the ability of the Health and Social Services Department to continue providing care to vulnerable community members. • Inclusion: Benefits Tribal citizens, Alaska Native, and Native American peoples in CVTC's ANVSA, including those without reliable backup power.	\$50,000- \$250,000	Home- and communit y-based services provider	Multi- Community or Participating in Regional Hub-and- Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Chickaloon Native Village	Chickaloon Village Traditional Council Technology Advancement and Innovation Project	AK	CVTC has developed a sophisticated telephone and enterprise network system that connects multiple facilities through a centralized Administration office. Aquos Board Interactive technology is currently used at the Ya Ne Dah Ah School, Administration Office, and Government building meeting space to support meetings, trainings, and collaborative learning. CVTC also maintains a strong Information Technology Department led by an Information Technology Officer with over 30 years of experience in network design and deployment who will manage this project. CVTC’s existing laptops, desktop computers, and tablets are outdated and no longer support the needs of modern service delivery. Aging equipment reduces staff efficiency, creates increased demand for IT support, and limits compatibility with current platforms. Additionally, the current phone system has not kept pace with staffing growth and it is outdated as well. The lack of modern interactive technology in the Tribal Court and Police Department also limits opportunities for training, collaborative learning, and virtual participation in education, health, and wellness programs for staff, youth, and community members. Updating these systems will strengthen CVTC’s ability to deliver efficient services, support safety through communication, and coordinate care across programs and departments.	CVTC proposes to replace outdated technology infrastructure by purchasing a new multi-line phone system to serve all brick-and-mortar facilities, along with new laptops, desktop computers, and tablets for staff across multiple service departments. These devices will support program administration, telehealth coordination, case management, community safety and service, and outreach activities. The project will also install two Aquos Board Interactive systems to support restorative justice court hearings, virtual meetings, staff training, and collaborative learning across departments and with partner agencies. CVTC staff will provide all orientation and training required for the new equipment within the first month of installation. Additionally, they will continue to provide ongoing technical expertise to ensure systems operate optimally. By modernizing its technology infrastructure, CVTC will improve internal and external communications, increase staff efficiency, and strengthen coordination of services across programs. These upgrades will also expand opportunities for partners and community members to participate in remote delivery of services, education, health and wellness programming for community members in rural areas.	\$250K-\$1M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Chickaloon Native Village	Ya Ne Dah Ah School Legal Status and Technical Transformation Project	AK	The Ya Ne Dah Ah School, founded in 1992, is a multi-age learning center located north of Palmer serving students from preschool through high school. Many of our students struggle in traditional school environments due to social-emotional and health-related challenges that require individualized learning plans and flexible teaching approaches. Technology has become an essential tool in supporting these diverse learning needs. Preschool students use educational apps on iPads to build early math and literacy skills and ensure kindergarten readiness. Students in kindergarten through 12th grade utilize Chromebooks to access math and language arts curriculum through our educational partner, the Mat-Su Central School District. However, much of our current technology is aging and failing. Funding will support the purchase of new Chromebooks, iPads, staff computers, and equipment for existing smartboards, ensuring reliable access to digital learning tools. Additionally, establishing the Ya Ne Dah Ah School as a 501(c)(3) nonprofit will allow us to access private funding opportunities, strengthening long-term sustainability for educational, cultural, and wellness programming in our community.	Chickaloon Village Traditional Council (CVTC) will implement this project using existing internal capacity and established professional partnerships to ensure efficient project execution. CVTC’s Information Technology staff will procure, configure, and deploy all technology purchased through this project. Equipment will be purchased through existing government contracts with Dell and Apple to ensure competitive pricing and reliable procurement. All technology purchases will be completed within one month of receiving notice of funding. Following procurement, CVTC's Information Technology staff will configure and prepare all devices for classroom use. The new Chromebooks, iPads, and smartboard support computers will be fully deployed in time for the 2026–2027 school year beginning in August 2026, ensuring students and teachers have reliable technology for instruction. In parallel, Chickaloon Village Traditional Council will initiate the process of establishing the Ya Ne Dah Ah School as a 501(c)(3) nonprofit organization. Upon notice of award, CVTC's Executive Officer will contract with Sonosky, Chambers, Sachse, Miller & Monkman, LLP to provide legal expertise in preparing and filing the necessary documentation for nonprofit status. The Council’s Finance Officer will also engage an experienced tax professional to assist with establishing financial reporting systems and compliance requirements associated with nonprofit operations. Finally, internal policies and procedures will be developed by CVTC Administration and Accounting staff to ensure ongoing compliance with nonprofit governance, financial reporting, and annual filing requirements. These steps will position the Ya Ne Dah Ah School for long-term operational sustainability and expanded access to funding opportunities.	\$50,000- \$250,000	Home- and communit y-based services provider	Multi- Community or Participating in Regional Hub-and- Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Chickaloon Village	Chickaloon Village Mat-Su Recovery Access and Outpatient Center	AK	The Mat-Su continues to face major gaps in timely, coordinated, and culturally responsive behavioral health and substance use services. The CHNA explains that residents are experiencing increased mental health concerns, inability to afford the cost of care and/or insurance, and limited provider availability for primary, specialty, and behavioral health care. The CHNA also reflects a long-standing need for a stronger behavioral health continuum, better local access, and more coordinated systems that address addiction and recovery resources. CVTC proposes to address this need through the Chickaloon Village Mat-Su Recovery Access and Outpatient Center, a recovery services project, based in Palmer and serving the broader Mat-Su Borough. CVTC proposes that our Recovery Services Department be expanded to lead a culturally grounded recovery access, assessment, outpatient treatment, and care coordination model for adults and families impacted by substance use and co-occurring behavioral health needs. This project is both a service expansion and a systems-building opportunity. It will expand local access to intake, screening, assessment, counseling, peer support, recovery case management, and coordinated referral pathways while also building the staffing, infrastructure, partnerships, and billing readiness needed for long-term sustainability.	CVTC will establish the Chickaloon Village Mat-Su Recovery Access and Outpatient Center in Palmer to expand access to outpatient behavioral health and substance use recovery services for residents of the Mat-Su. CVTC proposes that our Recovery Services Department be expanded to lead a culturally grounded recovery access, assessment, outpatient treatment, and care coordination model serving Tribal and non-Tribal residents with a particular focus on rural residents, Alaska Native and American Indians, and individuals facing transportation, cost, and system-navigation barriers. The project has six core components. First, CVTC will secure and equip leased commercial space in Palmer to provide an accessible, appropriate, and welcoming outpatient service setting. Second, CVTC will recruit, hire, and support a multidisciplinary team capable of providing intake, screening, assessment, counseling, recovery case management, peer support, cultural recovery supports, billing, and administrative functions. Third, CVTC will establish the operational infrastructure necessary for long-term success, including Electronic Health Record (EHR) workflows, telehealth capability, billing, credentialing readiness, data collection, quality assurance, and referral tracking. Fourth, CVTC will provide direct services including intake, comprehensive assessment, individualized treatment and recovery planning, individual and group counseling, case management, peer support, family engagement, and coordinated referrals to higher levels of care when needed. Fifth, CVTC plans to partner with CITC on this project to strengthen service development, workforce support, care coordination, referral pathways, and reimbursement readiness, while also coordinating with other referral, workforce, and service partners as appropriate. Sixth, the program will incorporate culturally grounded recovery planning, family-centered support, and community connection that reflect Chickaloon’s values and respond to the needs of Alaska Natives and American Indians in our service area.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Chickaloon Village	Chickaloon Village Mat-Su Diversion, Reentry, and Wellness Navigation Program	AK	The Mat-Su continues to face major gaps in coordinated behavioral health, recovery, and stabilization services, especially for people whose needs intersect with the justice system. The CHNA emphasizes the need for coordinated systems that connect residents to behavioral health, addiction, recovery resources, basic needs, transportation, and work, and notes that the behavioral health continuum of care has remained a major concern for years. At the same time, Alaska’s Civil Diversion Agreement model has shifted from law-enforcement-led to prosecutor-led diversion to support more diversions to Tribal courts. The agreement materials also note that Tribal remedies may be used in lieu of state prosecution for certain eligible offenses and may include restorative justice hearings and circle sentencing. In addition, Chickaloon has recently been contacted by the Department of Corrections (DOC) regarding reentry support and by the Department of Law (DOL) regarding possible work diversion monitoring in the Anchorage and Mat-Su area. CVTC proposes to address these needs through the Chickaloon Village Mat-Su Diversion, Reentry, and Wellness Navigation Program by leading a culturally grounded model for adults involved in Tribal court, referred through state diversion pathways, participating in work diversion, or returning from state incarceration, creating a pathway from justice involvement into stabilization, accountability, healing to wellness supports, and recovery-oriented services.	CVTC will establish the Chickaloon Village Mat-Su Diversion, Reentry, and Wellness Navigation Program through the Judicial Services Department to expand access to coordinated behavioral health, recovery, wellness, and stabilization pathways for justice-involved adults in the Mat-Su. The project will serve Tribal and non-Tribal residents, focusing on rural residents, Alaska Native and American Indian populations, and individuals whose justice involvement is connected to behavioral health, substance use, unstable living conditions, transportation barriers, unemployment, or limited access to care. This includes adults involved in Tribal court, referred through state diversion pathways, participating in work diversion, and reentering the community from state incarceration. The project has six core components. First, CVTC will build a judicial-services-based intake, screening, and navigation process for adults referred through diversion, work diversion, and reentry pathways. Second, CVTC will develop staffing and workflows to support assessment, case coordination, compliance monitoring, reentry planning, employment support, and referral follow-up. Third, CVTC will create core program infrastructure, including case tracking, referral coordination, data collection, interagency communication, and documentation practices that support accountability and continuity of care. Fourth, CVTC will provide direct supports, including diversion intake, reentry planning, individualized wellness and accountability plans, court-based monitoring, community accountability pathways, and navigation. Fifth, CVTC will recruit and formalize coordination with DOL, DOC, the Chickaloon Village Mat-Su Recovery Access and Outpatient Center, and other partners to support referrals, transition planning, work diversion implementation, and continuity of care. Sixth, the program will incorporate culturally grounded remedies, restorative approaches, healing to wellness principles, family and community connection, and recovery-oriented pathways that reflect Chickaloon’s values and respond to Alaska Native and American Indian populations in the service area. This project is designed to create a reliable pathway that connects judicial services, recovery services, and community supports. It is also designed to strengthen long-term sustainability by creating a more consistent referral funnel into treatment, case management, peer support, outpatient care, and related services as those systems mature.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Chickaloon Village	Chickaloon Village Mat-Su Youth and Family Wellness Access Center	AK	The Mat-Su continues to face major gaps in coordinated behavioral health care for children, youth, and families. The CHNA emphasizes that coordinated systems are needed to address behavioral health and promote healthy foundations for children and families, and it identifies children and families, and the behavioral health continuum of care as ongoing priorities. Community input specifically notes that children affected by the opioid crisis are being left behind, that counseling can take 6–8 months, and that families need more coordinated, affordable, and culturally aware mental health care. The CHNA also shows that school-based behavioral health is already a viable and growing model in the Mat-Su. Sunshine Community Health Center’s Behavioral Health in Schools program is able to bill for some services and serves 15 schools and more than 400 students annually. That creates a clear opportunity to build a Chickaloon-centered youth and family behavioral health model with stronger long-term sustainability. CVTC proposes to address these needs through the Chickaloon Village Mat-Su Youth and Family Wellness Access Center. Our Family Services Department would lead a culturally grounded model that creates a structured pathway from family stress, youth behavioral health needs, victimization, child welfare involvement, or school/community referral into screening, stabilization, counseling, family support, and longer-term wellness services.	CVTC will establish the Chickaloon Village Mat-Su Youth and Family Wellness Access Center through the Family Services Department to expand access to coordinated behavioral health, family stabilization, and wellness pathways for children, youth, parents, caregivers, and families in The Mat-Su. The project will serve Tribal and non-Tribal residents, with a focus on rural residents, Alaska Native and American Indian populations, children and youth with behavioral health or substance use concerns, and families facing trauma, transportation barriers, poverty, child welfare involvement, victimization, or limited access to care. The project has six core components. First, CVTC will build a family-centered intake, screening, assessment, and navigation process for children, youth, and caregivers referred through Family Services, schools, community partners, victim services, Indian Child Welfare Act (ICWA), child welfare, Youth Program, Native Youth Olympics (NYO), Raising Youth Success (RYS), 477, and Culture Camp pathways. Second, CVTC will develop staffing and workflows to support child and family assessment, individual counseling, family therapy, group services, behavioral health case management, family support, and referral follow-up. Third, CVTC will create core program infrastructure, including documentation practices, billing and credentialing readiness, telehealth capability, case tracking, quality assurance, and data systems. Fourth, CVTC will provide direct services, including screening, intake, comprehensive assessment, individualized care plans, youth counseling, family counseling, caregiver support, case management, and coordinated referral to higher levels of care when needed. Fifth, CVTC will formalize coordination with schools, early childhood and family partners, Southcentral Foundation, referral providers, and internal coordination with Judicial Services and Recovery Services where cross-referral is appropriate. Sixth, the program will incorporate culturally grounded family support, identity, connection, family healing, and community-based wellness pathways that reflect Chickaloon’s values and respond to Alaska Native and American Indian children and families in the service area. This project is designed to create a reliable pathway that connects family services, behavioral health, community supports, and long-term wellness. It's also designed to strengthen sustainability by creating a billable and coordinated youth and family program.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Chignik Bay Tribal Council	Chignik Sub-Region Health Systems Planning and Youth Environmental Health Initiative	AK	The Chignik sub-region — five communities (Chignik Bay, Chignik Lagoon, Chignik Lake, Ivanof Bay, and Perryville) in the Lake and Peninsula Borough — faces a convergence of urgent, unaddressed health system threats. All five communities are off the road system, reachable only by small aircraft or boat. Health care depends entirely on a single sub-regional clinic, yet the foundations that enable that clinic to function are deteriorating. Provider recruitment is undermined by the absence of adequate housing — a barrier so fundamental it prevents the community from sustaining minimal staffing. The clinic is physically threatened by coastal erosion, with no engineering assessment or protection plan in place. There is no local healthcare workforce pipeline, leaving the sub-region perpetually dependent on outside providers who are difficult to recruit and harder to retain. The community's youth have no access to programs connecting environmental health to their wellbeing, despite living in a subsistence-dependent environment where Harmful Algal Blooms, shifting ecosystems, and contamination pose direct and growing health risks. Each gap is serious in isolation. Together, they describe a health system without the infrastructure to sustain itself. This project addresses all four through targeted planning and youth programming that will position the Chignik sub-region for transformative investment in future funding cycles.	This project has four distinct but complementary components, each addressing a foundational gap in the Chignik sub-region's health system. Youth Environmental Health Literacy Program. Operating out of the existing Tribal Building in Chignik Bay and open to youth from all five sub-regional communities, this program delivers structured health education connecting environmental conditions to individual and community health outcomes. Core topics include how Harmful Algal Blooms and paralytic shellfish poisoning threaten subsistence food safety, how climate-driven ecosystem changes create new health risks, and how environmental stressors affect physical and mental wellbeing. Provider Housing Plan. RHTP funding will support engagement of a qualified planning consultant to assess provider housing needs and options in Chignik Bay, evaluate existing housing stock, develop financial feasibility analysis, and produce an implementation-ready plan for submission in a future capital funding cycle. Clinic Erosion Protection Plan. The Harris Subregional Clinic — the only healthcare facility serving the sub-region — is threatened by active coastal erosion. RHTP funding will support an engineering assessment documenting the current threat, evaluating protective infrastructure options, developing cost estimates, and producing a pre-development plan to support future capital funding applications. Healthcare Workforce Training Plan. RHTP funding will support a planning process to design a locally grounded healthcare training pathway for sub-regional community members. The plan will assess community interest, identify viable certification pathways including Community Health Aide/Practitioner, Behavioral Health Aide/Practitioner, EMT, Emergency Trauma Technician, First Responder, and other allied health roles, develop a partnership framework with BBAHC and training institutions, and produce an implementation-ready workforce pipeline plan for future funding.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Lake and Peninsula Borough	Deferred or Not Advanced

Chilkat Indian Village	Klukwan Emergency Fire Response Initiative	AK	Village residents in Klukwan are often the first to respond when emergencies occur, stepping forward to protect their community. However, our community currently lacks the equipment, training, and organized response capacity necessary to safely respond to structural fires. Many structures in the Village contain large amounts of Class A combustible materials, allowing fires to spread rapidly before outside assistance can arrive. Response from outside the community may take 30 minutes to an hour and is not guaranteed. In a small rural community, a single structure fire can quickly escalate into a life-threatening emergency and result in the loss of multiple homes. Despite these risks, Klukwan possesses a strong foundation for building local response capacity. Community members have expressed interest in organizing a volunteer responder team, and the Village has already begun investing in fire safety equipment, including approximately \$90,000 in self-contained breathing apparatus (SCBA). This project represents an opportunity to support and equip the community members who already step forward during emergencies, allowing Klukwan to build a safe, organized, and sustainable structural fire response capability.	CIV proposes to establish a Village-based structural fire response capability designed for the scale and needs of the community of Klukwan. This effort builds upon the longstanding reality that Village residents are often the first to act when emergencies occur. CIV is coordinating a community-led initiative to organize and support these responders while ensuring they have the equipment, training, and safety infrastructure necessary to respond effectively to structural fires. Funding through the Rural Health Transformation Program would catalyze the development of this program by allowing CIV to equip and train a local responder team composed of community members who have expressed interest in protecting the Village. The project builds upon existing community investments in fire safety equipment, including approximately \$90,000 in self-contained breathing apparatus (SCBA), and local technical expertise available within the Village to support responder organization, equipment planning, and training coordination. This effort also represents an important step in developing a local emergency response workforce in Klukwan. By training community members in structural firefighting and emergency response protocols, the project builds practical skills and creates pathways for community members to develop emergency service capabilities that are critically needed in rural Alaska. Further, this creates pathways future emergency service roles within the Village. Project activities will focus on establishing the foundational elements of structural fire response capacity. This includes procuring structural firefighting apparatus and safety equipment guided by National Fire Protection Association (NFPA) 1901 standards, acquiring turnout gear for community responders, and providing foundational structural firefighting training. CIV will also work with responders to develop response protocols appropriate for a small rural community and to formally organize the Village responder team. While the immediate focus of this project is structural fire response, this effort represents the first phase of building broader emergency response capacity within Klukwan over time. By organizing and equipping the community members who already step forward during emergencies, the project will establish a safe, sustainable Village-based response capability that strengthens protection of life, housing, and community health.	\$1M-\$5M	Single Community	Haines Borough	Deferred or Not Advanced

Chilkoot Indian Association	Chilkoot Indian Association Workforce Childcare Stabilization Initiative	AK	Haines is a frontier Alaska community experiencing healthcare workforce strain compounded by limited childcare access. The community currently has only one licensed in-home infant provider, with a documented waitlist of nine infants. Healthcare employees in Haines report difficulty securing reliable childcare, creating barriers to recruitment, retention, and workforce stability. In small rural systems, the loss or delayed recruitment of even one provider can significantly affect appointment availability and continuity of care. As healthcare infrastructure expands locally, workforce support systems have not kept pace. The Chilkoot Indian Association (CIA), a federally recognized tribal government, owns a building with the potential to house licensed childcare services. While structural rehabilitation funding is being pursued separately, there is an immediate opportunity to develop a workforce-supportive childcare model designed to address childcare-related barriers to healthcare employment. By advancing planning, program design, and implementation readiness for a tribally operated childcare facility, this project seeks to strengthen rural workforce stability and support reliable healthcare access for residents of Haines.	CIA will implement a phased Rural Health Workforce Childcare Stabilization Initiative designed to address childcare-related barriers affecting healthcare workforce recruitment and retention in Haines. Structural rehabilitation of a tribally owned building, including foundation and roof repair, is contingent upon separate capital funding currently being pursued. RHTP funds will not be used for major construction activities. RHTP investment will support planning, program design, and workforce-aligned implementation readiness activities necessary to establish a licensed childcare program serving healthcare and essential service workers. Key activities include: • Conducting a childcare demand assessment focused on healthcare and essential service workers • Developing a culturally grounded early childhood curriculum that incorporates local cultural knowledge and values • Interior childcare space planning aligned with licensing requirements and child development best practices • Designing an ADA-accessible outdoor playground space; currently there are no ADA-accessible playgrounds in the Haines community • Developing childcare safety plans and operational policies • Completing licensing preparation and regulatory compliance planning • Establishing a contract for nutritious meal services to support daily childcare operations • Developing a childcare workforce recruitment and staffing model • Establishing evaluation metrics to measure workforce stabilization impacts Through these activities, CIA will establish a childcare program that integrates cultural identity, accessibility, and safety while supporting workforce stability. By sequencing planning and program design prior to facility readiness, the project ensures that once structural rehabilitation is completed, childcare services can be launched efficiently and sustainably. This initiative aligns with Alaska’s Strengthen Workforce and Health Care Access priorities by addressing childcare access as a key barrier to workforce participation in rural communities.	\$1M-\$5M	Single Community	Haines Borough	Advance to Implementation Application

Christian Health Associates	Expanding the Healthy Smiles Forever Model of On-site Oral Healthcare to Rural LTC Facilities	AK	Delivery of adequate oral care to residents in long-term care (LTC) facilities has been neglected in the United States, including Alaska. It is very difficult for most residents in these facilities to be transported to obtain dental treatment. Many private dental practices cannot accommodate patients with these physical and mental disabilities. Lack of oral hygiene or clean dentures can lead to a proliferation of oral bacteria. Along with other conditions seen in the LTC populations, this increases the risk for aspiration pneumonia and may add complications to many other systemic diseases. Based on projections from the Alaska Department of Labor and the U.S. Census Bureau, Alaska's 65+ population has increased from 70,889 in 2015 to 118,725 in 2025 and is projected to reach 134,849 by 2035. This project will provide oral care in the growing elder population on-site in LTCs. This project fits into the state's initiative: Expanding and maintaining access to essential health services in rural, remote and frontier communities. Specifically the project fits into the category: maximizes care close to home by expanding access to primary, behavioral and oral health care within integrated systems. This project also fits under the potential use of funds to deploy mobile dental clinics and expand access to remote and frontier health options.	Healthy Smiles Forever is a model that is successful in 5 sites in Anchorage and the Mat-Su Valley. It has been operating for 10 years. The oral health clinics provide on-site care. The benefits include: - Critical services to underserved seniors and disabled individuals provided close to home. - Reduced need to transport patients that have significant mobility issues. (Ex. need Hoyer lift) - Clinical providers with expertise in geriatric treatment. - Reduced cost to facilities. - Increased preventive care. - Improved systemic health with improved health care for residents. - Partnership with medical care providers for improved overall health. - Training for long-term care (LTC) staff on providing routine oral health care for residents. - Improved quality of life for residents in ways as simple as being able to enjoy eating their meals or being able to smile and talk with others when dental needs are met. - Expertise in recruiting and hiring providers to serve this population group. This project will help to develop on-site oral health clinics in LTC facilities outside of Anchorage, initially expansion to 5 rural sites, with the possibility of future expansion to all nursing homes in Alaska. The planning steps will include: - Develop a template for expansion, including recommendations for clinical space, equipment, supplies, staffing, recruitment, billing, LTC staff training. - Analyze the best structure for expansion (one organization with many sites, independent sites, etc.) - Develop recruitment strategies. - Study improved reimbursement process from Medicaid and other insurers. - Hire a project manager. - Meet with partners and interested parties to expand the existing multi-disciplinary work group. - Hire consultants for space evaluation, accomplishing project goals, etc. as needed. - Purchase improved technology for existing sites (scanner for 3-D dentures, cloud-based billing system, etc.)	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Matanuska-Susitna Borough	Advance to Planning

Christian Health Associates	Anchorage Project Access - Project REACH: Reducing Equity Gaps in Access to Care and Health Outcomes	AK	As of early 2026, more than one in 10 Alaskans (approximately 73,300 residents based on recent data) are without health insurance. Alaska has one of the highest uninsured rates in the nation. This high uninsured rate is compounded by the expiration of enhanced premium tax credits and potential new work requirements for Medicaid. Alaskans lack access to specialty care due to the high cost of health insurance and limited plan options in Alaska. Other barriers include the high cost of health care, extensive wait times, difficulty navigating complex systems of care, transportation barriers, language barriers, and a lack of outreach to rural populations regarding donated specialty care in Anchorage. Limited access to affordable health insurance results in a lack of access to life-saving and essential specialty medical, dental, and mental health care, often resulting in health conditions progressing to higher acuity levels, protracted courses of treatment, overutilization of hospital emergency departments or crisis centers, sustained ill health, and the inability to meet family obligations, maintain employment, and achieve financial solvency and optimal health. Alaskans suffer from high rates of cancer, obesity, heart disease and diabetes. If specialty health care is provided earlier in a person’s health journey, health issues may be resolved, hospitalizations can be avoided, and patients have their health and hope restored in order to achieve optimal health.	Project REACH will increase access to life-saving donated specialty medical, dental, and mental health services for uninsured or underinsured Alaskans and improve health outcomes for patients enrolled in APA’s efficient and effective system of care. Project REACH will expand access to APA’s network of over 850 committed volunteer specialty doctors, dentists, licensed therapists, and ancillary care providers, centrally located in Anchorage, by increasing outreach to health clinics in outlying communities. APA serves residents across the state in the hub communities of Anchorage and the Mat-Su Valley. No cost mental health services are offered virtually to all areas of Alaska. Project REACH allows APA to specifically connect with over 100 health care clinics across Alaska to increase referrals to APA’s donated specialty health care program. By increasing APA’s outreach to rural communities, and expanding the capacity to serve uninsured Alaskans, APA will maximize primary care providers’ ability to connect rural residents with donated specialty care. For over 20 years APA has provided Alaskans with critical health problems with life-saving donated specialty health care services. Project REACH will increase capacity by adding a full-time Patient Care Coordinator and a full-time Community Access and Engagement Specialist to APA’s current direct service team allowing the program to meet the rapidly increasing need for donated care services across Alaska. APA’s Project REACH strengthens Alaskans’ lifelong health and well-being, provides outcome-driven health care systems, and increases workforce development and innovation. Project REACH achieves these goals through the following initiatives of the RHTP program: Healthy Beginnings - serving Alaska’s pregnant and postpartum women, infants and children Health Care Access – increasing Alaskans’ access to primary, behavioral, oral, specialty, home and community-based health services across rural communities for patients ages newborn to seniors Healthy Communities – investing and enhancing access to preventive and primary care services that enable early chronic disease management and improve population health Strengthen Workforce – developing and retaining direct service health care professionals through employment and training Spark Technology and Innovation – enhancing telehealth, facilitating data sharing and system interoperability, and testing new delivery modalities using emerging technologies.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Christian Health Associates	Anchorage School Based Health Centers: Increasing healthcare access for students	AK	ASBHC increases healthcare access so students can succeed at school and in life. We operate five school-based clinics and three itinerant sites in Anchorage. This project addresses two gaps: limited access to care at Romig Middle School and limited capacity to identify and manage chronic disease risk. Romig is the largest middle school in Alaska and serves a diverse student population with significant healthcare needs. Because the building is overcrowded and space has been unavailable, ASBHC has only provided itinerant services, reaching fewer than 30 students per year. Although consistent services began at adjacent West High School in fall 2025, the space has not supported practical access for Romig students. As a result, many—particularly those who face barriers to community care—lack consistent access to comprehensive, school-based services. Student data show a need for earlier identification of chronic disease risk. While ASBHC collaborates with school nurses to provide urgent care, most visits are comprehensive wellness exams for students who otherwise lack primary care. In 2025, nearly 25% of students seen were identified as at risk for cardiovascular disease or diabetes based on BMI and/or blood pressure. The clinic lacks point-of-care testing to fully assess and manage these risks. Expanding access at Romig and strengthening screening at all sites will improve student health outcomes and long-term well-being.	Rural Health Transformation Program funding will support two coordinated strategies. First, beginning in the 2026–27 school year, ASBHC will expand consistent services to a shared Romig/West clinic location. School administration has identified appropriate space that will allow regular access for Romig students and improved collaboration with the Romig school nurse, while continuing services for West students. Funding will support staffing the site at least one day per week, increasing as demand warrants. No additional supplies are required for this expansion. Second, ASBHC will implement point-of-care testing to strengthen identification and management of obesity- and diabetes-related risk during comprehensive wellness exams. Funds will support purchase of newly released testing equipment and supplies, development of clinical protocols, staff training, and the first year of implementation. Parent consent forms have been reviewed by legal counsel and will be incorporated into Anchorage School District online registration for 2026–27. A vendor bid has been secured. On-site testing will allow providers to deliver immediate education, monitor trends, make informed referral decisions, and coordinate care with families and community specialists. Students identified as at risk will receive case management and follow-up to ensure continuity of care. Together, these strategies expand access, strengthen preventive services, and improve long-term health trajectories for students.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

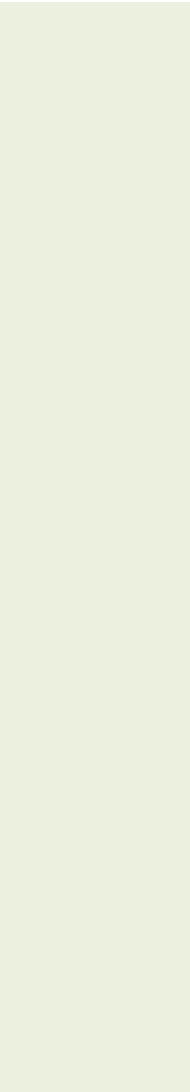
Christian Health Associates	Cornerstone Health Counseling Telehealth and Counselor Training	AK	Living in rural Alaska presents challenges to receiving needed behavioral health services, including geographic isolation, limited service availability, social stigma and high-stress work. Many in rural areas of Alaska live miles from the nearest health center. Others are unable to continue established therapy while working seasonally in rural areas. Existing clinics experience staff shortages, and behavioral health providers in Alaska feel stressed by heavy workloads.	Cornerstone Health Counseling employs 10 licensed therapists, including psychologists, licensed professional counselors, clinical social workers and licensed marriage and family therapists. Cornerstone also has therapists trained in substance misuse. Cornerstone provides training and supervision for master-level therapists working towards licensure. This supervision is a required step towards licensure. Most of these supervisees go on to provide behavioral health services throughout Alaska, while some continue at Cornerstone. Cornerstone serves clients from Anchorage and the Mat-Su Valley through in-person visits and also serves a limited number of clients in rural areas via telehealth visits. With a limited investment in equipment, personnel and engagement tools, Cornerstone will expand its telehealth services to serve more people in rural Alaska. Cornerstone will also continue to train and supervise therapists working towards licensure to mitigate the staffing shortages in behavioral health.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Chugach Regional Resources Commission	Alutiiq Pride Traditional Foods Wellness Hub: Healthy Food Complex Readiness & Compliance	AK	Rural and frontier communities in the Chugach region face persistent barriers to healthy eating and wellness, including high food costs, seasonal supply disruptions, and limited local infrastructure for safe storage, handling, and culturally grounded nutrition education. In 2021, CRRC acquired three 40-foot food infrastructure containers (freezer, game processing, and controlled-environment unit) to strengthen food security, but the funding covered purchase/delivery only—not design, permitting, site preparation, or utility connections—so the assets remain temporarily placed, not fully code-compliant, and underutilized. This project opportunity is to convert those existing assets into a sustainable, year-round wellness and healthy eating platform that advances prevention, self-determination, and community resilience.	CRRC will advance the Alutiiq Pride Traditional Foods Wellness Hub at our Alutiiq Pride Marine Institute (APMI) campus in Seward as a “Healthy Communities” wellness-center platform focused on healthy eating and lifestyle change. During the project period, CRRC will complete A/M/E (as needed), permitting and compliance planning, and construction-ready design for long-term, code-compliant operation of the three containers, including a clear pathway for permanent siting and utility connections. In parallel, CRRC will implement allowable minor upgrades and equipment needs that enable reliable nutrition education, cooking classes, Traditional Foods programming, and safe cold storage/handling.	\$50,000-\$250,000		Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Kenai Peninsula Borough	Deferred or Not Advanced
Chugachmiut	Expanding Rural Access to Comprehensive Behavioral Health Services	AK	Alaska faces a shortage of accessible behavioral health and neurodevelopmental services, particularly in rural and remote communities. Families often experience long wait times for psychological evaluations, autism and fetal alcohol spectrum disorder (FASD) diagnostics, therapy, and specialized interventions. Limited provider availability, geographic isolation, and fragmented care systems make it difficult for individuals to receive timely and coordinated support. As a result, many families must travel out of state, creating financial burdens and delays in care. These gaps are especially evident among individuals entering intensive outpatient treatment programs, including Recovery Camp, where participants frequently present with complex co-occurring conditions such as trauma, substance use disorders, neurodevelopmental conditions, and cognitive impairments. Without comprehensive diagnostic assessment, these underlying conditions may go unidentified, resulting in incomplete treatment planning and increased risk of relapse or repeated levels of care. This project would establish a multidisciplinary program that provides assessments, autism and FASD diagnostics, therapy services, and case management for children, adolescents, and adults across Alaska. By expanding access through both telehealth and in-person visits, the program will reduce travel burdens, improve care coordination,	Our proposed approach addresses the critical shortage of behavioral health diagnostic and treatment services in Alaska through a comprehensive, multi-disciplinary program that integrates psychological, neurodevelopmental, and physical health services under one coordinated model. The program will provide timely assessments for autism, FASD, ADHD, learning differences, mood disorders, and other neurodevelopmental conditions, reducing the need for out-of-state travel and improving access for rural communities. A team-based model will guide care, bringing together a psychologist, psychiatrist, psych registered nurse, behavioral health clinician, speech and language pathologist, occupational therapist, physical therapist, and administrative and billing support staff. Providers will conduct comprehensive psychological, neurophysical, and developmental testing to identify cognitive, emotional, behavioral, and neurological needs, and collaborate to create unified, evidence-based, culturally responsive, client-centered treatment plans. The assessment team will be based on the Chugachmiut Regional Health Center in Seward, providing in-person and telehealth consultations, assessments, and clinical services. Family-centered support will be a key component, including counseling, parent education, and group services designed to strengthen the home and community functioning. Behavioral analysis will support autism services and case management, while speech, language, and physical therapy services will address developmental needs. RHTP funding in year one will support the recruitment and hire of up to nine clinical provider and support staff, HIPAA-compliant telehealth hardware and software, occupational and physical therapy equipment and sensory tools, clinical assessment tools, and office equipment.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Kenai Peninsula Borough	Advance to Implementation Application

support earlier diagnosis and treatment, and significantly enhance outcomes.

Behavioral Health clinicians will receive specialized training in autism, FASD, PTSD, and trauma-informed care to deliver targeted counseling services. Future funding may be used to hire additional staff and expand service delivery as need dictates. Billing for reimbursable services starting year two will help sustain the program long-term.

The program will outreach to clinics and hospitals across Alaska to explain the service model, and will develop formal partnerships with tribal health organizations, schools, hospitals, community programs, and state agencies, establishing workflows for referrals, intake, consent, data tracking, and quality assurance.



Chugachmiut	Expanding Rural Access to Diagnostic Imaging Through Digital X-Ray Technology	AK	Rural Chugachmiut clinics serve geographically isolated communities where access to diagnostic imaging is limited or unavailable locally. Patients frequently must travel by small aircraft or boat to regional hospitals for basic imaging studies, creating delays in diagnosis and treatment and increasing healthcare costs. Limited access to timely imaging can delay identification of fractures, respiratory illness, infections, and other acute conditions, often resulting in unnecessary emergency referrals or medevac transport. These delays also place an additional burden on rural providers who must make clinical decisions with incomplete diagnostic information. This project addresses these challenges by equipping five rural clinics with portable digital X-ray systems that enable local imaging and secure transmission for interpretation. Expanding local diagnostic capabilities will reduce travel burdens, accelerate treatment decisions, and strengthen rural providers' ability to deliver safe, high-quality care close to home. The five clinics to receive the X-ray systems are the Chugachmiut Regional Health Center in Seward, the Arch Priest Nicholas Kompkoff Health Clinic in Chenega, the Anesia Anahonak Moonin Health Clinic in Port Graham, the Tatitlek Health Clinic, and the Nanwalek Health Clinic.	Chugachmiut Health Services proposes to acquire and deploy five digital X-ray systems across rural clinics serving geographically isolated Alaska communities. These portable digital radiography units are designed specifically for small or remote clinical environments and will enable on-site diagnostic imaging for patients who currently must travel long distances for basic imaging services. The systems will be integrated into existing clinic workflows and electronic health record infrastructure to allow imaging studies to be obtained locally and securely transmitted for radiology interpretation. This approach ensures that rural providers can rapidly access diagnostic information while maintaining continuity of care within the broader regional health system. Implementation will occur in several coordinated steps. First, equipment procurement and site readiness activities will ensure clinics have appropriate space, electrical capacity, and network connectivity for safe system operation. Next, installation and calibration will be completed in partnership with the equipment vendor. Clinical staff will receive structured imaging training through established education modules and hands-on instruction provided by Southcentral Foundation's Medical Imaging Training Coordinator. Training will include equipment operation, radiation safety, image quality standards, and clinical workflow integration. Cross-training of multiple staff members at each site will ensure ongoing operational continuity. Once deployed, the systems will support real-time or near-real-time image transmission to radiology interpretation services at Alaska Native Medical Center. This allows rural providers to receive timely diagnostic guidance and strengthens coordination between village clinics and regional specialty services. Quality assurance procedures will be incorporated into routine clinic operations to monitor image quality, utilization, and workflow efficiency. This implementation model maximizes the use of existing rural clinical infrastructure while expanding diagnostic capability in a safe, sustainable, and scalable manner. By bringing modern diagnostic imaging directly into rural clinics, the project strengthens frontline care delivery, reduces diagnostic delays, and improves rural providers' ability to manage urgent and chronic health conditions close to home.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Kenai Peninsula Borough	Advance to Implementation Application

Chugachmiut	Expanding Rural Access to Point-of-Care Laboratory Diagnostics	AK	Timely access to laboratory testing remains a significant challenge for rural Chugachmiut clinics serving geographically isolated Alaska communities. Many sites rely on laboratory specimens being transported to regional facilities for analysis. Weather disruptions, transportation limitations, and infrequent courier schedules often delay results by several days. These delays can postpone diagnoses and treatment for conditions such as diabetes complications, dehydration, renal dysfunction, electrolyte abnormalities, and infection. In some cases, providers must make clinical decisions without laboratory confirmation or request unnecessary patient travel to regional facilities. This project addresses the opportunity to expand point-of-care diagnostic capacity by equipping rural clinics with Piccolo Xpress Laboratory Analyzers. These analyzers enable essential chemistry testing to be performed on site during the patient visit, allowing providers to make faster and more informed clinical decisions while reducing dependence on off-site laboratory services.	Chugachmiut Health Services proposes to purchase and deploy five Piccolo Xpress Laboratory Analyzers across multiple rural clinic sites. The Piccolo system provides rapid, CLIA-waived chemistry testing using small sample volumes, making it well-suited for remote settings with limited laboratory infrastructure. The five clinics to receive the analyzers are the Chugachmiut Regional Health Center in Seward, the Arch Priest Nicholas Kompkoff Health Clinic in Chenega, the Anesia Anahonak Moonin Health Clinic in Port Graham, the Tatitlek Health Clinic, and the Nanwalek Health Clinic. Implementation will include equipment deployment, staff training, quality control procedures, and integration into existing clinical workflows. Providers will be able to perform chemistry testing during patient visits, allowing results to be reviewed immediately and incorporated into clinical decision-making. Staff will receive standardized training in equipment operation, specimen handling, quality assurance procedures, and documentation practices. Cross-training of multiple staff members at each clinic will ensure operational continuity and reduce disruption from staff turnover. Quality control and compliance procedures will follow established CLIA-waived testing standards. Routine monitoring will ensure accurate test performance, proper documentation, and ongoing staff competency. This approach allows rural clinics to expand diagnostic capabilities while leveraging existing workforce and infrastructure, reducing care delays and strengthening providers' ability to manage both acute and chronic conditions locally.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Kenai Peninsula Borough	Advance to Implementation Application

Chugachmiut	Nanwalek Rural Health Access and Workforce Stabilization: Clinic Renovation and Provider Housing	AK	Remote Alaska communities face persistent barriers to healthcare access due to geographic isolation, workforce shortages, and limited healthcare infrastructure. In Nanwalek, the Community Health Aide Program serves as the foundation of healthcare delivery; however, limited clinic infrastructure and lack of provider housing constrain the ability to expand services and maintain consistent visiting provider rotations. Without reliable housing, visiting physicians, dentists, and behavioral health clinicians must rely on temporary accommodations that limit the duration and frequency of clinical visits. This reduces continuity of care, delays access to services, and places increased pressure on CHA/P providers who serve as the community’s frontline healthcare workforce. The current clinic also lacks dedicated infrastructure required to support behavioral health counseling and dental services. Behavioral health services require private spaces to ensure confidentiality and effective treatment, while dental services require specialized equipment and appropriate clinical space. Renovating the Nanwalek Clinic provides an opportunity to strengthen healthcare infrastructure, expand integrated healthcare services, and stabilize the rural healthcare workforce. By improving facilities and providing housing for visiting providers, this project will increase local access to medical, dental, and behavioral health care while reducing reliance on costly medical travel outside the community.	Chugachmiut Health Services will renovate the Nanwalek Clinic to enhance healthcare delivery capacity and strengthen an integrated rural healthcare model that supports the CHA/P workforce. Project renovation components include: • Interior modifications of building interior space to create two on-site provider housing units to accommodate visiting physicians, advanced practice providers, dentists, behavioral health clinicians, and other specialists • Reconfiguration of clinic interior space to establish a dedicated behavioral health counseling room designed to ensure privacy and support confidential mental health and substance use treatment • Creation of a fully equipped dental treatment area capable of supporting preventive, diagnostic, and restorative dental services • Reconfiguration of existing clinical space to improve care coordination between CHA/P providers, primary care providers, dental clinicians, and behavioral health professionals • Infrastructure improvements required for safe clinical operations, including infection control standards and utilities necessary to support dental equipment The renovated facility will allow visiting providers to coordinate services with primary care visits, enabling patients to receive medical, dental, and behavioral health services during the same visit. This integrated care approach supports early intervention, improves continuity of care, and reduces unnecessary travel for services that can be delivered locally. Chugachmiut will coordinate closely with tribal leadership, community representatives, and rural construction partners to ensure the project reflects community priorities and can be implemented efficiently within the logistical constraints of a remote Alaska village.	\$1M-\$5M	Clinic	Single Community	Kenai Peninsula Borough	Advance to Implementation Application

Chugachmiut	Prince William Sound and Lower Kenai Tribal EMS Workforce & Sustainability Demonstration	AK	Rural communities in Chenega, Tatitlek, Port Graham, and Nanwalek face persistent barriers to timely emergency medical care due to geographic isolation, severe weather, limited transportation access, and declining volunteer responder capacity. The four communities collectively serve nearly 600 residents and rely on only 1–2 active Emergency Trauma Technician responders to maintain local emergency response coverage. Historically, emergency responses depended on small volunteer groups, but workforce turnover, inconsistent training, and increasing regulatory requirements have made this model fragile and difficult to sustain. Without stable, licensed EMS services, these communities face delayed response times, inconsistent coverage, air transport, and preventable escalation of emergencies before transport can occur. Limited leadership structure, standardized equipment, and billing capacity further constrain long-term system stability. This project demonstrates a scalable rural EMS transformation model that replaces instability with licensed operations, local leadership, and fiscal sustainability. Establishing EMS Leads in each community and embedding services within a coordinated regional system creates a regional framework that can support coordinated EMS system development across rural Alaska. The initiative supports statewide priorities to strengthen EMS capacity through workforce training, improved patient assessment and triage, and stronger emergency response coordination.	Chugachmiut Health Services will implement a phased, regionally coordinated approach to modernize EMS across Chenega, Tatitlek, Port Graham, and Nanwalek. The project establishes a hub-and-spoke model anchored by EMS Leads in each community, shared clinical oversight, and standardized operational systems while preserving local response capacity. Key components include: Community-Based EMS Leadership: Dedicated EMS Lead positions will be established in each village to manage training coordination, quality assurance, licensing compliance, and operational continuity. This leadership structure strengthens tribal governance and creates a framework that can serve as a model for other regions, avoiding the need for additional state-level administrative structures. • Standardized Equipment and EMS-Specific Connectivity: Deployment of modern EMS equipment and portable and vehicle-mounted communication devices used solely for licensed emergency response and telemedicine consultation. These tools support real-time clinical coordination and may also be utilized for remote skills refreshers and high-fidelity simulation-based training to sustain competency in isolated environments. Connectivity investments exclusively cover EMS-specific equipment, excluding community broadband or telecommunications infrastructure construction or expansion. • Structured Workforce Advancement: Expansion of Emergency Trauma Technician (ETT), CPR, and continuing education pathways to build responder capacity and establish advancement into EMT and Advanced EMT (AEMT) certification. Ongoing continuing medical education (CME), mentorship, and leadership development create a defined workforce pipeline into Community Health Aide and allied health programs. This “grow-our-own” workforce strategy strengthens long-term rural health capacity by creating pathways for local residents, including students in mentored school programs, to enter the healthcare workforce through EMS training. • Operational and Fiscal Integration: Formalization of Incident Command, documentation, quality assurance, and billing systems aligned with state regulatory requirements and reimbursement standards, ensuring financial sustainability and ease of replication. This approach emphasizes administrative simplicity, tribal governance, and modular system design. The framework intentionally allows phased regional expansion by leveraging existing licensing, reimbursement, and health system infrastructure.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Kenai Peninsula Borough	Advance to Implementation Application

Chugachmiut	Strengthening Rural Alaska Dental Access Through In-Clinic Digital Dentistry	AK	Rural communities served by Chugachmiut Health Services face significant barriers to timely access to custom dental appliances such as crowns, night guards, and other patient-specific devices. Currently, most appliances must be fabricated by off-site dental laboratories located in Anchorage or other urban centers. This process requires physical impressions, shipping, and multiple patient visits, resulting in extended turnaround times and delays in care. For patients in remote communities such as Chenega, Tatitlek, and Nanwalek, access to dental care is further limited by weather-dependent transportation, high travel costs, and infrequent provider availability. These barriers can lead to missed follow-up appointments, delayed treatment completion, and worsening oral health conditions. Rural and Alaska Native populations experience these access challenges disproportionately. This project presents an opportunity to strengthen rural dental care capacity by implementing digital dental scanning and 3D printing technology directly within Chugachmiut clinics. Local fabrication of dental appliances will reduce reliance on distant laboratories, shorten treatment timelines, reduce patient travel, and support more timely, equitable access to essential dental services for rural patients.	Chugachmiut Health Services proposes implementing four digital dental scanning and 3D printing systems to establish in-house fabrication of dental appliances across its regional clinic network. Each site will be equipped with a TRIOS intraoral digital scanner and a SprintRay Pro2 GOTO 3D printing system, including ProWash S, NanoCure, and NightGuard Flex materials, creating a fully integrated digital dental workflow from scanning through final appliance production. Using this system, dental providers will capture high-resolution digital scans and design patient-specific appliances that can be fabricated on-site. This capability will allow clinics to produce crowns, night guards, and other dental appliances with same-day or rapid turnaround, significantly reducing delays associated with external dental laboratories and shipping from remote communities. Vendor-supported training will be provided to dental providers and assistants to ensure competency in digital scanning, design software, printing protocols, post-processing, infection control, and quality assurance procedures. Training will support the safe integration of the technology into routine dental operations and ensure adherence to clinical standards. Once installed and operational, the systems will be incorporated into everyday dental workflows to support restorative care, preventive services, and improved treatment planning. This approach will enhance local service capacity, reduce patient travel for dental care, and allow rural clinics to provide more timely and comprehensive treatment. The four clinics receiving the digital dental scanning and 3D printing systems are the Chugachmiut Regional Health Center in Seward, the Arch Priest Nicholas Kompkoff Health Clinic in Chenega, the Tatitlek Health Clinic, and the Nanwalek Health Clinic.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Kenai Peninsula Borough	Advance to Implementation Application

Chugachmiut	Strengthening Rural Dental Care with Advanced 3D Imaging	AK	Access to advanced dental diagnostic imaging is limited in rural Chugachmiut communities, often requiring patients to travel long distances for specialty dental imaging or treatment planning. This creates delays in diagnosis, treatment initiation, and follow-up care for conditions such as impacted teeth, complex extractions, infections, temporomandibular joint disorders, and dental trauma. The absence of on-site cone beam computed tomography (CBCT) limits the scope of dental services that can be safely and effectively provided locally. This project addresses that gap by equipping the clinic with a Planmeca ProMax 3D Plus (20 × 10) system to expand diagnostic capability and reduce the need for off-site referrals.	Chugachmiut Health Services proposes to acquire and implement the Planmeca ProMax 3D Plus (20 × 10) CBCT system within the dental program at the Chugachmiut Regional Health Center in Seward. This system will support high-resolution 3D imaging for comprehensive dental diagnostics, treatment planning, and procedural safety. Implementation will include vendor-supported installation, calibration, and staff training consistent with Alaska regulatory and professional standards. Imaging workflows will be integrated into existing dental operations and referral processes, allowing providers to diagnose and manage more complex dental conditions locally while maintaining appropriate specialty consultation when needed.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Kenai Peninsula Borough	Advance to Implementation Application
Chugachmiut	Alaska Tribal Medical Transportation and Escort Program for Rural Patient Access	AK	Rural Alaska residents often face transportation barriers when accessing healthcare services. In many communities, patients with mobility limitations, disabilities, or complex medical needs may have difficulty traveling to local clinic appointments due to limited accessible transportation options. In addition, many rural patients must travel long distances to access specialty care located in regional healthcare hubs. While travel assistance may be available, patients who require a medical escort often do not have someone available to accompany them. As a result, some patients delay or miss critical appointments, discontinue treatment, or experience complications due to incomplete follow-up care. Establishing a Tribal Medical and Clinical Escort Program will address these gaps by providing accessible transportation to local clinics and escort services for patients traveling outside their communities for specialty care. The program will address two transportation needs: accessible local transportation to ensure patients can attend clinic appointments and medical escort services to support patients traveling outside their communities for specialty and hospital-based care.	The Alaska Tribal Medical Transportation and Clinical Escort Program will establish a structured service to support rural patients facing transportation barriers to accessing healthcare. The program will operate through a referral-based coordination model that identifies patients who require transportation assistance or escort services to safely complete medical travel. Providers, care coordinators, and discharge planners will identify patients needing services based on mobility limitations, clinical complexity, functional limitations, or safety considerations. Patients will be triaged to the appropriate level of transportation or escort support depending on their needs. The program will include the purchase and operation of wheelchair-accessible transportation vehicles to support patients traveling to local clinic appointments within hub communities. These vehicles will allow patients with mobility limitations, disabilities, or complex medical needs to safely attend clinic visits, diagnostic appointments, and follow-up care when accessible transportation is unavailable. For patients traveling outside their communities for specialty care, the program will provide two levels of escort services. Non-Clinical Medical Escorts: Trained escorts will assist with travel logistics, appointment navigation, communication support, medication pickup, reinforcement of discharge instructions, and safe return travel. Clinical Medical Escorts: Clinically trained personnel, such as registered nurses, licensed practical nurses, emergency medical technicians, and other licensed	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough	Deferred or Not Advanced

staff, will provide higher-level support when medical monitoring is required, including assistance with oxygen and medical equipment, as well as coordination with receiving providers.

Escort services will be coordinated with rural clinics, Tribal health organizations, hospitals, and specialty providers to ensure continuity of care. Program performance will be monitored through indicators such as referral completion rates, reductions in missed appointments related to transportation barriers, and patient safety outcomes during travel.

Chugachmiut	Energy Upgrades to Improve Healthcare Access in Nanwalek and Port Graham Village Clinics	AK	Health care services in Port Graham and Nanwalek are challenged by unpredictable electric power fluctuations, which endanger sensitive electronic devices and computer equipment and temporarily limit the services that village health care workers can provide. The brownouts and outages often coincide with stormy weather, frequent to the area, when health care workers should be most at the ready to respond to residents. These outages are the result of Port Graham and Nanwalek’s dependence on tree-strung power lines at the remote end of the Railbelt power grid. When trees fall on the lines and branches brush against them, it often causes an electrical fault that will flicker lights, shut down equipment, create brownouts or cause total power outages, and disruptions in one village impacts power supply in the other. As we contemplate transformative measures that will maximize care close to home for life-long health -- whether it's expanding telehealth infrastructure, empowering providers' use of appropriate AI, or encouraging regional communication -- we cannot ignore that obstacle created by the lack of reliable, high-quality power. Addressing the power issues affecting these clinics will enable sustainable healthcare improvements for decades to come.	Port Graham and Nanwalek are only a small part of HEA’s geographically large, diverse power grid, and there simply isn’t the staff or financial resources available to address the issues underlying the energy reliability of the two village clinics. This project will move beyond temporary, quick fixes by hiring a dedicated Energy and Health Resilience Project Coordinator who will perform a system valuation, manage energy upgrade projects, research grants and lead a capital campaign, work with vendors to conduct feasibility and assessment studies, work with stakeholders and develop a strategic plan and timeline that Chugachmiut can act on after the RHTP Year 1 project period concludes. The Energy and Health Resilience Project Coordinator will be contracted for one year, with an option to extend into the future if services are deemed necessary.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Chugachmiut	Rural Health Workforce Stabilization and Provider Incentive Program	AK	Healthcare workforce shortages remain one of the most significant barriers to healthcare access in rural Alaska. Remote communities frequently experience prolonged vacancies in essential healthcare positions due to geographic isolation, limited housing availability, travel costs, and fewer employment opportunities for provider families. These workforce shortages contribute to: • Long wait times for appointments • Limited availability of primary and specialty care services • Increased reliance on temporary or itinerant providers • Reduced continuity of care and increased provider turnover Healthcare organizations serving rural populations often dedicate substantial resources to recruitment and onboarding, which strains already limited administrative capacity. Recruitment cycles for rural healthcare positions can exceed 12 months, and frequent turnover can disrupt patient-provider relationships and continuity of care. This project addresses the opportunity to develop a sustainable workforce stabilization model that supports long-term provider retention in rural communities. By combining structured recruitment incentives with practical relocation supports, the program aims to reduce recruitment barriers and establish a more stable healthcare workforce serving rural Alaskan residents.	This project will establish a structured rural provider incentive program designed to recruit and retain essential healthcare professionals serving rural and remote communities. The program will provide financial incentives for high-need providers who commit to serving in rural communities for a five-year period. Eligible provider types may include physicians, advanced practice providers, nurses, dentists, pharmacists, behavioral health professionals, community health aides, and other clinical and community health professionals whose services are essential to maintaining access to healthcare. Incentives will be structured to encourage long-term retention, with payments distributed across the five-year commitment period and a larger portion of incentives provided in later years of service. Participants who do not fulfill the service commitment will be subject to repayment provisions to ensure responsible stewardship of funds. To address relocation barriers, the program will also provide targeted transition supports, including housing placement coordination with local housing partners, temporary housing stipends, and childcare assistance during the early transition period. These supports help reduce common barriers to rural recruitment and improve provider stability during the critical first years of employment. Implementation will occur in three phases: Phase 1 – Program Development (Months 1–6) Development of program policies, incentive structure, recruitment strategy, and partnership agreements. Phase 2 – Recruitment and Placement (Months 6–24) Recruitment of providers, coordination of relocation supports, and placement in participating rural communities. Phase 3 – Retention and Evaluation (Years 2–5) Monitoring provider retention, evaluating workforce stability, and refining program strategies based on outcomes. Program performance will be monitored through ongoing data collection and evaluation.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Kenai Peninsula Borough	Deferred or Not Advanced

Chugachmiut	Strengthening Rural Health Access Through Mobile Satellite-Enabled Response Units	AK	Rural healthcare delivery in Alaska frequently relies on mobile response units—including ambulances, community health response vehicles, and public health outreach vehicles—to provide care in geographically isolated communities. However, these vehicles often operate without reliable internet connectivity, limiting access to critical clinical and communication tools. When connectivity is unavailable, healthcare teams cannot access electronic health records, conduct telehealth consultations, transmit patient information, or coordinate effectively with hospitals and emergency services. These limitations delay clinical decision-making, reduce situational awareness during emergencies, and can affect patient safety. Connectivity gaps are especially problematic during medical emergencies, disaster response, severe weather events, and patient transport between communities and hospitals. Chugachmiut Health Services proposes deploying vehicle-mounted satellite internet systems to support mobile healthcare delivery and emergency response operations. These systems will provide reliable, high-speed connectivity for designated healthcare and response vehicles operating in rural communities. By enabling real-time communication, telehealth capability, and access to clinical systems in the field, this project will strengthen emergency response capacity, improve care coordination, and support more timely and effective healthcare delivery for rural Alaskans.	RHTP funding will support the procurement, installation, and deployment of vehicle-mounted satellite internet systems on designated healthcare and emergency response vehicles serving rural communities. The project will include the following implementation components: Equipment Procurement Satellite internet systems, mounting hardware, and vehicle power integration components will be purchased to support reliable connectivity in mobile environments. Vehicle Installation and Integration Satellite terminals will be installed on selected response vehicles used for emergency response, outreach services, and mobile healthcare delivery. Systems will be configured to ensure reliable connectivity while vehicles are stationary or operating in remote areas. Testing and Deployment Connectivity systems will be tested in operational conditions to confirm coverage, reliability, and performance in rural environments. Training and Workflow Integration Healthcare providers, EMS personnel, and CHA/P staff will receive training on the appropriate use of mobile connectivity systems during patient care, emergency response, and outreach activities. Once deployed, mobile connectivity will support real-time EHR access, telehealth consultations, emergency coordination with regional hospitals, and improved communication during patient transport or remote response activities.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Kenai Peninsula Borough	Deferred or Not Advanced

Chugiak Vol Fire and Rescue Co Inc	Establish a prehospital Blood Program(Plasma)	AK	By equipping our advanced life support units with pre-hospital plasma capability, we will: Improve Access: Deliver blood product resuscitation within minutes of EMS arrival rather than after a 30–45 minute transport. This is especially critical in a frontier setting where distance and weather create unavoidable delays. Improve Quality of Care: Align our rural EMS system with national best practices for trauma and hemorrhage management, improving patient outcomes and survivability. Improve Sustainability: Strengthen the local emergency response system by reducing preventable mortality and long-term disability, thereby decreasing downstream healthcare costs and improving overall community resilience. Chugiak’s rural character, limited hospital proximity, and challenging environmental conditions make pre-hospital plasma not a convenience, but a necessity. This program ensures that residents of ZIP Code 99567 receive equitable, high-quality emergency care comparable to urban communities, despite geographic barriers. Ultimately, this initiative enhances survivability for trauma patients, supports rural healthcare infrastructure, and advances health equity for Alaskans living in remote and frontier regions.	We propose implementation of a Pre-Hospital Plasma Program integrated into our ALS ambulance service. Our approach includes the following key components: 1. Deployment of Plasma on ALS Units Our frontline ALS ambulance will be equipped to carry thawed plasma for emergent administration in cases of traumatic hemorrhage, hemorrhagic shock, and other critical medical indications. This will allow plasma to be administered at the point of care often 30 to 45 minutes before hospital arrival during the most time-sensitive phase of resuscitation. 2. Commercially Available Blood Storage System We will purchase and install a commercially available, temperature-controlled blood cooler/storage unit designed specifically for pre-hospital transport. This system will maintain required storage temperatures, provide continuous temperature monitoring, and ensure compliance with regulatory and blood bank standards for blood product integrity and safety. 3. Partnership with Blood Bank of Alaska Plasma will be procured through an established partnership with the Blood Bank of Alaska. We will coordinate closely with their medical and laboratory teams to ensure appropriate handling, storage, tracking, and documentation protocols are in place. 4. Rotational Inventory Management Program To ensure sustainability and eliminate waste, we will establish a rotational exchange program with the Blood Bank of Alaska. Plasma units nearing expiration will be returned to the blood bank for in-hospital use and replaced with fresh units. This system ensures: Zero or minimal product waste Responsible stewardship of a scarce resource Long-term financial sustainability of the program 5. Training and Clinical Oversight All ALS providers will receive training in plasma administration, transfusion protocols, recognition of transfusion reactions, and documentation requirements. The program will operate under established medical direction and evidence-based clinical guidelines. This approach leverages existing ALS infrastructure, builds strong regional healthcare partnerships, ensures regulatory compliance, and creates a financially responsible and sustainable model for delivering advanced resuscitative care in a rural/frontier environment. By integrating plasma capability into our pre-hospital response system, we are effectively extending hospital-level resuscitative care into the field, dramatically improving outcomes for severely injured and critically ill patients in our community.	\$50,000-\$250,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Circle Village Council	Circle Community Wellness Space Initiative	AK	Circle currently lacks a dedicated space for community wellness programming, fitness activities, and nutrition education. While the community has an existing multi-purpose building, portions of the interior remain unfinished and cannot yet support structured wellness programming. Rural communities like Circle experience disproportionately high rates of chronic disease, including diabetes, heart disease, and obesity. Limited access to recreational facilities, preventive health programming, and nutrition education contributes to these health disparities. Residents must often travel long distances to access health services or organized wellness activities. The unfinished space within the community’s multi-purpose building presents an opportunity to develop a permanent wellness facility that supports physical activity, healthy eating initiatives, and culturally relevant health education. Completing the interior build-out will allow the Tribe to establish a dedicated wellness center that serves youth, adults, and elders. By investing in community wellness infrastructure, Circle Native Community can strengthen preventive health programming, increase opportunities for healthy lifestyles, and improve long-term health outcomes in this rural community.	Circle Native Community proposes to complete the interior build-out of an existing multi-purpose community building to establish a Community Wellness Center and Health Education Space. Funding will support renovation and construction activities needed to finish the facility, including development of a wellness activity space, classroom area for nutrition and cooking education, and office space to support wellness programming. The facility will serve as a hub for a variety of community-driven programs including: -Physical fitness and recreational activities -Nutrition education and cooking classes focused on healthy diets -Traditional foods education and preparation workshops -Youth recreation and healthy lifestyle programs -Community wellness workshops and cultural activities The design will allow the space to serve multiple purposes, supporting both wellness programming and extracurricular community activities. The facility will also provide space for itinerant health educators, trainers, and visiting providers to deliver health promotion programming. Circle Native Community will collaborate with regional partners, local schools, and Tribal leadership to implement programs that reflect community priorities and cultural practices.	\$250K-\$1M	Single Community	Yukon-Koyukuk Census Area	Deferred or Not Advanced

City & Borough of Yakutat	Yakutat EMS and Fire Response System Rebuild and Technology Modernization	AK	Yakutat Public Safety provides Fire and Emergency Medical Services to the City and Borough of Yakutat and surrounding areas within one of Alaska’s most remote and geographically isolated regions. Emergency services are volunteer-run and serve residents, seasonal workers, visitors, and nearby communities where access to advanced medical care often requires air or marine transport. Due to weather, transportation barriers, and distance from referral facilities, local emergency response is frequently the first and most critical point of care available to community members. Yakutat is currently rebuilding its EMS system from the ground up due to aging infrastructure, outdated equipment, communication limitations, and long-standing challenges sustaining volunteer responder capacity. Much of the emergency response equipment currently in use is outdated or expired, limiting safe and effective response capability. Rather than restoring past systems, the community has an opportunity to rebuild EMS using modern infrastructure, updated technology, and coordinated clinical partnerships to create a sustainable emergency care system for the future.	The proposed project will rebuild and modernize EMS and Fire response capacity through replacement of outdated and expired emergency response equipment, modernization of dispatch and communication systems, and integration of EMS operations with Yakutat Community Health Center to improve patient care coordination and transitions. The project also includes development of standardized volunteer responder training and certification pathways, recruitment and retention strategies to sustain volunteer responder capacity, and joint training and coordination exercises between responders and clinic staff. These improvements will allow responders and clinical teams to work together more effectively while strengthening the long-term sustainability of emergency services. This effort is expected to benefit rural and remote residents by improving the reliability and coordination of emergency response, expanding access to timely emergency and urgent care services, improving patient stabilization prior to transport, reducing preventable emergency transfers when safe local treatment is possible, and strengthening community safety and resilience through sustainable emergency response capacity.	\$250K-\$1M	Single Community	Yakutat (City and Borough)	Advance to Implementation Application

City and Borough of Juneau	Instructor Development	AK	Alaska faces persistent EMS workforce shortages, particularly in rural and frontier communities where volunteer and combination departments struggle to recruit and retain certified providers. A major barrier is limited access to locally based EMS instructors and Instructor Coordinators authorized to deliver and oversee EMT and ETT programs. Southeast Alaska agencies often rely on outside instructors, creating delays, travel costs, and inconsistent course availability. Currently, instructor capacity does not meet regional demand for EMT-1, EMT-2/Alaska Advanced EMT and ETT training. Without growing in-state instructor infrastructure, communities risk reduced response capability, increased provider burnout, and gaps in advanced prehospital care. This project addresses a critical workforce development opportunity: building sustainable, regionally based EMS instructor capacity. By developing new EMT, Advanced, and ETT instructors, along with Instructor Coordinators, CCFR will create a scalable training framework that supports certification, recertification, and long-term workforce stability across Southeast Alaska.	CCFR will implement a structured EMS Instructor Development Program designed to increase regional training capacity and reduce reliance on outside educators. The project will: • Provide Methods of Instruction (MOI) training to qualified EMS providers • Deliver the Alaska-specific EMS Instructor course • Support credentialing of new EMT-1, EMT-2/Advanced, and ETT instructors • Develop multiple Instructor Coordinators to oversee course quality and compliance • Establish standardized curriculum delivery and mentorship processes Participants will include CCFR personnel and regional EMS partners in Southeast Alaska. Selection will prioritize experienced providers committed to long-term instructional roles. Two training phases are anticipated: Phase 1 – Instructor Development MOI and Alaska EMS Instructor courses will be delivered locally. Candidates will complete required teaching practicums under supervision. Phase 2 – Instructor Coordinator Development Qualified instructors will be supported in completing additional requirements to become Instructor Coordinators, allowing regional autonomy in course approval and oversight. Following instructor credentialing, CCFR will host EMT and ETT programs to validate instructional capacity and immediately expand workforce output. This project strengthens workforce infrastructure by embedding education capability within the region, decreasing travel barriers, reducing course cancellations, and increasing frequency of certification opportunities.	Under \$50,000	Home- and community-based services provider	Single Community	Juneau (City and Borough)	Advance to Implementation Application

City and Borough of Juneau	Community Health Data and Billing Infrastructure	AK	CCFR Community Health Division is currently only funded through CBJ funds and has no reimbursement / revenue structures despite having close to 5000 transports, contacts and responses. Historically, growth has been achieved by pursuing local CBJ one-time awards or state/national grants. Not having billing infrastructure within our non-emergency functions has slowed potential growth, despite ever increasing community need. Specifically, we have seen significant fluctuations in the stability of grants that support mental health and substance use treatment. Finally, as the largest community in SE Alaska Juneau is a gold mine of community health data that is often difficult to distribute and use at the state and national level. This difficulty has mostly come from staff being overextended within their role and research and data management being triaged much lower.	To address our structural gap I would like to hire a contractor with specialized knowledge of Imagetrend, Alaska billing requirements, and data report systems within Imagetrend. This contractor would build billing and data collection infrastructure to provide program sustainability, better quality improvement systems, and allow CCFR to gather and distribute data more effectively.	\$50,000-\$250,000	Home-and community-based services provider	Single Community	Juneau (City and Borough)	Advance to Planning
City and Borough of Juneau	Enhancing Youth Health and Wellbeing Through Activities	AK	Juneau is an expensive community. It is difficult to ensure that all youth have access to healthy activities such as summer camps, sports, or appropriate gear for engaging in fishing, hunting, or gathering. Our organization partners with the Juneau Community Foundation and has limited funding available to provide scholarships to youth to participate in these types of programs and more, but unfortunately, there are simply not enough funds available to meet the need. Youth receive a cap of \$300 annually, however this often times barely covers the cost of one camp. Our organization also provides funds to local youth serving organizations through an annual grant process. Again, there is more need than there are funds to go around. While we are able to provide some amount of funding to nearly all the organizations that apply, it is always less than they request, leaving them to decide what to cut. This proposal aims to address both of these issues.	Additional funds provided to the Youth Scholarship Program will ensure that youth living in low income families are able to attend more than one camp a summer or take part in a youth sport and still do summer camps. We know that the more youth engage in healthy activities, the more a habit is formed for these types of things, and habits develop young grow healthy adults. Currently, 5-18 who qualify for free or reduced lunch at school, qualify for 100% of the scholarship funds and that is still not enough to ensure they are able to take part in the same amount of healthy activities as youth who come from families that have resources available to them. Many families put their young children in summer camps all summer long for example. This helps with childcare for the summer and keeps their kids out of trouble. This should not be an option for only families who have the resources to do this. Increasing the funds we are able to give out for Youth Activity Grants to our partners providing critical programming for youth across the community, including activities such as boating, running, fine arts, dance, theater, swimming, and more, will allow these partners to provide top notch services to youth in Juneau and have the funding required to meet the needs of the community.	\$50,000-\$250,000		Single Community	Juneau (City and Borough)	Deferred or Not Advanced

City and Borough of Juneau	Planning to increase the resiliency of Juneau's emergency sheltering services	AK	Despite providing what seems to be a significant scope of services for this population, those services that are provided are provided by a disparate set of organizations that coordinate with variable effectiveness. Further, some of the services to those who struggle the most (due to substance use and/or behavioral/mental health struggles) are clearly insufficient and we struggle as a community to find the staffing capacity, staffing expertise, and - occasionally - the financial resources to improve the outcomes we see within that hardest-to-serve group.	At a conceptual level, we're looking to bring on a consultant with expertise in this arena who can give us a series of concrete and specific recommendations that are eligible for future RHTP years that will expand and improve our community-wide ability to serve this group. While CBJ is the primary funder of this work, other funders exist (most notably - the Juneau Community Foundation and HUD), and the number of social services organizations participating is significant - St. Vincent de Paul, the Juneau Housing First Collaborative/The Glory Hall, and the non-profits operating out of the Teal Street Center are those most notable.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced
City and Borough of Juneau	Walk Southeast Expansion: Promoting Community Health Through a Region-Wide Walking Challenge	AK	When the program launched, participants tracked their mileage using a paper tracker. In response to participant feedback, Walk Southeast integrated the My Virtual Mission (MVM) app in 2022, which allows participants to visually track their progress along the Alaska Marine Highway route from Juneau to Ketchikan. The app was well-received, increased participation and retention, and has become a cornerstone of the participant experience. However, the MVM app costs \$6.50 per participant, a small fee that adds up as participation has surged. It has always been a core value of Walk Southeast to remain free and accessible to all, eliminating any financial barrier to staying active. Over the years, app costs have been covered through a patchwork of community budgets and sponsorships, and while we have successfully secured a presenting sponsor in the past, sponsorship has proven year-to-year to be unpredictable, making it difficult to rely on as a stable funding source for the program's continued growth. Beyond the app, Walk Southeast has an opportunity to expand its reach by promoting the program across all of Southeast Alaska, not just the four lead communities. Targeted outreach would invite more rural and remote residents to participate, directly advancing the program's mission of making free, accessible wellness programming available to every Southeast Alaskan. This grant would ensure Walk Southeast remains free, fully supported, and growing for years to come.	This grant would ensure Walk Southeast remains free and accessible to every Southeast Alaskan who wants to participate and stay active all summer long. Funding would directly cover the \$6.50 per-participant cost of the My Virtual Mission (MVM) app, which allows participants to visually track their progress along the Alaska Marine Highway from Juneau to Ketchikan — a feature that has become central to the participant experience and a key driver of engagement and retention. During the grant period, Walk Southeast will also begin exploring the development of a custom, branded mobile app to replace the third-party MVM platform long-term. A Walk Southeast app would be built for both iOS and Android, be free for all participants, and be designed specifically around the program's unique Alaska Marine Highway route experience. This would eliminate the recurring per-participant licensing fee entirely, further strengthening the program's long-term financial sustainability. In addition, this grant would meaningfully expand Walk Southeast's promotional reach beyond its four lead communities (Juneau, Ketchikan, Sitka, and Petersburg) to all residents across Southeast Alaska. An expanded promotion budget would fund targeted outreach through social media, YouTube, local news outlets, radio spots, and audio ads on platforms like Spotify and podcasts. This multi-channel approach would ensure that rural and remote residents, who stand to benefit most from a free, low-barrier wellness program, are aware of and encouraged to join the challenge. Together, these investments would strengthen the program's foundation while broadening its impact. They will ensure Walk Southeast continues to grow as a region-wide wellness initiative for years to come while supporting the program's long-term financial sustainability.	Under \$50,000		Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough)	Deferred or Not Advanced

City of Aleknagik	Aleknagik Rural Health Access Strategic Plan	AK	Aleknagik is a remote community in the Dillingham Census Area where extreme geography, weather, and limited transportation options create persistent barriers to timely, reliable care. The City’s small population and seasonal workforce fluctuations make it difficult to sustain clinic operations, recruit and retain staff, and maintain essential infrastructure. Residents must often travel or defer care, and the local clinic’s capacity is constrained by workforce housing, technology, and transportation logistics. This project will develop a comprehensive strategic plan to strengthen long-term health care access for residents of Aleknagik by addressing infrastructure, workforce sustainability, clinician housing, and transportation barriers that affect care delivery in this remote community. Through collaboration with City leadership, regional health care providers, Tribal partners, and the Alaska Municipal League, the initiative will evaluate municipal health barriers and identify sustainable approaches to maintain and expand access to primary care, preventive services, and telehealth. The plan will synthesize local priorities with regional referral patterns and federal allowability to chart costed, phased actions that can be implemented over time. This effort aligns with Alaska’s Rural Health Transformation Program goals to improve rural access, support workforce sustainability, and advance community-based solutions that reduce disparities in remote Alaska communities.	The 12-month planning process will focus on three critical areas, supported by structured engagement and data-sharing with partners: (1) Sustainable Rural Workforce Strategy—co-design a recruitment and retention plan with BBAHC/regional partners that right-sizes coverage. Assess training and precepting pathways, define shift/coverage models, and evaluate potential workforce housing solutions (site options, utilities, concept designs, cost ranges, phasing). (2) Long-Term Operations & Infrastructure for the Municipal-Owned Clinic—complete an operational review of the municipal-owned clinic and develop a capital improvement plan. (3) Transportation & Connectivity to Higher Levels of Care—assess medical transport gaps and weather contingencies; coordinate with regional transportation providers (air, marine, ground) and EMS to strengthen dispatch/communication, shared protocols (e.g., treat-in-place/alternate destination), and reliable connectivity to Dillingham and Anchorage. Cross-cutting activities include establishing a community-led Steering Group, executing data-sharing MOUs, and producing deliverables: a costed, prioritized 5-year implementation roadmap; a funding and policy alignment matrix (RHTP initiatives and other federal/state sources); draft partner MOUs; and an evaluation and data plan. The Alaska Municipal League (AML) will support strategic planning, implementation readiness, and subsequent execution, in coordination with local and regional partners.	\$50,000-\$250,000	Single Community	Dillingham Census Area	Advance to Planning

City of Bethel	New EKG Monitors (3)	AK	The Bethel Fire Department currently relies on older EKG monitors that have become unreliable in field conditions and occasionally produce inaccurate or inconsistent readings. These limitations can make it more difficult for emergency medical responders to quickly and confidently assess patients experiencing chest pain, heart rhythm abnormalities, or other cardiac-related symptoms. In a remote community like Bethel, where patients may need to be transported long distances for advanced care, accurate and timely cardiac monitoring is essential for making appropriate treatment and transport decisions. The Bethel Fire Department responds to medical emergencies across the community, often in challenging weather and operational conditions. When EKG equipment produces false readings or cannot be relied upon in the field, it creates uncertainty for responders and may delay diagnosis, treatment, or coordination with hospital-based providers. This project addresses the opportunity to modernize Bethel’s emergency medical response capabilities by replacing aging EKG monitors with reliable, up-to-date equipment. Improved cardiac monitoring will allow first responders to obtain accurate diagnostic information in the field, share data with receiving medical facilities, and provide better-informed patient care during emergency response and transport.	The City of Bethel will address the limitations of outdated cardiac monitoring equipment by purchasing three modern, field-reliable EKG monitors for use by the Bethel Fire Department’s emergency medical service response teams. These monitors will replace aging units that occasionally produce inaccurate readings and are no longer dependable in demanding field conditions. The new EKG monitors will be deployed on frontline emergency response units so that paramedics and emergency medical technicians can perform accurate cardiac assessments at the scene of medical emergencies and during patient transport. The Fire Department is responding to five EMS calls per day. The equipment will allow responders to quickly identify heart attacks, abnormal heart rhythms, and other cardiac conditions and transmit diagnostic information to receiving medical facilities when necessary. This capability will improve clinical decision-making in the field and support better coordination with hospital providers. The project approach focuses on strengthening existing emergency medical services infrastructure rather than creating new programs. By equipping responders with modern diagnostic tools, the Bethel Fire Department will improve the reliability and quality of pre-hospital care provided to residents and visitors in the community. This investment will enhance the department’s ability to deliver timely, accurate cardiac monitoring during emergencies and ensure patients receive appropriate care and transport decisions based on dependable diagnostic information.	Under \$50,000	Single Community	Bethel Census Area	Advance to Implementation Application

City of Bethel	Bethel Community Sports Project	AK	The City of Bethel currently has limited indoor recreational equipment available to support organized sports, youth programs, and community fitness activities. Because Bethel is a remote community with long winters, extreme weather, and few indoor recreation spaces, residents often have limited opportunities for regular physical activity during much of the year. The lack of adequate sports equipment and organized programming contributes to reduced physical activity, particularly among youth, which can negatively affect physical health, mental health, and overall community well-being. The Bethel Community Sports Project equips the community gymnasium with modern sports equipment, storage systems, and presentation technology needed to support recreational and organized activities. The project will enable the City to expand youth sports leagues, open gym activities, and community recreation programs, like the annual summer camp it hosts. Bethel is a community constructed on sand pads on top of tundra. The tundra with its wet holes, spongy mounds, and irregular land formations is not conducive to sports and organized play. Running on the tundra is dangerous. Improving access to structured recreation and physical activity will help promote healthier lifestyles, strengthen youth engagement, and support community wellness. Increasing opportunities for regular exercise and positive social activities represents an important investment in preventive health and long-term wellness.	The City of Bethel will address limited opportunities for indoor physical activity by purchasing the sports, storage, and projection equipment identified in the Bethel Community Sports Project equipment list and making it available for regular use in the community gymnasium. Bethel experiences long winters, severe weather, and limited outdoor recreation opportunities for much of the year, which means that many residents, especially youth, have few consistent opportunities for exercise. This contributes to sedentary lifestyles and higher rates of adverse health conditions such as obesity, diabetes, and high blood pressure, which are common concerns in many rural Alaska communities. By equipping the gymnasium with basketball, volleyball, pickleball, and other recreational sports equipment, the City will be able to expand youth sports leagues, school and after-school programs, adult recreation leagues, and open gym opportunities. These programs will provide residents with safe and accessible ways to stay physically active throughout the winter months when outdoor exercise is limited and during summer months when the Kuskokwim River is cold and weather is often cold and wet during rain events. Regular participation in sports and recreational activities helps increase physical activity levels, improve cardiovascular fitness, manage body weight, and reduce risk factors associated with chronic diseases. Providing accessible opportunities for exercise can also help counter sedentary lifestyles and support healthier habits in a community where access to fresh foods and health care services can be limited. By increasing opportunities for regular exercise and active recreation, the project supports prevention of chronic disease and promotes healthier lifestyles, strengthening long-term community health in Bethel.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area	Deferred or Not Advanced

City of Bethel	Bethel Public Safety Cadet Program	AK	The City of Bethel faces ongoing challenges recruiting and retaining qualified police officers and firefighter/EMTs to serve the community. Like many rural western Alaskan towns, Bethel must often rely on recruiting personnel from outside the region, which can be difficult due to geographic isolation, high living costs, and the demanding nature of public safety work. As a result, vacancies and staff turnover are high, placing a great strain on the community's emergency response system. At the same time, many local high school students may be interested in public service careers but have limited exposure to what the professions of police officer, firefighter, or emergency medical technician involve or how to pursue those careers. Without opportunities to learn about these professions early, potential local candidates may not consider these career paths. The Bethel Public Safety Cadet Program addresses this opportunity by introducing Bethel High School students to careers in law enforcement, fire protection, and emergency medical services through classroom instruction, mentorship, and hands-on learning experiences. By exposing students to these professions and providing guidance on training and career pathways, the program will help build a local recruitment program of future public safety professionals who are ready, willing, and able to serve their community.	The City of Bethel will address the challenge of recruiting and retaining public safety personnel by establishing a Public Safety Cadet Program at Bethel High School. The program will be taught by experienced Bethel Police Department officers and Bethel Fire Department firefighter/EMTs and will introduce students to careers in law enforcement, fire protection, and emergency medical services. The course will combine classroom instruction with hands-on training modeled after successful cadet and explorer programs used by public safety agencies nationwide. Students will learn about the roles and responsibilities of first responders, including emergency medical responders, fire safety and rescue techniques, basic incident command, teamwork, leadership, and community policing principles. Instruction will also include demonstrations of equipment, participation in supervised practical exercises, and discussions about career pathways, required certifications, and training opportunities. In addition to technical skills, the program will emphasize professionalism, physical fitness, decision-making, and public service values that are essential for careers in emergency response. Students will also have opportunities to observe or participate in training exercises with local police and fire personnel to gain a realistic understanding of the profession. By providing early exposure, mentorship, and career guidance, the program will encourage interested students to pursue training as police officers or firefighter/EMTs after graduation. This approach helps build a locally based workforce that strengthens the long-term capacity of Bethel's public safety and emergency medical services.	Under \$50,000	Single Community	Bethel Census Area	Deferred or Not Advanced

City of Cordova	Cordova Rural EMS Advanced Patient Assessment, Telemetry & Hospital Integration Initiative	AK	Our rural and remote community faces unique challenges that can create delays in patient care and strain our limited EMS resources. A key issue is the delay in transferring critical patient information to the receiving care team, which can slow staffing mobilization, treatment preparation, and clinical decision-making. We often rely on radio or verbal reports, which may be incomplete or delayed. In our rural settings with limited hospital staffing and on-call personnel, these delays can extend time to treatment for urgent conditions such as cardiac events, trauma, or respiratory emergencies. Additionally, access to advanced prehospital monitoring and diagnostic equipment is limited, restricting of EMS crew's ability to perform timely patient assessment, triage, and treatment during transport. Without tools that capture and transmit vital signs and clinical data to hospitals in real time, opportunities for early intervention are missed. This project addresses these challenges by providing our EMS crew with modern monitoring equipment capable of real-time telemetry, improving early clinical data transfer, and enhancing coordination between pre-hospital and hospital teams. Expanding access to specialized equipment and accelerating information flow will reduce unnecessary delays, strengthen patient triage, and support more effective, timely care—improving outcomes and sustainability for rural and frontier communities.	In our rural and remote community, every second matters, yet we often face significant barriers to delivering timely, high-quality care. Limited staffing, tough to access locations, and gaps in communication between the EMS team and hospitals can delay critical interventions. When a patient experiences a cardiac event, trauma, or respiratory crisis, hospital staff may not have full visibility into the patient’s condition until arrival, requiring additional time to mobilize personnel and prepare specialized equipment. Meanwhile, in the field, we lack the tools needed to share advanced patient assessment, triage, and real-time decision-making in a timely and effortless fashion, leaving both patients and care teams at a disadvantage. This project seeks to transform prehospital care in Cordova by equipping Cordova's EMS provider with advanced monitoring devices that can capture vital signs and clinical data and transmit them directly to the hospital in real time. By sharing accurate patient information before arrival, hospital teams can activate appropriate staff, ready critical equipment, and implement directed treatment protocols immediately, reducing delays and improving patient outcomes. Patients receive faster, more precise care, and we can make more informed on-scene decisions, including triage and interventions. The initiative will be implemented over 12 months in three coordinated phases. Phase 1 establishes wireless connectivity across all EMS units, ensuring reliable and secure telemetry. Phase 2 integrates the monitoring devices into daily EMS operations and includes comprehensive training for staff and volunteers on device use, patient assessment, and data workflows. Phase 3 connects EMS data streams to the hospital system, enabling pre-arrival alerts, early triage, and real-time collaboration between prehospital and in-hospital teams. By combining technology, training, and workflow integration, this project directly addresses the delays caused by staffing gaps, limited information transfer, and restricted access to specialized equipment. It strengthens our rural EMS capabilities, improves care coordination, and ensures patients receive timely, high-quality emergency care, even in a geographically isolated setting. Ultimately, the project enhances the sustainability, efficiency, and quality of prehospital care, creating a safer, more connected healthcare system for our community.	\$50,000-\$250,000	Single Community	Chugach Census Area	Advance to Implementation Application

City of Cordova	City of Cordova- Replacement of the Bob Korn Memorial Swimming Pool and Bidarki Recreation Center	AK	Both facilities are aging and are experiencing significant structural and mechanical deterioration due to decades of use and exposure to the harsh coastal environment. The Bob Korn Memorial Swimming Pool is currently closed, following the discovery of significant structural issues that occurred after a prolonged water loss investigation. The closure has highlighted the community’s reliance on the facility and the urgent need for a long-term solution to restore aquatic services in Cordova. Replacing these facilities will allow the city to develop modern recreation and wellness infrastructure designed to support injury prevention, drowning prevention, physical activity, behavioral health, and emergency preparedness for residents of all ages. The City of Cordova is committed to ensuring that future recreation and aquatic facilities meet the long-term needs of the community and continue to serve as critical public health and safety resources for Cordova and the surrounding region.	The City of Cordova proposes to undertake a comprehensive planning and design process to guide the rehabilitation or reconstruction of the Bidarki Recreation Center and the Bob Korn Memorial Swimming Pool. This process will evaluate the current condition of the facilities, identify long-term community needs, and develop a feasible and sustainable path forward for restoring these critical recreation services. The project will begin with a master planning phase that includes facility assessments, engineering analysis, cost estimating, and community engagement. The planning process will explore options for renovation, reconstruction, and modernization, with an emphasis on safety, accessibility, energy efficiency, and long-term operational sustainability. Through this process, the City will work with design professionals, community stakeholders, and partner organizations to develop a phased implementation plan and construction-ready designs. This approach will position the City to pursue construction funding and implement improvements that restore reliable recreation and aquatic services for Cordova residents.	Over \$5M	Single Community	Chugach Census Area	Deferred or Not Advanced

City of Cordova	Cordova Public Safety Dispatch Modernization Initiative	AK	Cordova Public Safety Dispatch needs to implement E911/NG911-ready technology. We have the GIS mapping and addressing complete, but without the modernization of our dispatch center, we do not have the ability to identify callers and their location when a call comes in. Our obsolete radio console is no longer being updated, is not consistently reliable, and makes heavy radio traffic difficult to manage. In Alaska, seconds matter. Currently, “silent” 911 calls/open line/hang-ups have no actionable response path. Language barriers, the inability to speak, cold exposure, unconscious callers, and victims in fear cause a delayed response. Visitors who are unfamiliar with local addresses or landmarks may not know where they are. Without E911/NG911-ready technology, there is confusion, radio congestion, and reduced operational readiness. According to The After-Action Report from the 2026 Active Shooter Training conducted by The Alaska State Troopers, radio communication issues, caller identification, and location were identified as the largest correctable gaps in assistance. The Cordova Public Safety Dispatch Center is staffed 24 hours a day, 365 days a year, often by one dispatcher. Without an integrated, modern 911 call handling solution, a more powerful radio console, and ergonomic workstations, precious time is spent using separate applications, duplicating data entry, and managing increased radio traffic when trying to convey vital information to responders.	The Cordova Public Safety Modernization Initiative will use a comprehensive, integrated, and proactive approach for this opportunity to improve first response in the community, further aligning with our commitment to excellence. Since 1909, The Cordova Department of Public Safety and The Cordova Volunteer Fire Department have worked together to provide emergency responses and remain uniquely qualified to serve our community. Together, we have been good “stewards” of past grant funding awarded for communications equipment, fulfilling the requirements and goals set forth in the opportunity. Going back to 2008, there have been documented efforts to transition to the industry standard of dispatch technology. We have continued to refine the approach to implementation geared toward success. Today, we are working with reputable vendors for E911 Call Handling Solutions, Radio Consoles, and Workstations. We have obtained quotes for equipment and installation. The local phone carriers are informed of our intention to implement this initiative and are compliant and compatible with the systems to be put in place. The Phase II request letters are prepared. The City Council will be presented with a resolution to re-instate the allowable E911/NG911 surcharge to fund the project into the future. Integrating E911 call handling solutions with our Computer Aided Dispatch (CAD) system would bridge the gap between the current applications we use to provide pre-arrival instructions during Fire, EMS, or Police calls. The ability to access these protocols from one application would save valuable time. This approach will allow dispatch to obtain vital information from the caller and update responders in real-time, without having to toggle between applications or duplicate data entry. Integrating a modern radio console that provides better range, multiple secure channels, and allows single channel recording would create improved communication between dispatch and responders. Modernizing all aspects of dispatch concurrently is the most efficient and effective way to implement the changes we are proposing. We have addressed the need for GIS mapping and addressing and are ready to move forward with an E911 call handling solution, modern radio console, and improve workflow by incorporating ergonomic workstations, cable and dust management, lighting, sound-dampening, and climate control.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Chugach Census Area; Yakutat (City and Borough)	Deferred or Not Advanced

City of Delta Junction	Being Healthier Together- Outdoor Fitness Park Project	AK	The City of Delta Junction currently lacks sufficient outdoor recreational amenities that support physical activity for all ages. Children, families, and seniors have limited access to safe, free, and engaging fitness options, which contributes to sedentary lifestyles and fewer opportunities for healthy family interaction. This project presents an opportunity to expand the Community Park with inclusive play, fitness, and walking amenities that encourage daily physical activity, promote lifelong healthy habits, and provide an accessible gathering space for residents and visitors alike.	The City of Delta Junction will address this opportunity by expanding Community Park with facilities designed to promote active, healthy lifestyles for all ages. The project will include installation of a children’s play structure, an outdoor fitness multi-station with bodyweight equipment, a splash pad, and a one-mile walking path with educational storyboards. These improvements will create a safe, free, and accessible environment for daily physical activity, family engagement, and outdoor learning. By offering amenities that support both structured exercise and recreational play, the project will encourage consistent use of the park and foster long-term healthy habits within the community.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Southeast Fairbanks Census Area	Deferred or Not Advanced
City of Delta Junction	Delta Junction EMS Services	AK	The City of Delta Junction is working to create a sustainable emergency medical services (EMS) system that will serve future generations in a rural and remote setting. Currently, long-term stability of ambulance services is a challenge due to limited resources, staffing constraints, and the high cost of providing advanced care across a large service area. This project presents an opportunity to establish a utility-style model for ambulance services through collaboration with Rural Alaska Emergency Services (RAES), Delta Area Response Team (DART), Delta Medical Transport (DMT), and AVEL eCare. Together, these partners will support the development of an advanced life support (ALS) system for the REAA15 service area. This project allows the City to take the first critical steps toward building a coordinated, reliable, and financially sustainable EMS system for the community.	The City of Delta Junction will address this opportunity by implementing a utility-style ambulance service model supported through strategic partnerships and modern medical technology. The City will collaborate with Rural Alaska Emergency Services (RAES), Delta Area Response Team (DART), Delta Medical Transport (DMT), and AVEL eCare to create an integrated advanced life support (ALS) system for the REAA15 service area. This approach includes acquiring and equipping an ambulance capable of providing ALS-level care, integrating telehealth support for real-time medical oversight, and coordinating staffing, dispatch, and response protocols among partner organizations. By combining local responders with telemedicine-enabled ALS capabilities, the City will improve patient outcomes while controlling long-term operational costs. This collaborative, scalable model establishes the foundation for a financially sustainable and reliable EMS system that can meet current needs and adapt for future generations.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Southeast Fairbanks Census Area	Deferred or Not Advanced

City of Fairbanks	The Fairbanks MIH Transformation Plan	AK	The current pre hospital healthcare system no longer fulfills its original purpose. It was created to address emergency needs by stabilizing patients and transporting them to appropriate hospitals. Over time, especially after the pandemic, ambulances and emergency rooms have become the primary source of care for many individuals who do not understand how to access the broader healthcare system. Ambulances and emergency rooms were never intended to provide chronic healthcare services, yet outdated policies, complex healthcare systems, limited access to primary care, and a payer model that supports ambulances solely for ER transport have exacerbated these challenges. If unaddressed, these conditions could eventually cause the healthcare system to collapse. The City of Fairbanks’ project seeks to resolve these issues by fundamentally changing how individuals navigate the healthcare system. The Mobile Integrated Healthcare (MIH) program will facilitate access and support for individuals to appropriate medical care, saving time and reducing system costs. Community paramedics will provide support and advocacy, home healthcare, in-field treatment, and enable patients to connect with primary care providers either in person or through telehealth. This approach strengthens chronic care management, reduces unnecessary emergency use, and modernizes care delivery, not only in rural areas, but across the healthcare system.	The City of Fairbanks project under Alaska’s Rural Health Transformation Program will expand Mobile Integrated Healthcare (MIH) and develop a telehealth integrated access hub to improve care for vulnerable residents in Interior Alaska. Fairbanks is well positioned to pilot a scalable model that reduces geographic, resource, and cultural barriers to care. The MIH program is currently delivered through a single community paramedic pilot, which has already shown measurable success and validated the effectiveness of this approach. This project will expand that proven pilot into a fully staffed, scalable division of the Fire Department capable of meeting community-wide demand. The project will strengthen the existing MIH program by adding community paramedic positions to provide 24/7 preventive, in home services such as chronic disease monitoring, medication support, and non emergency visits that will lower avoidable ER use and ambulance transports. A fire station will be repurposed into a telehealth access hub offering virtual consultations for primary and behavioral health care for individuals who struggle to succeed in the traditional healthcare setting. The effort focuses on a new partnership for individuals leaving Fairbanks Correctional Center with limited medication supplies and no primary care. It will continue to serve other high need populations: patients discharged from Fairbanks Memorial Hospital without stable housing, seniors lacking support systems, and others who have difficulty securing or following up for timely care. A multidisciplinary MIH team—paramedics, case managers, and peers—will coordinate services, offer advocacy and transportation, and work closely with the Mobile Crisis Team and Emergency Service Patrol to ensure ongoing support. Funding through this project will provide access to a board certified physician for consultation, prescriptions and lab orders, expanded innovation, and reducing treatment delays. Collaboration with regional and tribal partners will improve communication and outcomes for individuals with complex medical and behavioral health needs. By emphasizing prevention, continuity, and integrated support rather than crisis driven response, the project aims to reduce preventable hospitalizations, improve patient stability, and ease pressure on emergency systems. Leveraging Fairbanks’ role as a hub creates a sustainable model that can be adapted across Alaska to strengthen rural healthcare delivery.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough	Advance to Implementation Application

City of Gustavus	Community CPR: hands-only CPR training, dispatcher-assisted CPR, advanced CPR training & equipment	AK	Population growth and seasonal surge: Gustavus is an off-road rural community in SE Alaska, and gateway to Glacier Bay National Park. Between the 2010 and 2020 decennial census counts, its population increased by 48%, making it one of the fastest growing communities in Alaska. The population of 664 triples during the summer due to the influx of the seasonal workforce, tourists and seasonal residents. Limited number of emergency responders: Gustavus VFD responds to structural and wildland fires, EMS, search and rescue, watercraft and aircraft incidents, behavioral emergencies, and hazardous materials events. It has a mutual aid agreement with the NPS and additionally provides medevac transport of cruise ship passengers from the Park to the airport. GVFD is staffed by a part-time Fire Chief, EMS Coordinator, and volunteers. Emergency dispatch is provided by a small number of volunteers. Like many residents, GVFD volunteer responders support themselves and their families through seasonal income as well as personal subsistence food harvesting and gathering. Delayed response due to road conditions and other factors: Gustavus has limited paved State-maintained roads linking the Park, Dock, Airport, City facilities and School. The majority of residences are on unpaved roads which are frequently rutted and seriously potholed. Response on the longest primary gravel road can take 20 to 60 minutes, not including snow conditions. Medevac flights are subject to weather-related delays.	Each year over 350,000 people experience cardiac arrest outside of a hospital, of which four out of five occur at home with only 10% surviving due to lack of timely CPR. This project was inspired by King County, WA which has trained more than 70% of its region’s population in CPR through community and school-based training programs. It has one of the highest survival rates (44%) of witnessed, shockable, sudden cardiac arrest in the country. CPR is the first link in the chain of survival, and the goal of this project is to address challenges to emergency care presented by our unpaved road system, limited number of responders, and the need for training, equipment and supplies. The project is designed to achieve timely access to CPR and treatment in 3 phases: Phase I: Bringing adult hands-only CPR classes to the community with a focus on small-group residential environments. Phases 1 and 3 training will be available to all sectors and venues, including government and private sector worksites, churches, school, preschool, social groups, public events, and the seasonal workforce (charter boat captains and lodges). Phase 2: Implementing dispatcher-assisted pre-arrival CPR instructions for family members and on-scene bystanders. Statistically, bystander CPR occurs in a minority of incidents of out-of-hospital cardiac arrest, and the goal is for the dispatcher to provide hands-only CPR instructions to the caller until the ambulance arrives to provide defibrillation and other vital interventions. Phase 3: Providing responders with the equipment, supplies, and training they need to support a patient before transport to definitive medical care. Starting with the dispatcher, this includes training in hands-only adult CPR progressing with “stop the bleed” training, and Basic Life Support training and certification. For responders, CPR equipment is needed for training in assessment, monitoring, and cardiac interventions as well as advanced EMS and Instructor training and certification.	Under \$50,000	Other	Hoonah-Angoon Census Area	Deferred or Not Advanced

City of Homer	HVFD Ambulance Acquisition: Expanding Pre-Hospital Emergency Care Capacity	AK	This project is an opportunity to advance two RHTP initiatives, expanding appropriate care availability and investing in capital infrastructure, in direct response to a documented and growing community need. HVFD currently operates two NFPA-compliant ambulances. For a service area of this scale and complexity, that is not sufficient to ensure consistent access to quality emergency care. Call volume has increased 25% over the past three years alone, from 680 calls in 2023 to 747 in 2024 to 848 in 2025 — and the rate of increase is accelerating. Concurrent call events — which occur on average 10 times per month — leave the region without an available unit, creating dangerous gaps for residents with no other emergency medical options. Because each ambulance transports only one patient at a time, multiple casualty incidents immediately exhaust two-unit capacity, requiring mutual aid from neighboring jurisdictions typically 20 to 30 minutes away — an unacceptable delay where geography and distance already constrain response. This gap represents a failure of the only emergency medical infrastructure serving rural, remote, and frontier communities across our service area. A third compliant ambulance directly right-sizes HVFD's pre-hospital emergency capacity to match documented and growing demand — a reasonable, well-justified capital investment that strengthens the long-term sustainability of emergency medical services across the Southern Kenai Peninsula.	HVFD proposes to purchase a fully outfitted, NFPA-compliant ambulance to ensure three deployment-ready units are available — eliminating the coverage gaps that occur when both existing units are simultaneously committed to calls. While HVFD volunteers can staff an additional unit from the station when one is available, the absence of a third compliant ambulance means that option does not currently exist. In a region where weather, geography, and distance already limit emergency response options, a 20-to-30-minute gap in transport capacity during a multiple casualty event can be the difference between timely care and a preventable outcome. A third unit directly addresses this vulnerability — ensuring HVFD can initiate transport for multiple patients simultaneously, reducing dependence on distant mutual aid, and delivering consistent, high-quality emergency response to the rural and remote communities that depend on Homer as their medical lifeline. This capital investment right-sizes our pre-hospital care capacity to meet documented and growing demand, sustaining access and quality emergency medical care and transport infrastructure in our region.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced
City of Houston	Houston's Health & Recreation Initiative	AK	Problem / Opportunity: The city owns a barren, fire-prone parcel and an outdated, non-accessible playground, and lacks public sports fields and modern recreational amenities within city limits. This forces families to travel for youth sports and limits local opportunities for physical activity, social connection, and preventive health outreach. Revitalizing the site into a multi-use park, inclusive playground, community stage, ball field, and expanded campground converts a hazard into an accessible community hub that supports year-round exercise, childhood development, mental well-being, mobile clinic access, school programming, and outdoor tourism—addressing clear gaps in infrastructure that affect health, equity, and local economic resilience.	The project will convert a city-owned, fire-prone parcel into a multi-use recreation complex that increases physical activity, social connection, preventive health access, and outdoor tourism. The Feasibility and design work will produce buildable plans, cost estimates, and an operational model that enable rapid implementation and sustainable operations.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

City of Houston	Station 9-3; Combined Fire Station and Public Works Facility: Feasibility Report	AK	Station 9-3 presents an opportunity to shorten response times, expand firefighter capacity and community training, protect road-maintenance assets for reliable winter access, and provide a flexible venue for vaccinations, screenings, and health education. The combined facility also supports campground and tourism improvements, strengthens emergency staging and sheltering, and can reduce long-term economic and health costs—potentially lowering insurance exposure and preventing large-scale losses from future wildfires or disasters.	We will deliver a combined Fire Station and Public Works facility that shortens emergency response times, protects road-maintenance assets, and creates flexible space for preventive health outreach. The Feasibility Report funded by this request will produce the technical, financial, and community documentation needed to secure construction funding and implement the project.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced
City of Kenai - Fire Department	Kenai Fire Department Rural Mobile Healthcare and EMS Transformation Initiative	AK	Rural EMS agencies across Alaska are facing increasing pressure from workforce shortages, rising medical call volume, and limited access to advanced diagnostic tools in the prehospital setting. In the Kenai Peninsula Borough, EMS providers frequently respond to patients experiencing cardiac arrest, respiratory failure, trauma, and complications from chronic disease. These emergencies often occur far from hospitals, requiring extended transport times and rapid stabilization in the field. At the same time, rural healthcare systems are experiencing growing access challenges as hospitals and clinics face staffing shortages and increasing patient demand. As a result, EMS providers are increasingly serving as the first point of contact with the healthcare system for many residents. However, traditional EMS systems were designed primarily for transport rather than functioning as integrated healthcare providers within the broader care continuum. This project represents an opportunity to strengthen rural healthcare delivery by expanding EMS capabilities, improving workforce capacity, and integrating technology that allows earlier diagnosis, better stabilization, and stronger coordination with regional healthcare partners. By enhancing the role of EMS as a mobile healthcare resource, this initiative will improve access to care and patient outcomes for rural residents in the Kenai Peninsula.	The Kenai Fire Department proposes a multi-component initiative to strengthen rural emergency medical services, expand workforce capacity, and integrate EMS more effectively into the regional healthcare system. The first component focuses on improving patient care during emergency response and transport. Investments in advanced EMS equipment—including powered patient transport devices, portable ventilators, and portable ultrasound—will allow providers to better stabilize critically ill patients and identify life-threatening conditions earlier in the course of care. Upgraded cardiac monitoring systems with hospital connectivity will enable EMS clinicians to transmit patient data directly to receiving facilities, improving coordination and preparation for incoming patients. The second component focuses on workforce development. Rural EMS agencies across Alaska face persistent challenges recruiting and retaining paramedics. This project will establish a structured pathway for current employees to advance their education through paramedic training programs. Funding will support tuition, travel, housing, clinical internships, and staffing backfill during training. In addition, a proactive emotional wellness and resiliency program will support workforce retention, reduce burnout, and strengthen the long-term sustainability of EMS services. Maintaining a healthy and resilient workforce directly supports reliable access to emergency care for rural residents while creating sustainable career pathways for EMS professionals. The third component focuses on strengthening EMS education and training infrastructure through the development of a simulation-based medical training program. High-fidelity simulation allows providers to practice complex medical emergencies in a controlled environment, improving clinical decision-making, teamwork, and patient care performance while supporting ongoing training for regional EMS providers. The final component explores the future role of EMS as a mobile healthcare resource through partnerships that connect EMS providers with healthcare professionals using telemedicine and nurse consultation services. These models may support treatment-in-place	\$250K-\$1M	Single Community	Kenai Peninsula Borough	Advance to Implementation Application

options and improved care coordination when emergency transport is not required.

Together, these initiatives will strengthen access to care, support workforce sustainability, and improve healthcare delivery for residents of the Kenai Peninsula.

City of Ketchikan	Annual Public EMT Course	AK	Rural island communities like Ketchikan face persistent challenges in maintaining adequate EMS staffing, particularly during seasonal population surges, severe weather events, and large-scale incidents. Cruise ship season significantly increases call volume, while the local system relies heavily on a limited number of career staff and volunteers. Geographic isolation and the cost of traveling off-island for EMT training create barriers for community members who want to serve as volunteer responders. As a result, volunteer capacity, disaster surge staffing, and regional mutual aid strength can be insufficient during high-demand periods. Limited redundancy increases strain on existing providers, raises burnout risk, and threatens overall system resiliency. This project addresses the opportunity to strengthen rural EMS sustainability by funding one community EMT course annually. By providing consistent, locally accessible certification, the program expands the pool of trained responders, builds surge capacity, supports mutual aid partners, and improves island-wide emergency coverage in this frontier setting.	The City of Ketchikan Fire Department proposes to fund and host one state-approved community EMT course annually to strengthen volunteer capacity, regional response partnerships, and disaster surge staffing. Each year, the City will coordinate delivery of a full EMT certification course that meets Alaska and National Registry standards. The course will include classroom instruction, hands-on skills labs, scenario-based simulations, and required clinical and field experience in partnership with Ketchikan Gateway Borough EMS and regional response agencies. Funding will support instructor compensation, training equipment and replacement supplies, simulation materials, textbooks, background checks, administrative coordination, and certification exam preparation support. Where appropriate, the program will offset exam fees to reduce financial barriers for volunteers. Recruitment efforts will prioritize volunteer responders, rural fire departments, tribal partners, community members interested in disaster response roles, and individuals seeking to strengthen regional mutual aid capacity. Outreach will occur through local emergency response agencies and community networks to ensure broad regional participation. By offering the course locally each year, the project eliminates common rural barriers such as travel, lodging, and limited course availability. Consistent annual access ensures that new volunteers can enter the system regularly rather than waiting multiple years for training opportunities. Over the years, this approach will build a larger and more reliable pool of certified EMTs capable of supporting routine EMS operations, seasonal population surges, cruise ship-related call volume increases, and disaster response. The annual model creates predictable workforce growth, improves system redundancy, and strengthens island-wide and regional EMS resilience in this geographically isolated community.	\$50,000-\$250,000	Single Community	Ketchikan Gateway Borough	Advance to Implementation Application

City of Ketchikan	Ketchikan High School EMT Program	AK	Rural Alaska communities face persistent emergency medical services (EMS) workforce shortages driven by geographic isolation, limited local training pathways, and high recruitment and relocation costs. Ketchikan relies heavily on recruiting certified EMTs from outside the region, which can be costly and often results in lower long-term retention. Workforce instability impacts emergency response capacity, increases strain on existing providers, and threatens overall healthcare system resiliency. At the same time, rural youth have limited access to locally available healthcare career pathways. Without early training opportunities, many students leave the community for education and may not return, further weakening the local workforce pipeline. This project addresses both challenges by fully funding the Ketchikan High School EMT course for five years, creating a sustainable, community-based EMS workforce pipeline. By providing state-approved EMT certification within the high school, the program increases local certification rates, strengthens staffing stability, and builds long-term workforce sustainability from within the community.	The program will deliver a state-approved EMT certification course integrated into the high school curriculum. Students will receive classroom instruction, hands-on skills training, and supervised clinical and field experience in partnership with Ketchikan Gateway Borough EMS. Upon successful completion, students will be eligible to sit for the National Registry or Alaska EMT certification examination. Funding will support instructor compensation, training equipment and medical supplies, simulation materials, student textbooks, certification exam fees, and program coordination. Stable funding ensures the course can be offered consistently without interruption due to annual budget uncertainty. The program will also incorporate mentorship opportunities with local EMS providers, exposure to career pathways in healthcare, and coordination to support graduates transitioning into part-time, volunteer, or career EMS roles within the community. By embedding EMT training within the high school setting, the project removes rural access barriers such as travel, housing, and tuition costs that often prevent students from pursuing certification. Students can graduate high school with an industry-recognized credential and immediate eligibility for employment in a high-demand field. This approach will increase the number of locally trained EMTs, strengthen recruitment and retention, reduce reliance on out-of-area hiring, and improve overall EMS system stability in this geographically isolated community.	\$50,000-\$250,000	Single Community	Ketchikan Gateway Borough	Advance to Implementation Application

City of Ketchikan	Ketchikan Mobile Integrated Healthcare Stabilization & Nurse Practitioner Expansion	AK	The City of Ketchikan operates a Mobile Integrated Healthcare (MIH) program that has demonstrated success in reducing avoidable emergency department (ED) visits and improving care coordination for high-utilizing and medically complex patients. However, as a geographically isolated island community with limited primary care capacity and workforce shortages, Ketchikan continues to experience preventable EMS transports, emergency department congestion, and gaps in chronic disease follow-up. Patients with complex care needs—including elders, individuals with chronic disease, and high utilizers of 911 services—often lack timely access to primary care and in-home follow-up. This results in avoidable hospital utilization, higher system costs, and strain on EMS staffing. To stabilize and expand this proven MIH model over five years, the City seeks to embed a full-time Nurse Practitioner (NP) within the MIH team. This addition will expand clinical capability, increase diversion from emergency transport, and strengthen hospital and primary care coordination in a rural, frontier setting.	The City of Ketchikan proposes a five-year stabilization and expansion of its existing Mobile Integrated Healthcare (MIH) program through the addition of a full-time embedded Nurse Practitioner (NP). The MIH team will continue proactive identification of high EMS utilizers, patients with chronic disease, recently discharged hospital patients, and individuals at risk of avoidable ED utilization. With the addition of an NP, the program will expand from primarily assessment and referral services to higher-level clinical intervention delivered in-home. Key components include: • Embedding a full-time NP within the MIH team • Conducting in-home assessments and chronic disease management • Providing limited prescribing, medication reconciliation, and treatment adjustments within scope • Delivering post-discharge follow-up within 24–72 hours • Coordinating closely with PeaceHealth Ketchikan Medical Center and local primary care providers • Supporting telehealth consultation when specialty access is limited The NP will reduce the burden on local primary care providers by managing appropriate low-acuity conditions and chronic disease follow-up in the home setting. This model expands diversion capability from emergency transport and enhances continuity of care. Over five years, funding will stabilize staffing, formalize data tracking and outcomes measurement, and strengthen reimbursement pathways to support long-term sustainability. This approach aligns with RHTP goals by improving access, strengthening workforce capacity, enhancing care coordination, and advancing innovative rural care delivery models.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough	Advance to Implementation Application

City of Ketchikan	EMS Simulation & Training Equipment Modernization Initiative	AK	Ketchikan’s EMS system serves a remote island community where providers must manage complex medical, trauma, obstetric, pediatric, and behavioral health emergencies with limited access to specialty care and potential transport delays due to weather and geography. In this frontier setting, maintaining high clinical competency is critical to patient safety and outcomes. However, much of the current training equipment is aging and lacks the fidelity needed to replicate realistic, high-acuity scenarios. Limited simulation capacity reduces opportunities for hands-on practice, especially for rare but high-risk events such as advanced airway management, cardiac arrest, or mass casualty incidents. In rural systems where providers may encounter certain critical cases infrequently, inadequate training tools can increase clinical error risk and impact certification success rates. This project addresses the opportunity to modernize EMS training infrastructure by investing in high-fidelity mannequins, advanced airway trainers, trauma simulation tools, and ongoing equipment refresh funding. Strengthening simulation capacity will improve provider competency, enhance certification preparation, and support high school EMT programs, community courses, and in-service training. By improving training quality locally, the project strengthens workforce readiness and patient care outcomes in a geographically isolated community.	The City of Ketchikan Fire Department proposes to modernize and expand EMS training capacity through the acquisition of high-fidelity simulation equipment and establishment of an ongoing equipment refresh plan. The project will invest in advanced training tools, including high-fidelity adult and pediatric mannequins, advanced airway trainers, trauma simulation equipment, and scenario-based training technology. These tools will allow providers to replicate realistic emergency conditions such as cardiac arrest, respiratory failure, obstetric emergencies, pediatric trauma, behavioral health crises, and mass casualty incidents. New equipment will be integrated into: • High School EMT certification courses • Annual Community EMT courses • Ongoing in-service and continuing education training • Skills verification and competency assessments • Interagency disaster and mutual aid exercises Simulation-based training will emphasize hands-on practice, team communication, critical decision-making, and error prevention in a controlled learning environment. Instructors will receive training on equipment utilization to ensure consistent, high-quality delivery. Funding will support initial acquisition, instructor training, maintenance planning, and a structured multi-year replacement schedule. Establishing ongoing refresh capacity ensures that equipment remains current, functional, and aligned with evolving clinical standards. By embedding modern simulation into all levels of EMS education, the project strengthens clinical competency across career and volunteer providers. Improved training quality supports higher certification pass rates, enhanced confidence, and reduced clinical error risk. This approach builds durable training infrastructure that supports workforce development, improves patient care quality, and enhances long-term EMS system resilience in this geographically isolated community.	\$250K-\$1M	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

City of Ketchikan	Ketchikan Fire Boat & Maritime Emergency Response	AK	Ketchikan is a remote island community with a heavy reliance on maritime transportation for commerce, tourism, and daily life. The harbor supports commercial fishing vessels, freight traffic, floatplanes, and seasonal cruise ships. Approximately 1.7 million cruise ship passengers are projected this summer, exceeding Juneau due to passenger caps, along with thousands of additional air-travel visitors accessing fishing lodges and charter vessels. Marine environments present unique risks, including vessel fires, fuel spills, traumatic injuries, hypothermia, cardiac events, and potential mass casualty incidents. However, the department's dedicated fireboat went out of service in 2023, eliminating primary marine firefighting capacity. Current marine response capability is limited relative to the scale and complexity of maritime activity. A significant vessel fire or large scale emergency could quickly overwhelm land-based resources and delay critical medical intervention. This project addresses the urgent need to restore and enhance maritime emergency response capacity through acquisition of a dedicated fire boat capable of firefighting, rescue, and EMS support. Expanding marine response capacity improves access to care in areas unreachable by road, strengthens surge readiness during peak tourism season, and enhances long-term healthcare system resilience in this geographically isolated coastal community.	The City of Ketchikan proposes to enhance maritime emergency response capacity through acquisition and full operational integration of a dedicated fire boat equipped for firefighting, rescue, and EMS support. The vessel will be outfitted with marine-grade firefighting pumps and suppression systems, rescue equipment, advanced life support (ALS) medical equipment, interoperable communications, and capacity to support mass casualty incidents. Design specifications will align with harbor risk assessments, cruise ship traffic demands, and regional mutual aid needs. Implementation will include: • Finalizing vessel specifications based on operational risk analysis • Procurement or retrofit of a fire boat meeting marine safety and firefighting standards • Installation of medical and rescue equipment • Training of fire and EMS personnel in marine firefighting, rescue operations, and onboard medical care • Integration into emergency response protocols and cruise ship contingency planning • Coordination with harbor authorities, local clinics, and PeaceHealth Ketchikan Medical Center The fire boat will operate as a frontline response asset for vessel fires, dockside emergencies, search and rescue operations, shoreline incidents, and marine-based medical emergencies. It will also serve as surge capacity during cruise ship season, large-scale public events, and disaster scenarios. Operational protocols will ensure seamless transition from on-water stabilization to land-based EMS transport and definitive care. Joint training exercises with local and regional partners will strengthen interagency coordination and mutual aid readiness. By combining modern marine firefighting capability with onboard EMS treatment capacity, the project ensures timely access to emergency care in areas not reachable by road. This approach strengthens patient outcomes, improves system redundancy, and enhances long-term emergency response sustainability in this geographically isolated coastal community.	\$250K-\$1M	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

City of Ketchikan	Ketchikan Full Time EMS Instructor and Workforce Development Coordinator	AK	Ketchikan’s EMS system is expanding its workforce development efforts through a High School EMT program, annual community EMT courses, enhanced simulation training, and Mobile Integrated Healthcare (MIH) clinical integration. However, these initiatives are currently supported largely by line staff who balance emergency response duties with instructional responsibilities. This creates scheduling conflicts, increases burnout risk, and limits the consistency and scalability of training programs. In a geographically isolated island community where EMS serves as a primary point of healthcare access, inconsistent training coordination can affect certification compliance, workforce retention, and overall system resilience. As workforce demands grow—particularly during seasonal population surges and disaster events—the need for structured, professionalized training oversight becomes critical. This project addresses the opportunity to establish a full-time EMS Instructor dedicated to coordinating student EMT programs, leading public certification courses, overseeing continuing education, maintaining regulatory compliance, and supporting MIH clinical training. By centralizing workforce development under a dedicated role, the City can ensure consistent training quality, reduce strain on operational staff, and build a sustainable, locally driven EMS workforce model for the long term.	The department will establish and fund a full-time EMS Instructor position for five years to centralize and professionalize EMS workforce development across all training programs. The EMS Instructor will serve as the dedicated coordinator and lead educator for: • The Ketchikan High School EMT program • Annual Community EMT certification courses • Continuing education and recertification for career and volunteer staff • Certification tracking and regulatory compliance • Simulation-based training integration • Clinical training support for the Mobile Integrated Healthcare (MIH) program This position will develop standardized lesson plans, skills verification processes, and scenario-based curricula aligned with Alaska and National Registry requirements. The instructor will coordinate clinical placements, manage training schedules, maintain certification records, and ensure all providers meet continuing education standards. By removing instructional responsibilities from line staff, reduces burnout risk and scheduling conflicts that occur when responders must leave shifts to teach. A full-time instructor ensures predictable course scheduling, improved instructional consistency, and expanded training capacity. The EMS Instructor will collaborate with Ketchikan Gateway Borough EMS, the School District, PeaceHealth Ketchikan Medical Center, local clinics, and regional response partners to align training standards and support joint exercises and mutual aid readiness. This centralized model will support student recruitment, volunteer certification growth, ongoing professional development, and MIH clinical competency. The approach builds a durable training infrastructure that strengthens workforce stability, improves certification outcomes, and enhances overall EMS system resilience in this geographically isolated community.	\$50,000-\$250,000	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

City of Kotzebue	City of Kotzebue EMS and Fire Safety Workforce Pathways	AK	The City of Kotzebue’s Fire Department and EMS first response team provide ambulance services, medevac coordination, and fire response for Kotzebue and the broader Northwest Arctic region. The problem is that emergency response capacity is strained by workforce shortages and training barriers, combined with outdated and unreliable radio communications (static/coverage issues) that reduce coordination, delay response, and increase safety risks during medical emergencies, fires, and disasters. This project opportunity is to strengthen the region’s emergency health care system by building a sustainable local workforce pipeline—creating clearer pathways to fire and EMS certifications, supporting training participation with temporary coverage, and engaging youth through an Explorer-style/high school training approach—while also improving response readiness through required testing and safety practices (e.g., hydrant/extinguisher hydrostatic testing). Together, these efforts will improve response time, coordination, and continuity of care for rural residents across the Northwest Arctic.	The City of Kotzebue will address this opportunity through a coordinated approach that strengthens both the systems and the people needed to deliver reliable emergency response for Kotzebue and the Northwest Arctic region. First, the City will improve emergency communications by upgrading Fire/EMS first response radios and installing a repeater to reduce static and eliminate coverage gaps. Reliable communications are essential for dispatch coordination, responder safety, and continuity of care during medical emergencies, fires, and medevac events—especially in rural Alaska where weather and distance can delay advanced care. At the same time, the City will focus on building a sustainable local workforce. The project will establish clearer pathways for residents to access training and certifications for fire and EMS roles, coordinating closely with Maniilaq Association and other regional partners to align training needs, testing requirements, and practical steps for participants to progress toward credentials. Because training often requires travel and time away from duty, the City will also support temporary coverage so emergency response services remain available while responders attend required trainings. To ensure long-term sustainability, the project will strengthen the pipeline of future responders by expanding youth engagement through an Explorer-style program and/or high school training opportunities that help students gain first response skills and see a realistic career pathway in fire and EMS. Finally, the City will include key readiness activities—such as hydrostatic testing and other safety checks for hydrants and extinguishers—so equipment and systems remain dependable and meet operational needs. Together, these efforts will improve response coordination and reliability today while building a stable, locally trained workforce for the future, strengthening emergency health care access and outcomes across Northwest Alaska.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Northwest Arctic Borough	Deferred or Not Advanced
City of McGrath	Upgrade fire department personal gear and fire hose for city volunteer fire department	AK	Both house fires and wildfires are a threat to the lives of our community members. The volunteer fire department is over 30 years old and the equipment is either worn out or needs improvements for the safety of the fire fighting crew. The coats and helmets are too old to be of primum safety to those who wear it.	When awarded with funding for new equipment, we will purchase coats and helmets which fit the fire fighters. We will purchase new fire hose to replace worn pieces in our fleet.	\$50,000-\$250,000	Single Community	Yukon-Koyukuk Census Area	Deferred or Not Advanced

City of Nenana	Nenana Healthcare Alliance	AK	Nenana faces health care challenges related to the lack of infrastructure that supports healthy activity, social connection, hygiene access, and the delivery of health-centered programming and services. Extreme cold and extended winter darkness limit outdoor activity, yet the community lacks indoor spaces where residents can safely walk, exercise, gather, or participate in health programs. Seasonal darkness in Interior Alaska contributes to seasonal affective disorder, depression, and increased suicide risk, and Alaska’s suicide rate is roughly twice the national average. Nenana also lacks space where organizations and providers can deliver behavioral health services, trauma-informed programs, wellness activities, food security services, and other community health supports. Youth, families, adults, and seniors all lack safe places to gather, particularly during winter months. Limited community space reduces opportunities for physical activity, social connection, and wellness programming, including support for residents managing physical or behavioral health conditions and those in recovery. Nenana has also lost many informal gathering places, a trend that accelerated after the COVID-19 pandemic, leaving few locations where residents can connect, access services, or participate in healthy activities. Some residents also live in housing without running water, creating barriers to regular hygiene practices that support health.	The project will renovate underutilized indoor and outdoor areas to create a year-round space where residents can gather, stay active, access hygiene resources, and participate in healthcare-related programs. It will include showers and a potable water filling station. Indoor space will support movement and wellness activities during winter months when outdoor activity is limited by extreme cold and darkness. Lighting designed to help address SAD will support mental well-being. Fitness equipment and open space will allow residents to participate in stretching, strength, and movement activities suitable for different ages/abilities. A recovery-oriented area supports wellness and recovery activities. Outdoor areas will include space and equipment that encourage safe movement, recreation, and healthy activity during warmer months. The space will support a range of health-related programming that currently has no suitable location in Nenana. Activities to include; movement classes, youth recreation opportunities, parenting groups, recovery support meetings, senior mobility activities, physical therapy, sports medicine, mental health, and wellness programs that encourage physical activity and social connection. The space will also support food distribution and other services that improve access to healthy food. Railbelt Mental Health plans to expand trauma-informed programming, behavioral health support, crisis outreach, and food bank services serving vulnerable residents. The project will also partner with the local school district to provide enhanced opportunities for P.E. classes, physical activity for students when outdoor recess or activities are not possible due to winter conditions. A TA provider will be hired to expand partnerships and coordinate programming within the facility. The TA will work with local organizations, service providers, tribal partners, and community groups to identify needs, recruit program providers, communicate opportunities, and ensure the space is actively used for health-related services and community wellness activities. Access to healthy activities and community connection can also help Nenana retain teachers, health care workers, and other essential staff who serve the community. By creating a welcoming place where hygiene access, health programs, and community services can operate locally, the project will strengthen prevention efforts, expand behavioral health support, and help residents stay active and connected.	\$1M-\$5M	Single Community	Yukon-Koyukuk Census Area	Advance to Implementati on Application

City of Palmer	Lifesaving Access Through Automated External Defibrillator Installation and Deployment	AK	Palmer Fire & Rescue serves the community of Palmer, Alaska and surrounding rural areas where access to immediate advanced medical care can be limited by distance, weather, and response times. Sudden cardiac arrest requires rapid defibrillation, yet not all department apparatus and facilities are currently equipped with standardized Automated External Defibrillators (AEDs), and some existing units are aging or nearing end-of-service life. Fire apparatus are frequently the first arriving resource to medical emergencies, creating an opportunity to significantly improve survival outcomes through expanded AED availability. Without consistent deployment across all response units and stations, there is a risk of delayed defibrillation during critical early minutes of cardiac arrest. This project will address these gaps by purchasing and deploying AEDs across all apparatus and facilities, ensuring consistent, reliable access to life-saving equipment. Standardizing AED placement will strengthen emergency medical response capability, improve patient outcomes, and enhance the long-term resilience of rural emergency care in our service area.	Palmer Fire & Rescue proposes to improve early cardiac arrest intervention across Palmer, Alaska and surrounding rural response areas by purchasing and deploying Automated External Defibrillators (AEDs) on all frontline apparatus and within all department facilities. This project will standardize access to defibrillation equipment, ensuring responders have immediate access to life-saving tools regardless of which unit arrives first on scene. The project will include the acquisition of AED units along with necessary accessories such as adult and pediatric electrode pads, spare batteries, mounting hardware, and protective carrying cases. Equipment selection will prioritize reliability, ease of use, and compatibility with current responder training practices. Once acquired, AEDs will be installed on all response apparatus and placed in accessible locations within department facilities. Implementation will be supported through structured training and integration into existing operational procedures. All personnel will receive refresher training on AED use, emphasizing rapid deployment during cardiac arrest incidents and reinforcing current medical response protocols. AED inspection and maintenance will be incorporated into the department’s routine apparatus and equipment check processes to ensure long-term readiness. To support sustainability, the department will integrate replacement consumables and future lifecycle costs into annual operating and capital planning. Data collection through incident reporting will allow the department to track AED utilization and support continuous improvement in response practices. By standardizing AED deployment and reinforcing responder training, this project will strengthen early intervention capabilities, reduce delays in defibrillation, and enhance the overall effectiveness and reliability of rural emergency medical response.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

City of Pelican	Community Wellness Center Planning and Feasibility Study	AK	The City of Pelican is a remote community with limited access to health and wellness infrastructure. Residents travel by boat or plane to reach larger communities for many health services and wellness opportunities. Like many rural communities, Pelican faces growing concerns related to chronic disease, aging population needs, behavioral health, and social isolation. At present, the city does not have a dedicated wellness or community health facility where residents can gather for physical activity, health programming, or educational resources. At the same time, Pelican owns a former school building that is not being used and presents a significant opportunity to serve community health needs. Renovating this existing structure into a Community Wellness Center will create a centralized space for fitness activities, health education programs, and community gatherings that promote community health and lifestyle changes. The proposed planning and feasibility study will evaluate how the building can be safely and efficiently renovated to support these functions while ensuring long-term sustainability. The project will lay the groundwork for developing a wellness facility that promotes preventive health, supports social connection, and improves quality of life for residents. Establishing a dedicated wellness center will help Pelican strengthen community resilience, support healthy lifestyles, and provide a foundational space for future health programming in a remote setting.	The City of Pelican will conduct a comprehensive planning and feasibility study to evaluate the conversion of an existing city-owned former school building into a multi-use Community Wellness Center. The study will assess how the facility can be renovated and operated to support community health, wellness programming, and educational resources while ensuring long-term sustainability for a rural community. Key components of the project include: 1. Facility Assessment of the existing building will determine renovation requirements, code compliance needs, and potential design options for the space. This assessment will evaluate structural conditions, accessibility improvements, energy efficiency opportunities, and building systems to identify the most practical and cost-effective approach for renovation. 2. Community Engagement and Needs Assessment will identify the types of wellness and community programs residents most want and need. Community input will help shape the design and programming of the facility, including potential uses such as fitness space, group exercise classes, youth activities, senior programming, health education events, and library services. 3. Conceptual Plans and Cost Estimates: These plans will evaluate how the facility could be configured to support a wellness center and library while maximizing the use of existing infrastructure. The study will also explore options for equipment needs, operational staffing, and potential partnerships with regional health organizations or community groups. 4. Sustainability Plan will support operational, asset management, and sustainability planning for the building. This will include identification of potential funding sources, operational models, and development strategies to ensure the facility can be successfully implemented and maintained over time. By completing this feasibility and planning effort, the City of Pelican will create a clear, community-driven roadmap for transforming an underutilized public building into a wellness and community hub that supports healthy lifestyles, social connection, and improved quality of life for rural residents. The project aligns with RHTP initiatives: Healthy Communities: Establish wellness centers to promote community health and lifestyle changes Health Care Access: Provide a dedicated space for community health and education programming	\$250K-\$1M	Single Community	Hoonah-Angoon Census Area	Deferred or Not Advanced

City of Port Alexander--Health Department	Remote Island Community Emergency Response System--Helicopter Pad, Flood Lights, and Alert Sirens	AK	We would like to be able to provide a safer, more reliable area for U.S. Coast Guard helicopters to land as they pick up patients in life or limb-threatening emergency situations. Often this may be when the conditions are not ideal, and the designation of an appropriate area with a well-engineered landing pad would make the incident safer for all and help get the patient to needed medical care more quickly. We are also a fishing port, and would be a destination for fisherman and other mariners in the area who need medical assistance and/or transportation to a higher level of care. The other problems include a lack of reliable and efficient way to alert the community to an emergency, where we don't have cell service and some also lack internet and landline, and a lack of lighting outdoors (ie. floodlights) for emergency incidents at night in our off-grid (and car-free) town, including fires, earthquakes, mass casualty or single casualty events.	This project would include the research and purchasing of flood lights and alert sirens for both sides of the bay along which our community is located. This could take place fairly quickly; consultation from other emergency response organizations would be sought. The creation of a helicopter pad would include 1) the selecting and securing of a site and design of a pad with consultation of the U.S. Coast Guard, 2) the hiring of an engineer, 3) a request for bids from contractors, 4) the purchasing of and arranging shipment for materials, 5) the receiving and stationing of materials, 6) the construction of the pad. The receiving of materials and construction should take place in the summer months, ideally. If clearing and leveling of a lot is required, this will add another phase.	\$50,000-\$250,000	Home- and community-based services provider	Single Community	Prince of Wales-Hyder Census Area	Deferred or Not Advanced

City of Saint Paul	Community Farm Design and Coordinator: Improving Rural Health Through Food Access and Sustainability	AK	The food system on Saint Paul Island faces challenges due to its isolation, reliance on imported goods, and logistical difficulties. Transportation is a major hurdle, with freight arriving by infrequent barges or air cargo, both of which are subject to delays and weather disruptions that affect the quality and availability of food. Limited food shipments have led to decreased availability of fresh food options and increased reliance on shelf-stable foods, all of which contribute to growing health concerns. The island has only one grocery store and it routinely carries reduced availability of fresh fruits and vegetables. Saint Paul Island functions as a food desert, with residents relying heavily on processed and packaged foods that are high in sugar, salt, and fat. In the 2023 Food Security Assessment of Saint Paul Island, 81% reported that the poor condition of available produce made it difficult for households to obtain healthy food from the local store. Limited access to nutritious foods contributes to broader health disparities in the community. Early childhood obesity is particularly concerning here where diet-related health conditions are more prevalent. On Saint Paul Island, residents experience high rates of chronic health issues such as high blood pressure, diabetes, asthma, and mental health challenges. The local school does not offer a lunch program, requiring students to go home for lunch, which can limit consistent access to balanced meals.	The City of Saint Paul seeks funding for two components to advancing the Saint Paul Island Community Farm: 1) completing 100% design and engineering of the facilities, and 2) hiring a full-time Coordinator. 1) Completing the remaining engineering and design plans is the next step in the City’s advancement of this project. With funding, the City is ready to hire a firm to complete design plans and produce construction documents for the greenhouse, chicken house, and compost facilities. The City has conducted community surveys, outreach and engagement of the project and received overwhelming support. A feasibility study, business plan, infrastructure plan and conceptual design have already been completed, as well as a strategic plan for incremental growing and expansion of farm. The site for the farm has already been secured. The City owns the 1-acre land parcel on which the Community Farm will be constructed, and the water, waste heat and electricity to which the farm will be connected. 2) Hiring a full-time Community Farm Coordinator is essential to ensuring the success and long-term sustainability of the Saint Paul Island community farm project and its impact on community health. The Coordinator ensures the farm is designed with the community, for the community. During the planning and design phase, the Coordinator will act as the bridge between the community, designers, engineers, and project partners to ensure the farm is designed to meet community needs and is practical to operate once built. Once design has been completed, the Coordinator will serve as Project Manager to coordinate communication between contractors, designers, and the community while preparing for launch. Once construction has been completed, the Coordinator will manage the day-to-day operation and long-term success of the community farm. The City also intends to partner with the local school, health clinic, and tribal government to promote nutritional education and healthy lifestyles. The Community Farm will include educational programs that teach people how to grow their own food, how to prepare healthy meals using fresh produce, and increase their knowledge and understanding of nutrition. These education opportunities can help people adopt healthier eating habits and make better food choices.	\$250K-\$1M	Single Community	Aleutians West Census Area	Deferred or Not Advanced

City of Saint Paul	Saint Paul Island EMS: Access, Quality, Sustainability	AK	Saint Paul Island, Alaska is a fishing community currently undergoing an economic crisis caused by the severe decline in the Bering Sea crab stocks. In normal years, the City of Saint Paul collects on average \$2,700,000 in fisheries taxes. For the past four years the City collected \$0 from fisheries tax revenues. As a result, the City has been forced to implement budgetary cuts, layoffs, hiring freezes, and other painful measures to withstand the loss of revenues and continue to provide essential municipal services. The City has reduced its staff from 42 to 16 employees since the crab closure began in 2021. We have taken out loans, requested emergency government funding, and written dozens of grant applications seeking funding for capital improvement projects, equipment, supplies, training, and personnel. The Aleutians/Pribilof Islands region of Alaska, characterized by its remote location and sparse population, typically has a limited presence of public safety officers compared to more densely populated areas of the state. Prevention of fatalities and rapid treatment of serious injuries is of critical importance to the Saint Paul Island community. The need for a full-time EMS Coordinator is further substantiated by a high volume of medical calls and medivacs that occur each year on Saint Paul Island, significant considering the small population.	By establishing a dedicated, full-time EMS Coordinator, Saint Paul Island will have a centralized, professional leader who ensures reliable emergency response, high-quality care, and sustainable EMS operations. This role directly mitigates the risks posed by limited personnel, remoteness, and environmental challenges, ultimately safeguarding community health and survival. 1. Enhancing Access to Emergency Care • Coordinate EMS staffing schedules to ensure consistent coverage despite limited personnel. • Develop and maintain relationships with regional hospitals and air transport providers, optimizing medivac coordination in the event of weather delays or limited essential air service. • Implement contingency response plans for times when travel is disrupted by storms or other environmental hazards. 2. Improving Quality of Care • Provide continuous training and certification management for EMS personnel, ensuring responders are prepared for high-acuity cases in isolated settings. • Establish and monitor evidence-based treatment protocols, including trauma stabilization, cardiac emergencies, and other critical care scenarios. • Conduct regular quality improvement reviews of medical calls and medivacs to identify gaps and implement corrective measures. 3. Increasing System Sustainability • Lead administrative and operational oversight, including compliance with state and federal EMS regulations, equipment readiness, and fleet maintenance. • Pursue grant funding and community partnerships to expand EMS capacity and resources, ensuring long-term program viability. • Implement preventive health initiatives and community outreach programs to reduce emergency incidents, supporting overall public safety. 4. Mitigating Geographic and Environmental Barriers • Develop strategies to address the challenges of limited transportation and unpredictable weather, ensuring rapid response even when standard evacuation routes are delayed. • Coordinate closely with regional medivac services to prioritize critical cases, improving survival outcomes for residents.	\$50,000-\$250,000	Single Community	Aleutians West Census Area	Deferred or Not Advanced

City of Seward	Expanding Rural Care Beyond the Hospital Walls – Integrated Home Health, DME & Home Oxygen Program	AK	Seward faces significant and interconnected gaps across the full continuum of home-based care. On the non-medical side, limited availability of home support services contributes to caregiver burnout, delayed discharges, and in many cases prevents patients from returning home to Seward altogether, driving avoidable emergency department use in the process. The gaps extend into clinical care as well. Without access to local skilled nursing or home therapy services, patients managing chronic conditions after discharge have no reliable support structure, increasing their risk of readmission and making continuity of care nearly impossible to achieve. Perhaps most critically, Seward has no local durable medical equipment or oxygen vendors. Patients requiring oxygen or essential equipment face significant delays in obtaining it, and in some cases are discharged without the safe supports they need simply because no other option exists. Taken together, these gaps produce outcomes that are harmful and costly: longer hospital stays, unsafe discharges, increased readmissions and emergency department visits, and a higher total cost of care. This project represents a clear opportunity to address all three layers of this problem through an integrated home-based model that meets patients where they are and keeps them safely in their community.	This project implements a phased, integrated model that combines home support services, medical equipment access, skilled clinical care, and care coordination into one unified system rather than a collection of separate programs. In Year 1, the focus is on building the foundational services Seward currently lacks entirely. A non-medical home support program will provide companionship, safety checks, meal preparation, light housekeeping, transportation, personal care, and medication reminders, giving patients the day-to-day support they need to remain safely at home. Alongside this, a local DME and home oxygen program will be launched, establishing community inventory of oxygen concentrators, nebulizers, respiratory equipment, walkers, and wheelchairs. Same-day or next-day oxygen setup will be available, with patient and caregiver education built in and direct integration into hospital discharge workflows. Together these two components enable safe and timely discharges, deliver immediate impact on patient safety, and build the workforce and operational foundation needed for the next phase. In Year 2, the model expands into licensed skilled home health services, including registered nurse visits, physical and occupational therapy, chronic disease management, and post-hospital recovery care. A unified referral and intake system will standardize discharge planning and formalize coordination across the hospital, primary care, and all home-based services. Telehealth and remote monitoring capabilities will support respiratory and clinical follow-up, with early intervention protocols for high-risk patients. The result is a fully integrated continuum: services, equipment, clinical care, and coordination working together to transform how Seward delivers care outside the hospital walls.	\$250K-\$1M	Single Community	Kenai Peninsula Borough	Advance to Implementation Application

City of Seward	Expanding Rural Diagnostic Access: MRI with Modular POD Infrastructure	AK	Seward currently has no local MRI access, leaving a critical gap in diagnostic capability for a community that is 125 miles from the nearest scanner. When patients require MRI for neurological, spinal, or soft-tissue conditions, they face significant travel burdens, transfer delays, and the fragmentation of care that comes with being evaluated in one facility and imaged in another. For emergency and inpatient cases where timely diagnosis directly affects outcomes, these delays are not merely inconvenient but clinically consequential. The financial impact compounds the clinical one. Advanced imaging revenue that should stay within the community currently leaves with every patient transferred elsewhere for MRI services. Beyond direct revenue loss, the absence of MRI capability creates a meaningful barrier to specialist recruitment. Physicians considering practice in a rural community expect access to the diagnostic tools their patients need, and without MRI, Seward is at a structural disadvantage in attracting and retaining the specialists that would strengthen its broader care capacity. This project addresses all of these dimensions at once by establishing local MRI services, closing the diagnostic gap, reducing transfer burden, retaining revenue, and creating the infrastructure needed to support a more complete and sustainable rural healthcare system.	This project will establish local MRI services through the installation of a 1.5T MRI unit housed in a modular POD, providing a practical and efficient solution for a rural facility without the construction demands of a traditional fixed installation. Implementation will begin with site preparation and the necessary utility connections to support the unit safely and reliably. Once operational, the service will be staffed by on-site MRI technologists who will perform scans locally, eliminating the need for patient transfers for diagnostic imaging. Image interpretation will be provided through remote radiology, leveraging telehealth infrastructure to deliver timely reads without requiring on-site radiologist coverage. An integrated referral pathway will connect the MRI service directly to the emergency department, inpatient care, and outpatient providers, ensuring that ordering, scheduling, and results flow efficiently into existing clinical workflows.	\$1M-\$5M	Single Community	Kenai Peninsula Borough	Advance to Implementation Application

City of Seward	Community Trauma and Emergency Simulation Training Center	AK	Rural Alaska healthcare systems face a fundamental tension: low patient volume paired with high-acuity, high-risk emergency events. Clinicians must be ready to respond to rare, life-threatening situations without the benefit of frequent real-world exposure to build and maintain those skills. Compounding this, access to consistent hands-on training in rural settings is extremely limited, and sending staff outside the region for training carries significant costs in travel, lodging, and backfill staffing while creating delays in skill development and refresher training. High workforce turnover adds further pressure, requiring repeated onboarding and skill validation with limited infrastructure to support it efficiently. At Providence Seward Medical Center, a Level IV Trauma Center, maintaining trauma readiness is not optional. Yet the current training model depends heavily on staff leaving the community, resulting in variability in emergency preparedness and virtually no opportunity for the interdisciplinary EMS and hospital joint training that rural emergency response demands. This gap between required readiness and practical, ongoing training access represents a clear and urgent opportunity. This project will establish the Community Trauma and Emergency Simulation Training Center as a regional hub for simulation-based training and workforce development, strengthening emergency preparedness, workforce capability, and patient outcomes across rural Alaska.	Providence Seward Medical Center proposes the development of a regional Simulation and Workforce Development Hub to deliver consistent, high-quality, simulation-based training and interdisciplinary emergency preparedness across the region. At the core of the program is a robust simulation-based emergency training curriculum built around high-fidelity scenarios reflecting the realities of rural emergency care. Teams will train on multi-patient and mass casualty events, rural-specific response challenges, and critical skills including obstetric emergencies, airway management, hemorrhage control, stabilization, and patient transfer. Real-time debriefing following each simulation will reinforce clinical decision-making, communication, and teamwork in ways that classroom instruction cannot replicate. Workforce development and continuing education will be delivered locally, eliminating the cost and delay of sending staff out of the region. Structured onboarding and competency validation for new staff will address the ongoing challenge of workforce turnover, while regular skill refreshers ensure that all team members maintain readiness in a low-volume, high-risk environment. The training model is designed to be scalable, allowing topics and complexity to expand over time. A dedicated EMS and hospital joint training component will bring these two teams together through integrated simulation exercises, standardized emergency response protocols, and regional drills focused on communication, handoffs, and coordinated response. Finally, PSMC will serve as a regional training hub, extending access to surrounding communities and partner organizations through shared scheduling models and regional infrastructure that no single rural facility could sustain alone.	\$250K-\$1M	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

City of Seward	Modernizing Rural Emergency Diagnostics: CT Scanner Replacement and Imaging Infrastructure Upgrade	AK	The hospital's current CT scanner is outdated and increasingly unable to meet the demands of modern emergency and inpatient care. Slow scan times, lower image quality, and failure to meet current trauma, stroke, and radiation dose standards increase the risk of delayed or inaccurate diagnoses in time-critical situations. Recurring equipment failures disrupt clinical workflows, delay care, and drive up operational costs. The existing scanner also cannot support expanded screening or preventive imaging programs, and its limitations create a meaningful barrier to recruiting and retaining the skilled physicians and technologists that rural communities depend on. Replacing the scanner presents a clear opportunity to address all of these challenges at once. A modern CT system would improve trauma and stroke evaluation through faster scan times and superior image clarity, enabling confident and timely clinical decision-making. Enhanced image quality would strengthen teleradiology and specialty consultation, reduce unnecessary patient transfers, improve throughput, and ensure compliance with current regulatory and accreditation standards. Upgrading this essential infrastructure would stabilize emergency services, expand local access to imaging and screening, and improve provider recruitment, keeping more care safely within the community.	This project will replace the hospital's outdated CT scanner with a modern 128-slice system, providing the diagnostic capability required to meet current standards for emergency and inpatient care in a rural setting. Installation will be accompanied by upgrades to the control room and workstation infrastructure to ensure the full capabilities of the new system can be utilized effectively. Advanced imaging protocols for stroke, trauma, pulmonary embolism, and cardiac evaluation where appropriate will be integrated into clinical workflows, standardizing the hospital's approach to time-critical diagnostic scenarios. PACS and image transmission capacity will be improved to support faster, higher-quality image sharing with teleradiology partners and consulting specialists, reducing the need for patient transfers for interpretive support. Comprehensive staff training on the updated technology will ensure that clinical and technical teams can operate the new system confidently from day one. A service contract will be established to maintain uptime reliability, protecting the investment and ensuring that equipment failure does not continue to be a source of care disruption.	\$1M-\$5M	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

City of Seward	Rural Hospital Safety: Security Remodel, Access Control & Triage Redesign	AK	The hospital’s current physical layout and security infrastructure were not designed to meet today’s rural healthcare safety, behavioral health, and infection prevention demands. Open access to clinical areas, lack of controlled entry points, unsecured nurse stations, and an inadequately designed triage and intake environment create increased risk of workplace violence, limit patient privacy, and hinder the ability to rapidly identify and isolate high risk or infectious patients. The absence of a designated waiting and intake area further contributes to uncontrolled patient flow, reduced staff visibility, and barriers to safe access to care. This project presents a critical opportunity to modernize security, access control, and triage spaces to protect staff, improve patient safety and dignity, strengthen infection prevention, and ensure safe, structured access to care from the point of entry through triage.	This project is a remodel and systems integration effort, not new construction. It modernizes the physical and operational security infrastructure of the hospital through a coordinated set of interconnected improvements. At the core of the project is the installation of an electronic badge access control system throughout inpatient and Emergency Department areas, establishing clearly defined and secured access points to all clinical zones. Nurse stations will be redesigned with enclosed or semi-enclosed configurations, shatter-resistant materials, and controlled entry points to protect staff while maintaining efficient care delivery. A controlled visitor access system will be implemented alongside upgrades to the security camera and monitoring system, with improved lighting and line-of-sight design to enhance situational awareness throughout the facility. Duress alarms and panic buttons will be integrated to give staff immediate access to support when needed. The triage area will be remodeled to include private, confidential patient assessment rooms, a clear workflow for rapid identification of infectious symptoms, and designated early isolation capability. This directly addresses both patient dignity and infection control in the highest-traffic area of the facility. The waiting area will be expanded and optimized to improve patient flow, allow separation of patients when needed, enhance monitoring and visibility, and support safe and controlled access into clinical care areas. The project will be completed with comprehensive staff training on both security protocols and infection control procedures, ensuring that physical improvements are matched by the knowledge and practices needed to sustain them.	\$1M-\$5M	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

City of Soldotna	Soldotna Creek Park Inclusive Play Renovation	AK	Opportunities for inclusive outdoor play are limited across much of rural Alaska. Many playgrounds are not designed for children who use mobility devices or who benefit from sensory-friendly environments, which can prevent some families from fully participating in community recreation. The City of Soldotna maintains several parks that serve residents across the central Kenai Peninsula, but there is currently no dedicated play space intentionally designed to accommodate children of all abilities in Soldotna or in surrounding communities. The proposed project site is located near a highly used Kenai River access point that draws families and visitors for personal use fishing and sportfishing. This location provides a unique opportunity to create a recreation space that encourages active outdoor lifestyles while supporting healthy food traditions common throughout Alaska. Increasing access to safe, inclusive places for children to be active is an important strategy for preventing chronic disease and supporting long-term community health. By creating a space where children of all abilities can play and families can gather outdoors, this project will help reduce barriers to physical activity, encourage healthy habits at an early age, and increase opportunities for social connection.	The City of Soldotna proposes to renovate an existing volunteer-built playground into an inclusive play environment that supports physical activity, social interaction, and healthy development for children of all abilities. Soldotna Creek Park features a well-loved and heavily-used community playground, built by and for community members in 2011, however the non-traditional volunteer-built structures lack the accessibility features and universal design that would make the playground accessible for children of all abilities. The project will incorporate key elements of inclusive playground design, which may include: - o ramp-accessible play structures and transfer platforms - o inclusive swings and motion-based play equipment - o sensory play features such as tactile panels - o accessible pathways and seating areas for caregivers and individuals with mobility devices - o gathering and rest areas that support family participation The park’s location adjacent to a popular Kenai River fishing access area will further support outdoor recreation by providing a family-friendly environment where visitors can fish, walk, play, and gather in one location. The park hosts frequent community events, festivals, live music, and other gatherings that create important opportunities for positive social connections. The park is already equipped with ADA accessible trails that connect the playground to the rest of the park amenities. These combined activities encourage healthy lifestyles that include physical activity, outdoor time, and access to locally harvested foods such as salmon.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

City of Togiak	Jake’s Place Satellite Facility: Renovating the Togiak Family Resource Center for SUD Treatment	AK	The Bristol Bay region faces an acute shortage of accessible SUD treatment, with demand far exceeding capacity. Jake’s Place in Dillingham, the primary regional provider, experiences chronic overcrowding that results in wait times of more than a year for residential treatment. For rural communities such as Togiak, this delay has serious consequences. Currently, 48 Togiak children are in out-of-home foster care due to parental drug and alcohol use, and community concerns related to impaired driving and alcohol-related harm remain high. In a recent public survey, 67% of respondents identified drug- or alcohol-impaired driving as a high-priority concern, reflecting widespread recognition that substance use is undermining health, safety, and family stability. The opportunity lies in re-purposing an existing community asset: the underutilized Family Resource Center in Togiak. The facility is structurally suited for renovation and is owned by a regional partner with a vested interest in long-term community benefit. Strategic investment through the Rural Health Transformation Program would allow this space to be converted into a satellite treatment facility, expanding regional capacity without new major construction. By leveraging existing infrastructure and established treatment providers, this project addresses an urgent health crisis, reduces regional bottlenecks, and prevents the displacement of rural residents seeking recovery by bringing services closer to home.	The project will implement a regional hub-and-spoke model that aligns directly with Rural Health Transformation Program priorities related to access, system integration, and behavioral health infrastructure. The City of Togiak will partner with the Bristol Bay Native Corporation, owner of the Family Resource Center building, and with Bristol Bay Area Health Corporation and Jake’s Place, the region’s established substance use treatment provider. The City of Togiak will lead project planning, coordination, and capital improvements, while Bristol Bay Native Corporation will provide the facility asset and support long-term stewardship of the building. The project has deep community support, and the City Council unanimously voted to move this initiative and LOI forward. Jake’s Place will operate the renovated facility as a licensed satellite program, delivering residential treatment, outpatient services, aftercare planning, and recovery education consistent with state clinical standards and regional practice models. Bed capacity will be allocated to meet Togiak needs while also serving regional overflow, directly relieving pressure on the Dillingham hub. The project will be completed in phased stages to ensure readiness and cost control. The first phase will focus on planning, developing partnerships, and a comprehensive needs assessment, including space programming, regulatory review, and community input. The second phase will include pre-development activities, architectural and engineering design, and final cost estimates. The third phase will complete renovation within the existing building footprint, consistent with RHTP guidelines that prioritize renovation over new major construction. Formal partnership agreements will define roles, operational responsibilities, and coordination protocols. This approach ensures the facility is clinically sound, culturally responsive, and fully integrated into the regional continuum of care while maximizing the impact of RHTP capital investment.	\$50,000-\$250,000		Multi-Community or Participating in Regional Hub-and-Spoke	Dillingham Census Area	Advance to Implementation Application

City of Togiak	Finalization of the Billy Blue Emergency Access and Safe Transport Route for the Community of Togiak	AK	Togiak faces an acute emergency access and public safety gap that directly threatens health outcomes for the entire community. The single route to the Togiak School, the designated safety zone and emergency shelter, is a danger year-round. When the route is unsafe or impassable, EMS and first responders are delayed and timely evacuation is threatened. This need is strongly documented through community planning. During the 2020–2025 TTSP public involvement process, finishing the Billy Blue Road was identified as the top community priority. In the community survey, 75% cited poor road design as a high priority concern, and 71% cited lack of an evacuation route and safety shelters. This letter of interest was approved and endorsed by the Togiak Common Council, and other community organizations were involved in crafting this narrative. The opportunity presented here is to finalize a heavily vetted, community-driven project that creates a direct, reliable route for emergency services and to the entire population’s emergency shelter site. Recent events in rural Alaska demonstrate the urgent need for safe and timely evacuation routes, and we have seen the real-life effects of weather events on communities. Because the project is fully engineered, environmentally vetted, and aligned across multiple funding partners, it represents a high visibility opportunity for RHTP to demonstrate the transformative impact the program will have on rural health care.	Our approach is to use RHTP funding to expand on existing design and engineering work and finalize the Billy Blue Road, moving a long-planned community priority into implementation with a clear pathway to near-term impact. The project is in the ready-to-launch phase. The Traditional Council of Togiak previously secured a Safe Routes to School grant through the Alaska Department of Transportation, and engineering and design have been completed. Environmental and permitting steps have also been advanced, including a U.S. Army Corps of Engineers public notice. Togiak is requesting \$2 million in RHTP funds to complement a larger \$4 million funding package and close the remaining construction gap. RHTP dollars will be used to mobilize quickly, procure materials, secure contractors, and complete the final stage of the 3,216-foot road that provides a direct route to the school and higher ground. The City of Togiak and the Traditional Council will jointly oversee implementation, coordinate local logistics, and ensure community communication and safety during construction. This is a coordinated, multi-agency effort designed to maximize impact and minimize duplication. We are collaborating with Senator Murkowski’s office, the Denali Commission, the Bureau of Indian Affairs, and the Bristol Bay Native Corporation to align funding, technical support, and delivery timelines. The project will be managed with clear milestones, including contractor procurement, material staging, construction start, substantial completion, and operational acceptance. Progress will be tracked through schedule and budget reporting, construction inspection documentation, and readiness checks for emergency access use. By improving the year-round reliability of the route to the emergency shelter and upper subdivision, the project advances Alaska RHTP Initiative 2 (Health Care Access) and Initiative 3 (Healthy Communities). It represents a structural change to the local emergency response system by removing a high-risk bottleneck that can delay EMS and evacuation, particularly during winter and coastal events, and by enabling safer access to higher-elevation land for future housing and community resilience.	\$1M-\$5M	Single Community	Dillingham Census Area	Deferred or Not Advanced

City of Togiak	Strengthening Rural EMS Response Capacity in Togiak	AK	Togiak’s EMS response system faces operational barriers due to the absence of climate-controlled storage for emergency vehicles and their equipment. The community’s primary EMS vehicles are stored outdoors year-round. Sub-zero temperatures expose vehicles and equipment to extreme cold and freeze–thaw cycles that degrade medical supplies and electronics. In warmer months, rain, humidity, and moisture intrusion increase the risk of corrosion, condensation damage, and deterioration of medical devices and vehicle components. EMS responders must store critical supplies separately and enter freezing vehicles when responding to emergencies. Cold starts, temperature-related equipment limitations, and time required to prepare vehicles in severe weather can delay response and limit providers’ ability to deliver care immediately upon arrival. These conditions have direct clinical implications. EMS personnel may be required to assess and stabilize patients in vehicles that remain at sub-zero temperatures while equipment reliability may be compromised by exposure. In emergencies such as trauma, cardiac events, and acute illness affecting vulnerable residents, these operational barriers can affect the timeliness and effectiveness of care. Addressing these infrastructure limitations presents an opportunity to strengthen the reliability and readiness of Togiak’s rural EMS system by ensuring emergency vehicles and critical equipment can be stored in stable, climate-controlled conditions.	This planning project will evaluate options for establishing climate-controlled EMS vehicle storage in Togiak. Because multiple potential sites exist within the community, the project will focus on evaluating 3 feasible facility strategies and identifying the most effective and sustainable location for implementation. Planning activities will include: site feasibility analysis for three potential locations; engineering and structural feasibility review; evaluation of space requirements for emergency vehicles and equipment staging; EMS operational workflow analysis; development of preliminary cost estimates for each option; permitting and regulatory pathway review; and preparation of an implementation roadmap for a future capital project. Option 1: Clinic-Connected Emergency Response Facility (Preferred): This option would expand space adjacent to the existing BBAHC clinic building to provide climate-controlled storage directly connected to the facility. Co-locating emergency vehicles with the clinic would allow EMS responders to deploy immediately from the primary point of medical care in the community while supporting equipment staging and potential integration with the clinic’s planned waste heat recovery system. Option 2: Municipal Facility: This option would convert an existing 1500 SF municipal building near the City administrative offices into a climate-controlled emergency vehicle storage facility supporting EMS and fire response operations. Co-locating public safety assets could improve coordination between emergency responders and provide shared operational space. Option 3: Old School Gym Conversion: This option would evaluate partial renovation of the unused 10,000 SF City-owned gymnasium to support heated emergency vehicle storage. Improvements may include installation of overhead vehicle access, insulation upgrades, heating systems, and interior space for emergency equipment staging. Project Timeline May–August 2026: Site evaluations, facility assessments, and EMS operational needs analysis. September 2026–February 2027: Engineering feasibility review, space planning, and evaluation of integration with clinic operations and energy systems. March–June 2027: Development of cost estimates, permitting pathway analysis, and comparative evaluation of the three facility options. July–October 2027: Selection of a preferred site and preparation of an implementation roadmap to support future capital funding and construction.	\$50,000- \$250,000	Single Community	Dillingham Census Area	Deferred or Not Advanced

City of Togiak	Technical Assistance for Togiak Health System Transformation	AK	The RHTP represents a once-in-a-generation opportunity to structurally stabilize and improve Togiak's health system. The primary barrier to executing this transformation is not a lack of vision or local leadership, but the administrative bandwidth and specialized grant management skillset required to navigate complex federal compliance, budgeting, reporting, and detailed proposal requirements, especially for staff who have not had the opportunity to attend trainings, work closely with federal grantors, or gain hands-on experience with large healthcare-related projects. The RHTP Applicant Resource Guide specifically allows funds to be used for "Technical assistance, planning, and project design support" as well as building internal systems for sustainable service delivery. The opportunity is to fund a contractor who is familiar with Togiak's unique logistical challenges and can provide structured training, tools, and coaching to City and Traditional Council staff so that grant administration and compliance functions are sustainable locally after the RHTP funding period.	Our approach is to retain a professional consultant or consulting firm to provide training and hands-on coaching that builds local capacity in grant management, compliance, and reporting, so that Togiak can sustainably administer funding after the RHTP funding period. The consultant will be familiar with Togiak's context and logistical realities and will focus on transferring knowledge, creating repeatable tools, and strengthening internal processes. The consultant will work with City staff, the Traditional Council, and the broader community to deliver training on RHTP and federal grants, develop practical templates and checklists, and support staff as they draft narratives, build budgets, outline sustainability plans, and secure essential partnership agreements. By treating project design and grant management capacity as a foundational step, we align directly with RHTP's allowable uses for capacity-building activities. This approach ensures our primary infrastructure projects are meticulously designed to meet federal standards while remaining community-led and culturally appropriate.	Under \$50,000	Single Community	Dillingham Census Area	Deferred or Not Advanced

City of Togiak	Togiak Early Childhood Health Access Facility Improvements	AK	In Togiak, access to preventive health services for young children is limited by geography, provider availability, and the absence of specialized pediatric services within the community. The Head Start facility where these activities occur faces environmental and infrastructure limitations that affect its ability to safely support these services. The building relies on aging mechanical systems and limited kitchen infrastructure that are increasingly difficult to maintain in a rural setting with constrained access to technical support and replacement equipment. Key building systems have reached the end of their useful life and require capital replacement rather than routine maintenance. The facility’s boiler system is aging and increasingly unreliable, creating risks for consistent heating in a region with extreme winter temperatures. The HVAC system provides limited ventilation and air exchange, resulting in poor indoor air quality and increased risk of respiratory illness transmission among young children. The kitchen lacks adequate equipment, ventilation, and sanitation infrastructure required to safely prepare and store food in compliance with federal nutrition program standards. These deficiencies cannot be addressed through routine maintenance because they involve full system upgrades, code-compliant infrastructure improvements, and structural rehabilitation necessary to restore the facility’s ability to safely support program operations.	The project will focus on three priority improvements that directly affect facility safety and functionality: kitchen modernization, ventilation system upgrades, and boiler system replacement. Together, these improvements will restore core building systems necessary to safely support Head Start nutrition services and early childhood programming. During the initial project phase, the City of Togiak and BBNA will complete project planning, procurement, and coordination with facility staff to ensure construction activities minimize disruption to Head Start programming. This phase will include final scope verification, contractor procurement, materials ordering, and scheduling of work during periods that reduce impacts on classroom operations. Kitchen upgrades will modernize food preparation infrastructure to meet Alaska Department of Environmental Conservation and federal sanitation, food safety, and temperature control requirements necessary for Head Start nutrition services. Improvements will include replacement or installation of compliant food preparation equipment, improved food storage capacity, and upgrades necessary to meet federal program standards. These improvements will allow staff to consistently prepare and serve meals that comply with federal nutrition guidelines for young children. Ventilation system improvements will restore the building’s air recirculation and filtration system. Work will include repair or replacement of ventilation components to improve air exchange and indoor air quality. These upgrades will reduce the transmission of respiratory illness in a congregate setting serving young children and improve overall environmental health conditions within the facility. Boiler system upgrades will replace aging glycol-based heating components that currently present reliability risks during winter months. Work will include removal of failing components and installation of updated heating infrastructure designed for reliable operation in extreme rural conditions. These improvements will ensure stable indoor temperatures and safe facility operation throughout the year. Construction and installation activities are expected to occur over approximately 12-16 months (ending prior to the October 2027 deadline), with key milestones including project procurement and contracting, system replacement and installation, final inspections, and return to full operational use of upgraded systems.	\$50,000- \$250,000	Single Community	Dillingham Census Area	Deferred or Not Advanced

City of Togiak	Togiak Rural Health Workforce Housing Renovation to Support Recruitment and Retention	AK	The Ayojiak and duplex properties require significant renovation to remain viable for workforce housing. Housing in remote Alaska communities reflects the challenges of rural construction and logistics. Materials must be transported long distances by air or barge, skilled contractors are limited, and buildings often operate for decades in harsh weather conditions with limited opportunities for major renovation. As a result, housing that may have functioned historically for local use can fall below modern code, safety, and livability standards expected by clinicians traveling from outside Alaska. The Ayojiak residence currently requires substantial repairs and system replacements to address health and safety concerns and bring the structure into compliance with applicable codes, including upgrades to interior finishes, kitchen and bathroom components, heating and ventilation systems, plumbing, lighting, and exterior elements such as roofing, windows, insulation, siding, and the fuel tank. The City-owned duplex faces similar challenges. The vacant unit requires interior improvements including flooring replacement, cabinetry, windows, and interior finishes, as well as exterior siding replacement. Completing exterior improvements across the full building would reduce long-term maintenance costs and extend the useful life of the property. Since housing units are in poor condition, they cannot reliably support the workforce positions they are intended to serve.	The City of Togiak will renovate two existing City-owned housing units: the Ayojiak residence and one unit of the City-owned duplex. Renovations will bring both structures into compliance with applicable safety and building standards and restore them as functional workforce housing. The Ayojiak residence renovation will follow the scope identified in a March 2026 contractor estimate from PTP Construction Services totaling \$512,125. Planned work includes replacement of flooring, kitchen cabinets and appliances, bathroom renovation, interior sheetrock repair and painting, interior door replacement, lighting and electrical upgrades, installation of a new Toyotomi heating system, plumbing upgrades, water heater replacement, and ventilation improvements. Exterior work includes roofing replacement, window replacement, insulation upgrades, wall and siding repairs, and replacement of the fuel tank. The duplex renovation will focus on the currently vacant unit of the City-owned building. Planned improvements include flooring replacement, cabinetry upgrades, interior finishes, window replacement, and exterior siding improvements. Because the structure shares a single building envelope and exterior systems, exterior improvements will be completed across the full duplex, simplifying construction and ensuring consistent protection of the building structure while extending the useful life of the property. The City is obtaining an updated construction estimate for the duplex renovation before the end of March 2026. Project implementation will follow the timeline below: May–June 2026: Finalize construction scope, confirm updated contractor estimates for the duplex, and complete procurement and contractor selection. July–September 2026: Order building materials and coordinate transportation logistics for delivery to Togiak. Fall 2026 – Summer 2027: Complete construction and renovation work on the Ayojiak residence and duplex unit, including interior system replacements, structural repairs, and exterior improvements. August–September 2027: Conduct final inspections, complete any remaining repairs, and prepare both housing units for occupancy. All work will be completed prior to the September 30, 2027 project deadline.	\$250K-\$1M	Single Community	Dillingham Census Area	Deferred or Not Advanced

City of Togiak	Tuyuryaq Youth Activities and Cultural Wellness Center Planning Initiative	AK	Youth and families in Togiak face increasing behavioral health challenges and limited access to structured prevention activities. Community assessments conducted through the Togiak Native Connections program identified strong community concern about youth mental health, loss of cultural connection, and the lack of safe spaces where young people can gather, learn from Elders, and participate in healthy activities. The community is also experiencing rapid loss of Yugtun language use and traditional knowledge transmission between generations. Local Elders continue to hold deep cultural knowledge related to subsistence, traditional practices, and healing, but opportunities for youth to learn directly from Elders are increasingly limited. Without intentional spaces that support intergenerational engagement, these connections—and the protective health benefits they provide—continue to decline. The City of Togiak owns the former Togiak School building, which includes a library and adjacent classroom space that are centrally located within the community and accessible to residents. These spaces present an opportunity to establish a dedicated community wellness environment that supports youth activities, cultural learning, and prevention-focused programming. Planning for the Tuyuryaq Youth Wellness and Cultural Center will position the community to transform existing unused infrastructure into a space that strengthens youth well-being, cultural continuity, and community health.	The City of Togiak will undertake a structured planning process to prepare for renovation of the library and adjacent science classroom within the former Togiak School building to create the Tuyuryaq Youth Wellness and Cultural Center. The planning phase will focus on developing facility design concepts, engineering assessments, and renovation scope documentation needed to support a future capital renovation project. The planning effort builds directly on priorities identified in the Native Connections Community Needs Assessment, which highlighted strong community support for youth activities, cultural learning opportunities, and dedicated spaces that support youth and family wellness. During Months 1–2, the City will initiate project startup activities and conduct procurement for professional services required to complete the planning work. This will include issuing requests for proposals and selecting qualified architectural and engineering professionals with experience in rural facility planning and renovation. During Months 3–8, the selected architectural and engineering team will conduct facility assessments and develop conceptual design options for converting the existing classroom and library areas into flexible community wellness spaces. This work will include building condition review, space planning concepts, and identification of structural, mechanical, or accessibility improvements needed to support future programming. During Months 8–10, the project team will develop preliminary renovation scopes and cost estimates based on the design concepts and engineering review. These estimates will provide the City and its partners with realistic construction budgets and allow refinement of renovation priorities. Throughout the planning process, the City will coordinate with key community partners—including the Togiak Traditional Council, Togiak Natives Limited, community Elders, and youth leaders—to ensure the facility design reflects how the space will support youth activities, cultural learning, and community wellness programming. During Months 9–12, the project team will finalize the planning package, including conceptual facility designs, engineering review, renovation scope documentation, and construction cost estimates. These deliverables will position the City and its partners to pursue renovation funding and move efficiently into implementation once capital funding is secured.	\$250K-\$1M	Single Community	Dillingham Census Area	Deferred or Not Advanced

City of Unalaska	Unalaska Fire Department Development of a Mobile Integrated Healthcare Program	AK	Communities throughout the Aleutian region face persistent disparities in access to healthcare services, particularly behavioral health care. Geographic isolation, transportation barriers, limited healthcare workforce availability, and the high cost and complexity of travel to regional medical centers contribute to delayed care and limited access to preventative health services. Because of these challenges, emergency medical services are frequently utilized as a primary point of entry into the healthcare system for individuals experiencing behavioral health crises, substance use disorders, or other unmet healthcare needs. First responders regularly encounter patients who require coordinated follow up care and connection to services beyond the traditional emergency response and transport model. In response, the City of Unalaska is developing a Mobile Integrated Healthcare program through the Unalaska Fire Department. Mobile Integrated Healthcare expands the role of prehospital providers to address both emergent and non emergent healthcare needs by integrating EMS with primary care, behavioral health services, and community based healthcare resources.	Our intent is to establish an Mobile Integrated Health program that integrates EMS providers with facility based healthcare partners to improve early behavioral health intervention, increase preventative healthcare engagement, and connect patients with appropriate services before conditions escalate to emergency situations. Our approach emphasizes integration with existing systems, partnerships with key local stakeholders, and future sustainability. The City has already begun early planning efforts to guide development of this model. Two ongoing studies are currently underway to inform program design and implementation. The first is a comprehensive Community Health Needs Assessment, and the second is a Behavioral Health Assessment focused on identifying service gaps, barriers to care, and opportunities for improved coordination between healthcare providers.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area	Advance to Implementation Application
City of Wasilla	Enhancing Emergency Medical Communications Across Rural Alaskan Areas with Radio Modernization	AK	Reliable radio communication is essential to the delivery of emergency medical services. Aging consolettes increase the risk of technical failure, reduced audio clarity, and limited redundancy between primary and backup facilities. As the central emergency response communication hub for the region, dispatch must maintain uninterrupted contact with field responders. Any communication disruption can delay medical care, compromise responder safety, and increase the probability of negative patient outcomes. Modernizing our radio infrastructure presents a critical opportunity to strengthen the resilience and effectiveness of emergency health coordination across the expansive and diverse service area.	We propose replacing radio consolettes in both our primary dispatch center and designated backup center to ensure operational continuity and redundancy. The project will include procurement of modern consolettes, installation, system integration, interoperability testing, and staff training. Updated systems will provide improved audio clarity, enhanced reliability, and failover capability between facilities to maintain uninterrupted service. By strengthening the communication link between dispatch and first responders, this project enhances coordination, reduces operational risk, and supports timely emergency medical response across the expansive and diverse service area.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Copper River Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced

City of Wasilla	Implementing NG911 Core Services and ESInet for Rural Emergency Communications	AK	Emergency communications systems across the United States are transitioning to Next Generation 911 infrastructure designed to replace aging legacy systems and improve system resiliency. Alaska remains the only state that has not yet implemented Next Generation Core Services (NGCS), which provide the core routing and interoperability capabilities required for Next Generation 911. The MatCom Public Safety Communications Center proposes to implement NGCS and an Emergency Services Internet Protocol Network (ESInet) to modernize the region’s emergency communications infrastructure. As one of the largest regional communications centers in Alaska, MatCom is well positioned to serve as the first 9-1-1 center in the state to deploy these services. Implementation of NGCS would establish a modern call routing architecture that allows emergency calls to be dynamically routed based on the caller’s geographic location while also providing system redundancy. In the event of a system outage, infrastructure failure, or surge in call volume, emergency calls could be automatically rerouted through the ESInet to another Public Safety Answering Point (PSAP) with similar operational capacity. This capability eliminates single points of failure in the emergency communications system and ensures that 9-1-1 calls continue to be answered even during major incidents or infrastructure disruptions.	MatCom will implement Next Generation Core Services (NGCS) and an Emergency Services Internet Protocol Network (ESInet) through a phased deployment designed to ensure uninterrupted emergency communications services. The project will begin with system design, vendor procurement, and coordination with telecommunications providers and regional Public Safety Answering Points (PSAPs). Following procurement, NGCS and ESInet infrastructure will be deployed and integrated with MatCom’s existing call handling and computer-aided dispatch systems. This integration will enable location-based routing and secure IP connectivity between PSAPs. Once installed, the system will undergo comprehensive testing and operational validation. Dispatch personnel will receive training, and coordinated testing with partner PSAPs will ensure interoperability and system reliability. Upon completion, the system will transition to full operational use, providing a redundant emergency communications network capable of automatically rerouting 911 calls to another PSAP of similar capability during outages or surge events.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Copper River Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced

City of Wasilla	Modernizing 911 Computer-Aided Dispatch (CAD) to Strengthen Emergency Health Response Across Alaska	AK	The Matanuska-Susitna Borough, Chugach and Copper River Census Areas continue to experience population growth and increased demand for emergency services. Our existing CAD system is aging and lacks the functionality required to support modern emergency medical coordination across large distances. It no longer meets the operational complexity required to coordinate emergency medical response across a large and geographically diverse service area. Maintaining outdated technology limits interoperability, slows data exchange, and reduces situational awareness for dispatchers and first responders. In rural areas, where distances are significant and resources may be limited, inefficiencies in dispatch coordination can directly affect patient outcomes. A new CAD system will improve call processing times, mapping precision, responder tracking, and interagency communication between EMS, fire, and law enforcement agencies service an expansive and diverse area. This project presents an opportunity to modernize critical emergency communication infrastructure to ensure reliable, coordinated access to emergency medical care.	We are proposing replacing our current CAD system with a modern, fully integrated platform designed to support high-volume emergency medical dispatch operations across a rural and regional hub service area. The new system will include enhanced GIS mapping, improved address verification, real-time unit status tracking, interoperability with partner agencies, advanced reporting capabilities, and system redundancy to ensure uninterrupted operations. Implementation will include procurement, system configuration, data migration, staff training, testing, and phased deployment to minimize service disruption. The project will also ensure integration with regional EMS providers serving the Matanuska-Susitna Borough, Chugach and Copper River Census areas. This approach strengthens the connection between community members in crisis and first responders delivering emergency health care. By equipping call takers and dispatchers with reliable tools, we improve response coordination, reduce delays, and enhance the quality and sustainability of emergency medical access across Alaska.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Copper River Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced
City of Wasilla	The Wasilla Public Library Expansion	AK	This is a capital improvement project to add to the Wasilla Public Library building in order to be able to have room to add staff, technology and additional materials and extend the open hours to the public. This is wanted by the community because right now the library is only able to be open to the public 40 hours a week, due to limited staffing ability. That is only 10-hours less than what the Alaska State Library recommends for a community our size.	An architect has been hired to design adding an additional 2,600 square feet to the current library to create 5-7 workstations, and an additional office, to increase capacity for staff. Once the design is complete, the City would move to hire a contractor to expand the building. This would allow the library to accommodate the expected area growth and public demand for the next 20-30 years.	\$250K-\$1M	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

City of Whittier	Whittier Rural EMS Access and Response Modernization Initiative	AK	The City of Whittier faces significant healthcare access challenges due to its geographic isolation, transportation limitations, & reliance on local emergency medical services as the primary point of care during emergencies & non-emergencies. Whittier is connected to the road system through the Anton Anderson Memorial Tunnel, a single-lane tunnel shared by rail & vehicle traffic operating on a controlled schedule. This infrastructure can delay emergency transportation & limits rapid access to hospital-based care as one transport to Anchorage can remove all responders from the city. The nearest hospital-based emergency department is more than 60 miles away, requiring over an hour of travel, one-way, under ideal conditions. Transport times may be further delayed by tunnel scheduling, weather conditions, or seasonal traffic congestion. As a result, Whittier Fire Department EMS personnel often serve as the community’s frontline healthcare providers for extended periods while patients await transport to definitive care. In addition to serving approximately 260 year-round residents, Whittier experiences large seasonal population increases from tourism, charter fishing, & cruise ship traffic. These factors increase demand for emergency medical services & highlight the need to strengthen local EMS response capabilities, improve coordination with regional healthcare providers, & ensure reliable emergency care for residents & visitors in this remote community.	The City of Whittier will address barriers to healthcare access in this isolated coastal community through the Whittier Rural EMS Access and Response Modernization Initiative, a coordinated effort to strengthen emergency medical response, expand access to clinical support, and improve long-term sustainability of rural emergency medical services. The project will expand telehealth-enabled EMS capabilities, allowing personnel to consult with physicians and advanced medical providers in real time during emergency and non-emergency responses. This capability will support improved clinical decision-making, enhance patient stabilization during extended response or transport intervals, and improve coordination with receiving hospitals prior to patient arrival. The initiative will also improve emergency communications and interoperability by upgrading equipment and strengthening connectivity with regional healthcare providers and emergency response partners. Reliable communication systems will improve information sharing, patient care coordination, and emergency response effectiveness in Whittier’s mountainous and maritime environment. To support long-term sustainability of rural healthcare services, the project will invest in workforce development through advanced EMS training, recruitment, and retention efforts. In partnership with the Chugach School District, the department will also expand student exposure to EMS and healthcare career pathways, helping develop a future local workforce pipeline. Together, these efforts will strengthen Whittier’s emergency medical system, improve patient outcomes, and expand reliable access to emergency healthcare for both residents and visitors in Prince William Sound.	\$250K-\$1M	Single Community	Anchorage (Municipality); Chugach Census Area	Deferred or Not Advanced

ClaimExcel	ClaimExcel: Precision Revenue Recovery & Protection for Rural and Critical Access Hospitals	OH	Alaska’s rural and critical access hospitals face a compounding financial challenge: they are systematically underpaid by insurance payers, yet lack access to the specialized staffing, technology, and bandwidth to detect and recover these losses. Industry data indicates that 1 to 5% of net patient revenue is lost annually to claim underpayments alone. The root causes are structural. Payer reimbursement rules are complex, payer-specific, and change frequently. Bundling logic, modifier requirements, and contract terms vary by payer and region. Payers apply undocumented processing patterns not reflected in contracts. For resource-constrained rural facilities, auditing every claim against these moving targets is not feasible. The consequences are severe. Zero-pay and underpaid claims are written off. Low-dollar underpayments, uneconomical to pursue individually, accumulate into material losses. Preventable denials consume staff time on rework instead of collections. Readmission clawbacks cost hospitals an average of \$15,500 per event with zero Medicare reimbursement. Meanwhile, billable Transitional Care Management visits go uncaptured. This project addresses a clear opportunity: deploying automated claims analysis technology purpose-built for rural hospital revenue cycle challenges, requiring no upfront investment, no new system integration, and minimal operational disruption – converting overlooked reimbursements into recovered and protected revenue.	ClaimExcel’s approach is a phased, low-burden implementation designed for facilities with limited IT and revenue cycle resources. Phase 1 – Claim Recapture & Underpayment Recovery: Each hospital provides 18-24 months of 837/835 data via secure SFTP. Our AIDA engine performs comprehensive retrospective analysis, examining every line item. AIDA sequences each line item, checks modifiers and groupers, validates quantities against proprietary databases, matches NDCs with J-codes for pharmacy claims, documents unique payer processing patterns, and notes payer-specific reimbursement modifications. Within 2 to 3 weeks, hospitals receive preliminary findings; actionable rebilling reports follow by weeks 4 to 5, and more detailed and specialized reports thereafter. Phase 2 – Proactive Scrubbing & Editing: Once recovery is underway, we activate front-end claims scrubbing that identifies and corrects billing errors before initial payer submission. Each claim is verified against thousands of coding and billing requirements using a continuously updated database, with customizable configurations tailored to each facility’s payer mix. This shifts hospitals from reactive denial management to proactive prevention, delivered via seamless EMR/PM/RCM integration without disrupting operations. Phase 3 – Readmission Revenue Protection (powered by Reveleum): Using 837/835 data plus a daily Medicare discharge file (HL7), this service automatically flags high-risk discharges and generates call lists for timely PCP follow-up. It eliminates readmission clawbacks and captures previously unbilled TCM revenue through automated post-discharge workflows. Across all phases, hospitals receive ClaimExcel’s Advanced Analytics & Reporting Portfolio – including denial root-cause heatmaps, timely filing risk radar, PLB takeback reconciliation, 340B opportunity detection, observation hours accuracy checks, modifier audits, and contract variance analysis, among others. We are developing additional report modules with other rural and critical access hospitals, and wish to continue doing so with Alaskan facilities, to address reimbursement patterns unique to their settings. Our goal is to onboard at least 5 to 10 Alaska hospitals in Year 1, expanding each subsequent year.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Coastal Villages Region Fund	Weather Data Infrastructure for Healthcare Access in Western Alaska	AK	Coastal Villages Region Fund (CVRF) serves twenty rural communities along the Bering Sea coast of Western Alaska, offering economic development programming to over 9,000 residents. Our communities are primarily accessible by air (and boat during the summer), relying on gravel airstrips as the most direct connection to hospital-based medical services. These airstrips lack reliable weather observation stations (where they exist, FAA weather stations are often out of service). Without real-time weather data, it's difficult for pilots to accurately assess conditions before departure. Without this data, it is unrealistic to utilize instrument landing procedures, which can result in pilots being restricted to visual flight rules and make them unable to land when ceilings drop. The result is a systemic gap in healthcare access: flights (including air ambulance services, at times) are routinely grounded or diverted during adverse weather, which can delay or even prevent medical evacuations that can mean the difference between life and death. This same infrastructure gap limits routine transport for patients needing specialty care, prenatal visits, or behavioral health services available only at regional hubs. Our project proposes to address this challenge by deploying community-based informational infrastructure that will increase the availability of quality weather data. Our goal is to make this data available to help facilitate better access to healthcare.	Our project will expand healthcare access our region by addressing a critical gap in aviation infrastructure: the lack of reliable, near real-time weather data. We will install high-fidelity weather stations in communities across the CVRF service area. These stations will continuously measure and report essential meteorological conditions. This data will be available to pilots, air ambulance dispatchers, and healthcare coordinators, enabling significantly more informed decisions about flight safety and feasibility. Coastal conditions along the Bering Sea can vary dramatically over short distances due to terrain, proximity to water, and localized fog and wind patterns. With reliable weather reporting in place, pilots will be equipped to make better go/no-go decisions before departure, reducing both unnecessary cancellations during flyable conditions and risky attempts during genuinely unsafe weather. Air ambulance dispatchers will have the information needed to route aircraft efficiently and plan realistic transport timelines. CVRF will serve as the lead applicant and primary implementing organization. We anticipate contracting with aviation weather specialists and meteorological equipment providers experienced in Arctic and coastal deployments.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area	Deferred or Not Advanced
College Gate Elementary	College Gate School Garden	AK	This project directly addresses food insecurity for the students of College Gate Elementary. The school garden will supply fresh produce to families with students at this Title 1 school, provide educational opportunities and empower children with the knowledge of how to grow food.	College Gate Elementary is a neighborhood school that also houses a Yup'ik immersion language school. Yup'ik is one of 20 distinct indigenous languages of Alaska. There is ripe opportunity to bring Alaska Native elders to the school garden to work alongside the children, sharing knowledge and stories. We plan to do things like plant sour dock and teach our Yup'ik language students about a tradition from the village of Chevak in which children play a game of chewing on the leaf while trying to not make a face at the sour taste.	Under \$50,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Comagine Health	Alaska Value Based Care Specialty Learning Collaborative to Improve Access, Outcomes, Cost	WA	Alaska faces ongoing challenges in engagement and ability to effectively implement Value Based Payment. This is due to multifaceted issues, including high costs of providing care, geography, lack of adequate access made worse through workforce shortages and turnover, difficulty providing consistent access to specialty and behavioral health care, and low patient volumes in rural locations. The Alaska Value Based Care (VBC) Specialty Learning Collaborative is a proposed learning, communication, and engagement model for organizational leaders, primary and specialty clinicians, and diverse health-related professionals, Tribal health partners, and other sectors to improve the delivery and coordination of care for Alaskans needing specialty care, and to facilitate readiness and success of Value Based Pay and Care implementation across the state. The overarching strategy is to launch a collective impact initiative that organizes and incentivizes healthcare organizations to collaborate rather than compete in addressing specialty care and coordination needs of Alaskans. This statewide effort will be operationalized through a phased, multi-year roadmap that integrates four mutually reinforcing domains: Clinical Care Delivery, Workforce Expansion, Technology Adoption, and Payment Innovation. This holistic approach ensures that improvements in one area support and accelerate progress in others and will provide a foundation for VBP spread, including participation in federal models.	The Alaska VBC Learning Collaborative would be structured to facilitate multidisciplinary and cross-sector voices and perspectives and borrow from successful learning models and approaches that have been used in Alaska and elsewhere, such as the ECHO Model; All Teach, All Learn; and other didactic and case-based learning methods. It would include topics that are specific to certain audiences or groups within complex care, and topics that cross sectors and roles. It would integrate technological solutioning and implementation guidance in alignment with VBC contracts and participation in federal VBP initiatives. The first phase of designing and developing the learning collaborative will include assessing needs of state partners, multidisciplinary provider groups, caregivers and people with lived experience, and other key stakeholders to inform the overall content and structure of the collaborative and to enable more effective recruitment for participation. This phase may include a brief survey of community partners, key informant interviews, and other avenues for collecting diverse voices and perspectives. A planning group or steering committee would be selected at this phase to guide planning elements. A second phase would be recruiting organizations and individuals to participate in the collaborative and to work with identified partners to prepare learning materials and content. Goals of the VBC Learning Collaborative include: - Coordinating and harmonizing multidisciplinary voices and perspectives to design, create, and implement a statewide, cross-sector approach to supporting Alaskans in need of specialty care and coordination. - Supporting cross-sector providers to operate within, and at the top of, their scope of practice to coordinate care efficiently and effectively. - Improving understanding of resources and effective strategies across state- and community-level perspectives to improve care for Alaskans with complex care needs. - Promoting evidence-based, VBP-aligned interventions through the expanded use of telehealth and other emerging technologies. This includes deploying Remote Patient Monitoring (RPM) for high-risk patients. - Establishing virtual specialty networks to improve access to key specialists such as cardiology, endocrinology, nephrology, and behavioral health clinicians which all provide unique access challenges and virtual care opportunities and also provide opportunities to pilot VBP strategies in focused, high-impact ways.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Comagine Health	Building Alaska's Maternal Health Data Infrastructure for Rural Hospitals	WA	Rural hospitals in Alaska face significant challenges maintaining maternal quality improvement infrastructure due to limited staffing, low birth volumes, and constrained analytic capacity. These barriers make it difficult for small facilities to efficiently collect, analyze, and use maternal health data to guide clinical improvement and participate fully in statewide quality initiatives. At the same time, Alaska has identified improving maternal and infant outcomes, particularly in rural communities, as a critical priority. This project proposes the creation of an Alaska Maternal Data Center (AMDC), a proven and shovel-ready solution designed to strengthen rural hospitals' ability to participate in statewide maternal quality improvement efforts. The AMDC will build on the Maternal Data Center platform developed by the California Maternal Quality Care Collaborative (CMQCC), which is already successfully operating in multiple states, including Oregon where Comagine Health oversees statewide implementation and supports participation from small and rural hospitals. Through partnerships with the Alaska Perinatal Quality Collaborative and the Alaska Hospital & Healthcare Association, this project will deploy an automated data platform that reduces reporting burden while generating timely, actionable insights to support maternal safety initiatives and improve maternal and neonatal outcomes across Alaska.	Comagine proposes to support Alaska's rural hospitals improving maternal and neonatal outcomes by creating the Alaska Maternal Data Center (AMDC) - a proven, shovel-ready solution designed to strengthen participation in statewide maternal quality improvement (QI) efforts. The AMDC will leverage the Maternal Data Center platform developed by the CMQCC. This secure, web-based platform is in use in California, Oregon, and Washington to provide hospitals timely, standardized maternal and newborn quality data. By automating data collection and reporting processes, the platform reduces administrative burden while enabling hospitals to participate more effectively in statewide maternal safety and quality initiatives. Comagine is an active CMQCC partner and oversees and operates the Oregon Maternal Data Center (OMDC). We manage statewide hospital recruitment, onboarding, and engagement, including participation from small and rural hospitals. We work closely with the Oregon Perinatal Collaborative to use OMDC data to support maternal safety initiatives, identify disparities in maternal outcomes, and guide hospital-based QI. Our work has resulted in reduced maternal morbidity and mortality from underlying drivers such as severe hypertension and obstetric hemorrhage. This experience provides a tested operational model that can be readily adapted for Alaska. In partnership with the Alaska Perinatal Quality Collaborative and the Alaska Hospital & Healthcare Association, Comagine will recruit hospitals, implement the AMDC platform, and provide hands-on onboarding, training, and ongoing analytic support. Participating hospitals will receive performance reports and practical guidance to help teams interpret data, identify opportunities for improvement, and implement evidence-based maternal safety practices. The project will prioritize rural and critical access hospitals that have limited internal analytic resources but play a critical role in providing maternity care in remote communities. By strengthening access to timely, actionable maternal health data and providing tailored technical assistance, the AMDC will help hospitals reduce reporting burden, strengthen participation in statewide initiatives, and support safe, high-quality maternity care close to home for Alaska families. Comagine will facilitate peer learning and collaboration among participating hospitals, accelerating shared improvement and spreading best practices across Alaska's maternal health system.	\$250K-\$1M	Statewide	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Comagine Health	Chronic Disease and Behavioral Health Management Learning Platform and Collaborative	WA	Alaska’s rural healthcare system faces ongoing challenges related to workforce knowledge, skill application, resource availability, and inconsistent outcomes of care. While several established training and education programs exist, and some organizations have quality improvement infrastructure or staff, these efforts often operate in silos and are difficult to sustain. This results in duplicated costs, variable effectiveness, inadequate health team support, and uneven patient experiences and outcomes across care settings. A unified, coordinated, sustainable Alaska-specific collaborative learning structure and training platform structure focused on culturally and age-appropriate care is needed to better support providers and ensure consistent, high-quality care for key chronic disease prevention and management, including behavioral health issues such as depression and substance use. There is also a need for structure in determining effective interventions including technology. This opportunity encourages engagement of key community partners related to workforce development/upskilling/quality improvement work and expand multi-modal workforce effectiveness and impact. Our approach aims to improve care quality, outcomes, and costs around high impact issues, by streamlining resources, reducing duplication, and enabling a consistent, culturally responsive, technology-enabled, improved standard of care that results in better health outcomes across Alaska’s rural health system.	Through convening a broad cross-section of Alaska stakeholders and other partners, and by leveraging existing partners, including a qualified training platform provider, Comagine would work with existing and new Alaska partners to establish: • Collaborative group learning structure for organizations to ensure effective and sustainable improvement around chronic disease prevention and management, including behavioral health care. • Evidence-based learning strategies that will enable participants to overcome common barriers collectively as well as leveraging and spreading best practices. • Learning topics that reflect needs identified by stakeholders, include emerging technology-related issues (such as effective integration of RPM and patient wearables), as well as specifically targeting the cardiovascular “risk triad”—hypertension, diabetes, and chronic kidney disease (CKD)—and integrating support for co-occurring behavioral health conditions like depression and substance use disorder. • Functional assessments and individualized organizational facilitation to support: - o Workflow redesign - o Structured quality improvement coaching – including helping each organizational participant to develop a defined improvement plan with measurable objectives, timelines, performance indicators. - o Data review and performance tracking • Centralized training and resource repository focused on chronic disease prevention and management, complex care management, and behavioral health management topics. • Curated culturally and age-appropriate learning to support health workers across multiple rural care settings, reflecting the uniqueness of providing healthcare in rural Alaska settings. The first phase of designing and developing the learning collaborative and platform will include assessing needs of state partners, multidisciplinary provider groups, caregivers and people with lived experience, and other key stakeholders to inform the overall content and structure of the collaborative and learning platform beyond the issues identified above. This phase may include a brief survey of community partners, key informant interviews, and other avenues for collecting diverse voices and perspectives. A planning group or steering committee would be selected at this phase to guide planning elements. A second phase would be recruiting organizations and individuals to participate in the collaborative and to work with identified partners to prepare learning materials and content.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Comagine Health	Telemedicine Facilitated by Community/Behavioral Health Aides, Peer Support Specialists, and Doulas	WA	Telemedicine can increase health care access in areas with geographic, workforce, and other barriers to care. Many underserved populations, however, experience technical challenges (such as lack of digital technology or broadband strength) or lack experience with this modality. Facilitated telemedicine is an approach successfully used to address these challenges. In this approach, healthcare associates who do outreach directly to underserved populations, such as community health aides, behavioral health aides, peer support specialists, and doulas facilitate in-person connectivity between patients and off-site clinicians. The approach can be particularly helpful with regions experiencing specialty care gaps and populations that experience barriers to traditional in-office care. For example, our team provides implementation support to a project that utilizes peer recovery support specialists to facilitate telemedicine for hepatitis C and other infectious diseases in Oregon, reaching people who use drugs or are in early recovery in rural and remote areas as well as urban underserved populations disconnected from care. The proposed concept provides the opportunity to connect Alaska’s existing networks of community-based health workers with large Alaska-based telemedicine clinicians to increase access to care.	In the Concept Formation phase, we will engage partners and gather information to identify key gaps, needs, and resources relevant to facilitated telemedicine implementation. The aim is to ensure the implementation approach is tailored to the specific needs of communities and populations in Alaska and plan a staged implementation rollout. We will interview relevant organizational representatives to collect formative information about care gaps and local staffing resources, rooted in geographic, demographic, and community characteristics. Interviews will inform development of a draft implementation plan, including recommended priorities (e.g., specialty/health concerns, community worker types, geographic areas). We will provide the draft to interest holders for feedback and host group sessions to revise the draft using a community-engaged participatory approach. The proposed facilitated telemedicine project could require clinical workflow modifications, training and technical assistance for clinicians and community health workers (CHWs), and potential technology upgrades. CHWs engage people through outreach or home visits and mediate trusting relationships with remote clinicians (often specialty providers). Community health workers facilitate telemedicine appointments by coordinating with clinicians, helping patients prepare questions and understand what to expect, and bringing technology or technology assistance to patients. Other responsibilities include supporting patients in medication adherence, communicating with clinicians about side effects, and addressing resource barriers. Clinical/systems workflow changes are often necessary, such as listing the community health worker as a delegate to facilitate information exchange and telemedicine visit linkage. Remote clinicians and local community health workers form trusting relationships as part of a care team; for example, local doulas work closely with OB/GYN telemedicine clinicians, and local peer support specialists work closely with telemedicine infectious disease and addiction medicine clinicians. When the project is ready to launch, we will use the EPIS (Exploration, Preparation, Implementation, Sustainment) Framework to guide implementation, as we have in a facilitated telemedicine initiative with partners in Oregon. The proposed project once launched will include focused planning with participating organizations, tailored guidance materials, training, and ongoing technical assistance.	Under \$50,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

CommuniCare Technology, dba Pulsara	Pulsara TOTAL CARE	MT	Pulsara is a secure, HIPAA-compliant communication and logistics platform designed to unite the entire care team—including Emergency Medical Services (EMS), hospital staff, Tribal Health Organizations (THOs), and specialty providers—onto a single, real-time patient channel. By replacing fragmented communication methods like radio reports and multiple phone calls with a simplified digital workflow, Pulsara significantly reduces treatment times for time-sensitive conditions. Key Focus Areas aligned with Alaska's RHT submission: Maternal & Child Health: Connects remote village clinics with urban Maternal-Fetal Medicine (MFM) specialists via live video for imaging reviews and consultations. Acute Care Access: Speeds up stroke and STEMI response by linking pre-hospital teams directly to neurologists and cardiologists. Behavioral Health: Facilitates secure video consultations between field providers and specialized centers for immediate crisis intervention or MAT support. Community Paramedicine: Links paramedics with medical control to reduce high-cost, unnecessary transports from isolated areas accessible only by air or water. Innovation in Frontier Medicine: Utilizes Virtual Consult Centers and secure image sharing to provide immediate specialist expertise in remote settings.	Our proposed approach transforms the patient journey from a series of fragmented "one-to-one" handoffs into a unified, many-to-many communication ecosystem. Instead of information being locked in silos—like radios, faxes, or isolated phone calls—we place the patient at the center of a dynamic digital channel. The Three-Step Workflow: Create, Build, Communicate The solution is operationalized through a scalable workflow that adapts to any scenario, from routine transports to mass casualty events: Create: The Patient Channel A clinician (EMS, rural nurse, or GP) initiates a dedicated, time-stamped channel for a specific patient. This replaces the traditional "radio report" that often only reaches a single dispatcher. Build: The Dynamic Team As the case evolves, the necessary specialists are added with a single tap. This includes internal teams (Radiology, Cath Lab) and external partners (Flight crews, urban specialists). This creates a "virtual hallway" where every stakeholder sees the same data simultaneously. Communicate: Real-Time Multimedia Exchange The team uses the channel to share mission-critical data that traditional tools cannot handle: Live Video: For immediate "eyes-on" specialist consultations. Instant Messaging: For rapid coordination and ETA updates. High-Res Imagery: For secure sharing of ECGs, wound photos, or medication lists. Shift from "Push" to "Pull" Coordination In traditional rural healthcare, a facility must "push" a patient through the system by making dozens of phone calls to find an available bed. Our approach enables a "Pull" Model: Regional centers post patient status and needs on the platform. Specialty hubs view this data in real-time and "pull" the patient to them, using telehealth to confirm care capabilities before the transfer even begins. Infrastructure-Light Deployment Because this is a SaaS (Software as a Service) approach, it requires no proprietary hardware. It turns existing smartphones and tablets into powerful medical hubs, ensuring that a frontier clinic has the same communication capabilities as a Tier 1 Trauma Center.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Community Based Coordination Solutions	Alaska Community Crisis Follow Up Navigation	WA	Crisis events such as high ED utilization, hospital admissions, EMS calls and incarceration, are often a result of unmet healthcare and psycho-social needs. By being available to individuals and service providers immediately after these crisis events, our staff will help individuals navigate through these gaps to decrease recycling through these crisis events. Year 1 focuses resources where volume and impact are greatest (Anchorage & Fairbanks North Star Borough) using boots on the ground field navigation teams that: • Engage crisis individuals in the field and at the ED bedside • Provide appropriate post crisis follow up after referral • Address SDOH barriers (transportation, benefits, housing coordination) • Link and accompany individuals to primary care and BH/SUD care • Maintain 24/7 on call availability for enrolled members and partner providers Years 2-5 we would expand to additional areas of the state with the same approach.	CBCS will staff and provide direct field navigation. We will use a team-based approach with multiple navigators and one program manager and can adjust the size of the navigation team based on the volume of referrals. We would engage individuals for one month after referral from each crisis event. We would be available 24/7 to the individual and community resources. We are going to identify and fill the gap by navigating enrollees between the crisis event and their ultimate needs after the crisis. Field navigators will meet people where they are, as referred by the crisis responder, (home, ED, shelters, street outreach, encampments) identify the gaps in care (ex-transportation, social needs, housing etc.) and help them navigate to needed resources such as primary care, behavioral health providers, available housing resources, substance use resources and more. After one month we will provide warm hand-off to needed resources as identified. CBCS will hire locally and with a cultural and lived experience focus. Possible enrollment criteria for the program include but are not limited to the following: • 4+ ED visits in the past 12 months • Recent BH/SUD crises • Repeat 911 utilization • Homelessness/unstable housing • Target cases as identified by EMS providers • Target referrals as identified by local Jail staff	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough	Deferred or Not Advanced

Community Based Coordination Solutions	Alaska Community Navigation for Unserved Populations	WA	Frequent emergency department (ED) use in rural Alaska reflects untreated behavioral health conditions, unmanaged chronic disease, and social determinant barriers that make routine care difficult to access—especially for populations who currently lack structured follow up after a crisis event. CBCS’s proven national field navigation model directly addresses these gaps by meeting individuals where they are, resolving immediate medical, behavioral, and social needs, and stabilizing them before they return to crisis-level utilization. This program is going to target cohorts often underserved such as children experiencing behavioral health crises, individuals released from jail, postpartum mothers at heightened clinical risk, and psychiatric hospital discharges who routinely fall through care transitions. Across multi state implementations, CBCS’s trauma informed, boots on the ground navigation model has achieved approximately 60% reductions in ED visits, targeted 50% reductions in hospital admissions, and \$40,000 in annual cost avoidance per enrollee, with several programs demonstrating 2:1 ROI and 80% reduction in psychiatric readmissions. These outcomes highlight a strong opportunity to bring CBCS’s standalone model to Anchorage and Mat-Su region, scaling proven results to new populations who have historically lacked access to consistent crisis-to-care navigation.	CBCS will independently implement a high-impact field navigation model designed to reduce ED overuse by addressing medical, behavioral health, and social determinant needs among high-risk individuals. CBCS navigators will provide 24/7 community based engagement, meeting participants at the point of crisis or referral—homes, EDs, shelters, encampments, jails, or psychiatric hospitals—and offering transportation, appointment accompaniment, advocacy, housing navigation, benefits support, and rapid linkage to behavioral health and medical services. CBCS will refine referral pathways (ED alerts, EMS, corrections, hospitals, providers), create real time communication loops, and operate continuous quality improvement cycles. Navigators will address immediate stabilization needs—behavioral health linkage, detox referrals, housing and utility support, food resources, transportation—ensuring participants move toward consistent outpatient follow through. Core Methods 1. Identify & Engage: Real time ED/EMS alerts plus community, jail, hospital, and crisis referrals. 2. Enroll & Assess: Individualized plans integrating medical, behavioral health, and SDOH needs. 3. Coordinate & Accompany: Intensive appointment support, advocacy, and consistent follow up. 4. Stabilize: Rapid resolution of transportation, housing, benefits, and basic-needs barriers. 5. Track & Improve: CBCS monitoring dashboards tracking utilization, follow through, SDOH resolution, and outcomes.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Community Based Coordination Solutions	Alaska Community Navigation Workforce Development Initiative	WA	Costly crisis events across Alaska stem from: • Behavioral health challenges • Chronic disease • Siloed communication • Geographic barriers • Unaddressed social determinant needs CBCS has traditionally addressed these issues by establishing boot on the ground programs, such as with the HUMS program in the Matsu Burrough. We recognize that some communities already have established staff that would like training in our proven Navigation model. Through this proposal, CBCS will train Alaska’s existing workforce to scale and sustain successful outcomes using CBCS’s model, proven across multiple regions nationwide, but designed to be particularly effective in rural communities in which traditional training opportunities may be limited.	CBCS will not provide field navigation. Instead, CBCS will build and support Alaska’s workforce, including tribal, rural, justice-involved, and urban teams. CBCS supplies the infrastructure, training, and performance model; Alaskan organizations supply the boots on the ground workforce. CBCS Responsibilities: • Initial & ongoing training that includes trauma informed engagement, SDOH navigation, crisis follow up, care planning, motivational interviewing, field safety. • Coaching & supervision support, including weekly case review, fidelity monitoring, and continuous quality improvement. • Operational toolkits, workflows & templates • Coaching on CBCS' 24/7 availability model • Monthly reporting tied to measurable outcomes like ED reduction, outpatient linkage, SDOH resolution. • Workforce recruitment support, emphasizing local hiring and lived experience Alaska Staff Will Learn: • Direct field engagement • Appointment support • Transportation coordination • Assisting enrollees with access to available benefits • Crisis follow up • Relationship based navigation We would seek DOH’s assistance in identifying partners with existing staff that would benefit from this training. We can adapt our capacity to meet a variety of needs, but a recommended approach would be to target one large community and/or partner in year 1, along with 1-2 remote communities and/or partners, to allow for proof of concept. Subsequent years would focus on targeted expansion over the rest of the state.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Community Connections	Building a behavioral health workforce pipeline: Internship, supervision, and Housing supports	AK	Community Connections’ accredited Children’s Mental Health program historically served ~130 youth at a time; today, workforce shortages limit us to ~80 with long waiting times. The binding constraint is the supply and retention of master’s level behavioral health therapists (and some SLP/OT roles). Caseloads have stretched to ~17 per clinician under a wraparound model with high Medicaid documentation demands. Despite competitive pay, licensing supports, supervision, and robust recruitment efforts (bonuses, relocation, search firms), relocation to island communities remains a barrier—chiefly due to scarce, expensive, and often low quality housing. Opportunity: Build a durable, local pipeline that keeps care close to home by (1) launching a structured internship to employment pathway with tele supervision for Master’s clinicians; (2) creating stackable “grow your own” credentials (Direct Support Roles → UA occupational endorsements → BSW/BA Psych → Case Managers → MSW/MS Psychology) with tuition supports and limited paid study time; and (3) offering time limited housing supports that remove an immediate barrier to recruitment and early retention. This right sized, rural strategy restores capacity, stabilizes access for families in Ketchikan and on Prince of Wales Island, and creates long term resilience in our local workforce.	1) Internship to Employment (Master’s level): • Routine graduate placements (e.g., UAA MSW; UAA Psychology) with tele supervision by licensed LCSW/LPC; weekly individual + group supervision; competency rubrics; hour tracking; documented evaluation. • Conversion ladder: Internship → provisional hire → supervised hours toward licensure; structured mentorship in Ketchikan and POW communities. 2) Stackable “Grow Your Own” Pathway: • Entry via Direct Support Professional roles; enroll staff in NADSP e Badge. • Transition to Occupational Endorsements (OE) in Behavioral Health/IDD (UAS/UAA/UAF), then BSW/BA Psychology, then MSW/MS Psychology (in state). This aligns with AK workforce infrastructure and provides multiple on-ramps. Tele-supervision will also be provided concurrently to clinicians and other direct care roles, including case managers. • Supports: targeted scholarships/tuition, test fees, and limited paid study time aligned to performance. • Cultural grounding: Orientation and ongoing consults with Ketchikan Indian Community (KIC); CHAP/BHA alignment where appropriate. 3) Time Limited Housing Supports (recruitment/early retention): • Limited 6–12 months’ tenancy for interns/new hires at 60–70% of fair market value, tied to a 5 year service commitment (with prorated repayment for early departure). • Approach: master lease or set aside units; explore co use with RYC/KIC to maximize throughput and equity. 4) Spark Youth Engagement in Behavioral Health Roles (High schools in Ketchikan and POW): • Classroom talks/career fairs, site visits/shadow days, and a short summer BH assistant intro workshop hosted by Community Connections; dual enrollment into UA OEs for interested seniors. 5) Partnerships & Governance: • Universities: UAA, UAS, UAF (MOUs; academic liaisons). • Local/Tribal partners: Ketchikan Indian Community; Residential Youth Care (shared supervision/placements/housing coordination). • Management cadence: Bi weekly reviews; monthly steering; clear Standard Operating Procedures for supervision, documentation, and housing eligibility; KPI dashboard. 6) Timeline (first 18months): • Q1–Q2: finalize MOUs/manuals; Operating Procedures; enroll first DSP/NADSP cohort; stand up tele supervision; secure initial housing units. • Q3–Q4: host 4–6 graduate interns; 6–10 staff in OEs; begin tenancy; provisional hires. • 18 Months: maintain 4–6 interns; expand OEs/BSW/BA cohorts; 2–3 admissions to MSW/MS Psych; reach ≥70% intern→hire conversion.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Advance to Implementation Application

Community Connections	EHR Optimization and acquisition/implementation of scheduling software	AK	Community Connections’ ability to deliver timely BH services in the remote island communities of Ketchikan and Prince of Wales Island is limited by two technology gaps. First, our EHR (CareLogic) was selected because RHTP emphasizes interoperable, configurable systems that support reporting, coordinated care, billing accuracy, and value based participation. Yet without specialized configuration, we cannot access utilization reporting, progress toward goals data, or automated billing exports—functions explicitly prioritized in RHTP’s Spark Technology & Innovation initiative. As a small rural provider, our limited internal IT capacity means these features remain unused, forcing reliance on spreadsheets and manual work that increases administrative burden and reduces access—barriers the RHTP State Application highlights as major challenges for rural Alaska. Second, our Children’s Mental Health program requires fast, reliable, multidisciplinary scheduling across homes, schools, foster homes, and community settings. RHTP acknowledges that providers must adopt technology that improves communication, reduces delays, and supports coordinated care near home. Our current paper scheduling system cannot support this, resulting in missed appointments, inefficient staffing, and delayed care. Together, these technology gaps reduce access, quality, and operational efficiency in communities already experiencing significant behavioral health workforce and service shortages.	Our two part project directly reflects RHTP’s emphasis on strengthening rural health systems through modern technology, technical assistance, workflow redesign, and improved data infrastructure. 1) CareLogic EHR Optimization (Consultant Led) • Hire a CareLogic experienced consultant—an approach explicitly permitted as “technical assistance” and “project planning/data/reporting” support across RHTP initiatives. • Conduct discovery, data mapping, and define minimum viable reporting aligned with RHTP’s call for interoperable systems and actionable analytics. • Build automated EHR→billing exports and reconciliation logs, consistent with RHTP’s value based payment readiness and fiscal sustainability goals. • Create dashboards for utilization, authorizations, caseloads, and engagement—matching RHTP guidance to improve access, reduce burden, and enable data driven care. • Add outcome/goal tracking features that align with RHTP’s targeted outcome and quality improvement expectations. • Train staff with SOPs and quick reference tools, advancing RHTP’s workforce support objectives. 2) Scheduling/Coordination Software for CMH Program • Identify simple, mobile friendly scheduling tools that improve real time communication, consistent with RHTP’s Spark Technology initiative prioritizing digital tools that enhance access and coordination. • Pilot 2–3 options with field based staff; select the most reliable across rural settings. • Configure core features: team calendars, automated text alerts, cancellation notices, crisis slot flags, and appointment reminders—aligned with RHTP’s aims to reduce care delays and strengthen community based service delivery. • Provide short, hands on training; deploy super users to support transition. • Monitor early adoption to ensure usability and sustained impact. Together, these two components reduce administrative burden, improve care coordination, and enable rural Alaska families to receive services closer to home—core priorities of the RHTP Vision and State Plan.	Under \$50,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Advance to Implementation Application

Community Connections	Prevention and Telehealth HUB for Children	AK	In our rural island region, the most significant gaps for young children occur before they enter kindergarten. Many 3–5 year olds show social emotional and behavioral challenges yet do not meet the criteria for special education preschool or our Medicaid funded behavioral health program. As childcare disruptions rise, families lose stability and children miss the chance to benefit from early, structured support. At the same time, after school hours remain the most vulnerable time of day for school age children, with many families lacking safe, enriching options. Across all ages, children frequently wait for months or years for evaluations or specialty therapies due to shortages of local clinicians and dependence on off island travel. This results in avoidable escalation—issues that could be addressed with early intervention are instead left to grow until they trigger larger crises. The opportunity is to create a single, prevention first entry point for young children: expanding the Little Sprouts therapeutic group, launching KAP Littles for after school support, and establishing a telehealth hub that brings specialists directly into our community through a shared space model. By blending early childhood enrichment with timely access to behavioral health and developmental specialists, families get help sooner, and children receive the consistent support they need for healthy development.	1) Expand and Enhance Little Sprouts (3–5 years) • Lease a dedicated child friendly space to run daily therapeutic groups. • Open enrollment to the broader community, including children who struggle socially or emotionally but are not eligible for behavioral health services. • Add a peer buddy model, offering pro bono participation for typically developing children who can serve as trained peers and support group dynamics. • Embed parent coaching, warm handoffs, and coordinated transitions to preschool or other services. 2) Launch KAP Littles (ages 5–13) • Design and pilot a structured after school program focused on social emotional learning, physical activity, enrichment clubs, community building, and homework support. • Offer a safe, engaging alternative during the hours when many youth lack supervision or structured activities. • Integrate children with diverse needs—BH eligible youth, children with disabilities, and those needing additional support but not meeting eligibility criteria. 3) Establish a Rural Telehealth Hub • Create two multi use telehealth rooms equipped for behavioral health, OT, PT, SLP, ABA, and social work services. • Use trained paraprofessionals to facilitate remote sessions, reinforce therapeutic recommendations, and support follow through. • Reduce the need for inter island travel and compress wait times for evaluations and therapy. • During start up, use time limited locum tenens clinicians to provide rapid access while permanent hires are recruited and credentialed. 4) Systems Integration and Value Readiness • Develop coordinated workflows linking Little Sprouts, KAP Littles, Early Learning, and Children’s Mental Health. • Build referral pathways, scheduling processes, and analytics needed for future value based pilots. • Provide training for paraprofessionals, supervisors, and partners (schools, Tribal organizations, university programs). This approach immediately increases capacity for early prevention while building the infrastructure for sustainable, long term access.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Advance to Implementation Application

Community Connections	Increase Healthcare access through Advocacy and Navigation	AK	Community Connections serves individuals from birth through adulthood across three major service systems—Early Intervention, IDD, and Children’s Mental Health—each with its own eligibility, timelines, and documentation requirements. Families often struggle to navigate these complex pathways, especially during key transitions: toddlers losing Early Intervention eligibility at age 3, youth shifting between BH and school services, and adults entering or leaving IDD programs. Too many families give up before completing eligibility steps, leading to long delays or crisis driven re engagement. RHTP emphasizes that Alaska’s rural communities need prevention-focused, early-connection strategies, streamlined access, and supports that help families enter systems before needs escalate. Our current processes are fragmented—each program manages its own referrals, denials, and handoffs. We lack structured ways to follow discharged clients or track whether they successfully connected to alternative services. Missed follow-through translates into preventable crises, unmet service needs, or loss of developmental progress. The opportunity is to establish a Family Advocate & Navigator (FAN) who ensures earlier identification of needs, consistent follow-through, and warm handoffs across programs and partner agencies. This position will bridge program silos, reduce preventable crises, and help families access the right service at the right time.	1) Prevention-Focused Intake & Early Connection • Create a single, proactive entry point for families; provide early screening, simplify eligibility steps, and reduce delays. • Track all denied or deferred referrals; ensure successful connections to internal or external services (schools, tribal health, EI, BH, IDD). • Use early relationship-building and routine follow ups to keep families engaged. 2) Navigation Across Developmental Stages • Support critical transitions: – Age 3 Early Intervention exits → preschool/BH supports – Youth moving between BH levels of care – Adults entering or exiting IDD services • Provide persistent, trauma informed navigation through complex eligibility pathways. 3) Coordinated Care Planning • Facilitate cross program huddles when individuals receive services in more than one program. • Align treatment/goal plans to avoid duplication or conflicting protocols. • Strengthen communication among providers, schools, OCS, foster families, and tribal partners. 4) Data Tracking & Learning • Build simple intake and discharge tracking tools—core RHTP expectations for data-enabled improvement. • Track time to service, dispositions, lost-to-follow-up cases, and preventive connections. 5) Rural Emphasis • Use phone/text/tele-navigation to reach families in remote villages and foster placements on Prince of Wales Island. • Provide warm handoffs that do not require families to navigate systems alone. RHTP Fit: • Mirrors Initiative #3: early intervention, prevention, family support, locally tailored community health work. • Advances Initiative #2: coordinated access, navigation for IDD/BH, improved rural care pathways. • Follows Evaluation Framework guidance: clear need, measurable outcomes, rural impact, sustainability.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Deferred or Not Advanced

Community Connections	Increased Access: Pediatric Speech Therapy Expansion in Southern Southeast Alaska	AK	Today, families across Ketchikan, Metlakatla, and Prince of Wales Island have almost no access to pediatric speech language pathology. The only option is two itinerant SLPs who fly in for a few days each quarter, serving only 0–3 year olds due to grant restrictions, and unable to successfully bill many insurers. Children over 3, including those with speech delays, hearing loss, autism, developmental disabilities, or academic language needs, currently have no local provider. The result is long delays, missed early windows for intervention, and widening gaps in communication skills that affect social, emotional, and academic functioning. The lack of local SLP capacity also increases costs. The travel model is expensive, inconsistent, and not reimbursable at scale. It is fully grant dependent and the travel does not allow billing to private insurance or Medicaid. Families in rural villages and remote communities are disproportionately affected because they rely on limited transportation and cannot benefit from brief itinerant visits. The opportunity is clear: recruit and hire a full time pediatric SLP to serve ages 0–18 across the region. A permanent clinician removes the 3 year old cutoff, expands access to underserved school aged youth, creates continuity, and establishes a stable reimbursement base that supports long term sustainability.	1) Recruitment and Hiring of a Full Time Speech Language Pathologist • Conduct a national search focused on rural experienced pediatric SLPs. • Offer relocation assistance, supervision support, and rural practice incentives to attract qualified candidates. • Onboard the SLP into Community Connections’ interdisciplinary team, serving Ketchikan, Metlakatla, and communities across Prince of Wales Island. 2) Immediate Expansion of Access • Begin providing evaluation and therapy for ages 0–18. • Remove the 3-year-old eligibility cliff by opening services to school aged youth who currently have no local options. • Offer speech language care in homes and clinic settings, and via telehealth where appropriate. 3) Integrated Care Across Programs • Work directly with Early Learning, IDD, behavioral health, and school partners to coordinate care, share developmental insights, and ensure consistent support. • Provide ongoing parent coaching and home-based strategies to reinforce gains. 4) Financial Sustainability and Billing Expansion • Credential the SLP with major insurers, or Medicaid. • Implement billing workflows that allow reimbursement for all eligible services, including for youth ages 3–18. • Use standardized and/or criterion reference documentation and CPT codes to ensure consistent, compliant billing. 5) Optional Regional Partnership Capacity • If caseload allows, the SLP may contract with Sitka’s Infant Learning Program (including Hoonah and Kake) to provide supplemental services, further strengthening regional sustainability and workforce efficiency. This approach replaces an unstable, costly, grant dependent model with a comprehensive, sustainable, year-round speech language service that meets the needs of rural children and families.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Deferred or Not Advanced

Community Connections	Southeast Alaska Early Intervention Expansion & Outcomes Project	AK	Under current Part C rules, a child must show a 50% developmental delay to receive Early Learning services. Many children with meaningful, emerging delays—especially in language and social emotional development—fall below this threshold and receive no support until struggles become severe. In rural Southeast Alaska, this often leads to preventable special education placements, higher family stress, and missed opportunities for early skill building. This problem reflects several statewide gaps that RHTP explicitly aims to fix: fragmentation in early identification, lack of coordinated developmental monitoring, long delays in accessing supportive services, and insufficient preventive strategies in rural communities. Children involved with OCS, children with mild to moderate speech and/or motor delays, and those experiencing trauma are particularly vulnerable to falling through the cracks. The opportunity is to build a regional prevention and early intervention demonstration—alongside Sitka’s Center for Community and Juneau’s REACH—that evaluates outcomes for children with 25–49% delays who currently receive little or no support. This aligns directly with RHTP priorities to enhance preventive care, improve early childhood development, strengthen navigation, and reduce long term system costs.	1) A Prevention First Regional Early Learning Demonstration (Primary: Healthy Communities) • Serve children with 25–49% delays who currently fall below eligibility but are at elevated developmental risk. • Use state accepted assessments, quarterly monitoring, parent coaching, and warm handoffs to create a continuous early connection pathway. • Expand developmental monitoring and support for children involved with OCS and those living in remote communities. 2) Strengthen Regional Partnerships (Community Connections, REACH–Juneau, Center for Community–Sitka) • Establish MOUs in the first 3–6 months outlining shared goals, data responsibilities, referral pathways, confidentiality protections, and coordination expectations. • Develop uniform protocols across all three organizations for standardized assessments, quarterly progress monitoring, documentation, and follow through into kindergarten. • Conduct a joint regional training series for Early Learning staff and supervisors to ensure fidelity in assessment, parent coaching, data collection, and developmental tracking. • Create a shared “minimum dataset” for tracking outcomes across sites and aligning learning cycles. 3) Longitudinal Tracking Into Early Elementary School (Secondary: Health Care Access) • Build a unified multi year dataset following children from enrollment through K–1 to examine reductions in special education referrals and gains in school readiness. • Track outcomes by delay category (25–49% vs. ≥50%) and monitor results for OCS involved children. • Strengthen coordination with school districts and pediatric partners to ensure continuity of supports. 4) Improve Access and Navigation • Streamline referrals, follow through, and transitions across Early Learning, preschool, behavioral health, disability services, and school based supports. • Use telehealth supported coaching and remote case consultation to reach families throughout Southeast Alaska. 5) Build Sustainable Billing and Funding Pathways • Expand private insurance billing through staff credentialing, appropriate CPT code utilization, and documentation aligned with insurer requirements. • Use blended funding to sustain developmental monitoring and family coaching long after the RHTP period. 6) Continuous Improvement & Regional Learning • Quarterly regional review sessions among Ketchikan, Juneau, and Sitka teams to refine assessment fidelity, share trends, and make course corrections based on data.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Community Inclsusion Services	Tech Enabled Therapeutic Homes for Complex Care in Rural Communities	AK	Across Alaska’s rural communities, individuals with complex medical, behavioral, or developmental needs who meet institutional levels of care often lack access to coordinated services close to home. Geographic isolation, limited specialty providers, workforce shortages, and infrastructure gaps leave rural systems unable to consistently deliver the intensity of care needed. As a result, preventable hospitalizations, emergency visits, and costly institutional placements far from home occur, separating people from their families, cultures, and communities. The long-standing problem of people living in rural communities with complex, nursing facility–level needs face multiple barriers: limited local providers and specialists, long travel distances, frequent facility closures, and fragmented home and community based services. As a result, they are often forced into institutional care far from home, experience preventable hospitalizations and emergency visits, and lose the social, cultural, and environmental supports that ensuring well being. Workforce shortages and underfunded rural systems mean that even motivated local providers cannot consistently deliver the intensity and coordination of care these individuals require. Addressing this gap creates an opportunity to advance institutional diversion and deliver coordinated, technology-enabled care that allows people with complex needs to remain safely in their homes while strengthening rural health system sustainability.	The project makes it possible for people who meet an institutional level of care (e.g., nursing home or hospital at home criteria) to remain safely in their own homes and communities, supported by a coordinated, technology enabled interdisciplinary care team. By integrating virtual specialty care, remote monitoring, and locally delivered in home supports, the model advances institutional diversion and enables people with complex needs to receive high-acuity services close to home. The approach seeks to reduce avoidable hospitalizations and institutional placements, improve quality of life, and strengthen the stability and sustainability of rural health and social care systems This rural healthcare transformation project will create a technology enabled, home based model that delivers institutional level, person centered care in a therapeutic home environment so that people with complex needs in rural communities can remain safely in their own homes despite limited local professional resources. The model combines telehealth platforms, remote monitoring and supervision, virtual companionship and specialty consultation, shared digital care plans, and secure messaging to enable continuous coordination among providers, caregivers, and family members. Technology also allows staff to remain available remotely 24 hours a day for supervision, consultation, and rapid response when needed. The Project builds a therapeutic home environment by integrating family involvement, cultural strengths, and community resources into each person centered plan of care. Local direct support staff provide in-home assistance while technology enables clinical oversight, interdisciplinary collaboration, and access to specialists who may not be physically present in rural communities. This coordinated model supports both client stability and workforce sustainability by extending the reach of rural providers, improving care coordination, and enabling safe, high-quality care delivery in home and community settings.	Under \$50,000	Single Community	Kodiak Island Borough	Advance to Implementati on Application

Commure	AI-Powered Clinical Intelligence for Rural Alaska: Documentation, Billing & Provider Retention	CA	The promise of technology has often failed rural healthcare. Nationally, administrative costs exceed \$1 trillion, and providers spend nearly six hours daily on non-clinical tasks. In Alaska, these challenges are magnified by geographic isolation and workforce shortages. Alaskans face high costs of care and severe clinician burnout, as providers spend significant time on documentation rather than patient care. Commure addresses this opportunity with an AI-native platform designed to remove administrative waste and optimize financial performance. We specialize in Ambient AI Scribing, which provides passive listening during encounters to automatically generate structured clinical notes with 92% accuracy. This directly mitigates clinician burnout and reduces documentation errors by 31%. Furthermore, our Financial Platform automates the revenue cycle, achieving a 97% first-pass rate and a 53% reduction in filing denials. By integrating these Agentic AI solutions into existing workflows, we ensure rural clinics capture every dollar earned while freeing clinicians to focus on care. With a proven footprint of 55+ clinicians in 14 Alaska cities, Commure is uniquely positioned to strengthen the economic and operational foundation of Alaska’s rural health system.	Commure addresses the administrative and financial fragility of Alaska’s rural healthcare through an integrated, AI-native approach that automates the most burdensome aspects of care delivery. Our solution targets three critical pillars: clinical documentation, revenue cycle stability, and patient access. (1) Eliminating Documentation Burdens with Ambient AI: To solve the crisis of clinician burnout, we deploy Ambient AI Scribing. This technology uses passive listening to transcribe patient encounters into structured clinical notes in real-time. - The Solution: Our AI engine achieves industry-leading accuracy (F1 Score >0.92), reducing documentation errors by 31%. - The Impact: This returns hours to the clinician’s day, allowing them to focus on the patient rather than a screen, directly addressing the retention challenges in frontier communities. (2) Strengthening Financial Stability via Autonomous RCM: Rural clinics often operate on thin margins and suffer from undercoding or filing denials. Commure’s Financial Platform creates an autonomous revenue cycle that bridges the gap between the clinic and the payer. - The Solution: We automate claim generation, appeal creation, and reconciliation. - The Impact: Our partners see a 53% drop in timely filing denials and a 97% first-pass claim rate. This ensures that Alaska's rural facilities capture every dollar earned to remain operationally viable. (3) Bridging Geographic Gaps with AI Navigation: To address the geographic isolation and patient coordination hurdles, we implement an AI Call Center and Intelligent Care Navigation. - The Solution: Conversational AI agents handle 70–90% of scheduling calls and guide patients through care needs assessments and eligibility checks. - The Impact: This streamlines the patient journey across vast distances, reducing no-shows by 10–15% and ensuring patients are prepared for care before they arrive at a regional hub. By embedding these agentic AI solutions directly into existing EHR workflows, such as Epic, Athena, and Oracle Health, Commure transforms routine operations into a proactive, data-driven ecosystem. This approach doesn't just add another tool; it creates "digital connective tissue" that makes rural health systems more human-centered and economically resilient.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Sitka (City and Borough)	Deferred or Not Advanced

Compass Therapy LLC	Alaska Speech, Swallow & Cognitive Access Initiative	AK	Rural, remote, and frontier Alaskan communities face significant barriers to accessing specialized neurologic speech-language pathology services. Individuals living with Parkinson’s disease, stroke, dementia and other neurologic conditions commonly experience progressive voice disorders, swallowing impairment, and cognitive-communication decline, yet many rural areas lack clinicians trained in evidence-based neurologic treatments provided by speech language pathologists. Geographic isolation, high travel costs, severe weather, limited specialty workforce capacity, and mobility limitations related to neurologic disease frequently delay care. Many individuals with these conditions have difficulty traveling long distances for appointments, contributing to delayed treatment, avoidable hospitalizations, aspiration-related complications, and reduced functional independence. Caregivers in rural communities also assume complex medical responsibilities with limited training or support. This project addresses the gap in accessible neurologic speech, swallow, and cognitive services by expanding telehealth-based treatment and caregiver training for rural Alaskans. By bringing specialized care directly into patients’ homes, the initiative reduces travel burden while improving safety, independence, and quality of life.	The Alaska Speech, Swallow & Cognitive Access Initiative will provide telehealth services in three areas: voice therapy, swallowing management, and dementia support. Voice therapy will address neurologic voice disorders, including treatment such as LSVT LOUD to improve vocal loudness and speech clarity. Swallowing services will include screening, swallow safety education, compensatory strategies, and coordination with medical providers to reduce aspiration risk. Dementia support will include caregiver training, such as evidence-based dementia communication strategies from the Positive Approach to Care® program. Services will be delivered through secure telehealth to reduce travel burden and weather-related barriers. To address technology limitations, the project will establish a telehealth equipment loan bank including tablets (e.g., iPads), adjustable tripods, and portable sound level meters to support therapy participation and voice practice. Outcome measures—including vocal intensity data, functional swallow indicators, and goal attainment—will guide quality monitoring. Three Medicare-enrolled clinicians are preparing to complete LSVT LOUD certification and the Positive Approach to Care® training. The organization plans to hire an additional 2–5 speech-language pathologists over the next year to expand neurologic rehabilitation access across rural Alaska.	Under \$50,000	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

COOK CENTER FOR HUMAN CONNECTION	Helping Alaska’s Helpers: Healthy Beginnings for Every Community	UT	Alaska has built innovative Tribal and rural health systems, yet most mental health support for children and families still depends on scarce clinicians and crisis-driven care that many rural families cannot reliably reach due to barriers like workforce shortages, distance, weather, and roadless communities. In practice, the adults who are with children every day, including parents, caregivers, and school staff, are asked to respond to depression, anxiety, trauma, and suicidality with little preparation, few tools, and strong stigma in small villages and communities. They also rarely receive health literacy training that links mental health to everyday drivers of wellbeing, such as nutrition, physical activity, sleep, and stress management, even though these “root causes” are central to Alaska’s strategy for preventing chronic disease and suicide. This gap between formal services and everyday helpers is especially stark in roadless villages and frontier districts, where travel is costly and school-based mental health staff are limited or absent. The opportunity is to treat these adults not as an afterthought, but as a primary lever for upstream prevention. We can give every rural district and community a practical, Alaska-proven way to build family efficacy, health literacy, and educator capacity around mental health and wellness. This work aligns with RHTP’s Healthy Beginnings and Healthy Communities initiatives and is woven into existing school and Tribal efforts.	Cook Center's “Helping Helpers Help” model is grounded in credible research and backed by a federal Education, Innovation and Research (EIR) grant from the U.S. Dept. of Education, which carefully vetted the project's logic model, research rationale, and outcomes. Helping Alaska's Helpers adapts this evidence-based framework for a fully virtual, school-hub suite of supports across all 53 rural school districts. PROMOTING PREVENTION THROUGH SCHOOL-ANCHORED SUPPORTS Districts place Cook's ParentGuidance.org medallion on their websites giving every family free, confidential 24/7 access to 70+ therapist-led courses. The website’s 300+ Ask-a-Therapist film clips feature FAQs submitted by parents and answered by licensed therapists to provide immediate answers and tools related to parents’ most urgent concerns. Live, interactive Mental Health Series webinars for families and school staff build mental health literacy and parenting skills. All resources preserve parent anonymity. STRENGTHENING FAMILY AND COMMUNITY RESILIENCE WITH EVIDENCE-BASED COACHING Because local services are scarce and waitlists long, families need timely, individualized help. ParentGuidance.org provides confidential parent coaching with weekly 30-minute tele-health sessions, secure messaging, and an app-based curriculum grounded in a cognitive-behavioral framework. Coaches use skills-based strategies and proven approaches to help caregivers recognize warning signs, strengthen routines, set healthy boundaries, and respond constructively to challenges such as anxiety, depression, and conflict. Coaching provides timely, personalized support that strengthens caregiver-child relationships and bolsters family and community resilience. BUILDING HEALTHY COMMUNITIES THROUGH EDUCATOR CAPACITY Fully virtual educator professional development is selected by each district from a menu including Trauma-Sensitive Environments, QPR Suicide Prevention, and Self-Care for Teachers, equipping school adults to recognize distress, respond with confidence, and connect families to resources. Implementation follows a statewide structure with local flexibility: Cook Center and district leaders plan PD, webinar themes, and outreach aligned with Tribal and community priorities. As the trusted voice for rural school leaders, the Alaska Council of School Administrators (ACSA) builds on Cook's existing partnerships to coordinate launches across all 53 rural districts and sustain engagement through ongoing collaboration.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Cook Inlet Counseling	Cultivating Impact- Responding with Care- Linking Effective strategies	AK	Through various collaborations and community coalitions, Cook Inlet Counseling has participated in several activities and ongoing meetings that have assessed access to behavioral health services on the Kenai Peninsula. We have found that three populations have the greatest disparity in access to behavioral health services — youth, people 65+ , and justice involved women. In recent years, our community has seen a significant spike in youth mental health issues and based on the Alaska Youth Risk Assessment Survey, Kenai Peninsula students have drug/alcohol use rates that are 5-10% higher than state average. We currently do not have the capacity to address these issues, but through expanding services and increasing preventative measures we can better serve our youth. Men 65+ are another demographic on the peninsula that are high risk for mental health issues and often do not have support systems in place. In 2025, of the 2811 calls received by 988 on the Kenai Peninsula, 2262 of them were from men over 65 in the Soldotna area. Our community needs to find new strategies to engage these individuals who often socially isolate themselves. A third group that often falls in the gaps of the continuum of care is women incarcerated at Wildwood Pretrial. Most resources are directed at the male sentenced population which leaves justice involved women without access to services that would reduce recidivism, including assessments. Evaluation and collaboration is needed to bridge these gaps.	Initial concept includes targeted outreach and advertisement, focus group/information gathering, and creating a targeted action plan to engage with each group. We will identify needs and determine which services would be most beneficial for each population. We use a person-centered care approach to all services, so input from individuals and their families will guide the formation of programs and support to follow. Additional recruitment and training of staff to ensure all clinicians, support staff, and community partners are qualified to address the specific needs of each group will be completed based upon information gathered. Partnerships with Parents, adult children, medical providers, in home health providers, and others to be identified will be established to support efforts in the youth and elder populations. Advocacy and coordination with DOC, District Attorney, Public Defender, DOJ and medical/behavioral health providers will be established to improve outcomes for the pretrial population. We expect to address the behavioral health needs of youth and 65+ populations, using information collected in the initial phase, with targeted interventions, population specific programing, and building community supports through our coalitions. We will partner with the 100% Communities Alaska to increase community supports and with the 100% Behavioral Health action team and its RHTP program, if it is funded, to address many needs of justice involved individuals.	Under \$50,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Cook Inlet Tribal Council	Chanlyut Residential Behavioral Health Renovation & Integrated Care Expansion	AK	Chanlyut was built in 2011 as a men's reentry housing unit. In the years since, it has evolved into a co-ed, trauma-informed ASAM 3.1 residential behavioral health program, but the physical facility was never redesigned to match this clinical evolution. Today, participants sleep in open, dorm-style rooms with a male and female wing of up to seven individuals each, with no meaningful privacy for sleeping, changing, or rest. Group therapy spaces are undersized and inadequate for evidence-based therapeutic interventions, fundamentally inconsistent with the trauma-informed, culturally responsive care that CITC's model requires, particularly for Alaska Native individuals arriving from rural communities already navigating the stress of an unfamiliar urban environment. These physical conditions directly suppress treatment engagement and enrollment. In the most recent fiscal year, Chanlyut served only 45 unique individuals against an annual capacity of 56 at full census. When participants need basic medical care, they must leave for outside appointments, disrupting therapeutic schedules and increasing dropout risk. CITC's psychiatric nurse practitioner manages psychiatric services but lacks nursing infrastructure to address routine medical needs on-site. The opportunity is to transform Chanlyut into an integrated, high-quality, culturally responsive residential facility where Alaska Native people experience belonging, connection, and healing.	Working from 35% construction documents already developed in partnership with the Alaska Mental Health Trust and an architectural and engineering firm, CITC will renovate Chanlyut using a phased approach that keeps the program fully operational throughout construction. The renovation scope reconfigures dorm-style sleeping areas into semi-private rooms, right-sizes group therapy and meeting spaces, and upgrades medication management and staff support areas. Cultural design will be incorporated through a separate engagement with a cultural design contractor, such as SALT or a similar firm specializing in Alaska Native design. This work will be reflected entirely in furnishings, fixtures, and equipment (FF&E) and requires no changes to construction documents or structural scope. This component aligns with the RHTP Health Care Access initiative's call to strengthen Tribally led Traditional Healing within the care environment. CITC's dual-certified family and psychiatric nurse practitioner will be supported by a newly hired nurse case manager to provide on-site medical assessment and basic acute care for residential participants. This capacity, functioning like an embedded walk-in clinic, will manage minor illness, post-hospitalization monitoring, medication reconciliation, and preventive health screenings without requiring participants to leave the facility, keeping them continuously engaged in the therapeutic environment. This directly advances the RHTP Health Care Access goal of improving primary care access and creating multidisciplinary teams that integrate medical and behavioral health services. In parallel, CITC will configure its CareLogic EHR system and train staff to extend behavioral health billing to currently non-billable programs including Reentry, Family Wellness, and Victim Services, programs expanding access to behavioral health care. This billing infrastructure investment positions CITC for long-term financial independence and aligns with the RHTP Pay for Value: Fiscal Sustainability initiative's call to invest in IT infrastructure and team-based care workflows. CITC will also evaluate AI-assisted clinical documentation tools to reduce provider documentation burden, consistent with the RHTP Spark Technology and Innovation initiative's priority to empower providers' use of appropriate AI tools for care delivery.	\$1M-\$5M	Single Community	Anchorage (Municipality)	Advance to Implementation Application

Cook Inlet Tribal Council	Pre-Development Planning for Cultural Center	AK	Cook Inlet Tribal Council (CITC), headquartered in Anchorage, serves Alaska Native individuals and families whose home communities span virtually every rural, remote, and frontier region of Alaska. CITC proposes pre-development activities for the construction of a Cultural Center on CITC-owned land in Anchorage to address the need for culturally grounded spaces that promote wellness, connection, and access to services for Alaska Native people living in or traveling through Alaska’s largest urban hub. While Anchorage has athletic and cultural facilities, few spaces intentionally combine cultural programming with physical activity in an Alaska Native-centered environment, leaving many residents without a welcoming, culturally grounded gathering space. The proposed Cultural Center will address this gap by creating a space where cultural engagement, physical activity, and community connection occur together. Programs such as Native Youth Olympics, traditional dance, and intergenerational cultural activities will promote active lifestyles, strengthen identity, and support knowledge sharing among youth, families, and Elders. The Cultural Center will also serve as an entry point to CITC’s services for underserved populations, connecting them to education, workforce, and behavioral health programs. This aligns with RHTP’s Healthy Communities and Health Care Access Initiatives.	The CITC Cultural Center will serve as a vibrant, wellness-focused gathering place for Alaska Native people and the broader community. Building a Cultural Center has been a long-imagined community vision, and CITC is ready to bring it to life. The proposed Cultural Center will be an innovative facility designed to promote healthy lifestyles and strengthen cultural identity through “Culture as Prevention” programming. Unlike facilities that are associated with illness or crisis, the Center will represent a positive, community-centered space focused on wellness, connection, and cultural pride. CITC currently serves more than 12,000 people annually, including more than 1,200 youth who participate in the Native Youth Olympics (NYO) Games program each year, and all participants will benefit from the opportunities the Center provides. The facility will include: • A multi-purpose gymnasium designed to host traditional games that promote physical fitness in Arctic environments, youth recreation, traditional dance practices and performances, family activities, and community events such as craft fairs or film showings. • A commercial kitchen and cafeteria will allow for demonstrations and hands-on learning opportunities for fish and wild game processing, cooking classes, preparation of food for gatherings, and meal kit distribution. • An exercise room will provide training space for traditional games and physical preparation for subsistence activities. • Shower and laundry facilities will promote hygiene and self-care, with exploration of a sauna to support traditional wellness practices. • Dedicated craft rooms will enable instruction and collaborative work in sewing, basketmaking, drum making, and other traditional arts. • Classroom spaces will support CPR and first aid training, traditional healing, outdoor survival skills, gardening instruction, vocational learning, and potential expansion of childcare programming. • Office space will support facility operations, event planning, and program enrollment counseling, while display areas will showcase traditional tools, games equipment, and cultural artifacts. • Outdoor areas will support gatherings, gardening instruction, and cultural activities. Existing CITC programs will support staffing through an expanded Cultural Department. By integrating culture, physical activity, and community gathering, the Cultural Center will improve health outcomes and create a lasting hub for Alaska Native wellness in Anchorage.	\$50,000-\$250,000	Single Community	Anchorage (Municipality)	Advance to Implementation Application

Cook Inlet Tribal Council	Cook Inlet Tribal Council's Healthcare Professions Training Initiative	AK	Alaska faces a persistent shortage of trained healthcare professionals and behavioral health providers. Workforce reports estimate the state needs more than 9,400 new healthcare workers every year to meet demand, yet training programs produce far fewer graduates—for example, only about 346 new registered nurses graduate annually despite a need for roughly 1,400. This gap strains the healthcare system and limits available services, particularly in rural communities where recruitment and retention are more difficult due to geographic isolation and high living costs. Cook Inlet Tribal Council proposes a healthcare training initiative designed to expand the supply of licensed, high-demand healthcare professionals through credential pathways that can be completed in two years or less. The program would provide tuition assistance, structured case management, employer partnerships, and means-tested living stipends to ensure participants successfully complete training, obtain licensure, and secure employment in Alaska. The model builds on CITC’s successful implementation of the Health Profession Opportunity Grants (HPOG) Program from 2011–2021, during which more than 730 participants enrolled in healthcare training and nearly 300 were placed in healthcare employment. The program directly supports the goals of the Alaska RHTG program by strengthening the healthcare workforce and expanding access to essential health services in rural, remote, and frontier communities across the state.	Cook Inlet Tribal Council proposes the Healthcare Professions Training Program to expand Alaska’s healthcare workforce by preparing participants for licensed, high-demand healthcare careers through credential pathways that can be completed in two years or less. Priority occupations include Licensed Practical Nurse (LPN), Registered Nurse (RN), Certified Medical Assistant, Phlebotomist, Diagnostic Medical Sonographer (Ultrasound Technician), and Emergency Medical Technician (EMT)/Paramedic. These occupations were selected because they are in critical shortage across Alaska and represent accessible career pathways that offer strong wages, long-term advancement opportunities, and the ability to serve communities in need. Participants enrolled in the program will receive comprehensive supports designed to ensure successful completion of training, licensure, and employment. Services include tuition assistance, payment of required books and equipment, licensure exam costs, and means-tested living stipends for up to five months to help participants maintain housing and household stability while completing intensive training programs. Each participant will receive dedicated workforce case management and develop an individualized success plan that identifies strengths, career goals, and potential barriers. Case managers will provide ongoing guidance and connect participants to supportive services such as childcare, housing assistance, and other stability support to ensure students remain on track and successfully complete their training. The program will be housed within CITC’s Career Development Department, which has a proven track record in providing comprehensive workforce training and employment services that help individuals obtain meaningful, sustainable careers. Recruitment will occur through multiple channels including CITC’s website, social media, job fairs, community and health events, and partnerships with organizations such as the Alaska Primary Care Association and Tribal health providers. CITC will work strategically with the tribes in the Cook Inlet region to promote this opportunity and recruit enrollees. CITC will also recruit from within its own workforce, creating opportunities for employees to obtain healthcare credentials that increase employees’ earning potential while filling critical positions within the organization—ultimately increasing service delivery and improving access to care for the communities CITC serves.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Cook Inlet Tribal Council	Generative Leadership Fellowship Initiative	AK	Cook Inlet Tribal Council is Alaska's largest tribal nonprofit, serving over 13,000 Alaska Native and American Indian people annually through health, education, employment, and social services. Despite this scale, a small percentage of CITC's AN/AI employees hold formal leadership roles; a gap that mirrors a statewide pattern. Across tribal organizations in Alaska, leaders consistently identify the absence of structured, culturally relevant leadership development as a barrier to organizational resilience and succession. When leadership roles turn over or go unfilled, the impact lands directly on the consistency and reach of health services, especially at smaller tribal organizations operating health clinics or wellness programs with lean administrative teams. To date, this work has existed as a recurring board goal; resourced year to year, dependent on existing staff capacity, and not yet institutionalized into a permanent operational structure. This project funds the infrastructure that changes that: a dedicated FTE, a formal Fellowship with competitive selection, and a regional tribal partner pipeline that current operating budgets cannot support. The goal is not to fund what already exists, but to build what makes it permanent.	CITC launched the foundational elements —the Supervisor Essentials cohort and Leadership Development Planning (LDP) framework — in FY26 to meet a board goal. These are operational but not yet institutionalized: no dedicated staff, no formal Fellowship, no mechanism to reach partner organizations. The components below represent genuinely new infrastructure that current budgets do not support. Nine Generative Leadership Competencies form the program foundation: Strategic & Transformative Leadership, Emotional Intelligence & Respectful Leadership, Financial Acumen & Resource Management, Operational Excellence & Results Delivery, Stakeholder Engagement & Communication, Connection to CITC Mission & Vision, Business Acumen, Code & Standards of Conduct, and Ethics. Each is anchored in Tribal Wisdom and embedded in CITC’s job descriptions and performance reviews. The Supervisor Essentials cohort (16 sessions over 4 months) expands to half-day formats with applied workplace assignments and scenario-based workshops. Curriculum includes dedicated sessions on urban-rural leadership dynamics, exploring distinct communication norms, management approaches, and workplace realities across village and urban environments, including flexibility for subsistence practices, always grounded in Tribal Wisdom. Tribal leaders join as guest presenters, bringing lived perspective into sessions. Two cohorts annually, capped at 10 participants, preserve small-group quality. The Fellowship launches as a formal, competitive program for AN/AI leaders within CITC and at Cook Inlet tribal partner organizations, with planned expansion to additional regions as the model matures. CITC’s Tribal Partnerships Manager will conduct targeted outreach through established contacts. Selection requires a nomination letter, personal statement, resume, HR review for good standing, and one year of continuous service. Fellows receive stipends and travel support for in-person milestone events, with the majority of sessions delivered virtually. Participants earn completion certificates tracked in CITC’s internal tracking systems. LDPs establish 12-month SMART goals reviewed quarterly with supervisors, creating a documented growth record and built-in evaluation data. A dedicated FTE manages curriculum development, Fellow coordination, and outcome tracking.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Cook Inlet Tribal Council	Nat'uh Commerical Kitchen Renovation	AK	CITC's main facility, Nat'uh, houses a kitchen that cannot support food and nutrition programming. It has storage and refrigeration but lacks core food preparation infrastructure: no commercial stove, no exhaust hood, and no commercial dishwasher. Without commercial licensure, all food-based programming is limited to demonstrations using pre-prepared ingredients; participants may observe but cannot cook, eat, or take home what is produced. CITC's Family Wellness classes, serving Alaska Native families, many recently relocated from rural communities, are constrained to demonstration-only format, preventing the hands-on experience that builds lasting nutrition skills. The facility's most accessible ground-floor space is leased to a cafe tenant whose lease expires in May, leaving prime community real estate underutilized for health purposes. CITC participants, many in a recognized food desert, have consistent demand for healthy food access and culturally relevant nutrition programming. Interest in expanded food distribution, elder meal support, and youth nutrition programming is strong, and the absence of a licensed kitchen is the single structural barrier to all of it, a direct missed alignment with Alaska's RHTP Healthy Communities priority.	CITC proposes a two-component project: (1) capital renovation of its existing kitchen and adjacent cafe space into a fully operational, commercially licensed facility, and (2) launch of food health programming made possible by that infrastructure. Kitchen renovation core improvements will include: installation of a commercial stove and code-compliant exhaust hood (routed through the south exterior wall); a commercial sanitizing dishwasher; reconfiguration of the ground-floor cafe space into a CITC-operated food distribution counter and community wellness hub; acquisition of a delivery vehicle; and all permitting and inspection work required to achieve commercial kitchen licensure under Alaska DEC requirements. With a licensed kitchen in place, CITC will expand and launch: • Upgraded from demonstration-only to fully hands-on cooking instruction, incorporating traditional Alaska Native foods, subsistence practices, and culturally grounded nutrition education. Participants will prepare and eat what they cook. • Regular bulk food distribution, with sourcing partnerships prioritizing Alaska-grown and culturally appropriate foods. • A Meals on Wheels-style delivery program for elders and families in reunification, phased in as operations stabilize. • Meals and food education for afterschool programs, camps, and youth services in CITC's network. • Entry-level kitchen roles as an employment pathway for CITC workforce development participants. • Connecting kitchen use to locally harvested foods, reinforcing cultural identity and food self-sufficiency.	\$50,000-\$250,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Cook Inlet Tribal Council	NYO Video and Coach Development for Rural Alaska	AK	CITC’s NYO program is among the most established Indigenous youth wellness programs in the state. With more than 1,000 athletes competing annually across Junior (grades 1–8) and Senior (grades 7–12) statewide games, and hundreds more participating in school and community programs year-round, NYO is a proven, community-trusted vehicle for delivering the protective factors most critical to rural health: physical activity, cultural identity, belonging, mentorship, and resilience. The instructional video library that enables this statewide reach is now significantly out of date. Rules and best practices have changed since the original videos were recorded. Rural coaches who depend on these videos as their primary training resource are working from information that may disadvantage athletes and increase injury risk, while urban athletes with access to experienced officials in person bear none of this cost. The coach network that supports NYO is also informal and inconsistently resourced. Many community coaches are passionate volunteers with deep cultural knowledge but limited access to structured training. This project addresses both gaps: restore the equity of the video library and invest in the coaches who bring it to life in communities across the state.	This project has three integrated components: a re-shoot of the Junior and Senior NYO event videos, a new whole-athlete wellness video series, and a statewide coach development program, in direct support of the RHTP’s Healthy Communities initiative and its call for scalable, culturally grounded prevention programming in rural and frontier Alaska. For the event videos, Junior content (grades 1–8) will emphasize foundational form, safe technique, and joyful participation, while Senior content (grades 7–12) will address advanced execution, competitive standards, and biomechanical precision. Both sets will reflect current official rules, feature athletes across skill levels and backgrounds, and be produced for low-bandwidth delivery, distributed free through YouTube and thumb drive, consistent with the RHTP’s Spark Technology and Innovation initiative. A new whole-athlete wellness video series will ground NYO participation in holistic health. Content will cover event-specific warm-up and mobility sequences, nutrition guidance emphasizing whole foods and traditional Alaska Native foods, and mental preparation strategies. These videos connect the physical practice of NYO to the broader healthy lifestyle and chronic disease prevention goals of the RHTP’s Healthy Communities initiative, and create a natural integration point with the Alaska Tobacco Cessation Program. The coach development program will bring 30–50 rural coaches to Anchorage for multi-day, in-person training led by CITC’s Head Official. Curriculum will cover updated rules, safe coaching, evidence-based youth mentorship, and early identification of youth in distress, positioning coaches as an extension of the rural behavioral health and Traditional Healing workforce, aligned with RHTP’s Health Care Access initiative. A train-the-trainer framework and potential formal certification will build self-sustaining local capacity.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Copper River Basin Child Advocacy Center	Child Advocacy Center - Prevention Education and Access to Services	AK	The CRBCAC is an existent program, established in 2009 and a nationally accredited CAC since 2015. The CRBCAC's mission is to unify a community approach to child abuse prevention and response. Access to the CRBCAC, medical services and other community service provider locations, such as behavioral health, pharmacy, food bank, etc., in regards to transportation may be a challenge for families, especially that live furthest in the service area, and are more isolated with minimal financial resources. This is especially difficult in the winter, with rugged and inclement weather and road conditions, where income and resources are minimal due to seasonal employment. Furthermore, the CRBCAC has been providing school prevention/health programs to grades K-12, throughout each School District in all three service areas, through established collaborative agreements. Throughout the last few years, the CRBCAC has been understaffed due to various issues. This has been a difficult endeavor for the existing two full-time and two part-time staff that are each located throughout the three different locations.	Alleviating the transportation shortage or lack there of, in our vast rural locations is the purchase and use of a company vehicle. This approach will not only allow for kids and their families to access the CRBCAC for services, with the assistance of staff, but will also allow for further follow-up supports, in-home visits, behavior health, other medical and health services. Review the job description, advertise and hire a CRBCAC Prevention Coordinator/Specialist who's schedule will be dedicated to providing the prevention/health programs to students in all three School Districts, including the home-schoolers, to ensure continuity of this mandated educational service. Staff has the expertise in this subject matter, making this a more supported environment for students and teachers.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Copper River Census Area; Southeast Fairbanks Census Area	Deferred or Not Advanced

Copper River Emergency Medical Services Council Inc	EMS Led Sustainable Transformation of Rural Health Care in Alaska’s Copper River Census Area	AK	The rural Copper River Census Area's only certified ambulance service is a local non-profit EMS Council (CREMS) with a 45-year track record of sustainability. This longevity belies a complete lack of dedicated EMS funding from local, regional, state or federal sources. CREMS very existence requires and demonstrates its continuous focus on long-term sustainability. However, maintaining fiscal sustainability without baseline funding often requires CREMS to sacrifice the planning and implementation of advancements, expanded services, additional training, and critical equipment. CREMS must adapt sustainably even while facing a dramatic spike in demand for services. The volume of 911 EMS dispatches in the Copper River Census Area has more than doubled since 2018. Access to urgent & emergent services decreased sharply in 2022 when the only local after-hours medical facility within a 120 mile radius ended all after-hours care. The entire region also lacks any clinical after-hours stabilization or treatment for SUD, behavioral health, or other crisis intervention needs, aside from 911 (or 988). Despite being under-resourced and facing existential challenges, EMS has no choice but to provide all of these significant and necessary services because no-one else is available and EMS is required to respond when dispatched through the 911 system. EMS is uniquely positioned to leverage its increasing roles in rural health care as increased opportunity for sustainable transformation.	CREMS approach to the EMS led sustainable transformation of rural health care in the Copper River region will focus on developing a model of care that includes after-hours telehealth based medical direction, expanded training programs, and a local workforce of cross-trained, multi-disciplinary personnel for EMS, Mobile Crisis response, Critical Care, MIH and local SUD treatment. CREMS will pilot additional and expanded EMS based services with the potential for self-sustaining revenue streams to include non-emergent medical and SUD treatment; non-ambulance medical transportation; interfacility ground transport by ambulance; and ground transport by ambulance directly to the Emergency Room (instead of relying on a rendezvous with medevac or ground intercept). CREMS will proactively expand a growing network of existing partnerships outside of traditional EMS based organizations in order to expand services, increase training opportunities, and deploy telehealth alongside advanced medical technologies. CREMS will also facilitate mutually beneficial and sustainable partnerships among willing Emergency Services organizations especially within the Copper River and Southeast Fairbanks Census Areas. Expanded collaboration among regional EMS services and first responder groups will yield unique, transformative and sustainable efficiencies, expand access to services, improve shared technical assistance, reduce waste, increase resilience, and increase the sustainability of EMS while it adapts to an expanded role in the healthcare system throughout the Copper River and Southeast Fairbanks Census Areas. If successful in the Copper River and/or Southeast Fairbanks Census Areas, this project will have a high probability of replicable success and sustainability in other rural service areas throughout AK and the US. CREMS will also support innovative and transformative local, regional, and statewide training programs. Specifically, CREMS hopes to partner with other organizations working towards the vision of a “rural health technician” and “paramedic practitioner” training program (informally introduced to CREMS by the Alaska Prehospital Education Consortium).	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced

Copper River Native Association	CRNA Health System Analytics Platform for Rural Population Health Management	AK	Copper River Native Association (CRNA) provides integrated health services to rural communities throughout the Copper River region of Alaska, including primary care, behavioral health, dental services, and community wellness programs. However, CRNA’s operational, clinical, and financial data exist in separate systems that do not communicate easily, limiting the organization’s ability to conduct timely analysis and support effective decision-making. Currently, staff must manually compile reports from multiple systems and analyze spreadsheets to understand patient trends, service utilization, and program performance. This process can take weeks and delays CRNA’s ability to identify emerging health issues or respond quickly to community needs. The lack of integrated data infrastructure also limits CRNA’s ability to stratify patients by risk level and identify individuals or populations at higher risk of poor health outcomes. Without this capability, it is more difficult to design targeted interventions that improve chronic disease management and behavioral health services. This project will address these challenges by developing an integrated analytics platform that consolidates clinical, operational, and financial data into a centralized dashboard. Improved access to actionable data will allow CRNA to identify high-risk patients, monitor community health trends, and implement data-informed strategies that improve health outcomes across its rural service region.	Copper River Native Association (CRNA) proposes to develop and implement an integrated population health analytics dashboard that consolidates clinical, operational, and financial data into a single reporting platform to support data driven decision making and improved health outcomes. Currently, CRNA’s data systems operate independently, requiring staff to manually compile information from multiple sources to analyze patient trends, service utilization, and program performance. This project will establish a centralized analytics infrastructure that enables leadership and clinical teams to access timely, actionable information. CRNA will begin by selecting a healthcare analytics platform capable of integrating with the organization’s electronic health record (EHR) system and other operational data sources. Once a platform is selected, CRNA will engage a qualified data developer through a contract or consulting agreement to configure the system, establish data connections, and build customized dashboards tailored to CRNA’s operational and clinical needs. The dashboard will integrate key datasets across CRNA programs, including patient encounters, clinical indicators, behavioral health services, and operational metrics. These dashboards will allow staff to monitor trends in chronic disease management, behavioral health needs, and service utilization across the communities served by CRNA. The platform will also support patient risk stratification, allowing CRNA to identify individuals and populations at higher risk and design targeted interventions to improve care. CRNA will partner with the Alaska Native Tribal Health Consortium (ANTHC) to support integration between the analytics platform and CRNA’s electronic health record system. ANTHC will assist with development of secure data interfaces and provide technical support to maintain interoperability between systems. Implementation of the dashboard is expected to occur over approximately twelve months and will include vendor selection, system configuration, data integration, and dashboard development. Once operational, the platform will support ongoing population health management, quality improvement initiatives, and strategic planning to improve healthcare access, outcomes, and sustainability for rural communities in the Copper River region.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Denali Borough	Deferred or Not Advanced

Copper River Native Association	Strengthening Rural Health Access Through Provider Housing	AK	CRNA serves rural and frontier communities in the Copper River region where recruiting and retaining health care providers is difficult due to geographic isolation and limited housing availability. In recent years, CRNA has relied heavily on locum tenens providers to maintain services, increasing operational costs and reducing continuity of care for patients. Frequent provider turnover also affects patient engagement. When providers change frequently, patients must repeatedly share their medical history and rebuild care relationships, which can reduce trust and participation in care. A primary barrier to recruiting long term providers is the lack of adequate housing in the Glennallen area. The challenge is not affordability but the overall shortage and condition of available housing. CRNA currently leases apartments from the housing authority, but many units are small or in poor condition and are not suitable for providers or families seeking longer stays. For example, a recent septic failure in leased housing left providers without functioning housing for several weeks, forcing CRNA to secure temporary lodging at additional cost. Planning and developing dedicated provider housing near the health center will strengthen CRNA’s ability to recruit and retain providers, improving continuity of care and supporting long term access to health services for rural residents in the Copper River region.	CRNA will address the provider housing barrier by advancing a structured planning and design effort to develop dedicated provider housing on CRNA owned undeveloped land adjacent to the health center. This project period will focus on defining a feasible housing concept that directly supports recruitment and retention of long term clinical staff and reduces reliance on short term staffing. The goal is to establish a ready to implement plan that CRNA can use to pursue construction financing and begin development. CRNA will begin by confirming the desired housing scope based on workforce needs, including the number and type of units most likely to support recruitment, such as family appropriate units that can accommodate providers relocating with spouses and children. CRNA will then complete site planning activities to assess utility access, site conditions, and development requirements on the parcel, including any needed surveys, environmental considerations, and permitting pathways. During the project, CRNA will develop preliminary architectural concepts and cost estimates to determine an appropriate unit design for rural Alaska conditions. Planning will include a focus on durable construction, livability for long term stays, and proximity to the health center to support provider safety, accessibility, and quality of life. CRNA will also evaluate operational policies for housing use, including eligibility, occupancy terms, maintenance responsibilities, and how housing will be incorporated into recruitment packages. To ensure the project advances beyond concept, CRNA will use this project period to complete key pre development deliverables needed for implementation. These deliverables include a defined development plan, preliminary design and site layout, realistic construction cost estimates, and a phased implementation strategy. The project will also position CRNA to pursue follow on capital funding, including identification of potential construction funding sources and preparation of a competitive application package. By the end of this project period, CRNA will have a clear and actionable plan to develop provider housing that strengthens workforce stability and improves access to consistent care for rural residents in the Copper River region.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Denali Borough	Deferred or Not Advanced

Copper River Native Association	Sustainable Emergency and Urgent Care Access Planning for Rural Ahtna Communities	AK	CRNA serves the rural Ahtna region of Alaska, providing primary care, behavioral health, dental, and other essential services to approximately 2,700 residents across a large and geographically isolated service area. Although the community is connected by road, access to emergency and urgent care remains limited, with the nearest hospital emergency departments located several hours away. As a result, many patients requiring urgent or emergency treatment must be transported by medevac, which is costly and often dependent on weather and aircraft availability. CRNA currently receives ambulance transports and provides emergency stabilization for patients prior to transfer. However, because CRNA is enrolled with CMS as a group practice rather than a facility designation that supports urgent or emergency care reimbursement, the organization cannot fully recover the costs associated with providing these services. Moving forward, CRNA seeks to evaluate sustainable service delivery models that would allow the organization to continue providing emergency stabilization and urgent care services while maintaining financial viability. This project will explore options that strengthen local access to care, reduce reliance on medevacs, and ensure residents of the Ahtna region can receive timely emergency care closer to home.	CRNA will conduct a comprehensive feasibility and impact analysis to determine the most effective and financially sustainable model for improving emergency stabilization and urgent care services in the Ahtna region. This effort will focus on identifying practical solutions that allow CRNA to address the current gap in care, reduce reliance on costly medevac transports, and lower the overall cost of patient care while maintaining long-term operational sustainability. To support this effort, CRNA will engage an experienced rural health care consulting partner with expertise in rural emergency care delivery, CMS enrollment and reimbursement pathways, and rural facility planning. The consultant will work closely with CRNA leadership, clinical staff, and local EMS partners to review current patient utilization patterns, stabilization practices, transfer volumes, and financial impacts associated with emergency transports. The feasibility analysis will evaluate several potential service delivery models that could improve access to timely care while creating a sustainable reimbursement structure. One option includes establishing an urgent care service enrolled with CMS as Place of Service 20, supported by telehealth providers and enhanced diagnostic capabilities such as on-site CT imaging. Another option will explore the feasibility of developing a critical access–style stabilization model with limited bed or swing-bed capacity supported by telehealth hospitalists or emergency physicians. These models would allow patients requiring urgent assessment or stabilization to receive care locally before transfer when appropriate. In addition to evaluating these specific options, CRNA will request that the consultant identify other innovative models suitable for frontier health systems that could help the organization meet its goals of improving local care access and reducing avoidable medevacs. The analysis will also include a review of CRNA’s existing facility layout to determine what space modifications or infrastructure improvements may be necessary to support expanded emergency or urgent care capabilities. The final outcome of the project will be a detailed feasibility report and implementation roadmap that outlines the most viable service model, identifies operational and capital needs, and provides clear recommendations for CRNA to strengthen emergency care access for the rural communities it serves.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Denali Borough	Deferred or Not Advanced

Cordova Community Medical Center	Close-to-Home Cancer Care: Expanding Safe Chemotherapy, Infusion, and Pharmacy Services in Cordova	AK	Cordova Community Medical Center (CCMC) serves a remote, weather dependent community where patients needing advanced pharmacy services or chemotherapy/biologic infusions must travel by plane or ferry, creating delays in care, financial strain, and avoidable risk. We propose a phased expansion of pharmacy and nursing capabilities to (1) meet USP <797> and <800> standards for hazardous drug handling and sterile compounding, (2) launch select outpatient chemotherapy/infusion services on site, and (3) implement an automated dispensing system (ADS) to strengthen medication safety, security, and efficiency. In parallel, we will formalize tele oncology consults and shared care protocols with Anchorage based specialists so patients can initiate and continue indicated regimens in Cordova. This project reduces costly travel, mitigates weather related delays, and establishes a sustainable, high value service line that strengthens our CAH’s operational stability while improving continuity of care for elders, people with chronic and complex conditions, and Alaska Native residents.	Phase 1 – Readiness (months 0–12) • Infrastructure & Safety: Design and install modular clean room components and environmental controls to achieve USP <797>/<800> compliance for hazardous drug receipt, storage, and preparation. • Medication Safety Technology: Procure and deploy an Automated Dispensing System (ADS) to improve inventory control, reduce diversion risk, and streamline nurse workflows in a low staffing CAH environment. • Workforce Upskilling: Credential and competency validate pharmacists and nurses in hazardous drug handling and chemotherapy administration (e.g., didactic training, simulation, precepted cases at partner sites). • Tele Oncology Setup: Execute MOUs with Anchorage oncology/rheumatology clinics; configure a dedicated telehealth consult space and workflows for treatment plan review, virtual consults/follow ups, and shared care oversight. Phase 2 – Service Activation (months 12–24) • Go Live: Begin select outpatient chemotherapy/biologic infusions locally under remote specialty oversight; expand to other hazardous medication infusions (e.g., rheumatology) as competencies mature. • Quality, Data, and Billing: Implement checklists, sterile compounding audits, and event reporting; align coding/billing, payer pre auth, and prior approval pathways; integrate telehealth and infusion data with hospital IT/HIE workflows where feasible. RHTP Alignment & Allowable Uses: • Health Care Access: Expands access to specialty infusions “as close to home as possible” through targeted facility/IT upgrades and tele specialty programs. • Enhance statewide pharmacy capacity: Supports pharmacist training, medication management, and technology enabled dispensing solutions. • Spark Technology & Innovation: Funds telehealth enabled specialty care, IT upgrades, and interoperability/HIE participation. • Strengthen Workforce: Funds upskilling, rotations, and retention for rural providers. This approach advances the State’s key objective to increase specialty service access in rural hub communities, with foundational milestones falling in RHTP’s first 18–24 months.	\$1M-\$5M	Hospital	Single Community	Chugach Census Area	Advance to Implementation Application

Cordova Community Medical Center	Cordova Community Medical Center Behavioral Health Integration	AK	Through this grant we have the opportunity to integrate our Community Behavioral Health and Primary Care clinics offering increased access to health care, reducing duplication of effort and documentation, lowering the cost of offering care, reducing stigma and allowing for early intervention and team based care. This approach has been shown to positively impact the high correlation between chronic diseases and mental health. and improves treatment responses for deiabetes, heart disease, depression and eanxiety. These are all leading causes for long term disability and early mortality. Our project offers the opportunity to help with the issue of provider shortages: we have been unsuccessfully recruiting for a Behavioral health Clinician for 3 years. In an integrated model behavioral health specialists can support PCP's allowing for better care coordinations, faster treatment, icreased satisfaction and better overall health outcomes. This oppportunity would allow us to transition form grant funded behavioral health services to a more sustainable model. This request seeks planning funds to support design, engineering, education, staff training, and operational planning that will strengthen health care delivery and community well-being in Cordova and the surrounding region. This initiative aligns with the RHTP goals of expanding access to care, strengthening workforce capacity, improving integrated health services, and leveraging technology to improve rural health outcomes.	Our proposed approach has the following components: Facility & Construction: Design and renovations to create dedicated behavioral health treatment rooms within the primary care space which would include soundproofing and trauma informed design, private intake/waiting/calming room, telehealth space and secure medication and documentation storage. Workflow Integration: Design of workflow integration to include shared scheduling and referral pathways, warm handoffs from primary care to behavioral health, care coordination for clinic ED and community providers and clear escalation protocols for high-risk patients. Staff Education and Training: Training for staff to include integrated model training, MAT training, trauma informed care training, deescalation training, work flow changes for referrals and warm handoffs documentation standards, and use of telepsychiatry and telehealth tools. Technology and Telehealth: Design to provide secure telehealth platforms to access specialists not available in Cordova, shared EHR workflows and remote supervision and consults when on site staff are not available.	\$50,000-\$250,000	Hospital	Single Community	Chugach Census Area	Advance to Implementation Application

Cordova Community Medical Center	Cordova Community Medical Center Kitchen Remodel, Multi Use Dining and Senior Technology Space	AK	CCMC proposes a planning initiative to modernize the hospital kitchen, enhance nutrition service capacity, increase operational efficiency, and transform the adjacent dining room into a flexible multi-purpose community space for seniors. This space will serve daily patient, senior, and staff dining needs while functioning as a senior gathering area and education and technology training hub, enabling internet access, basic digital skills training, and telehealth support for older adults as well as health and nutrition education activities. Our Community Health Needs Assessments, for at least the last 12 years, have identified a need for increased supports for our elders. This project offers the opportunity to do so. Our project plans to leverage technology to improve 1) supply purchasing, 2) meal planning and preparation 3) senior health literacy, 4) access to senior benefits including Medicare and Social Security and 5)to create a space for seniors to get assistance with technology, nutrition and health education and to participate in sevents and activities. This request seeks planning funds to support design, engineering, education, staff training, and operational planning that will strengthen health care delivery and community well-being in Cordova. This project aligns with RHTP goals of workforce training, technology innovation, and community health engagement, especially for aging populations and prevention activities.	This initial request for the first year would include: Architectural and engineering design assessments for kitchen modernization Planning and workflow design for energy-efficient, tech-enabled kitchen systems Space planning for dining area redesign with senior-focused technology learning zone Operational assessments for new equipment, workflows, and digital nutrition systems Year two would include: Renovations of the existing space based on the designs generated in year 2 Development of staff training plans for kitchen technology, digital inventory, and senior tech support Year 3 Focus on use and implementation of added services, assessment of impact and outcomes to ensure goals are met	\$50,000-\$250,000	Hospital	Single Community	Chugach Census Area	Advance to Implementation Application

Cordova Family Resource Center	Healthy Beginnings & Safe Communities: Cordova Youth and Family Wellness Initiative(SART/CAC)	AK	Rural and remote communities such as Cordova face significant barriers to accessing timely health, behavioral health, and victim support services. Cordova is not connected to the road system, and residents must rely on limited local providers or costly travel by air or ferry to access specialized medical and behavioral health care. When incidents of domestic violence, sexual assault, or child abuse occur, the availability of trained responders and specialized medical or forensic services can be limited or delayed. As a result, survivors may wait extended periods for care, travel long distances during a crisis, or choose not to access services at all. Youth in rural communities also often have limited access to prevention programming that builds mental health resilience, healthy relationship skills, and other protective factors that reduce violence and trauma. Without consistent prevention efforts and coordinated response systems, communities face increased risks of untreated trauma, long-term health impacts, and reduced community wellbeing. This project will address these challenges by expanding youth prevention programming and strengthening coordinated, trauma-informed response services through CFRC’s Sexual Assault Response Team (SART) and Child Advocacy Center (CAC). By increasing trained on-call advocates and expanding telehealth connections to medical and forensic professionals, CFRC will improve timely access to care and strengthen coordination among community partners.	CFRC will address these challenges through a coordinated approach that strengthens youth prevention programming and improves access to trauma-informed response services in Cordova. Under Healthy Beginnings, CFRC will expand youth-focused prevention activities in partnership with local schools, tribal partners, and community organizations. Programs will include evidence-informed education that promotes mental health resilience, healthy relationships, bystander awareness, and protective factors that help prevent violence and trauma before it occurs. Youth programming will be delivered through school-based activities, community events, and ongoing engagement opportunities that encourage positive peer connections and supportive adult mentorship. Under Healthy Communities, CFRC will strengthen its Sexual Assault Response Team (SART) and Child Advocacy Center (CAC) coordination to ensure survivors of violence have timely access to advocacy, medical care, and supportive services. The project will expand recruitment and training of on-call advocates to increase response capacity and ensure advocates are available when incidents occur. CFRC will also work with regional partners to expand telehealth options, allowing survivors to connect with medical and forensic professionals when local providers are unavailable. CFRC will continue to coordinate closely with local law enforcement, health providers, schools, and tribal partners to ensure a collaborative and trauma-informed response system that improves access to care and supports long-term community health and safety.	\$50,000-\$250,000	Single Community	Copper River Census Area	Advance to Implementation Application

Core Kinetics DBA PlayWorks Pediatric Therapy Services	Expanding Access to Pediatric Occupational Therapy Services for Alaska Children	AK	Alaska children frequently experience delays in accessing pediatric occupational therapy services due to geographic isolation, limited provider availability, and travel barriers. Early intervention is critical for children experiencing developmental delays, sensory processing challenges, and difficulties with motor coordination or daily living skills. When services are delayed or unavailable, children may struggle to succeed in school, participate in play, and develop essential life skills. This project seeks to address the gap in accessible pediatric occupational therapy services for rural communities. By expanding service capacity and implementing telehealth-supported therapy, Core Kinetics DBA Pediatric Therapy Services can reach families who would otherwise go without care. The opportunity lies in leveraging workforce and technology. Recruiting and retaining more providers allows more delivery of needed services to Alaska children. Telehealth, when appropriate, allows access to children who otherwise might face barriers such as weather restrictions, limited travel opportunities or local access to OT services. Utilizing community partnerships to deliver effective therapy services that fit the unique needs of remote communities is also imperative. This project will allow Core Kinetics DBA Pediatric Therapy Services to build a scalable model of pediatric therapy delivery that improves early access, reduces wait times, and supports families in helping their children thrive.	Core Kinetics DBA Pediatric Therapy Services will implement a multi-component approach to expand access to pediatric occupational therapy services for rural Alaskan communities. First, the project will expand telehealth occupational therapy services, enabling children and families to receive therapy sessions remotely. Telehealth will include individualized therapy sessions, caregiver education within the session to improve follow through of OT strategies, and home-based activity planning designed to support children's development within their natural environments. Secondly, Core Kinetics DBA Pediatric Therapy Services will continue strong partnerships with schools, early intervention programs, pediatric clinics, and referral sources such as Help Me Grow Alaska to improve referral pathways to other needed services and identify children who may benefit from occupational therapy services earlier. These partnerships will help ensure families are aware of available services and can access them more efficiently. Third, Core Kinetics DBA Pediatric Therapy Services will seek partnership with other disciplines such as Speech Language Pathologists and Physical Therapy providers to increase delivery of high-quality care as a team to improve specific discipline oriented outcomes. Fourth, the project will include in-person visits when feasible to provide direct assessment, hands-on therapy, and collaboration with other provider partnerships. These visits will help strengthen relationships with community partners and enhance service delivery. Finally, Core Kinetics DBA Pediatric Therapy Services will monitor program outcomes through service utilization data, caregiver feedback, and developmental progress measures. This data will inform ongoing improvements and help demonstrate the effectiveness of the expanded service model. Through this integrated approach, the project will increase access to therapy services, empower caregivers, and promote positive developmental outcomes for children in rural Alaska.	\$50,000-\$250,000	Private practitioner	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bristol Bay Borough; Copper River Census Area; Dillingham Census Area; Fairbanks North Star Borough; Kenai Peninsula Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced
Core Kinetics DBA PlayWorks Pediatric Therapy Services	Expanding Access to Pediatric Occupational Therapy Services for Children in Rural Alaska	AK	Children in Alaska experience delays in accessing pediatric occupational therapy services due to geographical isolation, limited provider availability, lack of partnership with other aligned disciplines including SPL and PT, and travel barriers. We have recently taken measures to address these care delays in our small clinic, adding expansion of services to Fairbanks. We see an opportunity to assist more Alaska children through the development and management of a hearty occupational therapy team, strong partnership with SLP and PT, and continuation of diligent work with other stakeholders/referrals sources such a Help Me Grow Alaska. Ongoing and growing attention to these opportunities will greatly influence future Alaska generation's participation in meaningful functional activities in all areas of life which is the foundation of occupational therapy.	Core Kinetics DBA PlayWorks Therapy Services proposes the acquisition and retention of additional OT staff and other administration, partnership with SLP and PT if available, expansion/maintenance of existing facilities and equipment, implementation of telehealth when necessary and travel and lodging when needed for services in Anchorage and Fairbanks. These are high-value endeavors requiring funding.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough	Deferred or Not Advanced

CorVent Medical	Transforming Rural Care: CorVent Medical's Next-Gen Telehealth Tools	ND	Alaska's frontier geography, severe weather conditions, extended transport distances, and limited access to specialty care create persistent clinical and operational challenges. Critically ill patients may deteriorate during interfacility transfers, lack access to necessary specialty services locally, or experience clinical decline while awaiting transfer to a higher level of care. This Letter of Intent (LOI) aligns closely with two Alaska Rural Health Transformation Program (RHTP) initiatives—Health Care Access and Spark Technology and Innovation—and outlines a coordinated, statewide strategy to strengthen healthcare delivery across rural and frontier communities. The proposed approach focuses on standardization, improved clinical support, and innovative technology solutions to address the unique challenges of providing timely, high-quality care in Alaska's remote settings.	Project Approach: Action Plan: Modernize the State Ventilator Stockpile Replace twenty (20) aging, end-of-life HT-70 ventilators currently managed by the Alaska Department of Health (DOH) Division of Public Health – Rural and Community Health Systems with fifty (50) CorVent RESPOND stockpile ventilators. Per Karl Edwards, Warehouse Manager, and Nathan Wormington, Emergency Program Manager, current devices are no longer serviceable due to Medtronic discontinuing its ventilator portfolio. In addition, traditional PHEP/HPP funding has not supported replacement of this outdated technology. Enabling these devices with CorVent RPM will standardize equipment across Critical Access Hospitals (CAHs) and support statewide remote patient monitoring and telehealth initiatives. Standardize Ventilation and Monitoring Across CAHs Equip all thirteen (13) Critical Access Hospitals with RESPOND mechanical ventilators and Barnacle RPM gateways capable of connecting to the RESPOND ventilator and up to four additional clinical technologies, including systems such as Stryker LIFEPAK monitors. This integration supports real-time clinical oversight and improved coordination of care. Enable Continuous Monitoring During Transport Equip all twenty (20) CAH ambulances and emergency transport vehicles with mobile RPM kits designed for transport and frontier connectivity. These systems will enable continuous physiological monitoring and remote clinical oversight during interfacility transport. (Air transport readiness planning and associated budget considerations may be incorporated into the final proposal.) Project Implementation: The project will deliver all core hardware technologies in 2026, followed by a phased activation and expansion of RPM capabilities from 2026 through 2030. This structured deployment approach will support measurable adoption, clinical integration, and long-term sustainability, with full statewide operational maturity anticipated by the end of 2030.	\$1M-\$5M	Statewide	Bethel Census Area; Chugach Census Area; Dillingham Census Area; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Sitka (City and Borough); Wrangell (City and Borough)	Deferred or Not Advanced

Council of Athabascan Tribal Governments	Council of Athabascan Tribal Governments Traditional Healing Program	AK	CATG delivers primary healthcare in 4 interior villages. These Gwich'in Villages are remote and fly-in only with access that can be intermittently affected by weather. Recent economic challenges have cut back on air flight services to these communities. The Gwich'in people have traditional territory and family relationships that extend from Alaska to the Yukon Territory and into the Northwest Territories Canada. The health status of Gwich'in in Alaska is disproportionately affected by high rates of chronic disease such as obesity and heart disease, and behavioral health issues. These issues are compounded by limited access to primary care and behavioral health services. Traditionally Gwich'in have a wealth of knowledge related to managing health across these remote and extreme regions to live and thrive in. These traditional medical practices have been affected by ongoing imposition of western education and medicine practices. There is interest in learning, practicing and rejuvenating these practices that can have significant impacts on health especially mental health of our communities. There are a few Elders left that have the training and wealth of knowledge of these practices and they are eager to mentor and train the next generation of healers. Developing a traditional medicine program delivered alongside the allopathic primary care medicine delivered in the region presents an opportunity to have a profound impact on the health of the people in the interior.	The Council of Athabascan Tribal Governments Traditional Healing Program will provide land-based learning opportunities that allow community members to learn directly from recognized Gwich'in knowledge holders and traditional healers. The program will focus on experiential learning, cultural teachings, and mentorship to support the revitalization of traditional healing knowledge and strengthen culturally grounded approaches to health and wellness in CATG communities. CATG will contract a recognized traditional healer and knowledge holder from across Gwich'in country to share their knowledge and expertise within CATG villages. Training opportunities will be open to community members of all ages, including youth, adults, and Elders. Participants will have opportunities to learn through hands-on experiences that may include traditional stories, cultural teachings, and the collection, preparation, and use of traditional plant medicines. The traditional healer and teaching team will spend one week in each participating village, including Fort Yukon, Arctic Village, Venetie, Beaver, and Birch Creek, establishing temporary land-based learning camps. Instruction will primarily occur outdoors and on the land, allowing participants to learn within the natural environment where traditional healing practices developed. Teachings may include plant medicine identification and preparation, cultural storytelling, sweat lodge ceremonies, and other traditional practices depending on what is appropriate and seasonally available in each community. CATG will work closely with Tribal leadership, Elders, and community members to guide program planning and ensure activities reflect the unique cultural knowledge and priorities of each village. CATG staff will coordinate travel logistics, community outreach, and program scheduling to ensure training opportunities are accessible to community members. Subsequent years of this program will evolve from the teachings and expand to mentorship and apprenticeship opportunities for those interested. Participants who wish to pursue additional learning opportunities will have the option to travel to a permanent traditional healing camp on the Dempster Highway in the Yukon Territory. Throughout the project, CATG will gather feedback from participants and community leaders to guide future program development and explore ways traditional healing practices may complement existing health services provided through CATG clinics.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Yukon-Koyukuk Census Area	Advance to Implementation Application

Council of Athabaskan Tribal Governments	EMS Infrastructure: Mechanical CPR and Ventilation Equipment	AK	Fort Yukon, located 145 air miles northeast of Fairbanks in Alaska's interior, faces critical challenges in emergency medical response due to extreme geographic isolation, limited EMS personnel, and harsh environmental conditions. During cardiac and respiratory arrest scenarios, the current reliance on manual CPR, use of the AED, and bag-valve-mask ventilation is compromised by minimal staffing—often requiring a single provider to manage multiple critical interventions simultaneously. This creates dangerous gaps in care quality during the most time-sensitive emergencies. The opportunity exists to leverage mechanical resuscitation technology (LUCAS mechanical CPR device and portable automated ventilators) to augment limited human resources, maintain consistent high-quality resuscitation during prolonged transport times, and free providers to perform other critical interventions. This equipment addresses Fort Yukon's unique challenges where transport times to definitive care in Fairbanks may exceed 60 minutes, weather conditions frequently limit air evacuation, and the volunteer/minimally-staffed EMS agency struggles to provide continuous manual CPR during patient movement and extreme cold conditions.	The project will equip Fort Yukon EMS with LUCAS mechanical CPR devices and portable automated ventilators as force multipliers for limited personnel. Implementation includes: (1) Capital equipment procurement—LUCAS-2 or LUCAS-3 device and compact transport ventilator suitable for cold environments (2) Streamlined training protocols designed for Fort Yukon's volunteer and part-time EMS providers, utilizing online modules and on-site hands-on sessions to minimize time burden; (3) Development of simplified deployment protocols that account for single-provider scenarios; (4) Integration with existing telemedicine infrastructure connecting to Fairbanks hospital or ANMC to provide remote physician guidance during device use; (5) Cold-weather equipment modifications and heated storage solutions; (6) Quality improvement tracking through Alaska's EMS data systems. The approach recognizes that while randomized trials show mechanical CPR does not improve survival in well-staffed urban systems, guidelines specifically identify rural settings with limited personnel, prolonged transport, and challenging environments as appropriate use cases where manual CPR quality cannot be sustained.	\$50,000-\$250,000		Multi-Community or Participating in Regional Hub-and-Spoke	Yukon-Koyukuk Census Area	Advance to Implementation Application

Council of Athabascan Tribal Governments	Growing Health in the Yukon Flats: Expanding Food Security, Safe Water, and Diabetes Prevention	AK	The Council of Athabascan Tribal Governments (CATG) proposes to expand its Special Diabetes Program for Indians (SDPI) prevention activities by improving water quality, increasing local food production, and providing nutrition education in the Yukon Flats region of Interior Alaska. CATG serves remote Alaska Native communities including Arctic Village, Beaver, Fort Yukon, and Venetie. These villages are not connected by road and rely on air transportation for most goods. The high cost of food and limited availability of fresh produce create barriers to healthy eating and contribute to chronic disease, including diabetes. This project will address these challenges by improving access to safe drinking water and healthy foods while increasing community knowledge of nutrition and food preparation. CATG will provide household water filtration systems in Beaver where water quality concerns exist. To improve food security, CATG will supply indoor gardening systems with seeds and plant nutrients so residents can grow vegetables year-round. CATG will also provide gardening supplies, healthy cooking classes, nutrition education, and food preservation training focused on foods commonly available in rural Alaska, including canned, frozen, and locally harvested foods. Staff or contracted educators will conduct these classes in participating communities. These activities will strengthen diabetes prevention efforts while improving food security and overall community health.	CATG will implement this project through collaboration with community members, Tribal leadership, and local health staff. The program will be coordinated through the CATG Health Department and will build on existing diabetes prevention and health education activities currently supported through the Special Diabetes Program for Indians (SDPI). Community Health Aides, behavioral health staff, and health educators will assist with outreach, participant recruitment, and delivery of education sessions. These staff already serve residents in the participating villages and have strong relationships with community members, which will help ensure participation and program success. CATG will also work with local Tribal governments and community organizations to host gardening demonstrations, cooking classes, and food preservation workshops in accessible community spaces. These activities will provide hands-on opportunities for residents to learn practical skills for improving nutrition and increasing food security. Local residents with experience in gardening, food preservation, or traditional food preparation may be engaged as instructors or mentors to support community participation and share knowledge. When needed, CATG will hire or contract qualified educators to deliver nutrition and gardening training. Distribution of water filtration systems and indoor gardening units will be coordinated through CATG staff working directly with households in Beaver and other participating communities. Staff will provide training on how to install and maintain water filters and how to use indoor gardening systems to successfully grow vegetables throughout the year. CATG has extensive experience managing federally funded health programs and delivering services in remote Alaska communities. The organization operates health clinics in Fort Yukon, Arctic Village, Beaver, and Venetie and has established systems for community outreach, program management, and reporting. This project will build upon CATG’s existing infrastructure and trusted community relationships to deliver practical, culturally relevant programs that support healthier lifestyles and improved access to nutritious foods.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Yukon-Koyukuk Census Area	Advance to Implementation Application

Council of Athabascan Tribal Governments	Yukon Flats Behavioral Health & Community Wellness Initiative	AK	The Council of Athabascan Tribal Governments (CATG) proposes the Yukon Flats Behavioral Health & Community Wellness Initiative to expand access to behavioral health services for remote Alaska Native communities through an integrated model combining tele-behavioral health, digital cognitive behavioral therapy (dCBT), youth prevention programming, and culturally grounded community wellness activities. CATG serves rural communities in the Yukon Flats region of Interior Alaska including Arctic Village, Beaver, Fort Yukon, and Venetie. These communities are not connected by road systems and residents must travel by small aircraft or river transportation to access specialty health services. Geographic isolation, behavioral health workforce shortages, and economic barriers significantly limit access to mental health care. Behavioral health conditions such as depression, anxiety, trauma, and substance misuse are among the most urgent health concerns in the region. Traditional therapy models alone cannot meet the growing demand for services in rural Alaska. This project will expand behavioral health screening, telehealth services, and digital CBT treatment within CATG clinics while strengthening prevention through youth programming, family engagement, and cultural healing activities led by elders and community leaders. Together these strategies will improve access to care, strengthen community resilience, and support long-term behavioral health outcomes across the Yukon Flats region.	The Yukon Flats Behavioral Health & Community Wellness Initiative will implement an integrated behavioral health model that expands clinical services, increases access to telehealth and digital mental health tools, and strengthens prevention through culturally grounded community programming. CATG will expand behavioral health screening within its primary care clinics using standardized tools such as PHQ-9 and GAD-7. Patients identified with mild to moderate depression or anxiety will be referred to digital cognitive behavioral therapy (dCBT) programs, while individuals requiring more intensive services will receive counseling or referral to specialty behavioral health providers. To address workforce shortages and geographic barriers, CATG will expand tele-behavioral health services connecting patients with psychiatrists and behavioral health specialists outside the Yukon Flats region. Telehealth consultations will support psychiatric evaluations, medication management, and follow-up care while allowing patients to receive services locally at CATG clinics. The project will also implement a digital cognitive behavioral therapy platform providing structured, evidence-based treatment for depression and anxiety. Patients will access guided therapy modules using clinic-based tablets or personal devices when internet connectivity is available. Clinic staff will assist with patient enrollment and provide brief support to ensure successful participation. Prevention programming will focus on youth and families by strengthening protective factors and increasing awareness of mental health resources. Activities will include youth leadership programs, after-school wellness activities, and prevention education addressing substance misuse, stress management, and suicide prevention. Family workshops will support parents and caregivers in recognizing behavioral health challenges and promoting healthy coping strategies. Culturally grounded wellness activities will also be incorporated to strengthen resilience and community connection. Elders and cultural leaders will guide cultural education, storytelling, and traditional knowledge sharing. Healing circles, cultural gatherings, and land-based activities will provide opportunities for community members to connect, support one another, and reinforce traditional approaches to wellness. Together, these strategies create a coordinated system of care that expands access to behavioral health services.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Yukon-Koyukuk Census Area	Deferred or Not Advanced

Council of Athabaskan Tribal Governments	Yukon Flats Community Based CPR Education Programs	AK	Out-of-hospital cardiac arrest (OHCA) survival in rural areas is approximately 50% lower than in urban settings, with rural patients having reduced odds of return of spontaneous circulation and survival to hospital discharge. Rural Alaska faces unique challenges including prolonged EMS response times, geographic isolation, and limited access to advanced medical care, making immediate community response critical. Community-wide CPR training programs are an evidence-based strategy to address this disparity. Studies show that community CPR initiatives can increase bystander CPR rates by up to 126%, improve AED use by 108%, and increase survival by 59%. Bystander CPR and AED use improve outcomes across both urban and rural settings, with rural communities showing particularly strong benefits. Targeted, community-based CPR training, delivered through instructor-led sessions and culturally appropriate approaches has demonstrated 10–19% increases in bystander CPR rates and improved neurological outcomes. Brief 30-minute trainings can be as effective as traditional multi-hour courses, making widespread dissemination feasible. Because rural patients experience longer EMS response times (7.5 vs 5.9 minutes), empowering community members to act as first responders through CPR training is one of the most impactful strategies to improve survival in rural Alaska.	Core Training Elements 1. Hands-Only CPR Emphasis The American Heart Association recommends hands-only CPR as an acceptable alternative to traditional CPR for bystanders, addressing two commonly cited barriers: fear of performing CPR incorrectly and fear of infection from mouth-to-mouth ventilation. This simplified approach is particularly appropriate for rural communities where rapid skill dissemination is essential. 2. Competency-Based Training Model Current recommendations emphasize competency-based models focusing on learner outcomes rather than just course participation, with contextualized learning that prepares rescuers for the stressful cardiac arrest environment. 3. Multiple Delivery Modalities Effective programs should incorporate: - Instructor-led sessions for hands-on practice with feedback - Video-based self-instruction for broader reach - Brief 30-minute sessions to reduce time barriers - Spaced learning (shorter, more frequent sessions) for better skill retention 4. AED Training and Placement Given the particularly strong association between bystander AED use and survival in rural settings, programs should include AED training and strategic placement of public-access defibrillators in high-traffic community locations. Implementation Strategies Community Engagement: Successful programs involve community members in program design, taking into consideration the uniqueness of each community's barriers and opportunities. Training should address community-specific concerns including accessing emergency services in remote areas. Partnerships with Existing Infrastructure: Incorporating CPR education into existing community structures (schools, workplaces, public safety departments, tribal organizations) enhances sustainability and reach. Cultural Adaptation: Programs should be tailored to Alaska Native	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Yukon-Koyukuk Census Area	Deferred or Not Advanced

communities, incorporating cultural values, language considerations, and traditional community structures to maximize engagement and effectiveness.

Covenant House Alaska	Holistic Care Navigation & Wellness Engagement for homeless, systems-involved transitional age youth	AK	Young adults ages 18–25 who are system-involved, aging out of foster care, or experiencing housing instability face significant barriers accessing preventive health care, behavioral health services & primary care. These barriers are particularly pronounced for youth connected to rural and remote communities where geographic isolation, provider shortages, and transportation limitations reduce access to timely care. As a result, many delay seeking care until health concerns escalate, contributing to behavioral health crises, avoidable emergency department utilization, and untreated physical and mental health conditions. Youth who relocate to Anchorage from rural regions, or who are aging out of systems in the city, often lack support to navigate the health system, enroll in Medicaid or other coverage programs, or connect with primary care and behavioral health providers. At the same time, few prevention and wellness platforms are designed to engage young adults in health education and healthy lifestyle activities. Digital wellness platforms that use gamification offer a scalable approach to health promotion and prevention. By leveraging mobile technology that many young people already use, these tools can deliver education, behavior tracking, and incentives that reinforce healthy choices. This project addresses an opportunity to strengthen prevention and early intervention through holistic care navigation, primary care engagement, and technology-enabled wellness participation.	This project will implement a coordinated model designed to increase access to preventive care, behavioral health services, and primary care while promoting healthy lifestyles among at-risk, vulnerable, and system-involved youth ages 18–25 in Anchorage, many from rural areas. The proposed approach integrates structured health navigation, clinic engagement, wellness outreach, and technology-enabled prevention and health promotion tools to address barriers to care and improve health engagement among vulnerable youth who are connected to rural communities. The project includes several integrated components. First, CHA will establish a Holistic Care Navigation team to support youth in accessing primary healthcare services and navigating the health system in Anchorage. Navigators will assist youth in scheduling appointments at CHA’s onsite Wellness Clinic (FQHC), operated by Southcentral Foundation, as well as other health providers in the community. Navigators will also help youth enroll in Medicaid or other health payor programs, arrange transportation, provide appointment reminders, facilitate behavioral health referrals, and support access to telehealth services when in-person care is unavailable. This structured navigation approach will increase utilization of primary care & behavioral health services while strengthening continuity of care. The project will also deploy a digital wellness engagement platform (Software-as-a-Service) that uses an “out of the box” solution with gamified wellness activities to promote wellness, healthy life style choices, education, physical activity, and mental wellness engagement. Youth will participate in wellness challenges and short health education missions designed to reinforce healthy lifestyle behaviors. A Youth Design Team comprised of CHA’s Youth Advisory Board will beta test the platform prior to launch to ensure the user experience is responsive to youth needs. An incentive management platform will also be integrated with the wellness engagement platform so that youth earn points for completing verified wellness activities, education modules, or skill-building tasks. Points can be redeemed for things such as gift cards and prizes, reinforcing sustained engagement in healthy behaviors. Finally, the project will incorporate the ACEs Aware Stress Busters framework, an evidence-based approach that helps young people build resilience and develop practical strategies for managing stress and improving mental well-being.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Covenant House Alaska	Planning for Rural Expansion of the Holistic Care Navigation & Wellness Engagement in the Y-K Delta	AK	Young adults ages 18-24 in Alaska who are system-involved, aging out of foster care, or experiencing housing instability face significant barriers accessing preventive health care, behavioral health services, and primary healthcare. These barriers are particularly pronounced for young people who are connected to rural and remote communities where geographic isolation, provider shortages, and transportation limitations reduce access to timely care. As a result, many young people delay seeking care until health concerns escalate, contributing to increased behavioral health crises, avoidable emergency department utilization, and untreated physical and mental health conditions. CHA has long standing relationships in the Bethel region through partnerships with Tundra Women’s Coalition, Bethel Community Foundation, and the Lower Kuskokwim School District. These relationships create an opportunity to explore how CHA’s Holistic Care Navigation and Wellness Engagement model could be adapted to rural settings. This planning project will assess community needs, strengthen partnerships, and design a coordinated approach that improves access to care, prevention resources, and wellness engagement for youth living in the Y-K Delta.	This planning project will develop a framework for expanding CHA’s Holistic Care Navigation and Wellness Engagement model into Bethel and rural communities in the Yukon–Kuskokwim Delta. The project will focus on partnership development, community engagement, and service model design rather than direct implementation. First, CHA will conduct structured planning conversations with regional partners including YKHC, Tundra Women’s Coalition, Bethel Community Foundation, the Lower Kuskokwim School District, and other local organizations that serve youth. These discussions will explore current service gaps, barriers to healthcare access, and opportunities to coordinate services for transitional age youth (ages 18-24) with regional health and service systems. Second, the project will explore how a care navigation model can support young adults in accessing preventive care, behavioral health services, and primary healthcare. Planning will assess whether a paraprofessional navigator or community health worker model can help increase utilization of primary health care services, assist youth in scheduling and keeping appointments, enroll in Medicaid or other healthcare payors, access telehealth services, and follow through with referrals. These roles may be embedded within community-based organizations or school systems depending on local capacity. The planning process will also explore how technology enabled wellness engagement tools can support prevention, health promotion and adopting healthy behaviors. CHA will assess the feasibility of deploying a digital wellness platform that allows young people to participate in wellness challenges, health education activities, and mental wellness engagement regardless of location. Input from end users will be solicited to help shape the design of these tools so that they reflect the interests and priorities of young people in the region, and to identify challenges and solutions for implementation. Finally, CHA will develop a rural implementation roadmap that includes defined partnerships, staffing models, technology requirements, and evaluation metrics. This planning process will ensure that any future implementation is grounded in community input, culturally responsive approaches, and strong cross sector partnerships.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area	Deferred or Not Advanced

Covenant Youth of Alaska	Aarigaa House: Fairbanks	AK	Rural Alaska young adults often leave home to pursue education or employment in hub communities like Fairbanks. In doing so, they lose daily connection to family, elders, and cultural anchors that sustain mental and physical health. Without stable housing and relational support, many struggle to establish healthy routines, access preventive care, or build resilience. Aarigaa Fairbanks represents an opportunity to intervene at this pivotal transition. By combining affordable housing, mentorship, shared meals, outdoor recreation, and trauma-informed leadership, CYAK addresses the root causes of poor health — isolation, instability, and disconnection — while strengthening lifelong habits of physical activity, nutrition, and mental resilience. This upstream investment supports both Healthy Beginnings and Healthy Communities priorities.	CYAK is in the process of purchasing and renovating a residential property (previously a bed and breakfast) in Fairbanks to expand the proven Aarigaa House model previously operated there and currently thriving in Anchorage near UAA's campus. The approach includes five integrated elements: 1. Safe, Flexible Space Renovations will ensure code-compliant, welcoming residential space with areas adaptable for wellness workshops, shared meals, physical activity, and visiting mentors. The home will function as dual-purpose living and community space. 2. Relational Workforce Development A full-time Resident Director will live on-site, providing daily mentorship, structured rhythms, and accountability. Staff will receive training in trauma-informed care, suicide prevention, de-escalation, and intercultural competency — strengthening Alaska’s rural-support workforce pipeline by providing residents with support and encouragement as they pursue education or employment. 3. Healthy Habit Formation Residents participate in shared meal planning and preparation, outdoor recreation, service projects, and structured community gatherings that build mental resilience, nutrition awareness, and active lifestyles consistent with prevention-focused health goals. 4. Strategic Partnerships CYAK will coordinate with UAF, local organizations, Tribal organizations, and health providers in Fairbanks and rural communities to create referral pathways and collaborative programming. 5. Technology & Statewide Connection Secure connectivity will allow tele-mentoring, remote engagement with Alaska Native leaders and elders, and facilitate access to behavioral health or primary care consultations when needed. This model strengthens community-based preventive infrastructure while preserving local voice and cultural identity.	\$250K-\$1M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough	Deferred or Not Advanced

Covenant Youth of Alaska	Community and Wellness Catalyst	AK	Many rural Alaska communities continue to experience the long-term effects of historical trauma, cultural disruption, and rapid social change. Early 20th century epidemics dramatically reduced populations and disrupted the transmission of cultural knowledge, family structure, and community leadership. Subsequent economic and cultural shifts further accelerated these changes. Today, many communities are actively seeking ways to strengthen wellness, prevent substance abuse, and restore healthy community rhythms rooted in culture, relationships, and shared responsibility. This project responds to that opportunity by supporting community-led wellness efforts that strengthen protective factors and interrupt destructive coping patterns. Through cultural gatherings, mentorship, service to elders, and weekly community connection practices, the project aims to restore bonds of trust, strengthen identity and agency, and promote healthy lifestyles across generations.	This project focuses on prevention, collaboration, and strengthening community-based wellness practices. The initiative will begin with a culturally grounded entry process that honors local leadership and prioritizes listening, relationship building, and collaboration with Tribal, church, and community leaders. The program will launch with a regional cultural gathering designed to catalyze a movement of wellness. Participants from multiple communities will come together to share cultural practices, explore personal and community identity, and strengthen bonds of trust. The gathering will include cultural exchange through songs, dances, storytelling, outdoor activities, and small-group talking circles that create space for reflection, connection, and healing. Activities will emphasize culturally meaningful practices such as gathering food from the land and water, serving elders, and participating in traditional forms of community life. These activities promote physical activity, cultural identity, and intergenerational connection. Following the gathering, participants will enter an eight-week season of weekly wellness practices supported through local gatherings, mentorship relationships, and digital connection. Participants will be encouraged to identify personal goals related to health, sobriety, relationships, and community service. Seven community coordinators will be hired to facilitate weekly potlucks or gatherings in partnership with local institutions such as schools, churches, or Tribal facilities. Coordinators will help participants stay connected, encourage mentoring relationships, and assist individuals who wish to access professional behavioral health services. The program will conclude with community feasts celebrating progress and reinforcing community bonds.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Kenai Peninsula Borough; Kusilvak Census Area; Matanuska-Susitna Borough; Nome Census Area	Deferred or Not Advanced

Covenant Youth of Alaska	Connected Communities: Rural Alaska Behavioral Health Access Initiative	AK	Rural Alaska communities face significant barriers to accessing behavioral health care. Alaska Native youth experience some of the highest rates of suicide, depression, trauma exposure, and substance abuse in the nation. Yet many villages have limited or inconsistent access to behavioral health professionals, prevention training, and early intervention resources due to their geographic isolation. Making in-person training, services, and professional collaboration difficult and costly. As a result, youth, families, and community leaders often lack access to practical mental health education and tools that could help address challenges before they escalate into crisis. Research consistently shows that youth in distress are most likely to confide in peers before approaching professionals. This creates an opportunity to equip youth and young adults with skills to recognize warning signs, respond appropriately, and connect peers with trusted adults or professionals. Additionally, rural Alaska faces a critical shortage of practitioners. Many communities rely on visiting providers or services that are difficult to access. This project addresses both challenges by expanding community access to behavioral health education while intentionally exposing youth and young adults to behavioral health career pathways. By strengthening prevention skills and inspiring future professionals, the project supports both immediate community needs and long-term workforce development in rural Alaska.	This project expands behavioral health education, training, and workforce exposure for youth, young adults, and families in rural Alaska through a technology-enabled community model. Participating villages will receive a technology package and technical support that enables them to host virtual trainings, peer support groups, and professional engagement in a shared community space. Each community will also identify a local coordinator responsible for organizing gatherings, promoting participation, and supporting program activities. Once infrastructure is established, the program will operate through four core components: 1. Community Behavioral Health Training Regular virtual training sessions will provide practical education for youth, families, and community leaders. Topics may include grief and loss, suicide prevention, trauma awareness, substance abuse prevention, Adverse Childhood Experiences (ACEs), and Mental Health First Aid. These trainings help communities recognize warning signs early and respond effectively to behavioral health concerns. 2. Peer-to-Peer Youth Support Training Youth leaders will receive Mental Health First Aid and suicide prevention training, equipping them to recognize warning signs among peers, offer appropriate support, and connect individuals with trusted adults or professionals when needed. 3. Annual Rural Alaska Virtual Behavioral Health Summit A statewide virtual summit will connect rural communities with behavioral health professionals, educators, and prevention resources. The summit will share current research, practical tools, and culturally responsive strategies for supporting behavioral health in rural communities. 4. In-Person Rural Behavioral Health Provider Summit An annual in-person gathering will bring together behavioral health providers serving rural Alaska to share best practices, strengthen collaboration, and explore innovative approaches to care delivery in remote communities. Youth and young adult participants will engage with providers to learn about education pathways and career opportunities in behavioral health. Together, these components strengthen prevention, increase access to training and professional expertise, and help develop the next generation of behavioral health professionals serving rural Alaska communities.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Kenai Peninsula Borough; Kusilvak Census Area; Matanuska-Susitna Borough; Nome Census Area	Deferred or Not Advanced

Criterion Healthcare	Statewide Rural Hospital Facility Assessments and Management Technology for Sustainable Access	SC	The State of Alaska’s RHTP priorities, specifically Initiative #2 Health Care Access, emphasize the urgent need to identify and prioritize rural facility renovations for completion by 2030. Currently, rural infrastructure decisions often occur in a vacuum; the opportunity is to replace fragmented, reactive maintenance with a standardized, statewide evaluation framework. By utilizing a consistent team of experts to perform FCAs, we ensure that infrastructure deficiencies are measured against the same yardstick across all 13 CAHs. This comparable data is essential for the DOH to effectively and equitably prioritize the 20% of RHTP funds capped for capital expenditures. Furthermore, the integration of Maintenance Management Software (MMS) provides a bridge between high-level state planning and local hospital operations. By providing hospitals with active data and unlimited software access through 2030, we empower administrators to shift from emergency repairs to proactive capital planning across 2, 5, and 10-year horizons. This foresight is critical for remote facilities, where the logistical costs of "urgent" procurement are often prohibitive and unavoidable. The Project culminates in the annual "Condition of Rural Hospitals in Alaska" report. This deliverable provides the DOH with a robust, data-backed investment plan to allocate RHTP funds to the most financially critical hospitals, ensuring that facility health never becomes a barrier to patient care.	Criterion utilizes a technology-driven, six-step framework to establish a comprehensive facility management and capital planning process. This approach is designed to evaluate and prioritize critical repairs at both the individual hospital and state levels through the following phases: Phase I: Strategic Alignment and Baseline Discovery • The project begins with direct engagement with the DOH to align objectives and confirm the scope, which primarily focuses on the 13 CAHs, but may expand to regional centers like the 39-bed rural hospital in Bethel. • To ensure site visits are high-impact, the Team first surveys the hospitals to collect existing data on facility conditions, capital initiatives, and any renovation or expansion plans, and if a facility management software is used. Phase II: The Technical Deep-Dive (Facility Condition Assessments) • Criterion deploys a specialized team of senior-level engineers and design professionals to conduct week-long, on-site Facility Condition Assessments (FCAs). Unlike standard visual inspections, this technical evaluation investigates concealed infrastructure—including systems above ceilings, exterior walls, roofs, etc. —while benchmarking diagnostic and treatment rooms against national Facility Guidelines Institute (FGI) standards. Phase III: Digital Integration and Operational Sustainability • The data gathered during the FCAs forms the foundation of a customized Maintenance Management Software (MMS) implementation for each hospital. This system automates and documents preventive maintenance, repairs, and replacement activities. By digitizing these workflows, hospital administrations gain a transparent overview of facility needs and associated costs, moving away from reactive "emergency" repairs and toward active capital planning. Phase IV: Statewide Synthesis and Long-Term Oversight • In the final phase, Criterion aggregates data from all individual FCAs to produce a landmark statewide report: “The Condition of Rural Hospitals in Alaska”. This report provides the DOH with a prioritized roadmap of critical capital needs, timelines, and cost estimates across the rural health system. To ensure this data remains actionable, Criterion will monitor these facilities and deliver updated annual reports to the DOH through 2030.	\$1M-\$5M	Statewide	Bristol Bay Borough; Chugach Census Area; Dillingham Census Area; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Sitka (City and Borough); Southeast Fairbanks Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

Cross Road Health Ministries, Inc.	Glennallen Rural Clinic Infrastructure and Medical Staff Housing Renewal	AK	Rural healthcare facilities in Alaska must operate in extreme weather conditions and remote environments where reliable infrastructure is essential to maintaining healthcare services. The Glennallen clinic campus provides healthcare services to residents of the Copper River Basin and surrounding communities but relies on aging infrastructure systems and building components that require replacement and rehabilitation. The campus includes the primary healthcare clinic as well as housing used by medical staff. In rural Alaska communities where housing availability is extremely limited, staff housing is essential for recruiting and retaining healthcare providers. Aging building components—including windows and doors in both the clinic and housing units—must be replaced to maintain safe, energy-efficient facilities capable of withstanding severe winter conditions. Critical infrastructure systems serving the campus are also approaching the end of their useful life. These include the central boiler system serving the clinic and aging water and sewer lines that support both the clinic facility and staff housing. This project will also support engineering and architectural assessment of the clinic facility to guide additional improvements needed to sustain healthcare services in the future. Addressing these infrastructure and facility needs will help ensure the Glennallen clinic remains a reliable healthcare hub for rural communities.	Cross Road Health Ministries will implement a phased infrastructure improvement project at the Glennallen clinic campus designed to strengthen the reliability of healthcare services and medical staff housing. The first phase of the project will address critical building and infrastructure systems that have reached the end of their useful life. This work will include replacement of aging windows and exterior doors at both the clinic facility and staff housing units. These improvements will strengthen building integrity, improve energy efficiency, and ensure facilities can withstand severe winter conditions common in Interior Alaska. This phase will also include replacement of the central boiler system serving the clinic facility, as well as replacement of water and sewer lines that support both the clinic building and staff housing units. These upgrades will improve system reliability and reduce the risk of service disruptions caused by infrastructure failure. During the first year, engineering and architectural assessment of the Glennallen clinic will also be conducted to develop plans for a future renovation project intended to modernize the clinic facility and improve clinical space functionality and patient flow. If funding becomes available, the second phase of the project would implement renovations identified through the engineering and architectural planning process. These improvements would support long-term sustainability of healthcare services at the Glennallen clinic. Construction activities will be coordinated carefully to minimize disruption to clinic operations. If necessary during limited construction periods, temporary use of mobile clinic capability may be utilized briefly to ensure patient services remain available. Together, these improvements will strengthen the reliability of the Glennallen clinic campus and support continued healthcare access for rural communities across the region.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Southeast Fairbanks Census Area	Advance to Implementation Application

Cross Road Health Ministries, Inc.	Rural Clinic Access, Technology, and Communications Resilience Project	AK	Rural communities served by Cross Road Health Ministries’ clinics in Glennallen and Delta Junction face significant barriers to timely healthcare due to geographic isolation, long travel distances, severe weather conditions, and limited healthcare infrastructure. Residents across the region often travel several hours to reach hospitals or specialty providers in Fairbanks or Anchorage, and transportation disruptions can delay access to care. Rural clinics must also maintain reliable clinical equipment, communications systems, and power infrastructure to coordinate patient transfers, consult with specialists, and respond to emergencies. Aging equipment, limited telecommunications redundancy, and power interruptions can create operational vulnerabilities that disrupt care delivery. In addition, many remote communities within the service region have limited ability to travel to clinic locations for preventive screenings or routine healthcare services, further contributing to delayed diagnosis and treatment. This project addresses these challenges by modernizing clinical equipment, expanding telehealth capability, deploying mobile clinic units to reach remote communities, and strengthening operational resilience through emergency communications systems and backup power infrastructure. These improvements will expand access to care, improve coordination with regional healthcare partners, and help ensure clinics remain operational during disruptions.	Cross Road Health Ministries will implement coordinated technology, infrastructure, and access improvements at its Glennallen and Delta Junction clinics to expand healthcare access and strengthen operational resilience across the region. The first component will modernize clinical equipment used for patient assessment and preventive screening. New equipment—including blood pressure kiosks, vital signs monitors, audiology screening equipment, ADA-accessible exam tables, and updated laboratory chairs—will improve diagnostic capability, increase patient accessibility, and support earlier identification of chronic health conditions. The second component will expand healthcare access through deployment of two mobile clinic units equipped with laboratory capability. These mobile clinics will allow providers to deliver preventive care, screenings, and basic diagnostic services directly in remote communities that cannot easily travel to Glennallen or Delta Junction. To support these services, the project will include two service vehicles at each clinic location to transport medical staff, equipment, and supplies for mobile clinic operations and community outreach. These mobile clinic services will allow Cross Road Health Ministries to expand preventive and diagnostic care beyond traditional clinic walls and strengthen healthcare access throughout the broader service region. The third component will strengthen clinic technology systems by improving electronic health records, telehealth connectivity, and secure data exchange with specialists and referral providers. The fourth component will improve operational resilience through installation of High Frequency (HF) radio communications systems and backup electrical generators at both clinic locations. These systems will allow clinics to maintain communication with referral providers and emergency medical services and continue clinical operations during telecommunications or power disruptions. The final component will implement upgraded accounting and supply management software to improve financial oversight, inventory management, and supply tracking across both clinic locations. Together, these improvements will expand healthcare access, strengthen clinic operations, and improve reliability of healthcare delivery for rural communities served by the Glennallen and Delta Junction clinics.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Southeast Fairbanks Census Area	Advance to Implementation Application

Cross Road Health Ministries, Inc.	TeleSpecialist Access and Rural Urgent Care Stabilization Model	AK	Rural communities served by Cross Road Health Ministries face significant barriers to accessing urgent and specialty care due to geographic isolation, long travel distances, and limited local medical resources. Residents across the Copper River Basin often travel several hours to access specialty providers or higher levels of care in larger communities such as Fairbanks or Anchorage. Severe weather, transportation delays, and seasonal road hazards can slow travel and medical transport. When patients experience urgent medical conditions, local providers must assess and stabilize patients while coordinating transfer to higher levels of care when necessary. Rural clinics often operate without on-site specialty expertise. Providers must make complex clinical decisions without immediate access to specialist consultation, which can delay treatment decisions and increase the burden on rural providers. This project addresses these challenges by implementing a TeleSpecialist-supported care model that allows providers to consult with specialists and referral providers in real time. Telehealth consultations will support clinical decision-making, help stabilize urgent care patients, and reduce unnecessary patient travel. HF radio communications capability will also ensure clinics maintain coordination with referral providers, emergency medical services, and healthcare partners during telecommunications disruptions.	Cross Road Health Ministries will implement a TeleSpecialist-supported care model at its Glennallen and Delta Junction clinics to improve access to specialty consultation and strengthen the clinics’ ability to manage urgent care situations. The first component of the project will establish telehealth consultation capability within each clinic. Existing clinical rooms will be equipped with telehealth technology that allows providers to connect with specialists and referral providers located in Fairbanks, Anchorage, and other locations. During normal clinic hours, providers will be able to consult with specialists in real time to support diagnosis, treatment planning, and patient management. The second component will focus on strengthening the clinics’ ability to stabilize urgent care patients when transfer to higher levels of care is required. Providers will use telehealth consultation with specialists to assist with clinical decision-making and patient stabilization while coordinating transport when needed. The third component will establish resilient HF radio communications capability at both clinic locations. HF radio communications systems will ensure clinics maintain communication with referral providers, emergency medical services, and healthcare partners during telecommunications disruptions. Staff training will ensure providers and support staff are comfortable using telehealth systems, stabilization protocols, and communications equipment. Regular testing of communications systems will be incorporated into emergency preparedness and continuity-of-operations planning.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Southeast Fairbanks Census Area	Advance to Implementation Application

Cross Road Health Ministries, Inc.	Glennallen and Delta Junction Community Health, Prevention, and Rehabilitation Initiative	AK	Rural communities across Interior Alaska face higher risks of chronic disease due to limited access to preventive healthcare services, rehabilitation resources, and wellness programs. Residents served by the Glennallen and Delta Junction clinics often travel long distances to access physical therapy, preventive health programs, and education that supports chronic disease prevention and recovery from injury. Without local access to rehabilitation services and preventive health programs, individuals recovering from injury or surgery may experience delayed recovery, reduced mobility, and increased risk of long-term disability. Limited access to preventive care also contributes to higher rates of chronic conditions such as diabetes, tobacco-related illness, and cardiovascular disease. Food insecurity also affects some rural households and can make it difficult for residents to maintain healthy diets needed to manage chronic health conditions. This project will address these challenges by expanding physical therapy and rehabilitation services, strengthening prevention programs focused on diabetes prevention, tobacco cessation, and weight management, and supporting community partnerships that promote wellness, healthy activity, and improved access to nutritious foods. These combined efforts will improve health outcomes and strengthen long-term community wellness across Interior Alaska.	Cross Road Health Ministries will implement a coordinated community health initiative that expands prevention programs, rehabilitation services, and wellness education across Interior Alaska communities served by the Glennallen and Delta Junction clinics. The first component of the project will expand rehabilitation and physical therapy services by adding equipment and resources that allow patients to receive therapy locally. These services will help individuals recovering from injury, surgery, or chronic conditions improve mobility and maintain independence without traveling long distances for care. The second component will strengthen prevention programs focused on reducing chronic disease risk. Education and support services will address diabetes prevention, tobacco cessation, weight management, and healthy lifestyle choices. These programs will help residents better manage health risks and improve long-term health outcomes. The third component will support community wellness initiatives including youth physical activity programs, community fitness activities, and health education partnerships with local schools and community organizations. The fourth component will support local food security partnerships that help improve access to nutritious foods for rural residents. By improving access to healthy food options and providing nutrition education, the project will help support healthier diets and improved management of chronic conditions. Together, these coordinated efforts will strengthen prevention, rehabilitation, and wellness services available to residents of Interior Alaska. Community wellness programming may also include peer-support groups and behavioral health support activities that provide additional resources for individuals managing stress, lifestyle changes, and chronic disease prevention goals. These activities will complement prevention programs focused on diabetes prevention, tobacco cessation, weight management, and healthy living.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Southeast Fairbanks Census Area	Deferred or Not Advanced

Cross Road Health Ministries, Inc.	Glennallen and Delta Junction Rural Healthcare Workforce Development and Training Pipeline	AK	Healthcare workforce shortages remain one of the most significant challenges affecting rural healthcare delivery in Alaska. Clinics serving remote communities often struggle to recruit and retain providers, nurses, medical assistants, and other healthcare professionals needed to maintain consistent services. For rural clinics such as those operated by Cross Road Health Ministries in Glennallen and Delta Junction, workforce shortages can limit service availability and increase strain on existing providers. Geographic isolation and limited training opportunities make it difficult for local residents to pursue healthcare careers while remaining in their communities. At the same time, many rural residents are interested in healthcare careers but lack access to training opportunities that allow them to gain experience and enter the healthcare workforce. This project addresses these challenges by establishing a workforce development pipeline that provides internships, mentorship, and training opportunities for individuals interested in healthcare careers. By supporting the development of local healthcare professionals, the project will strengthen workforce stability and improve access to healthcare services across the region. In addition to hands-on internship experiences, the program will support pursuing recognized healthcare training and certifications.	Cross Road Health Ministries will implement a workforce development initiative designed to train and support healthcare professionals serving rural communities in Glennallen and Delta Junction. The first component of the project will establish internship and training opportunities that allow students and community members to gain hands-on experience in rural healthcare settings. Participants will work alongside clinic staff and learn practical skills related to patient care, clinic operations, and healthcare administration. In addition to hands-on internship experiences, the program will support participants pursuing recognized healthcare training and certification pathways where appropriate. These may include training programs for medical assistants, community health workers, rehabilitation support staff, and other rural healthcare support roles. By helping participants move toward recognized certifications and career pathways, the program will strengthen the long-term healthcare workforce serving Glennallen and Delta Junction. The second component will provide mentorship and professional development opportunities for individuals pursuing healthcare careers. Experienced providers and healthcare staff will guide participants as they develop skills and explore career pathways within healthcare fields. The third component will focus on training in areas where rural clinics experience workforce shortages, such as medical assistants, clinic support staff, rehabilitation services, and health program coordination. The final component will focus on retaining healthcare professionals in rural communities by creating pathways for local residents to build healthcare careers while remaining in their communities. The program will prioritize opportunities for local students and community members interested in healthcare careers and will expose participants to a variety of healthcare roles including clinical support, rehabilitation services, and health program coordination.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Southeast Fairbanks Census Area	Deferred or Not Advanced
Cube Mobile Imaging	Mobile MRI or CT trailer to deploy at rural imaging clinics	MI	Our company wants to help alleviate the backlog of hospitals and imaging clinics facing challenged with medical imaging	We would work with a hospital or imaging clinic to prep one of our mobile medical trailers for immediate deployment. we would then coordinate logistics to getting the mobile MRI or CT onsite and work with the site to provide service and other needs to ensure they can efficiently scan patients and work through backlog they may have	\$50,000-\$250,000	Hospital	Statewide	Anchorage (Municipality); Dillingham Census Area; Fairbanks North Star Borough; Kenai Peninsula Borough	Deferred or Not Advanced

Curyung Tribal Council	Chythlook: A Culturally Grounded Peer Support Workforce for Rural Alaska	AK	Alaska's current peer support specialist training curriculum does not reflect the cultural, geographic, or service realities of rural Alaska. Existing curriculum draws from models developed outside the state by professionals unfamiliar with Alaska Native communities that are traditionally practiced across villages and small rural communities. These models assume access to treatment centers, therapists, and recovery meetings that simply do not exist in many parts of Alaska. More than 60% of Alaska communities are not connected to the road system. Alaska lost 357 people to drug overdoses in 2023 — the highest number ever recorded in the state. Alaska Native communities experience suicide rates two to three times higher than the national average, reflecting the long-term impacts of historical trauma and persistent gaps in culturally relevant services. Alaska Native communities are disproportionately affected by substance use and overdose deaths, yet Alaska Native leaders and rural residents remain significantly underrepresented in the systems that train and certify peer support specialists. Healing in many Alaska communities happens through relationship, connection, and accountability to community. Peer specialists are often the most trusted individuals to provide that support. Yet many rural Alaskans with lived experience and cultural knowledge have never had access to peer specialist training or certification. There is a disconnect that needs to be addressed.	This initiative will address the gap between Alaska's current peer support training system and the realities of rural communities by building a statewide, culturally grounded peer training infrastructure. Phase 1 — Curriculum Development: The first phase will convene rural Alaskan Indigenous leaders, elders, peer specialists, and rural behavioral health practitioners to redesign the Alaska Peer Support Specialist curriculum. The curriculum will be written by community experts whose knowledge comes from lived experience, cultural practice, and decades of recovery work in rural Alaska. The redesigned curriculum will integrate Alaska Native healing traditions, land-based wellness practices, traditional plant knowledge, community accountability models, and relationship-centered recovery alongside current best practices in peer support, trauma-informed care, and harm reduction. Phase 2 — Regional Trainings and Program Launch: Once the curriculum is developed, it will be delivered through six regional multi-day training events across Southeast Alaska, Southwest Alaska, and Northern Alaska. Training locations will serve as regional hubs for surrounding villages and rural communities. Participant travel support will ensure individuals from remote communities are able to attend. Trainings will be co-facilitated by experienced peer specialists and local cultural leaders. Phase 3 — Statewide Expansion: Following the initial trainings, the initiative will expand access to certification through a train-the-trainer model that builds regional training capacity. Graduates and partner organizations will be supported to deliver additional trainings within their own regions. Phase 4 — Sustainability and Integration: The final phase will focus on integrating the redesigned curriculum into statewide peer certification systems, tribal health programs, and regional behavioral health organizations, creating a sustainable pathway for growing Alaska's rural peer support workforce	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Dahl Memorial Clinic, Inc.	Remote Emergent Health Services the Skagway Borough	AK	Between 2024 and 2025, the volume in our emergency services department increased by 195%, exceeding the budget by \$1.5 million dollars. Only two months into 2026, we continue to see an increased pressure on emergent services (350% over last year in January and 174% in February). In order to sustain emergent healthcare in the north end of Lynn Canal, it is essential that the DMC hire at least one additional medical provider team (ie. Medical Provider, Registered Nurse, and a Medical Assistant) to remain on-call between May 1st and September 30th, 2026. The need is immediate and pressing. Without this, access to life saving medical care and the sustainability of that care will be compromised.	Dahl Memorial Clinic is a member of the Alaska Primary Care Association. Within that organization are 27 Federally Qualified Health Centers (FQHC) and 2 Look-Alikes. Of that membership, 7 Community Health Centers (CHC) face the same challenges and immediate need as the DMC as well all provide 24/7 emergent services with long distances between our clinics and a hospital and without the ability to bill properly for our services. Our approach, as a group, is twofold: first, we will submit a LOI as individual clinics to address the immediate need, and second, we will submit a larger LOI to ask for system change to address this critical need making it sustainable in the coming years. The issues faced by our clinics are identical: 1) reliance on emergency air transport, 2) limited billing capacity, 3) limitations in specialty care, and 4) the high cost of care in a remote area. Continuing to provide life saving medical services in remote areas through FQHCs is untenable statewide without significant change. This Letter of Intent, the "Remote Emergent Health Services the Skagway Borough" is to request immediate funding so that the Clinic can provide emergent medical services, including psychiatric and emergent behavioral health intervention, in a remote region of Alaska being overrun by medical need. The DMC has been in operation for 20 years and responded successfully to a fairly stable, annual demand of injury, disease, and emergency medicine. The Clinic is both the medical clinic, and morgue, and has never encountered sudden, massive increase in demand for emergent services as it has in the last two years. Historically, the DMC has three medical providers working daily in the winter months, and five in the summer months. The unprecedented increase in demand between 2024 and 2025 has provoked much concern from the Clinic and the Municipality of Skagway for emergent services in the Borough.	\$50,000-\$250,000	Federally qualified health center	Single Community	Skagway (Municipality)	Advance to Implementation Application

Dahl Memorial Clinic, Inc.	Remote Emergent Services Sustainability in Community Health Centers	AK	The Remote Emergent Services in Community Health Centers seeks to transform the current system of care in remote areas to provide sustainable access to emergent health and behavioral healthcare. FQHCs are not licensed Emergency Rooms and currently may only bill as clinics. Further, because they are not a 'destination point' of service according to insurance companies, even the ambulance ride to the clinic is not covered by insurance. They provide the services out of necessity, but cannot be reimbursed. Licensed Emergency Rooms are able to provide the level of care they provide because they can bill professional codes, facility codes, and Evaluation and Management Codes all on the same bill and insurance companies reimburse for those services. Further, because the clinics in question are remote, the vast majority of patients are sent by air to a higher level of care. Inclement weather, Civil Twilight airport limitations, and the availability of air assets are a significant barrier to these services, often leaving patients for extended periods of time being provided services, such as observation and management, for which the clinic cannot bill or be compensated. Medical professionals providing these services are on-call, providing a demanding level of clinical care, at extreme cost without the capacity for the clinic to bill for the life saving services provided.	The Remote Emergent Services Sustainability in Community Health Centers (CHC) is a multi-year proposal with a defined approach and the first phase ready for launch. The proposal is: 1. First Year System Adjustments and Data Collection: In 2026, a grant is designated specifically for remote Community Health Centers providing 24/7 emergent services. The fund will do two things: a. Clinics that provide remote (defined) 24/7 emergent care (defined) would be able to bill Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, facility codes, Evaluation and Management Codes, and professional services codes which are currently uncompensated, through the grant, and b. A contractor/monitor will be identified by the Department of Health (DOH), and paid, for financial auditing and collecting data on patients and medical outcomes. i. A dataset (defined) will be reported with each claim that will: 1. Compare current reimbursement with the extended reimbursement; 2. Specifically quantify actual cost of care (list of metrics); and 3. Provide specific demographics for the claims. ii. Each claim will be tracked and outcomes will be reported. c. An extensive cost benefit analysis will be compiled in the 4th quarter, with cooperation of the contractor/monitor, showing DOH/CMS cost effectiveness, outcomes, and sustainability. 2. Second Year System Adjustments and Data Collection: In 2027, based on the findings of 2026, the billing authorization process and flexibility will be adjusted for any further limitations, recommendations, or negative findings. a. Repeat Year One Process 3. Third Year Waiver/System Change: based on the findings of 2026/27, DOH and APCA will have information necessary to request a wavier to CMS and HRSA and, through this waiver, effect long-term system change. The waiver would introduce a facility type for CHCs that provide remote, emergent care. This wavier could look something like the Frontier Extended Stay Clinic (FESC) waiver but should include: a. The ability for CHCs providing this type of care to bill against facility codes, at a sustainable rate, for services provided and be reimbursed by insurance companies for the care. b. Funding for medical oversight of this wavier, potentially including payment for a Medical Doctor and specialty care.	\$1M-\$5M	Federally qualified health center	Statewide	Aleutians East Borough; Aleutians West Census Area; Bristol Bay Borough; Copper River Census Area; Haines Borough; Skagway (Municipality)	Advance to Implementation Application

Dahl Memorial Clinic, Inc.	Aging Alaskans in Community	AK	The envisioned senior center will have 1) a senior center offering senior lunches, activities, education, and engagement opportunities, 2) a pharmacy (already open), 3) a walk-in medical clinic for individuals over 65, 4) home health services delivered from the building, and 5) three ground-level assisted living home efficiency apartments for individuals needing non-complex, assisted living. The Portland House is a two-story, 5,000 square foot facility with apartments upstairs and offices, a pharmacy, and space for the senior center and clinic on the ground floor. The structure is on the corner of 5th and State Street and in the historic district of Skagway, AK. The Municipality of Skagway has designated funding furnishings for the senior center after the completion of the renovation, which is already underway. Additionally, this location has one of the few empty lots still available in the Skagway historic district. While the assisted living home apartments are envisioned to be built on that lot, this request is NOT for funding for those apartments, only the completion of the senior center itself so that services, including home health and the drop-in clinic, can begin.	In 2015, at the bequest of residents, the Municipality of Skagway commissioned a study through the Foraker Group (completed by Sheinberg Associates) to plan the building of a senior center. Further, they designated a site (a municipal lot on 11th and Broadway Street) as the site. While the study indicated a senior population growing at a greater rate than any other town in Alaska, greater than the average of the State of Alaska, and greater than the U.S. average with significant growth between 2025 and 2040, the funding eventually fell through and nothing was officially accomplished. A grass-roots movement has kept the discussion alive and with the donation of a structure and staffing provided by the Clinic, the potential to open for services this summer is very real. Unfortunately, there a few up-front costs that remain unfunded, namely: 1) a liability insurance policy to cover the first year of operations (after that, billing will pay for coverage), 2) a few remaining one-time cost renovation projects (ie. finishing the floor in the 1,200 square foot space, the purchase of computers and office equipment, and finishing the administrative office space of 300 square feet,) and 3) hiring an initial front desk staff to open the facility as gap funding prior to grants and billing providing income.	\$50,000-\$250,000	Federally qualified health center	Single Community	Skagway (Municipality)	Deferred or Not Advanced

Dahl Memorial Clinic, Inc.	Dahl Memorial Partnership	AK	Non-profit service providers often partner with non-profit real estate holding and development companies under Section 501 of the US Internal Revenue Code specifically to hold and maintenance property for a 'parent organization.' This removes the administrative and financial burden of property management, maintenance, risk of litigation, and insurance from the services provider (in our case a medical and behavioral health service) and places it on a non-profit organization with expertise in facility management. This is an imperative arrangement for many small clinics who, when they do not have such an arrangement, must hire or contract for maintenance services separately from the services they offer. In Skagway, this need is even greater as there are few blue collar professionals in the community (ie. there is no plumber or electrician that lives in Skagway) leaving staff at the clinic with the responsibility of fixing frozen pipes when their expertise and need is to see patients. Often, in clinics like Dahl Memorial, this leads to significantly higher costs in building maintenance and an inefficient use of personnel, reducing the number of patients that can be seen and putting the facility at risk of damage which often evolves into a barrier to seeing patients altogether.	Dahl Memorial Clinic has partnered with the Smith and Long Development Corporation as our property owner and manager. The Clinic will continue to provide medical, dental, and behavioral health care free from the cost and burden of maintenance, while Smith and Long will hold title and maintain those properties, and procure or develop new properties as programming at the Clinic expands.	\$50,000-\$250,000	Federally qualified health center	Single Community	Skagway (Municipality)	Deferred or Not Advanced

Dahl Memorial Clinic, Inc.	Three Eagles Recovery	AK	Alcohol misuse remains one of Alaska’s most pressing public health challenges. High prevalence of excessive drinking: According to the America’s Health Rankings 2023 data, 18.4% of adults in Alaska report excessive drinking (defined as binge or heavy alcohol use, the latter being more than eight drinks per week for females or 15 per week for males). Data from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) indicates that in 2023, Alaska ranked 13th among all states in alcohol consumption. Disparities among Alaska Native communities: National data shows Alaska ranks high for excessive drinking among American Indian/Alaska Native adults, with roughly 20.6% reporting binge or heavy drinking—significantly above healthier state averages. In fact, The Recovery Village reports 17.5 percent of Native Americans and Alaska Natives needed alcohol or illicit drug treatment, compared to 9.3 percent of people of other races and ethnicities. Youth risk behavior indicators: Data from Recover Alaska’s DASH Printout shows that alcohol use initiation before age 13 and youth binge drinking remain serious concerns for Alaska communities—a leading indicator of long-term misuse in adulthood.	Skagway is a small community on the north end of Lynn Canal in Southeast Alaska, best known for its colorful history and the Klondike Goldrush. It is remote enough to offer a secluded space, away from the pace of city life, yet close enough to amenities, including medical services, to provide the perfect place for recovery. More importantly, for the treatment model, Skagway is situated ideally for spectacular outdoor access. During the Klondike Gold Rush, thousands of men and women completed the journey from Dyea, Alaska (in Skagway Borough) to Lake Bennett, British Columbia. Today, the Chilkoot National Historic Trail is a 33-mile recreational trail with oversight of the National Park Service and provides unparalleled outdoor experience with an emphasis on history and human endurance over hardship. The Three Eagles Recovery Center seeks to capitalize on this history and message of resilience as a backdrop for therapeutic recovery from the ravages of substance abuse. The program will use Nature Informed Therapy as the basis of treatment, and a partnership with the US Parks Service and the Municipality of Skagway for the provision of trail maintenance as employment training services. As an 3.1 Level Recovery program, Three Eagles Recovery will be staffed by qualified medical and behavioral health professionals with additional professional experience and certification in Trailbuilding and National Outdoor Leadership. Curriculum and treatment plans will be built around outdoor excursions that focus on individual resilience and giving back to the community through trail maintenance of the extensive trail network in and around Skagway. Physical work, licensed education (as appropriate), Medically Assisted Treatment (MAT as appropriate), environmental education, and Nature-Informed Therapy (NIT) will be blended to build self-esteem and social skills, helping individuals process emotions and develop the resilience necessary to overcome their addiction. This approach has been proven successful as published in many professional journals including Recovery Horizons: Nature-Based Activities as Adjunctive Treatments for Co-Occurring Post-Traumatic Stress Disorder and Substance Use Disorders, published through the National Institute of Health in 2024. Such programs currently exist in partnership with the US Parks Service and have a template and process for implementation.	\$50,000-\$250,000	Federally qualified health center	Statewide	Skagway (Municipality)	Deferred or Not Advanced

Dataflow/Alaska Inc	Help on Call	AK	The Problem: Demographics, Distance, Culture and Lifestyle Healthcare is about humans. Modern healthcare interaction and delivery is through a variety of outsourced systems such as patient portal accounts, mobile apps, providers often expecting the customer to do their own work of creating and maintaining accounts, medical records, understanding forms, medical terminology (Do you have signs of edema? What is edema?). Customers often get help from a variety of 1-800 numbers with varying limited office hours, sometimes answered by outsourced impatient people with heavy accents.	"Responsive Help on Call" - DataFlow runs help desk services focused on warm responsiveness. This means answering on the second ring, avoiding a caller queue, simplify interaction with complex systems and organizations via hand-holding, independent validation and verification of statistics related to effectiveness and closure. We will help establish or assist other organization in combined services to ensure a 7-day/week 6am-midnight, highly-responsive help center that assists users throughout rural Alaska with electronic forms, discuss the meanings of fields. We will experiment with voice-call routing technologies and partner with each tribal group for young candidates to create village-level internships in auditing and data processing-related employment in the village. The scope of services is similar to patient intake, offering over the phone hand-holding assistance completing online forms. In cases where a user does not have a computer or a system is down, we will interact with the user to complete the form for them on their behalf. When a healthcare practitioner with the same systems we'll also assist them with the forms or get the systems reset over the phone so they can get back to focusing on the patient.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Dataflow/Alaska Inc	Village Technology Sustainment Center	AK	Dataflow/Alaska would like to be instrumental in creating a "Village technology sustainment center", which would specialize in Health IT standards and related technical educational opportunities targeted to the population. This would assist in addressing the gap in knowledge and infrastructure frequently found in rural areas.	The Problem: Modern systems of processes assume continuous robust tethering to central data systems. (robust and affordable internet) Modern technology support and sustainment logistics (break-fix methods) assume tight standardization of configurations (typically configured for urban environments) and availability of overnight shipping to a user from a depot. The logistical assumptions don't accommodate exceptions or innovation well. The Rural Solution: The village technology sustainment center will publish and evolve common rural deployment standards in translation charts with side-by-side formal technical standards in the chart and parallel rules of thumb for the appropriate target population to improve the accessibility of the technical knowledge. For example: "the maximum bend radius of the network cable is 3.7mm" or "shall comply with ANSI 273492-3 paragraph B found in this QR-Code link" would translate to "Don't even come close to creasing the wire. The bends shall not be sharper than a loop around a soda can." Other technical guidance would be similarly translated.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Daybreak Inc.	Mat-Su Mobile Social Service Navigation Project	AK	The Matanuska-Susitna Borough (Mat-Su) is in Southcentral Alaska about 40 miles northeast of Anchorage. The Mat-Su is Alaska’s fastest-growing region, home to more than 117,000 residents across 25,000 square miles. Within the borough there are three incorporated cities – Palmer, Wasilla, Houston; 26 unincorporated communities governed by community councils. The Mat-Su is the state’s second-most populous borough and third largest by land. Talkeetna and Trapper Creek are the most distant communities from the economic center of the borough, 70 to 75 miles north of Wasilla. There are often disparities between rural and more urban locations closer to the Core. Population and demographic trends differ across the subregions of the borough. There are often disparities between rural and more urban locations closer to the Core. The focus of the project is to assist in connecting people living in remote areas of the Mat-Su to assess needs and promote the social determinants of health. Specifically, to improve/increase access to housing, improve/increase access to SNAP, Medicaid, Social Security, and housing assistance. Community health workers will also collaborate with medical, dental, mental health and substance use disorder treatment by assisting in the coordination of care. The community health workers will bring navigation services to remote communities in the Mat-Su to assist families and individuals to obtain benefits, connect with health care providers and basic resources.	In year one, the project will utilize two community health workers who will travel to selected communities in the northern region of the Matanuska borough (Willow, Talkeetna, Petersville and Trapper Creek). Community health workers will set up weekly or bi-weekly scheduling to meet with residents to assist in meeting the known and unknown needs of people living in the selected communities. The community health workers will focus on the social determinants of health to increase the feeling of belonging and reduce social isolation in the northern communities of the Matanuska Susitna borough. The social determinants the team will focus on will be: - o Health services-lack of access - o Health and Well-being psychological stress - o Social support networks – access to support & services - o Income and Social Status- low income - o Physical/environmental- housing stability, homelessness . Community health workers will assist in reducing isolation, increasing access to medical, mental health, dental, traumatic and acquired brain injury, and other health related needs. After a brief assessment to determine immediate needs, a plan of care will be developed and used to fulfill the identified needs. Some examples are: • Assistance in filing for Medicaid and/or Social Security benefits • Referral to a medical provider • Referral to mental health services • Referral to SUD treatment services • Assistance in completing housing applications, energy assistance applications, and Basic Housing Assistance programs • Connected seniors to Meals on Wheels, SNAP benefits, and healthy food prescriptions • Assistance coordinating multiple appointments for lab work, testing, specialist appointments and providing follow-up as needed to improve attendance at scheduled appointments • Coordinating transportation services to allow participants to attend appointments • Obtaining a State of Alaska ID or replacing a drivers license (this may include assisting a female consumer to obtain the documents needed to secure a Real ID. • Improving personal hygiene by providing - o Shower vouchers - o Hygiene kits - o Laundry vouchers and supplies The community health workers would utilize an electronic health record (EHR) that would be connected to HealthTIE to assist in developing a continuity of care approach to ensure that all of the providers are aware of the work being done by the community health worker, and the progress or regression of the participants health and social determinant needs.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Delta Community Library	Library Expansion for Increased Community Wellness	AK	According to 2020 Census data, the community is home to 4,774 residents. Twenty three percent of households include children under age five, and 59 percent include children ages 6–17. This substantial youth population underscores the community’s ongoing need for accessible, family centered services and support. The library has long served as a critical resource for these families, offering after school programs, summer learning opportunities, and preschool activities that promote family engagement, social development, physical activity, and supplemental education. In 2025 alone, 157 children participated in the library’s summer programs. However, the current library facility—constructed in 2004—can no longer meet the needs of a population that has grown 17.3 percent since the 2000 Census. The building lacks adequate space for recreation, safe shelter during long winter months, and areas that support physical and mental enrichment. It is also insufficient for providing nutritional and behavioral education programs that families increasingly rely on. The maximum seating capacity of the children's area is just 20. In addition, the community faces a growing need for private, technology-equipped spaces where residents can participate in remote medical consultations and distance learning sessions. The existing facility cannot accommodate these essential services.	To better serve the mental and physical wellness needs of the community, the library facility will be expanded. The current size is just over 5000 square feet with two staff offices and a small staff workroom providing the only "private" areas. This project will add an additional 2000 square feet to the east side of the facility. This building was built with this expansion in mind. A dual-purpose meeting and activity room to provide for small groups to hold educational or physical activity sessions, meetings for private medical consultations, or distance learning sessions. An expanded children's area with increased seating, a small cooking area for nutritional education, and more shelving area for resources such as books, home learning kits, and games. This will enable our institution to improve on the foundation we have built over the years to encourage healthy habits in our area. The library is already a hub for the people of this area and this project would allow it to further meet the needs of both the young and aging population.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Southeast Fairbanks Census Area	Deferred or Not Advanced

Delve Group LLC	Alaska Healthcare AI Accelerator	AK	Alaska's healthcare and social service organizations face a widening AI capacity gap. AI task capabilities are doubling roughly every four months according to METR, an independent AI benchmarking organization. Organizations that build internal capacity now will harness that progress. Those that don't risk being inundated by it. Delve Group is an AI implementation practice headquartered in Anchorage, founded by lifelong Alaskans Kyle and Blythe Easterly. We see this gap up close across our Alaska clients, which include disability services nonprofits and healthcare organizations with locations across the state. AI adoption is ad hoc, driven by whatever tool came bundled with existing software, with no coherent strategy for evaluation or sustained improvement. Most organizations use a single AI tool by default and have no plan to do better. Commercial AI advisory models don't fit mission-driven healthcare organizations. These organizations need an approach that builds genuine internal capacity rather than vendor dependency, funded to serve organizations regardless of their ability to pay commercial rates. The Alaska Healthcare AI Accelerator delivers exactly that.	The Accelerator is an embedded advisory program. Delve Group works with each participating organization on an ongoing basis, modeled on the advisory engagements we already operate with commercial clients. This is not a workshop series or a one-time assessment. It is a sustained working relationship. All advisory work is delivered by teams of two. This is a core Delve Group operating principle: AI advisory work is creative problem-solving, and two people working together produce better results than one person working alone. A pair can observe meeting dynamics and track workflow details simultaneously, and challenge each other's thinking in real time. In Year 1, the two new AI Specialists funded by this program will be paired with Delve Group's founders as they onboard and develop applied expertise. As the Specialists ramp, they increasingly work together as a pair, with founder involvement shifting to oversight and cohort strategy. Each team works as a fly on the wall inside the participating organization, attending meetings virtually, observing workflows, and developing a deep understanding of where the organization's time and capacity are going. From that vantage point, the team identifies specific bottlenecks that AI tools can address and provides structured guidance on tool selection, adoption, and integration into daily operations. The emphasis is on building the organization's own judgment: teaching staff to evaluate AI tools, think through use cases, and sustain adoption as the technology evolves. The advisory relationship is virtual-first, so organizations anywhere in Alaska can participate. In year 1 we intend to enroll and work with between 4-5 organizations.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Denali Borough	Denali Borough Rural Health Care Transformation Project Coordinator	AK	A single rural health care coordinator role does not exist to convene partners to discuss challenges and explore solutions to providing sustainable health care access to Denali Borough residents. Many of the partners in our volunteer fire departments and clinical staff are already occupied with the delivery of basic medical services. This role will convene local organizations to collaborate and build community-driven solutions that improve health care access, quality, and sustainability. The coordinator will be responsible for sharing resources, creating plans to improve infrastructure, and expanding local capacity to develop solutions to barriers to accessing care, while also supporting community efforts in early childhood health and community health. The Coordinator’s scope and requested direct costs (e.g., IT equipment, basic furnishings, travel, and fringe benefits) will be tied to concrete project activities and outcomes, consistent with RHTP’s project-based budgeting approach and federal allowability rules.	The Denali Borough will address gaps in health care access and coordination by hiring a Rural Health Program Coordinator to lead a multi-sector, community-driven effort. The 2022 community health needs assessment included a preliminary analysis of the barriers and gaps in healthcare delivery. In the first year, the Coordinator will 1) formalize relationships with agencies and organizations and convene partners across primary care, behavioral health, oral health, specialty services, hospital/EMS, post-acute care, and social supports; 2) attend regional and statewide convenings to establish broader partnerships, networks, and advocate for programs that will improve health outcomes for Denali Borough residents; 3) serve as project manager for any additional projects funded by the RHTP program; 4) provide support to local organizations with limited capacity to ensure they can participate in programs to transform rural health care; and 5) develop and launch the application for the recently created Denali Borough Health Care Provider Services Loan Program. The proposed projects for RHTP funding that this role would manage represent a holistic approach to transforming health care in the Denali Borough. This includes proceeding with pre-development tasks for health care provider housing to address a housing shortage that affects the ability to staff health care provider positions, as well as projects to assess conditions of firehalls and community centers in our communities as the first step in identifying what renovations are needed for these essential facilities to ensure that they can meet the needs of the next generation. If funded for additional years, this position will focus on finding ways to address the top 5 health priorities identified in the 2022 Denali Borough health needs assessment: 1) access to health care; 2) mental health, alcohol, and substance use; 3) housing; 4) nutrition; and 5) physical activity and indoor recreation activities. We anticipate that one of the main approaches to ensuring health care access in our community in future years will be to identify a sustainable framework in which EMS teams are reimbursed. This will include examining local and regional options for sustainable funding sources through public-private collaboration.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough	Advance to Implementation Application

Denali Borough	Design for Health Care Provider Housing in the Denali Borough	AK	For two years leading up to the Interior Community Health Center (IHC) closing its satellite clinic in Healy in November 2025, the clinic operated without a permanent provider and offered significantly reduced services. During that time, residents frequently experienced weeks to months without access to in-person appointments, with only intermittent services available when a provider could travel to Healy. IHC shared that one of the significant barriers to staffing the clinic and recruiting a full-time provider was the lack of adequate housing available. The Denali Borough does not have affordable, year-round workforce housing to recruit/retain clinicians, leading to limited and seasonal health care access for residents. This project aims to strengthen and stabilize the workforce and reduce health vacancies to bring health care access back to Borough residents and make sure that access can be sustained in the future by creating housing devoted to health care workers. This request for pre-development funds for health care worker housing is a key first step in making health care provider housing a reality. The Borough intends to seek a multi-braided funding stream to construct the housing units.	To address the significant gaps in health care access in the Denali Borough, this project will plan and develop a dedicated, year-round housing complex for health care workers. The approach focuses on pre-development, design, and engineering activities that will lay the foundation for a sustainable workforce housing solution capable of attracting and retaining clinicians and other essential health personnel. The project includes 1) site analysis and feasibility studies to identify optimal locations for the housing complex, considering proximity to existing health facilities, utility access, and environmental factors, and 2) architectural and engineering design work to create housing units that meet professional standards, provide safe and functional living environments, and support long-term operational sustainability. The Borough will work closely with local health providers, community leaders, and potential resident staff to ensure the housing design meets operational needs, encourages retention, and aligns with workforce priorities. Input from these stakeholders will inform unit size, layout, shared spaces, and other amenities to foster a supportive, community-oriented living environment that promotes well-being and resilience among residents. This project is aligned with the RHTP initiatives: • Strengthen Workforce: The project directly grows a resilient health care workforce by reducing barriers to living in Denali Borough, pairing housing designs with RHTP supports such as time-limited housing or childcare stipends to accelerate recruitment and retention of skilled providers. • Health Care Access: Workforce housing underpins the reopening of the Healy clinic and integration with EMS programs, bringing essential health services closer to residents and reducing reliance on distant providers in Fairbanks. • Healthy Communities: Reliable housing supports sustained local health programming and preventive care initiatives, enabling clinics and community providers to offer wellness, education, and lifestyle support in safe, accessible environments. • Pay for Value / Fiscal Sustainability: Pre-development, design, and engineering planning ensures that housing investments are cost-effective, energy-efficient, and aligned with long-term capital planning, creating a sustainable model for workforce retention and reducing ongoing recruitment costs.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough	Deferred or Not Advanced

Denali Borough	Rural Health Care Facility Building Condition Assessments	AK	Rural communities in the Denali Borough depend on a small number of multi-use public facilities to deliver essential services, support emergency response, and provide space for community gatherings, health education, and wellness activities. These facilities are critical assets in a remote region where access to alternative infrastructure is limited. Aging buildings, deferred maintenance, and high energy costs pose risks to long-term operational sustainability and service reliability. These facilities are run by 3 non-profit organizations and the City of Anderson. These organizations lack comprehensive, up-to-date building condition assessments and energy audits for these facilities. Without an assessment, these organizations cannot effectively prioritize maintenance, plan capital improvements, or strategically invest limited funds. This reactive approach increases the likelihood of costly emergency repairs, service disruptions, and escalating utility expenses. This project seeks to address these challenges by conducting professional building condition assessments and energy audits for four key facilities. The assessments will identify maintenance deficiencies, safety concerns, and long-term capital improvement needs, enabling the non-profits to implement strong asset management practices and preventative maintenance planning. The audits will analyze energy consumption patterns, identify cost-saving measures, evaluate HVAC and ventilation performance, and recommend upgrades.	The proposed project supports rural health transformation by strengthening the physical environments that underpin emergency response, community wellness programming, preventive health initiatives, and maternal/child health supports. In rural Alaska, multi-use facilities are integral components of the broader health ecosystem. By improving environmental health, fiscal sustainability, and facility reliability, the Denali Borough is investing in the foundational systems that enable healthier communities and more resilient rural health infrastructure. This project seeks to improve the energy efficiency and infrastructure quality of community centers and fire departments by energy audits and building condition assessments. Specifically, the Denali Borough will conduct condition assessments and energy audits of four facilities – McKinley Village Community Center, Tri-Valley Community Center, the City of Anderson Fire Hall, and the Cantwell Fire Hall; the two community centers listed have volunteer fire departments co-located in their facilities. The Tri-Valley Community Center also houses a now vacant primary care clinic space and there is an organization interested in moving into the space to provide health care services – conducting a building-wide condition assessment is the first step in planning for potential renovations that ensure that this space remains sustainable for health care through the next 30 years. The Denali Borough’s proposed energy audits and building condition assessments align with RHTP initiatives by strengthening the infrastructure that supports health, safety, and emergency response in rural communities. By improving indoor air quality, identifying preventative maintenance needs, and reducing long-term energy costs, the project promotes healthier environments for families and children, supports reliable emergency medical response through well-maintained volunteer fire departments, and enhances community centers that host preventive health and wellness activities. The initiative advances fiscal sustainability through proactive asset management and energy efficiency, strengthens rural workforce resilience by improving working conditions for first responders, and lays the groundwork for technology and infrastructure modernization, collectively contributing to healthier, more sustainable rural communities.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough	Deferred or Not Advanced

Denali Borough	Tri-Valley Community Center Renovations	AK	The Denali Borough’s Tri-Valley Community Center houses the Tri-Valley Volunteer Fire Department, which also offers EMS services, a currently unoccupied clinic site, mobile dental hygiene services, and the annual fall vaccine clinic. The community center is additionally being considered as a potential site where DOH public health nurses could provide reproductive health services or other mobile health services. The borough’s community centers also serve as resilience hubs where people can gather during emergency events, such as wildfires or severe winter storms. To continue offering clinical care or expand medical services, serve as a resilience hub, and safely house fire and EMS personnel, the Tri-Valley Community Center requires an HVAC system that ensures appropriate air quality and temperature control, especially for vulnerable populations. The existing air handler and boiler heating system are outdated, unreliable, and in need of replacement. The lack of effective and reliable air handling and heating is especially concerning during extreme weather events that are becoming more commonplace, including during wildfires or severe winter storms.	The proposed project will replace the outdated existing airhandler and boiler heating system at the Tri-Valley Community Center with an upgraded HVAC system that provides improved air circulation and filtration capacity, as well as reliable heat and air conditioning service. The updates would ensure the community center is a safe, modern facility that can support existing medical care and VFD/EMS personnel, as well as ensure the Borough can expand healthcare facilities or wellness services, activities, and programs at the community center in the future. Additionally, the infrastructure upgrades will ensure that facilities remain functional and provide heat, shelter, and essential services to vulnerable populations during power outages, wildfires, extreme winter storms, and other emergencies.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough	Deferred or Not Advanced

Denali Family Services	Behavioral Health Workforce Expansion & System Transformation Initiative	AK	DFS seeks to address the persistent shortage of qualified behavioral health professionals serving youth and families in Southcentral Alaska, which limits access to timely, high-quality care. Workforce vacancies, high turnover rates, and limited opportunities for advanced training create barriers to expanding services for youth with complex behavioral health needs, particularly those with co-occurring neurodevelopmental conditions such as FASD, ADHD, and Autism Spectrum Disorder. At the same time, early childhood and school-based programs increasingly require specialized behavioral health expertise to manage challenging behaviors and support healthy social-emotional development. This project represents an opportunity to strengthen Alaska’s behavioral health workforce by investing in targeted recruitment strategies, career advancement pathways, specialized clinical training, and consultation supports such as the Pyramid Model and neurodiversity-informed practices. By stabilizing and expanding the behavioral health workforce while improving clinical competencies, Denali Family Services can increase service capacity, reduce wait times, and improve outcomes for youth and families across Anchorage, the Mat-Su Valley, and surrounding rural communities.	DFS proposes a comprehensive workforce development and system improvement approach designed to expand recruitment pipelines, strengthen workforce stability, and increase specialized clinical capacity in youth behavioral health. The project includes four coordinated strategies. First, DFS will implement a targeted recruitment and workforce expansion campaign, including professional media outreach and partnerships with Alaska training programs, to increase the number of qualified clinicians entering the organization. Second, DFS will establish structured professional development pathways through a Clinical Career Accelerator model that supports licensure advancement, supervisory training, and leadership development for existing staff. Third, the initiative will expand specialized training and consultation to improve the quality of services delivered to youth with complex behavioral health needs. This includes neurodiversity-informed training through the FASCETS Facilitator program and implementation of the Pyramid Model with ongoing mental health consultation to strengthen behavior management strategies, classroom supports, and early intervention practices. Finally, the project will include workforce stabilization strategies such as service commitment incentives and relocation assistance to improve staff retention and reduce vacancy rates. Together, these strategies will strengthen workforce capacity, improve treatment quality, and increase access to behavioral health services for youth and families across Southcentral Alaska and surrounding rural communities.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Advance to Implementation Application

Denali Family Services	Backcountry Alaska: Therapeutic Outdoor Behavioral Health Expansion Initiative	AK	Many youth served by Denali Family Services experience complex trauma, behavioral health challenges, and disruptions in family stability. While traditional therapy remains essential, many youth—particularly adolescents—struggle to engage consistently in office-based services. Recreational therapy has proven to be an effective intervention for youth with behavioral health challenges, especially when delivered through experiential, outdoor-based programming that encourages connection, teamwork, and healthy risk-taking. Backcountry Alaska, operated through DFS’s School and Community Based Services (SCBS) Recreational Therapy team, provides structured outdoor therapeutic experiences that support youth development while reinforcing treatment goals. However, expanding access to this program is currently limited by the availability of appropriate equipment and resources required to safely operate year-round outdoor programming in Alaska. Expanding this initiative presents an opportunity to strengthen engagement in behavioral health services, particularly for teens participating in DFS’s Transitional Independence Program (TIP). The program also creates a powerful recruitment and engagement incentive for youth entering DFS services, helping providers connect youth to meaningful, strengths-based activities that encourage participation in treatment.	Denali Family Services (DFS) proposes to expand the Backcountry Alaska program by investing in outdoor recreation equipment and infrastructure that will allow Recreational Therapists within DFS’s School and Community Based Services (SCBS) program to deliver year-round therapeutic outdoor programming for youth with behavioral health needs. SCBS provides behavioral health services to youth in home, school, and community settings. Recreational therapists play a key role in this model, using activity-based interventions to help youth develop emotional regulation, social skills, and healthy coping strategies. Backcountry Alaska builds on this work by using Alaska’s natural environment as a therapeutic setting where youth can practice these skills through structured outdoor experiences. With this investment, recreational therapists will integrate activities such as hiking, camping, fishing, kayaking, biking, and cross-country skiing into youth treatment plans. These experiences are intentionally structured to reinforce treatment goals and support youth in developing teamwork, leadership, resilience, and problem-solving skills. Activities are supervised by trained staff and coordinated with clinicians and case managers to ensure alignment with each youth’s behavioral health plan. The program also strengthens engagement for adolescents participating in DFS’s Transitional Independence Program (TIP). Teens often struggle to engage consistently in traditional therapy settings, and outdoor recreation provides meaningful, age-appropriate opportunities that encourage participation in treatment. Activities such as overnight camping trips, biking excursions, and winter recreation help teens build confidence, independence, and positive peer relationships while strengthening connections with supportive adults. Many youth with complex trauma or system involvement are hesitant to participate in traditional behavioral health care. Outdoor therapeutic experiences provide a strengths-based entry point that encourages youth to connect with providers and remain engaged in treatment. Through this approach, DFS Recreational Therapists will serve multiple cohorts of youth each year while strengthening treatment outcomes. By combining recreational therapy, outdoor programming, and clinical support, Backcountry Alaska expands access to engaging, community-based behavioral health interventions that build resilience and improve long-term well-being for youth served by DFS.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Denali Family Services	Therapeutic Foster Care Expansion & Stabilization Initiative	AK	Youth entering Alaska’s foster care system disproportionately experience adverse childhood experiences, including exposure to domestic violence, substance misuse in the household, chronic neglect, and intergenerational trauma. A substantial number of these youth require trauma-informed, highly structured family settings with caregivers who can effectively collaborate with mental health providers, schools, and community resources. Traditional foster homes, though well-intentioned, often lack specialized training and support to meet these heightened needs. As a result, children with intensive behavioral or emotional challenges are frequently placed in higher-level residential treatment centers or sent out of state—settings that are more costly, more restrictive, and less conducive to long-term well-being. Because of this, Alaska faces an urgent and growing need for TFH capable of supporting children and youth with significant behavioral health challenges. Data collected by DFS and the Office of Children Services (OCS) have revealed that every year dozens of Alaskan youth that need TFC are turned away or kept on waiting lists due to a lack of capacity. With the shortage of homes, struggling youth are placed in environments not suited to their level of need.	The proposed project is comprised of three components: recruitment, retention, and community recognition. To recruit Therapeutic Foster Parents (TFP), DFS will employ a multi-media marketing campaign in Anchorage and the Mat-Su valley, implemented by Walsh Sheppard Advertising, a local advertising agency with an existing partnership with DFS. The campaign will include digital, audio, and video outreach through social media, podcasts, radio, interviews, and TV. The goals are (1) to educate the public on foster care and TFC, youth behavioral health, and trauma; and (2) to recruit full or part-time foster parents. The campaign aims to increase the number of TFHs, increasing the capacity for DFS and keeping more Alaska youth inside the state for behavioral health care. Rather than a one-time recruitment push, this proposal establishes a structured five-year expansion plan aligned with the lifespan of the Rural Health Transformation Program (RHTP). Year One will launch a targeted, multi-media recruitment campaign (June–August) designed to generate approximately 150 applications and license the first cohort of 8–10 new therapeutic foster homes. Subsequent years will build upon campaign analytics, community engagement data, and refined audience targeting strategies to sustain annual recruitment gains. To increase retention, DFS will deploy AI-powered note writing documentation and compliance technology to 70 therapeutic foster parents to reduce administrative burden and improve Medicaid documentation compliance. Foster Parents write daily Medicaid notes for each child in their care, resulting in upwards of 20 notes a week in addition to providing 24/7 care to youth. This will reduce burnout, improve retention, increase documentation quality and timeliness, ensure Medicaid compliance, and build a stronger sustainability of community-based models. To strengthen community recognition, RHTP funds will support professional logo wear, identification materials, recruitment signage, and outreach materials for foster parents, outreach staff, and youth engagement. This improves public trust and recognition, recruitment effectiveness, professional cohesion among foster parents, as well as safety and credibility in community-based services.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Denali Healthcare Advocates	We are a nonprofit group working to bring year-round healthcare to the Denali Borough.	AK	The Denali Borough, home to nearly 1600 residents, includes the communities of Anderson, Healy and Cantwell, as well as numerous unincorporated residential communities. There is a clinic on Clear Space Force Station near Anderson, that most residents of the Borough cannot access; a seasonal urgent care clinic near Denali National Park (open May-September), and a small clinic in Cantwell, that typically is only staffed by a single medical assistant. This area had a fully operational clinic in Healy starting in 1972, that provided primary, urgent, and prehospital emergency care throughout the Denali Borough. Ownership of the Healy Clinic changed hands to Interior Community Health Center (IHC), and over the past 18–20 years, services and equipment have been gradually withdrawn. Consistent mid-level provider coverage diminished significantly after 2017. In May 2023, in-person provider availability was reduced to approximately four hours per week, dependent on provider travel from Fairbanks and weather conditions. This level of access was inadequate for a rural, geographically isolated population and the nearly 500,000 seasonal National Park visitors. Community efforts to restore services through the IHC were unsuccessful, and near the end of 2025 the provider closed its doors in the Denali Borough permanently. We seek to open a year-round clinic to provide primary and urgent care to our communities, as well as seasonal visitors and employees.	Our Board of Directors includes three Physician Assistants with approximately 75 years of combined experience delivering rural healthcare in Alaska, a Registered Nurse with 15 years of experience, and two local business professionals with extensive administrative and civic leadership within the Denali Borough. This structure ensures strong clinical oversight, fiscal accountability, and operational competence. We have identified potential sites, including the recently vacated clinic facility. We have local healthcare workers interested in local employment, eliminating the need to recruit and find housing for new hires. The biggest challenge we have faced is securing start-up funds. Through the Rural Health Transformation Plan, we seek funding to support the return of a locally owned and operated clinic, returning healthcare to those who live, work and recreate within the community. There are currently 5 PA’s, 4 RN’s, a Physical Therapist, multiple medical assistants and EMT 3’s, within our community that either are not employed, or work in larger communities out of necessity. Ironically, some of the local providers already see local community members at clinics located in Fairbanks, a minimum of 110 miles away. We seek to recruit and retain these qualified clinical staff, remodel potential clinic locations, outfit exam rooms, restore diagnostic capacity, stock critical supplies, and implement a sustainable rural healthcare delivery model that is governed locally and responsive to community need. We have a comprehensive outline for anticipate start-up costs, and operation costs for the first three years. These estimates are based on current costs and rates, for similar clinic operations.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough	Deferred or Not Advanced

Denali Insight LLC	Nenana Community Health & Wellness Strategic Planning Initiative	AK	Nenana is a rural Interior Alaska community of approximately 350 year-round residents, but functions as a regional service hub. During the academic year, the Nenana Student Living Center houses nearly 100 high school students from surrounding villages, significantly increasing the community’s service population. Nenana also supports neighboring Denali Borough communities through shared clinic access and mutual aid emergency response. In addition, an elder care facility serves residents who are no longer able to live independently, adding to the complexity of local health needs. Despite this interconnected service environment, Nenana does not have a formal health and wellness committee, updated community health assessment, or shared strategic framework guiding cross-sector collaboration. Health-related services are delivered by dedicated agencies but there is no structured mechanism to collectively identify community-wide priorities or measurable outcomes. This lack of coordination leads to fragmented approaches and limits the community’s ability to pursue funding in a unified, strategic manner. Without a shared understanding of strengths, service gaps, workforce needs, and prevention priorities, efforts may remain reactive rather than proactive. The opportunity is to conduct a structured, community-led assessment that results in a coordinated strategic direction and cross-sector steering committee to guide sustainable, aligned health investments	Denali Insight Consulting will conduct a Community Health & Wellness Needs and Readiness Assessment for Nenana to identify community-driven health priorities and develop a clear strategic direction for future health-related investments. The purpose of this project is to ensure that future initiatives, funding applications, and system improvements are aligned with needs identified directly by the community, relevant health organizations and supported by measurable, targeted outcomes. The project will be implemented in two integrated phases. Phase 1: Community Health & Wellness Needs and Readiness Assessment. This phase will include broad community engagement through multiple facilitated community meetings, stakeholder interviews, and a community survey. Engagement will intentionally target representation across age groups, service sectors, Tribal and non-Tribal partners, schools, EMS, behavioral health, elders, and families. Existing data sources will be reviewed to complement community voice. The assessment will evaluate current service strengths, access gaps, workforce considerations, prevention opportunities, and system readiness for future health investments. A written report will synthesize qualitative and quantitative findings and identify key themes, priority areas, and cross-sector opportunities. Phase 2: Strategic Direction and Steering Committee Development. Following the presentation of findings, Denali Insight will facilitate the formation of a Community Health & Wellness Steering Committee composed of representatives across Nenana’s health-related sectors. Through structured meetings, the committee will review findings, confirm shared priorities, and establish a strategic direction with defined focus areas, roles, and measurable outcomes for health related agencies in the community. Deliverables will include a final assessment report, summary presentation, and a strategic direction document outlining priority initiatives and recommended next steps to be distributed to health organizations. This approach ensures the assessment leads to coordinated action, targeted outcomes, and a sustainable, community-led framework for advancing health and wellness in Nenana.	Under \$50,000	Single Community	Yukon-Koyukuk Census Area	Advance to Planning

Denali Preschool and Learning Center	Strengthening Rural Early Childhood Health & Workforce Capacity in Denali	AK	Denali Preschool and Learning Center (DPLC) serves young children and families in the rural Denali Borough, where access to pediatric care, behavioral health services, and early intervention supports is limited. Early childhood educators are often among the first adults outside the home to observe developmental, behavioral, or emotional challenges in young children. However, many rural child care providers lack the training and resources needed to confidently respond to concerns such as trauma exposure, ADHD, developmental differences, and family stress. At the same time, the well-being of early childhood educators directly affects the quality and stability of care available to families. Rural early childhood staff frequently experience high stress and burnout, yet many programs lack the capacity to provide health or mental health supports for employees. This project will strengthen early childhood health outcomes by increasing staff training in trauma-informed care, developmental supports, and pediatric wellness while also improving workforce well-being through access to telehealth and mental health services. By building educator capacity and supporting workforce resilience, DPLC aims to create healthier early learning environments and stronger support systems for rural children and families.	Year 1 funding will strengthen the capacity of DPLC staff to support early childhood health and well-being through targeted training, workforce wellness supports, and the development of in-house expertise in early childhood health topics. First, DPLC will provide professional development focused on early childhood health and behavioral needs. Trainings will include trauma-informed care, strategies for supporting children with ADHD and other developmental differences, recognizing early behavioral health concerns, and working with families experiencing stress or adversity. These trainings will equip educators with practical tools to better support children in the classroom and to recognize when additional services or resources may be needed. DPLC will also identify and train one staff member to specialize in early childhood wellness and pediatric health topics. This individual will receive additional professional development and serve as an internal resource for the DPLC team, providing guidance, coordination of training, and support for staff and families. Over time, this role will expand to include offering informational sessions and community trainings focused on early childhood wellness and development. Over the five-year span of the Rural Health Transformation Program, DPLC plans to continue investing in this role through additional professional development opportunities. Second, the project will support the health and resilience of the early childhood workforce by expanding access to health and mental health services for staff. Through resources available from AllyHealth or a similar provider, DPLC can provide employees with affordable virtual medical and mental health care. In rural communities like ours, telehealth offers a practical solution where geographic distance and limited provider availability make in-person care difficult. DPLC will cover approximately \$30 per employee per month to provide access to virtual care and will offer wellness subsidies to help offset co-pays and other out-of-pocket expenses. Staff working more than 20 hours per week will receive a \$150 monthly subsidy, while staff working fewer than 20 hours will receive \$50 per month. Together, these strategies will strengthen workforce stability, expand educator capacity to support early childhood health needs, and improve the quality of care available to young children and families in the Denali Borough.	Under \$50,000	Multi- Community or Participating in Regional Hub-and- Spoke	Denali Borough	Deferred or Not Advanced

Department of Doing Good LLC	Culture-Driven, Tech-Enabled Recovery: Preventing Suicide and SUD among Alaska Native Youth	AK	1. A Sustained Behavioral Health Emergency in a Remote, High-Risk Region In the Northwest Arctic Borough, where approximately 83 percent of residents are AN, suicide occurs at a rate of 71.6 per 100,000 people, compared to the national average of 12.32 per 100,000. The region experiences suicide at nearly six times the U.S. rate. Alcohol and other substance use disorders are significantly elevated, alongside higher rates of depression, trauma exposure, and related mental health concerns. 2. Access to Preventive Intervention Limited in AN Villages Access to early intervention and preventative care remains limited. Some villages have no local support. Others rely on fly-in services or telehealth encounters that lack consistent, culturally grounded local support. Youth and families may wait months for care or never connect to services. The current health system is reactive, mobilizing resources at crisis points rather than building upstream supports that prevent escalation. 3. Reactive Systems and the Opportunity for Culturally Grounded Early Intervention For decades, mainstream behavioral health systems have focused on diagnosing and treating individual pathology with standardized clinical models. While clinical services are necessary, this approach often proves insufficient in AN contexts because it relies on Western diagnostic frameworks and locates “the problem” within the individual, rather than acknowledging historical, relational, spiritual, and systemic dimensions.	1. Culturally Grounded Digital Platform for AN Communities In collaboration with AN communities and technology partner Applichat, we will develop a culturally grounded digital Youth Recovery and Resilience Coaching web-based platform. The platform will be co-designed with Tribal partners to ensure cultural relevance, community ownership, and trust. Features will include culturally resonant language, traditional healing perspectives, and video messages from Elders, youth in recovery, Peer Support Specialists, and mentors that reinforce identity, belonging, and relational healing. The platform, promoted by a marketing campaign, will be designed for low-bandwidth environments common in rural Alaska, with offline access to core resources and the ability to expand into multiple AN languages over time. 2. Early Intervention Tools that Strengthen Resilience and Prevent Crisis The platform will provide daily check-ins, mood tracking, and culturally relevant prompts that support early behavioral health intervention. Users will receive supportive messaging, reminders about local cultural gatherings, and connections to community resources that reinforce connection to family, land, and tradition. Integrated crisis line access and direct referral pathways to local behavioral health providers will ensure users can receive immediate support when needed. By promoting early engagement and self-awareness, the platform helps shift behavioral health support upstream, reducing crisis-driven care and strengthening community-based prevention. 3. Community-Based Peer Workforce and Leadership Development The platform will connect youth and families with trained Peer Mentors and Recovery Coaches recruited from AN communities. These roles will provide culturally grounded support focused on mentorship, accountability, and connection rather than clinical treatment. Coaches will assist participants with goal setting, relapse prevention planning, life skills development, and navigation of local services. Peer workforce roles to create 5 Recovery Coaches, 3 Peer Mentors, and 2 Cultural Support Specialist positions, with clear leadership pathways from Coach to Lead Coach to Community Coordinator. Competitive salaries, mentorship, and ongoing professional development will strengthen workforce retention while expanding AN-led prevention and recovery support across communities. View year-one and complete five-year strategy summary here: https://culture-driven-recovery-gd5u0w8.gamma.site.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Dillingham Census Area; Nome Census Area; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Develop Medical Group LLC	Scaling Proactive Medicine to Cultivate Strong, Healthy, and Capable Alaskans	AK	Alaska faces rising chronic disease, declining physical and metabolic health, and growing strain on an already limited healthcare workforce. Many rural communities are experiencing population loss as families and professionals leave due to rising costs, limited resources, and fewer opportunities. Much of the healthcare system responds to disease after it develops, leaving limited time for prevention and lifestyle education and creating growing demand for more proactive, patient-centered care. These challenges are amplified in rural and remote communities, where access to reliable health information, whole foods, safe training environments, and preventive services is limited. Many Alaskans lack consistent support to build daily habits that protect long-term health and prevent chronic disease. This project expands access to Proactive Medicine—a prevention-focused model emphasizing early intervention, lifestyle habits, and measurable functional health. In addition to coaching, the practice provides medical evaluation, chronic disease management, and timely low-acuity care. This model complements primary care by reducing workforce strain and coordinating referrals when higher-acuity services are needed. Low-bandwidth telehealth, community-based training and nutrition education, and standardized outcomes tracking will demonstrate a scalable approach for Alaska.	This project builds on a physician-led Proactive Medicine practice that is launching services to serve Alaskans. Rural Health Transformation Program funding will allow the organization to expand its reach to rural and remote communities, strengthen community engagement, and increase the number of patients who can access this prevention-focused model. The project will scale low-bandwidth telehealth services so patients across Alaska can access prevention-focused medical care, chronic disease management, and ongoing coaching without frequent travel. This expansion will increase membership capacity and extend proactive care to patients with limited access to lifestyle-focused services. Funding will support key roles needed to expand access and engagement. Project support will include physician time dedicated to expanding clinical capacity and statewide outreach. An administrative assistant will improve patient onboarding, scheduling, and coordination. A content production contractor will develop culturally relevant health education and statewide outreach materials. A fitness coach contractor will support strength and conditioning workshops and asynchronous training and nutrition classes delivered through regional hub communities. Together, these efforts will expand Develop Medical Group’s reach, strengthen community engagement, and accelerate adoption of prevention-focused care across Alaska, providing a practical and sustainable pathway to improve access, support the healthcare workforce, and reduce long-term healthcare demand.	\$50,000-\$250,000	Family or primary care	Statewide	Anchorage (Municipality); Bethel Census Area; Nome Census Area; North Slope Borough	Deferred or Not Advanced

Diametrics.ai	Access, Workforce, Innovation, Creating healthy & Self-Sustaining patients, Alaskans & Hospitals	FL	Alaska’s twenty-nine boroughs and communities are at a critical state facing poor medical and financial outcomes, including potential hospital closures, workforce shortages and rising rates of chronic metabolic disease progression. This, coupled with, geographic isolation, poor medical access, negative financial outcomes and higher costs, provides a reactive-based model for critical access hospitals and rural clinics to attempt to manage both the physical and fiscal problems it faces. Diametrics.ai (“truth engine”) creates sustainable opportunities using a proactive approach, a RaaS model, in which it showcases multiple customizable spokes to enhance care that reaches further geographically, strengthens and sustains the rural clinical workforce, creates rural health infrastructure and tech, drives structural efficiency, empowers the community providers, and provides advance innovative care models and payment reform. This grant, combined with our platform, is a one-time chance for Alaska’s hospitals and rural clinics to embrace the overall transformation from a reactive to a proactive financially sustainable model. A focus on the chronically ill patients, by improving their metabolic health will show significant healthcare savings over a twelve-month period and longer.	Diametrics.ai’s proven clinical interventions with a patent-pending analytics platform to address the root causes of chronic disease while strengthening the financial stability of rural providers. Our hub and spoke model includes a variety of spokes that can be easily customizable to fit the needs of each Alaskan community. Below are example spokes Diametrics.ai. Lined up beyond these are an additional 25+ partners to provide the medical and financial protocols to move Alaskan healthcare to self-sustaining status for years to come. Diametrics.ai Platform – A HIPAA-compliant Results as a Service (RaaS) system, repurposed from its original design to now supporting Critical Access Hospitals and rural health systems. Diametrics.ai integrates predictive analytics, outcome tracking, and cost-savings modeling, quantifies treatment impact in real time, and provides transparent, population-level reporting. By unifying the perspectives of patients, providers, and payers, it ensures measurable, scalable, and sustainable results. Restorvia – A core evidence-based protocol, directly addressing insulin resistance, the driver of metabolic syndrome. Restorvia’s IRT3 has demonstrated proven results for both reversal and improvement in Type 2 diabetes, hypertension, cardiovascular disease, and neuropathy. IRT3 reduces costly complications, ensuring hospital solvency. Workforce – With the anticipated collaboration with the Recruitment Squad, knowledgeable medical staff will be recruited and hired. This workforce opportunity for positions would welcome all Tribal organization members. Exosome Regenerative Health Program: A clinic-based regenerative medicine service that enhances wound healing, organ repair, and soft-tissue recovery while expanding reimbursable specialty service lines. BioMech Health– A Remote Kinematic Motion 3D Advanced Balance and Gait Program, funded by the Center for Medicare & Medicaid Services, and developed by Dr. Frank Fornari. Remote kinematic motion sensors and analytics prevent falls, which can avoid future hospitalizations. RESTORE Program– A supportive education, lifestyle curriculum that empowers patients to sustain long-term health improvements, while strengthening workforce capacity through clinician training and patient engagement tools. RESTORE aligns with workforce development by training clinicians in lifestyle medicine and technology. Medically Tailored Meal Service – Upon request, access to medically tailored needs will be accessible.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Dillingham City School District	Healthy Students, Strong Futures: Expanding school-based health services in Dillingham	AK	Chronic health issues are impacting the Dillingham community. 38% of adults are obese, and 13% are living with diabetes. Teen suicide rates in rural Alaska are among the highest in the nation. Healthy communities begin with healthy children. Students in the Dillingham City School District face persistent barriers to timely and preventive healthcare due to geographic isolation, transportation challenges, and limited healthcare workforce capacity in rural Southwest Alaska. These barriers can delay the early identification and treatment of common childhood health concerns such as chronic conditions, developmental delays, behavioral health needs, and preventable illnesses. At the same time, the district has limited capacity to consistently deliver basic health instruction aligned with Alaska’s health education standards, leaving many students without regular access to foundational education on nutrition, physical activity, personal health, and disease prevention. Without both preventive care and health education, students are more vulnerable to avoidable health challenges that impact attendance, learning, and long-term wellbeing. 1. Centers for Disease Control, PLACES Interactive data. https://experience.arcgis.com/experience/22c7182a162d45788dd52a2362f8ed65	The Dillingham City School District proposes to establish a comprehensive school-based health support model centered on a dedicated school nurse position. This initiative will address gaps in healthcare access, preventive services, and health education for students in a rural, geographically isolated community. By embedding healthcare access and prevention within the school environment, the project will improve early identification of health needs, increase health literacy among students, and strengthen coordination between schools, families, and healthcare providers. The proposed approach supports the Rural Health Transformation Program initiatives of Healthy Beginnings, Health Care Access, and Healthy Communities by focusing on prevention, early intervention, and sustainable systems of care for rural youth. School-based health models are widely recognized as effective strategies for improving access to preventive care and early intervention, particularly in rural communities. By locating services where students already spend a significant portion of their time, schools reduce barriers associated with travel, scheduling, and healthcare system navigation. The school nurse will provide accessible, on-site health services during the school day. These services will allow students to receive timely assessment and care for minor illnesses and injuries without leaving the school environment. Providing basic health services on-site reduces disruptions to learning while ensuring that health concerns are addressed promptly. A second key component of the project is the implementation of routine preventive screenings and support for chronic disease management. Preventive screenings help identify health concerns that may otherwise go undetected, particularly in communities where access to routine healthcare visits may be limited. In addition to providing direct health services, the school nurse will support the delivery of health education aligned with Alaska’s health education standards. Strengthening health education is an important component of building healthier communities and promoting lifelong healthy behaviors. The nurse may support classroom instruction, provide age-appropriate health presentations, and collaborate with teachers to integrate health topics into existing learning activities. By introducing prevention-focused health education early, students gain the knowledge and skills necessary to make healthier choices throughout their lives.	\$50,000-\$250,000	Single Community	Dillingham Census Area	Deferred or Not Advanced

Disability Law Center of Alaska	Disability Access and Advocacy in Rural Alaska	AK	According to a 2025 Alaska BRFSS report, one in three Alaskans report living with a disability, which includes physical, cognitive, and behavioral health conditions. Alaskans with disabilities who live in rural locations can face challenges to receiving care, including access to and availability of treatment, care facilities, and care providers. The potential of the RHTP to create a significant expansion of health infrastructure and services into rural Alaska is a welcome development. However, as the RHTP is implemented, there will be a critical need to ensure its implementation takes place in a manner that is consistent with the consideration and protection of the rights of individuals with disabilities. This need is especially important for facilities that are licensed to provide services to individuals who are under involuntary commitment or in assisted living facilities who have an unfortunate history of facing instances of abuse, neglect, and rights violations by the institutions that are supposed to be caring for them. Given the time frame and unique logistical challenges that are presented by this major expansion of rural health service in our state, we propose to address this need by providing training, advocacy, and monitoring services to ensure that rural healthcare facilities and care providers have appropriate knowledge, policies, and training in place to protect the state and federal constitutional rights of individuals with disabilities.	The Disability Law Center of Alaska (DLC) is an independent non-profit law firm providing legal advocacy for people with disabilities throughout Alaska. Our mission is to provide protection and advocacy for Alaskans with disabilities through legal representation, education, and strategic advocacy to ensure their civil rights are protected. In 1977, DLC was designated by the Governor of our state as the official (and only) federally funded, Protection and Advocacy (P&A) agency for the state of Alaska. This designation gives us the legal authority to gain access to records and facilities as necessary to investigate complaints and reports of abuse or neglect, or to monitor the treatment and safety of residents and patients with disabilities. Our approach to protecting the rights of Alaskans with disabilities during the implementation of the RHTP is to provide training, advocacy and program/facility monitoring in rural Alaskan communities and to providers who plan to offer services in those communities. To achieve this goal, our project concept includes the following components: Outreach and Training for rural individuals with disabilities - DLC will make presentations and distribute educational materials on resident and patient rights at in-patient facilities and group homes in order to increase individuals’ understanding of their civil rights when living in congregate and clinical settings. Training and Technical Assistance for Families, Care Providers, and Health Care Professionals - DLC will provide education and information to family members, care providers, advocates, and facility staff and administrators around the state, assisting them to understand areas of the law related to disability rights relevant to RHTP implementation. Training will include sessions for facility staff and administrators as they review practices related to the care of individuals with disabilities. Monitoring Activities - DLC will travel to rural communities throughout the state to monitor health facilities that serve individuals with disabilities, including behavioral and other in-patient facilities and dual-licensed assisted living homes. The goal of monitoring will be to determine if facility infrastructure, policies, and practices comply with state and federal disability laws, that facilities are providing reasonable accommodations to individuals seeking services, and that facilities are not neglecting the health, safety, and rights of individuals with disabilities.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Discovery Southeast	Expanding children's outdoor opportunities for fitness and wellness	AK	The problem is a growing disconnect with the natural world, which negatively impacts our bodies and minds. Studies show, for example, that children spend averages as high as 8 hours a day viewing digital screens. This brings more indoor, sedentary lifestyles that are detached from the world around us, as well as detached from the traditions that allow Alaskan communities to thrive. With decreasing connections to the natural world, bodies are not nourished with natural foods or enriched with physical activity. Children have increased vision problems, lower vitamin D values, poorer immune systems, and worse sleep. Reduced fitness levels are tied to lower cardiovascular fitness, weaker muscle development, and higher rates of obesity. Perhaps even greater are the impacts on children's mental wellness, where we see increasing anxiety and depression, and decreasing resilience and attention - the latter of which often manifests in ADHD-related symptoms. Language and social development lags for children with less face-to-face interaction, children and adults experience greater isolation, and their problem solving and self-regulation functions are decreased when compared with children who experience more unstructured outdoor play. The opportunity is that we have awareness of this issue, in a place where cultures and traditions value outdoor connections. Discovery Southeast reliably provides local, outdoor place-based nature education, and is well positioned to expand it.	For almost 40 years we have provided nature education, predominately for elementary-age children, but including preschoolers to adults. Over the last decade - and particularly since the pandemic - the wellness benefits have been increasingly evident and important. This proposal will expand outdoor wellness and fitness region-wide. Everyday in our outdoor programs we watch children become more sure in themselves. We see them develop confidence and resilience, and reconnect to their bodies and nervous systems. We see them develop patience to sit at the base of a tree and map the sounds around them or sketch the veins in a devils club leaf. We watch then collaborate and problem solve to build a shelter or navigate a shore. And we watch them hike up a hillside happily, and come down tired. Learning like this has been fundamentally entwined with human development for tens of thousands of years, and has a formative, profound impact on wellbeing and cognition. This RHTP opportunity is a catalyst to improve and expand our outdoor programs in Southeast. We'll serve a broad age range from preschool to middle school, we'll ensure lessons are culturally and geographically relevant, and we'll expand the regional reach to the remote and rural communities in Southeast. This improved and expanded outdoor programming will benefit mental wellness and physical fitness of children and families, in ways deeply relevant for Southeast communities. In preschool, we'll develop our pilot outdoor preschool to be meaningful and replicable, so it can be used by every local preschool and care provider. We'll expand our own offerings, as well as provide outreach to local preschools and centers, and training and content for providers across the region in order to increase the quality and availability of preschool. We will expand our gardening program similarly, obviously bringing wellness benefits from meaningful time outdoors, but also orienting children and families to healthy foods. Finally our emerging middle school programs and extant elementary school programs will benefit from increased wellness components and culturally relevant themes. These improvements make stronger outdoor programs that are better situated for regional expansion. We will follow that through with enhanced outreach, regional collaboration, and professional development opportunities. Ultimately we intend to strengthen and expand our outdoor education programs in ways children region-wide benefit.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough)	Deferred or Not Advanced

District 49A Lions Foundation	District 49A Lions Sight Committee - bridging the eye care gap for Alaskans	AK	Healthcare in Alaska is broken. We are 31st state in avoiding care due to cost. Only six states have a higher percentage of uninsured residents. The US Institute of Medicine issued several reports in the early 2000s concluding that being uninsured is seriously hazardous to American health outcomes. A more recent (2014–2018) Commonwealth Fund survey discovered almost half of underinsured adults report medical bill and debt problems and 41% delay necessary care because of costs. For children, 80% of their overall learning is through sight. Parents who cannot afford eyecare for their child may not be aware of the vision issues that may exist. Specifically about eyecare, there is no sliding fee scale eye clinic in the entire state. Rotary International and Lions Club organizations are frequently approached by people who are uninsured or cannot afford copays for eye examinations, cataract surgeries, and corneal transplants. As of 2025, there no pro-bono surgical eye services for such procedures in the state. For example, one Homer teenager in Nov 2025 petitioned for a corneal procedure from multiple nonprofits to raise \$14,000 for it, as insurance did not cover the full amount. Only one eye clinic is involved with Project Access Alaska, and limits care to eight pro-bono, nonsurgical exams a year which is woefully inadequate. This is an opportunity for creating a resource to bridge that gap until a federally qualified health clinic adopts eyecare as a service.	The goal of the Lions Club 49A Vision Committee is directed toward Alaskans who: 1. Are “insured” yet cannot afford to access eyecare services because of high deductibles/copays. 2. Do not have vision insurance because their medical insurance does not provide for it. Our approach is to fund a preexisting committee of a charitable volunteer nonprofit. This Vision Committee (VC) is filled with community members of the local Lions Club chapters of Alaska. These members review requests for aid with consideration of insurance coverage, income and service type. The VC then determines whether to provide resources for their particular contextual need or assistance with funding for the purpose of vision care. Our unique model is the Alaskan premise of neighbors helping neighbors. It completely removes the barriers that stop so many Alaskans from accessing care: cost, and lack of knowledge. By addressing the acute need for vision services and treat issues promptly, we can improve health outcomes for hundreds of our friends, families, and neighbors, and improve the workforce who can resume reading and driving in their daily tasks. This also helps the children who cannot see their schoolwork so they can continue their education in whole.	\$50,000-\$250,000		Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Dillingham Census Area; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kuskilvak Census Area; Matanuska-Susitna Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality)	Deferred or Not Advanced
DMeyeCare, LLC	AI assisted retinal photos for diabetic patients within primary care offices	MT	In 2017, the CDC reported that only 47% of the Alaskan population was receiving a diabetic exam under medicare (https://www.cdc.gov/mmwr/volumes/68/wr/mm6845a3.htm#T1_down). My goal is to improve access and quality metrics by providing a fully autonomous retinal camera with AI driven retinopathy reports (FDA approved) in primary care offices and/or IHS facilities to increase the amount of diabetic patients getting retinopathy screenings.	I currently work at a community health center in Montana, and even with an eye care provider within the clinic we don't meet the target of 80%. There is a gap in care and my goal is to close that gap by workflow changes. I would like to place the camera right next to height, weight, vital station so within 1 minute the diabetic screening is accomplished. Any CNA, MA, nurse, or front reception can run this machine because it is a push of a button.	\$250K-\$1M	Specialist	Statewide	Bethel Census Area; Dillingham Census Area; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kuskilvak Census Area; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Docket Health, Inc.	Consumer Access to Preventive Health Data Using Docket	CT	Alaska has made progress in providing consumer access to immunization records through VacTrAK integration. However, many other preventive and early-detection results from public health programs remain difficult for rural families to obtain after testing is complete. These include newborn screenings, hearing tests, blood lead testing, and tuberculosis (TB) testing records. Rural and frontier communities face additional barriers, including workforce shortages, long travel distances, and fragmented documentation processes. Families may relocate between boroughs or transition between tribal and non-tribal providers, increasing the risk of delayed follow-up. Alaska’s Rural Health Transformation priorities emphasize Healthy Beginnings, Health Care Access, Strengthen Workforce, Pay for Value, and Spark Technology & Innovation. Expanding secure consumer access to verified preventive public health data directly builds on existing immunization infrastructure and represents a foundational step toward the broader modernization of rural preventive health systems.	Docket Health will lead a phased initiative to expand secure consumer access to selected preventive public health data domains held by the Alaska Department of Health. Alaska’s Health Information Exchange, healthEconnect Alaska, supports provider-to-provider exchange and public health reporting, including immunization registry exchange, electronic laboratory reporting, syndromic surveillance, cancer registry submissions, and behavioral health reporting through the Alaska Automated Information Management System (AKAIMS). This initiative complements those capabilities by extending verified public health data access directly to consumers. Phase 1 will focus on governance coordination with the Alaska Department of Health and alignment discussions with healthEconnect Alaska to ensure architectural consistency and policy alignment. Phase 2 will support secure integration, development, and deployment of consumer access workflows for: • Blood lead test results • Newborn bloodspot screening • Newborn hearing screening • Tuberculosis (TB) testing records This expansion builds directly on Docket’s existing VacTrAK integration in Alaska and leverages Docket’s demonstrated experience implementing statewide access to blood lead results in New Jersey. Phase 3 will focus on rural onboarding, communications, performance monitoring, and stabilization. Future expansion of additional preventive domains supported through HIE reporting channels may be evaluated in coordination with the Alaska Department of Health and healthEconnect Alaska, where legally permissible and aligned with state priorities. Where appropriate, SMART Health Links standards may be leveraged to enable secure, portable sharing of verified preventive records between families and authorized providers. This coordinated approach advances Healthy Beginnings, expands Health Care Access, strengthens Workforce capacity by reducing manual record retrieval burden, supports Pay for Value through earlier intervention, and advances Spark Technology & Innovation in alignment with Alaska’s Rural Health Transformation goals.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Docket Health, Inc.	Modernizing Alaska’s Annual School Immunization Reporting Infrastructure	CT	Rural and frontier communities face unique barriers to preventive health infrastructure, including limited workforce capacity, long travel distances, and inconsistent administrative support. Alaska’s school-based immunization compliance processes remain labor-intensive and inconsistent across districts, particularly in rural and frontier communities where staffing is constrained. School nurses must manually calculate grade-based compliance, reconcile documentation with VacTrAK, manage exemptions and enrollment conditions, and submit required reports during designated reporting windows. These processes vary across districts and rely heavily on manual interpretation of state requirements. This burden reduces the availability of school health personnel to provide direct student services and coordinate preventive care. In smaller rural districts, where a single nurse may support multiple schools, these demands place disproportionate strain and increase the risk of inconsistent tracking of compliance. Parents also often lack streamlined access to verified immunization records, leading to delays and duplicative documentation requests. There is a significant opportunity to modernize this infrastructure by expanding a proven, secure, IIS-integrated platform that automates compliance validation, improves parent access, enhances transparency in statewide reporting, and strengthens the sustainability of school-based preventive health oversight across Alaska.	This initiative will expand Docket for Schools statewide to modernize school-based immunization compliance workflows, aligned with Alaska’s Rural Health Transformation priorities, including Healthy Beginnings, Health Care Access, Strengthen Workforce, Pay for Value: Fiscal Sustainability, and Spark Technology & Innovation. The project team will prioritize early engagement with tribal community partners. Docket for Schools replaces manual reconciliation with automated validation tools that integrate directly with Alaska’s Immunization Information System (VacTrAK). The platform: • Automatically calculates immunization compliance using current state rules • Supports bulk roster uploads and structured exemption documentation • Applies enrollment conditions, including grace periods and other state-defined criteria • Generates multilingual parental follow-up letters with QR codes linking families directly to verified digital immunization records through the Docket consumer application • Automates CDC and state reporting requirements • Provides real-time dashboards enabling Alaska Department of Health staff to monitor trends by school, region, grade level, and immunization series Docket is live in production across multiple states and has onboarded over 150,000 students across more than 700 schools in Maine alone. Docket is under contract with 11 public health agencies nationally and has enabled access to more than 3.5 million IIS records through its consumer application, demonstrating both scale and adoption. The platform is designed to protect stability and support rural scale. Bulk school queries are processed asynchronously via a prioritized queue architecture to prevent disruption to consumer access. The system operates in read-only mode and does not write data back to IIS, minimizing technical risk. Security posture includes SOC 2 compliance, annual audits across security and privacy controls, third-party penetration testing, allow-listed email domains, and strict role-based access controls. A 24-month phased implementation will ensure disciplined statewide rollout. Phase 1 will focus on governance coordination and initial district onboarding. Phase 2 will prioritize rural and frontier expansion, training delivery, and performance monitoring. Phase 3 will focus on statewide stabilization and transition to low-cost, steady-state operations.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Dot Lake Village Council	TeeJuh Behavioral Health	AK	This project will strengthen early intervention, stabilize individuals and families, and build a sustainable rural behavioral health workforce. Rural residents in the Upper Tanana region face significant barriers to behavioral health care, including geographic isolation, limited local providers, high travel costs, and long wait times for services in urban centers. These gaps contribute to untreated trauma, substance misuse, domestic violence, and justice system involvement. TeeJuh Behavioral Health will address this disparity by expanding culturally grounded, community-based behavioral health services that integrate trauma-informed care, telehealth access, peer support, and coordination with Tribal justice and victim services	TeeJuh Behavioral Health will continue and expand our services through a culturally grounded, community-based behavioral health model designed specifically for rural and frontier Alaska. Our approach integrates early intervention, trauma-informed clinical care, peer support, and coordinated justice partnerships to address the root causes of instability and justice involvement. First, we will expand local access to services and implement new services to fill gaps in the existing Alaska health care system. These services will include individual and family counseling, substance misuse screening and intervention, domestic violence-related behavioral health support, and crisis response. By addressing unmet needs locally, residents can receive consistent care without prolonged delays or unnecessary travel. Second, we will embed culturally responsive practices into all services. Programming will incorporate Alaska Native values, Elder involvement, identity-strengthening activities, and land-based healing opportunities. This approach reinforces protective factors such as belonging, cultural connection, and intergenerational support, which are critical to long-term wellness in rural communities. Third, we will strengthen coordination with the Tribal Court, Sexual Assault Response Team, and local law enforcement to create clear referral pathways for survivors and justice-involved individuals. Integrated case management will ensure that clients receive behavioral health services alongside advocacy, safety planning, and accountability measures. Finally, we will build sustainability by training and mentoring local residents into behavioral health, peer support, and case management roles. Developing a local workforce reduces reliance on itinerant providers and increases long-term service stability. By aligning services with Medicaid reimbursement pathways and Tribal partnerships, TeeJuh will create a scalable and sustainable rural behavioral health infrastructure.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Fairbanks North Star Borough	Deferred or Not Advanced

Dr. Amy LLC	Expanding Rural Behavioral Health Capacity Through Trauma-Responsive Workforce Training	OR	Rural communities face persistent barriers to behavioral health access, including workforce shortages, long wait times, transportation challenges, and limited access to preventive and early intervention supports. These challenges are especially significant for children, caregivers, and the professionals who serve them. In many rural communities, families most often interact with trusted frontline providers such as pediatric teams, early childhood staff, family support workers, educators, and community-based professionals who want to help but may not have practical training in trauma-responsive care or brief behavioral health interventions. This project addresses that gap by strengthening the capacity of the existing rural workforce to respond earlier and more effectively. The opportunity is to expand access to meaningful behavioral health support by equipping professionals already embedded in local communities with practical, relational, and trauma-responsive tools they can use in everyday interactions. This approach helps rural communities build local capacity, improve family experience, and create broader system resilience without depending solely on hard-to-recruit specialty providers.	This project aligns with Alaska’s Rural Health Transformation Program priorities—particularly the Strengthen Workforce, Healthy Communities, and Healthy Beginnings initiatives—by expanding the capacity of the rural workforce to provide early behavioral health support for children and families. Dr. Amy King, LLC proposes a workforce development approach that strengthens behavioral health capacity across child- and family-serving systems in rural Alaska, improving access to support in communities where licensed behavioral health providers are limited. The project would provide trauma-responsive, relational health, and brief intervention training for professionals working in settings such as health care, behavioral health, early childhood, education, family support, and community-based services. The training model is designed to be practical, accessible, and immediately applicable in everyday work with children and families. Core activities may include direct training for frontline staff and supervisors, implementation support to help organizations apply the practices, and development of internal champions or train-the-trainer pathways to expand reach over time. Participants would build skills in understanding social-emotional development, recognizing the impact of stress and trauma, supporting regulation and felt safety, and using relational strategies that strengthen family engagement and resilience. Training will be delivered in partnership with Alaska organizations and adapted to reflect the cultural context of Alaska Native communities and rural service systems. The project is intentionally flexible so it can be adapted to local contexts while maintaining a focus on practical workforce tools. Rather than creating a new siloed service, the approach builds capacity within systems already serving rural families. This increases the availability of behavioral health support in trusted community settings and embeds these practices into workforce development, supervision, and daily service delivery, serving a workforce multiplier for rural Alaska. Rather than relying on expanding the limited number of licensed behavioral health providers, we will strengthen the skills of the broader workforce already interacting with children and families. By equipping frontline providers with practical relational and brief behavioral health tools, the project expands early support capacity in rural communities, allowing specialized providers to focus on highest-acuity needs.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

DRKUMO INC	Digital Health for Alaska Rural Health Transformation Program	CA	Rural Alaskans experience limited access to healthcare due to provider shortages and geographic challenges, leading to fragmented chronic disease management. This lack of continuous oversight results in preventable acute medical crises and high costs associated with emergency transport.	DrKumo will implement an end-to-end RPM program for 5,000 rural patients with hypertension, diabetes, or heart failure. Using our URAC-accredited, FIPS-compliant technology, local community health teams can monitor vitals "anytime and anywhere," with AI-driven analytics prioritizing high-risk alerts for immediate clinical review.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Dub Diversified LLC dba Looped Solutions	ARISE: Alaska Response Initiative for Safety and Empowerment	PA	Alaska consistently ranks among the highest states in the nation for rates of lethal violence against women, with Alaska Native women experiencing disproportionately high rates of violence across the state, including in many rural and Tribal communities. In rural and remote regions, geographic isolation, constrained specialty services, workforce shortages, and fragmented cross-sector coordination intensify the health system burden associated with domestic and intimate partner violence. Violence contributes to behavioral health destabilization, emergency department utilization, and long-term trauma exposure among children and families. Yet rural health systems often lack standardized, culturally responsive coordination pathways to support early identification and safe referral across clinics, Tribal health organizations, shelters, and law enforcement. ARISE, led by Looped Solutions in partnership with Alaska-based partner iEXIST, LLC, the Gabby Petito Foundation, and McKinley Research Group, will develop an Alaska-specific integration framework and implementation roadmap designed to strengthen how rural systems identify, coordinate, and respond to domestic and intimate partner violence. By engaging diverse rural contexts during the planning phase, the project will produce a community-informed model that improves referral coordination, reduces fragmentation, and builds the operational readiness necessary for responsible future implementation.	ARISE will operate as a structured planning initiative designed to assess current response systems, identify integration opportunities, and develop implementation-ready planning outputs that strengthen coordination across existing health, Tribal, and community response systems addressing domestic and intimate partner violence in rural Alaska. The project will be organized into four primary phases during the Year One planning period. Phase 1: Project Initiation and Partner Coordination The project team will finalize partner roles, establish communication structures, and confirm engagement strategies with participating communities and stakeholders. Early coordination with Alaska-based partners will guide regional context considerations and help identify appropriate rural engagement approaches. Phase 2: Stakeholder Engagement and System Assessment Structured engagement will be conducted across selected rural contexts, including listening sessions, interviews, and cross-sector discussions with health providers, behavioral health organizations, Tribal health representatives, shelter leaders, law enforcement partners, and individuals with lived experience. Engagement will focus on identifying current screening practices, referral pathways, coordination gaps, and safety considerations. Phase 3: Analysis and Framework Development Findings from stakeholder engagement and regional analysis will inform the development of an Alaska-specific coordination framework. This phase will also evaluate how technology-supported safety tools can responsibly align with existing rural systems while respecting governance considerations, confidentiality protections, and cultural context. Phase 4: Planning Outputs and Implementation Roadmap The final phase will translate engagement findings into implementation-ready planning outputs. Deliverables will include cross-sector coordination guidance, rural screening and referral pathway recommendations, governance considerations, digital safety standards, and a phased implementation roadmap designed to support future adoption by participating partners. Throughout the planning period, Alaska-based partners will guide community engagement and contextual considerations to ensure the resulting framework reflects the needs and realities of rural communities.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Kusilvak Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced

Eagle River Missionary Baptist Church	Emergency preparedness, for health and wellness development of a Hope Center for Change.	AK	Beyond emergency preparedness, ERMBC is pursuing a long-term vision to transform our campus into a hub for community health and wellness through the development of a Hope Center for Change. Situated on available church-owned land, this future multi-purpose facility would support: Health education and emergency preparedness training Cooking and nutrition classes Youth life-skills education for independent living Community-based wellness and prevention initiatives	ERMBC is committed to responsible implementation and sustainability. Our plan includes: Designated leadership oversight for health and safety initiatives, CPR/AED training or awareness for church leaders and volunteers, and clear emergency response protocols. Coordination with local emergency responders, when possible, to offer training for low-income individuals and other groups in the community. Ongoing maintenance and accessibility of equipment. Our church leadership and congregation are unified in support of this effort and prepared to partner with organizations committed to strengthening rural health outcomes.	Under \$50,000		Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area	Deferred or Not Advanced
Eastern Aleutian Tribes, Inc.	Aleutian Peninsula Regional EMS & Remote Patient Monitoring Program	AK	Communities along the Aleutian Peninsula face persistent gaps in emergency medical response and preventative health monitoring. Many communities rely on volunteer responders with limited resources and inconsistent coverage. When emergencies occur, the local clinic becomes the response center, contributing to provider burnout and delayed care. At the same time, rural Alaska experiences high rates of chronic disease, behavioral health crises, and substance use disorders. Many of these emergencies could be prevented if changes in patient health were detected earlier. Advances in wearable health monitoring technology now allow rural clinicians and paramedics to monitor patient health remotely. Devices such as the BioButton wearable monitor provide continuous vital sign tracking that can detect early signs of infection, respiratory illness, cardiac stress, or other health changes. This project combines regional EMS deployment, community paramedicine, and wearable remote monitoring technology to create a proactive health safety system for the Aleutian Peninsula. Rather than only responding to emergencies, the program will allow clinicians to identify early health changes and intervene before emergencies occur.	The proposed project will establish a technology-enabled regional EMS system serving communities across the Aleutian Peninsula. Key components include: 1. Regional Paramedic Deployment Paramedics will rotate into communities using a 30-days-on / 30-days-off staffing model. During their off rotation, paramedics will maintain employment in Anchorage partner EMS systems, ensuring workforce sustainability and clinical skill retention. 2. BioButton Remote Patient Monitoring High-risk residents will be offered BioButton wearable monitoring devices that continuously measure: • Skin temperature • Heart rate • Respiratory rate • Activity and recovery patterns These devices allow clinicians and paramedics to monitor health remotely and detect early signs of infection, respiratory illness, cardiac stress, or medical deterioration. Paramedics will use this data to proactively conduct home visits and clinical check-ins before emergencies occur. 3. Community Paramedicine Paramedics will provide additional services including: • Chronic disease monitoring • Behavioral health stabilization support • Post-hospital follow-up care	Over \$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality)	Advance to Implementation Application

- Medication compliance checks
- Preventive health monitoring using wearable data

4. Regional EMS Training Center

A regional training hub will support:

- EMT and paramedic training for rural residents
- Continuing education for volunteer EMS responders
- Simulation-based emergency training
- Telemedicine integration with hospitals

5. Integrated Emergency Response Network

The program will coordinate with:

- Tribal health clinics
- EMS departments
- Regional hospitals
- Medevac providers

This integrated system combines emergency response, preventative care, and remote monitoring technology to transform rural health care delivery. This would be done in stages with EAT service area communities first, then increasing to other communities until the Aleutian Peninsula is covered by trained EMs program.

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: The EAT Hypertension/Tobacco Reduction Initiative	AK	Hypertension and tobacco dependency are two of the most significant contributors to preventable illness in rural Alaska. These conditions frequently occur together and dramatically increase the risk of cardiovascular disease, stroke, and other chronic health complications. In the Eastern Aleutian Tribes region, nearly half of individuals with hypertension are also tobacco dependent. Managing these conditions is particularly difficult in remote communities where geographic isolation, workforce shortages, and limited access to ongoing monitoring prevent consistent care. Eastern Aleutian Tribes approaches this challenge through its definition of health as the well-functioning of a living human being, recognizing that long-term health requires proactive monitoring, lifestyle support, and early intervention. Recent advances in wearable health technology provide new opportunities to transform rural health care delivery. Devices such as the BioButton wearable monitor allow clinicians to monitor physiologic indicators remotely and identify early signs of illness or stress before a medical emergency occurs. This project integrates wearable monitoring technology with hypertension management and tobacco cessation programs to support the well-functioning of individuals while advancing the State’s goal of Healthier Alaskans.	This initiative will implement a technology-enabled chronic disease management program focused on reducing hypertension and tobacco dependency while improving the well-functioning of individuals and communities. Key program components include: 1. BioButton Wearable Monitoring Participants will be offered BioButton wearable monitoring devices that continuously track physiologic indicators including heart rate, respiratory rate, temperature, and activity levels. These devices allow clinicians to monitor health remotely and detect early physiologic changes that may indicate worsening hypertension, illness, or stress related to tobacco withdrawal. 2. Hypertension Management Participants will receive enhanced hypertension care including: • Blood pressure monitoring • Medication management support • Nutritional counseling • Physical activity promotion • Lifestyle coaching These services support improved cardiovascular health and long-term well-functioning. 3. Tobacco Reduction and Cessation Individuals who use tobacco will receive targeted cessation support including: • Nicotine replacement therapies • Behavioral counseling • Peer support resources • Relapse prevention support Reducing tobacco dependency significantly improves long-term health outcomes and supports the well-functioning of individuals. 4. Care Coordination RN case managers, primary care clinicians, and behavioral health providers will coordinate care plans using both wearable monitoring data and clinical assessments. This integrated approach helps individuals maintain better health and supports the broader goal of Healthier Alaskans.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality)	Advance to Implementation Application

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Nelson Lagoon Community Wellness Center	AK	Many rural communities lack accessible infrastructure that supports regular physical activity. Limited access to indoor recreational facilities can contribute to sedentary lifestyles, increased risk of chronic disease, and fewer opportunities for youth engagement. In communities such as Nelson Lagoon, weather conditions often make outdoor activity difficult for extended periods of the year. Without indoor spaces for physical activity, residents may struggle to maintain healthy routines. At the same time, unused public facilities such as the former school building represent an opportunity to create valuable community health infrastructure. Repurposing the former school building into a wellness and fitness center would create a centralized space for physical activity, youth programs, and community events that promote both physical and mental wellness. Investing in community wellness infrastructure supports healthier lifestyles and strengthens community resilience.	Eastern Aleutian Tribes will collaborate with local partners to convert the former Nelson Lagoon school building into a community wellness center and gymnasium. Facility Renovation The project will renovate and adapt the existing structure to support safe indoor recreation and wellness activities. Potential improvements may include: • Gym flooring and activity space improvements • Fitness equipment installation • Lighting and electrical upgrades • Heating and ventilation improvements • Safety and accessibility upgrades • Storage areas for sports and activity equipment Fitness and Recreation Programming The facility will support a variety of wellness-focused activities, including: • Community fitness classes • Youth sports and recreation programs • Indoor walking and exercise opportunities • Wellness education activities • Community gatherings focused on health and wellness Youth and Community Engagement The wellness center will provide a positive gathering space for youth and families, encouraging healthy activities and strengthening social connections within the community.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Advance to Implementation Application

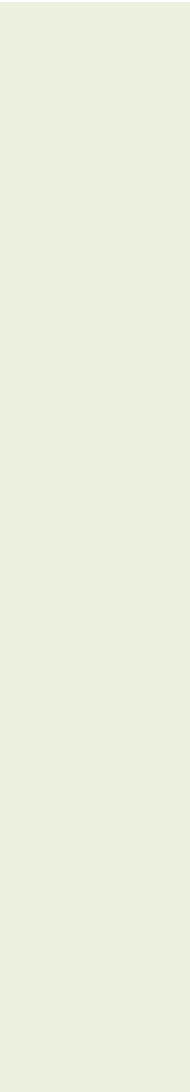
Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Portable Digital X-Ray Access for Nelson Lagoon	AK	Rural clinics often face challenges related to limited diagnostic capabilities. In communities without imaging equipment, providers must rely on clinical judgment alone or arrange travel to another facility for imaging. This approach can lead to unnecessary travel, delayed diagnosis, and increased costs for both patients and the health system. In remote Alaska communities, travel for medical services frequently involves charter flights or complex transportation arrangements. Eastern Aleutian Tribes has already deployed Fuji portable digital X-ray systems at other clinic sites across the region, and these systems have significantly improved patient care by allowing clinicians to diagnose injuries and illnesses locally. These systems have also reduced unnecessary travel and associated medical transportation costs by enabling providers to rule out conditions that would otherwise require referral. Nelson Lagoon remains the only clinic site without this capability. Providing portable digital X-ray access will close this gap and ensure equitable access to diagnostic services across the region.	Eastern Aleutian Tribes will purchase and deploy a Fuji Portable Digital X-Ray system for the Nelson Lagoon clinic. Key components of the project include: Equipment Acquisition Funding will support the purchase of a portable Fuji digital X-ray unit, which includes: • Portable imaging device • Digital detector system • Integrated imaging software • Secure transmission capability for remote radiology interpretation Clinical Integration The new imaging system will integrate with existing clinic workflows and allow images to be transmitted electronically for review by consulting radiologists and medical providers. Provider Training Clinic staff will receive training on safe operation of the portable X-ray unit and appropriate imaging protocols. Improved Care Coordination The system will support better coordination with regional hospitals and specialists by allowing providers to share imaging results quickly and accurately.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Advance to Implementation Application

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Rural Medication Access and Automated Pharmacy Dispensing Modernization	AK	Rural clinics often face challenges related to pharmacy staffing, medication storage, and timely medication distribution. Automated pharmacy dispensing technology allows clinics to provide efficient and secure medication access even when pharmacy staff are not physically present. Eastern Aleutian Tribes has successfully used PickPoint dispensing technology to improve medication distribution across its clinic network. These systems allow medications to be securely stored and dispensed to patients using unique access codes. However, the current machines are aging and nearing the end of their operational lifecycle. Aging equipment increases the risk of system failures that could delay medication access and disrupt clinic operations. Replacing the machines with new PickPoint systems will ensure reliable medication access, reduce pharmacy workflow burdens, and improve patient experience across the region. This investment strengthens rural health infrastructure while supporting the broader goal of Healthier Alaskans.	Eastern Aleutian Tribes will replace nine Pharmacy PickPoint automated dispensing units across its clinic network. Each replacement unit will include: • Secure automated medication dispensing system • Integrated pharmacy management software • Secure patient access technology • Installation, shipping, and system setup The new units will integrate with existing pharmacy workflows and electronic systems used by the organization. Key Program Benefits The upgraded systems will: • Improve patient access to medications • Reduce wait times for medication pickup • Improve pharmacy workflow efficiency • Enhance medication security and tracking • Reduce operational disruptions caused by aging equipment These improvements strengthen pharmacy services and ensure reliable medication access for residents living in remote communities.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Advance to Implementation Application

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Rural Oral Health Access and Dental Infrastructure Modernization Initiative	AK	Oral health conditions remain one of the most common health issues affecting rural communities. Untreated dental disease can lead to pain, infection, difficulty eating, and increased risk of systemic health problems. Rural communities often face delays in dental care due to limited provider availability and aging equipment that restricts clinic capacity. In some cases, patients must travel to larger communities for care, which can create significant financial and logistical burdens. Eastern Aleutian Tribes operates dental programs in multiple communities across the region, with the primary dental suites located in King Cove and Sand Point. These facilities serve as central hubs for dental services but require modernization to maintain safe and efficient operations. Additionally, smaller communities benefit from portable dental equipment that allows providers to deliver preventive and basic restorative services without requiring permanent dental suites. This initiative will modernize dental infrastructure and expand portable service capacity, improving oral health access across the region and supporting the broader goal of Healthier Alaskans.	Eastern Aleutian Tribes will implement a comprehensive Dental Infrastructure Modernization and Oral Health Access Initiative. The project includes two major components. Dental Suite Modernization – King Cove and Sand Point Existing dental suites will be upgraded with modern equipment to improve care delivery and provider efficiency. Equipment upgrades will include: • Modern dental treatment chairs • Delivery units and instrument systems • Digital intraoral imaging systems • Digital panoramic imaging capability • Sterilization equipment and autoclaves • Dental cabinetry and clinical workstations • High-speed and low-speed dental handpieces • LED operatory lighting systems • Digital radiography sensors and imaging software • Suction and vacuum systems • Air compressor systems • Instrument management and sterilization systems • Patient monitors and ergonomic provider equipment These upgrades will modernize the dental clinics and improve patient safety, efficiency, and provider workflow. Portable Dental Units for Rural Clinics The project will also purchase eight portable dental carts to support service delivery in smaller communities and provide backup capability for the larger clinics. Portable dental units will include: • Mobile dental treatment systems • Portable suction and compressor units • Portable dental instrument systems • Portable lighting and delivery systems • Portable sterilization equipment These units allow dental providers to deliver preventive services, screenings, and basic treatments in communities without permanent dental suites. Portable equipment also provides operational backup for the larger clinics if equipment failures occur.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Advance to Implementation Application

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Rural Telebehavioral Health and Community Crisis Response Network	AK	Behavioral health access remains one of the most significant challenges in rural Alaska. Communities often have limited local behavioral health providers, and travel to larger regional centers for care can be difficult and costly. These challenges contribute to delayed treatment, untreated mental health conditions, and increased risk of substance use disorders, suicide, and other behavioral health crises. Telebehavioral health services provide a proven solution to these access barriers by allowing individuals to receive care from licensed providers without leaving their communities. At the same time, rural communities occasionally experience traumatic events that affect entire populations, such as accidents, deaths, or disasters. In these situations, rapid deployment of trained Critical Incident Stress Management (CISM) teams can help communities process grief and trauma in a healthy way. This initiative addresses both needs by creating a coordinated system that provides ongoing telebehavioral health care and crisis response support, ensuring that communities receive both preventive care and rapid response when needed.	Project Concept Approach Eastern Aleutian Tribes will establish a Rural Telebehavioral Health and Crisis Response Network that improves behavioral health access and strengthens community resilience. Key components of the program include: Telebehavioral Health Services The program will expand access to licensed behavioral health providers through telehealth platforms. Services will include: • Individual counseling and therapy • Substance use disorder counseling • Psychiatric consultation and medication management • Trauma-informed behavioral health services • Youth and family behavioral health support Telehealth services allow residents in remote communities to access care without traveling long distances. Critical Incident Stress Management (CISM) Deployment The program will support the ability to deploy CISM teams to communities during times of crisis. These teams provide: • Immediate psychological support following traumatic events • Community debriefings and support sessions • Individual crisis counseling • Guidance for local leaders and responders managing community trauma Rapid response support helps communities recover from difficult events and reduces long-term behavioral health impacts. Integration with Local Health Systems Telebehavioral health providers and CISM teams will work closely with: • Rural clinics • Behavioral health case managers • Primary care providers • Community leadership	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Advance to Implementation Application

This coordination ensures that individuals receive appropriate care and follow-up support.



Eastern Aleutian Tribes, Inc.	Healthier Alaskans: School and Community Physical Activity Partnership Initiative	AK	Youth in rural communities often face limited access to organized sports and recreational programs compared to larger urban areas. Limited equipment, travel barriers, and funding constraints can restrict opportunities for regular physical activity. At the same time, physical inactivity contributes to increased risk of chronic disease, obesity, and mental health challenges among youth. Schools are one of the most effective environments for encouraging healthy behaviors and promoting active lifestyles. By partnering directly with schools, health organizations can help expand physical activity programming and support educators and coaches who work to keep students engaged in healthy activities. This initiative recognizes that collaboration between healthcare providers and schools can create stronger prevention programs that improve long-term health outcomes for youth and families. Investing in youth wellness today helps build healthier communities for the future.	Eastern Aleutian Tribes will collaborate with schools throughout the region to establish a School and Community Physical Activity Partnership Program. Physical Activity Programming The program will support expanded opportunities for physical activity through school-based and community activities, including: • Youth sports programs • Fitness and conditioning programs • Outdoor recreation activities • Community wellness events and competitions • After-school physical activity programs Equipment and Resource Support Funding may support the purchase of equipment and supplies that enable schools to offer more robust physical activity programs, including: • Sports equipment • Fitness training equipment • Indoor recreation supplies • Outdoor activity equipment School and Community Collaboration The program will work closely with school administrators, teachers, and community leaders to design activities that meet local needs and encourage participation among students and families. Activities will be designed to encourage participation across age groups and promote lifelong healthy habits.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Advance to Implementation Application

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Community Accounting & Finance Mentoring for Wellness and Resilience	AK	Financial stability plays a critical role in overall health and community resilience. In many rural communities, individuals and families face financial challenges related to high living costs, limited employment opportunities, and limited access to financial literacy education. Financial instability contributes to chronic stress, relationship strain, housing insecurity, food insecurity, and increased risk of substance use and other health challenges. Eastern Aleutian Tribes recognizes that improving health outcomes requires investing upstream in the factors that influence well-being. Providing practical financial mentoring can significantly improve the ability of individuals and families to manage resources, prepare for emergencies, and make informed financial decisions. This initiative addresses this opportunity by establishing a structured Community Accounting and Finance Mentoring Program that provides hands-on financial education and mentorship throughout the region. The program will strengthen financial skills, reduce financial stress, and support healthier individuals and families—advancing the broader goal of Healthier Alaskans.	Eastern Aleutian Tribes will implement a structured Community Accounting and Finance Mentoring Program designed to strengthen financial literacy, household stability, and community resilience. The program will deliver 12 mentoring workshops or camps annually, rotating across communities to ensure broad regional participation. Each workshop will include: • Hands-on budgeting sessions using realistic examples relevant to rural village economies • One-on-one mentoring opportunities for participants seeking individualized financial guidance • Practical tools and templates participants can take home (paper and digital formats) • Optional youth and family participation sessions to strengthen financial skills across generations • Resource navigation connecting participants to available social and community services Training topics will include: • Budgeting and cash-flow planning • Reducing high-interest debt and improving credit • Planning for travel expenses including medical travel and emergencies • Building savings habits and emergency funds • Understanding paychecks, benefits, and deductions • Protecting against financial scams and exploitation, particularly for elders Program coordination will be led by Program Manager Anita Moran, working with the EAT Accounting and Finance team to ensure practical and consistent delivery across communities.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Deferred or Not Advanced

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Community Beading for Wellness and Prevention	AK	Many rural communities experience limited access to structured wellness activities that promote mental health, cultural connection, and social engagement. Isolation, stress, and lack of positive extracurricular outlets can contribute to behavioral health challenges, particularly among youth and elders. Programs that provide meaningful activities and strengthen community relationships can significantly reduce these risks. Beading is a culturally grounded activity that supports both wellness and prevention goals. It provides a structured environment for learning, creativity, and intergenerational connection while strengthening cultural identity. Eastern Aleutian Tribes recognizes that prevention strategies that build community engagement and cultural connection can significantly improve overall well-being. This project establishes a consistent Community Beading for Wellness and Prevention Program that promotes social connection, reduces isolation, and strengthens community resilience while supporting the broader goal of Healthier Alaskans.	Project Concept Approach Eastern Aleutian Tribes will implement a structured Community Beading for Wellness and Prevention Program delivering 12 classes annually across the region. The program will be coordinated by Victoria Marquez, RN Case Manager, who will serve as the Beading Program Manager. Each class will be delivered in community settings and will include: • Supplies provided for each participant • Guided instruction and mentorship • Opportunities for intergenerational participation • Completion of a project participants can take home • Structured social engagement and wellness-focused participation Classes will rotate across EAT communities to ensure equitable access and consistent program delivery. EAT Designated employee (VM) will coordinate scheduling, participant outreach, supply ordering and distribution, class facilitation support, and outcome tracking. The program emphasizes participation across the lifespan, encouraging elders, youth, families, and working adults to participate together. This approach strengthens community relationships and promotes protective factors that support long-term well-being.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality)	Deferred or Not Advanced

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Rural Clinic Medical Equipment Modernization Initiative	AK	Rural clinics must maintain a wide range of medical equipment to provide essential healthcare services. Aging or limited equipment can restrict the ability of providers to diagnose conditions quickly, respond to emergencies, or perform routine clinical procedures. Because travel to larger regional medical facilities can be difficult and costly for patients, expanding diagnostic and treatment capabilities within local clinics significantly improves healthcare access. Eastern Aleutian Tribes operates seven clinics across remote communities, and upgrading equipment across the entire system ensures consistent standards of care throughout the region. Modernizing equipment will allow providers to deliver more comprehensive care locally while improving patient safety, clinic efficiency, and provider workflow. Investing in rural clinic infrastructure strengthens healthcare access and supports the long-term goal of Healthier Alaskans.	Eastern Aleutian Tribes is launching a Clinic Equipment Modernization Program across all seven sites to enhance diagnostic speed, patient safety, and emergency response. Key Upgrades & Investments ADA-Compliant Exam Beds: Improving accessibility and safety for elders and patients with mobility limitations. Ultrasound Systems & Training: Point-of-care units for rapid abdominal, cardiac, and musculoskeletal assessments. Cost: \$16,000 per site. LUCAS Chest Compression Systems: Automated devices providing consistent, life-saving compressions during cardiac emergencies. Cost: \$20,000 per unit. Point-of-Care CBC Analyzers: On-site blood count testing for immediate diagnosis of infections and anemia. Cost: \$11,000 per unit (plus \$2,000 annual consumables). IV Infusion Pumps: Ensuring precise delivery of medications and fluids. Cost: \$2,500 per unit. Oxygen Concentrators: Providing critical respiratory stabilization for emergency patients prior to transport. Unified Printing Systems: Standardizing infrastructure to streamline medical documentation and records management. Impact: This initiative replaces aging infrastructure with high-tech tools, ensuring our providers have the resources needed to deliver high-quality care in a rural clinical setting.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Deferred or Not Advanced

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Rural Community Garden and Healthy Food Access Initiative	AK	Access to healthy food remains a major challenge in many rural Alaska communities. The cost of fresh produce can be significantly higher than in urban areas, and transportation delays often reduce the availability or quality of fresh foods. These challenges contribute to diet-related health conditions such as hypertension, diabetes, and heart disease. Improving access to nutritious foods is a critical prevention strategy for improving long-term health outcomes. Community gardening programs have proven effective in increasing access to fresh foods while also promoting physical activity, social engagement, and community pride. This initiative will create opportunities for both community gardens and individual household gardens, helping residents grow vegetables and other healthy foods locally. The program will also provide education on nutrition and food preparation, helping families incorporate healthy foods into their daily diets. By improving food access and nutrition education, this project supports healthier communities and advances the vision of Healthier Alaskans.	Eastern Aleutian Tribes will implement a Community Garden and Healthy Food Access Program designed to strengthen food security and improve nutrition across the region. Key components include: Community Garden Development The program will support the development of community gardens in participating communities, providing space where residents can grow vegetables and other nutritious foods. Gardens may include raised beds, greenhouse structures, or protected growing systems suited to Alaska’s climate. Household Garden Kits Residents will have the opportunity to participate in household garden programs, receiving supplies such as soil, seeds, starter plants, and gardening tools. These kits allow families to grow healthy foods at home. Nutrition and Healthy Cooking Education The program will include workshops and community events focused on: • Nutrition education • Healthy cooking techniques • Meal planning with locally grown foods • Chronic disease prevention through diet Youth and Family Engagement Youth and families will be encouraged to participate in gardening activities, helping children develop healthy eating habits and practical food skills.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Deferred or Not Advanced

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Rural Elder Care Support and CNA Workforce Initiative	AK	Rural Alaska communities are experiencing growing needs related to elder care. As residents age, many require assistance with daily activities such as mobility, medication reminders, and basic health monitoring. In larger communities, these needs may be addressed through assisted living facilities or home health programs. However, in remote communities across the Aleutian region, such services are extremely limited or nonexistent. As a result, elders often face two difficult options: managing their health needs without adequate support or relocating to larger communities far from their families and cultural environments. Creating a small, community-based CNA workforce offers an effective solution that supports aging in place while strengthening local healthcare capacity. CNAs can assist elders with daily living needs, monitor changes in health status, and communicate with clinic providers when additional care is needed. This initiative recognizes that supporting elders in their homes is not only a healthcare priority but also a community priority that strengthens families and cultural continuity.	Eastern Aleutian Tribes will establish a Rural Elder Support Program that deploys Certified Nursing Assistants (CNAs) to provide support services for elders across the region. Key components include: CNA Workforce Deployment The program will employ two Certified Nursing Assistants who will travel across communities to support elders with basic health and daily living needs. Services provided may include: • Assistance with mobility and basic daily activities • Medication reminders and support • Basic health monitoring such as blood pressure and wellness checks • Assistance with transportation coordination for clinic visits • Support for elders recovering from illness or injury • Communication with clinic providers regarding changes in health status Integration with Clinic Care Teams CNAs will work closely with: • Primary care providers • RN case managers • Behavioral health staff • community health aides This coordination ensures that elders receive appropriate support and that emerging health issues are identified early. Community-Based Support By providing assistance directly in community settings, the program helps elders remain in their homes and maintain independence for as long as possible.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Deferred or Not Advanced

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Rural Environmental Health and Waste Backhaul Initiative	AK	Rural communities across Alaska often face unique challenges in managing solid waste. Limited land availability, aging landfills, and environmental risks make long-term waste storage difficult. In coastal communities across the Aleutian region, garbage accumulation can pose significant environmental and public health risks. Improper disposal or long-term storage of waste can contribute to water contamination, pest infestations, and exposure to hazardous materials. Waste backhaul programs provide a practical solution by transporting garbage and other waste materials to regional disposal facilities where they can be safely processed. However, the cost of transporting waste from remote communities is extremely high due to distance, transportation logistics, and limited shipping options. This initiative recognizes that environmental health is a critical component of community health. Supporting waste backhaul helps communities maintain safe living environments while preventing long-term environmental and public health risks.	Eastern Aleutian Tribes will collaborate with regional communities and partners to support a Rural Waste Backhaul Program that removes solid waste from remote communities and transports it to appropriate disposal facilities. Waste Backhaul Operations The program will support the transportation of garbage and other waste materials from participating communities to regional waste management facilities. Funding will support: • Waste containerization and staging • Transportation logistics and shipping costs • Coordination with waste disposal facilities • Environmental health oversight and planning Environmental Health Protection By removing waste from communities, the program helps reduce environmental health risks associated with waste accumulation, including contamination of land and water resources. Community Collaboration The initiative will work with community partners to ensure waste removal programs align with local environmental health priorities and community planning efforts.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Deferred or Not Advanced

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Rural Public Safety and Interdiction Partnership for Community Health	AK	Substance misuse remains one of the most significant contributors to poor health outcomes in rural Alaska. Alcohol abuse, illicit drug use, and related criminal activity contribute to injury, domestic violence, behavioral health crises, and chronic disease. In remote communities where resources are limited, the arrival of illegal drugs or large quantities of alcohol can rapidly destabilize families and communities. Clinics, behavioral health providers, and emergency responders frequently experience the downstream consequences of these issues. Interdiction efforts that prevent harmful substances from entering communities represent an upstream prevention strategy that protects community health. This initiative recognizes that public safety and public health are closely connected. By strengthening local law enforcement capacity to intercept illegal substances before they reach communities, this program helps reduce substance-related harm and supports healthier community environments. Investing in interdiction support allows communities to address substance misuse earlier in the chain of events, improving outcomes for individuals and families while supporting the broader goal of Healthier Alaskans.	Eastern Aleutian Tribes will establish a Rural Public Safety and Health Partnership that supports local law enforcement agencies in preventing harmful substances from entering communities. Key components of the program include: Interdiction Support Funding Funding will support local law enforcement agencies with resources needed to strengthen interdiction activities related to illegal drugs, illicit alcohol, and other harmful substances. Resources may include: • Specialized interdiction equipment • Training for law enforcement personnel • Operational support for targeted enforcement efforts • Travel and coordination related to interdiction activities Public Safety and Health Collaboration The program will strengthen coordination between: • Local law enforcement agencies • Tribal health organizations • Behavioral health providers • Community leaders Improved coordination ensures that prevention efforts align with broader health and wellness strategies. Prevention and Community Health Impact By preventing harmful substances from entering communities, the program reduces: • Substance-related injuries and overdoses • Domestic violence incidents • Behavioral health crises • Emergency medical transports related to substance misuse This prevention approach protects community well-being and supports healthier living environments.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Deferred or Not Advanced

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Sand Point Community Pool Restoration and Rural EMS Water Rescue Training Center	AK	Rural Alaska communities face significant barriers to maintaining infrastructure that supports both public health and emergency preparedness. Facilities such as community pools provide opportunities for physical activity, youth engagement, water safety education, and emergency responder training. Sand Point is a coastal community where residents regularly interact with the ocean through fishing, transportation, and recreation. Water-related accidents and cold-water exposure are real risks for residents, and many communities lack access to water rescue training facilities. Recent tragedies involving youth and water safety highlight the need for improved training and prevention efforts. Restoring the Sand Point community pool creates an opportunity to address multiple community health priorities simultaneously. The facility would support youth swimming education, drowning prevention, physical activity, behavioral health engagement, and EMS water rescue training. By investing in community infrastructure that promotes physical activity and safety education, this project supports Healthier Alaskans and strengthens the well-functioning of individuals and communities.	This project will restore the Sand Point community pool and establish it as a multi-purpose health, safety, and EMS training facility. Key components include: 1. Pool Restoration and Facility Improvements Funding will support repairs and upgrades necessary to restore safe operation of the pool facility, including equipment replacement, infrastructure repairs, and safety improvements. 2. Youth Swimming and Water Safety Programs Once restored, the facility will provide: • Youth swimming lessons • Water safety education • Drowning prevention programs • Structured recreational activities for youth These programs promote physical activity and injury prevention while strengthening community engagement. 3. EMT and EMS Water Rescue Training The facility will support training for EMTs and EMS responders across the region, including: • Water rescue techniques • Cold-water survival training • Emergency patient extraction • Team-based rescue scenarios This training is especially important for coastal communities where fishing, marine transportation, and ocean exposure are common. 4. Community Health and Physical Activity Programs The restored pool will also support community wellness programs that promote physical activity and overall health, particularly during winter months when outdoor activity options are limited. By combining community recreation, prevention programs, and EMS training, the facility supports both individual well-being and regional emergency preparedness.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough	Deferred or Not Advanced

Eastern Aleutian Tribes, Inc.	Healthier Alaskans: Tribal Culture Camps for Wellness, Resilience, and Healthy Living	AK	Culture camps have long served as important opportunities for Alaska Native communities to pass down cultural knowledge, traditional practices, and life skills from elders to younger generations. These gatherings often include activities such as subsistence education, outdoor skills, traditional crafts, storytelling, and community meals. Participation in these activities promotes physical activity, strengthens cultural identity, and creates meaningful connections between youth and elders. Research and community experience demonstrate that cultural engagement is strongly associated with improved mental health outcomes and reduced risk of substance use and other behavioral health challenges among youth. However, many tribes face financial barriers in organizing and sustaining these camps each year. This initiative will support tribal partners in hosting culture camps that promote physical activity, cultural education, and healthy eating. Investing in these programs strengthens protective factors for youth and families and contributes to healthier and more resilient communities.	Eastern Aleutian Tribes will collaborate with the seven tribes in its service area to support annual culture camps that promote health, wellness, and cultural resilience. Culture Camp Support The program will provide \$50,000 annually to support tribal culture camps across the region. Funding may support: • Camp supplies and materials • Transportation for youth and elders • Cultural instructors and knowledge holders • Outdoor and subsistence activities • Camp coordination and logistics These camps create opportunities for youth and families to engage in traditional activities while strengthening cultural identity and community connection. Healthy Food and Nutrition Component An additional \$10,000 annually will support healthy eating initiatives within culture camps. These funds may support: • Healthy meal preparation for camp participants • Traditional foods education • Nutrition education activities • Youth participation in food harvesting and preparation Providing healthy food options reinforces nutrition education and promotes lifelong healthy eating habits. Physical and Mental Wellness Activities Culture camp activities naturally incorporate: • Physical activity through outdoor engagement • Mental wellness through community connection • Cultural identity and resilience • Intergenerational learning These activities help strengthen protective factors that support long-term health.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area	Deferred or Not Advanced

eCare USA	Interior Alaska Virtual Care Network	AL	Healthcare delivery across Interior Alaska is challenged by vast geographic distances, small and widely dispersed populations, and limited access to specialty services. Rural clinics and critical access facilities often operate with minimal staffing and limited on-site resources, making it difficult to provide consistent specialty consultation, emergency support, pharmacy access, and coordinated follow-up care for patients living in remote communities. As a result, patients frequently must travel long distances or rely on costly emergency transport to receive services that could potentially be delivered closer to home. At the same time, rural providers are managing increasing patient needs with limited staffing and significant administrative burden, which can impact both workforce sustainability and continuity of care. These challenges create an opportunity to strengthen Alaska’s hub-and-spoke healthcare model by extending the capabilities of regional health systems into surrounding rural communities. Foundation Health Partners serves as a key regional hub for Interior Alaska and already supports a network of rural providers across the region. By leveraging technology-enabled care models and partnerships with Alaska-based implementation partner Vicinity, this project seeks to improve access to specialty consultation, emergency support, patient monitoring, and coordinated follow-up care for rural and frontier communities.	This project will establish a regional virtual care network that connects rural clinics and community providers across Interior Alaska with clinical expertise located at Foundation Health Partners. The approach focuses on expanding the reach of existing regional care resources rather than creating new standalone programs. Working with Alaska-based partner Vicinity, the project will deploy integrated virtual care capabilities that allow rural providers to access specialty consultation, emergency support, remote monitoring, and pharmacy services through secure digital connections. These tools will enable real-time collaboration between local providers and regional care teams, helping rural clinics manage more complex cases locally while ensuring patients receive timely specialty input when needed. The project will also introduce workflow tools designed to support rural clinical teams, including virtual nursing support, remote patient monitoring for high-risk patients, and technology that reduces documentation burden. These capabilities are intended to strengthen coordination across care settings and improve follow-up care for patients after emergency visits or hospital discharge. By building on the existing hub-and-spoke care relationships centered around Foundation Health Partners, this approach creates a scalable model that expands access to clinical expertise, supports rural providers, and improves continuity of care across Interior Alaska communities.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

ECHO Diabetes Action Network	Statewide Diabetes Specialty Access and Rural Care Transformation	AK	Diabetes is a high-cost, high-burden condition in Alaska, disproportionately affecting rural and medically underserved communities. Most Alaskans with diabetes—including those with complex conditions such as chronic kidney disease, retinopathy, obesity, and depression—are managed in primary care due to limited access to endocrinologists and other subspecialists across the state. Rural geography, workforce shortages, and specialty access gaps contribute to delayed treatment, avoidable emergency department visits, preventable complications, and significant travel burdens for patients who often must travel long distances within Alaska or out of state for specialty care. Primary care clinicians often lack timely specialty input for complex cases, leading to over-referral, under-treatment, or fragmented care. Alaska has strong Project ECHO infrastructure through the UAA, but a comprehensive diabetes-focused ECHO program has yet to be implemented statewide. This project pairs workforce development with real-time specialty consultation and virtual specialty care, strengthening diabetes management in primary care while reducing unnecessary referrals and patient travel. The initiative will establish a coordinated statewide diabetes specialty access model that strengthens primary care capacity, improves care quality, reduces avoidable costs, reduces clinician burnout, and advances sustainable rural health system transformation aligned with Alaska’s RHTP priorities.	This initiative complements EDAN’s RHTP proposal and partnership with UAA Alaska Project ECHO to launch statewide diabetes-focused ECHO programming for frontline clinicians and community health workers. EDAN will serve as the coordinating lead and implementation partner, aligning workforce development, specialty access, and quality improvement into a unified rural diabetes strategy. During recruitment and onboarding, participating clinics will also be introduced to a specialty consultation and referral platform (PicassoMD) to strengthen diabetes management and referral coordination. The project includes three integrated components: 1.Workforce Capacity Building through Diabetes Project ECHO In partnership with UAA, the project will launch an interprofessional Diabetes Project ECHO program. Through case-based learning and specialist mentorship, primary care teams will strengthen their ability to manage diabetes and related comorbidities locally, including CKD, obesity, depression, and retinopathy. This model expands local expertise, reduces professional isolation, and strengthens the rural workforce and care quality. Project ECHO will serve as the anchor statewide workforce development network. Clinics may participate in ECHO training, specialty consultation services, or both based on local needs. 2.Real-Time Specialty Consultation and Referral Optimization Participating clinics will gain access to a telehealth-enabled consultation and referral platform allowing primary care clinicians to obtain rapid specialist input through virtual curbside consultations, avoid unnecessary referrals, and co-manage high-risk patients with specialty support. 3.Virtual Specialty Access For patients requiring direct specialty evaluation, the project will deploy a Virtual Specialty Group model enabling tele-endocrinology visits with board-certified specialists. This allows rural patients to access specialty care without long-distance travel while maintaining care coordination through local primary care teams. Together, these components create a closed-loop specialty access model. Project ECHO builds long-term clinical capability, while consultation and virtual specialty care provide immediate support for complex cases. This approach improves diabetes outcomes, strengthens rural workforce capacity, reduces avoidable specialty utilization and travel, and advances RHTP priorities in Health Care Access, Strengthen Workforce, Pay for Value, and Spark Technology and Innovation.	\$250K-\$1M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

eClinicalWorks, LLC	eClinicalWorks and healow Support of the Rural Health Transformation Project (RHTP)	MA	The federal government has identified a problem that rural health populations nationwide face when trying to access affordable and accessible healthcare in their local communities. The RHTP is an unprecedented opportunity for the states and healthcare providers in rural areas of the country to design programs that will provide access to care to their patients using a variety of strategies, tools, and innovative technologies to bridge the gaps that they face. eClinicalWorks and healow bring innovate technology solutions that facilitate patient outreach, offer expanded access to care, and help manage populations of patients with chronic conditions. The use of these tools, along with Artificial Intelligence features in some of the products, are a workforce multiplier for those practices that are under-staffed and over-worked.	As States and rural health centers formalize their plans and determine how to execute on their state-funded programs, eClinicalWorks and healow are ready to provide technology tools that will streamline health center operations, give providers the tools they need to strategically manage populations of patients that are high risk patients, i.e., multiple chronic conditions, frequently admitted to the emergency room, at risk for readmittance, etc. The tools provide automation and intelligence to healthcare delivery, making patient management more efficient as well as effective. eCW and healow tools integrate seamlessly with the eClinicalWorks Unified Electronic Health Record and Practice Management (EM/PM) Solution; several of the healow products can also be used with other major EMR vendor products via a SMART on FHIR API. eClinicalWorks and healow provide end-to-end product implementation and training and ongoing customer service and technical support to all practices that adopt the products.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Ecotrust	Four Winds Resource Center: A Community Wellness Hub for Healthy Food, Socializing & Recreation.	OR	For a decade, volunteers fundraised and labored to transform an abandoned state asset into a thriving Community Hub — with programs including food security, emergency preparedness, tool library, fitness classes, youth activities, and community gatherings. This Community Wellness Hub model has been validated by the National Recreation & Park Association (NRPA) as a demonstrably effective strategy for advancing health equity through trusted community gathering places. FWRC’s Wellness and Social Connection scope of work directly implements these evidence-based benefits: expanding fitness classes, educational workshops, intergenerational events, and programming for residents at risk of social isolation. Despite the FWRC receiving the Haines Borough inaugural Community Builder Award in 2024, current Borough Assembly deliberations reflect active pressure from some members to eliminate the facility subsidy, citing per-capita density — effectively arguing that distance from town justifies fewer services. Upper Chilkat Valley residents pay equal Borough taxes. This project ensures a facility the state built for this community — held but disinvested by the Borough for ten years — can finally function as a fully resourced Community Wellness Hub delivering health equity to the most rural and lower-income residents of the Haines Borough. RHTP investment hires staff, builds infrastructure, and begins correcting ten years of institutional neglect for a community with no other option.	Four Winds Resource Center will apply NRPA’s Community Wellness Hub model — which establishes that trusted community gathering places, when staffed and intentionally designed, demonstrably improve health equity and quality of life across seven interdependent dimensions of well-being: cultural, economic, environmental, intellectual, mental, physical, and social. FWRC already delivers programs touching all seven dimensions. To fully utilize the facility and amplify our programming impacts, we will hire a director and build our organizational infrastructure. The Director will be an independent paid staff position, not a Borough employee — to lead day-to-day Community Wellness Hub operations and create a sustainability strategy. The Director will work closely with the Chilkat Valley Food Hub Coordinator & Victory Garden Coordinator to maximize efficiency and lessen the burden of volunteers. An identified need for Upper Valley rural residents is Transportation Coordination. The FWRC Director will work in coordination with SAIL to develop ride-coordination for elderly and disabled highway-corridor residents to access medical appointments and essential services. Eventually, we hope to acquire a community van to ensure reliable quarterly commodity food runs from Juneau and continued delivery of fresh produce to Haines Assisted Living and Haines Senior Center— currently we rely on volunteers driving at personal expense. We hope to expand programs and improve critical infrastructure through careful planning led by the FWRC Director. The CVFH — one of only 7 food hubs in all of Alaska — is the backbone of FWRC’s food security mission and operates as a satellite of the SEAK food bank, distributes SA food boxes as well as fresh produce grown in the onsite community garden. We will fund a Victory Garden Coordinator position for the 2027 season. Since its inception the VG has produced more than 4,000 lbs of fresh produce and generated more than 2,000 volunteer hours. An important next step is to develop and formalize EOC protocols with the Klehini Valley Volunteer Fire Department, Klukwan EOC Commander, Haines Volunteer Fire & Police Department, and Haines Avalanche Center. In January 2026, five or more avalanche closures cut the corridor off from town for days at a time. Alongside staffing, the Board and Director will develop formal HR, financial, and volunteer policies using the Foraker Group’s frameworks and complete a sustainability-focused business plan.	\$250K-\$1M	Single Community	Haines Borough	Deferred or Not Advanced

Ecotrust	Produce Prescription Program: Addressing food access and chronic disease in Southeast Alaska	OR	Southeast Alaskan communities face compounding challenges at the intersection of geography, food access, and health. Residents contend with high rates of diet-related chronic disease — including diabetes, hypertension, and cardiovascular disease — while lacking reliable access to fresh produce and high-quality protein foundational to prevention and disease management. Remote islands, coastal geography, and dependence on expensive barge and air freight make nutritious food not just scarce, but cost-prohibitive for many families. Yet Southeast holds significant untapped opportunity. The region has a rich subsistence harvesting tradition, a growing network of local producers, and strong tribal and community health infrastructure — a robust foundation for Produce Prescription / "Farmacy" models. This proven approach bridges food access constraints and preventative wellness while directing resources into local food systems. The opportunity is to formalize connection between food systems organizations, regional medical entities, local growers and harvesters, tribal organizations, and community members through a dedicated steering and planning committee. Intentional coordination is needed to bring stakeholders together around regional and community-specific pilot projects. This concept formation effort will build the cross-sector relationships, shared vision, and administrative readiness needed to create culturally grounded, community-led programs.	Addressing food access and chronic disease in Southeast Alaska requires community-specific approaches recognizing the region's strengths, geographic realities, and existing community infrastructure. Our programmatic planning will consider the following components: First, Tribal and Indigenous Food Sovereignty as a Health Strategy: For Southeast Alaska Native communities, access to traditional foods is not simply a nutritional issue — it is a matter of cultural continuity and identity, intergenerational health, and food security. We will pursue partnerships with Tribal entities to integrate traditional harvesting and distribution networks and subsistence foods into our programming and identify infrastructure that enables community-scale food sharing and distribution. Framing cultural food practices as a protective health factor positions this work squarely within health equity — and reduces community reliance on expensive imported goods. Second, Local Food Production as Health Infrastructure: In rural communities where transportation and logistics are challenging, a local food supply is critical. We will explore clinic - and school-based greenhouses and garden programs, and mobile processing and distribution units — investments that reduce supply chain vulnerability, strengthen emergency preparedness, and build long-term food system resilience. Third, Community-Led Coordination: Placed-based, community rooted, and culturally relevant programming is the priority. Southeast communities are uniquely distinct from each other with varying assets, needs, priorities, and limiting factors. A multi-disciplinary, multi-organizational steering committee — inclusive of Tribal governments, healthcare providers, local producers, and community members — will ensure that every element of the pilot program is grounded in local need, cultural values, and community-defined priorities. This collaborative structure is critical to the approach.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Edge Logistics Inc., DBA Aerolane	Rapid Air-Delivered Disaster Relief Using Pre-Positioned Aerocart Systems	TX	Alaska faces increasing disaster risk while many rural communities have limited infrastructure and medical capacity. When disasters occur, communities can rapidly exceed their local ability to provide emergency shelter, medical triage, and essential supplies. Rapid response is critical. However, traditional aviation-based disaster response requires dedicated aircraft, specialized crews, and pre-loaded cargo planes that remain on standby. This model is expensive and limits the number of response assets that can realistically be maintained. As a result, the ability to deliver rapid relief packages to remote communities is constrained by cost and aircraft availability. This project addresses the opportunity to dramatically reduce the cost of standby disaster readiness while expanding the number of rapid-response delivery points across Alaska.	The project proposes deploying Aerocart disaster relief trailers, glider-based cargo units that can be towed behind existing aircraft. Each Aerocart unit would be pre-positioned and loaded with disaster relief supplies. When a disaster occurs, any qualified pilot flying a compatible aircraft can tow the unit toward the affected area. Key features of the approach include: 1. Pre-positioned relief stations Aerocart units are stored with supplies ready for dispatch, allowing response within minutes rather than hours required to assemble cargo. 2. Distributed aviation participation Instead of requiring a dedicated aircraft and crew, many existing aircraft and pilots can participate in disaster response by towing the relief unit. 3. Attritable delivery system The Aerocart can be released and glide autonomously to a landing zone such as a rural airstrip or unimproved surface. 4. Lower standby cost Because the system uses existing aircraft rather than dedicated cargo planes, the cost of maintaining disaster readiness can be reduced significantly. This approach enables Alaska to maintain multiple rapid-response relief units distributed across the state while leveraging the aviation capacity already operating in rural regions.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Dillingham Census Area; Kusilvak Census Area; Nome Census Area; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Education Services of Alaska	Alaska Statewide School Mental Health Access Initiative	AK	Education Services of Alaska (ESA), part of the Alaska Council of School Administrators (ACSA), in partnership with Hazel Health, proposes to address a major gap in access to timely behavioral health care for Alaska students, especially in rural and remote communities. Across Alaska, youth face high rates of depression, anxiety, trauma exposure, substance misuse, and suicide risk, while families often encounter major barriers to care including provider shortages, long waitlists, weather, travel burdens, and high turnover in local systems. In many parts of the state, school-based mental health access is uneven, and over 25% of school districts do not have access to a counselor or mental health professional. This creates a clear RHTP opportunity. Schools are one of the few trusted, consistent institutions that reach children and families across urban, rural, and village Alaska. By using schools as an access point for licensed behavioral health services, Alaska can intervene earlier, reduce delays in care, and help prevent concerns from escalating into higher-acuity and more costly crises. Rather than replacing local providers, the proposed model is designed to augment existing capacity where it exists and fill gaps where services are limited or absent. Through ACSA’s statewide network and Hazel’s school-centered clinical model, this project would create a scalable, Alaska-grounded pathway to expand behavioral health access for students and families statewide.	ESA and Hazel Health propose a statewide, school-linked behavioral health access model for Alaska students and families. Hazel has been a trusted school-based healthcare provider since 2015. Hazel will deliver the clinical platform through Alaska-licensed behavioral health professionals, offering a structured telehealth model that includes referral intake, parent or guardian consent, clinical assessment, individualized treatment planning, therapy, family engagement, crisis protocols, and outcomes reporting. Therapists address a broad range of student needs, including emotional distress, anxiety, depression, suicidality, anger management, trauma, eating disorders, substance use, bullying, and challenges affecting academic success and social development. Treatment goals focus on measurable outcomes for symptom reduction and skill development. Services can be accessed by students at school or at home, reducing delays caused by travel, weather, scheduling, and limited local providers. Hazel’s model provides timely access while complementing local systems and transitioning students to community-based resources when appropriate. It is not a software-only referral marketplace and is not intended to displace existing Alaska providers. Services are provided at no cost to students and families, and uninsured students receive full care. Hazel Health maintains compliance with FERPA, HIPAA, CCPA, CIPA, and other relevant mandates. ACSA and ESA are critical to the success of the Alaska model. Rather than relying solely on a district-by-district market approach, the partnership uses ACSA’s statewide credibility, communications network, professional development capacity, and relationships with school leaders to create a trusted implementation channel. ESA will promote awareness, educate district leaders and administrators, support onboarding, address concerns, troubleshoot implementation, and provide ongoing professional development and feedback loops to support successful use across diverse school settings. The partnership also enables a more strategic rollout. ACSA’s deep knowledge of Alaska’s school landscape—including regional needs, school readiness, technical capacity, cultural considerations, and local risk factors—will help Hazel tailor implementation, referral pathways, communications, and district engagement strategies in ways difficult to replicate through a conventional outside-vendor approach.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Education Services of Alaska	Stronger Together: Safe and Healthy Schools in Alaskan Communities	AK	Many students and families in Alaska, particularly in rural communities, face a lack of connection and support within their schools. High rates of staff turnover make it difficult for students to establish lasting relationships with adults, which can contribute to misbehavior, risky behaviors such as substance use or unsafe sexual activity, disengagement from learning, and negative mental health outcomes like isolation, anxiety, and depression. Alaska Native children are disproportionately affected due to historical and ongoing trauma. The legacy of forced removal to boarding schools, cultural suppression, and systemic inequities has created high adverse childhood experiences (ACEs) scores and elevated dropout rates. Current school systems often fail to recognize Alaska Native culture, language, and ways of life, perpetuating these disparities. Trauma also affects other at-risk populations, including children in foster care, the juvenile justice system, LGBTQ youth, recent immigrants from conflict zones, and those living in high-poverty or high-crime areas. Strengthening belonging and school connection, encouraging regular school attendance, fostering discipline that is rooted in restorative practices and trauma-engaged environments, and ensuring consistent adult support are essential to improve the opportunity for increased student well-being, promoting positive behaviors, and supporting long-term academic and community success.	Schools and districts across Alaska are uniquely positioned to support the safety, health, and well-being of students, families, and communities by implementing trauma-engaged practices. This project strengthens four research-supported indicators of student well-being: (1) belonging and relationships, (2) school attendance, (3) restorative discipline, and (4) school crisis response and planning. Together, these indicators form a durable framework that fosters positive school environments and remains resilient even with staff turnover. The initiative uses a cohort model in which school leadership teams collaborate to guide implementation. Teams begin by developing a shared vision for trauma-engaged practices—why this work matters for their students and communities and how it benefits educators, families, and partners. This shared vision anchors improvements in school culture and supports stronger relationships across the community. With guidance from project partners and a dedicated coach, schools assess their readiness and capacity to implement trauma-engaged strategies. Teams identify existing strengths, resources, and systems that can support the work and determine where to begin—at the school, classroom, or community level. This approach ensures strategies are responsive to local needs and sustainable over time. Building trust among stakeholders is essential. Teachers, administrators, families, tribal leaders, elders, and community organizations will be engaged through clear communication, collaborative planning, and shared learning opportunities. These partnerships help ensure that practices reflect cultural values, community priorities, and local expertise. To support implementation, the project provides ongoing professional learning through webinars, asynchronous micro-credentials, and on-site consultation. Additional learning opportunities will be offered through statewide conferences and collaborative gatherings. These supports reinforce the four indicators of well-being and help schools integrate trauma-engaged practices into daily routines and systems. Continuous reflection and review of student data—including attendance and discipline trends—will help schools refine strategies and strengthen a sustainable culture of connection, resilience, and student success.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Effective Health Design	Alaska Healthcare Cost and Policy Commission	AK	Effective health care policy and reform require policymakers to understand cost drivers and market pressures while promoting efficient, evidence-based practices. Sound decision-making depends on access to accurate and comprehensive information on health care utilization, quality, and pricing. This information is necessary to evaluate programs and monitor efforts to improve access, reduce costs, and strengthen health care quality and population health. Alaska faces persistent challenges in these areas. Data from the Commonwealth Fund show that the percentage of Alaska residents over age 18 with a usual source of primary care has remained among the lowest in the nation since 2015. At the same time, Alaska continues to experience some of the highest health care costs in the United States. Implementing durable health policy under these conditions requires sustained, multi-year efforts that often extend beyond the terms of elected and appointed officials. These challenges are compounded by limited analytic and policy capacity within state government. The Department of Health and legislative health policy advisors operate with constrained staff resources while managing complex oversight responsibilities, limiting the state’s ability to fully evaluate policy options and plan for long-term system transformation.	The establishment of a public entity with a legal existence separate and independent from the state would provide a durable foundation for ongoing health policy analysis, development, and implementation in Alaska. Such an entity would support the evaluation and advancement of proven strategies that promote innovation in health care delivery while also providing a stable structure for the continued exploration of emerging health system models and long-term direction-setting for Alaska’s health care system. The Alaska Healthcare Cost and Policy Commission is proposed to be created as a public entity and an instrumentality of the state within the Department of Commerce, Community, and Economic Development, but with a separate and independent legal existence. This structure would allow the commission to maintain analytic continuity across administrations, conduct objective and transparent evaluation of health system performance, and support long-term planning necessary for effective system transformation. The purpose of this entity is to: (1) collect and analyze existing health care cost and quality data; (2) create an objective, reliable, and comprehensive central repository of health care information; (3) provide researchers, policymakers, and the public timely and transparent access to health care information while protecting individual privacy and proprietary data; (4) enable researchers, policymakers, and the public to make informed health care decisions and identify opportunities to reduce unnecessary health care costs; and (5) support ongoing evaluation of health system performance and emerging health care delivery models that improve access, quality, and sustainability of care. By strengthening Alaska’s analytic infrastructure and policy coordination capacity, this project would improve the state’s ability to design and implement strategies that expand access to care, address workforce shortages, and support sustainable service delivery models. These benefits are particularly important for rural, remote, and frontier communities where geographic isolation, limited provider availability, and higher service delivery costs create persistent barriers to care. Establishing this capacity will help ensure that future reforms are informed by reliable data, coordinated planning, and a long-term strategy that benefits all Alaskans.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Eko Health, Inc.	Expanding Access to Cardiac Disease Detection in Alaska with Eko Health and AI-Enabled Screening	CA	Rural and frontier communities across Alaska face significant barriers to timely cardiovascular care due to geographic isolation, limited healthcare infrastructure, and shortages of specialty providers. Many Alaskans rely on small rural clinics, tribal health organizations, and critical access hospitals where access to cardiologists, interventional specialists, and cardiac diagnostics are limited or require long-distance travel to regional centers. As a result, frontline clinicians must often manage cardiac and respiratory care with limited tools and resources and, often, without specialized training or consultation. These challenges can lead to delayed detection of cardiac disease, missed diagnoses, and avoidable transfers or complications. This project presents an opportunity to strengthen frontline cardiac capabilities in rural Alaska by equipping primary care providers and emergency clinicians with simple, accessible, and AI-enabled screening tools. Using Eko, providers can make more informed decisions about patient care and treatment options. Supporting rural providers with enhanced cardiac screening can help reduce gaps in access to specialty care, improve early detection of cardiovascular disease, and strengthen the ability of local healthcare systems to deliver high-quality care closer to home for underserved Alaskan populations.	This project aims to strengthen cardiovascular screening and care coordination across Alaska’s rural healthcare system by equipping frontline providers with accessible cardiac screening technology. The initiative will focus on equipping all ~25 Alaskan Community Hospitals and Critical Access Hospitals with Eko digital stethoscopes and SENSORA software, with primary care and emergency departments as the sites of care. Clinicians will be able to screen for cardiac conditions during routine visits and acute care encounters, improving early detection and helping guide appropriate referral decisions. Eko also seeks to partner with Alaskan health systems to deploy Eko stethoscopes, SENSORA licenses and Eko’s telehealth platform across their networks. System-level implementation will support cardiac screening during annual wellness visits and primary care encounters, while strengthening referral pathways and care coordination with cardiology and interventional specialists. Together, these efforts aim to expand access to early cardiac detection and improve continuity of cardiovascular care for patients across Alaska’s geographically dispersed communities. Initial efforts will focus on continued partner engagement and new partner acquisition with rural Alaskan hospitals and clinics to further identify priority sites and align implementation with local care workflows. In parallel, the Eko will support site readiness assessments, technology deployment, and integration into existing clinical and telehealth digital infrastructure (EHRs). Eko will provide clinician training, clinical education, and change management support to ensure successful adoption in primary care and emergency department settings. During the go-live phase, Eko will work closely with partner organizations to provide onboarding, technical support, and workflow optimization to ensure clinicians can effectively use the technology for cardiac screening.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Nome Census Area; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Wrangell (City and Borough)	Deferred or Not Advanced

Ekwok Natives Limited	Regional Behavioral Health & Cultural Wellness Access Planning in Bristol Bay	AK	Across Bristol Bay, substance use and alcohol-related mortality remain persistent challenges. Statewide data from the Alaska Native Epidemiology Center show disproportionately high alcohol abuse rates in the region. Rural communities across Bristol Bay face persistent geographic and infrastructure barriers that limit access to structured, multi-day behavioral health and culturally grounded wellness programming. While behavioral health providers operate within hub communities, many surrounding villages lack facilities that can safely and appropriately accommodate overnight stays, extended group programming, or multi-day intensives. Existing community buildings are often not configured for residential use, lack adequate safety systems, or are already fully utilized for other essential functions. Services are often centralized in regional hub communities such as Dillingham. This creates scheduling bottlenecks, limits participation from smaller villages, increases travel costs for residents seeking behavioral health support, and disrupts family and subsistence responsibilities. For many residents, these logistical barriers reduce participation in recovery-oriented or culturally grounded programming that requires engagement over multiple days. Expanding the number of rural communities capable of hosting these gatherings would strengthen the regional care delivery network by increasing the number of locations where behavioral health and prevention services can occur closer to home.	The Ekwok Lodge—located along the Nushagak River on a traditional site—previously hosted culturally influenced recovery camps incorporating subsistence activities, traditional practices, and community-based healing. However, deterioration of lodge structures has rendered the site unusable for safe, code-compliant programming. A facility assessment was completed in 2024, and a feasibility study/business plan are underway, due to be completed in June 2026. The project will support planning and design for renovation of the Ekwok Lodge facility to enable its use as a regional gathering site capable of hosting multi-day behavioral health, recovery, and cultural wellness programming for rural Bristol Bay communities. The Lodge will not provide clinical services directly. Instead, the planning effort will define the technical, engineering, and operational requirements necessary to restore the site as safe, compliant, overnight-capable infrastructure that regional partners can utilize for multi-day behavioral health and culturally grounded programming. The approach focuses on closing the gap between completed facility assessment and renovation readiness. Planning activities will include preliminary engineering and scoping to define renovation objectives; architectural refinement and space configuration aligned with multi-day programming needs; updated, inflation-adjusted cost estimates; ADA compliance integration; mechanical, electrical, and safety system planning; and development of a phased renovation pathway. This work will result in an implementation-ready package suitable for permitting, capital stacking, and future construction. In parallel, the project will engage regional partners—including Tribal organizations, community-based nonprofits, and behavioral health entities—to define utilization needs and ensure the facility’s design supports itinerant providers and locally convened programming. Engagement will inform spatial layout, overnight capacity assumptions, and operational considerations necessary to support structured, multi-day use. By the end of the planning period, the project will produce a defined renovation scope, updated capital estimates, and a clear pathway to implementation. This ensures that future investment results in safe, functional, and access-oriented infrastructure capable of expanding programming capacity beyond a single regional hub and strengthening access pathways for rural and frontier communities.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

ELLKAY	Expanding Secure Health Data Exchange for Rural and Remote Alaska Communities	NJ	Many rural and remote healthcare providers in Alaska operate across multiple systems that do not easily share health information. This lack of interoperability can create delays in accessing patient data, increase administrative burden, and make care coordination more difficult. This project addresses the opportunity to improve healthcare delivery by enabling secure and efficient exchange of clinical and administrative data between systems, helping providers access the information they need to deliver timely, coordinated, and high-quality care while supporting better-informed clinical decisions and improved patient outcomes for rural communities.	The proposed approach is to implement ELLKAY’s LKOpera interoperability platform to enable secure, reliable exchange of healthcare data between disparate systems used by rural healthcare providers. LKOpera will facilitate the integration and normalization of clinical and administrative data from multiple sources, allowing healthcare organizations to securely share and access patient information across systems. By supporting industry standards such as HL7 and FHIR, the platform enables efficient connectivity between providers, health systems, and other healthcare partners. This approach improves care coordination, reduces administrative burden, and helps ensure clinicians in rural and remote communities have timely access to the information needed to support informed clinical decisions and high-quality patient care.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

ELLKAY	Statewide Clinical Data Archiving to Modernize Alaska’s Health Data Infrastructure	NJ	Many healthcare organizations across Alaska continue to maintain legacy electronic health record (EHR) systems solely to retain access to historical clinical and administrative data. These systems are costly to maintain, difficult to support, and may no longer receive security updates. Maintaining aging technology creates financial and operational burdens, particularly for healthcare organizations serving rural and remote communities with limited resources. At the same time, historical patient information remains essential for clinical care, compliance, and operational needs. Providers must be able to access prior medical records and documentation even after transitioning to newer health information systems. Without an effective solution, organizations may be forced to keep outdated systems running indefinitely simply to preserve access to legacy data. This project addresses the opportunity to modernize how healthcare organizations across Alaska manage and access historical patient information. By implementing a centralized clinical data archiving platform, organizations can securely store and access both clinical and non-clinical data while retiring unsupported legacy systems. This approach improves sustainability, strengthens data security, and ensures continued access to critical patient information across the state.	Our proposed approach focuses on improving access to clinical information, strengthening care coordination, and modernizing health data infrastructure across rural healthcare facilities in Southeast Alaska. Many rural providers rely on multiple electronic health record systems, legacy platforms, or disconnected data sources, which can make it difficult for clinicians to access a complete patient history when delivering care. These challenges are amplified in remote communities where patients may receive services from multiple providers or travel between locations for specialty care. This project will implement a secure, centralized clinical data repository and interoperability framework that enables participating healthcare organizations to aggregate, manage, and access patient information from multiple source systems through a single, unified platform. Historical and current patient data can be securely consolidated and made available to authorized clinicians, improving visibility into a patient’s full medical history while reducing reliance on legacy systems that are costly to maintain. The proposed solution will leverage industry-standard interoperability technologies and secure cloud-based infrastructure to support reliable, scalable access to health data across geographically dispersed facilities. The platform will support common healthcare data standards and enable secure exchange of clinical information between participating providers, improving continuity of care for patients who receive services across multiple locations. By improving the availability and accessibility of clinical information, the project will help providers make more informed clinical decisions, reduce duplication of services, and support more coordinated care delivery. The solution will also help rural healthcare organizations modernize their health IT infrastructure while reducing operational burdens associated with maintaining aging systems. Ultimately, this initiative will strengthen healthcare delivery across Southeast Alaska by enabling better data sharing, improving care coordination, and creating a sustainable, scalable foundation for future healthcare innovation and system modernization.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

EM Consulting	Increasing Access to High Quality, Culturally Concordant Mental Healthcare in Alaska	CA	Alarming scarcity and disparities mark the current mental health landscape in Alaska: Mental Health Emergency: We are in the midst of a grave mental health emergency in this country, exacerbated by the COVID-19 pandemic, isolation, and the current socio-political turmoil in our country. Severe Shortage of Providers: There is a profound shortage of licensed behavioral health providers nationwide, and Alaska is no exception. There are reliable projections to 2033, demonstrating that this shortage will not improve. Disproportionate Impact on Communities of Color: Those who bear the brunt of this shortage are often people of color, including Indigenous Alaskans, Asian Pacific Islanders, LatinX communities and more, who have the least access to high-quality mental health care that meets their cultural and linguistic needs. Delayed Action on Workforce Development: While efforts to increase and incentivize a licensed behavioral health workforce are crucial, any influx of licensed providers is years away and will never fully meet the growing demand. This pathway is simply too slow and too inequitable to address our current crisis. Risk of Perpetuating Disparities: Without immediate and innovative solutions, we risk perpetuating existing disparities in access to and equity in mental health services in Alaska.	Lay counselors are trained helpers who do not have advanced mental health education, master’s degrees, or licenses, who are trained to provide mental health and substance use counseling, comparable to licensed clinicians.: Lay counseling practices are widespread in low and middle-income countries, demonstrating effectiveness in addressing mental health and substance use conditions amidst severe resource gaps. South Africa, India, Ghana, Ecuador, Kenya, and just a few other countries have been using lay counseling models for decades; for this reason, they have also given the field a deep and broad research base, demonstrating the effectiveness of this model. There is a large body of research showing unequivocally that lay counselors can be as effective as licensed clinicians. Lay counseling can be integrated into various direct-service positions, including various health and social care roles, such as case managers, health coaches, peer support specialists, first responders, legal aides, educational staff and wellness coaches. Lay counselors are supervised by licensed clinicians; while not regulated in any state, ethically and clinically, this is deeply important. If organizations that have sent staff to the LCA do not have licensed clinicians to supervise them, EM Consulting’s team provides this.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Emergency Care Research Institute (ECRI)	Technology-Enabled Solutions: Decision Making, Implementation, Assessment, and Evaluation	PA	ECRI is pleased to propose this project as a multifaceted approach to building a foundation to support responsible adoption of technology-enabled solutions in rural health centers to meet a variety of specific needs of rural communities and patients. This project will focus on supporting healthcare organizations in designing a robust infrastructure that will allow them to responsibly assess, adopt, and implement new technology-enabled solutions, including AI-enabled devices, mobile medical units, telehealth options, patient remote monitoring, and falls prevention video surveillance. Through a combination of technical assistance, education, training, and data insights, healthcare organizations will become better equipped to: (1) make well-informed decisions around procurement and implementation; (2) perform proactive risk assessments; and (3) utilize patient reported outcomes to inform the use of technology-enabled solutions. Since RHTP funds require timely investments, ECRI’s capabilities enable us to make decisions quickly, while still ensuring quality and safety. Using an approach that supports healthcare staff as well as patients and families can help reduce dissatisfaction, burnout, and the risk of preventable harm. Creating staff resiliency and patient engagement around the use of technology-enabled solutions is essential to success.	A. Decision Making, Procurement, & Implementation Planning of Technology-enabled Solutions Aim: Strengthen healthcare decision making by providing unbiased technical assistance, education, and training to assess the need, value, safety, and operational aspects of implementing technology. Objectives: 1. Virtual education and training activities for biomedical engineers, risk managers, quality and performance improvement professionals, supply chain management, healthcare leaders and clinicians Training topics: human factors engineering for health device and technology procurement safety, value analysis in the age of AI, creation of an AI governance structure, and essential change management concepts 2. Technical assistance activities: Monthly office hours staffed by ECRI subject matter experts Clinical evidence assessments and value analysis reports to assist in benefit analysis and decision making Resources on best practices to implement AI use governance structures Guidance on the safe integration of innovative uses of technology B. Proactive Assessment of Technology-Enabled Solutions Aim: Use of human factors approach to increase awareness and understanding of clinical- and safety-related risk factors and potential usability concerns when implementing technology-enabled solutions by providing hands on simulated learning and technical assistance. Objectives: 1. On-site, hands-on simulated learning activities: Simulation learning curriculum led by human factors engineers focusing on how to perform proactive assessments of both usability and safety for technology Guidance for healthcare staff to conduct proactive assessments and reactively learn from near miss and adverse events 2. Technical assistance activities: Monthly office hour sessions staffed by ECRI human factors experts Examples of safety risk assessments on various topics Strategies to conduct a needs assessment to identify current gaps in health information technology C. Evaluation of Patient Reported Outcomes Related to Technology-Enabled Solutions Aim: Create a web-based portal to collect and analyze patient reported outcomes related to the use of technology-enabled solutions, with a focus on both positive and negative outcomes that patients have experienced. Objectives: 1. Collect and analyze patient-reported outcomes on the use of technology-enabled solutions 2. Publish consumer alerts around safety concerns related to the use of technology-enabled solutions	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Envoy Integrated Health	Envoy Community Care Technology Enablement Initiative	AK	Alaska’s community-based organizations (CBOs) provide essential services that address health-related social needs, chronic disease support, care coordination, housing stabilization, transportation access, food security, and wellness navigation. These organizations are an essential piece of rural and frontier health care delivery, yet they lack consistent access to electronic documentation systems, interoperable tools, and affordable technology infrastructure. Instead, many CBOs rely on spreadsheets and paper files which do not allow for compliant data sharing. CBOs that do have electronic platforms often cannot integrate with statewide systems such as the health information exchange (healthEconnect). This creates fragmented information flow, duplicative efforts, high administrative burden, and inconsistent data quality. As Alaska advances value-based care and coordinates patient care statewide, the technology gap between clinical and community partners continues to widen. This gap is especially wide for small rural CBOs with limited resources. The existing Envoy Community Care Hub serves as a collaborative between CBOs and health care providers. This creates an opportunity for a shared, scalable, and sustainable CBO technology infrastructure, by expanding the existing Envoy Community Care Hub to include shared technology infrastructure and support.	Envoy proposes to build a centralized technology enablement program that equips Community Based Organizations with a standardized, health care compliant documentation platform. We will create economy of scale through group purchasing, shared implementation, and coordinated support. This project builds on the Envoy Community Care Hub, leveraging a trusted entity to work towards a statewide referral network and multi-sector partnerships. This initiative will reduce administrative burden and enhance interoperability by integrating directly into Envoy’s proposed statewide referral and coordination systems (Envoy Statewide Population Health Services Organization, separately proposed LOI). This project will also seamlessly integrate into Alaska’s health information exchange (healthEconnect). Our approach includes assessment, vendor procurement, platform configuration, integration development, onboarding, training, and ongoing support throughout the process. Cohorts of CBOs will be onboarded in phases, ensuring readiness and sustainability. This structured model positions Alaska's CBO network for long-term success in value-based care through high quality, interoperable technology infrastructure. Alternative payment models support folding community organizations into clinical work because of their recognized impact on health outcomes. This system will empower community partners to participate as peers in whole person care delivery, strengthen coordination between clinical and community sectors, and advance equitable access to services across Alaska.	\$250K-\$1M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Envoy Integrated Health	Medicaid Accountable Care Organization Pilot	AK	Alaska is preparing to shift toward pay-for-value but remains without a value-based model for its Medicaid program. Alaska Medicaid’s fee-for-service structures offer no incentive for prevention, coordination of care, or shared accountability. This leads to inconsistent, inefficient care and poorer health outcomes for beneficiaries. An Accountable Care Organization (ACO) is a group of providers working together to improve the quality and reduce the cost of caring for their patients. This is a tried-and-true value-based care model operating on the concept of shared savings: if costs are reduced while keeping quality high, the ACO and payer share in the cost savings. There are over 500 ACOs in the lower-48, and in 2022 ACOs saved Medicare \$4.3 billion dollars. Many states utilize an ACO model for their Medicaid programs, with studies demonstrating improvements in health care quality and decreased cost. In 2024, Envoy Integrated Health created Alaska’s first locally based ACO which outperformed quality benchmarks while saving Medicare \$7.6 million in its first year. Expanding Envoy’s proven ACO model to Alaska’s Medicaid population represents an opportunity to improve the quality and lower the cost of care in Alaska while encouraging participation in pay-for-value arrangements.	Envoy Integrated Health Network proposes a multi-year Medicaid Accountable Care Organization (ACO) pilot designed to modernize Alaska’s Medicaid incentive structure and payment system. This pilot project will translate our ACO model to Alaska’s Medicaid population using a shared savings model and national best practices to encourage keeping health care local, coordinated, and sustainable. As Alaska’s first ACO and the state’s largest Clinically Integrated Network, Envoy is uniquely positioned to adapt our successful model to Medicaid in a way that reflects Alaska’s geography, workforce realities, and care delivery ecosystem. The proposed pilot will establish a Medicaid ACO anchored in local primary care, specialty, and community partnerships. Our model emphasizes coordinated chronic disease management, telehealth-enabled access, and shared accountability for cost and quality outcomes. By retaining financial accountability and shared savings within Alaska, the pilot supports long term system sustainability and reinvestment in local clinics and care teams. Envoy is an Alaska-based physician-led collaboration between more than 40 primary care and specialty practices serving hundreds of thousands of Alaskans. Our network includes partnerships with both Anchorage non-tribal hospitals and their emergency departments. This places Envoy in an excellent position to be successful on a timeline that aligns with the RHTP. We propose this project under the “Defined Approach” designation to allow for the intensive planning and actuarial analysis needed for a successful ACO shared-savings approach. While Envoy’s ACO is operationally ready to participate in a Medicaid shared-savings program now, establishing a program with Alaska’s Medicaid will be the focus of the first year. Envoy’s first year activities will focus on data readiness assessment, evaluation, governance establishment, and model design to prepare for phased implementation in subsequent years. We will look to national best practices and adapt successful models from other states into Alaska’s unique healthcare system. We will work closely with the Department of Health to establish workflows for claims data and benchmark creation. This work plan is intentionally phased to allow for thoughtful design, measured implementation, and responsible expansion as capacity grows.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Matanuska-Susitna Borough	Advance to Implementation Application

Envoy Integrated Health	Specialty Care Coordination and Navigation Hub	AK	Health care in Alaska is a complex and poorly coordinated system. A large amount of health care spending is wasted on inefficiencies between rural primary care providers and specialty care providers who are primarily located in urban areas. Patients living in rural areas, regardless of payors, are tasked with coordinating and navigating these systems largely on their own, which can result in fragmented, delayed or missed care, poor health outcomes, increased financial burden, and emotional stress. To address the persistent challenges rural Alaskans face in accessing specialty care, we propose the creation of a Specialty Care Coordination and Navigation Hub. This hub will serve as a centralized system that streamlines communication, referrals, and care planning across geographic and institutional boundaries. By focusing on condition-based enrollment rather than insurance status, the hub ensures access for all patients diagnosed with complex conditions such as congestive heart failure, diabetes, or cancer. Envoy already plays a vital role in supporting rural health care by leveraging our network of specialty providers. In rural Alaska, where access to specialists is often limited, Envoy works to bridge the gap by facilitating consultations and ensuring that patients receive care that is timely and appropriate. This model not only enhances the quality of care for rural residents but also reduces the need for costly and logistically challenging travel to urban centers.	The hub will provide Alaskans with personalized care coordination through dedicated care managers who help patients navigate complex conditions, schedule all necessary appointments, and ensure that when patients travel to urban centers, they can complete multiple specialty visits in a single trip. Care managers can also coordinate essential screenings such as mammograms or colonoscopies during the same trip. The hub supports primary care providers through a specialist consultation line and a centralized referral system, reducing the burden of navigating fragmented networks and helping rural clinics quickly connect patients with appropriate specialists. To reduce unnecessary travel and improve continuity of care, the hub will integrate remote patient monitoring (RPM) and telehealth tools. These technologies allow providers to track and manage patient health metrics in real time, enabling Alaskans to remain in their home communities whenever possible. This model enhances safety, improves satisfaction, and lowers costs for patients and payors by minimizing emergency visits, hospitalizations, and duplicate testing. The hub will also collaborate with rural communities to establish local specialty clinics where Alaska-based specialists can travel to see patients on a scheduled basis. Combining in-person visits close to home with telehealth, RPM, and coordinated support from local providers creates a proactive system of care for people with complex needs. The hub represents a transformative approach to bridging the health care gap between rural and urban Alaska. By beginning with high-need conditions and expanding to other chronic and complex illnesses, it will create a seamless, patient-centered system that reduces travel, improves timely access to care, and strengthens collaboration between providers. Through integrated coordination, remote monitoring, and a single-call referral model, patients will experience fewer delays, better outcomes, and a more supportive care journey, regardless of insurance status. This approach addresses long-standing health disparities between urban and rural communities while offering a sustainable financial path forward. By reducing avoidable hospitalizations, emergency visits, and redundant services, the hub will generate meaningful cost savings for patients and payors. This project will synergize with other RHTP projects proposed by Envoy, including the Statewide Population Health Services Organization.	\$1M-\$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Envoy Integrated Health	Statewide Population Health Service Organization	AK	Alaska’s healthcare system is fragmented and siloed. Providers need high-quality, interoperable electronic health records and tools to manage the health of their patients. These services are essential for delivering coordinated and cost-effective care but are often too complex and expensive for provider practices to implement on their own. This barrier is even greater for small practices where access to affordable, interoperable electronic health records, population health analytics, care management tools, and automated quality reporting is out of reach. Without this critical healthcare infrastructure, Alaska’s goal of transitioning to pay-for-value will remain unattainable. If individual practices attempted to contract with vendors for these services separately, it would be cost prohibitive and worsen the fragmentation of care. High performing healthcare systems centralize these services to create economy of scale and ensure interoperability. A shared services model that makes services available and affordable to provider groups of all sizes does not currently exist in Alaska.	We will create a statewide Population Health Services Organization (PHSO) that provides shared electronic health records and population health tools for providers. The PHSO’s shared services may include high quality electronic health records systems, population health data aggregation and analytics, standardized quality metric reporting, centralized care management and coordination, electronic referrals, a remote patient monitoring and chronic disease management platform, contracting support for value-based care arrangements, risk modeling and actuarial support to evaluate participation in pay-for-value programs, and technical assistance to support providers transitioning to value-based care models. The statewide PHSO will work closely with Alaska’s state health information exchange (healthEconnect) and be interoperable with other Alaskan healthcare systems (e.g., tribal, hospital based, or federally qualified health centers). This will support and protect the investments the Department of Health has already made without being redundant or inefficient. Envoy Integrated Health is uniquely positioned to be successful in this project. Envoy is an Alaska-based physician-led collaboration between more than 40 primary care and specialty practices serving hundreds of thousands of Alaskans. Envoy’s mission is to establish a more coordinated healthcare delivery system and to improve population health. Envoy houses the largest Clinically Integrated Network (CIN) and started the first Alaska-based Accountable Care Organization (ACO), which has consistently outperformed benchmarks and saved Medicare millions of dollars each year. Envoy is a trusted entity among providers and has a built-in customer base committed to utilizing the services of the PHSO. Leveraging the size and reach of Envoy will allow the PHSO to attain success quickly, which is essential for the timeline of RHTP. Envoy is ready to begin immediately in standing up governance, technology, and operational frameworks that will support statewide participation and multi-payer alignment. The PHSO will focus on recruiting primary care practices, and Envoy membership will not be required to participate. The PHSO will maintain strong state alignment to ensure all tools and workflows support broader Rural Health Transformation Program goals including chronic disease management, access to telehealth, and sustainable participation in value-based payment models.	Over \$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Envoy Integrated Health	Alternative Payment and Value-Based Care Model Feasibility Assessment	AK	Alaska is at a pivotal moment as national value-based care models evolve to strengthen rural access, expand primary care services, and transition providers toward pay-for-value. However, Alaska lacks organizations that have participated in Advanced Alternative Payment Models (AAPMs) or taken advantage of emerging CMS models such as ACCESS, LEAD, and risk-bearing arrangements. Participation in these programs is vital for the future of Alaska’s shift to pay-for-value, but requires identification of their risks, opportunities, and operational implications. Alaska’s unique geography, cost structure, workforce capacity, and rural population make careful evaluation of these models essential prior to adoption. Alaska’s providers must prepare for participation in emerging alternative payment models. A structured feasibility assessment is needed to evaluate readiness, financial implications, operational impacts, and multi-payer alignment. This work positions Alaska to lead in value-based innovation while respecting local control. As Alaska’s largest Clinically Integrated Network (CIN), Accountable Care Organization (ACO), and pioneer in value-based care, Envoy Integrated Health is well positioned to lead this effort.	Envoy will lead a comprehensive, multi-model feasibility assessment to evaluate organizational readiness, financial sustainability, operational impact, and clinical implications of ACCESS, LEAD, REACH and other value-based risk-bearing programs. We will also assess the feasibility of provider participation in statewide models such as the CMS AHEAD model. This implementation-phase initiative begins immediately and includes onboarding actuarial, financial, and operational consulting partners. The assessment will include benchmarking, gap analysis, risk modeling, provider engagement, policy alignment, and readiness scoring across all models. The process will culminate in a clear, state-aligned recommendation for phased participation, future preparation, or deferral. The approach ensures decisions are data-driven, Alaska-specific, and clinically grounded. We believe our work will be generalizable to providers across Alaska and help guide them in transitioning to pay-for-value models.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Envoy Integrated Health	Value-Based Care Technical Assistance Program	AK	Alaska’s health care system operates on a fee-for-service model that is financially unsustainable. While the rest of the United States has shifted towards value-based care models that incentivize healthy communities, Alaska has lagged behind. Rural providers in particular stand to benefit from innovative care models that incentivize care coordination and chronic disease management. However, the transition to pay-for-value models requires significant expertise for providers to be successful. There are many lower-48 based organizations that provide technical assistance (TA) for value-based care, but they lack the local knowledge necessary to serve Alaska’s unique geography and health care delivery system. Value-based care expertise within Alaska is limited and needs to be scaled to be available to all providers, especially primary care providers. Creating local, trusted expertise in value-based care aligns directly with Alaska’s RHTP initiative of Pay For Value: Fiscal Sustainability.	Envoy Integrated Health will create a Value-Based Care Technical Assistance Program for health care providers and clinics across the state. This program will build the core competencies required for providers to participate in value-based care. As the largest and most successful Alaskan value-based care entity, we have the local knowledge and expertise needed to support Alaska’s Pay for Value initiative. Alaska’s unique care environment requires a technical assistance (TA) provider that understands national value-based care models and Alaska’s health care delivery system. We will achieve this by leveraging our current local value-based care experts, cultivating and supporting growth of new Alaskan value-based care leaders, and curating relationships with trusted national experts. Together, this “home team” will implement a two-pronged approach to TA: 1.) Targeted Technical Assistance: We will provide targeted TA to provider organizations with an emphasis on building capacity for primary care practices to participate in value-based care arrangements. We will start with readiness assessments and co-develop action plans with individual clinics. Our support will include value-based contract review and negotiation support, implementation planning and change management, performance benchmarking and attribution, financial modelling, and revenue-cycle and billing for primary care. TA will be delivered through on-site and virtual visits with individual clinics, group “office hours,” and webinars to engage rural clinics. 2.) Rural Provider Accelerator: We will use a rural accelerator model to quickly close the gap in value-based care participation between rural and urban centers. Cohorts of rural and frontier providers will engage in a 6–9-month accelerator featuring shared-learning “sprints” on data integration, care coordination, attribution accuracy, and population health tools. We will build partnerships and encourage information sharing with rapid cycle quality improvement and peer benchmarking. The accelerator will advance value-based care transformation and statewide standards while respecting local practices. This project is a cornerstone of Alaska’s RHTP Pay For Value initiative and will synergize with other RHTP projects proposed by Envoy, including the Statewide Population Health Services Organization and Specialty Care Coordination and Navigation Hub.	\$1M-\$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Eric Noll OD PC	Rural access to optometric care and staff recruitment	AK	Not enough exam availability. Unable to competitively recruit providers while maintaining enough income to cover day-to-day expenses secondary to reduced insurance reimbursements.	Use a 'head-hunter' to find and recruit more optometrists, and pay relocation bonuses. Any overage would be applied to travel costs in order to perform rural village exams.	\$50,000-\$250,000	Other	Statewide	Aleutians East Borough; Anchorage (Municipality); Chugach Census Area; Denali Borough; Juneau (City and Borough); Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced
Erotic Service Provider Legal, Educational, and Research Project, Inc	Who Rescued Who: Indoor Community Dog Park	CA	Dog ownership in Alaska has grown by leaps and bounds since COVID. Science continues to produce studies lauding the mental health and wellness impacts of pet ownership, so it is no surprise that, today, 38% of Alaskans own at least one dog – and among Alaskans over 60, dog ownership has increased by 77%. Unlike most other housepets, dogs must be frequently exercised. For Alaskans who work on the frontlines, such as hospital staff, late working hours means walking their dogs in the dark after work – a safety risk. For older Alaskans who own dogs, walking on ice poses a clear and present danger during the winter months. Outdoor dog parks are unregulated/unstaffed and can pose safety issues for both dogs and humans. Many low-income families who own dogs can benefit from material community support. Dog ownership is a wholesome avenue for community building. Community dog adoption events miss an opportunity when they take place in corporate pet store environments. People new to sobriety can be turned away from 12-step meetings that don’t accommodate dogs; by contrast, those in recovery can experience rehabilitative impacts, including durable recovery in finding common ground through dog ownership within the recovery community and with the community at large. Worker-ownership is an evidence-based approach to employment for populations that struggle to find living-wage jobs, including re-entry populations, sex workers transitioning out of the sex trade, and survivors of trafficking.	The proposed place-based brick-and-mortar indoor dog park, designed as a worker co-op employing re-entry populations, will offer fair wages and a safe wellness space for dog owners from many walks of life. Innovative community-building elements of the project include a coffee and ice cream bar, with a dining area specially designed to accommodate the presence of many dogs (e.g., dogs may sit near their owners, but will be separated by a wrought iron gate to prevent snack attacks) with seating designed to support conversation among the dog-owning community. As is customary for indoor dog parks, the floor will be engineered for washdown/drainage and covered with safe, washable antimicrobial turf. Our private park membership model requires vaccinations, spay/neuter, and temperament checks. With flexible play zones and webcam access for all, this community third space is designed to be inclusive and a place to connect with others. Located in a 5,000+ square foot warehouse, the indoor dog park will include benches, colorful fire hydrants, and social media-ready wall murals for selfies and our livestreaming social media dog content for Alaskans experiencing isolation. The project will employ a low-bandwidth “Arctic-friendly livestream” that works with satellite internet for Alaskans who live in rural, remote, and frontier locations. To serve low-income populations, the indoor dog park will offer discounted memberships as well as a pet food pantry and a dog toy library. To build geographically-specific community through place-based activities, we will build out the space as a community hub resource that offers social opportunities through sober dog events (Mutts & Mocktails), trivia nights, singles nights, monthly breed-specific meetups (Senior Sundays, Pittie Playgroups), event space rental (e.g., dog birthday parties), DogTalks (structured like TED Talks and featuring educational sessions with trainers, groomers, and veterinarians), family-oriented summertime “Dogapalooza” local dog product vendor pop-up events (including sponsorships, vendor fees, business signage, promo decals) monthly showcases for pet-friendly makers and artists, and community-based meet-and-greets with dog rescue partners on Saturdays. Anchorage has a high dog ownership: the Alaska State Veterinary Medical Association reports 105,000 dogs in Anchorage. With over 20 doggy daycares and dogboarding in the Anchorage area, we will partner with dog-serving businesses to cross-promote services.	\$50,000-\$250,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced	

ES Digital Health, inc	Alaska Provider DSCSA Compliance & Medication Access Initiative	AZ	The Drug Supply Chain Security Act (DSCSA) became fully enforceable on November 27, 2025. The law requires healthcare providers involved in prescribing, ordering, or dispensing prescription medications to maintain traceable transaction documentation across the pharmaceutical supply chain and produce those records within 48 hours during a regulatory audit. Civil penalties for non-compliance can reach up to \$100,000 per violation. Many rural healthcare providers remain unaware that these requirements now apply directly to prescribing and procurement workflows. As a result, numerous rural facilities operate and treat patients without automated DSCSA documentation systems. Physicians commonly issue 20–30 prescriptions per day. Without automated documentation tools, each transaction can represent potential regulatory exposure, which may accumulate rapidly across rural healthcare networks. Our proposal addresses this need by deploying WATTS, a fully operational DSCSA e-procurement and compliance platform integrated with a HITECH-certified, MACRA/MIPS-compliant EMR and a consumer-facing mobile application. The system automatically generates and stores required transaction records during prescribing and procurement activities, allowing providers to maintain audit-ready compliance while continuing normal clinical operations. Statewide deployment would equip Alaska’s rural providers with infrastructure to support DSCSA compliance while strengthening digital health systems.	We propose an immediate statewide deployment of the WATTS DSCSA Compliance Platform, a fully operational digital infrastructure designed to ensure providers can document prescription drug transactions in accordance with DSCSA requirements. The system comes integrated in a bundled package with three core components: 1. DSCSA e-procurement and documentation platform 2. HITECH-certified EMR system for clinical workflow integration 3. Consumer-facing patient mobile application Together, these technologies create a seamless data flow connecting prescribing physicians, healthcare facilities, vendors, and patients while automatically generating required compliance documentation. The platform can be deployed in two ways depending on facility needs: • As a primary HITECH-certified EMR system • As an add-on compliance and reporting layer for facilities that already operate an EMR Unlike most EMR systems, this platform utilizes structured data architecture, meaning clinical data is captured in standardized formats across specialties. This allows healthcare providers and state agencies to generate structured reporting outputs that support RHTP program reporting requirements, performance tracking, and regulatory oversight. Deployment would prioritize Alaska’s rural hospitals and clinics currently lacking DSCSA documentation infrastructure. Because the technology is already built, operational, and interoperable, the project focuses on rapid implementation and provider onboarding rather than software development, allowing providers to begin addressing compliance requirements quickly. Technology Certifications & Compliance Infrastructure The proposed system includes the following certifications and capabilities: • ONC HITECH Certified for Interoperability • MACRA/MIPS Certified for billing and quality reporting • FHIR / HL7 compliant for health data exchange • Web-based deployment architecture • Integrated Patient Portal • Consumer-facing mobile application • Live-time patient monitoring and real-world data capture (RWD/RWE) • Referral management and care coordination tools • Staff and workflow management systems The platform also supports • Improved clinical documentation • Structured outcome reporting for RHTP programs • Reduced billing errors and fraud, waste, and abuse risk • Enhanced patient engagement through mobile technology • Improved workforce efficiency and provider retention	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

ES DIGITAL HEALTH, INC	ES DIGITAL HEALTH INC AND EVENT MODULES DEPLOYMENT OF MOBILE CLINIC SPECIALTY CARE ROOMS	AZ	Event Modules proposes the deployment of 20 rapidly deployable Flex Space modular medical units that can be configured to create immediate two-room sterile clinics. Each unit can be transported easily, carried through standard doorways, and deployed by two people in approximately 15 minutes. Designed for Arctic conditions, the units include 4-inch foam insulation, HEPA filtration, positive or negative pressure airflow, pathogen-resistant materials, and climate control to maintain sterile environments for both patients and medical personnel. Rural communities in Alaska face significant challenges in accessing timely healthcare due to geographic isolation, limited infrastructure, and extreme weather conditions. In emergency situations such as disease outbreaks, natural disasters, or mass casualty events, many communities lack the physical medical infrastructure necessary to provide triage, treatment, or isolation care. The modular units support critical use cases including mobile clinics, triage and surgical rooms, infectious disease isolation units, patient intake offices, and emergency housing for non-ambulatory patients. Integrated connectivity—including bonded cellular communications, satellite connectivity, and AI-enabled monitoring ensures capability in remote regions. This will significantly improve rural healthcare resilience, enabling state agencies to deliver rapid medical response capabilities wherever they are needed. https://eventmodules.com/videos/	Event Modules' project will deploy 20 Flex Space modular medical units to support rapid healthcare response in underserved rural communities across Alaska. The units will be manufactured, configured, and delivered in coordination with state and local emergency management and public health agencies to ensure alignment with regional healthcare needs. We will provide training and oversight as well as User Manuals and Instructional Videos to train personnel for deployment of our modules. Each modular unit is designed for rapid transport and field deployment, allowing a two-person team to set up a sterile medical environment in approximately 15 minutes. The units can be transported via truck, air cargo, or barge to remote communities and positioned at clinics, emergency response sites, or temporary medical facilities as needed. Once deployed, the modules can be configured for a range of medical uses including triage and treatment rooms, infectious disease isolation units, surgical support areas, patient intake offices, or emergency housing for non-ambulatory patients. Built with Arctic-grade insulation, HEPA filtration, positive and negative air pressure capabilities, and pathogen-resistant materials, the units maintain safe, climate-controlled environments suitable for patient care in extreme weather conditions. Connectivity systems—including bonded cellular networks, optional satellite connectivity, and AI-enabled monitoring—will allow healthcare providers and emergency responders to maintain communication and operational awareness even in remote locations. Through coordination with public health agencies, these deployable units will serve as a flexible and scalable healthcare infrastructure solution that can be rapidly mobilized during emergencies, seasonal health surges, or disaster response situations.	Over \$5M	Clinic	Statewide	Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

ES DIGITAL HEALTH, INC	ES DIGITAL HEALTH INC and LIIFEID INC to avoid Fraud, Waste and Abuse in Medicaid and Medicare.	AZ	Rural, remote, and frontier communities in Alaska face persistent challenges in accessing timely, high-quality healthcare due to geographic isolation, workforce shortages, limited connectivity, and fragmented medical records. These gaps result in missed preventive care, delayed chronic disease management, and inefficiencies in Medicaid administration. This project addresses these challenges by deploying ES Digital Health record as the core clinical platform, integrated with LiifeID’s biometric identity verification. ES Digital Health record consolidates clinical encounters into actionable, patient-centered longitudinal care plans across providers, telehealth, and mobile health deployments. LiifeID secures patient identities, eliminates duplicate or fraudulent Medicaid enrollment, and maintains verified identity across the care continuum. Both platforms are interoperable, CMS-compliant, and aligned with federal Health Technology Ecosystem and ASTP/ONC criteria, ensuring secure, auditable, HIPAA-compliant data exchange. The initiative strengthens healthcare access, care coordination, and patient engagement in underserved communities while protecting program integrity and reducing Medicaid fraud, waste, and abuse. By combining biometric identity verification with a modern digital health record, this project delivers a scalable, flexible, and sustainable solution that improves access, quality, and outcomes for Alaska’s most vulnerable populations.	Our approach leverages the cloud-based ES Digital Health record integrated with LiifeID biometric identity verification to strengthen healthcare access, quality, and sustainability for rural, remote, and frontier Alaskans. Once funded by the State of Alaska, patients establish their own accounts, ensuring secure, longitudinal health records linked to verified identities. Biometric verification prevents duplicate or fraudulent Medicaid enrollment, preserves coverage continuity, and provides an auditable identity layer across the care continuum. The implementation has three components: 1. Patient and Provider Activation – Patients set up accounts with guided onboarding supported by local clinics and Community Health Aides/Practitioners (CHA/Ps). Providers access consolidated care plans for follow-up, chronic disease management, preventive care, and remote monitoring. LiifeID’s biometric verification removes duplicate identities and ghost enrollees at the point of enrollment—preventing recurring fraudulent payments before they enter the system 2. Operational and Clinical Workflow Integration – The platform consolidates encounters from multiple providers, mobile clinics, and telehealth into a single, patient-centered record. Mobile units for triage, maternal health, emergency response, or preventive screenings operate seamlessly with cloud-based records, supporting real-time documentation, follow-up alerts, and secure provider communication. Verified identity infrastructure extends to provider-side enrollment, reducing fraudulent billing tied to unverified or compromised provider identities This approach combines cloud-based, patient-controlled records with verified identity to enable scalable, sustainable healthcare delivery. It reduces administrative burden, strengthens Medicaid integrity, empowers patients, and supports evidence-based interventions. The solution is designed for rapid adoption, long-term maintenance, and measurable improvements in access, quality, and outcomes across Alaska’s underserved communities.	Over \$5M	Statewide	Anchorage (Municipality); Bethel Census Area; Denali Borough; Fairbanks North Star Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Matanuska-Susitna Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

ES Digital Health, inc	Financial Solvency and Sustainability through Value Based Models & Alternative Payment Methods.	AZ	Rural healthcare providers face growing financial pressures from declining reimbursements, workforce shortages, and limited access to capital, leaving many facilities vulnerable. Simultaneously, hospitals and clinics generate large volumes of clinical and operational data that currently carry no recognized balance sheet value, creating unrecognized economic asset value through what is now documented as an expense. This project introduces a two-phase model to unlock and activate that value. Phase 1 – Data Asset Appraisal: Qualified third-party valuation under FASB ASC 805/350 identifies and appraises seven or more years of historical healthcare data. Until appraised, the data carries zero financial value; once recognized as an intangible asset, it strengthens provider balance sheets and solvency. Phase 2 – Commercialization Facilitation: We help eligible providers to responsibly license the de-identified data for research, regulatory submissions, and real-world evidence. The project supports compliant partnerships with research institutions and industry seeking rural healthcare data. For example, if ten rural providers identify datasets valued at \$20M–\$40M each, Alaska has an ROI of \$200M–\$400M in new healthcare assets in year 1. Similar assets exist across thousands of urban providers nationwide. If successful state-wide, this project could establish a scalable model for unlocking healthcare data value and strengthening financial sustainability across rural America.	The Powell Firm and ESD propose a structured program to identify, appraise, and responsibly commercialize de-identified healthcare data generated by Alaska healthcare providers. The project uses a two-part operational model designed to unlock asset value and support ongoing monetization. Part 1 – Data Asset Appraisal and Recognition: Participating providers identify eligible datasets from routine care delivery. Independent third-party valuation specialists perform appraisals consistent with FASB ASC 805 and ASC 350 to establish Fair Market Value (FMV). Until appraised, these datasets carry no recognized financial value; once appraised, they can be recorded as identifiable intangible assets. This strengthens provider balance sheets, improves debt-to-asset ratios, and enhances borrowing and investment capacity. For example, a rural clinic with \$10M in revenue and 2% operating margin may see its longitudinal dataset valued at \$40M, transforming its financial profile. Part 2 – Commercialization Facilitation and Sustainability: After appraisal, the project establishes compliant partnerships with research institutions, pharmaceutical companies, biotechnology firms, and healthcare technology developers seeking de-identified real-world data. Ongoing support includes quarterly FMV reassessments, financial reporting guidance, training for CFOs, and continued partnership development, ensuring long-term governance and maximized asset value. Together, this model transforms routine healthcare data into a recognized financial asset, strengthening rural provider balance sheets, enabling access to capital, and supporting innovation in healthcare research and technology. If five participating sites each identify datasets valued between \$20M and \$60M, the program would unlock more than \$100M in newly recognized healthcare assets across Alaska in Year 1, creating immediate solvency, financial sustainability and profitability- ultimately improving the entire delivery of care throughout Alaska.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

ES DIGITAL HEALTH, INC	Patient Facing Digital Health App-secure for Patients Interoperable Data Infrastructure Initiatives	AZ	Alaska faces one of the most challenging healthcare delivery environments in the United States. Vast geography, extreme weather, and a widely dispersed population create significant barriers to coordinated medical care. Many rural communities rely on small clinics, rotating physicians, and telemedicine services for primary care. Patients frequently receive treatment across multiple facilities, including community clinics, regional hospitals, imaging centers, and laboratories. These providers often operate separate electronic medical record systems with limited interoperability, resulting in fragmented patient health information across institutions. When patients seek care at new facilities or require specialized treatment, providers may not have immediate access to critical medical data such as diagnostic imaging, laboratory results, medication histories, or prior diagnoses. This lack of access can delay diagnosis and treatment, increase healthcare costs, and reduce clinical efficiency. In some cases, procedures or surgeries are delayed while providers attempt to collect records from multiple locations. These challenges disproportionately affect rural Alaskans who must travel long distances for specialty care. Without timely access to complete medical records, providers may repeat diagnostic tests or postpone treatment, increasing both healthcare costs and risks to patient safety.	Project Concept and Approach ES Digital Health Inc. proposes statewide implementation of its secure, patient-facing Digital Health record to empower Alaskans to manage, maintain, and share their health information. The initiative aligns with federal priorities under the 21st Century Cures Act, CMS Interoperability and Patient Access Rule, and ONC information blocking provisions, supporting patient access, health data portability, and digital health innovation. Over five years, the project will enroll residents, provide education, and assist patients in creating and maintaining secure digital health records. The first-year budget will fund training, outreach, patient support, and integration of best practices for secure API interfaces with healthcare data silos. Educational resources include instructional videos, step-by-step guides, demos, and a hotline to assist patients with setup, document uploads, and sharing with providers. The platform enables patients to securely store and manage key medical information, including diagnostic imaging, lab results, physician notes, surgical reports, medication histories, and chronic disease records such as A1C and blood pressure tracking. Unlike mass EMR migrations, the focus is on clinically relevant data selected by patients, ensuring portability and usability. This data is private to the patient and in the patient control and maintenance. By consolidating records from hospitals, clinics, laboratories, and imaging centers, the system reduces inefficiencies, prevents repeated testing, and improves provider decision-making. It also reduces information blocking and ensures compliance with federal interoperability standards. Rural and mobile populations benefit particularly, as patients can carry a complete cloud-based health history between communities or facilities. Patients can send their records via QR codes, encrypted email, or secure links, to their providers improving continuity of care and supporting rural health equity. Patients can also tell their health story, and record their personalized records of nutrition, blood pressure, exercise or any other health care markers or attributes from their own personal digital health records. This initiative strengthens compliance with federal digital health requirements, enhances patient engagement, improves care coordination, and ensures lifelong, secure access to medical records, addressing Alaska’s unique geographic and rural healthcare challenges.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Denali Borough; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Sitka (City and Borough); Skagway (Municipality); Yukon-Koyukuk Census Area	Deferred or Not Advanced

ESO Solutions, Inc.	Alaska Rural EMS and Alternative Care Access Transformation Project	TX	The EMS/trauma model is under strain in rural communities. Many EMS requests are not time-sensitive, yet the default path is still ambulance response and long-distance transport, which can leave a community without coverage for true emergencies. Frequent callers and low acuity patients further strain local systems, while EDs become crowded with low-risk, high-utilizer visits. EMS and ED care are among the costliest access points for non-emergent medical needs, regardless of payor, and Medicaid patients disproportionately over-utilize EMS and emergency departments for non-emergent care. Options exist today for integrated care paths, treat-in-place, community paramedicine/mobile health, telehealth, behavioral health, and non-emergent transportation to alternative care sites. ESO data services and technologies can align EMS, hospitals, and payors with these alternative care paths and create a path to sustainable funding through enduring value to hospital and payors. Coordination is also needed for rural hospital patient transfers for air/ground transports, plus patient outcomes can be shared with EMS, hospitals, tribal health, and payors to improve care, quantify the impact on access, quality and costs. This ESO project will drive “transformation of the statewide EMS/trauma systems by enabling safer patient routing, stronger transfer coordination, statewide measurement that supports alternative payment models and long-term EMS sustainability” (page 39 of AK’s RHT application).	We propose a statewide data solution to align with AK RHPT initiatives 2, 4, and 6. We offer a proven, vendor-agnostic and standards-based interoperability technology framework that links 911 dispatch, EMS, hospitals, alternative care (telehealth, community paramedicine, mobile health, behavioral health, substance abuse), and payers in near real time. Our systems, proven in more than 1,500 hospitals today, can serve as the backbone of Alaska’s EMS and trauma modernization plan and support RHTP goals, metrics, and long-term sustainability by year five. Four ESO components work together to support operations, data sharing, and measurement. ESO Health Data Exchange (HDE) enables bi-directional exchange between EMS, hospitals, clinics, and other partners. It reduces manual handoffs and supports outcomes loop closure so partners can see what happened next. This linked data helps modernize EMS and can support sustainability as hospitals underwrite ongoing exchange once they see value. Our vendor agnostic approach integrates with many electronic medical record (EMR) systems, so EMS, MIH/CP, hospital, and other providers can keep their existing EMR. ESO EHR documents alternative care encounters and MIH/CP follow-ups outside the ED, including treat-in-place care, telehealth encounters, and field referrals. ESO Logis manages referrals, scheduling, follow-ups, and dispatch of MIH/CP resources when used. It also tracks status end-to-end for interfacility air/ground hospital transfers and low-acuity 911 navigation. ESO Data Studio provides statewide and regional dashboards for diversion, ED avoidance, transfer times, program reach, and outcomes, and supports stakeholder reporting and payment model analysis over time. We will implement a Medical Coordination Center program with two connected activities. Activity 1 (Transfers) establishes one workflow for rural transfers and patient placement, including interfacility air/ground transport. Logis runs intake, routing, and status; HDE shares required outcomes data to continuously optimize the model and ensure safety surveillance; Data Studio provides the operations picture and supports quality improvement. Activity 2 (Medical triage and patient diversion) adds safe 911 triage and navigation that supports treat-in-place, telehealth, MIH/CP follow-up, and alternate destinations, with documented encounters in EHR, coordinated workflows in Logis, exchange and loop closure through HDE, and ongoing measurement in Data Studio.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Esvyda Inc	Expanding RPM, CCM, Telehealth and Diagnostic & Coordinated Care Across Rural and Tribal Communities	CA	Alaska’s Rural Health Transformation Program identifies Initiative #6: Spark Technology & Innovation as a foundational strategy for strengthening care delivery across frontier, rural, and tribally diverse communities. The state’s focus on leveraging technology-enabled platforms to expand care as close to home as possible while improving diagnostic capabilities and coordination across hub-and-spoke systems directly aligns with Esvyda’s remote clinical infrastructure model.	Esvyda’s proposed approach to supporting Alaska’s Initiative #6 is to deploy an AI-enabled Remote Patient Monitoring (RPM), Chronic Care Management (CCM), and telehealth infrastructure tailored to frontier, rural, and tribal communities within Alaska’s hub-and-spoke healthcare system. Our bluetooth and cellular-enabled devices function in low-bandwidth environments, expanding chronic disease monitoring for conditions such as hypertension, diabetes, COPD, and heart failure without reliance on home broadband. Real-time data transmission strengthens coordination between village-based providers and regional hubs, improving diagnostic visibility and enabling earlier clinical intervention. Beyond technology, Esvyda provides structured escalation workflows, secure EHR interoperability, CMS-aligned reporting, and operational support including onboarding, training, documentation alignment, and billing readiness to ensure sustainable program implementation. We prioritize culturally responsive deployment by collaborating with local providers to adapt engagement strategies for Alaska Native and rural communities. Drawing from experience supporting tribal communities in Nevada, our goal in Alaska is to launch scalable pilots that strengthen coordination, reduce avoidable transfers, and expand high-quality care as close to home as possible.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Everbalance Wellness	Preventative Maternal and Pediatric Health Initiative for Alaska	AK	Many chronic health conditions begin developing during pregnancy and early childhood, yet most healthcare systems focus primarily on treating illness after symptoms appear rather than preventing dysfunction early. Families frequently struggle to access preventative guidance related to nutrition, gut health, environmental exposures, and metabolic balance during pregnancy and childhood. Pediatric concerns such as digestive issues, sleep disturbances, immune dysfunction, and behavioral challenges are increasingly common, but parents often receive fragmented care that addresses symptoms rather than underlying causes. In rural regions such as Alaska, access to preventative health services and specialized pediatric support is even more limited due to geographic barriers and healthcare workforce shortages. This project addresses an opportunity to implement a preventative, root-cause focused health program for mothers and children that combines early screening, education, and personalized interventions to support optimal development and long-term health. By focusing on pregnancy and early childhood, the program aims to intervene during the most influential window for lifelong health outcomes.	The project will establish a preventative health program designed to support families during pregnancy and early childhood through three core components. 1. Early preventative screening Participants will have access to targeted health assessments and functional laboratory testing that can help identify early imbalances before they develop into chronic conditions. These assessments may evaluate factors such as: nutritional status gut health and microbiome balance metabolic health indicators hormone balance during pregnancy and postpartum environmental and lifestyle factors influencing health Early identification allows families to take preventative action rather than waiting for symptoms to worsen. 2. Family-centered education Participants will receive structured education designed to help parents build foundational health knowledge and practical skills. Educational topics will include: nutrition for pregnancy, childhood development, overall wellness and longevity. Education will be delivered through group workshops, digital learning modules, and written resources, allowing families to revisit information and implement changes gradually. 3. Personalized prevention plans Based on screening results and lifestyle assessments, each participating family will receive individualized recommendations designed to support long-term health. These may include: nutrition and meal planning guidance targeted supplementation lifestyle interventions supporting sleep, stress regulation, and metabolic health early interventions for common pediatric concerns Care delivery will occur through telehealth and digital platforms, allowing participation from rural communities across Alaska. With cost being another major barrier to care, having the screening machine in office would drastically cut down on cost and therefore greatly improve access.	\$50,000-\$250,000	Private practitioner	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Evergreen Health LLC	Evergreen Health, expanding access to primary care	AK	Communities in and around Fairbanks, Alaska face limited access to consistent primary care, long wait times for appointments, and significant travel burdens to obtain routine and preventive services. Workforce shortages, lack of primary care physicians, and increasing demand for chronic disease management have placed strain on existing providers and emergency departments, resulting in fragmented and episodic care. Establishing Evergreen Health addresses this gap by expanding local access to comprehensive, relationship-based primary care, improving continuity of care, and reducing unnecessary reliance on higher-cost acute services.	Evergreen Health will address limited access and fragmented care in Fairbanks by establishing a patient-centered, relationship-based primary care clinic that serves as a consistent medical home for individuals and families. The clinic will expand appointment availability, prioritize preventive care and early intervention, and provide comprehensive chronic disease management to reduce avoidable emergency department use and specialty referrals. Evergreen Health will implement flexible scheduling, care coordination, and appropriate use of telehealth to improve access for patients traveling from remote areas. By focusing on continuity of care, patient education, and whole-person wellness, the clinic will strengthen long-term health outcomes while supporting a more efficient and sustainable local healthcare system.	\$50,000-\$250,000	Family or primary care	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced
Everts Air Cargo	Improved Medical and Food Safety through proper Storage and Transportation Phase I	AK	The addition of appropriate refrigeration equipment at transportation hubs allows carriers to properly store medical supplies and food items that are shipped via bypass mail or cargo. The installation of refrigeration systems also helps to eliminate issues that arise when air carriers are not able to move materials from the hubs to downline locations in rural areas. Currently, air carriers are forced via the bypass mail system to move cargo to the hubs as bypass mail is dated and requires it to move within a given time frame. Additionally, downline carriers cannot store large volumes of perishables properly and will deny the primary carrier delivering cargo to them during weather events that prevent flights. The addition of increased refrigeration capacity allows the transportation to occur without adding risks to the perishable items as well as allows carriers to not have to return the materials to the point of origin. Potentially, decreasing transit time and reducing shipping costs that are ultimately passed on to the consumer of the medical supplies or perishable food items. Ultimately, the goal of this project is to ensure safe medical supplies and wholesome food to rural Alaska all at a lower cost than current situation allows.	Phase I of the approach is to install modular refrigeration equipment that can be expanded at a later point in an effort to minimize overall costs while matching location needs. The Phase I stage will be monitored to ensure that perishable or temperature sensitive medical and food items are stored appropriately with equipment available.	\$250K-\$1M		Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Fairbanks North Star Borough; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Exit Glacier Greenhouse	Feeding Seward and Alaska with a Year Round Commercial Greenhouse	AK	Across Alaska we face significant barriers to accessing fresh, nutritious produce. Because food must be transported long distances by truck, barge, or air, produce often arrives in poor condition and is unaffordable. Those most impacted are families, low income households, elders, and those facing chronic health conditions. Many people across the Kenai Peninsula have limited or no access to healthy food options. As a result, many households rely heavily on processed and shelf-stable foods that are less nutritious. These conditions contribute to poor community nutrition and limited exposure to fresh vegetables, especially among children.I have witnessed local children who have never tried common vegetables such as broccoli. Without early access and exposure to fresh produce, it becomes difficult to build lifelong healthy eating habits. Increasing the availability of fresh produce is a foundational step toward improving nutrition. When healthy foods are accessible, affordable, and culturally accepted, families are more likely to incorporate them into everyday meals. This project recognizes that improving rural health requires addressing the underlying systems that shape food availability. Rather than relying solely on imported goods, the greenhouse model builds local capacity for sustainable food production. It strengthens the food system, supports community wellbeing, and provides a practical and sustainable solution to longstanding challenges in rural nutrition.	These outcomes can be achieved by operating a year-round arctic greenhouse that produces fresh vegetables in the Kenai Peninsula. By growing food within the communities it serves, the project will directly improve access to fresh, nutritious produce while reducing the cost and quality issues associated with long-distance transportation. A local greenhouse allows vegetables to be harvested at peak ripeness and delivered quickly, ensuring the community can access the full nutritional value and flavor of fresh food. The greenhouse will focus on consistently producing nutrient-dense produce that are often difficult to obtain in good condition in rural Alaska, including leafy greens, herbs, and fast growing common vegetables such as zucchini, snap peas and cherry tomatoes. Energy efficiency and sustainability are central to the design of the greenhouse in order to keep operating costs manageable over time. The structure will be highly insulated to retain heat during colder months while maximizing the use of Alaska’s seasonal sunlight. In addition, it will incorporate simple but effective sustainable technologies such as climate batteries, heat sinks, and solar panels. Climate batteries capture excess daytime heat from the greenhouse and store it underground, allowing that heat to be released at night to stabilize temperatures. Heat sinks provide additional thermal stability, and solar panels help offset electricity needs. Together, these systems reduce and eliminate energy consumption and support long-term operational sustainability and keep produce affordable. The greenhouse will also serve as an educational and community resource. It provides an excellent partnership opportunity with local schools by demonstrating local food production and sustainable technologies in action. This exposure helps introduce children to fresh produce while building awareness of healthy eating and sustainable agriculture. By combining local food production, energy-efficient greenhouse technology, and community education, this project creates a practical and sustainable approach to improving community access to fresh produce. The greenhouse will strengthen food security, improve the quality and affordability of vegetables, and help build a healthier food system in Alaska.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Fabric Labs, Inc	Connected Care Alaska: Statewide Rural Health Transformation	NY	Alaska has an opportunity to reimagine rural healthcare delivery through the Rural Health Transformation Program (RHTP), creating a statewide framework that strengthens providers, improves outcomes, and empowers patients. Rural health facilities—including critical access hospitals, rural health clinics, and Tribal health organizations—play a vital role in their communities but often operate with limited provider capacity and fragmented care coordination. Addressing these challenges requires modern infrastructure that expands clinical reach, improves care coordination, and enables providers to deliver care more efficiently. Connected Care Alaska addresses this opportunity by creating a patient-facing digital access point that simplifies how residents find and receive care across Alaska’s healthcare system. For example, the platform could be embedded within the Alaska State Office of Rural Health (SORH) website as a simple “Get Care Now” button under related services, allowing residents to locate clinics, schedule visits, access asynchronous care, or connect with providers virtually. By expanding virtual care and enabling statewide provider coordination, the initiative strengthens healthcare access, improves workforce capacity, and modernizes digital health infrastructure—directly supporting Alaska’s RHTP priorities.	Connected Care Alaska establishes a statewide digital access point that simplifies how residents locate and receive care. Built on Fabric’s Digital Front Door platform, the initiative provides a unified entry point where patients can access virtual care, receive digital triage, and connect with providers across Alaska’s healthcare network. Through Connected Care Alaska, AKDOH can implement statewide care access infrastructure integrating rural providers, Tribal health organizations, regional hospitals, and virtual clinicians into a coordinated network capable of delivering timely care regardless of patient location. The platform can be embedded within State of Alaska websites and participating rural provider websites, allowing residents to access services through familiar digital channels while reducing the burden of navigating multiple healthcare systems. A central component of the initiative is a statewide provider directory integrating rural clinics, Tribal health organizations, regional hospitals, and telehealth providers. Leveraging credentialing oversight through the Alaska Medical Assistance Health Enterprise System (AMHES), AKDOH can accelerate development of a comprehensive provider directory while ensuring accurate provider credentialing. Through this shared network, clinicians can serve as virtual “floaters,” supporting multiple communities when local provider capacity is limited. This model extends provider reach while directing patients to the most appropriate and available care. Fabric’s nationwide clinician network can also serve as a backstop when needed—providing overflow capacity during demand surges, supporting 24/7 coverage, and maintaining continuity of care. For an initiative of this scale to succeed, statewide coordination requires a neutral steward focused on equitable access and system efficiency. As both system steward and Medicaid payer, AKDOH is uniquely positioned to guide implementation, shape policy, and ensure equitable access across communities. Enabling residents to choose the appropriate venue of care—particularly for routine visits suited for asynchronous and virtual care—expands provider capacity while helping reduce per-member-per-month Medicaid costs and supporting long-term RHTP sustainability.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Facing Foster Care in Alaska	Alaska OCS Youth Orientation Initiative	AK	Foster youth enter the child welfare system without clear information about what is happening, who is involved in their case, or how to access the services meant to support them. This lack of orientation is especially hard on youth in rural areas or those moving among communities, where distance, limited staffing, and infrequent contact make it even harder to understand the OCS process, court expectations, or available resources. Many young people describe feeling confused, intimidated, or left out of decisions that affect their safety and well-being. This project creates consistent, youth-friendly orientation videos that explain the OCS case process, the roles of key adults, how court works, what rights youth have, and how they can advocate for themselves and access resources important to their care. The videos will be shaped with input from foster youth and alumni so the content is relatable, accurate, and grounded in lived experience. These videos offer a reliable way to provide consistent information to foster youth. They help bridge communication gaps created by geography, turnover, and limited access to in-person support. Clear, accessible information empowers youth to participate in case planning, understand how to access telehealth and behavioral health services, and know how to reach out when they have specific needs. This project builds a statewide, consistent foundation that helps young people feel informed and more in control from the moment they enter care.	This project will develop consistent, youth-friendly orientation videos that explain the OCS case process, the roles of key adults, what youth can expect in court, their rights, and how to access services and supports. The approach centers on co-design with youth, statewide consistency, and accessibility across Alaska’s diverse geographies. The first phase focuses on collaborative content development. Foster youth and alumni will shape scripts, identify priority topics, and ensure the tone reflects real experiences. FFCA will also partner with the Alaska Impact Alliance (AIA), which is creating parallel orientation videos for parents and kinship caregivers. Aligning the two projects strengthens shared messaging, reduces duplication, and improves consistency for families and youth. The second phase centers on production and accessibility. Videos will use clear, plain language and visuals that support comprehension for youth of different ages and learning styles. Modular content will allow youth to access information relevant to entering care, preparing for court, understanding case plans, or navigating placement changes. All materials will be optimized for low-bandwidth environments and available offline to address connectivity barriers in rural and frontier communities. The third phase focuses on statewide implementation. OCS will integrate the videos into early touchpoints such as entry into care, placement transitions, and pre-hearing preparation. Foster parents, kinship caregivers, and residential programs will receive guidance on using the videos to support youth understanding. Legal partners and tribal representatives will be encouraged to incorporate the materials into youth-facing interactions. Coordination with AIA’s project will help ensure youth and adults receive aligned, complementary information. Finally, the project will establish feedback loops to refine and update content. Youth and alumni will provide ongoing input, and OCS staff will report on usability and gaps. This continuous improvement process keeps the videos current, culturally responsive, and aligned with policy and practice changes. This approach builds a reliable, statewide foundation that helps foster youth understand their case, participate meaningfully in decisions, and feel more prepared and supported from the moment they enter care.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Facing Foster Care in Alaska	Communication Access for Foster Youth in Transition	AK	A major challenge is that cell phones are often tied to the foster family instead of the youth, leaving young people disconnected during placement changes—and even more so when they have no foster family at all. Transition-aged foster youth across Alaska, often lack reliable access to a phone, cutting them off from the systems meant to keep them safe. Without a phone, youth can’t participate in case planning, access telehealth, stay connected to family and friends, reach crisis support, or secure employment and housing. What this project addresses; • Connection to essential services such as virtual case meetings, telehealth, and remote education or employment. Youth without phones can’t access these consistently. • Safety and stability for youth facing placement changes or unsafe situations to call for help or reach trusted adults. • Participation in case planning to attend hearings, meetings, and opportunities for youth to advocate for themselves. • Connection to natural supports. Family, friends, and mentors are protective factors, yet many youth lose these connections simply because they lack a device. Providing foster youth in Alaska with a reliable cell phone is a simple, high-impact intervention that expands access to health care, safety, and opportunity. It ensures no young person is left behind because of geography or system involvement and creates a more equitable path for youth statewide.	Making sure foster youth in Alaska have a reliable cell phone that stays with them through every placement, transition, and move into adulthood. The first year is dedicated to building a strong foundation so the project is safe, sustainable, and ready for statewide use. This includes identifying a bulk phone and data plan that works across regions, creating simple digital-safety practices with OCS, and securing long-term support through discounted plans and corporate sponsorship. Once the system is in place, phones will be provided at key transition points—entering care, changing placements, or preparing for adulthood—so youth are never without a way to stay connected. A reliable phone allows youth to attend telehealth appointments, join virtual case meetings, and stay in regular contact with caseworkers, GALs, mentors, and family. It also supports daily needs like applying for jobs, communicating with employers, accessing online learning, and coordinating transportation. FFCA’s Peer Navigators and alumni leaders will stay connected with youth statewide, offering coaching, crisis support, and help using the phone as a tool for safety and independence. Their lived experience ensures youth get support that is practical, relatable, and grounded in what works. By bridging the distance between rural communities and the services concentrated in hub cities, this approach creates a more equitable, youth-centered system where every young person has a direct line to care, support, and opportunity.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Facing Foster Care in Alaska	Healthy Futures Through Strong Youth Advocacy	AK	Alaska is one of the few states that does not guarantee an attorney for every youth in foster care, relying instead on a mix of mandatory and discretionary appointments and a statewide network of GALs often supervised by an attorney. Foster youth depend on these advocates to protect their rights and elevate their expressed wishes. The Office of Public Advocacy (OPA) contracts for attorneys and GALs beyond their capacity for full time staff and in cases of conflict. Contract attorneys and GALs lack consistent access to foundational training in CINA law, trauma-informed practice, and ICWA. This results in uneven representation and can contribute to delays and poorer outcomes. By funding access to the Court Improvement Program’s digital CINA 101 and ICWA 101 trainings, this project builds a consistent baseline of knowledge across the contractor workforce. It strengthens the capacity of attorneys and GALs to provide effective, informed advocacy and supports better health, safety, and permanency outcomes for youth statewide, including those in rural and remote communities.	The project strengthens the quality and consistency of legal advocacy for Alaska’s foster youth by providing 31 contract attorneys and Guardians Ad Litem with access to two foundational digital trainings, CINA 101 and ICWA 101, developed by the Alaska Court System’s Court Improvement Program (CIP). CINA 101 provides 24 CLE credits (24 hours) of comprehensive instruction, and ICWA 101 provides 8.75 CLE credits (8.75 hours) focused on the Indian Child Welfare Act and culturally responsive practice. The project begins by coordinating with the Office of Public Advocacy and the Court Improvement Program (CIP) to ensure all contractors receive access to these trainings and accompanying materials as part of ongoing professional development. Access to high-quality, standardized training strengthens overall health outcomes for foster youth by ensuring that every child, regardless of where they live, has an advocate who can identify health needs early, push for timely services, reduce harmful delays, and maintain stability through the transitions that shape their physical, emotional, and behavioral well-being. A more prepared and consistently trained workforce improves the system’s ability to deliver equitable, effective advocacy across Alaska’s rural, remote, and urban communities.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Fairbanks Children's Museum	Fairbanks Wellness Coalition and Fairbanks Children's Museum Partnership	AK	As Fairbanks sole wellness and prevention agency, the Fairbanks Wellness Coalition currently rents an office from its fiscal sponsor, the United Way of the Tanana Valley, and does not have a location to offer consistent programming. There is a dire need for a safe community space for young adults to congregate without any risks of drug or alcohol use, and with the support of professionals who can connect them with resources. The Fairbanks Children's Museum is in the process of becoming the fiscal sponsor for the Wellness Coalition in order to provide a permanent location for them to expand their wellness and prevention programming to better serve Fairbanks and improve community health.	The Fairbanks Children's Museum recently secured a 50-year lease through a competitive RFP process to move into City Hall. Over 1,100 square feet of the space is going to be allocated to giving the Fairbanks Wellness Coalition a permanent home to significantly increase and improve their operations in Fairbanks. The Wellness Coalition is severely limited in its ability to fundraise and apply for grants with the United Way as its fiscal sponsor, and moving operations under the Children's Museum will significantly increase its ability to obtain funding to support its growth.	\$50,000-\$250,000		Single Community	Fairbanks North Star Borough	Deferred or Not Advanced
Fairbanks Children's Museum	Healthy Beginnings at the Fairbanks Children's Museum	AK	The Fairbanks Children's Museum serves families and children in a community with extremely limited early childhood education opportunities. Resources and support for new moms are limited, and isolation is ever-increasing, negatively impacting maternal health.	The Fairbanks Children's Museum came to be in order to address the absence of early childhood education opportunities and resources in Fairbanks. Additionally, the Museum began a Baby Mingle program offering free admission and breakfast to moms and their infants twice per month to allow them time to enjoy the museum in a quiet and calm environment, connect with other moms, and connect with maternal health resources. Additionally, FCM hosts Baby Cafe, a program put on by the Breastfeeding Coalition. They use the museum completely free of charge every Monday of the year to do check-ins with mothers and their newborns. They are able to do weigh-ins, get lactation support, and benefit from the knowledge of public health nurses in a safe, calm, inviting environment without the stress of visiting a doctor's office. Recently, FCM was awarded a long-term 40-year lease to relocate to vacant space inside City Hall. This move will allow us to expand our offerings, including maternal health support and access to early childhood education. In order to make this move, we need to design a capital campaign and complete design work for our updated facilities. In the meantime, as we continue to operate at our current location, we seek to significantly improve the space where the Breastfeeding Coalition is able to serve new moms and infants without burdening the Coalition itself with any additional expenses, because it provides all of its services for free. We would like to provide better seating options that lend themselves to breastfeeding, lactation consulting, and general postpartum comfort, as well as invest in supplies such as a device the Coalition can use to measure for breast pumps and additional scales so that new moms can be served effectively and efficiently.	\$50,000-\$250,000	Maternal health	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced

Fairbanks Children's Museum	Healthy Beginnings through the Golden Heart Early Learning Center	AK	There is a significant childcare shortage in Fairbanks, like there is across the entire state. This shortage significantly impacts our workforce development. Specifically, our learning center will prioritize care for city employees, including the Fairbanks Police Department and Fire Department. The childcare that is available in Fairbanks is consistently outpricing families in the community, so we are also seeking to provide affordable, high-quality care, in particular. FCM was recently awarded a long-term 40-year lease to relocate to space inside City Hall. The City has already spent \$750,000 renovating classroom space for our Early Learning Center to be established. The addition of an Early Learning Center in downtown Fairbanks will provide play-based educational childcare for 40 children, allowing folks to return to the workforce, and ensuring their children have every opportunity to get their healthy beginning. Play-based learning and access to robust early childhood education have long-term benefits that Fairbanks will see for decades to come, including increased high school graduation rates, decreased mental health crises into adulthood, and reduced reliance on public assistance resources. Additionally, FCM has created a model through the Golden Heart Early Learning Center that will ensure affordable tuition is maintained for all participating families. Childcare costs are ever-increasing as providers seek to pay staff a living wage. We will offset the costs associated with maintaining high-quality staff with Museum revenue and savings we will realize with the significantly reduced rent we will enjoy at City Hall.	\$50,000-\$250,000	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced

Fairbanks Integrated Community Services, INC	Fairbanks Street Medicine Program	AK	The Fairbanks North-Star Borough (FNSB) serves as a central hub of access for most of the Interior and Northern regions' healthcare and economic foundation. In line with this, the City of Fairbanks serves approximately 250 unique individuals experiencing chronic homelessness, with another 150 to 250 at any point across the year are experiencing some form of temporary homelessness status. Across the FNSB, there are hundreds of identified properties within the FNSB Code Enforcement Department that have individuals living in unfit for human habitation living situations. The critical side effect for individuals in critically housed or unhoused living conditions and the geographical diversity of Interior and Northern Alaska, is an inaccessible healthcare landscape often dependent on the emergency system. This project serves to address the unhoused and critically housed populations healthcare needs while reducing dependence on the emergency system.	The Assertive Community Treatment (ACT) model is an evidence-based practice model with a strong international evidence basis for providing care to individuals experiencing: serious mental illness, chronic substance abuse, and/or homelessness. This proposal intends to create an opportunity to bring the medical capacity of an ACT team to Fairbanks in supplementation of our existing clinical and case management functions. This proposal seeks to fund a full-time physician, one full-time APRN or PA, and two or three full-time nursing staff. The establishment of a full medical team that is capable of responding in the community would establish the first fully-functioning ACT team in the Interior Alaska region and would be capable of directly providing and supplementing healthcare across the FNSB and surrounding communities. This team would supplement the existing 8 full-time clinical and case management staff present at our organization (expanding up to 10 within the next 3 months) and would allow the full fidelity of the ACT model of care.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Yukon-Koyukuk Census Area	Advance to Implementation Application

Fairbanks Native Association	FNA Rural Behavioral Health & Workforce Access Initiative	AK	Rural Alaskans face distance, workforce shortages, and low awareness of how to access behavioral health care. These barriers delay help-seeking and complicate navigation into crisis lines and tele-health. FNA will aim to remove these barriers by deploying technology-driven messaging that tells consumers/ clients what services exist, how to access them, and how to pursue expanded workforce pathways in the Behavioral Health workforce development arena.	FNA will partner with Stream Alaska to produce and distribute four behavioral-health campaigns statewide via CTV (e.g., YouTube TV, Amazon Prime TV, Netflix (ad-tier), Hulu, Disney+) and targeted social media (Facebook, Instagram, social mirroring). Themes: (1) service awareness, (2) crisis access steps, (3) tele-health navigation, (4) rural workforce pathways. The 12-month plan: Month 1 mobilization/baselines, Months 2–3 creative + rural pre-tests, Months 4–11 deployment with monthly KPI dashboards and quarterly learning cycles, and Month 12 summative evaluation and scale plan. Targeting emphasizes rural ZIP codes; optimization uses A/B variants and channel mix. I will coordinate content fidelity with Clinical Leads and FNA Communications and use a formal change-control process to remain CMS-compliant.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kuskokwim Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Fairbanks North Star Borough School District	Growing Our Own: Building Alaska’s Future Health Workforce in Fairbanks with pathways & internships	AK	The Fairbanks North Star Borough School District FNSBSD is currently facing a critical gap in the regional healthcare clinician pipeline, specifically within specialized diagnostic and mental health roles. While student interest in medical careers is high, our current infrastructure lacks the accredited pathways and formal clinical agreements necessary to transition students from general education into professional certification in fields such as phlebotomy, medical laboratory science, and school psychology. By formalizing these technical tracks, the district can provide students with the credentials needed to enter the workforce immediately or pursue advanced postsecondary degrees with a solid foundation.	This five-year investment in student, intern, and employee health care pathways will improve the Fairbanks North Star Borough School District's capacity to facilitate student and community health improvement outcomes. Our approach blends rigorous technical training with meaningful community partnerships to build a clear and sustainable pathway into the healthcare and behavioral health workforce. Building on the district’s history of successful Career and Technical Education (CTE) programs, students will have access to specialized training that provides hands-on experience and prepares them to meet national certification standards. A dedicated coordinator will oversee student internships, ensuring all clinical hour requirements are completed through established partnerships with regional healthcare providers.	\$1M-\$5M	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced
Fairbanks North Star Borough School District	Healthy Schools, Healthy Futures: A Districtwide Wellness and Prevention Initiative in Fairbanks	AK	Schools play an important role in shaping lifelong behaviors for children. However, many of the Fairbanks North Star Borough School District's K-12 schools lack the coordinated resources needed to fully implement prevention-focused wellness initiatives. Wellness efforts currently exist in pockets. Some schools have implemented strong programs, while others lack equipment, supplies, or training to support similar efforts. This creates an opportunity to implement a districtwide wellness initiative that aligns equipment, professional development, technology, and prevention supports across all 28 schools. A coordinated approach will ensure over 11,000 students and nearly 1,500 staff members throughout the district benefit from healthier learning environments and consistent wellness practices.	The Fairbanks North Star Borough School District will implement a coordinated wellness initiative that integrates staffing, equipment, technology, training, and prevention resources across 28 schools. Schools will receive updated physical fitness equipment and classroom wellness materials that promote physical activity and healthy lifestyle habits. School health offices will receive nursing supplies that support student health needs and preventative care. Technology tools will support Multi-Tiered Systems of Support (MTSS) data tracking, allowing staff to monitor wellness indicators and evaluate prevention strategies using data. Professional development will prepare educators and staff to integrate wellness practices into classroom instruction and school culture. A staff wellness platform will support employee health and retention while helping educators model healthy behaviors for students.	Over \$5M	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced

Fairbanks Rescue Mission	Fairbanks Integrated Behavioral Health and Housing Stabilization Initiative	AK	The Fairbanks Rescue Mission serves between 600 and 1,000 men, women, and children each year through our emergency shelter, housing programs, and veteran services. Many of the individuals we serve struggle with mental health and behavioral health challenges and require case management, counseling, and crisis intervention in order to achieve stability. While many of our clients are Medicaid eligible, we are not currently a Medicaid billing agency and therefore cannot bill for behavioral health services. As the need for mental health support continues to grow, the cost of providing these services without reimbursement places increasing strain on our organization. To address this challenge, we are entering into a partnership with a statewide addiction and mental health recovery center to expand and formalize counseling services for our clients. This partnership will allow us to integrate licensed counseling into our shelter, housing, and case management programs, creating a more coordinated, one-stop approach to care. The primary challenge will be covering the cost of additional personnel and modest capital expenses during the initial period before Medicaid reimbursement begins. This project will help bridge that gap while building a sustainable behavioral health service model.	Fairbanks serves as a major hub for rural Alaska, and approximately 40 percent of the individuals we serve are Tribal members who travel from communities across the state seeking temporary shelter and support. Many arrive facing significant challenges, including mental health concerns, substance use disorders, trauma, and other behavioral health needs. Mental health issues, suicide, substance abuse, and alcoholism remain significant concerns in many rural communities, and individuals often come to Fairbanks seeking services that are not available in their home communities. The Fairbanks Rescue Mission is uniquely positioned to help address these needs because many of these individuals are already coming to our facility for shelter and support. One of the greatest challenges in behavioral health services is engaging individuals in treatment. Barriers such as transportation, unfamiliar environments, fear of seeking help, and social discomfort often prevent people from accessing care. By integrating counseling services where individuals are already staying, these barriers are greatly reduced. Through a partnership with True North Recovery, we will incorporate Medicaid-approved counseling services into the programs we already operate. While we do not intend to operate a full in-house treatment program, licensed counselors will work alongside our existing case management and support services to provide accessible behavioral health care to our guests. Our facility operates as a high-barrier shelter, requiring guests to remain drug and alcohol free. This environment supports individuals who are actively working toward sobriety and stability. Counseling and case management will be integrated into our existing programs, including our “30-60-90” program. While guests are typically guaranteed 30 days of shelter, individuals who are actively participating in programs or demonstrating progress toward independence are often able to stay longer. With the addition of Medicaid billing capability through this partnership, we will be able to expand counseling and case management services that support recovery, stability, and long-term independence for the individuals we serve.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Fairweather	Alaska Mobile Integrated Health & Community Care Network	AK	Many rural and frontier communities across Alaska face significant barriers to accessing healthcare due to geographic isolation, limited local healthcare infrastructure, workforce shortages, and long travel distances to regional medical facilities. Preventive care, chronic disease management, and routine health services are often delayed because patients must travel long distances or wait for periodic provider visits. These challenges can result in worsening health conditions, avoidable emergency evacuations, and higher healthcare costs. At the same time, many communities have dedicated local healthcare providers, such as community health aides and EMS personnel, who would benefit from additional clinical support and training opportunities to strengthen local capacity. This project presents an opportunity to expand healthcare access through a mobile integrated health model that delivers care directly to rural communities. By deploying mobile healthcare teams and supporting local providers, the project will improve access to preventive services, strengthen chronic disease management, and enhance the capacity of rural healthcare systems across Alaska.	The Alaska Mobile Integrated Health and Community Care Network will deploy mobile healthcare teams to deliver preventive and primary healthcare services directly to rural and frontier communities across Alaska. Using a mobile integrated health model, Fairweather will send trained healthcare professionals to communities where access to care is limited, providing services where people live and work rather than requiring patients to travel long distances to regional medical facilities. Mobile teams will provide preventive health screenings, chronic disease monitoring and management, vaccinations, occupational health services, and health education. These services will support earlier identification of medical conditions, improve management of chronic diseases such as hypertension and diabetes, and help reduce preventable emergency evacuations and hospitalizations. Fairweather has already demonstrated the effectiveness of mobile healthcare delivery through its work with the State of Alaska to deploy vaccination teams to rural communities and remote locations across the state. Through this partnership, Fairweather delivered vaccines and healthcare services to communities that would otherwise have limited access to care. This experience provides an operational foundation for expanding mobile healthcare services statewide. A key component of the project will be collaboration with local healthcare providers. Mobile healthcare teams will work alongside community health aides and other local providers to deliver care while providing hands-on clinical support that strengthens local healthcare capacity. This collaborative approach ensures services complement existing healthcare systems and supports continuity of care within rural communities. By combining mobile care delivery, preventive health services, and collaboration with Tribal health organizations and regional healthcare providers, this initiative will expand healthcare access, improve preventive care, and strengthen healthcare capacity in rural and frontier communities across Alaska.	\$1M-\$5M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Fairweather	Alaska Rural Emergency Response & Stabilization Network	AK	Many rural, remote, and frontier communities across Alaska face significant gaps in emergency response capacity. In some locations, communities lack dedicated emergency responders, organized EMS systems, or the vehicles and equipment needed to respond effectively to medical emergencies, accidents, or fires. When emergencies occur, local healthcare providers, community health aides, or community members may be required to manage critical situations while waiting for outside assistance to arrive. Alaska’s geography, extreme weather, and limited road infrastructure make traditional emergency response models difficult to implement in rural communities. These conditions create an opportunity to develop response systems specifically designed for remote environments that can support local providers and strengthen community-level emergency response capability. Fairweather has developed the Emergency Response Vehicle (ERV) concept after years of providing remote medical services across Alaska and recognizing the need for mobile response capability in communities that may lack both personnel and equipment. ERVs are designed to support trained responders by providing mobile medical stabilization capability and initial fire suppression support in environments where traditional emergency vehicles may not exist. Expanding this model presents an opportunity to strengthen emergency response capacity and improve healthcare resilience in rural Alaska.	This project will strengthen emergency response capacity in rural, remote, and frontier communities across Alaska by supporting local responders and healthcare providers with additional response capability, training, and mobile stabilization resources. Many communities face gaps in both personnel and equipment, limiting their ability to respond effectively to medical emergencies, accidents, and fires. The initiative is designed to support communities where dedicated responders, vehicles, or organized EMS systems may not currently exist. Mobile medical response teams will assist communities and local healthcare providers during critical incidents. These teams will coordinate with local clinics, community health aides, Tribal health organizations, and regional healthcare providers to improve stabilization and coordination of care. Earlier intervention can reduce risks associated with delayed treatment while patients await evacuation or transport to higher levels of care. Fairweather developed the Emergency Response Vehicle (ERV) concept after years of providing remote medical services across Alaska and recognizing the limitations of traditional emergency response systems in remote environments. Some Rural Communities lack the resources needed to reach patients or respond effectively to emergencies. ERVs are designed to operate in off-road environments and extreme weather while providing mobile medical stabilization capability. They can also support initial fire suppression in communities that may not have dedicated fire response infrastructure, helping protect critical assets such as clinics, housing, schools, and utilities. While ERVs are not required for the program to operate, they would enhance response capability in communities that currently lack emergency vehicles or organized response systems. Clinical protocols and responder training will be guided by Fairweather’s Medical Director, Dr. Michael Levy, who has served in the role for more than 15 years and provides EMS medical oversight for both the State of Alaska and the Anchorage Fire Department. His experience ensures that response practices and stabilization protocols align with current prehospital care standards. Through trained responders, coordination with local healthcare providers, and optional deployment of specialized response vehicles, this initiative provides a flexible model for strengthening emergency response capability and improving healthcare access in rural Alaska.	\$1M-\$5M	Home- and communit y-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Fairweather	Alaska Rural Health Workforce Training Network	AK	Rural and remote communities across Alaska face significant healthcare workforce shortages and limited access to training opportunities for providers who serve these regions. Healthcare professionals practicing in frontier environments must manage complex medical emergencies and chronic health conditions with limited resources, long transport times, and minimal access to specialty care. Despite these challenges, many rural providers must leave Alaska to obtain advanced clinical training or maintain required procedural competencies. This lack of accessible training infrastructure contributes to workforce shortages, limits providers’ ability to practice at the top of their license, and creates barriers to recruiting and retaining healthcare professionals in rural communities. The Alaska Rural Health Workforce Training Network will address this gap by establishing regional training hubs and mobile training programs designed specifically for rural healthcare delivery. By expanding in-state training opportunities and supporting the development of critical clinical skills, this project will strengthen Alaska’s rural healthcare workforce and improve access to high-quality care for communities across the state.	The Alaska Rural Health Workforce Training Network will establish a hub-and-spoke training model designed to expand clinical training opportunities for healthcare professionals serving rural and frontier communities across Alaska. Fairweather will lead development of regional training hubs in Anchorage, Prudhoe Bay, and Fairbanks, leveraging existing facilities and operational infrastructure to provide simulation-based clinical training, certification programs, and continuing education for healthcare professionals practicing in remote environments. Training programs will focus on skills required for rural healthcare delivery, including emergency stabilization, trauma care, critical care procedures, and management of complex medical conditions in settings where evacuation or specialty care may be delayed. Programs will support the training and continuing education of Emergency Medical Technicians, paramedics, nurses, nurse practitioners, physician assistants, and other healthcare professionals serving rural communities. The project will incorporate high-fidelity simulation training, hands-on procedural education, and certification programs designed to help providers maintain critical competencies required for rural practice. In addition to fixed training sites, mobile training teams will travel to rural communities to deliver training locally, reducing barriers for providers who cannot leave their communities for extended training. Partnerships with Tribal health organizations, EMS agencies, healthcare systems, and educational institutions will help align training programs with regional workforce needs and expand participation across the state. These collaborations will support coordinated workforce development efforts and strengthen healthcare systems serving rural Alaska. By creating in-state training infrastructure specifically designed for rural healthcare delivery, the project will expand access to professional development opportunities, strengthen workforce retention, and improve provider readiness to deliver high-quality care in Alaska’s most remote communities.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Family Centered Services of Alaska, Inc.	FCSA Partial Hospitalization Program	AK	One in seven Alaskans aged 12-17 had serious thoughts of suicide and 1 in 5 had at least one major depressive episode in 2021-2023 (SAMHSA, 2025). Partial Hospitalization Programs (PHPs) offer an appropriate level of care for children and youth with serious mental health concerns, but access in rural Alaska is extremely limited. Statewide, we know that youth often are stuck in a cycle that alternates between lower levels of care (outpatient therapy) and the highest levels of care (hospitalization or residential treatment), leading to unnecessary crises and/or losses of the gains from therapy, in addition to academic disruptions and challenges reintegrating back into their home communities. FCSA is licensed to provide intermediate level PHP services and has completed a feasibility study to do this; however, financial support is needed to operationalize our services. With the addition of PHP services, FCSA has an opportunity to transform the way services are delivered to rural Interior youth with serious mental health needs, filling a gap in transitional behavioral health services by providing a bridge between residential treatment and outpatient care. PHP services will build in educational programming via school district partnerships, improve access to the full spectrum of behavioral health services, allow youth to remain connected to family and their community systems, strengthen transitions between levels of treatment, and reduce system costs overall.	Our model aligns with all standards and licensing requirements and is structured to meet regulatory and staffing guidelines. A feasibility study is complete and RHT funds will support operationalization of the program. In Phase 1 we will develop a detailed implementation workplan with steps to formalize partnerships with school districts, referral sources, and community partners to assist rural families with housing and transportation needs. We will increase our staffing capacity to ensure continuity of care and effective transitions after discharge. Our telehealth expansion project will further support delivery of specialized pediatric services to rural youth within their home communities to ensure stability and successful transitions. In Phase 2 we will launch PHP services and begin referral coordination, working with partners to refer and enroll a limited number of youth. We are licensed to provide services to children aged 5-18; however, services will initially be offered only to youth aged 12-18. In Phase 3 we will scale up the program (by number of youth served and/or age of youth served), monitoring youth outcomes and program operations to ensure goals for the program and rural Alaskans are met. Our PHP will provide a structured, therapeutic environment for children and youth centered around a standardized daily schedule and designed with staffing ratios to support clinical intensity and safety. Each youth and their treatment team will participate in developing individualized Treatment Plans that include diagnosis, treatment team members, measurable goals, timelines, and discharge plans. All youth will receive a Behavioral Health Assessment from a qualified clinician with psychiatric or psychological assessment as indicated. Treatment services will include intensive individual, group, and family therapy and medication management services. The program includes an integrated educational component so youth may stay academically engaged during treatment. We already contract with Fairbanks North Star Borough School District for the Midnight Sun Academy, which lives within our residential treatment program and will also serve the PHP. Clinical and educational staff will collaborate to support individual learning needs and inform reintegration planning with a youth’s home school district. For families from rural communities, FCSA will work with our referral sources and community partners to coordinate transportation and lodging.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Matanuska-Susitna Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Family Centered Services of Alaska, Inc.	Leveraging Technology to Increase Access to Behavioral Health Services for Rural Youth	AK	There is a lack of specialized pediatric behavioral health services in Alaska’s rural communities. Often youth reach a point of crisis or hospitalization that could have been avoided. Added to challenges recruiting qualified clinicians, clinician capacity is also limited by administrative burden and documentation requirements; our clinicians currently spend over 20% of their time completing required documentation. This project presents a transformational opportunity to modernize the technological backbone of Family Centered Services of Alaska (FCSA) in a way that will directly expand access to behavioral health services for rural youth in Interior Alaska. By leveraging telehealth infrastructure and emerging AI-assisted clinical technology, we will significantly improve access to behavioral health services for our rural youth as well as the sustainability of our clinical workforce. These investments will support continuity of care for rural youth across the full continuum of behavioral health services. Services delivered within our residential treatment environment or other structured programs often result in strong therapeutic gains; however, maintaining those gains when reintegrating into home communities can be challenging when follow-up care is limited. This project will allow us to extend the reach of our clinical teams beyond our physical facilities to support behavioral health prevention, treatment, and stabilization services to rural youth throughout the region.	We will roll out the project in 4 phases: 1) infrastructure upgrades including workstation refresh and network capacity improvement; 2) deployment of AI clinical documentation tools and training; 3) telehealth expansion and community partnership development; and 4) monitoring and outcomes evaluation. In Phase 1 we will work with our IT department to ensure our systems have capacity to handle the increased technological load, completing any indicated upgrades to ensure seamless delivery of services and that telehealth delivery does not become tethered to a single location, truly enabling mobile healthcare and expanding the reach of services throughout Interior Alaska. In Phase 2 we will deploy AI clinical documentation software that will reduce the administrative burden for our clinical staff. This software will work like a “silent partner” that helps clinicians document sessions, assessments, treatment plans, screenings, and discharge summaries while ensuring necessary components such as risk assessment, treatment recommendations, goals, and interventions are addressed to meet all regulatory compliance standards. FCSA is currently in the process of evaluating AI clinical documentation platforms that are HIPAA compliant, specifically designed for behavioral health environments, able to integrate with our EHR platform, and proven to reduce documentation burden. The software is expected to significantly increase our clinicians’ capacity, and as administrative burden is reduced will set the stage for Phase 3, telehealth expansion and partnership development. In Phase 3 we will travel to communities to foster and strengthen partnerships necessary to support smooth implementation of expanded telehealth services, including with local schools to ensure connectivity and secure space are available for students to participate in telehealth visits without having to leave the building and miss school. We will also make any identified upgrades to our telehealth platform to ensure it has the proper capacity to handle the projected increase in demand. Once launched, while services will be delivered primarily via telehealth, quarterly trips to communities for face-to-face services will ensure stability of the clients being served, as well as stability of the community partnerships that support our telehealth program. Finally, we will undertake rigorous program evaluation (Phase 4). During this phase we will closely monitor program processes as well as client outcomes.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Matanuska-Susitna Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Family Outreach Center for Understanding Special-Needs, Inc.	FOCUS Electronic Health and Medical Records Software Project (FOCUS EHR/EMR Software Project)	AK	Alaska’s Part C Early Intervention program operates without a unified electronic health and medical record system (EHR/EMR), resulting in fragmented documentation, inconsistent data tracking, and administrative inefficiencies across rural providers. Many agencies rely on manual processes or disconnected systems that limit real-time care coordination, standardized outcome reporting, and accurate Medicaid billing. In a geographically vast state, this lack of centralized infrastructure delays services, increases staff burden, contributes to reimbursement challenges, and restricts statewide quality monitoring. This project presents an opportunity to modernize rural early childhood health infrastructure through a comprehensive, cloud-based care coordination and billing platform. A unified EHR will streamline documentation, strengthen Medicaid sustainability, support telehealth delivery, improve data transparency, and enhance equitable access to services for Alaska’s youngest children.	To address the lack of a unified system for Alaska’s Part C Early Intervention program, we propose implementing a comprehensive, cloud-based EHR/EMR platform supported by updated mobile technology for field-based providers. This project will include the purchase and deployment of a centralized EHR system with integrated IFSP documentation, care coordination, outcome tracking, and Medicaid and private insurance billing functionality. The EHR/EMR will standardize documentation across providers, centralize Individualized Family Service Plans (IFSPs), enable real-time service tracking, and improve interdisciplinary communication. Integrated billing tools will strengthen billing compliance, reduce claim denials, and stabilize revenue streams essential for rural program sustainability. Built-in reporting capabilities will allow for consistent data collection, quality monitoring, and equitable service tracking across communities. Implementation will include system configuration, data migration, staff training, and phased rollout to ensure minimal service disruption. Ongoing technical support and workflow refinement will promote long-term sustainability. By implementing an EHR/EMR, this approach strengthens rural health access, improves operational efficiency, enhances workforce capacity, and builds a sustainable foundation for high-quality early intervention services across Alaska.	Under \$50,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area	Deferred or Not Advanced
Family Outreach Center for Understanding Special-Needs, Inc.	FOCUS Technology Project	AK	Our current desktop computers, software systems, and mobile plans are outdated and inefficient. Providers are challenged to provide Part C services aligned with state and federal requirements, such as obtaining 'wet' parent signatures and timely documentation. This project provides an opportunity to modernize our technology to match the demands of the job, streamline the coordination of care for families, and reduce billing errors. Access to in-home hearing screening will lead to early detection and intervention of hearing loss and lead to better outcomes for children.	To ensure successful adoption, providers will be equipped with touchscreen laptops and mobile technology to support mobile documentation during home visits and telehealth sessions. These devices with e-signature software will allow real-time data entry in remote communities, reduce paperwork duplication, and increase time available for direct services. The technology upgrade will also support secure data transmission and compliance with IDEA Part C and state reporting requirements. Implementation will include staff training on the OAE hearing screener and streamline use of touch screen laptops. Ongoing technical support and workflow refinement will promote long-term sustainability.	Under \$50,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area	Deferred or Not Advanced

Family Outreach Center for Understanding Special-Needs, Inc.	FOCUS Workforce Development Project	AK	In Alaska, it is extremely difficult to recruit and retain highly qualified early interventionists including developmental specialists, occupational therapists, physical therapists, and speech-language pathologists. Our university systems have limited or no capacity to graduate professionals in these specialty areas, so we must recruit personnel from out-of-state and compete with private employers for these hard to fill positions. This project will invigorate and expand our recruitment and retention strategies, tools, and resources.	The project includes the following components to strengthen recruitment and retention of highly qualified early intervention providers: Develop on-going relationships with university systems located outside of Alaska as 'pipelines' for recruitment, which would include travel and participation in university sponsored career fairs and outreach activities; development of retention incentives, such as loan forgiveness options and scholarship opportunities; funding for advanced professional development opportunities aligned with the professional discipline, which would include reimbursement for travel expenses and fees, and targeted training to build provider capacity and reduce reliance on outsourced specialty services.	Under \$50,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area	Deferred or Not Advanced
Far North EMS Solutions	Alaska Rural Emergency Care Network	AK	Communities across rural and remote Alaska face persistent challenges accessing timely healthcare within a geographically dispersed healthcare delivery system. Patients often rely on emergency response systems and costly medevac transports when medical conditions worsen due to limited access to routine monitoring and follow-up care. Emergency responders—including EMTs and Emergency Trauma Technicians (ETTs)—are often among the most consistently available healthcare resources in rural communities. However, their role is typically limited to emergency response rather than ongoing patient monitoring or coordination with healthcare providers. There is an opportunity to strengthen Alaska’s rural healthcare system by expanding the integration of EMS responders into a coordinated network that supports early intervention and care coordination. By leveraging the existing EMS workforce and connecting responders with healthcare providers through telehealth-supported collaboration, communities can improve continuity of care while reducing avoidable emergency transports and medevac flights.	This project proposes the development of the Alaska Rural Emergency Care Network, a pilot initiative designed to strengthen healthcare access and coordination in rural communities through EMS integration, telehealth-supported collaboration, and workforce development. Community-Based Emergency Care Coordination Trained EMTs and ETTs will conduct scheduled outreach visits focused on monitoring and supporting individuals who may benefit from additional care coordination. These visits may include post-hospital discharge follow-up, monitoring of chronic conditions, medication adherence support, wellness checks, and connection to telehealth consultations with healthcare providers. Responders participating in the program will operate within their existing scope of practice and under protocols developed in collaboration with healthcare partners. Their role will focus on monitoring and connection to care rather than diagnosis or independent clinical treatment. Telehealth-Supported Collaboration When appropriate, responders will connect patients to healthcare providers through telehealth consultation during visits. This allows providers to assess patient conditions earlier and determine whether additional intervention or referral is necessary, helping prevent conditions from escalating to emergencies requiring transport. Workforce Development The project will provide additional training for EMTs and ETTs participating in the program to support care coordination, communication with healthcare providers, and patient monitoring. The program will begin as a pilot in select hub communities and will	\$250K-\$1M		Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway	Advance to Implementation Application

	generate protocols, training models, and coordination pathways that can be expanded to additional regions across Alaska.	(Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	

Far North Urgent Care	North Pole Far North Urgent Care	AK	Residents of North Pole, Alaska and nearby communities currently have no local urgent care facility to address immediate, non-life-threatening medical needs. As a result, individuals experiencing minor injuries, acute illnesses, or other urgent medical concerns must travel to Fairbanks to seek care through primary care clinics with limited same-day availability or hospital emergency departments. This creates significant barriers for patients, including travel time, transportation challenges, longer wait times, and higher healthcare costs. These barriers can lead to delays in treatment, increased use of emergency departments for conditions that could be treated in a lower acuity setting, and limited access to timely care for families living in this growing community. The absence of local urgent care services also places additional strain on regional healthcare facilities that already serve a broad rural and frontier population across Interior Alaska. This project presents an opportunity to establish North Pole Urgent Care, a dedicated urgent care clinic that will provide timely treatment for common acute medical conditions and minor injuries within the community. By creating a local access point for urgent medical care, the project will improve healthcare access, reduce unnecessary emergency department utilization, and strengthen the healthcare infrastructure serving North Pole and surrounding rural areas.	To address the lack of immediate healthcare services in the North Pole community, this project will establish North Pole Urgent Care, a new urgent care clinic designed to provide timely treatment for non-life threatening medical conditions and minor injuries. The clinic will serve residents of North Pole and nearby rural communities who currently must travel to Fairbanks for urgent medical care. North Pole Urgent Care will provide walk in access to care for a range of common urgent medical needs, including acute illnesses, minor injuries, infections, simple fractures, lacerations, and other conditions that require prompt medical attention but do not require emergency department services. The clinic will also offer basic diagnostic capabilities such as point of care laboratory testing and imaging to support accurate and timely diagnosis and treatment. The facility will be staffed by qualified medical providers and clinical support personnel trained to deliver efficient, high quality urgent care services. Extended hours and walk-in availability will help ensure that patients can receive care when they need it, reducing delays in treatment and minimizing the need for unnecessary emergency department visits. By locating urgent care services directly within the North Pole community, this project will improve access to timely medical care, reduce travel barriers for patients, and strengthen the local healthcare system. The clinic will also coordinate with regional healthcare providers and hospitals to ensure appropriate referral and continuity of care when higher levels of treatment are required.	\$1M-\$5M	Clinic	Statewide	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

FasPsych, LLC	FasPsych Telehealth and Utilization Initiative	AZ	Rural communities continue to experience a persistent and worsening shortage of psychiatric and behavioral health providers, resulting in delayed care, preventable crises, and excessive reliance on emergency departments. Rural healthcare facilities lack reliable access to psychiatric evaluations, medication management, and crisis intervention services. As a result, patients frequently experience long wait times to see a mental health professional, fragmented care pathways, and increased risk of hospitalization or emergency department utilization for conditions that could be managed earlier and more effectively. FasPsych’s mission is to expand sustainable access to high-quality psychiatric and behavioral health services in underserved rural communities through innovative telehealth staffing models. The purpose of this pilot program is to alleviate provider shortages, reduce system inefficiencies, and enable rural healthcare facilities to deliver timely, coordinated mental health care without incurring unsustainable staffing costs.	The project will implement a centralized telepsychiatry staffing model supported by fee-for-service workflows, enabling efficient provider utilization across multiple rural facilities. Strategies include targeted facility onboarding, rapid provider deployment, and continuous performance monitoring.	\$250K-\$1M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Ketchikan Gateway Borough	Deferred or Not Advanced

Fathoms Alaska	Canoe Camp	AK	According to the 2020 Alaska Native Injury Atlas, suicide attempt and suicide were the second leading causes of hospitalization and death respectively for Alaska Native and Indigenous populations in Southeast Alaska. This trend is consistent with patterns for Indigenous youth statewide. Across Alaska, the leading cause of hospitalization and/or death for Native youth ages 10-19 was suicide, at a rate approximately five times higher than that of their non-Native peers (Alaska Native Injury Atlas). Over half of these were confirmed or suspected to be alcohol-related. Our program will aim to support students struggling with mental illness and/or substance abuse. Canoe Camp’s goals are to directly improve the physical, psychological, and social wellbeing of youth and young adults in Southeast Alaska while also creating multiple protective factors, increasing access and relationship to local environments and cultural traditions. A growing body of work has shown youths’ exposure to nature improved mental health, cognitive function, heart health, and sleep. Recent research after the Covid-19 pandemic showed outdoor activities improve adolescents’ mental health and wellbeing by increasing their resilience to stressors. Canoe Camp consistently provides the opportunity for participants to immerse in the magnificent nature of their local ecosystems, and to improve their physical fitness, increase their self-awareness, and develop self-confidence by overcoming challenges.	Canoe Camp’s approach to increasing access to long term health-supporting experiences, protective factors, physiological wellbeing and community resiliency is to provide free, locally available programming that encourages physical activity, connection to place, and supportive peer and mentorship relationships. During Canoe Camp, participants spend multiple days on the water learning how to paddle, exploring coastal ecosystems, and practicing skills that require communication, trust, and shared responsibility. Canoeing is a collaborative activity, requiring effective communication, active listening, and teamwork. Participants will develop leadership and followership skills, fostering confidence, self-awareness, and self-actualization. While immersed in this natural-classroom, guides integrate age appropriate curriculum that includes; social and emotional learning opportunities, education around healthy habits and lifestyles, nervous system regulating and resiliency skills, and lessons that help to support and encourage self-awareness and confidence in their identity and belonging to people and place. These experiences support multiple dimensions of health. Regular physical movement and time outdoors promote physical wellbeing and resilience. Team-based canoe travel strengthens social skills and reduces isolation by building supportive peer networks. Structured play, teamwork, and mentorship create a safe environment that helps regulate stress and strengthen emotional wellbeing. In communities where access to mental health services can be limited, these experiences function as preventative care that builds protective factors for youth. Fathoms’ founders bring a combined 24 seasons of experience working with Alaskan youth in wilderness environments and have seen firsthand how connection to the natural world can support healing. Our team’s experience with at-risk youth, as well as in therapeutic and educational fields, allows us to provide a safe, supportive environment for emotional and mental expression. In the next five years, Fathoms will strengthen the sustainability of Canoe Camp by inviting Yakutat community members to participate in and facilitate the program. A locally guided model will increase community capacity to support youth wellbeing while ensuring the program can continue long-term.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Hoonah-Angoon Census Area; Prince of Wales-Hyder Census Area; Yakutat (City and Borough)	Deferred or Not Advanced

Finity	Whole Person Health Smart Solution for Alaska RHT: Innovative Technologies + Trained CHWs	OR	Rural Alaska faces extreme geographic isolation, workforce shortages, transportation barriers, seasonal access disruption, and high rates of maternal risk, behavioral health need, diabetes, and cardiovascular disease. Fragmented care, coverage instability, and preventable disenrollment further disrupt continuity. These challenges create a clear opportunity for Finity’s Whole Person Health (WPH) Smart Solution to unify engagement, coverage stabilization, and chronic condition support into one coordinated framework. Our model addresses rural fragmentation by: • Delivering structured Whole Person Health engagement • Stabilizing coverage and preventing avoidable disenrollment • Activating primary care and preventive screenings • Providing targeted Smart Chronic Condition Support • Producing measurable engagement, utilization, and outcome reporting In frontier environments where clinical resources are limited, a disciplined engagement infrastructure becomes the backbone of access and continuity. By combining technology-enabled outreach and programs with specialty trained CHW-delivered support, Finity strengthens Healthy Beginnings, Health Care Access, Healthy Communities, Workforce, Fiscal Sustainability, and Technology Innovation—turning rural constraints into a scalable, coordinated system of whole-person support.	Finity will deploy a structured Whole Person Health (WPH) Smart Solution integrating technology, engagement, benefit stabilization, smart condition support, and community partnerships to address Alaska’s rural health challenges. Key components include: 1. Engagement & Whole Person Health Navigation Engagement begins with coordinated, partner-branded outreach: • Targeted outbound calls and SMS reminders • Claims-driven identification of high-risk individuals • Outreach to individuals at risk for disenrollment • Proactive contact with recently disenrolled individuals Each engaged member completes a CHW-led WPH Assessment session including: • Comprehensive WPH Assessment and Profile • HEDIS-aligned SDOH screening • Depression screening when indicated • Primary care utilization review and scheduling support • Identification of unmet medical or behavioral needs • Education on benefits continuity This structure stabilizes coverage, strengthens primary care activation, and improves preventive compliance. 2. Finity Smart Programs Following WPH Assessment, clinically appropriate individuals enroll in: a. BabySmart – Maternal & Infant Health Provides prenatal and postpartum support delivered by doula-trained IHS b. DiabetesSmart – Diabetes Management Delivers DSMES-aligned education, medication adherence reinforcement, and glucose routine guidance c. LoseSmart – Prediabetes & Early Intervention An NDPP-aligned lifestyle program focused on reducing diabetes risk through structured nutrition, movement, sleep, and stress routines d. HeartSmart – Hypertension & Cardiovascular Health An AHA-aligned program supporting blood pressure monitoring, medication adherence, and heart-healthy routines e. MindSmart – Behavioral Health Provides emotional support, light CBT- and mindfulness-based routines, stress-management, and check-ins that reinforce stability Each Smart Program includes: • Structured IHS visits based on need • HEDIS-aligned screening • CBT-informed goal tracking • Primary care follow-up • Personalized LifeTracks • SDOH coordination • Education modules • Optional device/DME integration • Incentive-based engagement • Matched cohort outcome reporting	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

3. Technology Infrastructure
Finity’s SmartSaaS platform includes mobile apps for engagement and tracking, CHW workflow portals, analytic dashboards, device integration, and secure communication tools.

Fireweed Montessori	Facility Floor repairs and replacement of indoor and outdoor materials	AK	The childcare facility serving our rural community is experiencing deterioration of critical building surfaces and materials due to years of heavy daily use. Existing flooring has become worn and damaged, creating potential tripping hazards and making proper sanitation more difficult. Interior walls require repair and repainting due to scuffs, damage, and general wear that can impact cleanliness and the overall learning environment. In addition, several indoor and outdoor materials used by children for learning and play have become worn and need replacement to ensure they remain safe and developmentally appropriate. Because childcare resources in rural and remote communities are limited, maintaining safe, high-quality facilities is essential to ensuring families continue to have reliable care options. Without these repairs and replacements, the facility risks declining safety conditions, increased maintenance costs, and reduced quality of the environment for children. This project will address these issues by replacing damaged flooring, repairing and repainting interior walls, and updating indoor and outdoor materials. These improvements will create a safer, healthier, and more sustainable environment for children and families while helping ensure the continued availability of essential childcare services in the community.	Assessment and Planning We begin with a comprehensive inspection of all indoor and outdoor flooring areas to assess current conditions, identify safety hazards, and determine the extent of damage or wear. This includes evaluating subfloor integrity, drainage, surface coating, and material compatibility. Based on the findings, we develop a detailed plan outlining scope, priorities, timelines, and cost estimates. 2. Material Selection Flooring materials will be selected to meet the facility’s functional, safety, and aesthetic requirements. Indoor areas: Durable, low-maintenance materials such as epoxy, vinyl composition tile (VCT), ceramic tile, or polished concrete depending on usage. Outdoor areas: Weather-resistant, non-slip surfaces like sealed concrete, pavers, or asphalt with proper grading and drainage considerations. All materials will adhere to relevant industry standards and environmental/sustainability goals when applicable. 3. Phased Execution To minimize disruption to operations: Work will be scheduled in phases, prioritizing high-traffic or safety-critical zones first. Clear signage, temporary barriers, and alternate routes will ensure continued access and safety. Demolition, surface preparation, installation, and curing will be carefully sequenced for efficiency and quality. 4. Quality Control and Safety Each phase includes inspection checkpoints to verify surface leveling, adhesion, finish quality, and compliance with specifications. Our team follows strict safety protocols, including PPE use, dust control, and hazard signage, ensuring both worker and occupant safety throughout the process. 5. Final Inspection and Handover Upon completion, a joint inspection will confirm workmanship quality and performance. As-built documentation, material warranties, and maintenance recommendations will be provided to ensure long-term durability and ease of care.	Under \$50,000	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

First Choice OB/GYN	The Fourth Trimester	AK	The postpartum period, often called the "fourth trimester," is a critical yet historically neglected phase of maternal care in Alaska. Traditional care models rely heavily on a single six-week follow-up, leaving significant gaps in addressing postpartum depression, anxiety, and nutritional recovery. In the Mat-Su Valley and Anchorage, many new mothers face barriers to accessing specialized support during this vulnerable window, leading to poor long-term outcomes for both mother and child.	"The Fourth Trimester" redesigns the standard of care by making mental health and nutritional assessments mandatory components of the postpartum journey. Initiated by First Choice OB/GYN, the program adds structured virtual touchpoints between birth and the traditional 6-week visit. • Integrated Staffing: We will hire a Physician Assistant (PA), a Licensed Mental Health Therapist, a Registered Dietitian and administrative supportive staff as needed to facilitate various roles to form a dedicated postpartum care team. This team is expected to grow as the platform grows. • Virtual First Model: Utilizing our existing AthenaOne Electronic Medical Record (EMR) infrastructure, appointments will be conducted via telemedicine to eliminate travel barriers for new mothers. • Mandatory Touchpoints: To bridge the critical gap in early postpartum care, our program implements a high-touch telemedicine protocol ensuring all patients are scheduled and receive a clinical screening within the first seven days of delivery. This rapid-response intervention is designed to preemptively identify and manage perinatal mood and anxiety disorders (PMADs). Simultaneously, we address nutritional equity by delivering counseling specifically adapted for the Alaskan landscape. Our curriculum will navigate the complexities of food insecurity in remote regions by integrating traditional subsistence patterns—accounting for hunted, gathered, and home-grown foods, provide culturally resonant, evidence-based education resulting in nutritionally dense support for breastfeeding mothers, therefore benefiting both mom and baby.	\$250K-\$1M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Denali Borough; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area	Deferred or Not Advanced

Flagstar Staffing	Flagstar Staffing Letter of Interest	NY	Rural and frontier communities across Alaska face significant barriers to accessing consistent behavioral health support. Geographic isolation, workforce shortages, and limited availability of behavioral health professionals often leave communities without the outreach, care coordination, and early intervention services needed to support individuals experiencing mental health and substance use challenges. These gaps can lead to delayed treatment, increased crisis situations, and strain the already limited healthcare resources. Community Health Workers (CHWs) present a strong opportunity to help address this challenge. As trusted members of the communities they serve, CHWs are uniquely positioned to provide outreach, education, care navigation, and ongoing support for individuals who may otherwise have difficulty accessing behavioral health services. However, many rural programs struggle to recruit, retain, and deploy qualified CHWs due to limited local workforce pools and administrative capacity. This project will strengthen the behavioral health support network in rural Alaska by expanding the recruitment, retention, and deployment of CHWs who can provide culturally responsive, community-based support. By building a sustainable pipeline of CHWs and deploying them to rural and frontier communities, the project will help improve access to behavioral health resources, strengthen early intervention efforts, and support more stable community-based care systems.	Flagstar Staffing’s proposed approach focuses on strengthening Alaska’s rural behavioral health workforce by recruiting, retaining, and strategically deploying Community Health Workers (CHWs) while advancing the Triple Aim: improving population health, enhancing the patient experience, and reducing the per-capita cost of care. CHWs serve as trusted community-based professionals who can extend the reach of limited behavioral health providers in rural and frontier communities. To improve population health, Flagstar will build a targeted recruitment pipeline for CHWs with experience in behavioral health outreach, care navigation, and community education. Recruitment efforts will prioritize individuals with strong ties to rural and tribal communities, cultural competency, and the ability to engage individuals who may be hesitant to seek traditional behavioral health treatment. By expanding the availability of CHWs in rural areas, communities will gain greater access to early intervention, prevention programs, and behavioral health education that help reduce crisis events and improve long-term health outcomes. To enhance the patient and community experience, Flagstar will support CHWs through structured onboarding, ongoing engagement, and coordination with local behavioral health programs, tribal health organizations, and rural healthcare providers. CHWs will serve as consistent points of contact who help residents navigate behavioral health services, connect to social resources, and maintain engagement with treatment and recovery programs. This community-centered model improves trust, increases participation in behavioral health services, and ensures that care remains culturally responsive and accessible. To support cost-effective and sustainable care, the project will deploy CHWs to help reduce unnecessary emergency department visits, hospitalizations, and gaps in care by strengthening outreach, prevention, and care coordination efforts. By addressing behavioral health needs earlier and supporting individuals before crises occur, CHWs help healthcare systems operate more efficiently while improving outcomes for rural populations. Through targeted recruitment, workforce support, and coordinated deployment of CHWs, Flagstar’s approach strengthens the behavioral health workforce in rural Alaska while advancing the Triple Aim—improving health outcomes, enhancing community trust and patient experience, and supporting more sustainable healthcare delivery systems.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Fond of You Inc d/b/a Somethings	Virtual Low-Bandwidth Certified Peer Support for Youth and Young Adults in Rural Alaska	NY	Alaska’s youth are experiencing a severe and growing mental health crisis. Recent data show that 43% of Alaska high school students report persistent sadness or hopelessness, among the highest rates nationally, while two-thirds of teens with major depression receive no treatment. Youth suicide remains a critical concern, particularly in rural communities where limited access to behavioral health services leaves many young people without support. Geographic isolation, workforce shortages, and stigma continue to prevent youth from receiving early care. As a result, many reach crisis levels of care; in Alaska, suicidal ideation accounts for roughly 1 in 4 child and adolescent behavioral health emergency department discharge diagnoses. Mental health challenges also affect education. Nearly 45% of Alaska students are chronically absent, with depression, anxiety, and substance use among the leading contributors. Without early support, youth are more likely to miss school and fall behind academically. Many ultimately enter high-cost crisis systems, including emergency departments and out-of-state residential treatment, where approximately 130 Alaska youth are placed each month, more than 1,500 placements annually, leaving their school and community. This project addresses the opportunity to intervene earlier by connecting youth to timely mental health support before concerns escalate into crisis, helping youth stay connected to school and engaged in their communities.	Our approach expands access to mental health support by providing virtual peer mentoring for youth ages 13–26. Through our HIPAA-compliant app, young people can connect with certified peer mentors who share similar lived experiences and understand the realities of growing up in rural and remote communities. Youth are matched with mentors who are just a few years older and have relevant lived experience navigating mental health challenges. To strengthen trust and cultural understanding, mentors are recruited from Alaska communities across the state. Youth are matched with mentors from a different but similar community so they can connect with someone who understands their experiences while still maintaining privacy in small communities where confidentiality can be difficult. All mentors complete structured certification and training in youth mental health, crisis recognition, and trauma-informed support. Mentors are supervised by Alaska-licensed providers who oversee safety protocols, review cases, and support escalation when higher levels of care are needed. This clinical oversight ensures youth receive safe, high-quality support while allowing mentors to build authentic, supportive relationships. The program is designed specifically for Alaska’s geographic realities, functioning in low-bandwidth environments and can be accessed on basic smartphones, allowing youth in rural and remote areas to connect even with limited internet connectivity. All services are delivered through secure in-app chat or video, eliminating the need for travel and allowing youth to access support privately from their homes or communities. Mentors provide prevention and early intervention support, helping youth talk through stress, anxiety, or depression before challenges escalate. They support youth experiencing acute stress or emotional distress by helping them process what they are experiencing, develop immediate coping strategies, and provide ongoing support. When additional support is needed, mentors follow protocols and work with supervising licensed clinicians to escalate care or connect youth to appropriate resources. This approach prioritizes helping youth remain safely connected to care within their own communities whenever possible. By offering after-hours, confidential, and culturally responsive support, this approach creates a new model that strengthens Alaska’s behavioral health system while ensuring young people can receive help when and where they need it.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Food Bank of Alaska	Food Is Medicine - Increasing Produce Prescription Opportunity Across Alaska	AK	Across Alaska, hunger and nutrition insecurity are driving preventable health challenges and straining rural healthcare systems. Statewide, 1 in 7 Alaskans experience hunger, and rates are even higher in remote communities where food costs, transportation barriers, and limited retail options make accessing healthy foods extremely difficult. The most food insecure areas - Kusilvak, Bethel, Yukon Koyukuk, Nome, Northwest Arctic, and Prince of Wales Hyder - are all off the road system, demonstrating that the burden of food insecurity is concentrated in places where day to day life is already costly and complex.(Feeding America, 2023) Lack of access to nutritious foods contributes directly to higher rates of chronic disease, including diabetes, hypertension, and heart disease, and leads to increased emergency care utilization. Many healthcare providers in rural Alaska serve patients whose diet related conditions are worsened by limited availability of affordable, fresh produce, an essential component of chronic disease prevention and management. This project addresses the opportunity to integrate nutrition access into clinical care. By enabling healthcare providers to connect patients with reliable, low or no cost sources of fresh produce, we can intervene earlier, reduce the impact of preventable conditions, and support healthier outcomes in communities.	This project will build on 47-years of community-based work, leveraging a strong foundation of statewide coordination, strategic planning, and program piloting to expand prescription produce access across rural and remote Alaska. In 2025, we entered a 10-year partnership with the Alaska Department of Health to serve as the Resource and Coordinating Agency for Produce Incentive and Food Is Medicine Programs. This role positions us to strengthen collaboration among healthcare providers, community partners, and food access organizations to address nutrition insecurity as a key driver of health. However, RHTP funding is needed to accelerate impact, better integrate with the healthcare sector, and expand our scope. Specifically, we will: (1) Leverage existing infrastructure by integrating fresh produce into the Commodity Supplemental Food Program (CSFP), which currently serves approximately 2,500 nutrition-insecure seniors statewide. Adding produce to this monthly food distribution will immediately increase access among a high risk population. (2) Collaborate with healthcare experts to co-create standardized food insecurity and nutrition risk screening criteria usable across the continuum of care - from emergency departments and primary care to long term care settings - ensuring efficient identification of patients who would most benefit from produce prescriptions. (3) Identify priority populations for future project scaling, using statewide data, community insights, and healthcare partner referrals to ensure produce prescription programs reach those at greatest risk of diet related disease. (4) Implement the statewide Food Is Medicine strategic plan by launching produce prescription programs in additional rural communities and supporting local partners with training, logistics, and evaluation tools.	\$50,000-\$250,000	Statewide	Anchorage (Municipality); Bethel Census Area; Kenai Peninsula Borough; Matanuska-Susitna Borough; Yukon-Koyukuk Census Area	Advance to Implementation Application

Forget Me Not Grief Center of Alaska	Grief Center Alaska Outreach	AK	Rural and frontier communities in Alaska face gaps in grief support for children, teens, and adults. Losses from suicide, sudden death, substance-related causes, accidents, or chronic illness are common, yet few communities have structured programs. Geographic isolation, provider shortages, transportation barriers, and stigma limit access. This project provides peer-to-peer grief support that is culturally sensitive and responsive to Alaska’s diverse communities. Programs create safe spaces for participants to share experiences, normalize grief, strengthen coping skills, and build protective factors. Children and teens receive support that can reduce behavioral and academic challenges, while adults gain tools to navigate loss and support family stability. By expanding accessible, community-based, and culturally responsive grief support, this project addresses a critical service gap and strengthens behavioral health resilience across rural Alaska.	FMNGCA will implement a structured, peer-to-peer grief support program for children, teens, and adults, delivered in rural schools, community settings, and via hybrid formats when appropriate. Programming will be culturally responsive, honoring Alaska’s diverse communities, traditions, and values. Our approach includes: Program development and oversight – trained staff will design age-appropriate, trauma-informed curricula, supervise volunteers, and ensure consistent delivery. Peer support groups – facilitated sessions where participants share experiences, normalize grief, and develop coping skills in a safe, supportive environment. Outreach and community engagement – targeted marketing and education to connect families with services, build local partnerships, and increase grief literacy among caregivers, educators, and providers. Evaluation and quality improvement – collect participant feedback, monitor program fidelity, and refine approaches to meet community needs. By embedding grief support within trusted community institutions and building local capacity, this approach increases access, strengthens quality, and enhances sustainability of behavioral health services for Alaska’s rural, remote, and frontier communities.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough	Deferred or Not Advanced

Forgetmenot USA	AIR Care will offer Aging Inhome Resources by linking seniors to technology.	AK	One of the biggest barriers in our society is presented by technology. The goal of AIR Care is to train our elderly population in technology and various devices so they can access the resources they need.	Project Title: The Silver Link Initiative (AIR Care) The Project Concept The Silver Link Initiative moves beyond simple technical support to create a sustainable "human-centered ecosystem." Our approach utilizes an intergenerational mentorship model, pairing local youth with seniors for one-on-one coaching. Unlike standardized programs, this initiative is specifically engineered for the Alaskan context by prioritizing "offline-first" functionality for low-bandwidth regions, ruggedized hardware for harsh environments, and specialized training for critical state resources like the PFD and heating assistance portals. Societal Impact This initiative is designed to create a "Triple Win" for Alaskan society: Economic Efficiency: Empowering seniors to independently manage telehealth and resource applications reduces the strain on high-cost emergency services and rural transport. Health & Dignity: Digital literacy provides a proven defense against isolation, connecting elders to family and healthcare, thereby reducing rates of depression and cognitive decline. Community Safety: By educating our seniors on scam detection, we protect the financial security of Alaskan households and keep local resources within our economy.	\$50,000-\$250,000	Statewide	Bethel Census Area; Chugach Census Area; Denali Borough; Dillingham Census Area; Juneau (City and Borough); Kodiak Island Borough; Matanuska-Susitna Borough; North Slope Borough; Northwest Arctic Borough; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced
Forgetmenot USA	Data Link - hub for anyone (serves anyone who needs to connect to resources)	AK	The inability to connect directly to healthcare or other services.	Provide a connection to services through an online application designed for Alaskans. The online application would include healthcare facilities and resources geotargeted to serve the individual better. Potential clients or patients would be connected to resources and services based on location services, urgency, and proximity. Artificial Intelligence would be utilized.	\$50,000-\$250,000	Statewide	Copper River Census Area; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Foundation for End of Life Care, Inc.	Enhancing Hospice, Home Care Support and Utilization in Southeast Alaska	AK	After termination of support for Hospice & Home Health Care (HHC) in Juneau in 2022 by a non-profit provider, the City & Borough of Juneau (CBJ) restored these services under the auspices of the city-owned Bartlett Regional Hospital (BRH) a year later. Since then, BRH has been actively working to expand the supporting infrastructure. A collaborative effort led by the CBJ, BRH, The Juneau Community Foundation, and the Foundation for End of Life Care, Inc. coalesced to support start-up costs of Home Health & Hospice through the first five years (now in Y3). A major goal is sustainability for Juneau and outlying communities. Our region has the highest population over age 60 in the state, yet hospice care remains underutilized in Juneau (~60 patients a year) and it is often unavailable outside Juneau. Currently in its third year, rising costs, high turnover of hospice staff, and low patient utilization challenge HHC sustainability. More effective education aimed at physicians, patients and families on the value of HHC and a better understanding of the benefits of early referrals to HHC during the end-of-life process will have a positive impact on the program's revenue streams and long-term sustainability. The resulting program stability will allow BRH to more effectively partner with the Southeast Alaska Regional Health Consortium and volunteer organizations to extend and expand HHC services to outlying communities in southeastern Alaska.	The Foundation for End of Life Care (FELC) is committed to launching a comprehensive, multi-channel campaign aimed at raising awareness about hospice and home health care services. This campaign will leverage community events and educational initiatives, paired with ongoing education and training opportunities for healthcare staff and providers. The objective is to ensure information about critical hospice services reaches a broad audience while simultaneously strengthening the skills and knowledge of those delivering care. Development of Training Materials: As part of this initiative, FELC will develop specialized training materials for onboarding hospice providers, staff, and healthcare workers not only in Juneau but also in surrounding communities. These resources are designed to equip caregivers with the necessary knowledge, skills, and emotional resilience required to effectively support individuals and families through the hospice experience. Awareness Resources for Caregivers and Professionals The campaign will also feature a variety of customized, culturally informed resources such as educational videos, handouts, and podcasts or radio scripts. These materials will be tailored to increase awareness of available resources among family caregivers, volunteers, hospice administrators, physicians, nurses, social workers, and chaplains. By addressing the unique needs of each group, these resources will help ensure that everyone involved in hospice care is informed and supported. Regional Training Opportunities: All of these educational materials will be integrated into a robust training program specifically designed for rural medical responders. FELC will facilitate these programs, making them accessible to healthcare professionals and volunteers across the region. This approach will foster a community of well-trained individuals, ready to provide compassionate and competent care to those in need. Experience in Public Awareness and Professional Training FELC has a proven track record of successfully hosting public awareness events that are paired with training opportunities for healthcare professionals. These events have consistently focused on maintaining sustainable hospice programs and education, as well as bereavement counseling and training.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Foundations Physical Therapy LLC	Women’s Health Access Project; Strong Roots - Alaska Women’s Health Initiative	AK	Pelvic floor dysfunction, including bladder leakage, pelvic pain, low back pain, and core instability, affects many women during pregnancy and the postpartum period. Despite how common these conditions are, many women receive little education about pelvic health and have limited access to early screening or guidance on when to seek care. As a result, symptoms often go unaddressed for months or years, leading to preventable complications and reduced quality of life. In Juneau and many Alaska communities, access to pelvic health education and specialized providers is limited. Many women report they were never informed about pelvic floor changes during pregnancy, postpartum recovery, or the connection between pelvic health, bladder function, and core stability. This lack of early education frequently leads to delayed care and worsening symptoms. This project addresses this gap through two connected efforts: Strong Roots, a prenatal and postpartum pelvic health screening and movement program, and a broader Women’s Health Initiative that delivers monthly workshops, virtual learning opportunities and resource connections. Together, these programs increase awareness, support early symptom identification, and expand access to preventative women’s health education. By piloting this model in Juneau, the project will create a framework that can be adapted for other Alaska communities, improving access to women’s health education and preventative care in rural and frontier settings.	The long-term vision of this project is to establish the Alaska Women’s Health Initiative, a community-based effort designed to expand access to women’s health education, early screening, and coordinated care across Alaska. While the initial focus is pelvic health during pregnancy and postpartum recovery, the initiative will address women’s health needs across the lifespan, including reproductive health, contraception education, menopause, and healthy aging. The initiative will begin with a pilot program in Juneau through the Strong Roots Prenatal & Postpartum Pelvic Health Program. Strong Roots is a structured small-group wellness program providing early education, preventative support, and guided movement for women during pregnancy and postpartum recovery. During the first year, the project will develop and implement a pelvic health and pregnancy screening tool that can be integrated into primary care settings to help identify early signs of pelvic floor dysfunction and connect women with appropriate care when needed. Participants will receive small-group movement classes focused on core strength, pelvic floor function, birth preparation, and postpartum recovery, along with education on pelvic health, labor preparation, and postpartum healing. The program will also support early identification of symptoms with referral to appropriate medical care when needed and provide opportunities to build peer support during pregnancy and postpartum recovery. Grant funding will support key start-up infrastructure, including rehabilitative ultrasound equipment and pessary fitting supplies, expanding the ability to provide pelvic health screening, education, and conservative management of pelvic floor conditions. Additional support will fund part-time program coordination, technology for virtual workshop delivery, and operational costs necessary to launch and sustain the program. In the first year, the program aims to serve 40–60 women through Strong Roots and deliver 8–10 educational workshops. As the program develops, education will expand to additional Southeast Alaska communities through virtual workshops and partnerships with regional organizations such as SEARHC, allowing women in rural communities to access trusted health information without traveling long distances. Over time, the project will grow into The Alaska Women’s Health Initiative, a statewide education and collaboration network connecting healthcare providers, educators, and community organizations.	\$50,000-\$250,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Kodiak Island Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Four Valleys Community School Inc	FVCS Rural Preventive Wellness Infrastructure Initiative	AK	Residents of Girdwood, Indian, Bird, and Portage face significant barriers to accessing preventive health and wellness services due to geographic isolation, limited local infrastructure, and seasonal travel challenges. Although within the Municipality of Anchorage, these communities function as rural areas where accessing recreation, health education, and structured physical activity often requires 30–60 minutes of travel, which is frequently disrupted by winter conditions. The valley lacks a dedicated community recreation or wellness center, leaving residents to rely on costly private memberships, personal equipment, or travel outside the community. These barriers disproportionately affect families with limited income, older adults, and individuals at elevated risk for chronic disease. Limited year-round access to indoor recreation and preventive education contributes to reduced physical activity, social isolation, and lower exposure to practical nutrition and stress-management strategies, key drivers of obesity, cardiovascular disease, diabetes, and behavioral health challenges. This project addresses these gaps by expanding local preventive wellness infrastructure and creating reliable, affordable opportunities for residents to engage in health-promoting behaviors close to home, strengthening rural prevention capacity, and reducing long-term health system burden.	Four Valleys Community School has operated out of Girdwood School for over 45 years, serving the communities of Girdwood, Indian, Bird, and Portage. We maintain a Memorandum of Understanding with the Anchorage School District and currently hold a building-use permit to operate programs beyond normal school hours (2:00–8:00 p.m., Monday–Friday). FVCS currently offers a variety of recreational and educational programs, including adult basketball and pickleball, youth football, and open gym times. In addition to recreational opportunities, we utilize school classrooms for cooking classes, yoga sessions, guest speakers, and community education events. At present, FVCS maintains office staff Monday through Thursday. While we occasionally offer Friday programming, we do not have sufficient staffing capacity to do so consistently. To address this limitation, FVCS proposes hiring an additional part-time staff member to expand regular programming to include Fridays and potentially Saturday mornings. These expanded hours would become part of our standard operating schedule, providing predictable and reliable access for the community. An additional component of this project is expanding the breadth and quality of our wellness programming. FVCS currently relies primarily on volunteers, limiting consistent delivery of specialized preventive programming. While this model fosters strong local engagement, it limits our ability to offer specialized wellness programming consistently. Project funding would allow FVCS to: 1. Recruit credentialed fitness and preventive health instructors 2. Offer competitive stipends and mileage reimbursement to recruit instructors from Anchorage 3. Partner with local nonprofit organizations such as Turnagain Arm Health Center to provide expert-led classes in nutrition, stress management, and preventative health 4. Purchase essential recreation and fitness equipment Equipment purchases would include: Yoga props (bolsters, foam rollers, blocks) Light hand weights for fitness classes Basketballs, youth volleyballs, soccer balls, and other recreation equipment By strengthening staffing capacity, expanding instructor expertise, and improving access to equipment, FVCS will create sustainable, year-round wellness programming that is affordable, geographically accessible, and responsive to community needs.	Under \$50,000		Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Four Valleys Community School Inc	Turnagain Arm Youth Active Lifestyles Initiative	AK	Four Valleys Community School (FVCS) has provided weekly summer camps for more than 30 years, serving youth from Girdwood, Indian, Bird, and Portage. As the only organization offering full-summer programming in the valley, FVCS engages about 75 youth annually in environmental education, hiking, biking, and field sports, providing structured physical activity in a community with limited recreation infrastructure. During the school year, programs such as running club, Nordic ski club, indoor soccer, volleyball, and basketball rely largely on volunteers. Community feedback consistently identifies the need for expanded, year-round youth physical activity led by trained instructors. Geographic isolation limits access to youth recreation. Travel to Anchorage requires 30–60 minutes each way, with winter conditions often restricting safe participation and disproportionately affecting families with limited time or financial resources. Limited access to consistent physical activity contributes to sedentary behavior and missed opportunities to build healthy habits early in life. This project expands structured, instructor-led summer camps and secures indoor space for restroom access, sheltered meals, and programming during inclement weather. By expanding youth activity opportunities in a rural setting, this project supports Healthy Beginnings and Healthy Lifestyles goals and helps reduce long-term chronic disease risk.	Four Valleys Community School will expand structured, youth-centered physical activity programming through enhanced summer camps and strengthened year-round recreation opportunities in Girdwood. Active Summer Youth Programming Funding will support additional trained staff to lead full-day, instructor-guided outdoor adventures, including hiking, biking, field sports, and skill-building activities. These programs are designed to increase daily moderate-to-vigorous physical activity while developing confidence, teamwork, and outdoor safety skills. To reduce transportation and equipment barriers, funds will support bike rentals or the purchase of shared-use bicycles, ensuring that all youth can participate regardless of their access to personal gear. Funding will also increase shared transportation capacity to transport youth safely to local trailheads, expanding access beyond neighborhood trails. FVCS is currently pursuing a U.S. Forest Service trail permit to further broaden supervised access to regional trail systems beginning in 2027. Expert Instruction & Facility Access Girdwood Parks and Recreation provides access to tennis courts, pickleball courts, soccer fields, and other existing facilities. Funding will allow FVCS to recruit qualified instructors to provide structured skill development in these settings, increasing program quality and safety while fostering long-term engagement in physical activity. Healthy Beginnings: Safe and Supportive Infrastructure FVCS currently lacks a reliable indoor space for youth during summer programming. Funding will support rental of indoor facilities to provide safe restroom access, sheltered lunch areas, and structured indoor activity space during inclement weather. This ensures continuity of supervision, safety, and developmentally appropriate rest and creative time, particularly for younger children. By expanding access to structured, instructor-led physical activity and reducing barriers related to transportation, equipment, and weather, this project builds foundational healthy habits during childhood and promotes lifelong engagement in active lifestyles.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Frontier Community Services	Alaska Community Care for Medical Complexity Pilot	AK	Although Alaska has group homes and residential providers, many do not accept individuals with high medical needs because current Medicaid reimbursement does not reflect the level of care required. As a result, individuals with complex medical conditions often cannot secure community placements and may remain in hospitals or face institutionalization. Long-standing nonprofit providers like Frontier Community Services increasingly become the last option before institutional care, supporting individuals declined by other programs. Residential habilitation for individuals with IDD is funded at about \$333 per day, while individuals served through the Alaskans Living Independently (ALI) waiver receive residential support equivalent to roughly \$220–\$280 per day, even when they have similar medical needs. These rates are tied to waiver category rather than medical acuity. In contrast, hospital swing-bed care averages about \$961 per day and hospital long-term care can exceed \$1,200 per day. This project will pilot a model supporting individuals with high medical needs in community homes with appropriate staffing and medical oversight, demonstrating that community-based care is both more humane and significantly less costly than institutional placement.	This project proposes piloting a model that supports individuals with significant medical needs in community-based homes while demonstrating that reimbursement should be tied to the level of care required rather than waiver category or residential setting. Currently, Alaska’s Medicaid waiver system sets residential reimbursement largely based on waiver type and service category, rather than the actual medical complexity of the individual receiving care. For example, individuals served under the Intellectual and Developmental Disabilities (IDD) waiver may receive residential habilitation funding of approximately \$333 per day, while individuals served under the Alaskans Living Independently (ALI) waiver may receive residential support equivalent to roughly \$220–\$280 per day, even when they have similarly complex medical needs. These rates are significantly lower than institutional alternatives, where hospital swing-bed care averages approximately \$961 per day and hospital long-term care can exceed \$1,200 per day This structure unintentionally creates a system where providers are disincentivized from accepting individuals with higher medical acuity, as reimbursement does not reflect the level of care required. As a result, providers often prioritize individuals with lower support needs while those with complex medical conditions struggle to find community placements and face a greater risk of institutionalization. Our proposed approach is to incentivize providers to support individuals with high medical needs in home settings, rather than creating a system that inadvertently favors institutional placement due to reimbursement limitations. The pilot will utilize existing wheelchair-accessible homes already developed by our organization, along with accessible transportation vehicles assigned to those homes. Enhanced staffing will include higher wages for Direct Support Professionals to recruit individuals with CNA credentials and the employment of a Registered Nurse to provide clinical oversight, staff training, and coordination of medical care. During the five-year pilot, we will evaluate the true cost of providing 24-hour care for individuals with complex medical needs, including environmental accessibility, transportation supports, specialized staff training such as safe transfer techniques, medication administration protocols, and nursing oversight	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Frontier Community Services	Connected Independence: Advancing Rural Aging in Place	AK	Alaska is experiencing one of the fastest rates of population aging in the United States. Since 2010, the population age 65 and older has more than doubled, and by 2030 older adults will represent nearly 20% of the state. This rapid growth is occurring amid significant healthcare workforce shortages and geographic access barriers, particularly in rural communities. Most elders in regions such as the Kenai Peninsula wish to age in place. Frontier Community Services provides grant-funded in-home supports including transportation for groceries and prescriptions, light housekeeping, appointment coordination, and basic wellness assistance. While minimal, these services are essential to preventing malnutrition, medication non-adherence, and avoidable hospitalizations. Workforce instability threatens consistent delivery. Rural staff travel long distances in harsh weather, and turnover or illness often leads to canceled visits. Even short disruptions increase risk for elders living alone, where emergency response times may already be extended. An additional equity gap exists: access to medical alert and safety technology is often limited to low-income individuals. Many elders slightly above poverty guidelines cannot afford private monitoring services yet do not qualify for subsidies. This creates instability in home-based care, increasing preventable emergencies, hospital use, and long-term costs.	Frontier Community Services will implement a hybrid service delivery model that integrates structured in-person supports with purpose-built technology embedded directly into elders’ homes. Building on our existing senior and home care platforms, we will partner with ProCern to deploy the Live WellNest system and establish the community infrastructure needed to support its use across rural service areas. The proposed approach does not replace in-person care; rather, it strengthens and stabilizes it. Through Live WellNest, elders will receive a simplified tablet and optional wearable safety device designed specifically for seniors and adults with disabilities. The technology will provide daily check-ins, secure video communication with approved contacts, wellness content, appointment coordination, and centralized monitoring through a program dashboard. Wearable devices will offer fall detection, emergency SOS capability, and geo-tracking where appropriate. ProCern will support implementation by assisting with device deployment, connectivity configuration, training, and technical integration. Frontier Community Services will embed the platform within existing workflows, including service coordination, documentation processes, and staff oversight protocols. Staff will be trained to utilize the centralized portal to coordinate essential services such as medical appointments, grocery access, prescriptions, and personal wellness supports. The dashboard will allow real-time visibility into participant engagement, missed check-ins, safety alerts, and follow-up needs. This model creates a structured daily touchpoint with elders, even when in-person visits are limited by staffing shortages or weather conditions. Automated alerts and monitoring reduce reliance on manual tracking while enabling faster response to emerging concerns. Families may opt into communication features to strengthen transparency and connection. Data collected through the platform will support performance tracking, quality improvement, and reporting aligned with Rural Health Transformation Program goals. Metrics such as appointment attendance, check-in compliance, safety alert response time, and preventive engagement will inform continuous improvement. By embedding technology within established community-based services, this approach expands access, improves consistency, and strengthens workforce sustainability without requiring proportional increases in staffing.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Frontier Community Services	Bringing Alaska’s Children Home: Community-Based Therapeutic Care and Family Supports	AK	Children with developmental delays, disabilities, and complex behavioral health needs in rural and frontier communities often face significant barriers to accessing appropriate care and supportive services. Many families struggle to find childcare providers, after-school programs, or therapeutic environments capable of supporting children with higher levels of developmental, behavioral, or trauma-related needs. In many rural communities, these services simply do not exist, leaving families without reliable options when children are not in school. This gap is particularly challenging for children receiving services through the Individual Support Waiver, as families often need structured support during after-school hours. Individualized in-home supports during these times can be difficult to staff, and without structured programs available, children miss opportunities for therapeutic engagement, social interaction, and skill development. At the same time, more than 50 Alaska children are currently placed in institutional care outside of the state because appropriate residential and therapeutic supports are not available locally. There is also a growing workforce challenge, as Direct Support Professionals working extended shifts often lack access to reliable childcare. This project addresses these gaps by expanding therapeutic childcare, after-school programs, foster care options, and residential supports so children can receive care within their home communities.	Frontier Community Services (FCS) proposes developing a coordinated system of therapeutic supports for children with developmental delays, disabilities, and complex behavioral health needs in rural communities. FCS has served the disability community in the Central Kenai Peninsula since 1981, providing a continuum of services that support individuals and families across the lifespan. The project will establish a therapeutic daycare and after-school program that provides structured developmental, behavioral, and social supports for children whose needs cannot be met in traditional childcare environments. These programs will focus on strengthening social-emotional, cognitive, and adaptive skills through therapeutic play, behavioral health-informed practices, and individualized learning strategies. To expand community-based care options, the project will also license therapeutic foster homes and specialized daycare providers trained to support children with developmental disabilities, behavioral health needs, and trauma-related challenges. These homes will provide safe, stable environments where children can receive consistent care while remaining connected to their families and communities. The project will also support the disability services workforce by offering childcare options for Direct Support Professionals and other frontline workers who often work extended or 12-hour shifts. Providing reliable childcare will help strengthen workforce recruitment and retention, which is essential for sustaining services in rural communities. FCS already has the infrastructure to implement these services. As a Medicaid provider, the organization has established systems for service delivery and billing and currently operates residential services for adults with disabilities, providing experience in staffing and program management. FCS also operates an Infant Learning Program, where developmental specialists and educators design therapeutic learning environments that will help guide program curriculum. Over time, FCS will also work toward developing residential supports for children currently placed outside of Alaska in institutional care, helping more Alaska children receive services within their home communities.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Planning

Frontier Community Services	Building a Unified Data Warehouse for Rural Care Delivery	AK	Frontier Community Services operates nine different programs, each with its own database and reporting requirements. As a result, critical information about services, staffing, finances, and outcomes is spread across multiple systems, making it difficult to establish a single source of truth for organizational decision-making. Staff often must enter the same information into multiple platforms and rely on spreadsheets or manual reconciliation to understand program performance, service utilization, and financial sustainability. The rapid expansion of required technology systems has created an environment where administrative tasks are increasing and data entry is often duplicative, taking time away from direct service delivery and increasing administrative costs. This project presents an opportunity to work directly with ProCern, a reputable information technology company, to develop a centralized data warehouse that integrates key systems used across the organization. By allowing financial, workforce, clinical, and billing systems to communicate with one another, the organization will gain access to real-time information that supports better decision-making. With accurate and timely data, leadership will be able to assess staffing needs, allocate resources more effectively, and ensure programs remain sustainable while continuing to provide high-quality services to individuals and families in our rural community.	Frontier Community Services proposes partnering with ProCern, an experienced information technology company, to design and implement a centralized data warehouse that integrates information across the organization’s multiple platforms. Currently, key operational data is stored in systems such as MIP for accounting, ADP for payroll and workforce management, AlayaCare for clinical documentation and care coordination, and Waystar for claims processing. These systems operate independently, requiring staff to manually reconcile information across platforms. Through this project, ProCern will work with Frontier Community Services to build a secure data warehouse that connects these systems and creates a single, reliable source of information. The data warehouse will automate the flow of financial, workforce, clinical, and billing data into one integrated environment. This will allow leadership and program managers to access real-time dashboards and reports that provide a clear picture of program performance, staffing capacity, service utilization, and financial sustainability. The project will also include the development of reporting tools and training for staff to ensure the system is used effectively across the organization. By reducing duplicative data entry and streamlining reporting requirements, staff will spend less time managing disconnected systems and more time focused on direct service delivery. Ultimately, this approach will create a sustainable data infrastructure that supports informed decision-making, strengthens operational efficiency, and ensures Frontier Community Services can continue delivering high-quality services to individuals and families in rural Alaska.	Under \$50,000	Home- and community-based services provider	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

Frontier Community Services	Closing the Early Intervention Gap: Expanding Support for Alaska’s Youngest Children	AK	Alaska’s current eligibility requirement for the Part C Infant Learning Program requires a child to demonstrate a 50% developmental delay to qualify for services. This threshold leaves a significant gap for infants and toddlers experiencing moderate developmental delays (25–50%), many of whom are identified by health providers, early childhood programs, or the Office of Children’s Services but remain ineligible for early support. This gap is particularly impactful in rural communities where early intervention programs may be the only developmental support available before children enter school. Many of these children later qualify for special education under Part B at age three, meaning the system missed the opportunity to intervene during the most critical period of brain development. Frontier Community Services has operated the Part C Infant Learning Program on the central Kenai Peninsula since 1998 and has the infrastructure already in place to enroll additional children with minimal additional cost. When Medicaid is available, providers could also bill eligible services, helping offset targeted case management that connects families to health, behavioral health, and community supports. Expanding early intervention eligibility allows Alaska to act when it matters most—giving children the support they need early while reducing long-term education and service costs.	FCS proposes expanding access to early intervention by enrolling infants and toddlers experiencing 25–50% developmental delays through our existing Infant Learning Program (ILP) infrastructure. Since 1998, FCS has operated the Part C ILP on the central Kenai Peninsula, serving families through developmental screening, early intervention services, and family service coordination. Our program already has trained developmental specialists, established referral networks with health providers and child welfare partners, and strong community partnerships in place, allowing services to expand quickly and efficiently with minimal additional administrative cost. Children referred through health providers, early childhood programs, and the Office of Children’s Services would receive developmental screening and family service coordination designed to strengthen social-emotional, self-help, and cognitive development. FCS would also coordinate closely with the local Children’s Advocacy Center, complementing their robust clinic-based services by providing in-home supports that help families implement strategies within the child’s natural environment. In addition, FCS plans to expand its Fetal Alcohol Spectrum Disorder (FASD) clinic, bringing in additional specialists, including behavioral health therapists. While traditional early intervention services often focus on occupational therapy, physical therapy, or speech therapy, this model emphasizes parent coaching, play therapy, and behavioral health services that address developmental challenges related to trauma, environmental instability, or prenatal exposure. Services would support the entire family unit, whether children remain in foster care or reunify with biological families. FCS is also a certified behavioral health provider, allowing our team to deliver and bill for behavioral health services when clinically appropriate. When children are Medicaid eligible, the organization will pursue Medicaid reimbursement for covered services, helping offset the cost of targeted case management and family coordination. Because FCS already operates the regional ILP, implementation can begin immediately, with expanded screening, enrollment, and service coordination occurring within the first six months of funding.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Frontier Community Services	Dignity at Home: Expanding Hospice Care for Rural Elders	AK	Many elders living in rural and frontier communities wish to remain in their homes during the final stage of life, surrounded by familiar environments, family, and the communities they have spent decades building. However, in many areas hospice services are primarily tied to facility-based care, requiring individuals to leave their homes and move into assisted living or a hospice residence to receive end-of-life support. For elders who have lived independently for many years, this transition can be emotionally difficult and disrupt important family and community connections. This challenge is especially significant in rural communities where access to medical professionals is limited. Families often want to support loved ones at home but may lack access to medical guidance and coordinated care needed to safely manage end-of-life care. There is also an opportunity to strengthen home-based hospice care through the use of technology. Telehealth and remote access tools allow families and caregivers to connect with nurses, physicians, and hospice specialists at the touch of a button, providing consultation and guidance even when providers are not physically located in the community. By combining home-based hospice services with telehealth access to medical providers, we seek to create a model that supports dignity, comfort, and independence, allowing elders to remain in the place they call home while receiving compassionate professional support during the final stage of life.	Frontier Community Services (FCS) proposes developing a community-based hospice and palliative care program that allows elders in rural communities to remain in their homes during the final stage of life. FCS already provides Senior-In-Home grant-based services and adult day programming, which means the organization has the workforce, infrastructure, and experience necessary to deliver compassionate care in the home environment. This project will build on that existing foundation by expanding services to include hospice-level care designed specifically for rural and frontier communities. The program will begin by establishing hospice licensure and hiring a registered nurse to oversee end-of-life care. This nurse will coordinate services for individuals and families, provide clinical guidance to caregivers, and ensure that care plans focus on comfort, dignity, and respect for the individual’s wishes. FCS caregivers who already provide in-home supports will receive additional training in hospice and palliative care practices so they can assist individuals and families during this stage of life. To strengthen access to medical expertise in rural communities, the program will also incorporate living wellness technology and telehealth tools that can be installed in the elder’s home. These tools will allow caregivers and families to connect with medical professionals at the touch of a button, ensuring that questions about symptoms, medications, or comfort care can be addressed quickly even when physicians are not physically present in the community. Medical oversight will be provided through regular coordination with the individual’s primary care provider, ensuring continuity of care and physician involvement throughout the hospice process. FCS also currently has a physician on staff who can help initiate and guide the development of this program. As the program grows, physician oversight can be sustained through partnerships with additional providers or traveling medical professionals who serve rural areas. By combining existing home-based services, nursing leadership, telehealth technology, and physician collaboration, FCS will create a compassionate hospice model that allows elders to remain in the homes they have lived in for decades, surrounded by family and community. This approach honors the dignity of individuals at the end of life while improving access to hospice care in rural and frontier communities.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Frontier Community Services	Home-Based Care Workforce Initiative	AK	The Direct Support Professional (DSP) and Certified Nursing Assistant (CNA) workforce in rural Alaska faces increasing demands without a coordinated infrastructure to support competency, stability, and career growth. Providers must meet mandatory certifications such as MANDT, CPR, and medication administration by an Alaska-licensed RN, while also implementing best-practice trainings that are often costly and inconsistent across agencies. Many organizations develop internal trainers, leading to duplication of effort and variable standards. Workforce challenges extend beyond recruitment. DSPs and CNAs frequently face barriers such as housing instability, limited access to childcare, transportation challenges, and inadequate benefits. These pressures contribute to turnover, burnout, and service disruption. As care needs grow more complex for individuals with developmental disabilities and elders, expectations for skill and accountability increase, yet structured career pathways and regional training coordination remain limited. The issue is not simply a shortage of workers; it is the absence of a sustainable, competency-driven workforce model that supports professional development, removes practical barriers, and strengthens long-term retention in this essential field.	Frontier Community Services will establish a regional training and workforce development hub to strengthen healthcare access, quality, and sustainability in rural communities. The project will provide a training platform to train and license Certified Nursing Assistants (CNAs), help Direct Support Professionals (DSPs) move through the certification process aligned with national standards, and deliver required trainings such as MANDT, CPR, and medication administration by an Alaska-licensed RN. Training will be offered in both in-person and hybrid formats to expand rural access and reduce duplication across providers. This initiative builds upon our existing Good Life service model, which incorporates innovative scheduling structures that promote work-life balance, predictable time off, and reduced burnout. Frontier Community Services has already implemented this scheduling system internally and trained other providers to adopt this model, strengthening retention and improving service consistency. The goal of this approach is to create consistency and best-practice standards in workforce training while building a sustainable workforce pipeline beginning in middle and high school. By offering centralized, competency-based instruction through a regional hub, agencies will no longer need to independently hire and maintain in-house trainers. This model will generate cost savings while improving quality, uniformity, and long-term workforce development. Certifications earned through the training hub will be portable, allowing DSPs and CNAs to move between provider agencies — including the school district — without duplicative retraining. This portability reduces administrative costs, strengthens workforce mobility, and ensures providers invest in a credentialed workforce rather than repeatedly funding the same training across organizations. To support workforce stability, the project will integrate childcare assistance, housing supports, advocacy partnerships, and explore zero-interest or contract-based loan options to offset transportation and housing costs. Together, these strategies create a competency-driven, supported, and sustainable rural healthcare workforce.	Under \$50,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Frontier Community Services	Integrated Youth Employment and Behavioral Health Initiative (IPS-Y) for Rural Alaska	AK	Youth in rural Alaska face significant barriers when transitioning from adolescence to adulthood, particularly those involved in behavioral health systems, foster care, or the juvenile justice system. Many young people experiencing mental health challenges or substance use disorders struggle to access employment opportunities that provide stability and purpose. Traditional workforce programs often require youth to complete training or treatment before pursuing employment, which can delay engagement and contribute to disengagement from school, work, and community. In rural areas, these barriers are compounded by limited job availability, transportation challenges, and fragmented coordination between behavioral health services and employment supports. This project addresses the opportunity to integrate employment services into Frontier Community Services’ behavioral health programming through the evidence-based Individual Placement and Support for Youth (IPS-Y) model. IPS-Y has demonstrated strong outcomes nationally helping young people with mental health challenges obtain competitive employment and pursue educational goals while receiving behavioral health support. Through this initiative, Frontier Community Services will expand its behavioral health services to include IPS-Y employment supports, helping rural youth access meaningful employment earlier, strengthen recovery and independence, and build long-term economic participation in their communities.	Frontier Community Services will implement the IPS-Y model to support youth ages 16–24 experiencing behavioral health challenges in obtaining competitive employment and pursuing educational goals. Employment specialists will be integrated within Frontier Community Services’ behavioral health program to ensure employment services are coordinated with treatment and recovery planning. Using the IPS-Y model, youth will receive individualized employment services that focus on rapid job search, personalized job development, and ongoing job supports. Rather than requiring extended preparation or training before employment, youth will be supported in identifying their interests and pursuing competitive jobs quickly while receiving coaching and support as needed. The program will prioritize youth who face significant barriers to employment, including those aging out of foster care, involved in the juvenile justice system, or experiencing behavioral health and substance use challenges. Partnerships with local schools, community organizations, and workforce agencies will support referrals and coordination of services. Employment specialists will build relationships with local employers to identify opportunities that align with youth interests and community workforce needs. Additional supports may include transportation assistance, workplace accommodations, education coordination, and benefits counseling to help youth maintain employment while continuing their education or treatment. By expanding Frontier Community Services’ behavioral health services to include IPS-Y, this project will create a coordinated approach that supports youth independence, recovery, and long-term workforce participation.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Frontier Community Services	Kenai Community Access & Health Navigation Hub	AK	Rural communities on the Kenai Peninsula face persistent barriers to accessing social support services essential to maintaining health and independence. Individuals with developmental disabilities, aging adults, and people with behavioral health needs often must interact with multiple agencies to secure benefits such as Medicaid, Social Security, housing assistance, environmental modification grants, representative payee services, and employment supports. For vulnerable populations, these systems are complex and difficult to manage independently. Many individuals require assistance completing applications, understanding eligibility requirements, and maintaining program compliance. Documentation errors or missed deadlines can result in delayed services or loss of critical benefits such as Medicaid or SSI—benefits directly tied to accessing healthcare, medications, and long-term supports. Without coordinated assistance, individuals often experience disruptions in care, delayed treatment, or avoidable health crises. Access challenges are particularly evident on the Kenai Peninsula, individuals may only access Social Security through limited virtual appointments hosted at the Kenai Senior Center a few times each month. Capacity is limited, and individuals often arrive early to secure a slot for a virtual meeting. These barriers highlight a broader structural gap: essential services exist, but navigating them requires coordination many rural residents cannot manage alone.	The project proposes developing a comprehensive community navigation hub to help rural residents access and maintain critical health, disability, and social supports. The hub would provide a centralized location where individuals receive hands-on assistance navigating complex benefit systems while accessing the tools needed to complete applications and maintain eligibility. Trained navigators would work alongside individuals to understand program requirements, complete applications, gather documentation, and maintain compliance with ongoing reporting. Rather than expecting vulnerable individuals to navigate multiple agencies independently, navigators would provide step-by-step support through systems such as Medicaid, Social Security, housing programs, environmental modification grants, and employment supports. To strengthen financial stability and benefit compliance, Frontier Community Services would also serve as a Representative Payee agency. Representative payee services ensure essential expenses such as housing, utilities, medications, and healthcare needs are prioritized, helping prevent housing instability, service disruptions, and avoidable health crises. The hub would also include a technology resource library where individuals can access computers, secure internet, and digital tools needed to complete online applications, attend virtual appointments, and manage documentation. Staff would provide technical assistance to reduce barriers related to digital literacy and limited technology access. Transportation coordination would also be integrated into the hub model, helping individuals access medical appointments, benefits interviews, and community services. In rural areas where transportation barriers often prevent individuals from maintaining services, this coordination improves continuity of care. Frontier Community Services is a Medicaid provider agency, and this infrastructure positions the organization to expand into person-directed Medicaid waiver service support if available in Alaska. Frontier would assist individuals in understanding program requirements, managing service budgets, hiring support staff, and maintaining compliance while preserving choice and control. By combining navigation, technology access, financial stabilization, and transportation coordination in one location, the hub reduces system fragmentation, improves healthcare access, and supports sustainable community-based care in rural Alaska.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Frontier Community Services	Neighborhood Network: A New Model for Independent Living	AK	The Kenai–Soldotna area is experiencing a shortage of affordable housing, creating barriers for both individuals with intellectual and developmental disabilities (I/DD) and the Direct Support Professionals (DSPs) who provide essential services. Many individuals with disabilities rely on fixed incomes through Social Security or Medicaid benefits and cannot access market-rate housing. At the same time, DSPs often struggle to find affordable housing themselves, making recruitment and retention in rural communities difficult. Because of these housing limitations, many individuals who could live in more independent settings are instead placed in group homes that provide 24-hour care. In many cases, this level of care is not clinically necessary but becomes the only option due to housing and transportation barriers. This results in individuals living in more restrictive environments than needed and increases long-term service costs for the State of Alaska. The Neighborhood Network Project addresses this gap by creating safe, semi-independent housing where individuals can live with a compatible roommate and access support only when needed. Technology-enabled safety supports and nearby on-call staff allow individuals to live more independently while maintaining safety. The project also creates affordable housing opportunities for DSPs within the same neighborhood, strengthening workforce stability.	To address these housing and workforce challenges, the Neighborhood Network Project proposes developing a small, neighborhood-style housing community on subdivided land in or near Soldotna. This model would include multiple small homes designed to support independent living for adults with intellectual and developmental disabilities (I/DD), including studio-style homes for individuals and larger units for compatible roommates. The community would also include affordable housing for Direct Support Professionals (DSPs), helping recruit and retain the workforce needed to sustain community-based services in rural Alaska. This model would also provide long-term housing stability for individuals with disabilities who often face uncertainty in the private rental market. Rapid inflation and limited housing availability in the Kenai–Soldotna area have made it increasingly difficult for individuals living on fixed incomes to secure and maintain stable housing. Many individuals fear entering rental agreements due to unpredictable rent increases or the risk of losing their housing. By developing housing specifically designed for this population, the project would provide stable, predictable rental rates aligned with benefit allowances, ensuring individuals can remain in their homes long-term. In addition to resident and workforce housing, the development would include short-term housing for visiting specialists such as physical therapists, occupational therapists, speech therapists, and nurses who travel to the Kenai Peninsula to provide services. Currently, agencies rely heavily on short-term rentals such as Airbnb accommodations for these providers, which increases costs and limits service availability. Dedicated housing for visiting professionals would expand access to specialized care while strengthening the local service system. This neighborhood model allows individuals who do not require 24-hour group home care to live in safe, supportive housing while receiving technology-assisted and on-call supports when needed, reducing reliance on more restrictive residential settings.	\$1M-\$5M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

FRONTIER PSYCHIATRY, INC.	Behavioral Health for Rural Alaska: Telehealth, Training, and Early Intervention	MT	Alaska has among the highest suicide rates in the country and has for decades. Behavioral health workforce shortages affect virtually every community in the state, with rural, remote, and frontier areas hit hardest. Many Alaskans have no realistic path to seeing a psychiatrist. For those in crisis, the emergency department is often the only option, leading to costly and avoidable hospitalizations that strain an already fragile system. The workforce gap cannot be closed by recruitment alone. There are simply not enough psychiatrists, and the ones who are available are concentrated in urban centers. The opportunity is to pair immediate access to psychiatric and addiction treatment services via telehealth with investments that strengthen the capacity of local communities. Through Single Session Interventions, we can train thousands of Alaska's existing professionals, both licensed and unlicensed, to deliver evidence-based mental health support, while making free digital tools available directly to Alaskans. Through predictive risk stratification using health information exchange data, we can help local providers identify patients heading toward crisis and intervene earlier. Each of these strategies has been developed and tested in Montana, a state with the same structural challenges. The opportunity is to deploy them together in Alaska, in partnership with local providers and communities.	Our approach rests on a simple conviction: someone living in rural Alaska deserves the same quality of psychiatric care as someone living in Seattle or Salt Lake City. Geography should not determine the quality of care a person receives. Everything we propose is designed to close that gap. The first strategy is direct clinical care via telehealth. Frontier Psychiatry will deliver psychiatric and addiction treatment services to rural, remote, and frontier communities across Alaska. Our clinical team includes board-certified psychiatrists across child, adolescent, adult, addiction, geriatric, and perinatal subspecialties, along with advanced practice providers, a full-time pharmacist, case managers, and therapists. We do not simply prescribe medication. Every patient is connected to local primary care and community resources through integrated case management. Our pharmacist works directly with patients and providers to ensure medication adherence, avoid harmful drug interactions, and reduce polypharmacy. When local therapists are available, we partner with them. When they are not, our team fills the gap. The second strategy is statewide deployment of Single Session Interventions. SSIs are evidence-based, structured therapeutic encounters that produce meaningful clinical improvement in a single session. They can be delivered in person by trained professionals or digitally through free online platforms. We have direct experience with this model through our partnership with the State of Montana and Northwestern University's Lab for Scalable Mental Health, through which we made digital SSIs freely available to Montana youth statewide. In Alaska, we will train thousands of licensed and unlicensed professionals to deliver SSIs in person, while simultaneously deploying digital SSIs for youth and adults across the state. The third strategy is predictive risk stratification. We recently developed a tool using Montana health information exchange data that identifies which patients are at highest risk for an emergency department visit within 30 days. This allows our clinical team and local providers to intervene proactively rather than reactively. We intend to build the same capability in Alaska using Alaska's HIE infrastructure, giving providers across the state a shared tool for identifying and reaching patients before they reach a crisis point.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Frontline Mission	On site Clinical Care & Referral Services.	AK	Frontline Mission serves a vulnerable population in the Mat-Su Valley. The patrons who are benefiting from the services Frontline offers often suffer from physical, emotional, and mental health challenges. Through our connection with patrons, we often hear at Frontline that there is a fear that many individuals have towards medical personnel or medical buildings. Frontline has often worked in collaboration with medical doctors and clinics in the valley who have offered support to the individuals in need of health exams and appointments. Many patrons put off the opportunity to seek medical help until it's a dire medical emergency. This creates a problem in the individual's health, which often could have been avoided if they had sought medical assistance before it became a major issue. This fear exists for several different reasons; sometimes it comes from past trauma or a loss, sometimes it's a form of malpractice or a broken trust in the healthcare system. While fear is the main foundation for many individuals, others feel overwhelmed by the process of scheduling appointments, not knowing if they will have the means for transportation, especially to multiple locations, or simply overwhelmed by navigating a system that is unfamiliar. As a result, many individuals delay seeking medical attention until a situation becomes an emergency.	Frontline Mission’s approach would be to bridge the gap between vulnerable individuals and the healthcare system by building on the relationship and trust already established with the community. Because of the trust between Frontline and the community, we believe Frontline Mission will be able to successfully evaluate, treat, and refer patrons with their medical needs. This setting reduces many of the barriers that often prevent individuals from seeking care, including the fear that spreads to many areas in the medical field, transportation challenges, and the complexity of navigating healthcare systems. The focus of addressing the problem described above is to assess the need of each individual who needs medical assistance. In addition to basic medical treatment, Frontline Mission would refer patrons to medical providers we have partnered with in the past. Once the individual is assessed, basic medical treatment can take place on site. In addition to this, the medical care established at Frontline would connect patrons to established medical providers and facilities in the Mat-Su Valley to receive more advanced care. This support would include helping them through the referral process. This support may include helping individuals schedule appointments, understand their care options, and possibly offer support/ access to transportation if needed. Without the go-between organization in place, like Frontline, it is our concern that many individuals will not seek medical help or treatment until a very late stage in a medical crisis. This would allow Frontline Mission to complement existing healthcare services in the borough while ensuring that individuals who are most at risk are not left without access to healthcare assistance.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Galena City School District	Grow Our Own: High School CNA Certification Pathway for Rural Alaska	AK	The communities we serve are facing a real and growing healthcare workforce crisis. In the Yukon-Koyukuk Census Area and across rural Alaska, certified nursing assistants are among the most in-demand and hardest-to-fill roles in the healthcare system. For our students and their families, this is not an abstract policy problem. It means elders without adequate care, villages without trained health staff, and young people with no clear pathway into a healthcare career without leaving home. We operate two schools, uniquely positioned to change that. Sidney C. Huntington School serves our local Galena community, while our Galena Interior Learning Academy enrolls residential students from rural and remote communities across Alaska, many of which have no local healthcare training infrastructure. Both schools share campuses and CTE pathways, including Emergency Medical Services and Biomedical Science, so we know our students are interested in healthcare careers. A CNA certification pathway gives our students something they can use the moment they graduate, a portable, stackable credential that lets them return home and fill critical workforce gaps without the financial burden of out-of-community post-secondary training. That is the opportunity we are pursuing, and with RHTP support, we are ready to launch it in the 2026-2027 school year.	Rural Alaska does not have a healthcare workforce pipeline problem that needs years of study. We know what the problem is, we know who it affects, and we are ready to help fix it. We will launch our CNA certification pathway in the 2026-2027 school year, enrolling our first cohort of ~5-10 juniors and seniors at SHS and GILA who have already completed foundational coursework through our existing EMS and Biomedical Science CTE programs. These are students who have demonstrated interest in healthcare careers. Our pathway is built around the University of Alaska Fairbanks Community and Technical College Nurse Aide Occupational Endorsement, a focused, nine-credit program designed specifically to prepare students for the Alaska State Nurse Aide certification exam. The UAF CTC partnership gives our students something powerful: college-level credit and a state-recognized certification earned before they ever leave high school. That is a stackable credential they can carry into LPN, RN, or allied health programs if they choose to go further, or put to work immediately in their home communities the day they graduate. The program model is straightforward and can be implemented within Year One. Students complete preparatory coursework integrated into our existing CTE sequence here in Galena. We then bring the cohort to Fairbanks for approximately two weeks to complete classroom instruction and fulfill the required 48-hour clinical practicum at an approved long-term care or hospital setting. GILA's residential school model makes this feasible; our students already live and learn away from home. A structured two-week block in Fairbanks is not a barrier for them. By October 2027, our first cohort will have completed the requirements, sat for the Alaska State Nurse Aide certification exam, and be certified CNAs ready to return to villages across Alaska.	\$50,000-\$250,000	Single Community	Yukon-Koyukuk Census Area	Advance to Implementation Application

Galena City School District	A Pathway to Healthy Beginnings: IDEA PreK Family Support Program	AK	Our rural PreK population faces a compounding set of disadvantages including geographic isolation from early childhood services, limited local health and developmental support infrastructure, and caregivers who are navigating their children's critical developmental years without professional guidance or community resources. For families enrolled in IDEA's homeschool correspondence program, parents serve as the primary educator with most receiving no structured support specific to the health and developmental needs of children in the preschool range of 3 to 5 year old. Early childhood represents the highest-return window for intervention in developmental delays, behavioral health concerns, and chronic disease prevention. Research consistently demonstrates that unaddressed developmental delays in the PreK years compound through elementary school and beyond, and that rural Alaska Native children face disproportionate rates of adverse childhood experiences (ACEs) and chronic disease risk factors that are preventable with early, consistent support. Yet IDEA currently has no dedicated capacity to provide health referrals, developmental screening guidance, or family health education to this age group. IDEA's regional infrastructure already reaches these families. The gap is not access, it is specialized capacity. This project fills that gap by funding a dedicated statewide PreK Family Support Navigator embedded within IDEA's existing hub-and-spoke system.	GCSD will hire a full-time PreK Family Support Navigator housed within IDEA's program structure and operating across our nine regional hubs as a dedicated support resource for enrolled PreK families, with priority focus on rural and remote families lacking access to local early childhood health and developmental services. The Navigator’s core functions will include: (1) developing and delivering a weekly, structured club/workshop framework at all nine regional sites grounded in Alaska’s Early Learning Guidelines across all five domains (physical well-being and motor development; social and emotional development; approaches to learning; general knowledge and cognition; and communication, language and literacy); (2) administering the Ages and Stages Questionnaire (ASQ-3), a validated developmental screening tool for children ages 3-5, to proactively identify developmental delays and connect families to health, behavioral health, and early intervention referrals through tribal health organizations, IHS clinics, community health aides, and other local providers; (3) implementing the Teaching Strategies GOLD Observational Assessment Tool, using family observations to inform checkpoint ratings and provide a feedback loop for instruction; (4) developing a “Modeled Moments” video resource library of short, accessible, culturally reflective home activities that strengthen early learning and support assessment goals; (5) providing monthly one-on-one family contacts and supporting ECE leads through bi-weekly agenda meetings; and (6) building and maintaining a regional health referral network across all nine service areas. The hub-and-spoke delivery model is foundational to this approach. Each of IDEA's nine regional offices, located in Anchorage, Eagle River, Palmer, Wasilla, Fairbanks, North Pole, Soldotna, Anchor Point, and Juneau, serves as a hub from which the Navigator reaches spoke communities across a vast geographic footprint. Virtual and phone-based outreach removes the need for families to travel, while rural families who visit hub communities receive in-person support that deepens relationships and broadens service delivery. The Navigator will coordinate with IDEA's regional contact teachers, who maintain ongoing relationships with enrolled families, to ensure warm handoffs and integrated support. Tribal health organizations and regional health entities will be formalized partners with clear referral pathways to avoid duplication of existing services.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Galileo, Inc.	Expanding Primary Care Access & Sustainable Infrastructure: Delivering High-Value Care Close to Home	CA	There are systemic and structural access gaps that prevent the delivery of a full continuum of care close to home: 1. Gaps in the Continuum of Care: Many rural, remote & frontier communities lack consistent primary care infrastructure, creating primary care shortage areas. This isolation leaves underserved populations without a medical home, leading to delays in long-term disease management & acuity exacerbation. 2. Workforce Stretched to its Limit: Local clinicians face geographic & operational challenges that lead to severe provider burnout and recruitment challenges. Without a clinical wraparound, the lack of 24/7 urgent, primary & specialty care causes significant out-migration. Patients bypass local systems for expensive, out-of-region treatment, destabilizing the local health ecosystem. The Opportunity: 24/7 tech-enabled primary care infrastructure & safety net that: > Maximizes access close to home (#2) by enabling 24/7 urgent, primary, behavioral, & specialty care > Strengthens healthy communities (#3) by targeting the root causes of disease with a prevention-focused approach, utilizing locally tailored preventive care & long-term disease management > Strengthens workforce (#5) by acting as a clinical wraparound to reduce burnout & enable clinicians to practice at the top of their license > Sparks innovation (#6) by deploying a Mobile App and consumer-facing digital tools to improve population health management.	This project establishes a 24/7 Primary Care Infrastructure & Safety Net that supports patients and local providers at all times, not just after hours. By providing a "one-stop" digital medical home, we can resolve 90%+ of cases—ranging from simple to complex—without requiring patients to leave their community. > Wraparound Provider Supports: Enhancing availability, patient panel management, and expanding patient reach / practice catchment. Enabling care coordination, navigation and connectivity across Galileo, local providers, and community-based support. > Persistent Access & Reliability: Provides a 24/7/365 on-demand medical care that spans primary, urgent, behavioral, and specialty care, creating new access points and wrapping around existing local providers and care infrastructure to flexibly address acute to complex cases based on provider partnership preferences and community need. > Multispecialty Workforce Multiplier: Delivers direct access to over 20 clinical specialties through a primary care "front door," allowing complex cases to be managed in-place rather than referred out in concert with a patient's existing providers and local infrastructure. > Proactive Chronic Management: Addresses the root causes of disease through evidence-based interventions for diabetes and hypertension, having already demonstrated a 5.4 point average A1c reduction in engaged members. > Low-Bandwidth Resilience: Specifically engineered for rural, remote, and frontier Alaska, Galileo enables multi-modal communication – utilizing text and phone calls to remain functional in areas where video-based telehealth may be a challenge. > Clinical Continuity: Facilitates "virtual-to-physical" transitions through dedicated navigation teams and data sharing, ensuring seamless hand-offs and integration with local providers when hands-on care is necessary. > A Modern, Digital Patient Experience: Galileo deploys a Mobile App and consumer-facing digital tools that support a broad spectrum of care, including chronic disease self-management. By leveraging secure, data-driven tools, warm handoff protocols, and statewide data exchange, we enable efficient care, population health, and interoperability in remote areas.	\$1M-\$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Generational Vision Overseer	Lakefront Wellness & Prevention Access Project	AK	Many rural communities have limited access to safe, structured environments that support preventative health, physical activity, and mental wellness programming. While natural outdoor spaces exist, they are often underutilized due to safety concerns, limited infrastructure, or lack of facilities that allow organizations to provide structured programming. This project addresses that opportunity by upgrading an existing lakefront area to create a safe, accessible environment for community wellness activities. Improvements to walking paths, fences and shoreline safety, the dock, pavilion, parking area, and renovation of an existing cabin will allow youth organizations, community groups, and wellness programs to use the space for physical activity, health education, mentorship, and behavioral health support. By transforming an existing natural resource into a functional prevention-focused community space, the project expands opportunities for healthy recreation, strengthens community connection, and supports preventative health programming for youth and families.	The proposed approach focuses on renovating an existing homestead cabin to serve as the primary hub for preventative health programming, education, and community wellness activities. The renovated cabin will provide year-round indoor space where youth organizations, community groups, and wellness programs can host health education, mentorship programs, behavioral health support groups, and nutrition classes. The cabin will include bathrooms, a kitchen for cooking demonstrations and nutrition education, and flexible meeting space designed to support group facilitation and wellness programming. To complement the cabin and expand opportunities for outdoor activity, the surrounding lakefront area will also be improved to create a safe and functional environment for physical recreation and nature-based wellness activities. Planned improvements include a gear hub, upgrades to walking paths, shoreline safety enhancements, improvements to the existing floating dock, pavilion improvements for sheltered outdoor gatherings, and expansion of the parking area to accommodate vans and small buses transporting participants. Together, the renovated cabin and improved lakefront will create a combined indoor and outdoor wellness space that supports preventative health, physical activity, and social connection. This approach allows organizations serving at-risk youth and community members to offer consistent, structured programming in a safe and supportive environment throughout the year. In the second phase, the project plans to add a bathhouse and small bunkhouses to support extended youth programs, wellness retreats, and mentorship activities. These additions will expand the site's capacity for multi-day programming and allow organizations to host structured wellness and leadership programs that further support healthy lifestyles and community resilience.	\$250K-\$1M	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Genetic Support Foundation	Telegenetic Counseling for Rural Alaska: Expanding Preventive Genetic Health Access	WA	Genetic testing now plays an important role in preventive health care, including hereditary cancer and cardiovascular screening, prenatal and preconception care, pediatric genetic evaluation, and management of inherited conditions. However, access to genetics specialists remains extremely limited in rural and frontier areas such as Alaska. Many rural clinicians lack access to genetic counseling expertise, and patients often must travel long distances to receive specialty care. These barriers can delay diagnosis, limit preventive screening and care, and reduce patient understanding of genetic testing results. At the same time, clinicians increasingly encounter genetic testing in routine care but may not have ready access to genetics consultation when complex questions arise. The Genetic Support Foundation proposes expanding telegenetic counseling and genetics education services to rural Alaska communities. By leveraging telehealth technology and partnerships with Alaska health and community organizations, the project will improve access to preventive genetic health services and support clinicians in integrating genetics into routine care. This approach aligns with Alaska’s goals to expand specialty care access, strengthen the rural health workforce, and use innovative technology to improve health equity across geographically dispersed communities.	The proposed project will expand access to preventive genetic health services for rural Alaska through a telegenetic counseling and education model designed to integrate with existing rural health systems. The project includes three primary components. 1. Telehealth Genetic Counseling for Patients Board-certified genetic counselors will provide virtual consultations for patients referred by rural clinicians. Services may include hereditary cardiovascular and neurological disease risk assessment, prenatal and preconception counseling, pediatric and rare disease consultation, interpretation of genetic testing results, and guidance on preventive screening or care planning. Telehealth visits may occur through rural clinics or from patients’ homes depending on local infrastructure. 2. Clinical Support for Rural Providers The project will strengthen the rural health workforce by providing genetics expertise to clinicians who may not have ready access to specialists. Services will include case consultation, guidance on appropriate genetic testing, resource development, and continuing education on genetics in preventive care. 3. Patient and Community Education The project will also expand outreach and educational resources to help families understand genetic testing and inherited conditions. Current outreach efforts include engagement with Alaska health and community organizations such as Alaska Primary Care Association, Stone Soup Group, and the Alaska Down Syndrome Network to ensure resources reach families and providers across the state. GSF would also provide accessible educational resources about genetics and health, including materials from the Lettercase National Center for Prenatal and Postnatal Resources. These materials help patients and families understand genetic conditions and health decisions in clear, unbiased language. Together, these activities create a scalable telehealth model that improves access to specialty expertise while supporting local clinicians and strengthening preventive care services.	\$250K-\$1M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Geri-Gadgets, Inc.	Integrated Rural Fall Prevention & Behavioral Health Model	CA	Rural Alaska communities face a compounding challenge of fall risk, chronic disease burden, cognitive decline, and behavioral health stressors, intensified by geographic isolation, limited specialty access, workforce shortages, and transportation barriers. Falls remain a leading cause of injury-related hospitalization among older adults, while unmanaged agitation and cognitive impairment contribute to caregiver burnout, emergency utilization, and premature institutionalization. Many rural and frontier sites lack structured, non-pharmacological programming to address both physical and behavioral contributors to decline. Access to physical therapy, dementia-informed engagement, and preventive movement programs is limited, particularly in small, multi-use community settings. Broadband variability and staffing constraints further reduce the feasibility of technology-dependent interventions. The opportunity is to implement an integrated, infrastructure-light prevention model that strengthens local capacity to reduce preventable falls, stabilize behavioral symptoms, and support aging in place through durable, scalable systems designed for rural environments. Rural regions experience higher rates of fall-related injury and emergency utilization yet often lack sustainable prevention infrastructure. Without accessible, community-based intervention models, small sites remain reactive rather than preventive in addressing mobility decline and behavioral escalation.	The proposed approach implements an integrated, dual-pillar prevention model across multiple rural census areas through site-based deployment and workforce capacity building. Phase 1 focuses on cognitive and behavioral stabilization through deployment of Geri-Gadgets®, a patented manipulation system for the stimulation of cognitive abilities delivered through durable, washable sensory engagement kits. Participating adult day programs, senior centers, and community health hubs will receive kits and structured implementation guidance. Initial training will be delivered to site staff, followed by a train-the-trainer model supported by instructional videos and printable materials for low-bandwidth environments. This pillar addresses agitation-driven standing behaviors, supports structured engagement, and reduces caregiver strain in low-staff settings. Phase 2 introduces Exer-Square, a patented multi-function exercise platform supporting full-body strength, balance, coordination, and cognitive dual-task training through seated, standing, and floor-based progression. Manufacturing will occur through an established production partner, with deployment anticipated within approximately 90 days. Site staff will receive movement curriculum training and progression protocols to support safe, adaptable implementation. The model emphasizes practical integration into existing programming rather than creation of parallel services. Sites will incorporate movement sessions and sensory engagement blocks into current schedules, allowing sustainable continuation without additional staffing. Evaluation will include participant reach, session frequency, site participation rates, staff-reported behavioral stabilization, and aggregate site-level fall incident tracking where available. This low-burden reporting structure ensures feasibility for rural providers. By equipping local sites with durable, reusable systems and structured curriculum, the approach strengthens community-level prevention capacity, reduces reliance on external specialists, and creates scalable infrastructure for rural health stabilization. The model is adaptable for Tribal health organizations and culturally diverse communities due to its language-neutral, tactile design. By addressing mobility decline, chronic disease engagement, and behavioral stabilization in tandem, the approach shifts rural sites from reactive crisis response toward proactive, community-based prevention infrastructure.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Dillingham Census Area; Northwest Arctic Borough; Prince of Wales-Hyder Census Area; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

GigXR INC	EpiBrain: Holographic Patient Education and Engagement Platform for Addiction and Behavioral Health	CA	This is an opportunity to save lives, save money, and help Alaskans devastated by the fentanyl and drug epidemic return to their families and jobs. Drug overdose deaths in Alaska cost an estimated \$3.83 billion in 2023 - or \$11.45 million per death (CDC WISQARS). The total cost of deploying EpiBrain to every clinic in Alaska is less than the economic cost of a single overdose death. Approximately 90% of Alaska's overdose deaths involve opioids. FDA-approved medications for opioid use disorder cut fatal overdose risk by 60% or more, but only when patients stay in treatment. CDC SUDORS data indicate that Alaska's high death rate may be driven largely by treatment dropout, not lack of initial access. Early patient engagement delivered can increase retention up to 21 times. EpiBrain helps providers deliver that engagement at the point of care, during the critical early window when dropout risk is highest. Alaska's geography makes conventional approaches unworkable. Over 200 communities lack reliable broadband and are accessible only by small aircraft. EpiBrain operates offline-first giving a Community Health Aide in a remote community the same evidence-based tools as a clinician in Anchorage. The platform's modular design allows expansion to depression, trauma, and other co-occurring conditions without new hardware, maximizing the return on federal investment and building durable behavioral health infrastructure across rural Alaska.	In 2024, Alaska ranked #2 for opioid overdose deaths in the US and #1 for methamphetamine deaths. We will address the root causes of these substance use deaths and behavioral health morbidity and mortality through three integrated strategies: (1) deploying proven technology and media to give patients, families, and communities more accessible understanding of medical conditions and treatment options: we offer, partners implement, technology informs, and patients decide; (2) retaining patients in care through evidence-based technology and engagement modalities; and (3) scaling successful approaches to other behavioral health and chronic conditions using our partner's data and analytic capacities and the same technology and networks. Proven Technology: Our tools are already deployed, delivering results, and the tech has been proven. In a survey at an Anchorage-based substance use treatment clinic, three out of four patients preferred AR-based engagement using active medical models over written, verbal, or video explanations, and no patients preferred the standard verbal intake conversation (Isgro, Collins, & Kolachala, 2025). A full 92% reported improved understanding of their addiction, and 82% said they wanted to use the device again. Research further shows that early patient engagement consistent with HEDIS measures for substance use disorders can increase treatment retention up to 21 times (Williams et al., 2023). Partners: Through our partnerships with Alaska tribal health organizations, we have compiled complete provider lists for all substance use and behavioral health facilities in Alaska, tribal and private sector. In year one, we are positioned to contact, inform, and deploy to up to 300 facilities. Through the TAGGS database, we have also prepared current lists of all relevant behavioral health federal grant recipients in Alaska as potential partners. Effectiveness will be demonstrated through a performance monitoring and reporting program developed collaboratively with our partners. Data: Our approach relies heavily on the data and analytic capacity of partner organizations to scale efforts and prioritize reversing Alaska's critically low treatment uptake. Alaska mortality data reveals that from 2020 through 2024, approximately 98% of Alaska Native and American Indian opioid overdose decedents were not in treatment at the time of death (CDC SUDORS), a rate higher and worse than the Alaska overall rate (95.3%) and the national rate (93.2%).	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Girdwood Fire & Rescue Inc	Alaska Rescue Extrication Road Show	AK	The Girdwood Fire Department has a uniquely trained cadre of extrication instructors from previous grant awards and extensive hands on training under national lower 48 instructor trainers. We would like to share this knowledge and provide specific hands on skill training opportunities for departments with varying degrees of complexity specifically building up each department’s capabilities. Alaska Extrication Road Show would provide 4-5 instructors, basic equipment and coordinating damaged vehicles for hands on training traveling south on the Seward and Sterling Highways, reaching the smaller community emergency service response agencies. In April of 2023 The Girdwood Fire Department organized a \$300,000+ extrication grant purchase that benefited 11 different emergency service agencies on the Kenai Peninsula with extrication equipment. We would like to continue this momentum with additional education and techniques of operations. As vehicles continue to change with enhanced safety features they are only becoming more difficult and hazardous for the responder to access the entrapped patients. This training opportunity will be developed and delivered with each agencies current goals and objectives ranging from a basic one day extrication awareness course to a three day operations level intensive, all depending on each departments availability, personnel and needs.	The Alaska Extrication Road Show would be a coordinated training event that allows our team of instructors to travel between emergency services areas, spending one –three days per location working on knowledge and techniques too safely and efficiently remove patients from harm, hazard and transport to a definitive medical treatment facility. We plan on engaging each department prior to the training, coordinating and designing the training around their current equipment and operational capability to empower and enhance their immediate extrication capability. Our team of instructors would travel between the emergency service agencies with all the equipment and material to safely engage, educate and enhance the training opportunity. Providing multiple vehicles for each location in coordination with local tow and junk yard services along with environmental protection considerations is one of the logistical capabilities we can provide. With multiple tow capability vehicles and transport trailers we can provide the hands on training that is typically the largest burden for the emergency service agencies to attain for this type of operational training. Our current training outlines provides 2-4 vehicles per day of hands on operations depending on the number of participants. This would allow each participant to receive beneficial hands on experience that is not occurring in time of emergency but under supervised training and safety operations in a controlled environment. Over the years we have responded to many mutual aid incidents that the responders only have a basic understanding of the tool operations and while only limited use experience.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough; Kodiak Island Borough	Deferred or Not Advanced

Girdwood Fire & Rescue Inc	Alaska Rural Wilderness Medicine Conference	AK	Alaska has limited training opportunities for emergency service agencies to learn enhanced skills for supporting patients in austere situations. From Aviation, ATV/UTV, boating, hunting, hiking, climbing, skiing, biking or any of the other plethora of outdoor activities that end in accidents and unexpended injuries; Alaskan emergency services in underprepared in either limited personnel, equipment or knowledge while provide this expected and needed emergency response service. This conference opportunity would jumpstart the capabilities and build the relationships to support a multiagency approach in providing multi discipline teams to attack a rural emergency service response in difficult terrain, environments and hazardous conditions. The ability for agencies and personnel to train together and learn in an environment that promotes team work, collaboration and patient driven outcomes in a non-emergency setting only strengths our capability and response potential.	Hosting pre/post conference courses will provide bookend training to the core objective of better education our providers in the state of Alaska to provide the best possible care in the remote rural settings of the Alaska wilderness. Very few individuals get injured on the door step of their clinic and the time, distance and access to get an injured individual to definitive care can vary greatly. Providing a three day core conference highlight the key components to wilderness medical success, equipment and continuing training opportunities. While hosting intensive 3-5 day courses pre and post event creates the foundation for some or challenge other to new heights of patient care and success.	\$50,000-\$250,000	Statewide	Anchorage (Municipality)	Deferred or Not Advanced
Girdwood Fire & Rescue Inc	Expand Rural Patient Access Special Scenario Training: Water Rescue, REMS, Post Earthquake	AK	Problem: The skill level of rural Alaska ems agencies and providers to rescue and treat patients in water rescue situations, wilderness areas requiring rope systems and post earthquake scenarios varies widely across Alaska, as there is limited funding to train for special scenarios or complex patient management. Opportunity: Provide a series of special patient rescue trainings targeted at ems providers in communities with populations less than 10,000. This would expand the capacity and skill level (workforce development) of ems responders and rescuers in multiple rural communities translating directly into improved patient outcomes.	Girdwood Fire Rescue to host water rescue and REMS training annually for 2 years and on the third year provide a Train the Trainer course. The classes would be open to ems providers from communities less than 10,000 people (rural Alaska). The courses would bring instructors with national standards and certifications to Alaska. Girdwood previously hosted the first REMS class in Alaska in 2024. Scenarios students could take back to their own departments would be developed. Girdwood Fire Rescue would host a half day webinar on post earthquake injuries, treatment guidelines and presentations from providers who responded to large earthquake events.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Copper River Census Area; Denali Borough; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Lake and Peninsula Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Girdwood Fire & Rescue Inc	Girdwood Ambulance Staffing	AK	Improve consistency to ambulance response between Girdwood and Hope. Currently the ability of Girdwood to continue to respond south of the municipal boundary is in jeopardy without a funding source to maintain a staffing level. Girdwood Fire (a nonprofit) has been responding to vehicle accidents, multi-casualty accidents, train medical events and recreational medical emergencies south of Girdwood for decades. While Girdwood has 2 ambulances, our department is provided by the MOA the equivalent of 50% funding for staffing one Anchorage ambulance. Often we have 2 ambulances transporting patients during vehicles accidents or simultaneous incidents. Since we provide the emergency response south of the Anchorage boundary to the Hope cut off, the MOA is not willing to increase our ems funding to support those responses. Similarly we have approached the Chugach National Forest requesting help with funding for ambulance staffing or rescue equipment without success. If we don't have staffing from paid on call personnel not on shift for the second ambulance, the next closest ambulance being dispatched is from Anchorage. In January 2026 we had to discontinue response to Turnagain Pass for a three week period due to lack of paid on call staffing to be able to maintain response to our service area and to areas beyond the municipal boundary. We are continuing to see the paid on call staffing model we rely on to provide ems care erode due to Girdwood housing and food costs.	Our project requests funding for the Girdwood ambulance 24/7 with an ALS provider and an EMT. We already have the ambulance and medical supplies. We require staffing funding to implement 24 hr staffed shifts. The paid on call staffing model is not working as more of our firefighters are moving into Anchorage due to high housing and food costs in Girdwood. It is making is hard to recall paid on call staffing for the second ambulance for a motor vehicle accident or a second response when the first ambulance is already transporting. By having staffing in the station, we can provide consistency in care and response to Seward Hwy vehicle accidents and medical and traumatic injury patients in Chugach National Forest. We have been trying to solve this problem on our own. Besides unsuccessful funding requests to the MOA and Chugach National Forest, we requested the Turnagain Health Clinic (Girdwood Clinic) switch to urgent care or expand hours to evenings and weekends to relieve a portion of the ambulance transports, since the clinic is only open during the week, but that was also unsuccessful. Having already been forced into discontinuing service in January for 3 weeks due to staffing, we need to find stability in access to emergency response for the thousands of Alaskans that travel the Seward Highway.	\$250K-\$1M	Other	Anchorage (Municipality); Kenai Peninsula Borough	Deferred or Not Advanced

Girdwood Fire & Rescue Inc	Girdwood Fire & Rescue sUAS program	AK	Girdwood Fire and Rescue responds to the remote rural areas of the Southern portion of the Municipality of Anchorage and the northern portion of the Kenai Peninsula Borough along the Seward Highway. Responding and assisting multiple agencies with advanced backcountry medical rescue operations in the highest utilized State Park and Nation Forest lands in southcentral Alaska. Hooligan fisheries, hunting/fishing operations, snow machine and skiing along with many other year round recreational activities happen every day in these areas and are only increasing. The backcountry skier with a broken femur in Turnagain pass, to the buried Snowmachiner in Main bowl off Seattle ridge, or the patient that was found unconscious from hitting a tree skiing and three hours out at a remote cabin, the hiker that fell and has an open lower leg fracture, the list continues and is only becoming more complex. Being able to locate the patient rapidly, determine safe and efficient access while guiding the responding providers to the scene is what must happen first before any patient care, stabilization and transport options can occur. This is greatly increased with the ability to scout ahead, using thermal and other advanced imaging capability from a Small Unmanned Aerial System (sUAS). Providing the equipment, training, certification and overarching technology to make this happen is the goal of this project.	Girdwood Fire and Rescue has identified individuals with long term response potential, department service continuation of greater than five years and interest in creating a team of trained responders to operate and provide enhanced optical imaging capability during times of emergency and mutual aid response requests. This requires each individual to train and test for their FAA Part 107 license, operating under the department standard operating procedures for Emergency Drone Operations, working under the appropriate FAA Certificate of Authorization for emergency operations applicable uses and continued training and recertification every two years. The response profile would be scalable on need for the incident and can be staged to be launched remotely from the Fire station or once on location due to the variables and needs of the incident. Pilot in Charge (PIC) are the responders that would be able to provide the information to the incident command in a visual display to allow the best tactical decisions and support of the patients in need of medical services. We have found and have been successful in including this information in the patients Electronic Health Record as backup to the mechanism of injury and visual display of the scene for the definitive care providers.	\$50,000-\$250,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Girdwood Fire & Rescue Inc	Workforce Strengthening Girdwood EMS Providers	AK	Strengthen Workforce 1) Attracting and retaining a skilled workforce in Girdwood is difficult due to the high cost of living, and dangerous commute from Anchorage along the Seward Highway 2) Our fire department relies on a 50% paid on call workforce. The EMS providers as paid on call firefighters, are on shift 48hrs a month but only paid when they go on calls. Its is not cost effective for become a paid on call firefighter if you have to also pay for childcare to attend shifts or training 3) Girdwood needs locally based EMS providers that can respond from the community for incidents and in a disaster when the community is isolated by road conditions, rock slides or avalanches. 4) Girdwood has high housing, limited rental housing stock and high food costs compared to Anchorage, limiting the number of providers willing to live and work in Girdwood. 5) Girdwood ems call volume is often multisystem trauma from car accidents and recreation injuries. This provides a high stress load on ems providers who need professional ALS skills. It is easier to train a provider to a higher level of certification who likes working in Girdwood than to recruit into the community and workplace.	Strengthen Workforce 1) Offer structured retention bonus for Girdwood EMS providers that serve the Girdwood Community for 5 years or more 2) Provide monthly childcare support bonus for Girdwood EMS providers 3) Offer Girdwood housing bonus for all Girdwood responders that live in the Girdwood community 4) Offer Paramedic training funding for 1-2 members each year to train from AEMT/EMT2 to Paramedic	\$50,000-\$250,000	Single Community	Anchorage (Municipality); Kenai Peninsula Borough	Deferred or Not Advanced

Girdwood Health Clinic Inc	Fresh Start Clinical Integration: Connecting Prevention with Rural Chronic Disease Monitoring	AK	Chronic diseases such as hypertension and diabetes are leading causes of preventable illness, hospitalization, and rising health care costs in Alaska. Rural communities face particular challenges managing these conditions due to geographic barriers, limited workforce capacity, and delays in clinical follow-up. Residents of our service area often must travel long distances to access specialty medical services beyond primary care. These travel barriers, combined with limited clinical staffing, can delay adjustments to treatment when chronic disease indicators worsen. During these gaps in monitoring and follow-up care, uncontrolled blood pressure or blood glucose can lead to serious complications including stroke, cardiovascular disease, and kidney failure. The Alaska Department of Health’s Fresh Start program provides evidence-based prevention and behavior-change programs that support healthier lifestyles and chronic disease prevention. However, many participants require additional clinical monitoring and care coordination to manage established chronic conditions. TCH proposes the Fresh Start Clinical Integration Initiative to bridge this gap by integrating prevention programs with clinical chronic disease monitoring and care management. The project will expand nurse-led monitoring programs, strengthen referral pathways between Fresh Start and primary care, and develop a coordinated rural care model to improve chronic disease outcomes and reduce preventable complications.	Turnagain Community Health (TCH) proposes the Fresh Start Clinical Integration Initiative to strengthen coordination between public health prevention programs and primary care–based chronic disease management. The project builds on existing partnerships with the AK Department of Health’s Fresh Start program and TCH’s ongoing efforts to improve chronic disease outcomes through quality improvement initiatives and community outreach. The initiative will focus on four strategies. First, TCH will expand clinical chronic disease monitoring programs. This includes strengthening Self-Measured Blood Pressure Monitoring (SMBP) for patients with hypertension, expanding remote glucose monitoring for patients with diabetes, and increasing nurse-led care management to support medication adherence, treatment adjustments, and ongoing monitoring. These services will allow clinicians to identify worsening conditions earlier and intervene more quickly. Second, the initiative will establish coordinated referral pathways between Fresh Start prevention programs and TCH’s clinical teams. Participants in Fresh Start programs who are identified as having elevated chronic disease risk will be referred for clinical monitoring and care management. Likewise, patients receiving care at Turnagain Community Health may be referred to Fresh Start programs for lifestyle coaching, tobacco cessation, and prevention services. Third, the initiative will support development of a Remote Patient Monitoring (RPM) program that enables patients to track health indicators such as blood pressure and glucose levels between clinic visits. RPM tools will allow patients to monitor conditions from home while clinicians review data, identify concerning trends, and intervene earlier when treatment adjustments are needed. Fourth, the project will strengthen the role of CHWs in identifying high-risk patients and supporting engagement with both prevention programs and clinical care. CHWs will conduct outreach across dispersed communities, helping residents overcome barriers such as transportation, health literacy, access to services, and education on the use of RPM tools. Together, these strategies will create an integrated rural chronic disease care model that combines prevention programs, clinical monitoring, remote monitoring technology, and coordinated care. This approach will support earlier treatment escalation, improve chronic disease control, and reduce preventable complications.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough	Advance to Implementation Application

Girdwood Health Clinic Inc	Integrated Community Health Worker Navigation: Bridging Health Care & Community in Rural Alaska	AK	In rural Alaska many factors influencing health outcomes occur outside clinical settings. Transportation barriers, housing instability, food insecurity, and complex eligibility systems for health and social services often prevent patients from accessing care or managing chronic conditions effectively. These barriers frequently lead to delayed treatment, worsening health conditions, and avoidable ER visits or hospitalizations. At the same time, Turnagain Community Health (TCH) is experiencing demographic and economic trends within the communities we serve. We are caring for a growing number of older Alaskans on Medicare, as well as increasing numbers of uninsured and low-income patients who face significant barriers navigating health care systems and public benefit programs. CHWs help address these challenges by building trusted relationships with patients and helping them navigate health care and community resources. As integrated members of care teams, CHWs improve engagement with preventive and health care services, support chronic disease self-management, and assist individuals seeking treatment for substance use disorders. TCH currently employs three CHWs who serve as patient advocates and care navigators, helping patients address social drivers of health and connect with essential services. Demand for these services continues to grow. Expanding the CHW workforce will improve access, strengthen care coordination, and support healthier rural communities.	Turnagain Community Health (TCH) proposes to expand and strengthen its Integrated Community Health Worker Program as part of a coordinated effort to improve access to care and strengthen community-based health supports for rural residents in the Turnagain Arm region. Currently, TCH employs three Community Health Workers who are fully integrated members of the clinical care team. These CHWs primarily focus on addressing patients’ social drivers of health and helping individuals navigate complex systems that affect their ability to access care. Their work includes helping patients connect with food banks and other food assistance programs, assisting individuals experiencing housing instability or domestic violence in locating safe housing, coordinating transportation to medical appointments, and helping patients complete applications for Medicaid, Medicare, SNAP, Social Security, and other public assistance programs. Our CHWs also support patients experiencing substance use disorders by helping them identify treatment options, complete intake processes, secure admission to treatment facilities, and coordinate transportation and follow-up care. Through the Rural Health Transformation Program, TCH will expand its CHW workforce from three to five Community Health Workers in order to increase access to care navigation services for rural residents. In addition to expanding capacity, the initiative will evolve the CHW role to include structured health education and chronic disease management support. Working in partnership with medical and behavioral health providers, CHWs will assist patients managing conditions such as diabetes, hypertension, and obesity by helping them understand care plans, maintain engagement with treatment, and overcome barriers that interfere with treatment adherence. This initiative will also align closely with the emerging statewide Community Health Worker Network, in which Turnagain Community Health actively participates. Through this collaboration, CHWs will have access to standardized training, shared documentation tools, and coordinated referral systems that strengthen collaboration between clinical providers and community-based organizations. By expanding CHW capacity and strengthening care navigation services, this initiative will improve early intervention, enhance chronic disease management, support behavioral health and substance use disorder treatment engagement, and reduce avoidable emergency department utilization.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough	Advance to Implementation Application

Girdwood Health Clinic Inc	Rural Value-Based Care Transformation Initiative: Building A Sustainable Rural Health System	AK	Rural health systems face a structural mismatch between the care rural communities need and the way health care is traditionally reimbursed. Fee-for-service payment models primarily reimburse individual clinical services. These models provide limited financial support for many of the services that are most critical to improving rural health outcomes, including chronic disease management, care coordination, preventive care, behavioral health integration, and services addressing social determinants of health. For rural providers serving geographically dispersed populations, these limitations create significant barriers to improving health outcomes. Patients frequently face transportation challenges, delayed access to specialty care, and fragmented care across multiple providers. Without sustainable funding for proactive care management, providers are often forced to respond to advanced illness rather than prevent complications. Nationally, health systems are transitioning toward value-based payment models that reward improved outcomes and reduced total cost of care. However, participation in these models requires significant investments in data infrastructure, quality reporting systems, population health analytics, and care management workflows. Without support to develop these capabilities, rural health providers risk being excluded from emerging value-based care systems, potentially worsening existing financial and access disparities between rural and urban health systems.	The Rural Value-Based Care Transformation Initiative will prepare Girdwood Health Clinic d/b/a Turnagain Community Health (TCH) to successfully participate in value-based payment models while strengthening care coordination and population health management for rural patients. Key activities will include: • Joining Alaska Community Health Network LLC, a statewide clinically integrated network that supports collaborative quality improvement, data sharing, and value-based contracting among participating providers. • Participating in Resolute Health Alliance LLC, an Accountable Care Organization participating in the Medicare Shared Savings Program. • Developing internal population health management capabilities, including data analytics, quality performance tracking, and patient risk stratification. • Implementing care management workflows that support proactive outreach to patients with chronic conditions and complex care needs. • Training clinical and administrative staff in value-based care principles, quality improvement strategies, and data-driven population health management. These capabilities will enable TCH to identify high-risk patients earlier, coordinate care more effectively across providers, and align clinical strategies with payment models that reward improved outcomes. Importantly, this infrastructure will also support the success of our other RHTP initiatives focused on medication access, community health worker services, chronic disease management, and behavioral health integration.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough	Advance to Implementation Application

Girdwood Health Clinic Inc	Rural Pharmacy Innovation: Expanding Medication Access Through Innovative Technologies	AK	Many small rural Alaska communities struggle to sustain traditional pharmacies due to low patient volume, workforce shortages, and high operating costs. The Turnagain Arm region faces a critical risk to medication access. The area currently relies on a single privately owned pharmacy serving residents of Girdwood, Hope, Whittier, Bird Creek, Indian, and surrounding communities. The pharmacy is experiencing financial challenges common to rural markets and may not remain viable without structural changes. If it closes, residents would need to travel 40–90 miles to Anchorage for medications, creating barriers to timely treatment, medication adherence, and chronic disease management, particularly for elders, patients with complex conditions, and individuals receiving behavioral health services. Turnagain Community Health (TCH), an FQHC and the only provider of primary care and behavioral health services in the area, prescribes the majority of medications dispensed locally. The pharmacy owner has approached TCH about transitioning pharmacy services to the clinic. TCH proposes to develop a Rural Pharmacy Innovation model that integrates pharmacy services within the FQHC care model while leveraging telepharmacy, technology-enabled dispensing solutions, and participation in the 340B Program. This approach will sustain medication access, improve care coordination and health outcomes, and create a financially sustainable pharmacy model designed for small rural Alaska communities.	Turnagain Community Health (TCH) proposes to develop and implement a Rural Pharmacy Innovation model that sustains medication access while strengthening care coordination and improving health outcomes for residents of the Turnagain Arm service area. The project will transition the community’s existing pharmacy to an integrated model within the TCH FQHC, aligning pharmacy services with primary care and behavioral health to support a coordinated rural care delivery system. Financial sustainability will be achieved through participation in the federal 340B Drug Pricing Program, which will allow TCH to acquire medications at reduced cost and reinvest savings into pharmacy operations, medication affordability, and expanded services. This model addresses financial barriers that often prevent small rural pharmacies from remaining viable. To address rural workforce constraints, the project will implement a telepharmacy model in which licensed pharmacists provide remote prescription verification, medication counseling, and clinical consultation. On-site staff will support dispensing operations and patient education while maintaining pharmacist oversight and regulatory compliance. The project will also test technology-enabled dispensing solutions designed for rural communities. Potential innovations include secure automated medication dispensing kiosks or other remote dispensing technologies in accessible community settings. These tools will expand medication access across the service area while reducing travel barriers and operational costs. In addition to dispensing services, the project will integrate clinical pharmacy services into patient care, including medication therapy management, medication adherence support, and coordination with primary care and behavioral health providers. These services are expected to improve chronic disease management, support behavioral health treatment continuity, and reduce avoidable health complications. This project aligns with Alaska’s Rural Health Transformation Program priorities by expanding access to essential services, leveraging technology to overcome workforce and geographic barriers, and strengthening long-term financial sustainability of rural health care delivery. By combining telepharmacy, innovative dispensing technologies, and efficiencies created through the 340B program, the project will create a scalable model that may inform sustainable pharmacy solutions for other small rural Alaska communities.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough	Advance to Planning

Girdwood Health Clinic Inc	Rural Behavioral Health Access Expansion: Connecting Alaskans to Care	AK	Turnagain Community Health (TCH), an FQHC serving the Turnagain Arm region, has expanded behavioral health services in recent years through federal grant support. Mental health services increased by more than 35% following implementation of our Behavioral Health Service Expansion program, and new substance use disorder (SUD) and medication-assisted treatment (MOUD) services were integrated into primary care. Despite this progress, access to behavioral health care in our rural service area remains constrained by workforce shortages and geographic barriers. Recruiting and retaining behavioral health clinicians in small rural communities is difficult, leaving many patients without timely access to care. At the same time, mental health needs continue to increase, particularly among youth, seasonal workers, and individuals experiencing housing instability or substance use disorders. Local schools and community partners report a growing gap in mental health services for children and adolescents, with few local options for counseling or early intervention. This Initiative will address these challenges by strengthening workforce recruitment and training, expanding telebehavioral health services, and exploring school-based mental health service development. These strategies will improve access to care, strengthen rural workforce capacity, and support sustainable behavioral health service delivery in small rural Alaska communities.	Turnagain Community Health proposes a multi-strategy initiative to expand access to behavioral health services in rural Turnagain Arm communities by addressing workforce shortages, improving telebehavioral health infrastructure, and expanding community-based access points for care. First, the project will support behavioral health workforce development and recruitment. Despite successful program implementation, recruiting licensed behavioral health clinicians to rural Alaska remains a major barrier to sustained service delivery. RHTP support would allow TCH to develop innovative recruitment strategies, explore shared workforce models, expand clinical training partnerships, and provide professional development and support systems designed to attract and retain behavioral health professionals in rural communities. Second, the initiative will strengthen telebehavioral health capabilities. Telehealth has proven to be a critical tool for delivering care across the geographically dispersed Turnagain Arm region. Building on existing services, TCH will expand telebehavioral health capacity for therapy, psychiatric medication management, crisis consultation, and specialty behavioral health services. This includes strengthening technology infrastructure, developing telehealth workflows, and establishing partnerships with remote behavioral health providers to supplement local staffing capacity. Third, the project will explore development of school-based behavioral health services in partnership with local schools. Community leaders and school staff consistently report unmet mental health needs among children and adolescents. TCH will work with local school districts to evaluate the feasibility of establishing school-based mental health clinics or embedded behavioral health services, allowing students to access counseling and early intervention services within their schools. Finally, the project will continue strengthening integrated behavioral health care within the FQHC model. Behavioral health providers will continue to work alongside primary care teams, Community Health Workers, and care managers to deliver coordinated services addressing mental health, substance use disorders, and social determinants of health. Together, these strategies will create a more resilient and accessible behavioral health care system for rural residents of the Turnagain Arm service area.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough	Deferred or Not Advanced

Girdwood Health Clinic Inc	Rural Health Transformation Planning: Turning the Tide on Health Outcomes Across the Turnagain Arm	AK	Rural health systems must continually adapt to evolving community needs, workforce shortages, and changing health care delivery models. For small rural providers, limited administrative capacity often constrains the ability to pursue strategic planning, develop innovative service models, coordinate regional partnerships, and manage complex multi-year transformation initiatives. Turnagain Community Health is currently developing a coordinated portfolio of rural health transformation initiatives designed to enhance community-based outreach and care navigation, strengthen chronic disease management, expand behavioral health services, improve medication access and adherence, and support participation in emerging value-based payment models. While these initiatives offer significant potential to improve rural health outcomes, successful implementation requires dedicated planning and coordination capacity. In addition, rural communities in the Turnagain Arm region face broader system questions related to emergency medical services coordination, access to diagnostic services, expansion of preventive screening tools, and potential new service delivery models such as mobile integrated care teams and expanded urgent care capacity. The Rural Health Transformation Planning Initiative will address these needs by establishing dedicated capacity for grants management, rural health system planning, community partnership development, and coordination of multiple transformation initiatives.	Turnagain Community Health proposes to establish a Rural Health Transformation Planning Initiative that strengthens the organization’s ability to coordinate multi-year health system innovation efforts while supporting broader rural health planning activities across the communities we serve. The initiative will support a dedicated Rural Health Transformation Project Manager responsible for coordinating implementation of multiple RHTP initiatives while leading community health system planning efforts. Key activities will include three primary areas of work. First, the initiative will coordinate development and implementation of Turnagain Community Health’s rural health transformation portfolio. This includes projects focused on pharmacy access innovation, community health worker expansion, chronic disease monitoring integration with public health programs, behavioral health access expansion, and participation in value-based care networks. Coordinated project management will support implementation planning, grant management, evaluation design, and reporting across initiatives. Second, the project will support community health system planning in partnership with regional stakeholders. This includes collaboration with local emergency medical services providers to explore opportunities for improved care coordination, potential development of mobile integrated care teams, and strategies that allow primary care clinics to serve as alternative destinations for certain urgent care needs. These efforts may help reduce unnecessary emergency department utilization while improving timely access to care. Third, the initiative will support exploration of innovative service delivery models designed to address rural access challenges. Potential areas of evaluation include expanded diagnostic services such as laboratory and radiology capacity, adoption of new screening technologies, development of mobile clinic models or modular “clinic-in-a-box” care sites, and other strategies designed to improve access to preventive and urgent care services across geographically dispersed communities. Through coordinated planning, partnership development, and strategic evaluation of new service models, this initiative will help rural communities identify practical solutions that strengthen access to care and improve health system sustainability.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough	Deferred or Not Advanced

Girdwood Inc	Girdwood Workforce Housing Project	AK	There is not enough housing in Girdwood, as well as many small or remote communities of Alaska. Traditional onsite construction has proven to be uneconomical and unfeasible in many cases. Alaska needs to be a leader in new housing types. Modular housing has greatly improved in the past decade and we need to utilize the advancements in design, technology and cost efficiency to make Alaska a compelling place to live, work and play. Girdwood is a recreation hub and can be used as a driver to bring non-resident health care talent to Alaska. Modular housing can have a sigma associated with it, and we want to break that mindset, that not only can they be functional, but beautiful and fit a character of a community. We would like to design, engineer and plan a workforce neighborhood to benefit the Turnagain Arm Area. A Workforce Housing need is clearly identified in the recently updated Girdwood Area Plan. A site has been identified. A final report will be generated and published regarding how to export this concept to remote areas.	Girdwood Inc shall produce all the necessary documents required to be shovel ready for the workforce subdivision. A range of 30-50 workforce units are desired at the targeted location. Preference for units shall be given to employees of Turnagain Community Health, as well as emergency responders employed by Girdwood Volunteer Fire Department and Whittier Police. Additional units for teachers/staff at Girdwood School, as well as other essential workforce will be taken into consideration during the planning phase. The goal is to research the best modular housing type for arctic environments, with a preference on simple assembly, affordable shipping costs and long-term durability. Girdwood Inc will not only produce documents for the Girdwood workforce housing project implementation phase, but also create a template and checklist for creating a subdivision and necessary infrastructure for modular housing in rural Alaska, to maximize the knowledge and lessons learned during this planning stage. This grant would fund: surveying costs, land studies, permits, special inspections, planning, design, architect fees, consultant and grant administration. Girdwood Inc is months out from completing the Girdwood Workforce Childcare Project, where we fund-raised nearly 6 M to build a desperately needed childcare center. We were given a Community Innovation Grant from the State of Alaska that was used for planning, design and engineering. This model worked incredibly well and resulted in being well prepared to execute the construction portion over the last 10 months. The building is currently on budget and on time. Girdwood Inc has demonstrated it can take on multi-million dollar projects and is poised to take on this next pressing item in our community and state. Girdwood Inc intends to partner with Girdwood Community Land Trust, who has been working with municipal land holders and is already included in Heritage Land Bank's Annual and 5 year plan.	\$50,000-\$250,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Glacier Bear Community Peak Performance	Glacier Bear Community Peak Performance: Enhancing Rural Health through Community Recreation	AK	Like many rural Southeast Alaska communities, like Haines, are confronted with distinct health challenges primarily due to geographic isolation, limited infrastructure, and barriers to preventive care. The lack of community recreation infrastructure hinders residents' ability to engage in regular physical activities, which are essential for maintaining health and well-being. This situation is exacerbated by the harsh weather conditions, long travel distances to healthcare facilities, and limited built environments, which collectively create significant obstacles to maintaining an active lifestyle. According to statewide health reports, a considerable portion of Alaskans face chronic health risks, such as obesity, high blood pressure, and insufficient levels of physical activity. These conditions are prevalent among populations in rural areas, where access to preventive healthcare services is restricted. Additionally, musculoskeletal injuries, which are common in both youth sports and the occupational activities prevalent in this region (e.g., fishing, forestry), contribute to disability and healthcare costs.	The Glacier Bear Community Peak Performance project presents a significant opportunity to tackle these challenges head-on by developing a Community Recreation, Sports Performance and Injury Prevention Program led by a certified athletic trainer. The goal for this program is to assess the need for a community recreation and injury prevention programming. Determining if the need to build a Community Recreation Center to support activities. This initiative aims to: Enhance Preventive Care: By focusing on injury prevention and sports performance, the program will reduce the incidence of common injuries, thereby lowering healthcare utilization and costs. Expand Access to Services: Establishing structured, inclusive programs will improve access to recreation, health education, and wellness services, especially for underserved populations such as low-income families, elders, Alaska Native members, and those with limited mobility. Promote Health Equity: By eliminating participation barriers through sliding scale fees, culturally responsive offerings, and outreach partnerships, the initiative will intentionally reduce inequities in access to preventive health services. Strengthen Community Ties: Recreation spaces and programs will serve as vital hubs for physical activity and social connection, thereby fostering community cohesion and mental well-being. Build Local Capacity: The project will create sustainable community capacity for preventive health through the expansion of the healthcare workforce, including the addition of a locally available athletic trainer role. By addressing these issues through a community-centered approach, the Glacier Bear Community Peak Performance project promises to improve the quality of life for residents, enhance physical and mental health outcomes, and create a foundation for sustainable, long-term health improvements in Haines.	\$250K-\$1M	Home- and community-based services provider	Single Community	Haines Borough	Deferred or Not Advanced

Glytec, LLC	Glytec Glycemic Management - Implementing eCQM metrics mandated by Joint Commission and CMS	MA	Many rural hospitals still rely on paper-based insulin protocols and manual calculations to determine insulin dosing. This process is time-consuming and increases the risk of human error, especially in busy clinical environments. Even a single glycemic event—whether severe hyperglycemia or hypoglycemia—can significantly impact patient outcomes, length of stay, and overall cost of care. In some cases, miscalculated doses can lead to serious adverse events, putting vulnerable patients at even greater risk. Without real-time visibility into glucose performance, clinicians and leadership often lack the ability to proactively manage or intervene early. In addition, insulin dosing decisions can vary depending on the provider or nurse on shift, leading to inconsistent glycemic management across the same unit or patient population. This variability makes it difficult to standardize care, track performance, and consistently achieve optimal outcomes for patients with diabetes or stress-induced hyperglycemia. Digital glycemic management solutions help address these challenges by standardizing insulin dosing, reducing calculation errors, and providing real-time insights that support safer, more consistent glucose management across the hospital. All while helping to boost the confidence of the clinical staff and maintain the retention of nurses.	Align: Identify the glycemic safety leadership team and schedule a focused demo for the identified stakeholders Define: Confirm workflows and perform a risk assessment. Evaluate expected Return on Investment Implement: Train teams and bring the program live This is NOT another system to manage but is imbedded in the EMR/EHR.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Grimm Investments LLC, DBA Alaska Medical Transport	Bariatric Transportation	AK	There are currently no ambulances specifically equipped to transport bariatric patients in Southcentral Alaska.	AMT proposes retrofitting two ambulances to be capable of carrying bariatric patients. This includes bariatric specific stretchers and bariatric ramp and winch systems, to safely load and unload bariatric patients.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced
Guardian Flight	EMS and Aviation Workforce Development	AK	Rural Alaska’s emergency care system is constrained by three connected challenges: (1) workforce instability (burnout, turnover, vacancies) among village-level providers and rural clinicians; (2) limited access to hands-on training, especially for rare but high-risk emergencies; and (3) specialty transport bottlenecks, including neonatal capability concentrated in a single hub that can be stressed by back-to-back missions, weather, and distance. These constraints compound each other. When providers can’t access realistic, scenario-based training, confidence and readiness erode. When staffing is thin, providers have fewer opportunities to leave for training, and turnover rises. When specialty transport resources are centralized, rural facilities can experience delays that increase clinical risk — especially for newborns requiring tightly controlled transport conditions. The opportunity is to invest in a single integrated solution that addresses root causes: build local workforce pathways, deliver training where care occurs, and expand proven neonatal transport readiness closer to Southeast Alaska communities — creating durable statewide capacity rather than episodic fixes.	This project delivers a coordinated, implementation-ready approach aligned to Alaska RHTP’s Strengthen Workforce initiative, while also improving Health Care Access and Healthy Beginnings through specialty transport readiness. - Build a rural EMS pipeline with earn-while-you-learn support and relief coverage. Year one focuses on the scope of 20 EMT scholarships and 20 paramedic scholarships, structured to reduce barriers (lodging/logistics as needed) and to support rural Alaskans from villages into training and back into rural roles. Training is designed to be held in Alaska where possible, with planned high-volume clinical/ride experiences in the Pacific Northwest when required for competency and exposure. - Create durable training infrastructure: simulation + mobile delivery. The project establishes high-fidelity simulation capability and a mobile training model that delivers BLS/ACLS/PALS/NRP, skills validation, and rural-relevant emergency scenarios directly to providers. Year one includes mobile training delivered to 10 rural locations, reducing travel barriers and enabling recurring competency maintenance. - Expand neonatal transport readiness in Southeast Alaska using a proven model. The project positions an isolette and trained neonatal transport capability in Southeast Alaska, leveraging existing protocols, training standards, and clinical oversight from the established program to ensure consistency and patient safety while reducing delays caused by equipment/crew repositioning. Across all components, the project is designed for measurable improvement in access and outcomes, and to demonstrate the kind of system-level transformation Alaska’s evaluation framework prioritizes: strong need-to-intervene logic, measurable outcomes, coordination, sustainability, and feasible implementation.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough);	Advance to Implementation Application

Guardian Flight	Advancing Emergency Care Access for Rural Alaskans (Health Care Access)	AK	Rural Alaska faces a persistent mismatch between patient needs and the structure of emergency response systems. Non–time-critical medical concerns frequently result in ambulance dispatch, air transport, or emergency department utilization because there are few alternatives available at the moment of need. This dynamic strains limited emergency resources, increases costs for patients and payers, and can reduce availability for higher-acuity events. Workforce shortages and geographic distance further exacerbate these challenges. The opportunity is to modernize how emergency access points function by embedding clinical decision support and care navigation into existing 911 infrastructure. By doing so, Alaska can better match patients to appropriate levels of care, strengthen system sustainability, and improve patient experience, with all of this achieved without compromising safety or public trust in emergency services. This project does not restrict access to emergency services; it protects and preserves emergency capacity by ensuring that limited EMS and transport resources remain available for the patients who truly need them. This project complements investments in air medical transport by ensuring that transport is used when clinically necessary and avoided when better care can be delivered where patients are. Without intervention, increasing call volume and workforce shortages will continue to erode reliable emergency access in rural communities.	911 REACT operates as a 24/7 clinician-led care navigation service integrated with emergency dispatch and field response. When non–time-critical calls are identified, callers or responders are connected to Alaska licensed clinicians operating under physician-approved protocols. Clinicians conduct real-time assessments, provide clinical guidance, and coordinate the safest and most appropriate care pathway. These pathways may include telehealth consultation, referral to local or regional providers, coordination with rural hospitals, or escalation to EMS and transport when conditions warrant. The approach emphasizes flexibility and scalability across Alaska’s diverse communities, recognizing differences in local resources, geography, and population needs. The model aligns with Alaska’s priorities for technology-enabled care, workforce support, and system integration by leveraging centralized clinical expertise, interoperable data exchange, and standardized protocols. Implementation is designed to occur in phases, allowing for stakeholder engagement, refinement, and adaptation while maintaining consistency and safety statewide. Importantly, the approach enhances—rather than replaces—existing emergency response systems, reinforcing 911’s role as a trusted front door to care.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Guardian Flight	Regional Medevac Infrastructure Improvement (Dutch Harbor) & Fleet-Wide Garmin G1000 Modernization	AK	1) Dutch Harbor Infrastructure Improvements: Alaska’s rural healthcare access, especially for unplanned or emergency care, is tightly coupled to aviation readiness. In the Aleutians, distance, severe weather, and minimal redundancy mean that a single infrastructure weakness can isolate communities from urgent care. Guardian Flight’s Hangar in Dutch Harbor is a strategic outpost, but roof and facility conditions require repair to continue to reliably protect aircraft and equipment from harsh maritime exposure. Without improvements, corrosion and weather damage will ultimately render this hangar unusable. 2) Statewide Fleet Modernization: Statewide, aging avionics and limited approach capability delay access to care. This investment will put modern avionics in the cockpit and allow for access to the approaches needed to more reliably land in remote Alaska locations. The FAA through state and federal funding has already created a number of approaches but without the modernization – these aircraft cannot take advantage of the capabilities. Dutch Harbor functions as a regional aviation and medical access node for multiple island communities, not just Unalaska, extending the benefit of this investment far beyond a single location.	The project has two coordinated workstreams designed to protect access in the Aleutians while improving statewide medevac reliability: 1) Dutch Harbor Infrastructure Improvements: Complete targeted roof and facility repairs to restore weather protection, functionality, and year-round operational readiness. Improvements will focus on preventing moisture intrusion, reducing corrosion exposure, and ensuring the hangar can withstand the continued impact of maritime weather. Work can begin as soon as summer 2026. 2) Statewide Fleet Modernization: Modern avionics allow aircraft to fully utilize existing instrument approaches already developed by the State, converting prior public infrastructure investments into real, usable access for remote communities. We will upgrade three (3) fixed-wing aircraft in year one, five in year two, and five in year three. Overall, the target will be to modernize a total of eight King Air 350s and five King Air 200s—with Garmin G1000 avionics. Each installation includes acquisition, installation, certification, and standardized training for pilots and maintenance personnel. Together, these investments increase approach reliability and situational awareness, reduce unplanned maintenance and weather-related delays, and add a critical safety layer through auto-landing in rare pilot-incapacitation scenarios. The approach prioritizes durability, readiness, and uninterrupted service—delivering immediate benefits as assets return to service while building long-term system resilience.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Guardian Flight	Rural Clinic Support to Stabilize Emergency Patients	AK	Rural Alaska’s emergency healthcare system is constrained by distance, frequent weather-related transport delays and structural aviation access limitations. In many communities, clinics are clinically prepared to initiate care but lack the staffing depth required to safely sustain prolonged patient management when transport is delayed. These challenges are compounded by aging or limited airport infrastructure and other aviation constraints that reduce the reliability of medical transport during common Alaska weather conditions. This readiness project will address two interdependent challenges that together define rural emergency access reliability. The first is an assessment of rural clinic staffing readiness and sustainability, including evaluation of current staffing models, surge capacity, skill mix, and the ability of clinics to safely manage extended patient holds during transport delays. The second is an assessment of aviation related infrastructure and access at rural locations, including airport proximity to clinics, availability of instrument approaches and departures, runway and lighting limitations, weather reporting reliability, and other aviation factors that directly influence the safety and consistency of medical transport operations. By jointly assessing clinical staffing capacity and aviation access limitations, this project will identify targeted, high impact readiness improvements that strengthen rural clinics’ ability to safely stabilize patients.	Year one will serve as a structured planning and readiness phase that integrates rural clinic stabilization planning, aviation access assessment, and workforce alignment into a single coordinated effort. Additionally, a gap analysis and needs assessment will be performed on identified pilot communities and rural health clinics. Specific & Measurable: Within the 12month readiness period, the project will identify and assess a defined set of pilot rural communities representing Southeast Alaska, Bristol Bay, and Tanana Chiefs Conference regions. For each site, the project will complete standardized evaluations of (1) clinic staffing models, surge capacity, skill mix, and prolonged-hold capability, and (2) aviation access factors including airport proximity, specialized instrument approach availability, runway and lighting limitations, weather reporting reliability, and operational constraints affecting medical transport. Achievable: Assessments will be completed through coordinated site visits, stakeholder interviews, and data review in partnership with Tribal Health Organizations, the Alaska Native Tribal Health Consortium (ANTHC), and clinic leadership. Existing clinical and aviation operational data will be leveraged to ensure feasibility within the readiness timeframe. The project will also evaluate the role of technology-enabled transport coordination platforms, such as Transport.net, to support real-time transport requests, ETA visibility, and decision support across multiple air and ground providers during weather-impacted events. Relevant: Findings will directly inform readiness gaps that limit safe patient stabilization and transport reliability during weather-related delays, ensuring alignment with RHTP priorities focused on equitable access, sustainability, and system resilience. Time Bound: By the end of the planning year, the project will deliver: • Site specific readiness profiles for each pilot community • A consolidated gap analysis identifying priority staffing and aviation access limitations • Defined coordination pathways and readiness benchmarks • An implementation roadmap to guide future funding and phased deployment This structured approach ensures year one outcomes produce actionable, high impact guidance for strengthening rural emergency care access—without committing to unsustainable staffing models or infrastructure investments.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Guidance Global Consulting Inc.	Advanced Care Coordination and Care Management Solution	MD	Alaska’s rural, remote, and frontier communities face persistent barriers to accessing continuous, high-quality health care. Geographic isolation, limited road access, provider shortages, and high transportation costs make routine chronic disease management extremely difficult for many residents. These challenges disproportionately affect Alaska Native and American Indian (AI/AN) populations, rural elders, and individuals with complex chronic conditions such as diabetes, cardiovascular disease, obesity, behavioral health disorders, and chronic pain. Alaska also faces escalating behavioral health and opioid-related challenges, with rural and AI/AN communities experiencing some of the highest rates of overdose mortality, suicide, and untreated mental health conditions in the nation. The state is projected to face a shortage of approximately 5,000 nurses by 2030, and many communities rely on small rural clinics, tribal health organizations, or critical access hospitals that are already operating at capacity. Nearly 75% of Alaska communities are not connected to the road system, making travel for routine care extremely costly and time-consuming. As a result, many patients with manageable chronic conditions go long periods without monitoring or care coordination. Medication adherence declines, early warning signs are missed, and preventable health crises result in emergency department visits or hospitalizations that could have been avoided with proactive monitoring and support.	GGC will lead program design, implementation, governance, and evaluation for a statewide pilot deploying Outcomeus’ virtual concierge chronic care platform to rural and tribal communities across Alaska. The program will initially enroll approximately 500 patients across a three-year demonstration, with priority outreach to Alaska Native and American Indian populations, rural elders, and individuals with complex chronic conditions. Outcomeus will provide the integrated technology platform that enables continuous remote monitoring and virtual care coordination. The platform combines several established care models reimbursable through Medicare and Medicaid, including Remote Patient Monitoring (RPM), Remote Therapeutic Monitoring (RTM), Chronic Care Management (CCM), Principal Care Management (PCM), and Advanced Primary Care Management (APCM). These reimbursement pathways allow the model to become financially sustainable beyond the RHTP grant period. Through Outcomeus’ operational infrastructure and telehealth operations partner BlueStar Telehealth, the program will provide: • Remote physiological monitoring for conditions such as hypertension, diabetes, heart failure, COPD, chronic kidney disease, and obesity • Daily biometric monitoring by registered nurses with escalation protocols for clinical concerns • Virtual care coordination and patient engagement between clinic visits • Medication adherence monitoring and support • Behavioral health and sleep monitoring capabilities • Patient-reported outcome tracking to measure improvements in quality of life The program will also pilot innovative non-pharmacological chronic pain management solutions, including prescription-based virtual reality cognitive behavioral therapy for chronic pain and secure medication adherence technologies designed to support safe management of controlled substances and medication-assisted treatment. GGC will coordinate partnerships with Tribal Health Organizations, Federally Qualified Health Centers (FQHCs), rural hospitals, and community health programs across Alaska. Tribal partners such as the Alaska Native Tribal Health Consortium, Southcentral Foundation, and regional tribal health systems will be prioritized because of their central role in delivering care to AI/AN populations. GGC will oversee program governance, stakeholder engagement, implementation planning, data reporting, and performance evaluation.	Over \$5M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Guidance Global Consulting Inc.	AI-Enabled Chronic Disease and Community Wellbeing Initiative for Rural Alaska	MD	Alaska’s Rural Health Transformation Program identifies Healthy Communities and Health Care Access as key initiatives focused on prevention, chronic disease management, consumer-facing digital tools, and population health infrastructure. Chronic disease management in rural Alaska presents unique challenges. Geographic isolation, transportation barriers, and limited access to providers make sustained engagement with prevention and self-management programs difficult. These barriers are particularly significant in rural and Tribal communities where access to in-person services may be limited. Effective chronic disease management requires more than clinical care. It requires sustained behavioral engagement, emotional resilience, and adherence to prevention and treatment plans. This project addresses the opportunity to deploy scalable, mobile-first digital tools that support chronic disease self-management and behavioral resilience. GGC will serve as the Prime Integrator, responsible for program governance, implementation coordination, Tribal engagement, evaluation metrics, reporting, and alignment with Alaska’s Rural Health Transformation Program priorities. AffirmedYou LLC will provide the Inner Journey App and REACH+ AI platform, which deliver neuroscience-based mental fitness tools, AI-enabled emotional support guidance, and personalized recommendations, and expand access to digital prevention and self-management tools.	This initiative deploys an AI-enabled digital platform designed to strengthen chronic disease self-management and behavioral resilience across rural Alaska. Guidance Global Consulting (GGC) will serve as the Prime Integrator responsible for program management, governance design, Tribal engagement coordination, implementation oversight, evaluation metrics, and reporting. GGC will coordinate with Tribal Health Organizations, regional health systems, and state partners to ensure alignment with Alaska’s Rural Health Transformation Program initiatives. AffirmedYou LLC will serve as the solutions partner, providing the Inner Journey App and REACH+ AI platform. The Inner Journey App delivers neuroscience-based mental fitness and behavioral support tools that help individuals manage stress, strengthen resilience, and sustain healthy habits that support chronic disease management. Participants enroll through mobile access and receive AI-enabled guidance, mental fitness exercises, and behavioral support tools designed to strengthen resilience, emotional regulation, and personal well-being. The platform also integrates biofeedback and resilience tracking. Where applicable, biometric indicators such as heart rate variability and stress indicators can be incorporated to provide deeper insight into individual well-being trends. The REACH+ AI enterprise layer integrates biometric analysis, psychometric readiness assessment, and AI-generated development pathways. These personalized recommendations support improvements in resilience, sleep, cognitive performance, and behavioral adherence. In addition to individual support tools, the platform generates aggregated community-level dashboards that provide insight into engagement patterns, resilience trends, and adoption levels across participating populations. These insights support population health management by helping organizations understand behavioral engagement trends and identify areas where additional support may improve chronic disease outcomes.	\$1M-\$5M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Guidance Global Consulting Inc.	Alaska AI Community Health Workforce Extender Initiative	MD	Alaska faces a major challenge in healthcare delivery, driven by constraints related to people, time, and geographic access. Approximately 39% of Alaska’s population resides in a federally designated Health Professional Shortage Area (HPSA), covering 96% of the state’s land area. Approximately 28% of Alaska residents live in designated mental health professional shortage areas, and many boroughs have extremely limited access to primary care physicians. At the same time, Alaska’s healthcare workforce faces substantial shortages. The state’s health care industry is projected to require more than 9,400 new healthcare workers annually due to high demand and workforce turnover. These challenges are particularly acute in rural and Tribal communities where access to behavioral health services, primary care, and social support services is limited by geography, workforce supply, and infrastructure. This project addresses the opportunity to expand healthcare access through an AI-enabled healthcare workforce extender model. GGC will serve as the prime integrator responsible for program governance, implementation coordination, Tribal engagement, evaluation metrics, reporting, and alignment with Alaska’s Rural Health Transformation Program priorities. HumAlnity.AI provides an artificial intelligence platform that functions as a healthcare workforce extender, allowing healthcare professionals to support thousands of individuals simultaneously via phone, video, text message, and chat.	This initiative introduces an AI-enabled healthcare workforce extender model designed to expand access to healthcare across Alaska’s rural and Tribal communities. GGC will serve as the Prime Integrator responsible for program management, governance design, Tribal engagement coordination, implementation oversight, evaluation metrics, and reporting. GGC will coordinate with Tribal Health Organizations, the Alaska Department of Health, and regional partners to ensure the project aligns with Alaska’s Rural Health Transformation Program initiatives. HumAlnity.AI will serve as the solutions partner, providing the AI healthcare extender platform. HumAlnity.AI is an artificial intelligence system designed to function as a healthcare workforce extender, similar to how Physician Assistants or Medical Assistants extend the work of physicians. The system enables healthcare professionals to support individuals at any time through phone, video conference, text message, and chat in the ten most common languages spoken in the world, covering approximately 97% of the languages spoken at home by residents in Alaska. HumAlnity.AI has been certified in California as a Community Healthcare Worker (CHW) and Community Mental Health Worker (CMHW). These roles serve as trusted intermediaries between communities and healthcare systems by providing culturally appropriate health education, care navigation, social support, and connections to services such as transportation, housing, and food assistance. Community Health Workers have demonstrated strong impact in reaching underserved populations, reducing disparities, and lowering emergency room visits. The HumAlnity AI extender model allows healthcare professionals to scale these services significantly by enabling a single workforce member to support thousands of individuals simultaneously. The platform also addresses behavioral health needs. Community Mental Health Workers provide support to individuals with mental health conditions by conducting assessments, supporting care planning, facilitating resources, and offering crisis support. According to the Alaska Behavioral Risk Factor Surveillance System, approximately 66% of Alaska adults experience at least one social determinant of health risk factor, while nearly 20% experience four or more. AI-enabled healthcare workforce extenders can improve access to care while supporting Alaska’s efforts to expand community health workers and strengthen rural healthcare delivery.	\$1M-\$5M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Guidance Global Consulting Inc.	Alaska AI Workforce Balance & Access Stabilization Initiative	MD	Alaska’s rural and frontier healthcare systems face persistent workforce instability driven by geographic isolation, limited staffing pools, weather disruptions, and administrative inefficiencies. These challenges are particularly acute in small rural and Tribal health facilities where even a single vacancy can disrupt entire service lines. Manual scheduling processes further compound workforce strain by creating coverage gaps, increasing overtime, administrative burden, and reliance on premium labor or temporary staffing. Workforce volatility directly affects access reliability in rural communities, particularly for emergency services, maternal health, behavioral health, and critical inpatient services, and stabilizes rural healthcare access through AI-enabled workforce scheduling optimization. GGC will serve as the Prime Integrator responsible for program governance, Tribal engagement coordination, evaluation metrics, reporting, and alignment with Alaska’s Rural Health Transformation Program priorities. Duality Systems provides the Balance Scheduler platform, an AI-enabled workforce optimization tool designed to automate complex scheduling processes, improve workforce stability, and reduce administrative burden in hard-to-staff environments. Together, this initiative strengthens workforce stability, improves service coverage reliability, and supports long-term fiscal sustainability across rural and Tribal health systems in Alaska.	This initiative deploys an AI-enabled workforce scheduling optimization platform integrated with GGC’s rural health transformation framework. GGC will serve as the Prime Integrator responsible for program management, governance design, Tribal engagement coordination, implementation oversight, evaluation metrics, and reporting. GGC will coordinate with rural hospitals, Tribal Health Organizations, and regional health partners to ensure alignment with Alaska’s Rural Health Transformation Program initiatives. Duality Systems will serve as the solutions partner, providing the Balance Scheduler workforce optimization platform. The initiative begins with a workforce baseline and transformation assessment led by GGC. This assessment evaluates staffing variability, vacancy risk patterns, overtime utilization, and coverage gaps across service lines. Baseline operational metrics will be established to support ongoing evaluation of workforce stabilization outcomes. Following the baseline assessment, Duality will configure and deploy the Balance Scheduler platform across participating facilities. The system automates schedule generation while ensuring credential and skill-mix compliance, workforce preference integration, and real-time disruption management. Automated scheduling dramatically reduces the administrative time required to build schedules, allowing leaders to focus on patient care coordination and operational management. The platform also generates workforce analytics and operational dashboards tracking key performance indicators including schedule build time, coverage reliability, disruption response time, fairness distribution across staff schedules, overtime utilization, and administrative time avoided. GGC will integrate these operational improvements into broader workforce stabilization and governance frameworks, ensuring that scheduling optimization translates into measurable improvements in access, workforce retention, and fiscal sustainability.	\$1M-\$5M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Guidance Global Consulting Inc.	Alaska RHTP Implementation, Quality Improvement, and Performance Management Support	MD	The Alaska RHTP represents a historic investment to improve access, quality, coordination, and sustainability of healthcare services across Alaska’s rural and frontier communities. Successfully translating this investment into measurable improvements in health outcomes requires strong program design, implementation support, evaluation infrastructure, and coordinated engagement with healthcare providers, Tribal Health Organizations, and community stakeholders. Rural and Tribal health systems operate within complex environments that include geographic isolation, workforce shortages, fragmented care coordination, and financial pressures on critical access providers. These challenges require transformation initiatives that are grounded in data, aligned with community priorities, and supported by strong governance and performance monitoring systems. Guidance Global Consulting (GGC) proposes to support the Alaska Community Foundation and the Alaska Department of Health as a strategic advisory and program management partner to strengthen the implementation of the Rural Health Transformation Program. Drawing on deep experience designing and leading large federal healthcare transformation programs, GGC will support program planning, stakeholder engagement, performance measurement, evaluation, and continuous improvement to ensure that RHTP investments translate into sustainable improvements in access, quality, and health outcomes for rural and Alaska Native communities.	GGC will serve as an independent program management, quality improvement, and strategic advisory partner supporting the Alaska Community Foundation and the Alaska Department of Health in implementing the Rural Health Transformation Program. GGC’s approach focuses on strengthening the infrastructure required to translate funding investments into measurable improvements in healthcare delivery and population health outcomes. The work will begin with program design and alignment activities that support implementation of the six RHTP initiative areas. This includes developing implementation frameworks, performance management structures, evaluation plans, and reporting mechanisms that align project investments with statewide health priorities. GGC will support the development of performance metrics and evaluation frameworks that track progress across key indicators, including access to care, workforce capacity, quality improvement outcomes, care coordination effectiveness, and financial sustainability for rural providers. A core component of the work will be stakeholder engagement and collaboration across Alaska’s healthcare ecosystem, including engagement with rural hospitals, Tribal Health Organizations, community providers, public health agencies, and community-based organizations. The GGC team has significant experience working with diverse provider types across the healthcare system, including hospitals, physician practices, behavioral health providers, community health centers, and long-term care providers. We will also support learning collaboratives and technical assistance to participating organizations, helping providers adopt best practices in care delivery, quality improvement, data reporting, and operational transformation. GGC’s team brings significant experience from the CMS, where senior leaders managed and implemented national healthcare programs impacting more than 65 million Medicare and Medicaid beneficiaries. This experience includes oversight of federal healthcare portfolios exceeding \$6 billion, including national quality improvement programs, rural health initiatives, and programs supporting American Indian and Alaska Native populations. Through this initiative, GGC will support Alaska’s RHTP by strengthening program governance, ensuring rigorous evaluation and reporting, facilitating stakeholder collaboration, and helping ensure that transformation investments achieve measurable and sustainable improvements in health outcomes.	\$1M-\$5M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Guidance Global Consulting Inc.	Alaska Rural Data Modernization and Program Integrity Acceleration Initiative	MD	Rural healthcare providers in Alaska face fragmented data systems, manual medical record retrieval, and increasing federal documentation requirements that strain limited administrative capacity. In a largely fee-for-service Medicaid environment, payment accuracy, audit defensibility, and efficient record processing are critical to the financial stability of rural facilities that cannot absorb improper payment recoupments or penalties. Critical Access Hospitals and Tribal Health Organizations often lack the workforce and digital infrastructure to manage high-volume documentation. Many providers rely on paper and fax-based record submission due to limited broadband and EHR capabilities. These challenges result in delayed reimbursements, increased risk of improper payments, reduced audit defensibility, and staff time diverted from patient care. Commence leverages AI-powered record ingestion, classification, and automated outreach to digitize and organize medical records at scale. These capabilities streamline workflows, improve claims review accuracy, reduce administrative burden, and enhance documentation defensibility. Applied in Alaska’s fee-for-service and cost-based environment, the platform strengthens payment accuracy, frees staff for patient care, and supports long-term fiscal sustainability without requiring immediate adoption of risk-based payment models.	This initiative deploys Commence’s AI-powered medical record platform to digitize, classify, and connect medical records and claims data across Alaska’s rural provider ecosystem—enabling structured, review-ready data exchange without requiring providers to upgrade existing infrastructure. Commence’s platform ingests records from every submission modality: fax, mail, secure portal, electronic fax, API, and Health Information Exchange connections. This multi-path design is essential in Alaska, where many rural and frontier providers rely on legacy channels. Records are automatically ingested, classified by type—discharge summaries, lab results, physician orders, operative notes—de-duplicated, and delivered as standardized digital records. File processing times have dropped from roughly one hour to 380 seconds, a 9.5-fold increase, and medical record retrieval timelines have been reduced by over 75 percent in federal deployments. More than 16,000 FTE hours per year have been reclaimed through automation. For fee-for-service Medicaid providers, the platform enhances improper payment analytics, documentation defensibility, and workflow efficiency. Structured data outputs align provider records with coverage policies, reducing billing errors and audit exposure. For Critical Access Hospitals under cost-based reimbursement, automation reduces administrative burden and modernizes medical records, reclaiming staff time for patient care. For Tribal Health Organizations under the All Inclusive Rate, the focus is on documentation accuracy, audit preparedness, and secure data modernization. Tribal governance is addressed through consent frameworks and data-use agreements developed with each Tribal entity. The platform enforces role-based access, HIPAA-compliant data handling, and deployment on AWS GovCloud, meeting the security and privacy needs of sovereign Tribal data environments. Guidance Global Consulting serves as an integrator, ensuring the deployment model aligns with Alaska’s reimbursement landscape: fee-for-service Medicaid—improper payment analytics and workflow efficiency; cost-based Critical Access Hospitals—administrative cost reduction and record modernization; Tribal Health Organizations—documentation accuracy, audit preparedness, and secure data modernization while respecting Tribal governance.	\$1M-\$5M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Guidance Global Consulting Inc.	Alaska Rural Revenue Cycle Stabilization and Fiscal Sustainability Initiative	MD	Rural providers in Alaska face persistent operational challenges, including delayed reimbursements, denied claims, documentation gaps, limited administrative staffing, and high overhead in geographically isolated communities. In fee-for-service and cost-based environments, even modest revenue leakage materially affects sustainability. Independent medical practices and small rural facilities often lack advanced analytics, structured denial tracking, and proactive revenue integrity processes. For Tribal Health Organizations operating under the All Inclusive Rate model, documentation accuracy and compliance remain essential for audit defensibility and federal reporting. Our Solutions make independent medical practices thrive, not just survive, and operate under a results-based pricing model in which the company is not paid unless its clients are paid [CiBR Solutions Mission and Vision]. This model aligns incentives with rural providers and ensures a focus on measurable improvements in collections.	The initiative begins with a comprehensive, complimentary assessment of participating providers to identify revenue leakage, denial trends, documentation gaps, coding issues, and workflow inefficiencies. Based on the findings, we will develop a tailored revenue cycle improvement plan that addresses billing optimization, denial reduction, coding accuracy, and collections enhancement. Our billing services operate on a percentage-of-collections basis, aligning payments with actual revenue performance and incentivizing the maximization of legitimate reimbursement. Pricing varies based on the volume of claims, the size of the practice, and the complexity of cases, ensuring right-sized engagement for rural facilities. We monitor industry-standard KPIs and provide monthly one-on-one consultations to review performance trends, denial rates, collections cycle times, and recommend corrective actions [CiBR Solutions Mission and Vision]. This structured oversight strengthens accountability and continuous improvement. GGC, as Integrator, ensures that revenue cycle improvements align with Alaska’s broader RHTP fiscal sustainability goals. For fee-for-service Medicaid providers, the emphasis is on improving clean-claim rates, reducing denials, and accelerating reimbursement timelines. For Critical Access Hospitals operating under cost-based reimbursement, the emphasis is on reducing administrative overhead and strengthening the integrity of cost reporting. For Tribal Health Organizations operating under the All Inclusive Rate model, emphasis is placed on documentation defensibility, compliance alignment, and audit preparedness. GGC will coordinate cross-provider learning collaboratives, ensure alignment with the principles of voluntary RHTP participation, and integrate revenue cycle performance metrics into broader RHTP reporting frameworks.	\$250K-\$1M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Guidance Global Consulting Inc.	Alaska Rural Workforce Optimization and Readiness Intelligence Initiative	MD	Alaska’s Rural Health Transformation Program identifies Strengthen Workforce, Spark Technology and Innovation, and Pay for Value Fiscal Sustainability as core initiatives required to stabilize rural health systems across the state. The RHTP framework recognizes workforce shortages, geographic isolation, and operational strain as central barriers to sustaining healthcare delivery in rural, remote, and frontier communities. Rural healthcare providers face persistent recruitment and retention challenges. Workforce instability contributes to service disruptions, increased costs, and reduced access to care. While many workforce strategies focus on recruitment pipelines and financial incentives, long-term stability also requires addressing burnout, stress, and operational strain affecting frontline healthcare staff. Traditional workforce wellness programs rely on periodic surveys that provide limited insight into real-time workforce conditions. This initiative addresses the opportunity to establish a workforce readiness and resilience intelligence infrastructure that allows healthcare organizations to monitor workforce wellbeing, prevent burnout, and improve workforce performance. Guidance Global Consulting (GGC) will serve as the prime integrator responsible for program governance, implementation coordination, Tribal engagement, evaluation metrics, reporting, and alignment with Alaska Rural Health Transformation Program priorities.	This initiative deploys an AI-enabled workforce readiness intelligence platform designed to strengthen healthcare workforce resilience and operational performance across rural and Tribal health systems. Guidance Global Consulting (GGC) will serve as the Prime Integrator responsible for program management, governance design, Tribal engagement coordination, implementation oversight, evaluation metrics, and reporting. GGC will coordinate with Tribal Health Organizations, regional health systems, and state stakeholders to ensure alignment with Alaska’s Rural Health Transformation Program initiatives. AffirmedYou LLC will serve as the solutions partner, providing the REACH+ AI human performance and workforce readiness platform. REACH+ AI is a ten-module enterprise platform that combines biometric analysis, psychometric readiness assessment, and AI-driven coaching to improve workforce resilience, performance, and well-being. The system generates continuous readiness intelligence using biometric signals, including voluntary wearable integration, along with psychometric indicators that measure stress, resilience, engagement, and performance readiness. Participating workforce members complete an onboarding process including a structured biofeedback assessment across multiple wellness and human performance dimensions. These assessments generate individualized readiness profiles. The system analyzes biofeedback indicators such as heart rate variability and stress regulation, and produces AI-generated development pathways designed to improve resilience, sleep quality, cognitive performance, and stress management. In addition to individual development tools, the platform generates aggregated organizational dashboards that provide leadership teams with anonymized readiness intelligence across workforce populations. These dashboards allow healthcare organizations to monitor workforce stress levels, burnout indicators, engagement trends, and resilience improvements over time. By combining individual development tools with organizational intelligence dashboards, the initiative allows healthcare organizations to identify emerging workforce risks earlier and implement targeted interventions that improve workforce stability.	\$1M-\$5M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Guidance Global Consulting Inc.	Alaska Tribal Health Workforce & Quality Transformation Initiative	MD	Alaska’s RHTP identifies six statewide initiatives designed to improve access, strengthen workforce capacity, modernize infrastructure, and advance fiscal sustainability across rural and Tribal health systems. Each initiative requires workforce readiness to successfully implement transformation priorities such as alternative payment models, population health infrastructure, telehealth and digital systems, chronic disease management programs, and maternal and behavioral health services. Tribal health systems are central to rural care delivery in Alaska. However, workforce shortages, geographic barriers, and increasing administrative and performance expectations create significant implementation challenges. GGC, serving as the prime integrator, will coordinate implementation, governance, evaluation metrics, reporting, and alignment with Alaska RHTP priorities. GGC will work directly with Tribal Health Organizations and Tribal leadership to ensure culturally appropriate implementation and alignment with Tribal governance structures. NAHQ will provide the workforce competency infrastructure and training solutions needed to strengthen healthcare quality, safety, and performance-improvement capabilities across Tribal health systems. Together, this initiative supports the workforce capacity necessary for Tribal health systems to successfully implement RHTP initiatives and translate transformation investments into sustainable improvements in access, quality, and fiscal stability.	This initiative establishes a structured Tribal workforce competency and quality infrastructure aligned with Alaska’s Rural Health Transformation Program. GGC will coordinate with the Alaska Department of Health, Tribal Health Organizations, and regional partners to advance the statewide transformation goals while respecting Tribal governance and operational models, and to support performance tracking across participating organizations. NAHQ will serve as the solutions partner, providing workforce competency frameworks, training programs, and tools for healthcare quality capability development. First, the project will deploy NAHQ’s Healthcare Quality Competency Framework™ to assess workforce capabilities across participating Tribal Health Organizations. This nationally validated framework defines the domains and skills required for high-functioning quality systems. Assessments will identify gaps in quality and safety capabilities, data and performance improvement readiness, leadership development needs, and readiness to participate in value-based care models. The proposed pilot will include approximately 100 participants representing key quality and safety leaders across regions, followed by broader expansion to clinical and leadership teams in Year 2. Second, the project will implement HQ Concepts, a one-hour online foundational course that provides baseline knowledge of healthcare quality and creates a shared vocabulary across teams. This course supports frontline clinical and non-clinical staff across Tribal clinic sites by strengthening their understanding of quality improvement and patient safety principles. Third, the project will deploy HQ Principles, a six-hour certificate program for quality and clinical leaders that introduces core quality and patient safety principles, performance improvement methodologies, and structured pre- and post-assessments. Fourth, the initiative will support value-based care and fiscal sustainability readiness through education, benchmarking literacy, and change management support. GGC and NAHQ will assist Tribal organizations in aligning workforce competencies with participation in alternative payment models and sustainable care delivery models. Finally, the initiative will embed quality governance across Tribal health organizations by integrating competency-based quality and safety roles across leadership, clinical, and operational teams, strengthening organizational capacity for system-wide improvement.	\$1M-\$5M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska- Susitna Borough	Deferred or Not Advanced

Guidance Global Consulting Inc.	Interior Alaska Rural Mobile Care Extension Hub (MIHCP + Primary Care + CAH Transitions)	MD	Rural and frontier communities in Alaska face persistent barriers to accessing coordinated health services, particularly for individuals with complex care needs, chronic disease, behavioral health conditions, and social risk factors. Some Health systems operate in silos, creating gaps in care coordination across emergency medical services, hospitals, primary care, behavioral health providers, and community-based services. These challenges contribute to avoidable hospitalizations, delays in care transitions, and limited follow-up care for high-risk individuals. Mobile Integrated Health and Community Paramedicine (MIHCP) models offer an opportunity to improve access to care and coordination by extending the reach of the healthcare workforce into homes and communities. However, MIHCP programs require reliable technology infrastructure to manage referrals, coordinate services, document encounters, and track outcomes across many organizations. It's an opportunity to establish a rural mobile care extension hub supported by interoperable care coordination technology. GGC will serve as the strategic integrator, enabling Tribal engagement coordination, evaluation metrics, reporting, and alignment with Alaska's RHTP priorities. Julota will provide the care coordination platform that enables community-based care teams, paramedics, and healthcare providers to coordinate services, manage workflows, document care activities, and generate reporting across participating organizations.	The project will establish a Rural Mobile Care Extension Hub designed to support care coordination across emergency services, primary care providers, hospitals, and community-based organizations in rural Alaska. Guidance Global Consulting (GGC) will serve as the program integrator responsible for program governance, implementation coordination, Tribal engagement, performance measurement, and reporting. GGC will also support alignment with Alaska Rural Health Transformation Program priorities and ensure integration across participating healthcare organizations and Tribal health partners. Julota will provide the cloud-based care coordination technology platform that supports workflow management, documentation, referrals, and reporting across participating providers and care teams. The Julota platform enables healthcare providers and community organizations to coordinate services through shared case management workflows. It supports referrals between providers, documentation of patient encounters, care plan tracking, and reporting on services delivered. Through the platform, care teams, including paramedics, community health workers, and other providers, can document interactions with patients in real time and share information across participating organizations. This improves communication across providers and reduces fragmentation in care delivery. The initiative will support Mobile Integrated Health and Community Paramedicine programs by providing a centralized system to track patient engagement, coordinate follow-up care, and document care transitions from hospitals and emergency services to community-based care. Guidance Global Consulting will also support program monitoring and evaluation by establishing performance metrics, reporting processes, and oversight structures for implementation. This includes tracking utilization, care coordination activity, and service delivery metrics. The initiative will also incorporate engagement with Tribal Health Organizations and input from the GGC Tribal Advisory Board to ensure the model aligns with the needs and governance structures of Tribal health systems.	\$1M-\$5M	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Guidepost Pediatric Therapies and Educational Services	Integrated Rural Rehab and Healthy Communities Hub: Expanding Access	AK	GuidePost Pediatrics has experienced these workforce challenges firsthand. Recruiting/retaining talented clinicians in Wasilla—a community technically considered "urban" under some federal definitions but in reality a frontier environment serving vast rural catchment areas has been successful in many ways and challenging in others. With the help of the RHG, and creative strategies, competitive compensation, robust professional development, and a supportive workplace culture, we will increase the workforce. GPTES seeks to address critical gaps in pediatric behavioral/ occupational therapy services in the Mat-Su Borough and surrounding rural regions of Alaska when children discharge from in-patient facilities. Without timely intervention and coordinated care, these children face increased risks of academic struggles, emotional distress, and long-term health disparities. These workforce shortages create delays in care that can significantly impact child development. GPTES seeks to address this workforce challenge through targeted workforce development strategies designed to increase the number of clinicians trained in pediatric occupational therapy and behavioral health services. These strategies include clinical training partnerships with universities, mentorship programs for early-career providers, continuing education opportunities, and telehealth-supported supervision models. Technology partnership that are already developing support app that extend care.	Pediatric health needs among children in the Mat-Su region and across the state have increased significantly in recent years. Schools, peds providers, and families report growing concerns related to anxiety, trauma exposure, emotional regulation challenges, attention difficulties, and behavioral disorders. Pediatric BH requires specialized training in child development, family systems, trauma-informed care, and behavioral intervention strategies. Without providers trained in these areas, families often struggle to find appropriate support for their children. Without appropriate intervention, these challenges can interfere with school success, peer relationships, and family functioning. GPTES addresses these needs through three prong approach: workforce development, technology support, and healthy and early intervention with integrated pediatric behavioral health services. We are seeking to expand these services through our already-designed, extensive workforce development plan and renovation. Providers collaborate with occupational therapists and other clinicians to address the complex interplay among emotional regulation, sensory processing, and developmental challenges. Telehealth services further expand access to BH support for families living in rural areas. By reducing travel barriers and increasing appointment availability, telehealth allows families to access behavioral health services more consistently. Expanding pediatric behavioral health capacity in the Mat-Su region when we launched four years ago already has improved early intervention, reduce school disruptions, and strengthen family resilience. With 207 referring providers, and multiple social work and tribal networks and with our large presence in multiple schools, we are meeting needs that would not have otherwise been met. Through sensory integration strategies, play-based therapy, and skill-building activities, occupational therapists help children build the neurological and motor foundations required for successful participation in daily life. GPTES seeks to expand occupational therapy access by increasing provider capacity, developing telehealth service models, and strengthening interdisciplinary collaboration between occupational therapists and BH providers. Our Integrated care model enables all therapists to collaborate to address complex challenges. We have already designed a renovation to an exsisting building that adds housing to our facility for new providers.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

H.O.P. E. (Helping Ourselves Prevent Emergencie s)	Exam Room for Survivors of Sexual Assault	AK	HOPE will solve the problem of survivors needing to leave their homes on Prince of Wales to travel to a different community to obtain a sexual assault forensic exam after they have already experienced a life-changing, traumatic violation, which contributes to suicidal ideations, substance abuse, and chronic diseases in those who have been victimized. Creating a new examination space on the Island that would always be available for use improves access to healthcare, encourages partnerships, and invests in rural community programs to ensure the availability of remote care services.	HOPE plans to renovate one of the rooms in the current office space to become a dedicated exam room. The room has cabinetry included, but they may need to be removed to allow enough space for an exam table and necessary exam equipment. HOPE will furnish the room with the most sterile flooring available and purchase equipment for the room, such as an exam table, a culposcope, sinks, stools, and supply organizers. The room is already in a private area, and the door can be locked for safety as well.	\$50,000- \$250,000	Multi- Community or Participating in Regional Hub-and- Spoke	Prince of Wales- Hyder Census Area	Deferred or Not Advanced
Haa Tóoch Lichéesh	Náakw wooch jeex_ tootee / We give each other medicine- Connecting Traditional Healers Across Alaska	AK	Across rural Alaska, many communities lack access to culturally relevant preventative and behavioral health supports that reflect Indigenous knowledge, community relationships, and traditional healing practices. Alaska Native people were 91% more likely to die by suicide than the U.S. population overall and behavioral health provider shortages affect over 75% of rural communities, leaving critical gaps in culturally relevant care. Geographic isolation, limited provider availability, and health systems that often fail to reflect Indigenous cultural knowledge leave communities without trusted pathways for healthcare and healing. For generations, colonization and assimilation policies—including government-run boarding schools—disrupted Alaska Native healing knowledge by suppressing cultural practices and separating communities from traditional healing systems. These disruptions continue to affect community health today, contributing to behavioral health challenges, substance use, and chronic disease. At the same time, traditional healers across Alaska continue to carry knowledge that supports cultural connection, resilience, and preventative approaches to wellness. However, many practitioners work in isolation with limited opportunities for mentorship, training, or coordination. Strengthening networks of traditional healers represents an important opportunity to expand culturally grounded prevention and behavioral health supports while strengthening the rural health workforce.	Haa Tóoch Lichéesh will establish a Southeast Alaska Regional Healers Cohort weaving together healing, development, mentorship, and community service into a regenerative, self-sustaining system. The cohort will launch with intergenerationally structured Southeast Alaska community teams connected through regular in-person training and healing gatherings, quarterly virtual gatherings, and an online message board. Skill development will focus on circle facilitation, peacemaking, traditional foods, and rites of passage, alongside certification opportunities including Somatic Experiencing International. Cohort members will receive priority access to all training opportunities, with limited additional scholarships available to other Alaska-based practitioners when space allows. Members will receive business planning and financial systems support through SpruceRoot, and website and storytelling development through Cedar Group. Community teams will access implementation funds supporting mentor stipends, youth apprenticeship wages, medicine harvesting materials, and community programming — advancing community sovereignty while providing preventative and restorative care. Teams will map local healing and behavioral health resources, strengthen referral pathways, and develop shared protocols for ethical practice. Sustainability models under exploration include a healer support call line, a plant medicine cooperative, shared physical spaces, and fee-for-service training offerings. Cohort structure, learnings, and resources will be compiled and shared with other Alaskan regions to support program replication. Complementing the cohort, key statewide partnerships will advance culturally grounded care across Alaska. Kaasei Indigenous Foodways will coordinate a statewide plant medicine learning network, and together with the Kayaani Sisters, will host annual statewide plant medicine symposiums and train-the-trainer intensives. This partnership will also advance Alaska-based plant medicine curriculum and educational resources, while exploring longer-term training pathways for practitioners seeking deeper study in traditional practices. Snow Creek Medicine will develop infrastructure supporting healer sustainability statewide, including healer gatherings, a cooperative, and a call line.	\$250K-\$1M	Multi- Community or Participating in Regional Hub-and- Spoke	Anchorage (Municipality); Bethel Census Area; Haines Borough; Hoonah- Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

Haa Tóoch Lichéesh	Wooch yei tusnéxch / We heal each other- Elder-Led Boarding School Healing and Cultural Restoration	AK	The boarding school era disrupted language, culture, and family systems across Alaska Native communities. Today, every Alaska Native family continues to experience the intergenerational impacts of forced assimilation, cultural suppression, and separation from land and kin. Boarding school attendees had a 44% greater count of chronic physical health problems as adults compared with nonattendees. Many Elder boarding school survivors carry unresolved trauma with limited opportunity for culturally grounded healing. Rural health systems remain largely clinical in structure and are not designed to address the collective and intergenerational dimensions of this harm. Survivors often navigate healing in isolation, while community leaders working to return the remains of loved ones from boarding school sites carry complex emotional labor without coordinated support. Cultural knowledge and practices intentionally interrupted by boarding school policies are rarely integrated into prevention and behavioral health systems. Opportunities for Elders to share knowledge and for families to reconnect through cultural practice are limited by geographic isolation and resource inequities across rural communities. There is a critical opportunity to strengthen rural health transformation by building Elder-led, culturally grounded trauma healing infrastructure in Southeast Alaska—reducing isolation among survivors while restoring intergenerational pathways for cultural learning and community healing.	This project will establish a pilot Elder-Led Boarding School Survivor Healing Initiative in Southeast Alaska designed to build culturally grounded trauma-healing infrastructure that can expand across rural communities over time. 1. Survivor Healing Cohorts We will partner with 3–5 Southeast Alaska communities to establish locally led healing cohorts for boarding school survivors and directly impacted Elders. Each community will identify two compensated local leaders who will host structured gatherings grounded in cultural practice, storytelling, and collective grief tending. Haa Tóoch Lichéesh Coalition will provide coordination, facilitation support, and a shared framework while honoring each community’s cultural context. Quarterly virtual gatherings will connect the cohorts, strengthening regional connection and reducing isolation among Elders living in geographically dispersed communities. 2. Return-of-Remains Support and Coordination Circle Leaders engaged in efforts to return the remains of loved ones from boarding school sites and museum collections will participate in a quarterly virtual support circle. Lessons learned and emerging needs will inform longer-term coordination infrastructure for boarding school healing efforts across the region. 3. Cultural Restoration Mapping Through relationship-centered conversations with participating Elders, the initiative will document cultural gifts, interrupted learning, and areas of interest for skill restoration. This work will help identify opportunities for mentorship, knowledge sharing, and culturally grounded prevention strategies that strengthen protective factors for future generations. 4. Regional Elder Cultural Restoration Gathering In Year 2, the initiative will convene a regional gathering focused on reclaiming language, cultural practices, and knowledge that many survivors were prevented from learning during the boarding school era. 5. Elder Master-Apprenticeship & Knowledge Documentation As cultural knowledge and gifts are identified, participating Elders will have the ability to self-select into a compensated Master-Apprentice model of knowledge sharing with a local non-Elder community member. Apprentices would gain and document Elder traditional knowledge, following clan and tribe protocols for knowledge sharing. Together, these activities establish a scalable model for integrating culturally grounded trauma healing into rural behavioral health and prevention systems over a five-year arc.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Haida Canoe Revitalization Group	Transforming Community Wellbeing Through Cultural Competition	AK	The problem is that our community and neighboring communities across our region, and beyond, are struggling, and failing, to maintain anywhere near optimal mental and physical wellbeing. Drugs, alcohol, and behavioral health issues are rampant and chronic. Low self, as well as low community, esteem is prevalent and destructive across our region. There are many reasons for this. We are immersed in cultural trauma, identity uncertainty, career path confusion, alcohol & drug misuse, lack of purpose, economic uncertainty, underfunded schools, etcetera. The opportunity is that the RHTP grant timing is very good, we have the right people and organizations in the right places to make this project successful. With proper funding we can bring these people together to create a team which promotes healthy lifestyles using culturally appropriate community education, initiating a significant improvement in the lives of people in the Southeast region. In the foreseeable future we can also strengthen bonds with other regions. The people of the Southeast Region can really be empowered in a way that develops, physical, mental & emotional health, social connection, purpose & meaning. For the youth, a sense of identity can develop as an inner strength that will carry them through the most challenging of times for the rest of their lives.	The approach to this project is to bring potential affiliates together for discussions, identifying who is most suited to accomplish the various elements of work involved. We will hire several people, as well as incorporate students, to build traditional style canoes of combined natural and synthetic materials. There will be a focus on safety, quality, and beauty for an enhanced feeling/experience. These canoes will initially be distributed among 9 schools and 4 Federally Recognized Tribes on, or near, Prince of Wales island. An annual competitive multiday, traditional canoe inspired event will be hosted in Kasaan on Prince of Wales island. Schools, health organizations, tribes, individuals, and others will come together to compete, observe, play, network, relax, eat, bond, develop purpose, etcetera. Competitive events will be encompassing. They will include things such as single and team canoe racing, canoe tug of war, stunt canoeing, best looking canoe, etcetera. For participants less inclined to get involved in physical events, there will be competitive canoe academic sports such as canoe engineering/architectural design challenges, artistic design, etc. Challenges will include (but are not limited to) engineering, physics, hydrodynamics, etc. Throughout the event there will be health & wellbeing experts incorporating their knowledge and expertise, making the event an optimal pathway to wellbeing. The expertise range will be broad, it will encompass many areas of health and wellbeing, including but not limited to drug & alcohol prevention and recovery. There will be canoe making instruction and demonstration empowering more people get involved. Water safety courses prepare people for a variety of situations they may encounter during their lives in Southeast Alaska. In successive phases, canoes will be supplied to schools and tribes that are neighboring, yet distant from Prince of Wales island (a hub and spoke growth pattern). This will include teaching more people to make their own canoes. Each year the event will grow and reach further, it may even inspire replica events in other communities.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Haines Borough	Haines Wellness Initiative	AK	Mental health is an issue in Haines. We had 10 Title 47 involuntary commitments (emergency psychiatric holds) in 2025. One cell in the jail is stripped of furniture. Involuntary holds sleep on a mattress on the cement floor in a bare jail cell. We average 3 suicides every year, or 150 suicides per 100,000 people. This is 5.3 times higher than the Alaska rate of 28.2 per 100,000 and 11 times the national rate. Our suicides include people over 65. One-third of our community is over 65. The Haines Senior Center, designed for Seniors and Disabled gatherings, is used only a few hours each week. According to the National Council on Aging, adults over 65 have high suicide rates due to loneliness, sickness, and despair. With few opportunities for Seniors and Disabled to congregate, social isolation is prevalent in Haines. The Haines Pool is the number one public space for wellness activities during winter months, hosting over 300 people (15% of Haines) per week. It has large windows, bright lights, and tropical foliage, making it popular for light therapy during dark days. However, the ventilation system is 40 years old and doesn't meet today's standards for pools. In poorly ventilated natatoriums, chloramines become trapped in the air just above the water surface – exactly where swimmers breathe. Chloramine buildup causes severe respiratory, eye, and skin irritation. High humidity from poor pool ventilation causes poor air quality, mold, condensation and structural deterioration.	Haines Borough plans to launch The Haines Wellness Initiative as a cross-community effort to reduce suicides and mental health holds and improve happiness in Haines.. 1. Create a collaborative Haines Wellness Initiative group with healthcare providers, school staff, tribes, therapists, disability advocates, and first responders to outline health innovation projects, guide program choices, identify at-risk individuals, and advocate to destigmatize mental health issues within the community. 2. Develop 3 pilot projects that build and expand resources and track participants' mental health changes. Monitoring mental health changes will be done in collaboration with the local clinic and therapists. Pilot Project #1: Create a mental health hold room that looks less like confinement and more like a safe space. Mental health rooms are specialized, secure spaces designed for safety, comfort, and, in crisis situations, preventing self-harm. They feature anti-ligature fixtures, break-resistant materials, soft, calming colors, and 24-hour monitoring. To promote healing, these quiet rooms include ample natural light, art, and comfortable furniture for a non-institutional, calming atmosphere. We will provide staff training in crisis intervention, de-escalation, empathy building, mental health first aid, behavioral health, and mindfulness-based resilience. Pilot Project #2: Improve community-wide mental and physical health through expanding the use and capabilities of the pool and staff. First, improve air quality by replacing the HVAC and ventilation system, doubling air exchange to meet modern requirements, reducing chloramine and controlling humidity. Creating a healthy, safe, enjoyable indoor pool requires powerful air handling systems. Second, increase hours of operation and hire therapists to provide classes and aquatherapy for individuals with disabilities, collaborating with Southeast Alaska Independent Living (SAIL). Pilot Project #3: Develop the Senior Center into a community center that provides increased socialization opportunities for Senior and Disabled populations (1/3 of Haines) by providing daily meals, rides, and socially engaging activities like low impact yoga, tai chi, games, clubs, art and music therapy. Use mental health assessment tools to determine changes in mental health over 8-12 months.	\$1M-\$5M	Single Community	Haines Borough	Advance to Implementation Application

Haines Chamber of Commerce	Haines Community Potluck	AK	By providing a space for gathering and a meal made with whole foods, we are offering a health-giving service that benefits not only one's physical health but also one's mental health. The event is free and open to anyone who wishes to attend. Many individuals have been cited as saying they had not engaged in any social activity throughout the winter until this event was held. This can mean a great deal in relieving mental stress for these individuals, especially after stressful storms like the one we experienced last December. As soon as the roads were cleared, we hosted our first potluck with over 100 people in attendance. As a chef and restaurant owner, I served the main dish: homemade currywurst sausages with braised cabbage and homemade sourdough bread. We served everyone who attended. This model creates a space for those who have to share with those who don't. I always have food and the knowledge to create something with it. Creating a space where delicious whole foods can be shared for free helps community health, well-being, and commerce. Others who brought dishes to the event also felt they wanted to help, share, and to see our community gather together. This event has the opportunity to expand through the winter months. I'd like to see that it does, by reimbursing those who bring dishes, covering the cost of the space, the main dish, and providing adequate compensation for the time given to the organizers, ensuring the events longevity for years to come.	The project has been applied and tested, making the concept model successful and well-received. Hosting these potluck events not only upholds Alaska potlatch traditional values but also ensures that community members experience resilience and gratitude internally. Currently, funding has been raised through local business promotions. These businesses spend \$500 for a main dish and space rental. This amount of money feeds over 100 people for free. That is a cost of \$5 per person to have a large plate of diverse foods made locally by other community members. This sometimes means local products are incorporated into these foods, furthering the values of regional cuisines and the importance of healthy, locally produced foods. gaining access to healthy and affordable food can be a challenge for rural residents. Many rural areas lack food retailers and have limited supplies of fresh, affordable foods, even in areas where farming is important to the local economy. According to the Rural Health Information Hub website, in rural areas, access to food may be limited by financial constraints, transportation challenges, or a lack of grocery stores. Rural shoppers may be forced to rely on more expensive and less nutritious food, such as the types available at gas station convenience stores, or face a long drive to a town with a supermarket or grocery store that stocks fresh produce and other staples. Some rural residents and households are food insecure, meaning they cannot rely on access to sufficient, affordable, and nutritious food at all times, increasing the risk of poor health outcomes. According to the 2017 United States Department of Agriculture Economic Research Service (USDA-ERS) publication Food Insecurity, Chronic Disease, and Health Among Working-Age Adults, food insecurity is strongly associated with chronic disease and poor health, both of which disproportionately affect rural populations. Long-term food insecurity can affect physical and mental health, development, learning, productivity, and family well-being. If we were to provide 24 potlucks of the span of 6 months, we could provide over 2400 free meals to local residents.	\$50,000-\$250,000	Single Community	Haines Borough	Deferred or Not Advanced

Haines Huts and Trails	Haines Multi-Use Preventative Healthcare and Transportation Pathway System	AK	Haines is a remote community of approximately 2,500 residents facing significant barriers to physical activity and preventative health. Like many rural Alaskan communities, Haines experiences higher rates of chronic disease, limited access to healthcare services, and geographic isolation that compounds health disparities. With the development of a new hospital facility, Haines has a rare and time-sensitive opportunity to embed healthy living infrastructure directly into the fabric of the community. Currently, no safe, accessible, paved connection exists between the new hospital, downtown Haines, and the Southeast Alaska State Fairgrounds, leaving residents, particularly seniors and people with disabilities, without a reliable route to engage in daily physical activity or access essential services on foot or by non-motorized transit. This project will create an ADA-accessible trail and paved pathway linking these key destinations and integrating with existing trail networks. Research consistently demonstrates that accessible active transportation infrastructure reduces rates of obesity, cardiovascular disease, diabetes, and mental health challenges, directly reducing the burden on rural health systems. By connecting community anchors through a safe, inclusive corridor, Haines Huts and Trails will give every resident, regardless of age or ability, the opportunity to make physical activity a natural part of daily life, strengthening the long-term health of our entire community.	Haines Huts and Trails proposes to design and construct an ADA-accessible, multi-use pathway corridor connecting the new SEARHC hospital facility with downtown Haines, the Southeast Alaska State Fairgrounds, and the Haines High School pool and gym. The route will follow existing road corridors and public land where feasible, minimizing land acquisition challenges while maximizing community reach. There are currently sporadic trails and sidewalks throughout this area, however for them to become effective, reliable, and usable by the community, we need to turn this into a cohesive, well planned network. The pathway will serve a dual purpose: a safe, non-motorized transportation corridor for residents traveling to healthcare and recreation facilities, and a dedicated active-use trail that encourages daily walking and exercise. Paved and ADA-compliant surfaces will ensure year-round usability and equitable access for seniors, people with disabilities, and families with young children. The project will be developed in phases, prioritizing the segments with the highest daily-use potential and greatest connectivity gaps first. Each phase will include wayfinding signage, lighting where appropriate, and connections to Haines' existing trail network to extend the system's overall reach. Haines Huts and Trails will lead project coordination, working alongside local government, SEARHC, and community stakeholders to ensure the route reflects community needs. By embedding active transportation infrastructure into the built environment near a new healthcare facility, this project positions physical activity as an accessible, everyday choice, transforming how Haines residents engage with both their health and their community.	\$50,000-\$250,000	Single Community	Haines Borough	Deferred or Not Advanced

Haines Huts and Trails	Healthy Communities Trail Restoration: Investing in Preventative Health Infrastructure	AK	Haines Huts and Trails maintains an extensive network of non-motorized trails that serve as the primary outdoor recreation facility for residents of Haines, Alaska. These trails are used year-round by community members of all ages for hiking, running, skiing, and everyday active transportation, providing one of the most accessible and affordable forms of physical activity available in a remote community with limited fitness infrastructure. However, decades of minimal maintenance and capital investment have left this network in a significantly degraded state. Overgrown corridors, eroded tread, failing drainage structures, and deteriorating signage have made many trails difficult or unsafe to use, particularly for seniors, families with children, and people with limited mobility. As trail conditions worsen, fewer residents use them, directly undermining the community's most accessible preventative health resource. Haines is a rural community with elevated rates of chronic disease, limited healthcare access, and long winters that compound physical and mental health challenges. Restoring the trail network to a safe, welcoming condition is not a luxury, it is an investment in the daily health of the majority of our residents. This project represents an opportunity to reclaim and reinvigorate a community health asset that already exists, reaching residents where they are.	Haines Huts and Trails proposes to hire a dedicated four-person trail maintenance crew for three consecutive summer seasons to systematically address the maintenance backlog across our existing trail network. This crew-based model is the most efficient and proven approach to high-volume trail restoration, allowing coordinated, sequential work across the system rather than piecemeal repairs. During each summer season, the crew will prioritize work based on trail usage levels, safety concerns, and health equity, ensuring that trails most accessible to lower-income residents, seniors, and families are restored first. Core maintenance tasks will include tread restoration and erosion repair, drainage structure clearing and rebuilding, corridor brushing and blowdown removal, and signage replacement and wayfinding improvements. By the end of three full seasons, we anticipate completing the majority of the deferred maintenance backlog, returning the network to a condition that can be sustained through our organization's regular annual maintenance program. This three-summer investment is designed as a reset, bringing the system from a state of decline to one of stability and usability. Haines Huts and Trails will manage the crew directly, drawing on our organizational experience in trail stewardship and our deep familiarity with the network. Local hiring will be prioritized, creating seasonal employment in the community while building long-term local capacity for trail maintenance.	\$250K-\$1M	Single Community	Haines Borough	Deferred or Not Advanced

Haines Huts and Trails	Mosquito Lake Community Center Recreation Infrastructure Trail System	AK	The Mosquito Lake Community Center sits at the base of a 13-acre wooded parcel with moderate terrain rising into the Haines State Forest, terrain that is immediately suitable for hiking, biking, nordic skiing, and snowshoeing trails that support preventative healthcare measures. The vision for the Mosquito Lake Trail System is straightforward: a purpose-built, multi-use trail network radiating from the FWRC campus into the surrounding Haines State Forest, designed for Nordic skiing, downhill ski glades, mountain biking, hiking, and snowshoeing, and accessible to all residents regardless of income, fitness level, or prior outdoor experience. No such network currently exists in the upper Chilkat Valley. This project would utilize existing former logging roads that surround the community center, which are well-suited for developing a full trail network that community members can utilize year-round to increase their physical fitness and mental health. The planned trail system would serve four distinct use types across two seasons. In summer, multi-use trails would support hiking and mountain biking for all skill levels, with routes beginning directly at the FWRC campus and extending into the Haines State Forest. In winter, groomed Nordic ski loops and snowshoe trails would make the terrain accessible to families, elders, and youth who currently have no dedicated winter recreation infrastructure within reach.	Haines Huts and Trails will use this funding to conduct the terrain assessment, community engagement, state forest coordination, permitting groundwork, professional trail design, and detailed construction budgeting required to develop the Mosquito Lake Trail System. Phase 1: Terrain Assessment & Opportunity Mapping Conduct a terrain assessment of the FWRC parcel and adjacent Haines State Forest, evaluating grades, drainage, soil conditions, snow characteristics, and optimal corridor alignments for Nordic ski loops, downhill ski glades, mountain biking, hiking, and snowshoe trails. Conduct LiDAR-informed terrain analysis using 2021–2022 DGGS survey data for the Chilkat Valley corridor to identify sustainable trail alignments, avalanche risk zones, and optimal glade terrain above the FWRC campus. Phase 2: State Forest Coordination, Community Engagement & Permitting Initiate formal coordination with the Alaska Division of Forestry to understand land use authorization requirements, identify permitting pathways for trails extending into the Haines State Forest, and map the full extent of land available for trail development. Begin the permit application process for all trails crossing state forest land, including any required environmental review, cultural resource consultation, and agency coordination, establishing a clear permitting timeline for future construction. Convene community design input sessions at the FWRC activities room, gathering priorities from upper valley residents, elders, youth, and the Chilkat Indian Village of Klukwan on trail uses, alignments, naming, and cultural stewardship of these lands. Engage Chilkat Indian Village / Klukwan in a formal consultation process regarding trail alignment, naming, and land stewardship to ensure the trail system reflects Tlingit cultural values and territorial knowledge. Phase 3: Trail Master Plan, Design & Construction Budgeting Produce a professionally developed Trail Master Plan documenting all planned trail corridors, use designations (Nordic skiing, downhill glades, mountain biking, hiking, multi-use), difficulty ratings, phasing strategy, and long-term maintenance requirements. Develop a detailed, itemized construction budget for each phase of trail development, including contractor labor, materials, equipment, drainage infrastructure, trailhead facilities, and Alaska-specific cost factors, creating a fundable document for capital grant applications.	\$50,000-\$250,000	Single Community	Haines Borough	Deferred or Not Advanced

Haines Volunteer Fire Department	Haines Borough Rural Community Paramedicine, Mobile Integrated Health Program	AK	The Haines Borough consists of multiple small rural/frontier communities spread out over 2300 square miles, some of these are communities of less than 90 people. The people in these communities have a variety of needs that range from a lack of transportation to an inability to travel. Many have chronic medical problems that require frequent treatment and follow-up care. Mental health care is also a need as the Haines Borough has a suicide rate higher than the state average. All our communities are also in need of substance abuse counseling, medical care, and treatment. Furthermore, our community has no reliable access to the department of public health resources and no public health nurse. The schools in the community have no school nurse leaving students without access to preventive health education or assistance, let alone routine screenings. Other community non-profit organizations such as SAIL, Cornerstone Home Health can't keep up with demand for assistive devices. Hospice of Haines volunteers are non-medical and cannot provide medications for palliative care, this leaves patients unable to remain in home for their last days. There is a need for greater support with organizing community health fairs to provide hearing and vision screenings, to perform baseline concussion screenings. Finally, the volunteer EMS responders have been responding to increasing call volumes with dwindling numbers of responders, well over 400 per year.	We intend to approach our communities' needs by meeting those in need where they live or in a place they are able to meet and consider to be appropriate and safe. We will provide, coordinate, and facilitate care as needed for the individual patient, whether that is transportation, virtual telemedicine appointments, wound-care, medication delivery and/or administration. We will also provide social resource information and connect people to the agency that can best help them and provide follow-up to ensure completion of care. We will assist with community education at schools and community health fairs. The overall vision is to find and fill healthcare gaps in our community, either directly or as a secondary mediator/coordinator to provide care to residents while alleviating some of the pressure on our existing programs.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough	Advance to Implementation Application

Hallelujah Foundation	Pinewood – The Safe Home Project	AK	Hallelujah Foundation proposes to build, staff and operate a home for Alaskans with special needs resulting from severe mental illness. This home will fill an existing gap in the housing continuum providing an alternative to the Alaska Psychiatric Institute or similar settings. These Alaskans have either resided long term or frequently at the Alaska Psychiatric Institute, been incarcerated, or both because of the lack of suitable discharge options. When community alternatives cannot safely accommodate the needs of these individuals, the consequences are incarceration, homelessness, return to acute psychiatric care or death. As a result, individuals with special needs including co-occurring substance use disorders become part of the homeless population particularly in Anchorage, Fairbanks and Juneau.	The Pinewood Project is proposed to be a multi-year project ultimately resulting in the building, licensing, staffing and operating of a home designed for Alaskans with special needs resulting from severe mental illness. This project will fill an existing gap in the housing continuum providing an alternative to the Alaska Psychiatric Institute or similar settings. Intermediate steps include overall scoping of the project as well as finalizing architectural and engineering design. Hallelujah Foundation will provide the building site. Key areas of this project are currently estimated to be: 1) work with the SOA to establish a funding mechanism (preliminary research has happened already through technical assistance from the Mental Health Trust Authority supporting Agnew: Beck) 2) establish a care coordination model with partners to ensure that the people who need this type of placement of care receive it 3) work with the SOA to ensure that licensing and regulations needed for this placement facility align with the funding mechanism and 4) research and determine potential capacity considering span of life implications and resulting needs.	\$50,000-\$250,000	Home- and community-based services provider	Statewide	Anchorage (Municipality)	Deferred or Not Advanced

Hamilton Health Box	Rural Microclinic Network: Tech-Enabled Primary, Behavioral & Chronic Care	TX	Rural and frontier Alaska communities face persistent barriers to primary care access. Many are not road-connected, requiring air or seasonal transport to reach regional health centers. Residents often delay care or rely on emergency departments for manageable conditions. Chronic disease burden is high, with nearly 75% of adults living with or at risk for chronic conditions. Without consistent monitoring, these conditions worsen, driving avoidable hospitalizations and costly medical transport. All Alaska communities carry Health Professional Shortage Area designations, and recruiting providers to remote areas remains difficult. Alaska has strong regional hospitals and Tribal health organizations serving as care hubs. The gap exists at the community level, where residents need reliable local access to routine services and early treatment as well as specialists and maternal care. Alaska's RHTP identifies expanding primary care through right-sized infrastructure and technology-enabled models as a priority. This creates an opportunity for scalable care infrastructure that expands community-level access while strengthening the broader regional health system. Deployment will align with community-led regional health care delivery plans developed under the RHTP framework.	Hamilton Health Box will establish five mobile-capable Microclinics in rural Interior Alaska communities selected in collaboration with regional health systems, Tribal health organizations, and local stakeholders. Site selection will be informed by community-led regional health care delivery plans prioritized under RHTP implementation, ensuring deployments address validated gaps rather than duplicating services. Each Microclinic provides preventive care, physical exams, chronic disease management, medication management, pediatric and geriatric care, behavioral health support, access to maternal care and specialists, and treatment of minor illnesses and injuries. The care model combines local clinical staff with telehealth-supported physician oversight. Local clinicians perform exam components, collect vital signs and specimens, and facilitate diagnostic testing, enabling comprehensive evaluations when specialists connect virtually. Through partnerships with regional hospitals and specialist groups, clinics also provide specialty consultations and maternal health services. Each clinic is equipped with diagnostic tools, EHR systems integrated with healthEconnect Alaska, and telehealth infrastructure supporting real-time care coordination, advancing Initiative #6 (Spark Technology and Innovation) data-sharing objectives. Given the central role of Tribal health providers across rural Alaska, Hamilton Health Box will engage THOs early in planning to ensure Microclinics complement existing services, respect cultural priorities, and establish clear referral pathways. Mobile-capable units require lower capital investment than traditional facilities and deploy without new construction. Centralized physician oversight increases workforce efficiency. Hamilton Health Box will prioritize local recruitment and training to build community-based workforce capacity, supporting Initiative #5 (Strengthen Workforce) goals.	\$1M-\$5M	Clinic	Statewide	Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

HCBS Strategies, Inc.	ADRC/DDRC Mental Health & Substance Use Disorder Options Counseling Infrastructure Development	MD	Alaska faces a profound and interconnected crisis of homelessness, mental health disorders, and substance use disorders. On a single night in January 2024, over 2,600 individuals experienced homelessness statewide, while roughly 132,000 adults live with mental illness and approximately 50,000 individuals grapple with substance use disorders. This population often has complex care needs that span public and private resources and require frequent and coordinated support. However, while Alaska has built a network of ADRCs and DDRCs to provide options counseling and support in connecting to long-term service and support for older adults and most populations with disabilities, no agency, including the ADRCs and DDRCs, have built the systems and expertise to provide this support to people whose primary issue is a mental health and/or substance use disorder (MH/SUD). Alaska’s ADRCs and DDRCs are the primary front door for individuals looking to access publicly, privately, and community-funded supports. With their current reach, they are a logical front door for individuals with MH/SUD. To achieve this, HCBS Strategies will coordinate with at least three ADRC/DDRC sites to implement tracking systems, document available supports, and build relationships with State and provider agencies overseeing and providing these services. This effort will allow ADRCs/DDRCs to participate in a cross-agency effort to develop this infrastructure so that they can support these vulnerable individuals	This effort strives to improve outcomes for complex care MH/SUD populations by increasing ADRC/DDRC staff understanding and expertise on resources for this population; coordinating training, support, and other initiatives between ADRC/DDRC staff and State and local partners, including SDS, DPA, DBH, and Crisis Now; and, through at least three ADRC/DDRC project sites, providing direct support to individuals with MH/SUD. HCBS Strategies will function as the project manager and evaluator, contracting with and coordinating across at least three ADRC/DDRC project sites. ADRC/DDRC project sites will designate at least one primary staff to lead this project. These staff will be trained by partners on MH/SUD resources and statewide access process workflows. They will work directly with individuals with MH/SUD to provide options counseling that allows project participants to better understand resources available to them and access the most appropriate resources. Project staff will also work closely with DPA to streamline the Medicaid application process for project participants to enroll as many eligible individuals as possible and connect them with Medicaid resources. Following this, a key component of the project is to provide at least monthly follow-up with project participants for at least three months to ensure individuals are able to access and receive the identified services and supports. This follow-up will be especially critical for the vulnerable MH/SUD population, who may struggle if left alone to access supports. The goal of this project is to develop sustainable statewide infrastructure within the ADRCs/DDRCs and their partners so that this support can be embedded within ADRC/DDRC model ongoing. Much of the ongoing work performed by the ADRCs/DDRCs will be eligible for Medicaid Administrative Claiming (MAC), a sustainable source of funding already federally approved for ADRCs and DDRCs through SDS. Key components of the infrastructure include resource directories that outline local and statewide resources for individuals with MH/SUD that can be used by ADRC and DDRC staff to help people understand and access the options that best meet their needs; customized training provided by SDS, DPA, DBH, and Crisis Now on services, supports, and strategies for supporting the MH/SUD population; and direct support and coordination between the ADRC/DDRC project sites and the State and local partners to streamline access to services and supports.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

HEALING HOMES CONSULTING LLC	HEALING HOMES OF THE DENE - A Culturally Grounded Wellness Framework for Indigenous Communities	AK	Alaska's rural and Indigenous communities — particularly rural communities/villages across the Interior — face profound gaps in culturally responsive wellness support. Clinical systems are geographically inaccessible, and existing behavioral health services often fail to account for the cultural, relational, and land-based dimensions of healing that communities themselves identify as essential. The result is a persistent disconnect between what healing systems offer and what communities actually need. Healing Homes addresses this gap by building a wellness framework from Athabascan values rather than adapting Western clinical models. Before any program is designed or delivered, we must first understand each community on its own terms — its strengths, its needs, its existing resources, and its vision for healing. That foundational understanding is the work of Phase 1.	Phase 1 of Healing Homes will conduct a structured Community Landscape Analysis in partnership with six Tribal communities in Alaska's interior region. This is not a data extraction exercise — it is a relationship-building process grounded in community authority, cultural humility, and genuine co-design. The Landscape Analysis will map four interconnected dimensions in each partner community: • Healthcare infrastructure: Hub-and-spoke relationships between regional Tribal hospitals and village clinics; gaps in behavioral health, telehealth capacity, and emergency specialty care; and the current roles of Community Health Aides/Practitioners (CHA/Ps) and where expanded training or new workforce pipelines are needed. • Cultural and community assets: Traditional healing practices (including healing circles and elder-led guidance), Tribal Health Organization structures, and existing community-led programs that already support wellness and could be strengthened within the rural health transformation program framework. • Wellness gaps and disparity data: Community-identified priorities including behavioral health, suicide prevention, chronic disease, reentry and recovery needs, and outcomes disparities for Alaska Native populations. • Structural and environmental barriers: Geographic isolation, transportation access, permafrost and erosion threats to clinic infrastructure, and other structural factors that shape care access in each community. The analysis will be conducted through listening sessions with elders and cultural practitioners, conversations with community members and families, engagement with Tribal leadership and program staff, and review of existing data and community assessments. All findings will be reviewed and validated by each community before use. Phase 1 will produce: a Landscape Analysis report for each partner community; a cross-community synthesis identifying shared themes and opportunities; formal MOUs with each Tribal partner; a refined, community-informed version of the Healing Homes framework and its core tool (the Dene Assessment); and a co-developed Phase 2 implementation roadmap.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Fairbanks North Star Borough; Southeast Fairbanks Census Area	Advance to Implementation Application

Healing Lights Sanctuaries	Healing Hammocks Transformational Therapy Program	AK	In today's chaotic world, it can be almost impossible to find a space to be calm. Economic injustice, homelessness, chronic pain, government violence, grief, fear of the future, substance use impacts... We all face this list. And all of us, especially vulnerable members of our community and people in the workforce who support and care for them live daily with the results. These issues can cause debilitating behavioral and other health issues. Financial and logistics barriers often prevent access to resources that might help. Research shows significant value in employing holistic, spiritually responsive modalities (such as healing energy therapies) for help with relaxation, pain relief, and alleviating stress and anxiety. Impact on patients and caregivers is recognized and these therapies have been welcomed in hospitals for decades. Prioritizing access to culturally sensitive healing support for vulnerable people — and for those who care for them — is a critical need in Alaskan communities. "Hammock Healing" is a holistic project led by an Indigenous healer who has used Reiki and complementary energy healing modalities for decades to bring relief for neighbors experiencing homelessness, families living in shelters, at-risk youth, care providers, and hospice, behavioral health, and HIV-positive patients. The project will bring healing for several pilot locations and provide opportunity for people who are drawn to this work to train to become healers in their communities.	This project proposes to pilot the swaying peace of "Hammock Healing" with vulnerable youth and Emergency Medical Services personnel in Whittier, multi-cultural Community Health Workers, unsheltered neighbors in Fairbanks, participants accessing Indigenous-centered trauma healing circles in Anchorage, and pregnant and parenting people impacted by substance use in Sitka. The approach, using hammocks, rocking chairs, emotional support animals, healing music, and energy balancing therapies, helps participants shift their own energy to create a healing path for themselves. It grounds people and supports their reconnection with the real world by helping them step away from the soul-sucking artificial reality of social media and electronic devices. It helps people remember the power and value of connecting with our family, friends, and neighbors. To be more present and focus on what is around us. To be present with the power and healing of genuine human connections. We will support each group as a whole while mentoring participants who show interest in growing their healing skills through hands-on training and certifications that will help them build their ability to earn a sustainable income through this work. Logistics We'll implement our approach through building capacity, pilot projects, curriculum, and supporting healthy resilience in staff. Build Capacity Establish administrative and evaluation infrastructure capacity. Initiate staff training and support. Lease a space in Anchorage for local healing activities. Acquire and equip a vehicle to bring itinerant services to communities on the road system. Build relationships w/partner orgs. Share Hammock Healings with communities as we are invited. Pilot Projects Run 3-5 pilot projects, collect data, and identify trainees. Provide hands-on training for youth and adults with interest in sharing this healing modality in their communities (create a statewide network). Provide sound therapies, educational materials, and artistic activities to support local community. Develop culturally sensitive care protocol that can be adapted for use in rural, remote, and frontier communities. Curriculum Develop, test, and refine holistic flexible Hammock Healing healer training curriculum for youth (ages 14-24) and adults. Support Healer Resilience Provide training and holistic supports for healthy resilience of staff (including community-based healers) to sustain organic growth. Mutual support networking/gatherings.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough; Sitka (City and Borough)	Deferred or Not Advanced

Health Alliance Global, Inc.	Closing the Rural Care Gap: Mobile Diagnostic Technology for Alaska's Underserved Communities	FL	Alaska's rural and frontier health landscape is defined by stark geographic and systemic barriers. Over 200 communities lack road access to hospitals, and with only six urgent care locations statewide, the vast majority of rural Alaskans have no viable option for non-emergent care short of costly air transport. Clinical workforce shortages compound the problem — communities that do have facilities often cannot staff them consistently, leaving residents to delay or forgo care entirely. The human and financial cost is severe. Air medical transport for conditions that could be managed at an urgent care level consumes resources, disrupts families, and strains a system already operating at its limits. RHTP funding presents a rare opportunity to address this at scale. Dr Triage's MDU is purpose-built for exactly this environment — a deployable, telemedicine-enabled platform that integrates diagnostics, care coordination, and virtual provider access without requiring permanent facility construction or a full-time on-site clinical team. Beyond Alaska, this project represents a national proof point. CMS and state Medicaid programs lack reimbursement frameworks that adequately support rural urgent care and telehealth-first delivery models. A data-rich Alaska deployment creates the evidence base needed to drive payment reform — producing a replicable care model that can be adapted for frontier and underserved communities across the country.	Heal All proposes the phased deployment of approximately 70 MDUs into Alaska's highest-need rural and frontier communities — establishing a statewide network of accessible, technology-enabled urgent care access points where none currently exist. Deployment Model Each MDU operates as a 9am–9pm urgent-care-style access point, designed to manage the full range of non-emergent and lower-acuity presentations that today require air transport or go entirely unaddressed. This is not an ER replacement — it is a purpose-built intervention for the gap between those two extremes. By anchoring deployments within existing community infrastructure, MDUs minimize capital requirements and accelerate community integration. Staffing On-site teams will be composed of locally sourced medical technicians, nurses, and CHWs, supported remotely by Advanced Practice Clinicians and physicians operating within Alaska's regulatory framework. Prioritizing local hiring strengthens community trust, reduces workforce attrition, and ensures that economic benefit from the program remains in the communities it serves. Recruitment partnerships with PPO/PEO networks and Alaska-focused clinician placement firms will support consistent staffing across the network. Technology and Care Integration The MDU platform integrates EMR, remote diagnostics, real-time data capture, and population health analytics in a single deployable unit. This technology backbone enables care continuity across encounters, supports chronic disease management, and generates the structured outcome data essential for reimbursement advocacy. CHWs embedded in each site drive patient engagement, medication adherence, and navigation — functions that are critical in communities where trust in outside health systems has historically been low. Partnerships Effective deployment requires deep local alignment. Heal All will partner with Tribal and Alaska Native health organizations, community-based clinics, and public health officials to ensure each MDU is sited, staffed, and governed in a manner that reflects community priorities. These partnerships are not transactional — they are foundational to the program's clinical integrity, cultural competency, and long-term viability. Together, these elements constitute a scalable, replicable model: urgent-care access delivered through a lean, tech-enabled, community-rooted infrastructure designed to perform under Alaska's conditions and endure beyond the initial grant period.	Over \$5M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Health Lync LLC	Wellyfy Rural Alaska Telehealth & Workforce: IMG Pathways + Synchronous Diagnostics	TX	Alaska's rural, remote, and frontier communities face severe healthcare challenges due to vast geographic barriers, extreme weather, limited transportation (e.g., reliance on small planes, ferries, or snow machines), workforce shortages, high care delivery costs, and infrastructure gaps like inadequate water/sanitation in many villages. These result in delayed or reduced access to essential services, worse health outcomes (e.g., higher chronic disease burden, maternal/infant risks), provider burnout, and reliance on costly medevac or long-distance travel for basic care. The opportunity lies in leveraging innovative, low-burden solutions to strengthen the rural workforce and modernize delivery: accelerating entry of qualified International Medical Graduates (IMGs) into Alaska practices to address shortages, and equipping independent/telehealth-forward physicians with EMR platforms plus synchronous diagnostic tools (StethoCAPE for remote auscultation, OtoCAPE for otoscopy, and AI-enabled cardiac/hemodynamic triaging) to enable high-quality virtual exams. This reduces travel/wait times, eases administrative burdens, expands timely care close to home, and builds sustainable capacity—directly aligning with RHTP's goals for workforce strengthening, technology innovation, and improved access in frontier settings.	Wellyfy proposes a scalable, trust-based outbound acquisition and activation system tailored for rural, remote, and frontier Alaska. This low-burden approach empowers physicians to expand access without adding administrative weight, allowing them to focus on healing. We execute via two parallel, distinct tracks using our ready playbook (segmentation, LinkedIn/email sequences, call scripts, objection handling, KPIs): Track 1 – Workforce Strengthening: Identify and engage a deep pipeline of ECFMG-certified IMGs (USMLE Steps 1–3 passed) interested in Alaska practice. Provide expert administrative FastTrack Licensing support (Silver/Gold/Platinum tiers) to efficiently complete documentation, meet board requirements, and accelerate licensure—enabling motivated physicians to enter rural/frontier roles (e.g., family medicine, telehealth) sooner. Track 2 – Technology & Innovation: Target independent/telehealth-forward physicians serving or willing to serve Alaska. Offer subscription-based Wellyfy EMR platform subscriptions with optional cross-sell of patented synchronous diagnostic tools: StethoCAPE (remote heart/lung auscultation), OtoCAPE (remote otoscopy), and AI-enabled cardiac/hemodynamic triaging (submitted to DIU innovation challenge). These enable high-fidelity virtual physical exams, reducing travel, wait times, and medevac reliance while supporting timely, coordinated care in isolated areas. Implementation starts with targeted outreach (warm, empathetic, physician-centric tone—no hype, full transparency on timelines/processes). We build trust through clear explanations, respect for time, and light cadences (3–4 follow-ups max per channel, easy opt-outs). Conversions drive paid sign-ups (licensing tiers or EMR plans), with measurable outcomes tracked via dashboards. We seek early partnerships with Alaska rural clinics, Tribal health organizations, workforce programs, or telehealth networks to refine targeting, ensure cultural/local relevance, and co-deliver value. Readiness: Playbook is execution-ready for immediate Alaska adaptation (Phase 1 launch in weeks post-approval); scale via data-driven iteration (A/B testing, high-response segments). This approach directly advances RHTP priorities: strengthening rural workforce pipelines (IMG entry/retention) and sparking technology innovation (EMR upgrades, remote diagnostics, telehealth expansion) for sustainable, high-quality care close to home.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Health Management Systems, Inc. (HMS), a Gainwell Technologies Company	Expanding Gainwell Go™ for Care Management Mobile Connectivity	TX	Alaska Medicaid operates on a fee-for-service basis with no managed care organizations, meaning care coordination resources are limited and any tool that improves communication between members and their care teams has outsized value. The HMS/GW Team propose to address this care coordination and communication gap by expanding Gainwell Go™, a secure, member-facing mobile platform already positioned for deployment. HMS/GW brings two unique assets: operation of Gainwell Go™ and long standing, direct relationships with Medicaid members through fiscal agent and TPL services. Together, these assets create a strong foundation to shift from phone only communication to a richer mobile channel that can support care instructions, reminders, secure messaging, and eventually, remote monitoring. The opportunity is to partner with key stakeholders (e.g., AMCCI and the Department of Health (DOH)) to identify where mobile engagement can most meaningfully improve outcomes for care managed members. Early hypotheses focus on two high need areas: earlier engagement of pregnant members to improve prenatal care connections, and remote blood pressure monitoring for members with hypertension who have infrequent in person follow up. The HMS/GW Team will lead the assessment, pilot execution, and sustainability modeling to ensure that the State can scale what works.	HMS/GW Team will work directly with stakeholders (e.g., AMCCI, DOH) at each phase. The HMS/GW Team will provide structured assessment methodology and financial sustainability design delivering the analytical and technical lift that enables the HMS/GW Team and the State to move from concept to evidence-based action. Phase 1: Care Management Mobile Opportunity Assessment: An analysis based on qualitative and quantitative data will be assessed to identify where mobile solutions could best support the healthcare community for those in care management, convening stakeholders as well for input. Additionally, HMS/GW has been closely monitoring the customer feedback line and has identified real pain points for members in care management. From this work, we will build an initial assessment that will produce a prioritized roadmap, owned and endorsed by the State, with defined pilot parameters, member eligibility criteria, integration requirements, and measurable success metrics. Phase 2: Pilot Design and Concept Test: Based on the assessment roadmap, HMS/GW will direct the expansion of Gainwell Go™ for quick win use cases that can be deployed within year one. Our hypotheses will be validated through assessment; however, our initial focus areas include: • Maternal Health Engagement Pilot: The HMS/GW Team will work with stakeholders to identify care management-enrolled women of childbearing age where earlier pregnancy identification and prenatal care connection is a documented gap. The goal is to shrink the time between pregnancy identification and first prenatal contact for members particularly in communities where in-person access is limited and prenatal care in the first trimester is missed by over a third of women (e.g., Alaska IBIS data, Kusilvak and North Slope census areas). Phase 3: Pilot Design, Concept, and Scale: Example hypothesis to be validated through the assessment: • Hypertension (HTN) Remote Patient Monitoring (RPM) Pilot: HMS/GW Team will work with stakeholders to identify care management members with documented HTN in communities where routine in-person monitoring is infrequent.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Health Management Systems, Inc. (HMS), a Gainwell Technologies Company	Transforming Alaska's Rural Health Through Unified Data, Interoperability & Insight	TX	The opportunity: extend AK's CMS compliant framework to support broader use cases and pair it with an analytics platform that turns integrated data into insight, reducing fragmentation, improving coordination, and strengthening care. AK's fragmented data systems slow care because key information sits across state agencies, 229 Tribal health organizations, community partners, and rural clinics. With over 80% of communities off the road system and vast distances between hubs, these gaps hinder the RHT Program's need for secure, governed data sharing. AK has strong CMS aligned interoperability foundations and a clinically focused HIE through healthEconnect, but lacks a mechanism to integrate clinical data with Medicaid administrative, programmatic, transportation, and community-based information essential for operations. Without broader exchange capabilities, teams rely on manual processes, duplicate entry, and limited cross setting visibility, reducing efficiency and increasing burdens on rural residents who already travel long distances for care. AK also needs a flexible analytic environment integrated with its interoperability layer to enable enriched data, timely analysis, and actionable insights for the Rural Health Office, state agencies, Tribal partners, and local organizations. A unified dataset ensures consistent information for coordination, detecting fraud, waste, and abuse, improving program integrity, and supporting informed clinical decision making.	HMS/GW's approach is to enhance rather than replace current systems, minimizing implementation complexity, accelerating deployment, and supporting sustainability for resource limited providers. To accomplish this, HMS/GW will bring together and collaborate with healthEconnect and other state partners so that existing investments are leveraged to the greatest extent possible and that healthEconnect's clinical data exchange role is preserved and data governance and ownership remain intact. HMS/GW will extend this ecosystem by leveraging its CMS 9115 and 0057 Interoperability platform (Gainwell Connect™, which is currently being implemented in AK) to provide API-driven data exchange that complements existing HIE data exchange. Our interoperability platform allows for ingestion and exchange of data sources beyond those addressed through healthEconnect, including multi-payer claims, eligibility, patient-to-provider attribution, and non-clinical data from rural partners and community organizations. HMS/GW will harmonize and enrich these data sources in its Gainwell Genius™ analytics platform, applying normalization, risk stratification, quality logic, and cost-of-care methodologies to generate enriched, analysis-ready data. Through these solutions, stakeholders gain access to dashboards, standardized reporting, and ad hoc analytics that support population health management, quality improvement, utilization monitoring, and program oversight. In collaboration with rural health partners such as healthEconnect, we will leverage shared or interoperable technology platforms where possible to enable secure, efficient, and standards-based data exchange across participating organizations. We will seek to align on a common technical architecture to reduce integration complexity, accelerate onboarding, and implement consistent data governance and access controls. We will further work with AK and its partners to standardize analytic foundations across data and technology partners, which could include, for example, alignment on patient identity management and matching methodologies to support accurate longitudinal member records across care settings and data domains. By harmonizing infrastructure, governance, and analytics capabilities, AK will maximize existing investments while building a scalable, secure, and future-ready data ecosystem that advances interoperability, cross-sector integration, and measurable outcomes for Rural Health Transformation.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Health Management Systems, Inc. (HMS), a Gainwell Technologies Company	Value-Based Care Design, APM Development & Provider TA with VBC Analytics for Rural AK	TX	AK’s rural health providers operate under fee-for-service reimbursement that is financially unsustainable in low-volume, high-cost frontier settings. Without transitioning to payment models rewarding outcomes and providing stability regardless of volume, AK faces continued pressure on providers, leading to potential closures, access reductions, high costs of living, limited competition, and reliance of traditional fee-for-service model. AK’s RHTP application identifies voluntary VBC participation as a priority under Initiative #4, with careful attention focusing on the AHEAD Model as the goal and identifying Dual Eligibles as target population. Designing and implementing APMs for AK requires two capabilities no single organization provides alone: 1. Specialized actuarial, payment design, and provider transformation expertise to build models that work in AK’s extreme geography; and 2. An analytics platform connected to AK’s Medicaid data and operations that can measure VBC performance, identify care gaps, and monitor outcomes in real time PwC brings direct experience supporting Medicaid VBC programs with providers and payers in designing alternative payment methodologies, shared savings programs, and provider transformation roadmaps. The Genius™ analytics platform transforms Medicaid data into actionable insights for risk stratification, population health management, and VBC performance monitoring.	We propose an integrated approach combining PwC’s payment reform expertise with HMS/Gainwell’s embedded Alaska Medicaid operations and Genius™ analytics platform. The work is organized into four workstreams. Workstream 1 – Provider Readiness Assessment Assess financial stability, data maturity, clinical workflows, and organizational capacity for value-based care participation across Alaska’s regions. HMS/Gainwell will leverage access to Medicaid claims, utilization, and cost trends to support rapid data ingestion and readiness scoring. Assessment dimensions include financial (revenue cycle, cost structure), clinical (quality reporting capability, EHR maturity), operational (care coordination capacity, attribution readiness), and governance (leadership and board risk tolerance). The outcome is provider specific readiness scorecards identifying those prepared for early VBC adoption and those needing additional support. Workstream 2 – Alaska Specific APM Design Develop tailored alternative payment models, such as one-sided shared savings, prospective capitation with risk corridors, and episode-based payments for high volume rural conditions. Conduct financial modeling and actuarial analysis to test scenarios and inform program design. Evaluate alignment with CMS’s AHEAD model and other federal innovation approaches. Models will be adaptable for tribal health organizations, critical access hospitals, FQHCs, and community health centers. Workstream 3 – VBC Analytics Platform Configure Genius™ as the performance engine to measure quality outcomes, medication adherence, care gap closure, utilization, and cost trends for providers in APM arrangements. Develop real time dashboards for the Department of Health, Advisory Council, and providers to track implementation and results. Incorporate risk stratification and predictive analytics to identify high risk patients for proactive outreach. Population health management capabilities will support 360-degree member views integrating clinical, social, and behavioral data, delivered directly to providers or through their existing workflow systems. Workstream 4 – Provider Technical Assistance & Implementation Deliver hands on support for workflow redesign, care coordination models, quality measurement, and data infrastructure needs. Create provider facing materials and peer learning networks. Support DOH with phased VBC launches, continuous improvement, and long term sustainability planning.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

HealthFront Ventures	Workforce Development Initiatives: Structured Data System Measurement	TX	Alaska’s Rural Boroughs & Census Areas, Frontier, and Tribal Communities depend on a limited and geographically dispersed healthcare workforce serving patients across vast distances and challenging geographic conditions. Retaining, recruiting, and supporting your HCP Workforce across rural boroughs and census areas remains one of the most significant barriers to expanding access to care for Alaskans living in these rural communities. While Alaska has developed innovative care delivery models, including hub-and-spoke networks connecting regional medical centers with rural communities, many workforce initiatives operate with limited visibility into where HCPs are actively delivering care, where workforce capacity gaps exist, and how workforce programs are performed over time. Rural workforce reports consistently identify the “digital divide” and partial data as a key finding. Very few show which HCPs are actively delivering care in rural communities, and even fewer show what care those clinicians are delivering. Strengthening Alaska’s rural healthcare workforce therefore requires not only retention and recruitment initiatives, but also the ability to identify which clinicians are delivering care and what care is being delivered across rural communities. Programs alone do not transform systems. Learning systems transform programs.	HealthFront Ventures proposes deploying the Rural Workforce Intelligence Platform (RWIP™) to support Alaska’s Rural Health Transformation workforce initiatives. RWIP is a cloud-based LIVE workforce intelligence and engagement platform designed to identify, engage, and measure MD/DO, NP, and PA HCPs actively delivering care across Alaska’s rural boroughs and census areas. RWIP integrates medical and pharmacy claims data with National Provider Identifier (NPI) activity signals to provide near real-time visibility into the active rural healthcare workforce. By analyzing claims-verified HCP activity rather than static licensure records, RWIP enables Alaska partners to understand which clinicians are actively serving rural populations and where Rural HCP Workforce capacity gaps exist. Using AI-assisted pattern recognition with human oversight, the platform analyzes large-scale healthcare claims datasets to detect HCP activity patterns, Rural HCP Workforce participation trends, and emerging rural care delivery gaps. RWIP also enables states to measure what care is being delivered using standardized healthcare coding systems including CPT/HCPCS procedure codes, J-codes, ICD-10 diagnosis codes, and NDC medication identifiers, allowing workforce initiatives to generate quantitative performance metrics aligned with CMS program requirements. At the core of RWIP is HFV’s Structured Data Standard for Rural HCP Workforce Development, providing consistent data definitions, quantitative measurement methodologies, and reporting architecture aligned with federal policy and CMS program oversight. RWIP can be operational within approximately sixty days, allowing DOH and ACF partners to establish a statewide HCP Rural Workforce baseline and launch initiatives quickly while ensuring programs can be measured, evaluated, and strengthened throughout the RHT program lifecycle. Measurement readiness compounds. Hesitation compounds risk.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

HealthJay Inc.	Transforming Tribal Emergency Response: EMS–Behavioral Health–Community Care Collaborative	CA	Rural and frontier Alaska face severe care barriers due to fragmented services, provider shortages, and a lack of interoperable data sharing between EMS, clinicians, behavioral health, and community organizations. This disconnection leads to delayed care, high EMS recidivism, and unnecessary ER visits. The Opportunity: This project bridges these gaps via a simple, interoperable digital infrastructure. HealthJay introduces an "Apple-simple" technology approach specifically for underserved communities. By connecting EMS responders, clinicians, and CBOs through a shared coordination platform, we enable instant telehealth access to out-of-region specialists, expanding care without requiring arduous travel. Whole-Person Engagement: The platform goes beyond clinical care, allowing residents to book services, attend virtual health programs, join job interviews, and connect with local community groups. Remote patient monitoring and active app engagement generate real-time data, helping communities identify emerging health and social trends. System Sustainability: By leveraging FHIR-ready interoperable infrastructure, this model strengthens cross-sector collaboration and reduces administrative burdens. It transforms emergency response into a coordinated entry point for care, ensuring that rural Alaskan communities can maximize limited local resources while accessing a broader network of support.	This project proposes a coordinated care infrastructure to transform how rural communities respond to behavioral health needs, chronic conditions, and social determinants of health. HealthJay uses three mechanisms to expand care access, strengthen intervention, and enable collaboration among EMS, clinicians, behavioral health providers, and community organizations. Residents interact through the HealthJay app, a digital front door for telehealth, resource booking, reminders, and neighborhood support. 1. No-barrier telehealth to expand care access and enable care navigation. HealthJay deploys technology designed to remove participation barriers in rural settings. Auto-join sessions require no downloads, complex logins, or scheduling, allowing residents to connect quickly with clinicians or behavioral health providers. Responders, organizations, or residents can initiate tele-screening and care navigation. Out-of-area providers can easily participate, expanding access to expertise and enabling follow-up care without travel. 2. Behavioral health engagement through self-care and community support. A key innovation is shifting behavioral health intervention upstream before crises occur. Through the HealthJay app, residents receive automated reminders, AI-assisted outreach, and tools supporting medication adherence, appointment follow-up, and wellness. Neighborhood care watch networks allow trusted family or community supporters to receive alerts and check on individuals when risks arise. Residents can book services—counseling, recovery, peer support, job opportunities, housing, and community classes—to address underlying needs. 3. Shared data infrastructure enabling cross-sector collaboration. HealthJay connects EMS, clinicians, behavioral health providers, and community organizations through interoperable data infrastructure. Telehealth encounters, referrals, resource bookings, and community engagement are documented electronically and shared across partners. Multilingual surveys and standardized screening tools support community needs assessments and SDoH data collection, while FHIR-ready APIs enable integration with health information exchanges and provider systems. Together, these mechanisms create a closed-loop collaborative network where providers and organizations work from shared data to deliver coordinated care. This model expands access, strengthens early intervention, and helps communities move residents toward long-term stability.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough	Deferred or Not Advanced

HealthPulse Advisors LLC	Alaska Frontier Solvency & Reimbursement Architecture Initiative	OH	The primary opportunity is the mitigation of "Contract Lag." Alaska’s rural health systems are currently suffering from an estimated 8–15% net revenue leakage. This is driven by legacy commercial payer contracts (Anthem, United, etc.) with "stop-loss" and "rate-parity" triggers that haven't been updated to reflect 2026 labor and supply chain disruptions. In frontier settings, the cost of specialized labor and high-acuity drug delivery has outpaced reimbursement anchors. This gap effectively forces rural hospitals to provide interest-free loans to national payers. Correcting this financial friction is the highest-leverage opportunity to ensure the success of all other RHTP clinical initiatives.	We will deploy the Frontier Solvency Framework, utilizing our proprietary HealthPulse Reimbursement Intelligence (HRI) logic. This is a three-phased "Strike Team" approach: Phase 1: Rate Parity Diagnostics: We execute 7-day audits for participating rural sites to identify specific leakage points in current commercial agreements compared to 2026 benchmarks. Phase 2: Contract Re-anchoring: We lead the technical negotiation to move legacy agreements to defensible, cost-plus Medicare-linked logic. This ensures that every high-acuity case is reimbursed at a rate that covers the true "Frontier Cost of Care." Phase 3: Capacity Building: We provide Alaska’s rural CFOs and Administrators with Fortune 500-level negotiation data and automated diagnostic tools (M365-integrated) to maintain market parity independently. This approach bypasses traditional, slow-moving consulting models in favor of rapid, EBITDA-focused implementation that delivers results within the first 90 days of engagement.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

HealthPulse Advisors LLC	Rural Alaska Provider Reimbursement Optimization & Value-Based Care Readiness Program	OH	Rural Alaska health care providers — including Critical Access Hospitals (CAHs), Tribal health organizations, and Federally Qualified Health Centers — face a hidden financial crisis rooted in inadequate managed care contracts. Most rural providers lack access to specialized reimbursement advisory expertise, resulting in payer rates that are 15–30% below comparable market benchmarks, high rates of preventable claim denials, and millions of dollars in recoverable revenue that goes uncaptured annually. This fiscal gap directly limits the services rural Alaskans can access. Providers unable to cover operational costs cut hours, reduce specialty access, or close entirely. The problem is compounded by the complexity of Alaska's payer landscape — a mix of Medicaid managed care organizations, Medicare Advantage plans, Tribal health programs, and commercial payers — each with different contract structures that require specialized expertise to navigate effectively. Simultaneously, new CMS value-based care models (including the CMMI LEAD ACO Model, launching March 2026) represent significant financial opportunity for rural providers — but most lack the advisory support to understand, evaluate, or participate in these arrangements.	HealthPulse Advisors will deliver a statewide Reimbursement Optimization and Value-Based Care Readiness program for rural Alaska health care providers through three integrated service components: COMPONENT 1 — REIMBURSEMENT ASSESSMENT & BENCHMARKING (Months 1–6): HealthPulse will conduct individualized reimbursement gap analyses for up to 25 rural Alaska provider organizations. Each assessment benchmarks current payer contract rates against state and national standards, identifies underpayment patterns, quantifies recoverable revenue by payer, and maps denial rate trends. Priority focus on Medicaid managed care contracts, Medicare Advantage, Critical Access Hospital cost-based reimbursement, and 340B drug program optimization where applicable. Deliverable: a written Reimbursement Intelligence Report for each participating provider, with a prioritized revenue recovery roadmap. COMPONENT 2 — MANAGED CARE CONTRACT NEGOTIATION SUPPORT (Months 3–18): HealthPulse advisors work directly alongside rural provider managed care contracting teams (or, where no internal team exists, with provider leadership) to prepare and execute payer contract renegotiations. This includes: payer-specific rate benchmarking packages, counter-proposal drafting, negotiation strategy development, and ongoing support through the contract cycle. We bring expertise from both sides of the payer-provider table — directly applicable to Alaska's dominant managed care payers. COMPONENT 3 — VALUE-BASED CARE READINESS TRAINING (Months 6–24): HealthPulse will develop and deliver a virtual training curriculum for rural provider leadership on navigating CMS payment model transitions. Topics include: CMMI LEAD ACO model participation readiness, bundled payment opportunities, outcomes-based contracting frameworks, and Medicaid value-based purchasing strategies. Training is fully virtual, live-facilitated, and recorded for asynchronous access — designed for providers in remote communities with limited bandwidth for in-person travel. All services are delivered remotely with no geographic access barriers. HealthPulse will partner with an Alaska-based organization for community coordination and provider outreach.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Healthy Futures	Healthy Futures Challenge and Health Equity Program Expansion	AK	Health equity is a major problem in AK. Over 1 in 5 youth are below the poverty line. Our commitment to increase revenue to serve this need is a priority. Youth should have access to physical related activities. Too many kids face barriers with the cost of equipment, fees, travel, or even basic needs such as adequate footwear. The needs have increased due to decreased state/local resources, layoffs, increased cost of living, and events like typhoon Halong. We’re receiving increased requests for grants to participate in physical activities and simply ensuring children have boots/sneakers to recreate safely. We’ve seen a need in both rural and urban settings but those in communities off the road system have fewer resources available. About 1 out of 3 AK Native children are overweight/obese - a prime indicator of long-term health issues. Chronic conditions often develop early and Type 2 diabetes is being diagnosed increasingly in youth. We address this issue through a Healthy Futures Challenge (HFC) each spring and fall, which rewards children and schools that reach physical activity goals. The HFC requires an individual at schools to administer the program, usually a PE teacher in schools that have one. In schools with no PE teacher, this is a classroom teacher or administrator. High teacher turnover rates present another hurdle. Finding a person to fill the responsibilities of the coordinator role is a big challenge, especially in rural schools for reasons to be explained.	Our staff face numerous challenges recruiting school coordinators for the Healthy Futures Challenge, especially in remote areas. Currently, our coordinators are teachers who often play multiple roles in their schools so have limited time or resources available to administer the HFC. Since most Healthy Futures staff are based in Anchorage, they also have few opportunities to offer in-person support around HFC implementation. Our project concept approach is to offer \$500 stipends to the individual who signs up to administer the HFC for a school. These stipends would be contingent on the school meeting a student participation level criterion. The project would include a “Community Coordinator” campaign, aimed at recruiting an individual in the community who is not necessarily a school staff member, but could be a parent, family member, healthcare worker, or anyone interested in supporting the mission of our organization who is approved by the school. This person would reduce the workload of a school staff person, while ensuring that the HFC is operating in a manner that supports and enhances school curriculum. Our targeted recruitment plan for outreach to Community Coordinators includes working with groups such as: • Parent groups and aftercare/enrichment programs (e.g. parent-teacher associations, Campfire, 4-H, Boys & Girls Clubs, 21st Century Community Learning Centers, Alaska Afterschool Network). • Tribal organizations (e.g. tribal councils, tribal health organizations, regional corporations). • Paraprofessionals working within the school. Efforts may include, but are not limited to: • Announce the program through mechanisms such as the State of Alaska’s listserv, The Play Every Day campaign contacts, DEED (Department. of Education and Early Development) Information Exchange, Anchorage School District announcements, Alaska Native Tribal Health Consortium rural outreach network, newsletters, and social media. • Telephone calls and personalized emails to identified contacts. • Presentations at statewide or local events (e.g. AFN, SHAPE Conference, NYO, PTA meetings, superintendent and school board conferences, community events). Additional responsibilities of Community Coordinators will include help with promoting the Game Changer Fund/Kicks for Kids program to children from undeserved families. Having “boots on the ground” in a remote communities will help us identify youth/families in need of assistance and facilitate delivery of our services.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Healthy Interactions, LLC	Alaska Rural Health Transformation Access, Education, and Workforce Economic Self-Sustaining Program	WY	Cardiometabolic conditions (diabetes, heart disease, chronic kidney disease, and obesity) pose some of the most pressing health challenges in the U.S., with rural communities following a similar trend. Limited access to care, geographic isolation, overwhelming chronic disease demands on healthcare delivery systems, and persistent workforce shortages make effective disease management difficult. HI has decades of experience improving both healthcare capacity and effectiveness. This proposal focuses on improving access, capacity and effectiveness. In Alaska, an estimated 48,800 adults (8.3%) have been diagnosed with diabetes, and approximately 258,000 adults (36%) live with obesity, costing approximately \$1.2 billion annually. Obesity rates are expected to rise to 51% by 2030 (ADA, 2024). These figures emphasize the urgent need for scalable solutions to address this growing burden. To accomplish the goals set for Alaska’s RHTP, behavior change and education is needed for both providers and patients. HI has a proven model that utilizes Conversation Map® sessions to deliver effective education and behavior change planning in healthcare settings thereby strengthening prevention and chronic disease care. HI offers support provider programs and patient education initiatives, to extend care access, build trust, and support patients in managing lifestyle changes and treatment adherence for specific chronic disease conditions.	HI proposes this RHTP plan focused on prevention, chronic disease support, workforce expansion, and improved care delivery. The project includes four integrated aims that: a) strengthen access, b) expand clinical and community capacity, and c) improve rural health outcomes. Using a multi-component strategy, HI will enhance primary care delivery, build workforce capacity, and expand access to culturally relevant patient education. Aim 1. Improve patient self management and health literacy to expand education and support for chronic disease prevention and self-management. Aim 2. Grow the rural healthcare workforce through the Certified Primary Care Educators (CPCE) program in the first 20 practices, increasing access to patient education. Aim 3. Improve efficiencies in these 20 primary care practices to increase capacity for innovative care models and reduce provider burden. Aim 4. Strengthen primary care practices by introducing reimbursable education services that sustainably expand self management support. Initiatives A) Certified Cardiometabolic Primary Care Education Platform. A virtual, self-paced certification program for allied health professionals, equipping staff to deliver evidence-based cardiometabolic education and potentially qualify for reimbursement. (Workforce, Pay for Value, Healthy Communities). B) Practice Chronic Condition Education Program. Support for clinics to integrate evidence-based education workflows that reduce provider burden, expand access to chronic disease management, and improve team-based care. (Care Access, Healthy Communities). C) Patient Chronic Condition Education Program + Virtual Conversation Maps®. An evidence-based group education model using Conversation Map® tools to improve chronic disease understanding, engagement, and long-term self-management across rural communities. (Healthy Communities, Technology & Innovation, Care Access). D) Telehealth (AI enabled virtual support). A digital, AI enhanced tools health strategy that expands access to chronic disease support, enhances patient engagement, reduces load on rural providers, and strengthens coordinated care. (Technology & Innovation). HI is uniquely positioned to rapidly implement by leveraging our innovative engagement strategies and our full cardiometabolic Conversation Map® catalog. With these proven, ready-to-deploy resources rooted in evidence and real-world clinical insights, we can move quickly from planning to action and scale across Alaska.	\$1M-\$5M	Family or primary care	Statewide	Anchorage (Municipality); Bethel Census Area; Copper River Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Healthy Solutions with Angela LLC	The Alaska ROOTS Initiative —Rural Outreach, Optimization, and Transformation for Sustainable Health	AK	Rural Alaska faces some of the nation’s highest rates of preventable chronic disease. Geographic isolation, historic healthcare inequities, limited access to fresh and nutritious food, and the erosion of traditional subsistence knowledge have left rural, remote, and frontier communities with chronic disease rates among the highest in the United States, with Alaska Native and other underserved rural populations disproportionately affected. Several interconnected challenges drive this crisis. Type 2 diabetes affects Alaska Native adults at rates far above the national average, yet many rural residents lack access to structured, ongoing diabetes support, increasing the risk of complications and hospitalizations. Hypertension is also widespread and often undertreated because consistent monitoring and coaching are rarely available in rural communities. Nutrition access gaps persist across many regions where limited access to fresh foods and nutrition services makes long-term lifestyle change difficult. At the same time, Alaska’s preventive health workforce remains severely limited, leaving too few diabetes educators and dietitians to meet statewide demand. Alaska’s RHTP creates an opportunity to build a scalable chronic disease support ecosystem statewide. Healthy Solutions with Angela, LLC will combine Angela Manderfeld’s clinical expertise and rural health experience with CAPPA Health’s digital platform to deliver diabetes, hypertension, and nutrition programs statewide.	The Alaska ROOTS Initiative is a technology-enabled chronic disease management ecosystem built for rural Alaska's realities. Four integrated components address the most urgent chronic disease needs statewide: FLAGSHIP - Diabetes Support Program (DSP), Weekly Cohort Model: A new participant cohort launches every week, any referred individual begins structured diabetes support within 7 days, no waitlists. The DSP provides peer support, 1:1 lifestyle coaching from Angela (RD, CDCES, BC-ADM), biometric tracking, and AI coaching available 24/7 between sessions. Evidence: A1C reductions of 0.8–1.5 percentage points in participants attending 8+ sessions; reduced diabetes-related ED utilization. Healthy Lifestyle & Weight Management: Multi-week wellness program covering nutrition, physical activity, sleep, and tobacco reduction. Angela's 18 years as a certified group fitness instructor and personal trainer enables live virtual exercise classes alongside nutrition guidance, rare in rural health settings. Serves as a gateway to DSP for pre-diabetic participants. Hypertension Management with SMBP: Remote coaching with blood pressure device distribution, SMBP training, lifestyle modification, and medication adherence support. Average systolic BP reductions of 8–12 mmHg. Participant data transmits through the platform for real-time coach visibility. Digital Platform, Nutrition Access & Community Innovation: All programs delivered via HIPAA-compliant, FHIR-interoperable mHealth platform with bandwidth-adaptive technology for low-connectivity environments, contracted through Cappa Health. Nutrition components include farm referral partnerships (Pyrah's Farm Mat-Su Valley, Alaska Farmers Market Association, Delta Junction farms), medical nutrition therapy, cooking classes featuring traditional Alaska foods and food preservation, food resource navigation to WIC/SNAP/tribal programs, and health bucks incentives, all building skills and connections rather than food dependency.	\$1M-\$5M	Private practitioner	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

HealthyCon nect.AI	Healthy Connect for Every Alaska Resident	FL	HC offers HC Basic (an individual care plan, all you need is a cell phone, tablet, or PC with mobile web access) that incorporates a care plan, medication reminders, educational materials, and check-ins and that can be instantly shared with any other provider. This core base service adds value to the entire eco-system and in particular leads to instant telehealth access and then also easy expansion into CMS supported care management programs like ACCESS, CCM, RPM, and RTM. This increases core care for any patient and easy upgrade to care management programs with reimbursement or needed for value based care. This in effect turbocharges the whole HIE concept with a patient and provider shared infrastructure. Providers benefit from monthly economics, payers can see significant reduction in high cost care, and patients have simpler access via telehealth for routine and specialized needs. HC is leveraging data now available at the patient level, uses AI to summarize that for providers, and drives significant economic gains for any healthcare organization. It's a platform more than a service and should be considered patient and provider infrastructure. Here's an example: our provider have asked that we assess for patients with Medicaid redetermination requirements and notify them of required data submissions----they can open our app or mobile web, snap a picture of a class schedule or utility bill, and we upload to state.	HC believes that every Alaskan (age can be limited) should be enrolled in HC Basic (consent should be obtained) but it is free to very resident that does so. All we need is a roster and cell phone number or e-mail address, and our AI powered Care Assistant assembles patient data, creates a high level care plan, and does monthly check-ins, or reaches out if an event is detected. Its interactive, largely text or app messaging, and includes all important HIE data, Surescripts medication data, and the AI Care Assistant can answer questions or forward events to practitioners for action. This can be configured by patient, largely, based on needs and further configured by a linked provider. This is the core need for financial support during years 1 through 3. HC then identifies patients that can be enrolled in federal care management programs including ACCESS, CCM, RPM,, or RTM and can assist with pharmacy type programs as well. This creates both better care pathways for those that need it, all of the support services to deliver it (equipment, nurse coaches, program administration, claims management) etc. and creates a per patient subscription margin for providers or can be used to support value based care models, generating healthcare savings. This amount is substantial in many cases with 50,000 seniors in care management programs generating \$25MM in annualized income. HC Basic is proven for all patients to increase appointments, reduce no-shows, and should generate an additional visit per year with a provider, as importantly, for Medicaid patients, ensure coverage and reduce ER expenses. Keeping Medicaid patients eligible with redetermination requirements, this can be strongly positive too both for the State and for providers. The platform can also support other services from behavioral health (link to specialists, etc.) matching needs and available resources via telehealth, a concept well know by Alaska. The concept is quite simple: leverage an asset almost everyone has via satellite internet, mobile phone networks, or Internet in having a dynamic care plan populated with the most recently available data to improve care, reduce administrative costs, and access care management programs via Medicare and MA plans, and soon many Medicaid programs.	\$1M-\$5M	Family or primary care	Multi- Community or Participating in Regional Hub-and- Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Healy Lake Village Council	Healy Lake Clinic Restoration, Health Aide Housing Equipment & Emergency Transport	AK	Since a catastrophic septic failure in 2020, the Healy Lake clinic has been closed due to total building contamination. This has left our community with zero local healthcare infrastructure. Currently, residents must rely on a bush plane that only services the village twice a week. This lack of access has forced our elders to relocate to urban centers for routine care and leaves the remaining population at extreme risk during medical emergencies. We have a unique, time-sensitive opportunity to restore a sustainable healthcare ecosystem in Healy Lake. This project is shovel-ready and integrates three critical components: Infrastructure Restoration: Professional remediation of the existing clinic (\$343,750 including indirect/contingency) to provide a safe, sterile environment for care. Emergency Access: Acquisition of a dedicated medical transport boat (\$72,000) to provide immediate access to the road system, bypassing the limitations of the flight schedule. Workforce Synergy: The Tribe has already secured funding for Health Aide housing (completing Fall 2026). By fixing the clinic now, we ensure that when the housing is finished, the health aide has a functional, equipped workspace ready for immediate use. By funding this project, the RHTP will directly transition Healy Lake from a "healthcare desert" to a community that can provide high-quality, local care for its residents and elders.	Our approach is a coordinated, three-phase execution plan designed to restore clinical services in Healy Lake by the time our new Health Aide housing is completed in Fall 2026. Phase 1: Professional Remediation & Infrastructure Repair We will immediately contract the specialized firm that provided our \$275,000 estimate to begin site work. Decontamination: Full bio-remediation of the septic-contaminated zones to meet environmental safety standards. System Overhaul: Complete replacement of the failed septic components with a modern, high-capacity system designed for rural Alaska's sub-arctic conditions to prevent future failures. Interior Restoration: Reconstruction of clinical spaces, including sterile surfaces, pharmacy storage, and a telehealth-capable exam room. 2. Emergency Medical Transport Acquisition Parallel to the construction, the Village Council will execute the purchase of the \$72,000 medical boat package from Dewey’s Cook Inlet Marine. Customization: The vessel will be outfitted with a motor and trailer, then staged in Healy Lake to serve as a dedicated "water ambulance." Operational Training: We will establish a rota of trained tribal members capable of operating the vessel for medical transport to the road system, ensuring 24/7 emergency egress that is independent of flight schedules. 3. Workforce & Clinical Integration This project serves as the "anchor" for our broader healthcare strategy. Housing Synchronization: We are currently managing the construction of Health Aide housing (funded separately). By completing the clinic remediation now, we ensure the workplace is ready the moment the provider arrives. Administrative Oversight: Using the 15% indirect cost allocation, the Tribal Council will provide the project management and reporting necessary to ensure the grant is executed on time and within the 10% contingency budget. Expected Outcome By the end of this project, Healy Lake will have a fully certified, decontaminated clinic and a reliable emergency transport vessel. This	\$250K-\$1M	Single Community	Southeast Fairbanks Census Area	Deferred or Not Advanced

creates a sustainable "care ecosystem" that allows our residents—specifically our elders—to receive high-quality care at home rather than being forced to relocate for basic medical needs.



Heart of Eagle River Medical Clinic PC	Delivering Enhanced Patient Care to Rural Alaskans by Revitalizing Clinic Services & Systems	AK	We have two clinics, with the larger clinic in Eagle River subsidizing the smaller clinic in Willow. During COVID and again in 2024 we had two key medical providers retire from the larger clinic and have only been able to hire and retain one new part-time provider since that time. As a result, we are understaffed in Willow and were forced to close the Eagle River clinic on Saturdays. It has been difficult to find skilled office staff at an affordable hourly rate. Since 2020 our overall Medicare patient population has increased, but low reimbursement rates have not translated into more revenue to keep up with increased rents, taxes, and supply costs, as well as overtime wages for the additional coverage needed. Also, the largely Medicare/Medicaid patient population in Willow depends heavily on the Eagle River clinic's financial support while it too is struggling. Much needed IT and equipment upgrades in the clinics could not be realized so some patient services were discontinued, forcing our patients to travel long distances for diagnostic tests. Our loyal providers currently earn at the lower end of the wage scale (MD @ \$80/hr and ANP @ \$55/hr) and we want to give them much-deserved raises to retain them. We lack the funds for a website designer and have done very little advertising, resulting in limited introduction in our neighboring communities. Local involvement has historically been our primary method of outreach (i.e. the Willow community calendar & Jr. Iditarod).	We currently have two young people interested in training as x-ray tech assistants; one for the Willow clinic and the other for Eagle River. The boxes of retired patient files stored in both x-ray rooms (and commercial storage facilities) will be shredded so upgraded equipment can be installed. Patients will no longer need to travel to the emergency department for diagnostic images and this will help generate more income for clinic sustainability and eliminate storage facility fees. We are also exploring the possibility of bringing new staff onboard via SkillBridge, a federal program in which transitioning military personnel in their last 180 days of service gain training, apprenticeships, or internships in a civilian setting. The service member would continue to be paid by the Department of War while training and we, as the training partner, receive help in coverage and hopefully, a future employee. Ideally, we would do the full-time training in the Eagle River clinic but also integrate the trainee into the satellite clinic in Willow. Since there is no salary commitment on our part, we could conceivably use the proposed salary for the service member's temporary housing in Wasilla, conveniently situated almost exactly between the two clinics. New computers with electronic medical record and billing software will allow our providers and staff to more readily access and share patient information in a more timely manner and deliver more seamless patient care between our two clinics as well as with specialists, hospitals, insurance companies, and pharmacies. Outdated EKG, and PT-INR diagnostic equipment will be replaced with newer supported models for more comprehensive patient care. Currently the FAA now requires new private pilots to take a computerized color vision test and procuring this software will allow our Aviation Medical Examiner to administer this test and prevent our patients from traveling even further to fulfill this mandate. We anticipate the re-hiring of a part-time Advanced Nurse Practitioner starting in May, 2026 enabling the Willow clinic to expand its clinic hours of service and increase sustainability. A website will make our clinics more visible to potential patients, highlight patient services, and introduce our providers and staff to the communities we serve. Potential employees will also be researching our clinics and a website is one of the first tools they will use to inform them of location, community services, etc.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Denali Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Heart Of Gold Ministries International	Heart of Gold Ministries International	AK	According to the US Census Bureau's American Community Survey for 2019, Alaska had an estimated 11,000 disconnected youth, representing approximately 13.8% of the state's population aged 16 to 24. In an attempt to survive and escape the pressure attached to living and achieving a successful life youths and young adults often resort to violence, criminal activities, drug abuse among others and this is evident in the alarming increase in juvenile delinquency in Anchorage, Alaska. The neglect rate due to substance abuse in Anchorage according to The Office of Children's Services averaged 47.1% from Oct 2022 through Oct 2023. And over that same period an average of 595/Mo Out of home service reports were entered. According to the Anchorage Health Dept: Alcohol is the substance of highest use and misuse in the community, and the rates of alcohol addiction and alcohol-induced mortality are higher in Anchorage than they are nationally. Methamphetamine use is on the rise. Alaska had the highest rate in the nation of substance use disorder in 2016-2017 among 12-17-year-olds. The lack of behavioral and psychiatric health services exacerbates the substance misuse crisis. Alaska has a high rate of suicide mortality and suicide ideation, and Alaskans experience higher rates of serious mental illness than national average. The city lacks treatment providers, diverse treatment modalities, and treatment services that can treat co-occurring addiction and mental health issues.	Heart of Gold Ministries International (HGMI) aims to promote the well-being and prosperity of Alaska's people by facilitating their empowerment and capacity building through practical information and education. The organization offers a range of programs designed to enable Alaska's people to reach their full potential and become valuable members of society as well as functional family members. These programs include: Life Coaching Programs, Navigating Healthy Living Programs, and Substance Use Disorder Programs. The programs are equipped with a comprehensive set of services and resources to make a positive impact on the lives of families and empower them to achieve success in their personal lives, academic pursuits, and career development.	\$50,000-\$250,000	Single Community	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Heartland Intellicare	QualiNav Data Intelligence: Rural Patient Safety Network Hub Development	CA	Alaska's rural healthcare facilities face a persistent quality data crisis. Quality Directors, the professionals responsible for patient safety, regulatory compliance, and quality improvement - typically manage four to five additional job roles simultaneously, often without formal quality training or modern tools. The data they depend on to do their jobs is fragmented across spreadsheets, manual logs, and disconnected systems, making it nearly impossible to identify risks in real time or respond proactively. At the same time, Alaska's statewide rural patient safety network lacks a centralized digital home for its data reporting and analysis, meaning valuable comparative quality data is not easily accessible to the rural facilities that need it most. The RHTP presents a timely opportunity to address both of these gaps in Year 1: by building and validating automated, actionable quality data reports within the QualiNav platform through a focused group of approximately five rural healthcare facilities, and by establishing QualiNav as the statewide hub for rural patient safety network data. In turn, this lays the groundwork for full platform deployment in Year 2.	Heartland Intellicare, in partnership with the Alaska Hospital and Healthcare Association (AHHA), will conduct a structured Year 1 focus group build-out of the QualiNav platform with approximately five Alaska rural healthcare facilities. AHHA will identify and recruit willing facilities from its membership network. Heartland Intellicare will lead all technical development, implementation, and project execution. Year 1 work will concentrate on two core deliverables: - Automated, Actionable Quality Data Reports: Working directly with focus group Quality Directors, Heartland Intellicare will identify the highest-priority data reporting needs specific to Alaska facilities including quality metrics, regulatory compliance indicators, patient safety event tracking, and performance improvement data. The team will build, test, and refine automated report templates within the QualiNav platform that transform manual data entry processes into real-time, actionable dashboards. Focus group participants will provide ongoing feedback throughout the build to ensure reports reflect real-world workflows and decision-making needs. - Statewide Rural Patient Safety Network Data Hub: QualiNav will be configured to serve as the digital home for Alaska's rural patient safety network data reports, centralizing comparative quality data in a format that is accessible, interpretable, and actionable for Quality Directors across the state. This phased approach is an intentional, human-centered design approach. Year 1 generates the evidence, validated tools, and participant relationships needed to support a strong Year 2 application for full statewide deployment, including AI-driven workflow automation, the SCOUT chatbot for real-time compliance guidance, virtual mentorship, policy and procedure management, and the statewide peer learning network. This approach aligns directly with Alaska's RHTP Initiative #6 (Spark Technology and Innovation) - specifically the use of technology to improve care delivery and quality in rural hospitals; and Initiative #5 (Strengthen Workforce) through professional development and capacity building for quality leaders.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Sitka (City and Borough); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Henning Inc	Henning Inc Surge Capacity	AK	Henning seeks to address the growing need for consistent, year-round shelter and coordinated support services for individuals experiencing homelessness. In Anchorage and surrounding communities, many individuals lack access to stable shelter options outside of seasonal or emergency capacity, leaving people exposed to harsh weather conditions and disconnected from the health and social services necessary to stabilize their lives. Without reliable year round shelter, individuals experiencing homelessness face significant barriers to accessing health care, behavioral health treatment, and case management services. When people are forced to focus on daily survival—finding a safe place to sleep, staying warm, and securing basic necessities—it becomes extremely difficult to address underlying health needs, connect with providers, or work toward long-term stability. This project will expand Henning’s ability to provide safe, consistent shelter year-round while strengthening connections to critical services including primary health care, behavioral health support, housing navigation, and other stabilization resources. By increasing the number of individuals who can access shelter on a consistent basis, the program creates a stable environment where service providers can engage individuals, address immediate health needs, and support pathways toward permanent housing and improved wellbeing.	Henning will address the need for consistent, year-round shelter and supportive services through a coordinated, multi-pronged approach that emphasizes stability, access, and individualized support. The program is designed to not only provide additional safe shelter but also create pathways to health care, behavioral health services, and permanent housing. We will increase available beds by 100 beds ensuring that individuals experiencing homelessness have consistent access to safe, warm, and supportive accommodations regardless of season. Upon entry, each client will receive a thorough assessment to identify immediate needs, including medical care, mental health or substance use support, and housing barriers. This allows us to tailor services to each individual and prioritize urgent interventions. Trained case managers will work directly with clients to connect them to primary health care, behavioral health services, employment resources, and housing programs. By coordinating these services, the program reduces barriers and helps individuals move toward long-term stability. The project will leverage partnerships with local health providers, behavioral health organizations, housing agencies, and community-based nonprofits to ensure clients have access to a broad spectrum of support services. These partnerships also enhance efficiency and reduce duplication of effort across service systems. The program will track client engagement, service utilization, and housing outcomes to evaluate effectiveness, identify gaps, and continuously refine the approach to ensure maximum impact.	\$250K-\$1M	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Henning Inc	Rocket Fuel Feeding Kids Program	AK	Childhood food insecurity is a persistent challenge in Alaska, with approximately 1 in 6 children experiencing hunger. In Anchorage, many students rely on free and reduced-price school meals as their primary source of daily nutrition. When school is not in session—weekends, holidays, or breaks—these children often lack reliable access to nutritious food, leading to negative impacts on health, academic performance, and overall wellbeing. RocketFuel seeks to address this gap by providing take-home food bags for students attending Title I schools. By ensuring that children have access to consistent, nutritious meals even when school is closed, the program helps prevent childhood hunger, supports healthy development, and stabilizes families who are facing economic hardship.	RocketFuel will provide weekly take-home food bags to students attending Title I schools. Each bag contains a balanced combination of meals and snacks to sustain children through the weekend (approximately 2.5 days of food). Food bags are distributed discreetly through school partners, ensuring children can access support without stigma. The program is designed to scale efficiently: Identification: School staff identify students most at risk for weekend food insecurity. Distribution: Bags are packed weekly and distributed via school partners to students before weekends and holidays. Partnerships: The program partners with schools, community volunteers, and local food suppliers to ensure reliable delivery. Monitoring: Staff track participation and food bag distribution to ensure the program meets students’ needs and maintains quality. This approach ensures that children receive consistent nutrition while reducing the stress and instability families face when resources are scarce.	\$250K-\$1M	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Hillcrest Children's Center	Childcare Cooperative Network (CCN)	AK	Rural healthcare employers cannot recruit workers with children when no licensed childcare exists nearby. The root cause is structural. Opening a licensed childcare program requires a credentialed administrator, technical assistance, and renovation of appropriate facilities. None of these conditions exist in rural Alaska without deliberate investment. Conventional models have not broken this cycle because they depend on conditions rural Alaska lacks — stable financing, adequate wages, and low turnover. The local worker-owned cooperative (WOC) model addresses these root causes directly. Worker-owners participate in governance, financial decision-making and profit-sharing, thereby producing the wages, job satisfaction, and retention in community that make programs sustainable where others have failed. The Cooperative Childcare Network (CCN) has demonstrated this model works in Alaska. The first Administrative Cohort trained 17 professionals — exceeding initial goals — and multiple Anchorage programs are actively transitioning to worker-owned operations. A registered apprenticeship program creates an ongoing pipeline of credentialed worker-owners, treating licensed childcare as the skilled profession it is. RHTP investment will extend this proven approach to rural Alaska: training administrators, developing childcare sites near healthcare workplaces, and building the shared infrastructure that allows community-rooted programs to open, operate, and endure.	The CCN project addresses the rural childcare-workforce cycle through five coordinated strategies proven in Anchorage and ready to scale statewide. 1. Advocacy and Awareness. Two documentaries about rural childcare challenges and a media campaign will advance worker-owned childcare as workforce development strategies. 2. Rural Administrative Cohorts. Building on the completed Anchorage pilot, the CCN will support childcare administrative training cohorts for rural early childhood educators, enabling participants to meet Alaska's state licensing educational requirements. Flexible, rurally-adapted delivery will be designed in partnership with communities to reduce barriers to participation. 3. Childcare Apprenticeship Pathway. Workers will be supported to complete the 480 hands-on hours required for the Child Development Associate credential through a structured apprenticeship at hub-community licensed facilities. Future RHTP funding could support travel, lodging, and wages — removing the geographic barrier that has historically excluded rural workers from this credential. 4. Rural Childcare Site Development. Working alongside rural communities and healthcare employers, the CCN will identify and develop home and center-based licensed childcare sites in proximity to healthcare workplaces, tailored to each community's size, culture, and need. Site development will draw on lessons learned through the Community Innovation Grant, applying what the CCN has tested in Anchorage about startup barriers, facility readiness, and community engagement to ensure rural programs are built on a foundation designed to last. 5. Shared Administrative Services. The CCN is actively developing a shared services model providing backbone administrative infrastructure — licensing support, compliance, HR, and enrollment systems — to licensed childcare programs (home and center based, multilingual) in Anchorage, reducing startup barriers and improving long-term viability. Statewide expansion of worker-owned and worker-managed childcare supported by shared services will provide rural programs the same critical administrative support that makes Anchorage programs viable, and that rural programs currently have no access to. Together, these strategies move beyond training individuals to building the system-level infrastructure rural Alaska needs to grow and sustain its own licensed childcare — and by extension, its healthcare workforce.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Holck Consulting	AI-Enhanced Public Health Data Accessibility: Reimagining BRFSS, PRAMS, and CUBS Interactive Portals	AK	Alaska State public health data dashboards are often cumbersome to navigate, particularly for non-technical users. Data is often structured within drop-down menus, organized by topics, with different types of User Interfaces between dashboards, making it confusing and frustrating to locate data a user is hunting for (if that data even exists!). Often Alaska's rural communities are at a disadvantage in having limited technical expertise useful to consume information from these dashboards. Without this knowledge, non-optimal, minimal, or incorrect data may be used by decision makers, who are more likely to resort to simple Google searches or general conversational AI engines (e.g. ChatGPT). Conversational AI can be misleading and even dangerous, providing unvalidated, incorrect numbers and interpretation that can lead to incorrect or suboptimal health policy decisions.	We have developed a prototype conversational AI to explore an alternate approach to accessing Alaska BRFSS data. This prototype solves a key challenge when integrating AI into a data stream, namely the potential for “hallucinations” that could result in incorrect or misleading data estimates. To address this very real concern, we use a tiered approach: we first use AI to identify the top three indicators available in the actual backend SQL database, based on the user question; we then use the machinery of the dashboard itself (rather than relying on an AI agent) to return the estimates, calculated by the dashboard’s statistical software. This approach ensures that although a user may still choose an incorrect indicator, the result returned for the selected indicator is correct and not based on an AI hallucination. Finally, we will implement an AI interpreter assistant (restrained to appropriate data sources) that allows the user to receive assistance with understanding the results and compare (if available) to national estimates. By re-envisioning data dashboards to include “safe”, conversational AI, users that are not familiar with or aware of the different point-and-click navigation can access and, furthermore, receive assistance in understanding available data more quickly and accurately. We propose to build-out our prototype, and to fully integrate it into the existing Alaska BRFSS application. Subsequently the developed tool can expand and adapt to be incorporated into other similar Alaska public health dashboards and applications.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Holck Consulting	Alaska Public Health Dashboards Unified AI Query System	AK	Alaska maintains numerous specialized public health data portals (BRFSS, PRAMS, CUBS, infectious disease surveillance, vital statistics, environmental health, injury prevention, and others), each valuable, but siloed. Health providers, public health officials, tribal health organizations, community planners, researchers, and grant applicants currently must first determine which of these systems holds the information they need, then learn each system's unique interface and terminology, then manually compile findings across platforms. This multi-step process can consume hours before a user even begins addressing the actual health challenge. The burden falls hardest on rural Alaska's health workforce, where limited staff wear multiple hats and lack dedicated data analysis capacity. A rural health director seeking information on prenatal care, substance use trends, and injury patterns may need to navigate three or four separate dashboards, a time investment that is often unsustainable. This fragmented data landscape undermines the data-driven, informed clinical decision-making that RHTP's Spark Technology and Innovation initiative envisions, limits the ability to identify high-risk populations and tailor interventions as called for under Healthy Communities, and weakens rural communities' capacity to address their most pressing health concerns	We propose to create Alaska's first unified public health data intelligence portal: a single, AI-powered interface that can identify, query, synthesize, and assist in interpretation of information from the state's many public health dashboards. Users will ask a single natural language question and receive a consolidated, evidence-based response drawn directly from the relevant Alaska Data Hub dashboard(s). The tool uses advanced browser automation technology to navigate dashboards exactly as a human user would. It crawls the dashboards linked from the Alaska Data Hub website, maps their interfaces and data structures, and learns to retrieve specific information on demand. The AI-powered tool returns results directly from these dashboards by navigating them. Incorrect hallucinations or fabricated data are not possible. The source of all data retrieved and the navigational steps used are returned to the user for full transparency. If requested, the tool will interpret results in plain language. We have a functioning alpha prototype that demonstrates technical feasibility and validates this approach. For rural Alaska's health workforce, where limited staff juggle multiple roles with minimal data analysis capacity, this tool transforms a multi-hour research process across three or four separate dashboard systems into a single question answered in minutes, reducing data search and compilation time by an estimated 80-90%. The project directly supports RHTP's Healthy Communities initiative by building infrastructure that aggregates behavioral and health-related information across existing data systems, enabling providers, tribal health organizations, and communities to identify high-risk populations, tailor interventions, and support proactive chronic disease management at the community level. The project advances RHTP's Spark Technology and Innovation initiative as an appropriate AI tool that supports informed clinical decision-making, integrates advanced analytics across public health data systems, and enables population-level analysis to guide care management and resource allocation in rural and frontier communities.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Holck Consulting	PRAMS Comparative Dashboard	AK	Alaska currently lacks a mechanism for cross-state and cross-regional PRAMS comparison, which limits the ability of planners and community leaders to evaluate the effectiveness of maternal health programs. Without a national benchmark, it is difficult to determine if a specific rural health indicator in Alaska represents a success or a systemic lacking that could benefit from intervention. This "benchmarking gap" puts Alaska and its rural communities at a disadvantage when competing for national grants, and complicates the process of setting realistic, data-driven goals for maternal health improvement. There is a significant opportunity to build on an existing proof of concept dashboard to create a National PRAMS Dashboard that allows Alaska to compare its rural and regional indicators against other states, providing the essential context needed for effective advocacy and enhancing or improving program design	Our approach focuses on technical integration and comparative logic to make national (at state and regional levels) MCH data indicators accessible and actionable for Alaska stakeholders. 1. Multi-State Data Integration: We will develop a dashboard (prototype version already exists) that pulls PRAMS data from multiple participating states, creating a unified SQL-based backend. The dashboard will allow for seamless cross-state benchmarking and comparisons with demographic stratifications and filters, geographical mapping, and indicator cross-tabulation presented with an intuitive interface. Secure authorization and login to the dashboard will be implemented. 2. Rural Subgroup Analysis: A useful feature will be the ability to filter data by rural vs. urban subgroups across states. This allows Alaska to compare its "off-road" outcomes not just to its own "on-road" populations, but to somewhat similar rural populations in peer states. 3.Regional Benchmarking: We will integrate Alaska’s existing regional and THO-level data into the national framework. This allows Alaska regions to assess how they perform on important MCH indicators relative to other state-level averages or—as the tool matures—to similar rural regions/counties in the Lower 48. 4. Integrated Interpretation: Following the model of other R shiny dashboards we have built for the State, we will include built-in statistical estimates and guidance to help non-technical users (such as community grant writers) interpret these comparisons correctly and use them to build strong arguments for funding. By leveraging an existing prototype, we can focus the project period on greatly expanding and refining the user interface and available backend data to increasing capabilities, as well as on establishing the governance structures needed for additional multi-state data sharing	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Holck Consulting	Small Area Health Estimation for Rural Alaska: Local Data for Community-Level Decision Making	AK	Alaska's primary public health surveillance systems generate reliable statewide and regional estimates, but small rural community populations produce sample sizes too small for valid local data. This is not a minor technical limitation, but also a structural challenge. Communities with the greatest health burdens cannot document their specific needs, track whether local programs are working, or compete effectively for funding. The State similarly lacks the community-level evidence needed to target assistance efficiently. Small area estimation directly resolves this by applying advanced statistical modeling to existing surveillance data to generate valid community-level health estimates where direct measurement has never been feasible.	Our approach builds directly on Alaska's existing public health surveillance infrastructure rather than creating parallel systems. We will apply the most appropriate small area estimation method, which may include hierarchical Bayesian models, multilevel regression with poststratification, or spatial smoothing techniques. Standard SAE methods borrow statistical strength from neighboring areas to generate estimates where local samples are insufficient. Alaska presents distinct methodological challenges: communities separated by vast distances, significant cultural differences, and limited administrative data linkage. Our team's 30 years of working directly with BRFSS, PRAMS, and YRBS and deep familiarity with Alaska's rural landscape positions us to extend and innovate on these methods (e.g., create ensemble models) rather than apply them off the shelf. Validated models will be integrated directly into existing dashboard infrastructure (where possible), generating community-level estimates accessible through the same platforms users already rely on. Estimates will include calibrated uncertainty measures and suppression rules for cases where reliability thresholds are not met, preventing misinterpretation. The approach is iterative: models will be validated against available direct estimates and reviewed with rural health stakeholders before broader deployment. This ensures that what reaches communities is methodologically sound, interpretable, and genuinely useful for local planning, program evaluation, and funding applications.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Holck Consulting	Statewide Technical Assistance for RHTP Projects Success	AK	A significant gap exists between the innovative ideas of rural health leaders and their capacity to meet the rigorous evaluation and data-reporting standards of the RHTP. Many promising projects lack the internal biostatistical expertise to translate a project concept into a measurable, statistically valid well-designed study or assessment, which can lead to inconclusive findings or effects, which diminish conclusions drawn about project efficacy and can threaten long-term sustainability. This "design and evaluation gap" limits the ability of rural communities or organizations seeking to assist them to demonstrate the benefits of their program or study, and handicaps their ability to compete for continued funding.	Our group has a 30-year track record of helping Alaska organizations bridge this gap. This project proposes to utilize that expertise into a resource of assistance and guidance offered to RHTP participants in their project’s up-front design, analysis, and evaluation capacity they need, and offer the methodological integrity/rigor required to sustain it. Our experience makes us well-suited to provide this capacity and assistance, while also fostering local skill-building in methods and analysis as desired. We will establish a multidisciplinary "Evidence Hub" that provides: 1. Consultation & Office Hours: Direct access to experts in study design, epidemiology, statistics, data management, evaluation, and meaningful reporting of successes, helping communities and researchers design projects that are logically sound, statistically valid, and likely to yield measurable results that can be evaluated. 2. Methodological Translation: We will help groups translate their "big ideas" into specific, measurable variables and data collection protocols that satisfy both local needs and rigorous funding requirements. 3. Rapid-Response Design Support: Providing templates and practical guidance for evaluation tasks that are often neglected until it is too late to collect baseline data. 4. Coordination with State Partners: We will proactively coordinate with existing State evaluation contractors to ensure our TA is supplemental where needed, and focused on the upfront logic of study design, meaningful data collection, and appropriate analysis and reporting. By applying 30 years of Alaskan common sense to complex data problems, we help ensure that the findings produced by rural projects are based on solid, interpretable methodology to help communities and researchers obtain evidence that effectively demonstrate a project’s benefits.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Holck Consulting	Urban–Rural Classification Framework for Alaska Health Equity	AK	The primary problem is that standardized federal urban-rural definitions are a “one size fits all” approach designed for lower 48 population distributions, and they therefore fail to allow discerning the differences that exist across Alaska’s rural communities. For example, a hub community such as Bethel with a regional hospital and scheduled air service differs fundamentally from a remote village accessible only by seasonal barge or small aircraft, yet they are often lumped together as the same type of community in health research. While on/off-road classification is a crude refinement to even broader MSA definitions, it is still lacking in distinguishing Bethel or Juneau from more distant villages. There is a significant opportunity to build on previous efforts (such as the Alaska Rural Primary Care Facility Needs Assessment Project from 2000 and its “Isolation Score”) to create a validated, multi-dimensional tool that accurately reflects remoteness and health delivery capacity. This will resolve misclassifications that currently distort rural health policy and resource distribution	Our approach combines methodological rigor with practical validation to ensure the new classification system is both scientifically sound and useful for decision-makers. Framework Development: We utilize community characteristics such as travel time to trauma centers, available mode of travel (road/boat/plane), presence and extent of community health clinic and staffing, availability/location of specialty care, and transportation infrastructure (e.g. airstrip capabilities, scheduled flight frequency, etc.) Validation: The underlying data informing this classification will be validated against actual infrastructure (transportation and clinic), population demographics, and health outcomes data. We will test the framework to see if it more accurately predicts disparities in care access and chronic disease burden than existing more crude classification models. Tool Creation: The final product will not just be a report, but a reusable definition and mapping tool that can be integrated into existing State of Alaska health dashboards and research workflows. By building a system that stakeholders accept as a standard based on a database of accurate relevant factors and a well-designed algorithm, we create a common standard for Alaska health research and policy resource allocation that much more accurately reflects the actual living situation of our rural population.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Holt Chiropractic Clinic	Coastal Chiropractic	AK	I want to address health of local and rural patients that rely on alternative health care. This project would provide upscale services that does not short change patients due to lack of state of the art equipment. We would use equipment and techniques with proven results enhancing the individual health of each and every Alaskan that chooses to be seen in our stationary clinic or marine facility.	I propose a rebuild of the existing brick and mortar clinic that would facilitate, state if the art equipment (new chiropractic and exam tables, X-rays, CT, US, decompression, hyperbaric decompression, shockwave, lasers and up to date EHR system. This would also include a Marine platform (boat) that would also be outfitted with very similar state if the art equipment that could handle rough seas and saltwater environments. This platform would be a mobile clinic on the water that would be able to get access into all the communities of Southeast Alaska.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Sitka (City and Borough); Wrangell (City and Borough)	Deferred or Not Advanced
Homer Council on the Arts	Supporting Teen Wellness through Art	AK	The community of Homer has long sought to provide expanded access to youth programming out of school. Teens and students grades 7-12 have limited accessible programming outside of school. This program will provide a safe, supportive, and creative opportunities for teens.	HCOA will expand a current pilot project which provides a teen art space. Originally envisioned as a result-oriented teen created art project, we have learned that participating teens truly need a chance to be creative in a variety of art forms. By providing a space and access to supplies and materials, as well as a supportive facilitator, these teens are able to decompress, relax, commune with each other, explore their creativity, and develop their art. Additionally, we are piloting a teen art mentorship program. Targeted at at-risk or disadvantaged teens, this program will facilitate and provide mentorship pairings with local working artists.	Under \$50,000		Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

Homer Cycling Club	Eastland Trails: Expanding Rural Access to Preventive Outdoor Health Infrastructure	AK	Rural Homer and the surrounding lower Kenai Peninsula face persistent barriers to preventive health access. Residents experience limited year-round employment, high living costs, long travel distances to services, and restricted access to structured wellness programming. While Kachemak Bay State Park is a major regional asset, nearly all trails are located across the bay and require costly water taxi or aircraft access, limiting regular use by families, seniors, youth, and lower-income residents. The north side of the bay, where most residents live, lacks free, accessible, road-connected infrastructure that supports daily physical activity and structured wellness engagement. As a result, opportunities for routine movement, outdoor stress reduction, and community-based preventive health programming are unevenly distributed. This gap presents a significant opportunity: to develop an existing, underutilized and road-connected State Park unit as a designated rural wellness location that integrates physical activity, mental health benefits, and preventive health education into a durable public setting. Rather than building a new facility, this project transforms an existing public asset into a community-scale wellness platform embedded in the natural environment.	This project will transform the Cottonwood Eastland unit of Kachemak Bay State Park into a designated rural wellness location through a phased infrastructure expansion totaling approximately 11.5 miles of professionally built, sustainable multiuse trails, supporting health-focused improvements. Phase 1 (2025–2026) established the foundation for the wellness site, including construction of a public trailhead, parking, maintenance area, and approximately 3.5 miles of highly accessible, low-grade trail. This phase created safe, road-connected access and the core infrastructure necessary to support year-round physical activity and community programming. Phase 2 (2026–2027) — The subject of this RHTP request, expands the wellness platform by adding approximately 4.5 miles of additional trail designed to increase movement opportunities and accommodate diverse user abilities. Phase 2 also includes installation of health-focused and wayfinding signage promoting physical activity, chronic disease prevention, mobility maintenance, and nature-based stress reduction. Targeted enhancements to existing park facilities will support structured wellness programming such as walking groups, youth engagement, adaptive recreation, and community health initiatives. This phase represents the critical shift from a passive recreation area to active, designated wellness location. Phase 3 (2027–2028) completes the system with a 3 mile outer loop that expands capacity and ensures long-term scalability of programming and sustained community use. Together, these three phases transform an underutilized State Park unit into a lasting preventive health asset, expanding an existing recreation area into an accessible outdoor wellness space that supports physical activity, mental health, and long-term rural well-being.	\$250K-\$1M	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

Homer Hockey Association	Sustaining a Kenai Peninsula Rural Community Wellness Hub: Kevin Bell Arena Renovation	AK	Alaska's chronic disease burden is among the highest in the nation. Three in four Alaskans have or are at risk of chronic disease. Regular physical activity is one of the most effective tools for prevention and management, but access is limited in rural communities. Kevin Bell Arena is the only nonprofit ice rink in Alaska and the only dedicated indoor rink on the southern Kenai Peninsula. It serves over 15,000 residents a year, including Alaska Native villagers, Russian Orthodox communities, and rural families from Ninilchik through Homer and across Kachemak Bay. While the rink is well used and loved, the arena is over 20 years old, and critical building systems are failing. The boiler, fire suppression system, roof, parking lot lighting, and garage doors all require repair or replacement to keep the facility safe and operational. Homer Hockey Association (HHA) has operated the arena since 2005 and has maintained it responsibly, but the facility has reached a point where deferred investment is no longer an option. The refrigeration and mechanical infrastructure are also nearing the end of their useful lives. Without intervention, the arena risks closure, eliminating one of the only places for physical activity available to these rural communities. This LOI represents Phase 1 of a planned multi-year investment to address both immediate safety needs and long-term infrastructure.	Alaska's rural communities face a chronic disease crisis, and access to physical activity is one of the most effective tools to address it. Kevin Bell Arena operates September through April, providing indoor activity during Alaska's long winter months when outdoor options are severely limited. For Alaska Native villagers, Russian Orthodox communities, and rural families spread across the southern Kenai Peninsula, it is one of the only places where people of all ages can stay active close to home. During the summer months, the arena closes as Alaskans turn to the outdoors and the facility undergoes routine maintenance. For this project, HHA will complete arena repairs within the summer window, ensuring not a single day of community programming is disrupted. Phase 1 repairs will address the most urgent building system failures identified by HHA's maintenance and facilities team. Planned work includes replacement of the fire suppression system, boiler repair or replacement, roof repairs, installation of new parking lot lighting, and replacement of two garage doors. These repairs will bring the facility up to safe operating standards and reduce the risk of emergency failures that could force unplanned closures during the programming season. In parallel, HHA will commission a comprehensive assessment of the arena's refrigeration and mechanical infrastructure. This assessment will provide detailed cost estimates and inform a phased renovation plan for subsequent years of improvements, ensuring future investments are targeted, cost-effective, and properly sequenced. Shelly Laukitis, HHA's Finance Committee Chairperson and former board president, will serve as project manager. She will oversee contractors, manage timelines, and ensure all work is completed before the arena reopens in the fall. Her long tenure with HHA and deep familiarity with the facility make her well-suited to lead this work. Total estimated funding for Phase 1 is \$200,000. Upon reopening, a fully repaired Kevin Bell Arena will remain what it has always been for the southern Kenai Peninsula: one of the only places rural residents can stay active, healthy, and connected to their community through the long Alaska winter.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Homer OPUS	Homer OPUS: Advancing Rural Health Through Accessible String Education	AK	Homer OPUS proposes to use this opportunity to maintain and continue to expand the reach, breadth, and depth of our music education programs. Our goal is to ensure equitable access for students throughout the communities of Anchor Point, Homer and the smaller surrounding communities. This initiative will strengthen and extend OPUS’s established partnership with the Kenai Peninsula Borough School District (KPBSD), serving K–2 students at Paul Banks Elementary, Chapman School, and Fireweed Academy. This partnership is under an MOU which permits OPUS to provide violin instruction during the day. OPUS receives no funding from KPBSD. Additionally, this is an opportunity to maintain and expand our outreach to adults through mixed ensembles and performances. OPUS’s in-school programming provides free, high-quality, and inclusive music education at a foundational stage in a child’s academic journey. By integrating music into early elementary classrooms, the program fosters creativity, collaboration, and cognitive development while ensuring that access to arts education is not limited by geography or financial means. Through sustained expansion of these services, Homer OPUS seeks to contribute to the long-term vitality of the southern Kenai Peninsula by cultivating engaged learners, supporting educational music equity, and strengthening community connection through shared musical experiences across Homer, Anchor Point, and surrounding smaller communities.	Homer OPUS’s approach to this opportunity is to continue to provide access to high-quality string education to strengthen youth development, promote wellbeing, and support healthier rural communities across the Southern Kenai Peninsula. Our model integrates in-school instruction, afterschool ensembles, and community engagement to ensure consistent, equitable access to string music education for children and families. The project sustains in-school string instruction for K–2 students in partnership with the Kenai Peninsula Borough School District, Fireweed Academy, Paul Banks Elementary, and Chapman School. Delivering instruction during the school day removes common barriers such as cost and transportation, ensuring all students can participate regardless of background. Early exposure to music supports cognitive development, collaboration, and social-emotional learning during a critical stage of childhood growth. Afterschool programming deepens this impact through youth orchestras, ensemble learning, and performance opportunities. These programs provide safe, supportive environments where young people build confidence, teamwork skills, and meaningful peer relationships. Participation in music ensembles fosters belonging and engagement—protective factors that contribute to positive mental and emotional health. Cross-sector partnerships strengthen the Homer OPUS model. By collaborating with schools, behavioral health providers, youth-serving organizations, and community groups, the program expands access while aligning music education with broader efforts that support prevention, resilience, and connection. Partnerships with organizations such as Homer Youth Programs Everyday (HYPE) and South Peninsula Behavioral Services help extend outreach and increase participation among youth who benefit most from supportive programming. Homer OPUS also encourages multigenerational engagement through community performances, mentorship opportunities, and adult ensemble participation. These experiences build connections across age groups and strengthen community bonds. Ongoing evaluation will track participation and engagement, while feedback from students, families, educators, and partners guides continuous improvement.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Homer Senior Citizens Inc	Preserving Home: The HSC Senior Campus Renewal Project	AK	Homer Senior Citizens, Inc. operates the primary senior services campus serving older adults in our rural coastal Alaska community. Our campus includes an Assisted Living Facility, Adult Day Services, a senior center, and independent senior housing. In a frontier region with limited providers and significant geographic barriers, these services are essential to the local health care continuum. The core problem is instability caused by more than ten years of deferred maintenance combined with inadequate transportation capacity. Critical building systems and safety repairs now require comprehensive attention. In rural Alaska, contractor shortages, high material costs, and seasonal limits increase risk. If facilities fail or fall out of compliance, seniors may be forced to relocate hours away from family and providers, disrupting continuity of care. Transportation is also a major barrier. Many seniors no longer drive, public transit is minimal, and harsh weather restricts mobility. Missed appointments, delayed prescriptions, and higher emergency utilization result. HSC lacks sufficient transportation capacity to meet demand. A new micro-bus will provide reliable access to medical appointments, therapy, pharmacy services, and essential programs, while expanding service to community seniors. By stabilizing infrastructure and strengthening transportation, this project protects aging-in-place services, reduces strain on the health system, and ensures sustainable rural senior care.	Homer Senior Citizens, Inc. (HSC) proposes a phased five-year capital stabilization and transportation expansion strategy to address deferred maintenance and eliminate transportation barriers for rural seniors. Phase 1 (Year 1): Immediate Stabilization & Transportation Launch HSC will prioritize health and safety repairs identified through facility inspections, focusing on life-safety systems, critical mechanical components, exterior envelope stabilization, and compliance-related items in the Assisted Living Facility, senior center, and independent housing. During this phase, HSC will purchase a new ADA-accessible micro-bus to support Assisted Living and Adult Day Services transportation to medical appointments, therapy, pharmacy access, and essential shopping. Estimated Year 1 investment: \$750,000–\$900,000. Phase 2 (Years 2–3): Structural & Systems Rehabilitation HSC will complete major capital repairs including roofing, siding replacement, HVAC upgrades, parking and ADA improvements, and interior modernization to support infection control and aging-in-place standards. Transportation services will expand to include scheduled routes for community seniors. A formal preventative maintenance plan will be implemented to prevent future deferred maintenance. Estimated Years 2–3 investment: \$900,000–\$1,100,000. Phase 3 (Years 4–5): Sustainability & Expansion Remaining upgrades will focus on long-term durability and efficiency, including energy-efficient system replacements, accessibility enhancements, and establishment of a capital reserve fund. HSC will evaluate acquisition of a second light-duty vehicle if demand warrants. Estimated Years 4–5 investment: \$400,000–\$500,000. Five-Year Capital Plan (Total: \$2.1M–\$2.5M) Includes life-safety and compliance repairs; roof, siding, and envelope replacement; HVAC upgrades; accessibility improvements; interior modernization; ADA-accessible micro-bus (Year 1); potential secondary vehicle (Years 4–5); and capital reserve development. This phased approach protects essential rural health infrastructure, reduces emergency repair costs, stabilizes regulatory compliance, and builds a sustainable transportation program. Sequencing repairs and vehicle acquisition over five years ensures immediate impact and long-term operational resilience for seniors in our frontier community.	\$250K-\$1M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Hoonah City Schools	Healthy Body Healthy Minds	AK	The problems are lack of mental health and stigma around mental health which would be improved by having access and education at the school. In addition, physical activity is limited outside high school sports so teaching ways to stay active and providing education about why is important. We also want to respond to student requests to have more nutrition information and to use that information to learn to gather foods and use local food options for meals.	We would like to add a School Counselor at the school and work to develop a continuum of care for mental health among school youth and their families. We would do education and outreach to parents and the community as well. We would also like to act on student requests to educate youth about healthy food choices through a native foods based culinary arts class as well as regular education to all grades and their families on healthy nutrition choices. We would partner with the clinic and the tribe to provide culturally relevant information and local food options. Our last piece of the puzzle is physical activity and we would like to have a full time PE/Health instructor to provide regular physical activity and lifetime choices for students in K-12 with information regularly provided to families with family engagement in physical activity events. Access to this information and activities at the school helps the entire community as the school is centrally located and is the hub for many events throughout the year. This would also be used to provide work based learning at the high school level to have students intern at the clinic thus growing the workforce at that location and improving long term care.	\$50,000-\$250,000	Single Community	Hoonah-Angoon Census Area	Deferred or Not Advanced

Hope Community Resources Inc	Complex Care Children’s Home	AK	Hope Community Resources, Inc. submits this Letter of Interest for Rural Health Transformation Project (RHTP) funding to support the development of a Complex Care Children’s Home in Alaska. This initiative directly advances RHTP Goals #1 and #2 by expanding access to high-quality, in-state care for children with complex medical needs while building a more sustainable and cost-effective health system for rural and frontier communities. Currently, many Alaskan children with complex medical needs and intellectual and developmental disabilities often face significant barriers to receiving appropriate care within their home state. Due to the lack of specialized residential care settings capable of managing complex conditions, many children are placed in hospitals for extended periods or are sent out of state for care. These placements separate children from their families, communities, and cultural supports, and result in significantly higher costs to the State of Alaska compared to providing care locally. In many cases, children remain hospitalized longer than clinically necessary or are placed far from their families simply because appropriate residential care does not exist within Alaska.	Hope proposes to establish a licensed and certified Complex Care Children’s Home in Anchorage that would provide specialized medical and supportive services within a nurturing home environment. While the initial home is based in Anchorage, Hope intends to expand this model into additional rural environments such as the Matanuska-Susitna Borough and Kenai Peninsula. This model will allow children to receive the level of care they need while remaining in their home state, closer to family, culture, and community. Care will be delivered by a multidisciplinary workforce including nurses, certified nursing assistants (CNAs), and direct support professionals (DSPs), coordinated with medical and behavioral health partners. Hope is prepared to develop and staff a Complex Care Children’s Home within 18 months. Hope has extensive experience operating licensed residential services and employing specialized healthcare and support staff. Required resources include sustainable funding at levels comparable to existing Home- and Community-Based Services (HCBS) waiver programs. The has already been purchased; it was remodeled in FY25 for \$111K; and nursing and medical staff have been secured. The home is licensed for three children with the potential to support a fourth through respite services. The estimated annual cost per home is \$1,062,000.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; North Slope Borough	Advance to Implementation Application

Hope Community Resources Inc	Direct Support Professional (DSP) Mentorship and Internship Program	AK	Within Hope, the average employee tenure is eight years—an extraordinary statistic in the Intellectual and Developmental Disabilities (IDD) field. However, this number masks a critical challenge: turnover during the first year of employment is 48%. Nearly half of new employees leave before completing their first year. This instability creates inconsistent staffing, disrupts relationships in the lives of people receiving services, increases recruitment and training costs, and strains remaining staff. The IDD field is extremely rewarding, but it can also be demanding and unfamiliar to individuals without prior exposure or experience. Without structured support and meaningful connection during the first year, many promising employees struggle to successfully transition into long-term careers in human services.	To address these challenges, Hope proposes a two-pronged workforce development strategy: 1. Direct Support Professional (DSP) Mentorship Program Hope’s work is guided by a core organizational principle: “We embrace the role of a teacher, coach, and mentor.” This philosophy recognizes that developing strong professionals requires intentional support, guidance, and opportunities for growth. Building on this concept, Hope will develop and implement an internal mentorship program designed specifically to support employees during their first year of employment, helping new staff successfully transition into the field while strengthening long-term workforce retention. This program will: • Pair new employees with experienced DSP mentors • Provide regular, structured check-ins, coaching, and guidance • Assist new employees in integrating into both the workplace and the broader community • Reinforce mission connection and organizational culture • Support professional development and skill-building Mentors will receive compensation for mentoring hours conducted outside regular shifts, recognizing the value of this investment in our workforce. Over time, reduced turnover costs are expected to sustain the program beyond initial implementation funding. 2. Formal Internship Program Hope will launch a structured, unpaid internship program serving 8–10 students annually across disciplines connected to nonprofit and human services work, including: • Human Services • Behavioral/Mental Health • Human Resources • Accounting/Finance • Property Management • Employee Education and Training • Information Technology • Marketing and Events The program will include structured learning objectives, supervision, and mentorship from field professionals. Distance learning and remote placements will be integrated to promote workforce development in rural and underserved communities across Alaska. Internships will serve as both a recruitment pipeline and an opportunity to cultivate long-term advocates for the human services field.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; North Slope Borough	Advance to Implementation Application

Hope Community Resources Inc	Travel Community Support Specialist (TCSS) Pilot Program	AK	Across Alaska, the field of intellectual and developmental disability (IDD) services continues to face longstanding and persistent workforce shortages. These shortages stem from multiple systemic challenges, including a limited number of trained direct support professionals (DSPs) and wage structures that struggle to compete with other industries. As a result, providers are unable to consistently staff programs at levels necessary to meet community needs. The impact is felt statewide. People with IDD experience inconsistent access to essential supports. Staffing gaps lead to interruptions in day habilitation services, reduced community engagement opportunities, and limited continuity of care. Families—particularly those in rural regions—remain underserved and often face uncertainty about the stability of services. Within Hope’s programs, workforce pressures are predictable and ongoing. Programs rely heavily on overtime to maintain minimum staffing levels, which leads to higher operational costs and burnout among staff. When vacancies occur, service delivery becomes reactive rather than proactive, requiring emergency travel and costly short-term coverage solutions. At the same time, seasoned employees have limited internal mobility options, contributing to turnover and loss of institutional knowledge. These conditions create a cycle in which workforce instability directly impacts service quality, staff retention, and financial sustainability.	The Travel Community Support Specialist (TCSS) role is designed as a strategic response and solution to Alaska’s persistent workforce shortages in IDD services. It is modeled after Hope’s previously implemented and extremely successful Travel Direct Support Professional Program (www.hopealaska.org/traveldsp), which has strengthened and stabilized our assisted living home environments across the state. Under this pilot model, Hope will establish four (4) full-time TCSS positions and one (1) Scheduling Coordinator position, offering competitive wages and full benefits. These team members will be deployed across all regions in which Hope operates to stabilize services in communities experiencing staffing shortages or service gaps. They would work a schedule of one month on/one month off to allow for focused, comprehensive service delivery during deployment periods and still supporting employee wellness and work-life balance. TCSS staff will be cross-trained to work in a variety of residential and community-based services—such as day habilitation, recreational activities, and community engagement—increasing workforce flexibility and internal mobility. During deployments, they will: • Provide direct supports in residential and community-based settings • Provide relief to existing teams • Ensure continuity of care during staffing fluctuations • Reduce Hope’s overall overtime utilization • Expand services to underserved waiver recipients in rural and high-need communities By combining structured travel rotations, cross-training, full-time employment stability, and a dedicated four-person TCSS team, the TCSS program offers workforce solution that strengthens service delivery and staff retention statewide. Importantly, the TCSS position is not intended to replace current employees or existing positions, but to complement and support them. These specialists will provide additional capacity to support existing teams, especially when staffing shortages occur, and their role will be to fill gaps and prevent disruptions to community-based supports.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; North Slope Borough	Advance to Implementation Application

Hope Community Resources Inc	Inclusive Communities for Alaska: A Statewide Housing Initiative	AK	Hope Community Resources, Inc. is seeking funding to support our statewide initiative to advance neuro-inclusive community housing models across Alaska. Through a series of forums in rural communities statewide, this project will educate communities, gather lived experience input, and build a replicable blueprint that Alaska communities can use to develop inclusive housing solutions. Across Alaska, communities are experiencing growing housing and care challenges affecting underserved populations such as people with intellectual and developmental disabilities (I/DD), aging Alaskans, people with behavioral or mental health needs, and families providing long-term caregiving. Too often, people face a very narrow set of options such as institutional settings, licensed facilities, traditional group homes, or costly medical and long-term care placements. In many rural areas—including even Anchorage—the lack of housing options can lead to out-of-state institutionalization, risk of homelessness, caregiver burnout, and increased demand on health care systems. Inclusive housing models are an alternative, person-centered approach. These models integrate accessible, community-based housing, shared spaces, assistive technology, and flexible support services in ways that promote independence, social connection, dignity, and long-term stability. They also reduce reliance on institutional care environments such as nursing homes, group homes, and other facility-based systems.	Hope played a huge role in transitioning Alaska out of institutional care and into community-based living for people who experience I/DD. As part of the deinstitutionalization movement, Hope helped demonstrate that people thrive when they live in their own home and community. Today, families and providers are facing a new transition based on aging caregivers, changing support needs, and a growing desire for independence, inclusion, and long-term housing stability. Inclusive housing can accomplish the next evolution by creating neighborhoods where people can live with more autonomy, build relationships, and access supports while remaining fully part of their communities, which in turn supports and elevates health. Hope has successfully developed and operates intentional communities in Kenai and Willow that support people who experience I/DD. However, this housing model is still unfamiliar to many communities across Alaska, so our goal is to introduce the concept statewide, gather community insight, and develop a framework that can be replicated and adapted to different regions and populations. Through this initiative, Hope will organize a series of both in-person and virtual housing forums for people and families with lived experience, aging adults, family caregivers, housing providers, tribal organizations, behavioral health providers, and community leaders. These discussions will introduce how intentional community models could support a range of Alaskan populations while also identifying housing preferences, cultural considerations, and support needs across the state. Hope is requesting \$115,000 in RHTP funding, with which Hope will hire a project consultant to coordinate the project, identify communities and partnerships, travel to and facilitate forums, and document and analyze findings. The findings will be compiled into a “blueprint” that outlines the model’s philosophy, design considerations, partnership strategies, and paths to developing intentional community housing. The blueprint will be shared with communities, housing agencies, and service providers as a practical resource to support development of inclusive housing solutions across the state. Budget: • Project Consultant: \$80,000 • Statewide Housing Forums: \$20,000 • Travel: \$15,000	\$50,000-\$250,000	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; North Slope Borough; Sitka (City and Borough)	Deferred or Not Advanced

Hope Holders Ketchikan	HHKTN HUB & Hope Holders Alaska Navigators: Southeast Alaska Rural Health Transformation Initiative	AK	Rural Southeast Alaska communities face significant gaps in access to and connection with community, medical, and behavioral health services due to workforce shortages, geographic isolation, transportation challenges, and fragmented service systems. Individuals experiencing substance use disorders, untreated mental health conditions, housing instability, and food insecurity often struggle to navigate access to care until they reach crisis points. The closure of Ketchikan’s low-barrier shelter in 2024 intensified these gaps. Many individuals now rely on emergency departments and crisis response systems rather than supportive, preventive, or recovery-oriented services. The HHKTN HUB initiative addresses these challenges by establishing a regional coordination and peer navigation infrastructure that connects individuals to community partners, essential basic needs, medical and behavioral health services, housing stabilization programs, recovery pathways, and community supports, while strengthening collaboration across providers and agencies.	The HHKTN HUB will serve as the central coordination point for outreach, basic needs support, peer navigation, workforce development, housing stabilization, and community service integration in Ketchikan and across Southeast Alaska. The project establishes the Hope Holders Alaska Navigators program, a regional workforce and registry of Certified Peer Support Specialists to help individuals navigate community systems and connect to support services, medical providers, behavioral health treatment, housing programs, and social services. Key components include rural behavioral health navigation, a centralized HUB coordination model, housing stabilization services through the AKHFC NGS partnership in Ketchikan, peer workforce development through a Certified 40-hour training curriculum aligned with Alaska standards, and development of a Southeast Alaska Peer Support Registry. HHKTN’s behavioral health program will gradually launch between 2027 and 2028, transitioning outreach and navigation services to Medicaid-reimbursable behavioral health services and private foundation support. This initiative is structured as a five-year rural health transformation project focused on building sustainable infrastructure for community support, essential basic needs, access to medical and behavioral health services, housing stabilization, and workforce expansion across Southeast Alaska.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Matanuska-Susitna Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough)	Deferred or Not Advanced

Hope Sunrise Emergency Services	Community Paramedicine/Mobile Integrated Health for East Peninsula	AK	East Peninsula emergency agencies have a deficit of medical providers and access to medical care. Unincorporated communities have very limited economies, with only seasonal and limited employment, most community tasks are performed through volunteerism, and most volunteers are informally/minimally trained. Additionally, access to health care is challenging and many residents of rural unincorporated villages in Alaska go long periods without medical care, increasing health problems until they are so acute that an emergency transport is required. Mobile Integrated Health would fill the gap for communities that are not able to access the CHAP program and are too far from more populous areas to make routine medical care easy access. One of the key components of this model is that the training and education is geared to reflect the needs of the community served. Research shows bridging healthcare to rural communities is one of the best ways to improve access and patient care/outcomes, decreasing the overall burden on the health care system. Maternal and child care, elder care, access to healthcare, pay for value and strengthen workforce would all be addressed with the proposed program. Utilization of modern technologies (telehealth, electronic health records, high speed internet) would be applied to support and execute a Mobile Integrated Health/Community Paramedicine program. Advanced EMS providers would strengthen the training & response capabilities of these rural departments.	In 2001 Nova Scotia implemented a program utilizing paramedicine to reach rural and vulnerable populations. Implemented in three phases, it began by opening access to paramedics on a 24/7 basis for non-emergency services. Second phase and third phases expanded EMS’s clinical role in the health care system. Eventually, this leads to a special certification for expanded scope allowing specially trained ambulance personnel to deal with tasks related to elder care at in-patient facilities, to address care issues, routine wellness and assessment screening, along with other mundane tasks such as bloodwork, simple sutures, home-healthcare, and care coordination. This showed a reduction in transport and took place during the routinely busy transport hours of 9:00 am to 9:00pm. Community paramedicine (CP) programs located in the United States have also shown to be successful. In 2013, Maine started a pilot program to train and certify paramedics and EMTs to monitor patients who are at high-risk for hospital readmission. The goals included helping to manage chronic disease, addressing medication issues, and assessing patient living conditions. These services were organized by the individual program sites, mostly Fire and EMS departments, and are tailored to specifically address the needs of the vulnerable in their service community. Affiliated with paired hospitals, built on a fee-for-service model, and home-healthcare framework; Maine’s CP program proved to be sustainable and reproducible. HS would implement a similar program, using an AEMT/paramedic and a mobile integrated health vehicle to perform house calls and operate "clinic hours" to serve patients in the service area. Affiliated with local clinics, hospitals and an overseeing physician, the program could eventually be expanded to the rest of the East Peninsula unincorporated villages (Cooper Landing, Moose Pass, Lowell Point), increasing the overall level of medical training and health care access in our area. Ultimately, the program could be expanded state-wide to serve similar rural towns, villages and populations. At present, it is virtually impossible to get hospice, skilled nursing or other medical care beyond emergency response in unincorporated towns on the East Peninsula. The proposed program would alleviate and address many of these deficits in health care access.	\$250K-\$1M	Home-and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Planning

Hope Sunrise Emergency Services	Hope Sunrise Emergency Services Ambulance Replacement	AK	HSES serves a year-round population of roughly 150 residents with 1,000+ daily visitors in the summer. HSES supports the Kenai Peninsula Borough's emergency services by providing emergency response to the Hope and Sunrise communities, the 15 miles of Hope Highway, and surrounding Forest Service/borough wildland/backcountry areas. Due to extremely limited resources, response scope covers typical medical and fire calls, wildland fire, search and rescue and many other unusual wilderness emergencies. Our small, fully-volunteer station does not have adequate ambulance transport services to allow for reliable emergency response, meaning that we must heavily rely on mutual aid partners for patient transport when the current ambulance is removed from service. This causes increased demand on neighboring emergency services (Moose Pass, Cooper Landing Emergency, Girdwood), impacting response times for emergencies within their service areas due to supporting HSES with emergency response and transportation. This creates a waterfall effect leaving surrounding agencies unable to provide the standard of care, personnel, or equipment necessary to maintain safety within the East Peninsula emergency corridor. Replacing the HSES ambulance will ensure reliable response for Hope and Sunrise, the Hope Hwy., and attract new volunteers, potentially increasing HSES's service area into the Seward Highway corridor, reducing the overall burden on the entire East Peninsula emergency services system.	Funding this project will allow HSES to purchase a new ambulance, reducing downtime due to critical maintenance and repairs and will fulfill the critical need for additional ALS equipment onboard. Given the extremely rural location of Hope and Sunrise (15 miles from the Seward Highway corridor and an additional 45+ miles to the next town - Girdwood, pop. 1,500, Moose Pass, pop. 228, or Cooper Landing, pop.334), our ambulance is a critical piece of equipment as residents are unable to access any type of health care services in Hope or Sunrise beyond emergency medical services provided by HSES. The nearest primary care service provider is located approximately 50 road miles away in Girdwood, with the nearest hospital/urgent care over 100 road miles away. Air ambulance services are available outside of severe weather conditions; however it takes upwards of 40+ minutes to arrive on scene, and requires transport via ground ambulance to a landing zone. Emergency Services (EMTs) provide the only health care for both emergent and non-emergent situations within a 50+ mile radius, with the nearest hospital over 100 miles away. Replacing HSES' ambulance will increase the overall response capabilities and medical interventions available to patients who must endure long transport times for access to higher levels of care while significantly decreasing overall maintenance costs for HESE's small and under-funded department, allowing funds to be redirected for ongoing training for volunteer personnel. HSES would be able to purchase a vehicle with Advanced Life Support capabilities, thereby increasing the ability to host and train local volunteers with higher levels of care.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Hope Sunrise Emergency Services	Sanitation and Training for First Responders	AK	HSES serves a year-round population of roughly 150 residents with 1,000+ daily visitors in the summer. HSES supports the Kenai Peninsula Borough's emergency services by providing emergency response to the Hope and Sunrise communities, the 15 miles of Hope Highway, and surrounding Forest Service/borough wildland/backcountry areas. Due to extremely limited resources, response scope covers typical medical and fire calls, wildland fire, search and rescue and many other unusual wilderness emergencies. At present, our small, fully-volunteer station does not have adequate sanitation (septic, toilet, shower, hot water sink, dryer and hookup of existing extractor machine), or overnight bunk accommodations. This makes it dangerous for our volunteers, as they are currently forced to go home with clothing and persons potentially contaminated with carcinogens and/or pathogens after calls, increasing spread of illness in the community and risk to responder's families. The lack of overnight accommodations makes hosting outside trainers or volunteers from other communities virtually impossible. Responders must travel more than 50 miles to other stations for certification courses, continuing medical education credits and other training. Sanitation and accommodation improvements HSES would be able to attract more qualified first responders, host training for HSES and other East Peninsula agencies and vastly improve the quality of care offered to residents and visitors, alike.	Funding this project will allow HSES to purchase and install a septic tank, finish existing plumbing, conduct a percolation test on the exiting well, and install a small bathroom/laundry in our existing facility, providing an immediate risk reduction for volunteer responders, their families and the community at large by allowing responders to decontaminate onsite immediately after an emergency call, reducing the potential exposure to carcinogens, pathogens and illness. Additionally, HSES will be able to create overnight accommodations by renovating a portion of the upstairs administrative loft area to be an enclosed room with a bunk, so visiting trainers, EMTs and firefighters would have a place to stay. The addition of overnight accommodations will allow for the facility to become a staffed station, which greatly improves emergency response times, station management and maintenance. HSES has already secured in-kind promise of assistance from laborers, plumbers and carpenters in addition to an informal estimate for the total cost and timeline for these projects. Funding for this project will ensure that these necessary improvements come to fruition and will significantly improve access to health care for our rural Alaskan community, visitors, and surrounding East Peninsula service area. As a small, volunteer operated organization with limited financial resources resulting in a reliance on volunteer labor, lack of funding for these facility improvements has been a long-standing hurdle to a sustainable and safe emergency services station with the ability to provide advanced life support and highly trained personnel. Sanitation is the first step in HSES's ability to grow and providing appropriate decontamination and a restroom will allow HSES to host training and staff the station. HSES has standing offers from EMTs, paramedics and neighboring agency firefighters to both volunteer and provide training in Hope which is virtually impossible with the current lack of complete facilities, directly impacting our service's ability to receive training and achieve a consistent higher level of emergency care. Our responders are currently taking on great personal risk by volunteering at a station that does not have adequate sanitation. By completing the septic and bathroom/laundry facilities, we will improve safety and health of our volunteers which will have a ripple effect to the community. Healthy first responders equal a healthy community.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Hospice of Anchorage	Expanding Access to Resources through Hospice of Anchorage's Community End-of-Life Resource Center	AK	Alaskans traveling from rural villages, remote and frontier communities, and the Anchorage Municipality for medical treatment face significant gaps in access to DME and essential end-of-life care supplies. Many temporarily relocate to Anchorage for specialty care without the adaptive supports needed to remain safely housed. Others require equipment to return home but encounter supply delays, high transportation costs, or limited availability. Without timely access to essential equipment, families experience unsafe caregiving environments, prolonged time away from home, preventable escalation of care needs, or unnecessary emergency services utilization. These gaps affect individuals in geographically isolated communities as well as Anchorage households facing cost, housing, or access barriers. HOA operates a Community EOL Resource Center and DME Closet that provides no-cost resources, equipment and supplies to individuals from any Alaska community. Rural families rely on this center while in Anchorage for treatment and often transport equipment back to their home community. Anchorage residents depend on this resource to maintain safe in their home environments. Demand continues to grow, while infrastructure, tracking systems, and redistribution workflows limit consistent response. This project will strengthen and formalize this infrastructure and improve efficiency to support safer transitions, improved continuity of care, and healthier communities statewide.	HOA will implement a comprehensive expansion and systems improvement of its Community EOL Resource Center and DME Closet to strengthen continuity of care and community health stability across rural villages, frontier communities, and the Anchorage Municipality. The project will greatly expand inventory of high-demand items such as incontinence supplies, walkers, wheelchairs, commodes, and shower and transition benches. Storage systems will be upgraded to improve organization, sanitation workflows, and equipment turnaround time. Structured refurbishment and maintenance protocols will extend equipment lifespan and ensure safety standards are consistently met. HOA will modernize inventory and data system integration to strengthen operational efficiency and long-term planning. A digital inventory tracking system will monitor equipment distribution, turnover, and return cycles. Geographic utilization data will capture where individuals originate and where equipment is ultimately used, allowing better understanding of rural and Anchorage access patterns. This information will guide future Healthy Communities investment by identifying high-demand categories, emerging regional needs, and opportunities to strengthen continuity of care across Alaska and will help HOA programming for future fiscal years--shaping our strategy directly to need. The project will also formalize rural access and redistribution pathways. Structured intake guidance, discharge-aligned distribution processes, and equipment transport recommendations will support individuals traveling to Anchorage for treatment and safely returning to their home community. When equipment is returned, streamlined cleaning and redistribution workflows will reduce availability gaps and improve circulation. Staff and volunteers will receive training in equipment safety, sanitation standards, logistics management, and documentation. Written operational protocols will ensure consistency, accountability, and long-term resilience. Through these integrated improvements, Hospice of Anchorage will transform an essential but capacity-limited service into a structured Healthy Communities infrastructure model that reduces avoidable hospitalization, supports safe home-based care, decreases caregiver strain, and strengthens the ability of Alaskans in both rural communities and Anchorage to remain safely in their home environments.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Humetrix	Operationalizing Alaska Medicaid & Medicare Data to Strengthen Rural Care	CA	Rural Alaskans face not only access challenges, but also significant care coordination barriers due to the long distances they must travel for primary and specialty care, compounded by Medicaid coverage disruptions and churning. The result: • Lack of continuity of care • Medication errors and duplication • Avoidable hospitalizations and medevacs • Poor chronic disease control • Limited telehealth effectiveness • Higher risk for dually-enrolled elders and pregnant women The CMS RHT initiative presents an opportunity to address these challenges through consumer-facing tools and population health dashboards that transform Medicaid and Medicare claims into actionable clinical intelligence at the point of care. This directly supports CMS RHT goals: prevention, consumer empowerment, IT modernization, measurable outcome improvement, and rural sustainability, without new infrastructure builds.	Our approach operationalizes Alaska Medicaid and Medicare claims data into patient-facing and population-level tools. Step 1: Deploy Consumer Mobile Applications Provide Alaska Medicaid beneficiaries and dually-enrolled with CMS-approved mobile apps (iBlueButton, WhatMeds) that: • Aggregate Medicaid and Medicare claims • Generate easily sharable health summaries with up to date medication lists • Provide AI medication safety alerts • Offer personalized chronic disease guidance • Enable secure QR code-based sharing at any point of care To enable care coordination and continuity of care at every point of care, including during telehealth and ER visits. Step 2: Enable Point-of-Care Data Sharing Patient-facing applications generate a dynamic QR code. Providers instantly access the patient’s up to date medical history and medication list No EHR integration required. Works in low-bandwidth settings. Step 3: Support High-Risk Populations Target: • Dually-enrolled (care coordination and polypharmacy risks) • Pregnant women (prenatal care continuity) • Rural chronic disease populations Step 4: Operationalize Medicaid Data for Chronic Disease and Epidemiological Surveillance Deploy a population health dashboard that: • Identifies high-risk individuals • Monitor Chronic Disease and adverse outcomes • Supports value-based payment alignment (not sure, but also mentioned in challenges) Proven track record: The Humetrix platform processed 100M Medicare claim lines weekly for 18 months, monitoring 20M beneficiaries during the pandemic to help the military efficiently deliver its pandemic support mission nationwide. Alaska can use the same infrastructure to both improve healthcare access and reduce adverse outcomes and strengthen frontier care delivery.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Huslia Village	Huslia Water & Wastewater Project	AK	The Koyukuk River bank in Huslia erodes every fall and the Huslia Tribal Council is funding a House Moving Project so the homes do not go over the bank. There were four (4) homes relocated last fall. The Water Plant in Huslia is outdated and is in critical need of renovation/upgrade. Huslia is currently undergoing a freeze up in water and sewer lines to a majority of the homes in the community. There are elders that have been without running water and sewer for over four (4) months. City Water Needs: relocate Lift Station next to the river bank before it caves over. Order pressure pump. Need an updated assessment on how many homes are frozen. Huslia has been in dire need of reliable water; especially during the freezing winter months. This year (2025-2026) there are a total of 13 homes that have no running water due to freeze up. The majority of these homes are owned by elders. Water was shut off in the entire loop that was hanging over the river bank last fall.	Water lines need to be installed in the Birch Grove Subdivision for all the new homes as well as the relocated homes over the past 5 years. We need a water line to the new subdivision because of fire hazards to homes. Right now we only have a 1200 gallon water truck to combat fires. The homeowners of the relocated homes are under duress because they do not want to move their home onto lots that do not on the current water system. The Elders of Huslia have had running water for years and now they have to haul water or hire people to haul water for them. Some homes have been without water for over 11 years since their homes were moved back from the river bank. The current water plant in Huslia is in need of upgrades. Last month Huslia residents went 7 days without water due to mechanical issues. Parts needed to be ordered to repair the water plant. This project will help maintain the water plant so that no health issues arise for our children and elders from lack of water and sanitation.City Water Needs: relocate Lift Station next to the river bank before it caves over. Order pressure pump. Need an updated assessment on how many homes are frozen: so far there are 13 homes that are frozen out of 35. Need to re-insulate the frozen waterlines. Arctic Pipe is needed. Need A & B Foam-mix & foam up exposed lines. Need excavators and operators to dig up the exposed lines. Need to engage jumper lines. Need heat exchangers and large space heaters. Tribal Council also requests that the State Energy Assistance Program help homes that are frozen with the electric bills from the constant heat trace that frozen homes have to leave on. All materials/supplies will need to be shipped on the Ruby Marine Barge or by air: Everts and/or Wrights Air.	\$250K-\$1M	Single Community	Yukon-Koyukuk Census Area	Deferred or Not Advanced

IBM	Multi-payer analytic platform for data-driven decision making and population health management	AK	Alaska’s RHTP identifies a critical statewide need for integrated, multi-payer analytics to support data-driven decision making, population health management, program integrity (PI), and care transformation across rural, remote, and frontier communities. Today, key data assets, including Medicaid claims, public health, HIE, Tribal partner datasets, behavioral health, social determinants of health, and operational metrics, are distributed across siloed systems with limited interoperability. This fragmentation limits the State’s ability to understand rural disparities, evaluate RHTP-funded initiatives, identify inequities in access, and track outcomes across maternal health, behavioral health, chronic disease, specialty access, and the health care workforce. Rural providers also face significant capacity constraints to build and maintain advanced analytic systems. Without a coordinated statewide approach, Alaska risks duplicative investments, variable data quality, and inconsistent methodologies that undermine rural health transformation. IBM’s project addresses these challenges by establishing a secure, scalable statewide analytics platform based on Microsoft Fabric, built on Azure. IBM and Microsoft leverage their existing infrastructure, technology assets, and jointly aligned capabilities to deliver the platform in support of DoH initiatives. The platform will enable the State to independently evaluate outcomes, support provider innovation, and meet CMS reporting needs.	IBM will partner with Alaska DOH to design and implement, using a phased approach, a statewide population health analytics platform built on Microsoft Fabric, Azure. The solution creates a single, secure environment for multi-payer data integration, advanced analytics, and insight generation aligned to RHTP priorities. We leverage our Maestro metadata-driven orchestration framework to accelerate development and ensure repeatable patterns across the solution. The project begins with alignment to your strategy, governance, and security controls. We also perform workspace configuration to reflect Alaska policies, Tribal partnership considerations, and CMS requirements. IBM’s relationship of more than 15 years with Alaska Medicaid helps us align with existing systems and lowers delivery risk. Next, we deploy core intellectual property, including Maestro, Fabric Continuous Integration/Continuous Delivery (CI/CD) standards, and metadata configuration. Modern AI tools like GitHub, Copilot, and IBM’s generative AI accelerators streamline key tasks, such as pipeline creation, documentation, and data mapping, reducing burden on State staff. Integration proceeds through a phased data ingestion plan that prioritizes Alaska’s highest impact RHTP areas. Phase 1 will focus on Medicaid claims, Tribal Health data, provider files, and key behavioral health and maternal health indicators. Later phases will expand to HIE feeds, social determinants of health, EMS, chronic disease, and facility datasets as agreements mature. Using Microsoft Fabric and Power BI, IBM will build curated analytic enhancements for maternal health, behavioral health, chronic disease, EMS, and dual eligible populations. These models support dashboards, predictive analytics, risk stratification, provider benchmarking, regional hub and spoke insights, and longitudinal patient journey analysis. Solution administration includes environment promotion, end-to-end testing, knowledge transfer, documentation, and hypercare. The platform supports multi-tenant access, so local providers, universities, health systems, and Tribal partners can view data relevant to their specific needs, while the State retains neutral governance and statewide visibility. This type of State-led, centrally governed analytics platform designed for multi-stakeholder participation has proven to be more effective at delivering consistent insights, protecting sensitive data, and aligning with evolving policy/regulatory requirements.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

ID.me	ID.me for Alaska RHTP: Authorized by CMS, Seamless Access for Every Alaskan's Care Journey	VA	Alaska's significant investment in rural health access faces a structural challenge: the state's realities—with ~82% of communities lacking road connections and unreliable connectivity—make digital adoption fragile at the first step of getting individuals online. When residents cannot reliably prove their identity, key digital services like telehealth, RPM, care navigation apps, and patient portals experience limited engagement, increased support burdens to non-digital channels, and lower continuity of care, particularly for rural Alaskans, Alaska Native communities, elders, and complex-care patients. The opportunity is to establish a statewide "digital front door" that is secure, trusted, portable,, and inclusive. This will be a high-assurance credential that Alaskans can verify once and reuse across all RHTP-funded tools and participating organizations. This approach is practical: 225,477 Alaskans (~30.5% of adults) already have an ID.me verified login. 155,326 are NIST IAL2 verified (~21.0% of adults). This user base has grown from ~8K to 155K since 1/2021 (+1,837.5%). Leveraging this existing credential reduces friction, accelerates program uptake, and lowers the administrative burden for rural partners. This model is also aligned with CMS modernization (live on Medicare.gov) and healthcare interoperability goals, providing high-assurance identity and strong authentication with consent-based access to reduce "login sprawl" and mitigate AI-driven fraud.	We will deploy a statewide, reusable “digital front door” by integrating high-assurance identity proofing and sign-in (NIST IAL2 with strong authentication) into priority consumer workflows: telehealth access, RPM enrollment, care navigation/scheduling, and patient portals. The approach is designed for Alaska’s rural/frontier realities (low bandwidth, high travel burden) and aligns with CMS modernization patterns (e.g., Medicare.gov) to establish trusted identity for both improved access and program integrity. The project will proceed in four phases: Phase 1 — Partner and Use-Case Selection (Months 1 - 3): Work with Alaska DOH and Alaska-based implementers to select 1–2 initial “high-impact” use cases (telehealth, RPM, navigation/portal). Define minimal verified attributes required and confirm success measures (completion rate, support burden, time-to-access). Phase 2 — Integration and Rural-Ready Design (Months 3 - 6): Implement standards-based SSO integrations (OIDC/SAML) into selected tools. Configure appropriate policy (e.g., NIST AAL2 / IAL2) and apply “minimum necessary” attribute exchange with auditable, user-consented sharing. Offer multiple pathways for residents to succeed: (1) Self-serve, (2) Video Chat, and (3) In-person Phase 3 — “No Alaskan Left Behind” Onboarding & Implementation (Months 6–12): Train Alaska DOH support teams with playbooks and escalation paths. Demo performance reports and self-service dashboards Establish collaborative communication channels between fraud programs Phase 4 — Measure Value and Scale (Year 2+): Launch pilot(s) Monitor success metrics weekly for optimization, and expand to additional RHTP-funded tools and partners. Review feedback and lessons learned. Apply to products and operations to drive continuous improvement. This leverages existing in-state adoption to accelerate uptake, reduce duplicative identity work, and lower administrative burden while strengthening trust and auditability statewide.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Ideal Option	Rural Telemedicine Nurse Care Team for Substance Use Disorder	WA	Rural, remote, and frontier Alaskans face major barriers to evidence-based substance use disorder (OUD) treatment, including long travel distances, limited local provider capacity, and gaps in between scheduled appointments. While telemedicine can reduce travel, telemedicine-only models can still be episodic and may not provide enough support to keep high-need patients engaged, stable, and safe. This project addresses the opportunity to expand access to MOUD statewide while improving continuity and outcomes by pairing telemedicine care with Ideal Option’s Nurse Care Team, proactive nursing outreach, care coordination, and 24/7 triage support. The goal is to reduce treatment drop-off, prevent relapse/overdose risk, and provide a sustainable, scalable model for rural OUD care in Alaska.	We will expand access to evidence-based SUD treatment for rural, remote, and frontier Alaskans by pairing telemedicine-based MOUD services with Ideal Option’s Nurse Care Team and dedicating one full-time Nurse Care Team member based in Alaska. Patients will receive virtual clinical visits for assessment, medication, and ongoing treatment support, while the Alaska-based nurse provides the day-to-day coordination needed to keep patients engaged and safe between provider visits. The Alaska Nurse Care Team member will deliver proactive outreach (appointment reminders, check-ins, adherence support, and patient education), coordinate required in-person services locally when needed (labs, urine drug screens, referrals) and connect patients to behavioral health and community resources. This role will also support timely triage and escalation to providers for urgent clinical needs, helping reduce gaps in care and avoidable emergency department use. RHTP funds will support this dedicated Alaska-based staffing capacity, workflow development, and reporting infrastructure to operationalize the model statewide. Core clinical services will be sustained through Medicaid and other payer reimbursement, and the Nurse Care Team model improves retention and outcomes by strengthening continuity of care for patients who face the greatest geographic barriers.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Igiugig Village	Igiugig Community Emergency Response & Mobility Initiative	AK	Our small Alaska Native village of approximately 70 residents located at the outlet of Lake Iliamna with no road system access. Residents rely on small aircraft, boats, and snowmachines for transportation depending on the season. Access to health care depends not only on the availability of clinic services but also on the ability of responders and patients to travel safely across challenging terrain and weather conditions. Currently, the community faces several transportation and mobility barriers that affect emergency response and access to routine health care. Winter conditions often require snowmachines to reach residents experiencing medical emergencies, yet the community has limited emergency transport equipment. Transportation barriers also affect residents who need to reach clinic services, particularly Elders and those without reliable vehicles. Missed appointments and delayed care can occur when transportation is unavailable. In addition, one community member with a disability faces significant mobility challenges due to the lack of terrain-capable mobility equipment. This project addresses these challenges by strengthening emergency response mobility, improving transportation access to the clinic, and enabling mobility for residents with disabilities—helping ensure that geography does not prevent Igiugig residents from accessing care and fully participating in community life.	The Igiugig Village Council proposes to strengthen local emergency response capacity and improve transportation access to health services by acquiring essential mobility equipment for the community. The project will purchase two snowmachines and two rescue sleds to support winter emergency response, allowing trained responders to reach residents more quickly and safely during medical emergencies and transport patients across snow and ice to stabilization points prior to medevac or clinic care. To improve access to routine health services, the project will also acquire a small community vehicle that can transport residents to the local clinic. This will reduce transportation barriers for Elders, individuals recovering from illness or injury, and residents without reliable vehicles, helping ensure consistent access to preventative and routine care. Finally, the project will improve mobility and independence for a resident with a disability through the acquisition of an off-road mobility device (RipChair 3.0) capable of navigating rural terrain and winter conditions. This will allow the individual to safely move throughout the community and participate in local employment, including providing services such as snow removal. Together, these investments will strengthen emergency preparedness, improve access to care, and support inclusive participation in community life.	\$50,000-\$250,000	Single Community	Lake and Peninsula Borough	Deferred or Not Advanced

Iḻḻgaat Munaqsriviat	Iḻḻgaat Munaqsriviat Child Care Center Furniture & New Staff Training	AK	Rural communities face a critical shortage of licensed childcare, creating a significant barrier for families and the local workforce. In our community, limited childcare availability prevents many parents—particularly those working in healthcare, education, and other essential services—from maintaining consistent employment. This shortage also limits opportunities for young children to access early learning environments that support healthy development and school readiness. To address this need, our nonprofit is launching a new licensed childcare center scheduled to open in fall 2026. This project will create reliable, high-quality childcare that supports working families and strengthens the local workforce. The current funding request supports key startup components needed to safely open and operate the center. Funding will provide classroom furniture and essential learning environment materials required to meet licensing standards and create developmentally appropriate spaces for young children. It will also support startup training for new childcare staff through hands-on learning at an established licensed in-home childcare program, helping build staff capacity before the center opens. These investments will help ensure the program launches with a well-prepared workforce and safe, functional classrooms, allowing the center to begin serving children and families as planned in fall 2026.	Our approach is to establish a new licensed, nonprofit community childcare center that expands access to reliable, high-quality early childhood care while strengthening workforce stability in our rural community. The center is scheduled to open in fall 2026 and will provide safe, developmentally appropriate care for young children while supporting families whose ability to work is currently limited by lack of childcare. This project focuses on the essential startup components required to successfully launch the center. Funding will support the purchase of classroom furniture and learning environment materials needed to meet state childcare licensing standards and create safe, functional, and developmentally appropriate classrooms for infants, toddlers, and preschool-aged children. Well-designed classroom environments are critical for supporting children’s social-emotional development, early learning, and consistent daily routines. The project also prioritizes building a strong early childhood workforce prior to opening. Funding will support startup training for newly hired childcare staff through hands-on learning at an established licensed in-home childcare program that is owned and run by the regional Early Learning and Family Program Occupational Therapist. This training model allows new staff to gain practical experience in daily operations, child supervision, developmentally appropriate practices, and licensing requirements before the center begins serving children. In addition to staff preparation and classroom setup, the program is being developed in coordination with local community partners and employers who have identified childcare access as a major workforce barrier. The center is designed as a sustainable, community-based nonprofit service that supports working families, local employers, and essential service providers. By combining prepared staff, fully equipped classrooms, and strong community partnerships, this approach ensures the childcare center opens with the capacity to provide safe, reliable, and high-quality care. This investment addresses a critical gap in local infrastructure and creates long-term support for children, families, and the rural workforce.	\$50,000-\$250,000	Single Community	Northwest Arctic Borough	Advance to Implementation Application

Iliuliuk Family and Health Services, Inc.	IFHS Pharmacy	AK	Unalaska has no retail pharmacy. Residents, seasonal workers, and visitors must rely entirely on mail-order pharmacies to obtain prescription medications in a remote island community accessible only by air. Severe weather, flight cancellations, and supply chain disruptions routinely delay medication delivery for days—or longer. These delays create dangerous gaps in treatment, prevent timely initiation of new prescriptions, and jeopardize management of chronic and acute conditions. Patients managing diabetes, heart disease, asthma, infections, and behavioral health conditions cannot afford interruptions in therapy. Even short delays can result in worsening symptoms, preventable emergency department visits, or costly medevac transfers. In a community more than 800 air miles from the nearest tertiary hospital, the consequences of medication inaccessibility are amplified. The absence of a local pharmacy creates a critical break in the continuum of care. Providers prescribe medications that patients cannot reliably obtain, undermining treatment plans and straining limited clinical resources. This is not a temporary inconvenience—it is a structural access gap that places rural residents at ongoing risk. Establishing a telepharmacy-enabled retail pharmacy is an urgent and necessary step to ensure timely medication access, prevent avoidable complications, and stabilize healthcare delivery in this frontier community.	IFHS is prepared to immediately implement a retail pharmacy within its clinic using a telepharmacy model specifically designed for rural and frontier communities. The foundational planning, partnership development, and implementation groundwork for this project have already been completed. The primary remaining barrier is capital funding to complete the required facility modifications and launch operations. A licensed contractor has been identified to complete the limited renovations necessary to convert existing clinic space into a compliant retail pharmacy, including secure medication storage, workflow adjustments, and appropriate physical safeguards. Renovation plans are aligned with regulatory requirements and can begin promptly upon award. IFHS has also established a relationship with an experienced telepharmacy organization that will provide remote pharmacist oversight, prescription verification, patient counseling, billing, and payment reconciliation services. This partner manages secure technology platforms and regulatory compliance, ensuring safe dispensing without the need for a full-time on-site pharmacist. The operational model has been defined and is ready for execution. The project includes creation of a new on-site pharmacy technician position to manage daily operations, inventory, and coordination with the remote pharmacist. Training plans for existing clinic staff have been developed to support pharmacy workflows and medication reconciliation processes. Workforce preparation can begin immediately upon funding. Because the physical footprint has been identified, the contractor is ready, and the telepharmacy partner is secured, IFHS can move directly into implementation. This approach minimizes startup delays and ensures that Rural Health Transformation funds can be fully deployed within the available timeframe. By leveraging existing infrastructure, established partnerships, and a ready-to-launch operational model, this project represents a low-risk, high-impact opportunity to rapidly close a critical medication access gap in Unalaska. With funding in place, IFHS can quickly transition from planning to dispensing and deliver immediate, measurable improvements in rural healthcare access and continuity of care.	\$250K-\$1M	Federally qualified health center	Single Community	Aleutians West Census Area	Advance to Implementation Application

Iliuliuk Family and Health Services, Inc.	Unalaska Healthcare Critical Need Infrastructure Project	AK	IFHS operates the only primary and emergency medical clinic serving the island community of Unalaska. The existing clinic was constructed in 1992, and many core mechanical systems—including HVAC, exhaust ventilation, hydronic piping, and domestic water infrastructure, etc.—are original and currently either malfunctioning or inoperable. A State of Alaska grant is funding expansion for emergency and diagnostic imaging services. However, the funding is insufficient to complete the critical infrastructure needs required to ensure long-term reliability of the existing clinic which houses other services such as primary care and laboratory, etc. Recent system failures highlight the urgency of these improvements. The clinic’s boilers, originally planned for replacement during the expansion project, failed unexpectedly in 2025 and required emergency replacement to maintain operations. These boilers are connected to fuel systems and piping that is actively failing and needs replacement. Other mechanical systems remain outdated and vulnerable to failure, creating ongoing risk to healthcare delivery. Without additional investment, the clinic will continue operating with failing infrastructure that threatens reliable healthcare services in this remote community.	This project will complete critical renovation and infrastructure upgrades to the 30-year-old existing Iliuliuk Family and Health Services (IFHS) clinic facility while expansion of the clinic is already underway through a State of Alaska grant. The expansion project addresses new emergency care space along with new diagnostic imaging space, but available funding is insufficient to complete all necessary replacement of the existing building’s aging and failing mechanical systems. RHTP funding will be used to replace essential infrastructure within the current clinic to ensure reliable and sustainable healthcare operations. Planned upgrades include replacement of the primary air handling systems, exhaust ventilation fans, cabinet and unit heaters, and upgrades to hydronic piping and heating distribution. Additional improvements will include upgrades to domestic water piping, mechanical controls, and fire protection systems, etc. necessary to support safe and compliant facility operations. This will address failing systems and reduce the consistent occurrence of system outages that disrupt healthcare delivery. Updated mechanical infrastructure will also improve facility efficiency, ventilation, and temperature control, which are critical to maintaining a safe clinical environment in a remote healthcare facility. These renovations will be coordinated with the ongoing expansion project to ensure efficient construction sequencing and minimize disruption to clinic operations. Completing these upgrades concurrently will maximize the impact of the State’s existing investment while ensuring the long-term reliability of healthcare infrastructure serving this remote community.	Over \$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area	Advance to Implementation Application

Iliuliuk Family and Health Services, Inc.	Unalaska Rural Emergency Access Stabilization Project	AK	Iliuliuk Family and Health Services (IFHS) is the sole provider of urgent and emergency medical care for the remote island community of Unalaska, Alaska. The community has approximately 4,500 permanent residents, but during peak fishing and seafood processing seasons the population expands to as many as 10,000 people. Due to geographic isolation—more than 800 air miles from Anchorage—and frequent weather-related travel disruptions, residents and workers rely on IFHS for emergency care at all hours. Although IFHS operates as a Federally Qualified Health Center (FQHC) and Frontier Extended Stay Clinic (FESC), after-hours emergency care is not recognized as a reimbursable service under those designations and therefore is not adequately reimbursed through existing payment structures. IFHS currently provides 24/7 emergency care which is unsustainable with current allowable reimbursement. In 2025, IFHS provided 388 after-hours encounters, demonstrating consistent need for emergency care outside standard clinic hours. 22 patients required overnight observation while awaiting medevac transport, requiring continuous ICU-level care and monitoring by clinical staff. Maintaining emergency and after-hours coverage requires overtime staffing, on-call wages, supplies, and equipment readiness that are not fully recoverable through current reimbursement models. Without additional funding, IFHS will be unable to sustain emergency after-hours services.	This project will stabilize after-hours and on-call emergency medical services at Iliuliuk Family and Health Services (IFHS) through one year of targeted operational support while longer-term reimbursement solutions are pursued. Funding will support the personnel and operational costs necessary to maintain continuous emergency coverage outside standard clinic hours. Specifically, funds will be used for overtime and on-call wages for clinical staff, additional medical supplies required for emergency care, and equipment maintenance necessary to ensure readiness of diagnostic and treatment systems during after-hours operations. Maintaining after-hours coverage allows IFHS to respond immediately to injuries, acute medical conditions, and emergencies that occur in the community’s maritime and industrial workforce. These services frequently involve trauma care, acute illness stabilization, and evaluation of conditions that may require medevac transport to Anchorage. This funding will ensure IFHS can continue to provide timely emergency care while avoiding dangerous delays in treatment for patients who cannot safely wait until regular clinic hours. Local stabilization also reduces unnecessary medical evacuations by allowing providers to evaluate and manage conditions that can be safely treated on-island. The requested funding will support approximately one year of after-hours services while IFHS collaborates with other Alaska Community Health Centers and state partners to pursue longer-term policy solutions. These efforts include exploring mechanisms that would allow Federally Qualified Health Centers to bill and receive reimbursement for emergency services that are currently unreimbursed under existing payment structures. By sustaining after-hours services during this transition period, this project protects emergency access for residents, seasonal workers, and visitors while enabling development of a long-term, sustainable model for rural emergency care delivery.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area	Advance to Implementation Application

Iliuliuk Family and Health Services, Inc.	Aleutian Islands Diagnostic Access Improvement Project	AK	Iliuliuk Family and Health Services (IFHS) is the only emergency and urgent care provider on Unalaska Island, serving a remote community more than 800 air miles from the nearest tertiary hospital. As the sole Level V Trauma-designated facility in the State of Alaska, IFHS is responsible for the evaluation and stabilization of traumatic injury and acute medical emergencies in a frontier setting where weather frequently delays transport. The clinic’s current CT and X-ray equipment are beyond their serviceable life and increasingly unreliable. Equipment failure or degraded imaging capability creates significant risk in a community without alternative diagnostic resources. Without dependable advanced imaging, providers cannot safely rule out life-threatening conditions such as intracranial hemorrhage, appendicitis, internal bleeding, fractures, or other traumatic injuries. When imaging capacity is limited or uncertain, patients must be transferred by costly medevac flights for evaluation that could otherwise be performed locally. This increases healthcare costs, strains emergency transport systems, and exposes patients to unnecessary travel risk. The opportunity is to replace end-of-life diagnostic infrastructure with modern, reliable imaging equipment that ensures uninterrupted emergency evaluation, improves diagnostic accuracy, and strengthens the resilience of healthcare delivery in this remote region.	IFHS will install a new CT scanner and digital X-ray system within its clinic expansion currently under construction and scheduled for completion by the end of 2026. This project will transition diagnostic imaging from aging, temporary infrastructure to a permanent diagnostic suite designed to meet modern clinical standards. The current CT scanner is housed in a mobile trailer outside the clinic facility. The unit was designed specifically for mobile deployment and cannot be relocated into the clinic building. It is also past its expected service life and has become increasingly unreliable. While the mobile unit has allowed IFHS to maintain limited imaging capability, the configuration creates operational challenges related to space, environmental exposure, workflow inefficiencies, and long-term reliability. As the only emergency care provider on Unalaska Island, failure of this aging equipment would leave the community, surrounding Aleutian region, and largest fishing fleet in the country without immediate diagnostic imaging capability. Moving CT services into the new expansion will improve safety, infection control, patient flow, and coordination with emergency services. Upon award, IFHS will procure equipment through established medical imaging vendors experienced in rural Alaska installations. Equipment selection will prioritize image quality, radiation dose optimization, durability, and compatibility with existing digital imaging storage and tele-radiology systems. Installation will be coordinated with the clinic expansion construction schedule to ensure integration into the new imaging suite. Because the expansion is already funded and on schedule, this project does not depend on speculative construction. Imaging room design, shielding requirements, and workflow layouts have already been incorporated into the expansion plans. The upgraded systems will integrate with tele-radiology services for rapid remote interpretation and support IFHS’s responsibilities as Alaska’s only Level V Trauma-designated facility. Reliable local imaging will also reduce unnecessary medical evacuations for conditions that can be safely ruled out locally—an important consideration in a region where medevac transport can cost more than \$100,000 per incident. Continuing education for imaging technicians will ensure proficiency with the new technology and adherence to evidence-based imaging and radiation safety standards.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area	Deferred or Not Advanced

Iliuliuk Family and Health Services, Inc.	Unalaska Healthcare Workforce Mobility Project	AK	Residents of Unalaska depend on Iliuliuk Family and Health Services (IFHS) as the community’s primary provider of medical care. Due to the island’s remote location, IFHS relies heavily on locum and rotational staff to maintain adequate staffing and ensure continuous access to healthcare services. Unlike providers in most communities, locum staff traveling to Unalaska cannot bring personal vehicles. Shipping vehicles by barge is costly and impractical for temporary assignments. As a result, IFHS must maintain a small fleet of clinic vehicles to allow providers to travel between staff housing, the clinic, and community locations as needed. The existing IFHS vehicle fleet is aging and increasingly unreliable. Several vehicles require frequent repairs and are no longer considered safe for regular use. Maintaining unreliable vehicles creates operational challenges and risks interrupting transportation needed for clinical staff including emergency and on-call staff. This project will support the purchase and shipment of two new clinic vehicles to replace aging fleet vehicles. Reliable transportation will ensure locum providers can safely travel within the community and support the continued delivery of healthcare services in this remote island environment.	This project will support the purchase and transport of two reliable vehicles to replace aging fleet vehicles currently used by Iliuliuk Family and Health Services (IFHS) to support clinical workforce operations in Unalaska. Because Unalaska is an island community with no road connection to mainland Alaska, healthcare providers traveling to the community cannot reasonably bring personal vehicles. Shipping vehicles by barge is costly and impractical for short-term assignments. As a result, IFHS must maintain clinic-owned vehicles to allow locum and rotational staff to travel between staff housing, the clinic, and other locations within the community. The existing IFHS vehicle fleet has reached the end of its useful life. Several vehicles require frequent repairs and are increasingly unreliable, creating operational challenges for a clinic that depends on temporary providers to maintain staffing coverage. Often, the cost of repairs exceed the value of the vehicle. Project funds will be used to purchase two new vehicles suitable for year-round use in the local environment. Vehicles will be selected for durability, reliability, and safety in Alaska’s coastal climate. Funding will also support the cost of transporting the vehicles to Unalaska. Once delivered, the vehicles will be incorporated into the IFHS clinic fleet and used by locum and rotational staff to support daily clinic operations. Reliable transportation will allow providers to safely travel between clinic facilities, staff housing, and community locations as needed. By replacing aging fleet vehicles with safe and reliable transportation, IFHS will ensure that visiting providers have the mobility necessary to maintain clinical coverage and support continued access to healthcare services in this remote island community.	\$50,000-\$250,000	Federally qualified health center	Single Community	Aleutians West Census Area	Deferred or Not Advanced

Infinity Water, Inc.	Infinity Water: Expanding Healthy Beverage Access in Rural Alaska	AK	Sugar-sweetened beverage (SSB) consumption is strongly associated with obesity, type 2 diabetes, heart disease, and poor oral health. Reducing SSB intake is recognized as an important preventive health strategy that can lower risk for these chronic conditions. In the Yukon-Kuskokwim Delta, residents face disproportionately high rates of these health problems compared to statewide and national averages, placing a burden on local health systems. In rural AK, healthy alternatives to SSBs are limited by high cost and low availability. Confidence in public water systems is low, and stores do not carry affordable unsweetened beverage options. For example, a 12-pack of seltzer water in Bethel can cost \$18, while soda is often less than half that price. This pricing dynamic reinforces consumption of sugary drinks and undermines community efforts to improve diet quality. Children in the Yukon-Kuskokwim Delta experience approximately five times the national average rate of tooth decay, fillings, and missing teeth, a clear indicator of the impact of high SSB consumption on preventive oral health outcomes. Local health systems are challenged to address chronic disease and preventable illness in an environment where healthy beverage access is limited. This project addresses a rural health transformation opportunity by increasing access to affordable, appealing, unsweetened beverages that support healthier choices and chronic disease prevention in rural Alaska.	Infinity Water is a local nonprofit that has already demonstrated proof of concept by producing canned, flavored seltzer water in Bethel, providing an affordable, unsweetened alternative to sugar-sweetened beverages. The organization sources empty cans cost-effectively, uses volunteer labor, and has produced several thousand gallons of seltzer water. Products have been canned and sold through partnerships with local school sports teams as fundraisers. These pilot efforts show community interest, but current manual canning operations are slow and limited in scope. Without automation, Infinity Water’s capacity is constrained, preventing broad distribution to schools, concession stands, community events, and local stores. As a result, the project’s potential to improve access to healthy beverages and reduce SSB consumption across the community remains limited. This request would fund automated canning equipment to scale production capacity. Automation will increase output, improve consistency, and create a sustainable local operation that can reliably supply affordable seltzer water. Increased production supports multiple health-promoting goals: • Expanded distribution to school concession stands and community events, replacing sugary drinks with unsweetened alternatives. • A visible, community-led preventive health initiative that aligns with rural health transformation priorities for healthy communities and preventive care. • Continued partnership with sports programs and youth organizations to fundraise for healthy activities, reinforcing positive lifestyle choices. • The ability to produce and store canned water for emergency use when public water systems fail, enhancing community resilience. By moving from manual to automated operations, Infinity Water will transition from a small pilot into a scalable model that supports dietary health, preventive wellness, and community-based health promotion. Together, these impacts align with the Rural Health Transformation Program’s focus on prevention, innovation, community-driven solutions, and long-term sustainability. By scaling a proven pilot into an automated operation, this project transforms a small local effort into a meaningful rural health intervention that improves access to healthy choices and supports the long-term viability of health care in remote Alaska communities.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area	Deferred or Not Advanced

Inner Circle Mental Health	ResponderReady™ Alaska: Workforce Resilience for Rural EMS and Emergency Care	OK	Alaska’s rural and frontier communities depend on small EMS agencies, regional hospitals, and air transport networks to access emergency care. In many areas off the road system, there is little staffing redundancy. When EMS or emergency department positions remain vacant, when overtime becomes chronic, or when responders leave due to workforce strain, access to timely emergency care is reduced. Workforce instability therefore directly threatens the sustainability and continuity of rural health services. Alaska has invested significantly in health system transformation, including Medicaid expansion, telehealth growth, and strengthening of the Tribal health system. However, rural EMS agencies and emergency departments continue to face recruitment challenges, expanding clinical expectations, geographic isolation, and cumulative trauma exposure. These pressures contribute to burnout and turnover, undermining long-term system stability. The opportunity is to strengthen rural health sustainability by developing a structured, data-informed, and culturally adapted workforce resilience blueprint. ResponderReady™ Alaska will address this gap by building the foundation for coordinated retention infrastructure to support rural EMS and emergency departments and inform future RHTP implementation across frontier regions.	ResponderReady™ Alaska proposes a structured Planning and Infrastructure Build approach focused on workforce stabilization for rural EMS and emergency departments. Year 1 will establish the foundation for coordinated, retention-focused infrastructure aligned with RHTP workforce priorities. 1. Establish Alaska-Based Operations ICMH will secure an Anchorage operational base and hire Alaska-based staff, including a Partnerships & Training Director, Training Lead, Office Manager/Scheduler, and one licensed clinician. This ensures in-state presence, local hiring, and relationship-centered engagement before broader implementation. 2. Conduct Statewide Workforce Mapping ICMH will engage rural EMS agencies, emergency departments, and hospital leadership across geographically distributed regions. Structured interviews and site visits will assess turnover trends, vacancy duration, overtime burden, supervisory strain, and peer support readiness. Baseline workforce metrics (burnout, retention intent, workforce strain) will be collected in partnership with pilot systems. This assessment will result in an Alaska Responder Workforce Resilience Blueprint outlining region-specific retention strategies and implementation recommendations to guide future RHTP investment. 3. Co-Design Culturally Adapted Retention Infrastructure Rather than introducing pre-developed programming, ICMH will work with rural partners to collaboratively design peer support models, trauma-wise supervision practices, and referral pathways appropriate to each community’s operational and cultural realities. Cultural consultation and Tribal listening sessions will inform adaptation. 4. Expand Immediate Clinical Support One Alaska-based clinician will prioritize rural EMS and emergency department personnel, offering confidential sessions at no cost to reduce workforce strain and protect retention during the planning phase. Telehealth capacity will extend access to remote communities. 5. Build In-State Clinical Capacity Through the ResponderReady™ Clinician Certification program, Alaska-based clinicians will be trained in responder-competent care, strengthening long-term behavioral health capacity. This phased approach prioritizes relationship-building, measurable workforce assessment, and coordinated infrastructure planning in Year 1, positioning Alaska for sustainable implementation in RHTP Years 2–3 aligned with RHTP transformation goals.	\$1M-\$5M	Behavioral health/su bstance use disorder treatment	Multi- Community or Participating in Regional Hub-and- Spoke	Anchorage (Municipality); Bethel Census Area; Dillingham Census Area; Fairbanks North Star Borough; Kenai Peninsula Borough; Kodiak Island Borough; Matanuska- Susitna Borough; Nome Census Area; Southeast Fairbanks Census Area; Yukon- Koyukuk Census Area	Deferred or Not Advanced

Innovaccer	Innovaccer Data and AI Orchestration Platform to Support Alaska Rural Health Transformation	CA	For states to deliver on the RHT promise, technology has to do more than collect data. States need to focus on connecting data, interpreting it, and turning it into action. That’s where Innovaccer plays a critical role. Through its Healthcare Intelligence Platform, Innovaccer helps states design and execute high-impact RHT strategies built on three core pillars: connected data, empowered teams, and measurable outcomes. By unifying rural data and systems, the platform integrates EHR, claims, behavioral, and social determinants of health (SDoH) data into a single longitudinal record. This gives providers, care managers, and policymakers a holistic and real-time view of the populations they serve. This unified foundation enables whole-person care, supports risk stratification for maternal and chronic populations, and helps identify avoidable utilization such as emergency department visits and readmissions. On the performance side, Innovaccer’s automation capabilities simplify one of the most complex aspects of RHT implementation: quality reporting and oversight. The platform supports 100% DQM automation, integrates eQMs, and provides real-time dashboards that help states monitor progress across counties while maintaining CMS compliance. And because rural transformation can’t succeed without sustainability, Innovaccer’s platform is built for rural realities. It works in low-bandwidth environments, supports offline workflows for mobile clinics, and scales seamlessly.	To transform care, states must first transform their data infrastructure. Rural providers often operate on disparate systems, making it difficult to see the full picture of patient needs or measure outcomes at the population level. Rural healthcare can’t be modernized through policy or intuition alone. It needs a real-time view of what’s happening across providers, patients, and communities. A connected data foundation that integrates EHR, claims, behavioral, and social determinants of health (SDoH) data into one cohesive picture of care is what allows states to move from reactive management to proactive population health. Unified data enables states and care teams to: Identify high-risk populations - These include expectant mothers, individuals with multiple chronic conditions, or those in need of long-term services and supports (LTSS). Reduce avoidable utilization - Track preventable emergency visits and readmissions, enabling early interventions before crises occur. Simplify quality reporting - Automate eQMs and DQMs submissions to reduce the administrative strain that often fuels burnout in rural providers. Monitor Countywide Performance in Real Time - Gain live insights into outcomes across regions to track progress and direct resources where they’re needed most. But data alone isn’t enough; it’s what you do with it that counts. When data becomes actionable intelligence, it can drive collaboration across every layer of the rural care ecosystem. A nurse in a critical access hospital, a community health worker visiting homes, and a state Medicaid analyst can all draw from the same source of truth. That shared insight transforms coordination from a manual task into a continuous, intelligent process.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Innovation Horizons	Alaska Clinician Continuing Education Initiative	DC	Alaska faces a compounding public health emergency rooted in a critical gap: clinicians expected to manage the state's most complex patients are among the least equipped — not due to lack of dedication, due to lack of access to meaningful, unbiased continuing education. Every community in Alaska carries at least one Health Professional Shortage Area designation for primary, dental, or behavioral healthcare. Clinicians serving these communities — physicians, nurses, NPs, PAs, CHWs, and pharmacists — are often the sole point of care for patients with severe chronic disease: diabetes and hypertension far exceeding national averages, drug overdose death rates among the nation's highest, behavioral health co-morbidities, and complex polypharmacy. Alaska Native peoples, rural elders, and veterans are most affected. These clinicians face two barriers to ongoing education. First, traditional CE requires travel to urban centers — prohibitive when 75% of communities lack road access and no absence can be absorbed. Second, much CE that does reach rural clinicians is industry-funded and biased toward pharmaceutical interests rather than evidence-based, patient-centered care. This initiative will deliver accredited continuing education for licensed health professionals and targeted training for community health workers, with content tailored to the chronic disease burdens and care contexts most prevalent among Alaskans — immediately upskilling the workforce already on the ground.	Innovation Horizons will adapt its proven continuing education model — currently delivering free, accredited, independent CE to approximately 70% of licensed clinicians in Washington, DC through the DC Department of Health's Center for Rational Prescribing — into a comprehensive, Alaska-specific clinician education initiative grounded in behavior change science and Alaska's distinct public health realities. Content Development. Working with an Alaska-based clinical advisory committee — including nurses, physicians, community health aides, tribal health representatives, and pharmacists — we will conduct a formal needs assessment before each development cycle and produce six accredited courses annually, building a growing, durable library tailored to the Alaskan care context. Priority topics include diabetes and hypertension management, opioid stewardship, polypharmacy safety, behavioral health integration, maternal health, emergency preparedness, and culturally appropriate care for Alaska Native patients. All content will be unbiased, evidence-based, free of pharmaceutical industry influence, and grounded in peer-reviewed literature and current clinical guidelines. Accreditation. CE modules will be accredited through ACCME (physicians), ANCC (nurses), and ACPE (pharmacists), ensuring licensure-qualifying credit. Community health worker training tracks will align with Alaska's CHW certification framework, ensuring the full care team — not just licensed providers — benefits from structured, credentialed education. Delivery. Three tracks address Alaska's realities: low-bandwidth asynchronous online modules accessible from any clinic device; quarterly live virtual sessions for case-based discussion, expert Q&A, and peer connection that directly combat the professional isolation of frontier practice; and an Annual Clinical Education Manual physically distributed to remote clinics, CHA programs, and tribal health organizations for low- or no-connectivity environments. Evaluation. Coursework will be grounded in the theory of planned behavior to maximize practice change. Pre/post assessments will measure knowledge gains and intent to change practice. Utilization data will track reach by discipline, credential type, and geography. An Alaska-based project manager will oversee continuous quality improvement and ensure content evolves alongside Alaska's shifting public health priorities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Innovia GA, LLC	CONNECT Alaska: Community Outreach, Navigation, and Networked Engagement for Care Transformation	GA	CONNECT Alaska explores a model designed to strengthen connection and continuity of behavioral health care through structured virtual support communities. These communities may help individuals stay connected while on wait lists, after discharge, or during periods when additional connection may be helpful. This approach helps strengthen connection to care before, between, and beyond formal care encounters. These support communities are not intended to replace clinical services. Instead, they support the care provided by behavioral health professionals across Alaska. The model may also benefit individuals not currently receiving clinical care who could benefit from supportive interaction while navigating life stressors, isolation, or periods of transition. Through collaboration between Innovia Life and Alaska-based iEXIST, LLC, CONNECT Alaska will engage stakeholders to explore how this model can complement existing behavioral health care and strengthen the continuum of care for rural residents across Alaska’s regional service areas and hub communities.	CONNECT Alaska is a collaborative learning initiative exploring how structured support groups can strengthen participation in behavioral health supports across Alaska. The Year One effort emphasizes stakeholder engagement, demonstrations, and a small pilot to better understand how this model could complement existing behavioral health services while contributing to broader system strengthening. The project will begin with listening sessions and stakeholder conversations involving behavioral health providers, Tribal health organizations, community organizations, universities, and other collaborators. These discussions will help identify use cases for support groups, such as supporting individuals on wait lists, between appointments, after discharge, or during periods when additional peer interaction or encouragement may be helpful. Innovia Life representatives will participate in several in-person engagements in Alaska to demonstrate how the platform functions and build relationships with stakeholders. The Innovia platform enables structured support groups that provide technology-enabled interaction between clinical visits and other points of care. These engagements will take place in Anchorage, the Matanuska-Susitna Borough, and the Bethel Census Area to reflect regional hub, road-system, and off-road community perspectives. Following these engagements, the project will offer a limited number of demonstration seats allowing participants to explore the model and provide feedback on group formats, participation preferences, and barriers to participation. Some participants may be navigating life stressors, isolation, or periods of stress and may not yet need or be ready for clinical services. Supportive interaction can help individuals remain connected with support networks and strengthen pathways to care. During the Year One period, CONNECT Alaska will work with providers, community organizations, and regional stakeholders to identify locally informed ways this model could complement existing systems of care across Alaska. Insights from participants and partners will inform implementation approaches reflecting the geographic, workforce, and transportation realities of rural Alaska’s health system. This learning process will also help identify opportunities to strengthen participation in behavioral health supports between formal care encounters in communities where workforce capacity and access remain limited.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced

Integrative Learning Partners	Early Substance Use Intervention for Rural Alaska Youth	AK	Generally speaking, the problem/opportunity this grant seeks to address is the lack of early intervention opportunities for rural Alaskan youth displaying risk indicators for alcohol and substance abuse and addiction.	This project will develop and pilot a structured early intervention model for rural Alaska schools designed to respond to substance-related behavioral incidents involving middle and high school students. The goal is to provide a consistent and practical intervention that can be implemented immediately after a student is caught using or in possession of alcohol or drugs. Students involved in these incidents will complete a guided intervention experience designed to increase awareness of addiction risk, escalation patterns, and the long-term consequences of early substance use. The intervention will combine clear information about how substance use develops into addiction with culturally relevant narratives from Alaska individuals who have experienced substance misuse and recovery. The intervention will be delivered through a short digital learning module followed by a brief guided conversation with a trained school staff member. The conversation will use motivational interviewing principles to encourage reflection and help students consider how their current choices may affect their future health and goals. This approach adapts evidence-informed early intervention strategies commonly used in behavioral health, such as brief interventions and motivational interviewing, into a format that can be implemented within rural school systems. By embedding the intervention within existing school disciplinary processes and using a scalable digital platform, the model allows rural districts to provide early behavioral health intervention without requiring additional clinical staff. The project will pilot the model in two to three rural Alaska school districts and evaluate outcomes such as repeat substance-related incidents and student understanding of addiction risk.	\$250K-\$1M	Statewide	Fairbanks North Star Borough; Kenai Peninsula Borough; Kodiak Island Borough; North Slope Borough; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Integrity Solutions LLC	Healthcare Referral & Data Exchange Platform	AK	Integrity Solutions LLC Transforming Healthcare Infrastructure from Anchorage, Alaska to the Nation Integrity Solutions LLC is a healthcare technology and infrastructure company founded in Anchorage, Alaska, with a singular mission: to modernize how healthcare systems connect, communicate, and deliver care — especially in the most geographically complex and underserved environments in America. Born in one of the most logistically challenging healthcare landscapes in the United States, Integrity Solutions was not created in a major tech corridor or dense metropolitan market. It was forged in Alaska — a state defined by vast distances, rural isolation, tribal health complexity, extreme weather, and some of the highest per-capita healthcare delivery costs in the country. This foundation is not incidental; it is the company’s defining strength. Where most healthcare technology companies design solutions for urban hospital networks and retrofit them for rural use, Integrity Solutions built its model from the rural frontier inward. Anchorage is not simply the company’s headquarters — it is the proving ground that shaped its core philosophy: if a healthcare system can work in Alaska, it can work anywhere.	Integrity Solutions LLC proposes to develop and deploy a secure healthcare interoperability platform designed to streamline referral coordination, medical record exchange, and insurance verification between hospitals, clinics, and healthcare providers across Alaska. The project will focus on creating a centralized integration layer that enables providers to securely access and transmit patient information in real time, improving care coordination and reducing administrative delays. The proposed platform will utilize modern healthcare data standards, including FHIR-based APIs, to allow interoperability between existing electronic medical record (EMR) systems without requiring providers to replace their current software. Through a secure cloud-based infrastructure, the system will support real-time referral routing, access to relevant patient medical history and allergy information, and integrated insurance eligibility verification. This approach ensures that receiving providers have the necessary clinical and administrative information before a patient visit, improving efficiency and reducing redundant testing or delays in treatment. Implementation will occur in phases. The initial phase will focus on platform architecture, security compliance, and system design to ensure HIPAA-compliant data protection and scalable infrastructure. The second phase will involve development of the core platform and pilot deployment with one regional hospital and several clinics in the Anchorage and Mat-Su Valley region. During this pilot stage, the system will be tested to evaluate referral processing time, provider adoption, and administrative efficiency improvements. In the final phase, the platform will expand to additional healthcare facilities, including rural clinics and regional hospitals, supporting broader statewide interoperability. By focusing on integration rather than replacement of existing systems, this approach minimizes disruption for healthcare providers while delivering immediate improvements in referral management, data accessibility, and operational efficiency. The long-term goal is to establish a scalable healthcare interoperability infrastructure that strengthens care coordination, improves patient outcomes, and reduces administrative costs for healthcare providers throughout Alaska.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

IntellectAbility	Bridging the Gap: Advancing IDD Healthcare Workforce Capacity Across Rural Alaska	FL	People with intellectual and developmental disabilities (IDD), particularly those living in rural communities, face persistent barriers to timely, high-quality healthcare. In Alaska, where 82% of communities are not connected by road and many residents must travel long distances to reach hospitals, geographic isolation intensifies inequities. Workforce shortages, high provider turnover, limited specialty access, and few training opportunities further restrict access to clinicians prepared to address complex needs. As a result, the approximately 11,600 Alaskans with IDD experience significant disparities, including higher rates of preventable hospitalizations, non-urgent emergency department use, unnecessary diagnostic testing, and delays in diagnosis due to atypical symptoms and communication differences. Gaps in preventive care contribute to lower screening rates, higher rates of chronic disease, polypharmacy, longer hospital stays, and increased healthcare costs. A key driver of these disparities is the lack of structured training. Many clinicians report low confidence in managing IDD-related complexities and limited preparation in adapting care. Without targeted education and practical strategies to identify health risks, opportunities for early intervention are missed and inequities persist. This project addresses the shortage of IDD-specific training among Alaska’s rural healthcare workforce, strengthening capacity to deliver equitable, person-centered care statewide.	Our approach to delivering the Curriculum in IDD Healthcare eLearning course is designed to ensure accessibility, engagement, and measurable impact for healthcare providers across Alaska. The Curriculum in IDD Healthcare educates clinicians, including those delivering telemedicine, on important concepts to improve clinical and diagnostic skillsets. It includes the fatal five, which are the top preventable causes of illness and death in people with IDD, osteoporosis, common lab abnormalities, behavioral changes associated with underlying medical conditions, dental issues, mental health conditions, how to facilitate better communication in healthcare settings, and much more. The course is designed to enhance clinical skillsets and improve the capacity to deliver effective healthcare to people with IDD. The course will be hosted on our secure eLearning Platform (eLP), which provides a comprehensive learner experience. Each participant will have a secure account that tracks progress, allows bookmarking, and issues automated completion certificates. Built-in assessment and reporting tools capture participation and learning outcomes, while CME and nursing CEU tracking ensures professional development is accurately documented. To support statewide registration and engagement, we will develop a customized Alaska-focused landing page. This page will highlight the importance of IDD-informed care, clearly communicate available CME and CEU opportunities, provide a direct path for registration, and showcase testimonials and outcome data. Metrics from a prior study demonstrate that the course increased clinician confidence by 62% and medical student confidence by 108%, underscoring its effectiveness. The landing page will act as the central hub for licensed healthcare providers statewide, with enrollment analytics tracking reach and engagement. To maximize awareness and adoption, we will deploy a robust marketing strategy informed by successful statewide rollouts in other regions. This strategy will include targeted email campaigns to licensed healthcare providers, partnerships with professional associations, direct engagement with rural hospital systems and clinics, collaboration with the Division of Senior and Disability Services and other state agencies, as well as digital campaigns, including social media outreach. Together, these efforts are designed to create broad awareness, encouraging widespread adoption of the course among Alaska’s healthcare workforce.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

IntellectAbility	From Rural Risk to Rural Resilience: Improving Health Outcomes for Alaskans with I/DD	FL	People with intellectual and developmental disabilities (IDD), particularly those in rural and frontier communities, face significant barriers to timely, consistent healthcare. Geographic isolation, provider shortages, and limited local expertise delay identification of emerging health risks and reduce access to preventive care. Consequently, people with IDD experience profound disparities, including earlier mortality, higher rates of preventable death, later-stage cancer diagnoses, and lower rates of routine health screenings. They also have higher rates of chronic disease, mental health conditions, and dental disease, along with increased polypharmacy and inappropriate prescribing. People with IDD are more likely to experience abuse, unmet social determinants of health needs, longer hospital stays, avoidable emergency department use, and higher overall healthcare costs. These disparities are amplified in remote areas like Alaska, where 82% of communities lack road connections and many residents must travel hundreds of miles, often by plane, to reach hub hospitals. Without standardized tools to assess and monitor health risks, supporters and providers miss opportunities for early intervention. These systemic gaps perpetuate inequities in access, quality, and outcomes for some of Alaska’s most vulnerable residents.	Our approach addresses gaps in health care access, quality, and coordination for people with intellectual and developmental disabilities (IDD) in Alaska’s rural, remote, and frontier communities by leveraging the Health Risk Screening Tool (HRST) and its screening service. Recognizing geographic isolation, limited provider availability, and workforce constraints, this project introduces a structured, standardized process to assess health risks and support proactive care planning across dispersed communities. Potential timeline: Month 1: Stakeholder engagement and onboarding Months 2–6: Pilot cohort launch (500 participants) Months 6–12: Expansion to 80% waiver enrollment The project begins with outreach to state agencies (Division of Senior and Disability Services), provider associations (Alaska Association of Developmental Disabilities), Tribal Health Organizations and other community-based organizations to support adoption and integration of the HRST into existing systems. (This strategy has proven effective in multiple states leveraging the HRST statewide.) Screenings will be conducted remotely by trained IntellectAbility Raters, ensuring accuracy, consistency, and ease of implementation for providers. Individuals being screened are encouraged to actively participate in the process, supporting person-centered assessment and engagement. Each screening generates actionable insights to prioritize interventions, monitor risks, and develop individualized care plans. Training and technical support will further strengthen provider capacity and promote consistent, high-quality care. The HRST also generates de-identified, aggregated data to inform decision-making, identify trends, and highlight service gaps. This data-driven approach supports efficient resource allocation, preventive care initiatives, and quality improvement efforts for long-term sustainability. By combining standardized risk measurement through expert-led screenings, remote accessibility, training, and data-informed guidance, this model strengthens local capacity and promotes coordinated, equitable health outcomes for rural Alaskans with IDD.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

IntellectAbility	Strengthening Rural Care from the Front Lines: A Statewide Fatal Five Initiative	FL	Alaska’s ~11,600 individuals with intellectual and developmental disabilities (IDD), especially in rural and frontier communities, face persistent barriers to timely, high-quality healthcare. In remote Alaska, delay is not an inconvenience - it is a risk multiplier. When transport requires aircraft, prevention is the only scalable safety strategy. Geographic isolation combined with workforce shortages, high turnover, limited specialty access, and few IDD-focused training opportunities increase risks, resulting in higher rates of preventable hospitalizations, non-urgent emergency visits, unnecessary testing, delayed diagnoses, and higher healthcare costs. A key driver of these disparities is the lack of practical training for clinicians and frontline staff, who often report low confidence in managing IDD-related health complexities. Subtle but significant changes - especially the “Fatal Five” conditions (aspiration, dehydration, constipation, sepsis, and seizures) - can escalate quickly if not recognized. In rural Alaska, where emergency response and specialist care may be delayed, proactive intervention is critical. This project provides evidence-informed, practical training for Direct Support Professionals (DSPs), residential and day program staff, behavioral support specialists, community health aides, volunteers, and families. It strengthens workforce capacity, promotes person-centered care, and improves access, quality, and equity for rural Alaskans with I/DD.	The Fatal Five Fundamentals eLearning program provides practical, evidence-informed training to frontline supporters who provide direct care to people with IDD. It equips supporters with the skills to recognize early signs of health destabilization and take timely action to prevent avoidable crises. The course is comprised of seven self-paced modules, with knowledge checks built in to ensure learner engagement and retention. It is accredited by the National Alliance for Direct Support Professionals (NADSP), providing recognized professional development for participants. Total course completion time is roughly 4 hours. The course will be accessible to all provider agencies, tribal health partners, community-based organizations, and families across the state. We will develop a robust marketing strategy including direct email promotion, bulletins, and partnerships with the Senior and Disability Division, Alaska DD Association, and community providers to drive course adoption. Delivery is flexible: it can integrate into existing Learning Management Systems (LMS) used by the State, or it can be hosted through our secure electronic Learning Platform (eLP), which includes user management, tracking, reporting, and certification functionality. Disruptions in connectivity are accommodated through bookmarking of forward progress, ensuring learners can complete the course even in areas with intermittent internet access. SCORM-compliant integration ensures compatibility with most LMS environments, allowing seamless adoption. The content is practical and role-focused, emphasizing skills that non-clinical supporters can apply in daily care. Participants learn to identify early warning signs, recognize subtle changes in health status, document observations, and communicate concerns effectively to clinical partners. Training also covers proactive prevention strategies and guidance for escalating concerns when necessary. Completion tracking and reporting dashboards allow the State to monitor uptake, identify gaps, and evaluate impact, supporting RHT goals of measurable improvement in workforce capacity, care quality, and population health outcomes. By combining statewide access, flexible delivery, role-relevant skills, self-paced modules with engagement checks, accreditation, and robust reporting, the Fatal Five Fundamentals initiative builds sustainable, rural-ready capacity to prevent the Fatal Five and improve health outcomes for Alaskans with I/DD.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Interior AIDS Association	Hepatitis C Confirmation Test Machine	AK	Hepatitis C Confirmatory testing is not easy to access. IAA has done HCV screening tests for years, but we have had to rely on other healthcare providers to confirm reactive results of the Orasure fingerstick screening. People who screen positive may not follow through with confirmatory testing, or may delay it - during which time they can be transmitting the disease to others through sharing of drug use equipment. It is especially important for pregnant women to avoid HCV, or be treated as soon as possible. With this Hepatitis C Confirmatory testing machine, we can eliminate the waiting period for confirmation and reduce the number who are lost to care because they do not follow through with confirmation. With people in the room when they get a positive test, staff can immediately take steps to ensure linkage to care for HCV Treatment. If they have health coverage, they can receive case management assistance to make an appointment. If not, and they are not Alaska Native Beneficiaries with access to CAIHC, staff can assist them to access treatment through Pharmaceutical Assistance Programs, or other sources for the medication. IAA is insured for limited primary care - so our doctors could prescribe.	1. Purchase the Hepatitis C Confirmatory testing machine. "With Cepheid's Xpert® HCV, patients can undergo testing, receive a diagnosis, and seamlessly connect to treatment and care in a single visit. This efficient process has the potential to save time and can ensure more patients stay in care, leading to more people cured of hepatitis C." 2. Work with the State of Alaska, Section of Epidemiology to ensure proper use and training. Kira England, Syndemics Lead, informed us of this opportunity and they are willing to offer support to ensure success. 3. Add HCV Confirmatory Testing to our existing Prevention Program, wherein we already screen for HIV, HCV and Syphilis. 4. Ensure linkage to care for people who test positive for HCV.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Single Community	Fairbanks North Star Borough	Advance to Implementation Application

Interior AIDS Association	OTP Medical Services Renovation	AK	IAA's Medical Services are related to IMAT - a comprehensive Opioid Treatment Program. Medication is dispensed to patients every day of the year. The current medical area is made up of two rooms and the "kitchen" walkway between them. The sink is in the center area, while the medication dispensing area is in a separate room at one end with no water access. The bathroom that patients use to give urine specimens is off the center walkway. The Med room is a concrete box about 10 feet square. It does not meet DEA requirements by itself for Medication storage, so two safes are contained inside the room for methadone and buprenorphine storage. The doctor's exam room is at the other end of the center walkway - also with no sink. Ventilation inadequacy leaves the Medication Room so warm it has a permanently-running air conditioner in it. Reorganizing the existing space to increase the size of the Medication Dispensing room and add a sink for handwashing and adequate ventilation will improve the quality of the nurse's work environment. The Exam Room, which is about 8 feet square can be expanded into the unused "walkway" space to make a reasonably-sized room for the doctor and nurse to work in with patients. A handwashing sink and improved ventilation completes the exam room space. The walkway area will be smaller and more efficient with room for storage.	Our Medical Services area was not designed for its current purpose. It was sort of a staff break room. This renovation project will allow us to correct that problem. Our building was well-surveyed two years ago by Design Alaska engineers - the walls we want to move are movable. With this renovation, ventilation can be added to the expanded Medication Room - allowing us to remove the constantly-running portable air conditioner. The areas that must be accessed to add and/or move sinks is accessible from the rooms and from crawl space underneath when necessary - which is kept warm by the steam heat pipe coming into the building from the street. Design Alaska will create the renovation plans. Then we need to find a contractor to complete the renovations.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Single Community	Fairbanks North Star Borough	Advance to Implementation Application

Interior AIDS Association	Health Technology Modernization	AK	PROBLEM 1 is aging and outdated computer infrastructure. The OPPORTUNITY is this RHTP funding paired with the current identification of a new modern server, network improvements and new workstation computers that can keep up. We have a quote and a plan. PROBLEM 2 is an electronic health record that lacks the programming to support a fully digital health record and integrated billing capacity. The OPPORTUNITY is that a plan exists and is ready to implement to take the OTP’s electronic health record platform out of the paper age and into the modern digital age with confidence and security. PROBLEM 3 is a lack of opportunities for patients to interact with their health care experience digitally; we still depend on paper forms. This funding offers the OPPORTUNITY to hand a patient a tablet to complete a form or a survey instead of writing on paper, which must be scanned, and still does not interface with the EHR. The EHR has an APP that patients can use to enter information into their own records. While they could use their phones – if they have one – a tablet in the clinic is a better option. Five tablets would meet the need at peak traffic times.	New Server: The solution to the problem of an outdated server is to acknowledge that we have used the aging system to its limits, and to purchase and install a new server system based on current and emerging technology. In order to operate the upgraded EHR, the old server must be replaced. Our IT contractor has developed a description, explanation, and quote for costs associated with installing a new server. Workstations –With a server that operates on modern technology, 10 of our workstations must be replaced in order for the system to work effectively. Scanners are a necessity for maintaining a digital record, even if we have tablets to replace some paper. If this project is funded, the workstations and scanners will be ordered at the same time, creating an opportunity for discounts. Our IT Contractor is very familiar with our workflows, he will be installing the new server and will order the workstation configurations as needed for different functions. Workstations slated for replacement have been identified and the order will be placed within 24 hours of the notice of funding award. Otherwise, we have to order them individually or at least in smaller numbers when funding is identified. Electronic Health Record Upgrade: Plans have been developed with the EHR vendor, Netsmart. The system is Methasoft – which supports MOUD dispensing and record keeping. The plan includes installation/activation of the billing module and configuration of the system to enable direct billing. It also includes improved interfaces for clinical staff and patients: electronic signature pads, kiosk for efficient check-in and optional payment portal. With the added services come additional fees. For 10 years, the previous owner of Methasoft (Netalytics) charged IMAT for only 5 users (\$500/month). The new company and the new system is still quite reasonable, but is now \$1,049 per month plus the fee for billing. Our approach to this new problem is to request financial support for the fees for one year. It will take time and wages to scan and integrate our existing paper files. The efficiency gained in direct billing will be realized after the full transition is complete. We can sustain the fees after the first year because money is saved on data entry that we pay for now. Tablets for digital patient interface in the office can be purchased at any time upon recommendation of our IT Contractor in regard to security, capacity and durability.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced

Interior Alaska Center for Non Violent Living	Interior Alaska Rural Legal and SART Advocacy Initiative	AK	Survivors of domestic violence and sexual assault in rural Interior Alaska often lack consistent access to advocacy during medical, legal, and investigative processes. While coordinated response systems exist in Fairbanks, many rural survivors must travel long distances or navigate these systems without support. Traveling to Fairbanks may require survivors to leave their community, employment, childcare responsibilities, and cultural support systems. These barriers can prevent survivors from seeking care or participating in the legal process. This project addresses the opportunity to bring coordinated advocacy services directly to rural communities, ensuring survivors have access to trauma-informed legal and medical accompaniment without having to leave their home communities unless they choose to do so.	The Interior Alaska Center for Non-Violent Living (IAC) will establish two Legal and Sexual Assault Response Team (SART) Rural Advocate positions serving Interior Alaska’s 42 rural villages. The advocates will: Provide legal advocacy, including court accompaniment and meetings with law enforcement or prosecutors. Provide medical accompaniment during sexual assault forensic exams. Travel to rural communities when needed so survivors can access advocacy services without leaving their home community. Coordinate with rural health clinics, law enforcement agencies, and the Fairbanks District Attorney’s Office to ensure survivors receive coordinated support. Participate in the Interior Alaska SART Multidisciplinary Team to strengthen system collaboration. Work with tribal and regional partners to ensure services are culturally responsive and accessible. By staffing two advocates, the project increases the ability to respond to requests across a large geographic region and reduces response delays caused by travel distances between communities. By strengthening coordination between rural health providers, advocacy services, and the justice system, this project will help rural health systems deliver more effective trauma-informed care for survivors of violence while reducing the need for survivors to travel outside their communities for support.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough	Deferred or Not Advanced

Interior Alaska Hospital Foundation	Project “North Star”: Concept Formation for a New 24/7 Interior Alaska Hospital for 6,000+ Alaskans	AK	The residents of the 70,000-square-mile Delta Junction market face severe geographic isolation; they rely on small primary care clinics and endure a dangerous 2+ hour transport for emergency care. The primary opportunity of Project "North Star" is to solve this acute lack of access by establishing a financially viable, 24/7 hospital in Delta Junction. Second, this new hospital will serve as a physical hub to integrate other Alaska RHTP initiatives. Based on our discussions at the January 2026 DOH convening, the facility will incorporate a medical-based wellness program, advanced telehealth platforms for access to specialists, and innovative workforce development strategies. The specific opportunity for the FY2026 funding cycle is to execute the critical "Concept Formation" phase. Leveraging a small current grant and donations, this RHTP funding will allow the IAHF to verify market demand, determine specific service lines, develop conceptual designs and Total Project Budgets, and ultimately file a Certificate of Need (CON).	Project North Star directly advances the RHTP “Health Care Access” initiative by expanding essential services in a geographically isolated, severe-weather region. Our approach is a highly disciplined, multi-year initiative divided into four phases: Concept Formation, Implementation, Construction, and Operations Start-Up. Crucially, FY2026 RHTP funds will only be used for Concept Formation; they will not supplant existing funds or be used for actual construction. Our approach is not a dream, but is built on years of effort. In 2012, the IAHF secured funding for a feasibility study to determine what healthcare services could be sustainable in the region. The results 14 years ago were that a CAH and long-term care beds could be supported by the market. However, 14 years ago, HRSA told the IAHF to start with an FQHC, and the IAHF did, and now the opportunity is to fulfill the IAHF mission. The FY2026 approach is hands-on and data-driven. We will tackle unique logistical hurdles, collaborating with A&E firms to determine viable construction means, methods, and costs for extreme interior Alaska weather without port access. We will utilize empirical data to define the facility's scope and verify its financial sustainability. This approach builds in structural accountability, culminating in a strict “go/no-go” decision. If the data proves the hospital is viable, we will recruit an established operator (e.g., Providence, SEARCH). If deemed unviable, the IAHF will halt the project, and the DOH may reallocate unspent funds, ensuring zero risk of wasted state resources. The Concept Formation Phase focuses on viability, but in financial planning, we will also consider staffing, service alignment, and IT alignment for Value-Based Care success!	\$1M-\$5M		Multi-Community or Participating in Regional Hub-and-Spoke	Southeast Fairbanks Census Area	Deferred or Not Advanced
Interior Community Health Center	Improve blood pressure control in 50% of the 320 patients with hypertension by September 30, 2027.	AK	ICHC is addressing uncontrolled hypertension--a well-known chronic health condition that is a contributor to one of the greatest known causes of disability and premature death (i.e., heart disease and stroke). For this project, ICHC is focusing on uncontrolled hypertension in its adult population.	ICHC will contract with a remote patient monitoring (RPM) nursing service to provide daily monitoring of the patient's blood pressure via Bluetooth or cellular blood pressure monitors that link with the patient's Electronic Health Record. The RPM nursing team will alert ICHC's providers if patients' blood pressure readings are too high. ICHC's providers will then follow up with the patient.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough	Advance to Implementation Application

Interior Community Health Center	Increase access to medications for people living in poverty in the Interior of Alaska.	AK	The most recent community needs assessment, a partnership between Foundation Health Partners, the State of Alaska public health nursing and ICHC, reveals access to primary care as a top need. As ICHC is one of the few agencies in Fairbanks that provides a sliding fee discount, ICHC identifies many patients that have difficulty paying out of pocket for their medications. Inability to afford needed medications has been documented in various studies. When people cannot afford their medications and they go without, chronic conditions and other health related needs go unmet, resulting in the development of more serious and complicated conditions. This project will improve access to pharmaceuticals by discounting the patient’s medication cost. For example, an epi pen which ICHC can buy at cost through its 340B contract is \$29.65 a box, versus full cash pay without a discount card at Fred Meyer retails for \$762.99.	ICHC’s proposed approach to increasing access to medications for people living in poverty in the Interior of Alaska is to 1) utilize its existing 340B consultant list (including our auditor, Forvis Mazars, because they too have a division that provides contractual services for FQHCs who participate in the 340B program). ICHC would execute this contract by November 1, 2026 and select a consultant from this list to provide overall consultive services. 2) ICHC would contract directly with a pharmacy to provide a pharmacist by December 31, 2026. 3) ICHC would purchase a remote pharmacy dispensing machine (RPDM) and issue a design build renovation of its lobby by March 31, 2027. 4) ICHC would substantially complete its lobby renovation and installation of its RPDM by June 30, 2027, and 5) by September 30, 2027, patients will have access to discounted 340B pharmaceuticals in its lobby.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough	Advance to Implementation Application

Interior Region Emergency Medical Services Council	Alaska Interior Region Emergency Medical Services Cooperative - A Comprehensive Strategy for RHTP	AK	The Interior region faces a critical fragility gap in emergency medical services. Currently, EMS delivery is fragmented into localized, often uncooperative silos. This balkanization results in inconsistent medical oversight, disparate training standards, and inefficient resource allocation. While the spirit of Alaskan EMS is built on local independence, the administrative and logistical burdens of modern healthcare have outpaced the capacity of these small isolated agencies. In the roadless and remote communities of the Interior, the lack of a unified emergency medical services support structure leads to delayed care and a dangerous reliance on expensive, late-stage medevacs for conditions that could be treated in place. Furthermore, the traditional EMS model, designed for urban rapid response, fails to address the chronic and primary care needs of the frontier. The result is a system where the population is underserved by a binary transport or nothing model.	This concept applies a shared services approach to a vast, frontier landscape. By centralizing the business of EMS (education, medical direction, fiscal oversight, and supply chains) we allow local providers to focus on what matters most: the patient. This is an EMS Co-op designed to leverage economies of scale, ensuring every Alaskan community has access to high-level clinical and emergency care, regardless of geography. Pillar 1: The Regional EMS Cooperative Structure The goal is to eliminate systemic fragmentation by establishing IREMSC as the central support and coordination hub for regional operations. -Unified Medical Oversight -Regional Training Hubs (workforce development) -Centralized Logistics & Supply Chain -Administrative Support Services (unified executive functions) Pillar 2: EMS Operational Tiers (Hub and Spoke) This tiered model optimizes personnel deployment across both road-connected and off-road systems, reorganizing resources based on evaluated community needs. -Community based hybrid volunteer/paid BLS response and transport capability. -ALS Critical Care Intercept on Roadways. -Alaska Remote Duty Paramedic deployment rural and frontier communities. -Coordinated Surge Capacity for personnel & medical logistics. Pillar 3: Mobile Integrated Health & The Alaska Remote Duty Paramedic Initiative This is the system’s force multiplier. ARDPI transitions the paramedic from a transport provider to a remote clinical practitioner, a true physician extender delivering primary care to the most vulnerable Alaskans. •The Remote Duty Paramedic Model - New provider type •Remote Care Islands - primary care touch point with clinical competency •MIH - RDP coordinates resources and care •Specialty Engagement Teams: local asset (dental, OBGYN, behavioral health, public health initiatives) •Local Clinical Support - EMS training, clinical resource for CHA, ALS intervention and operational relief for rural providers. By transitioning to a regional cooperative model, IREMSC moves beyond the outdated transport-only paradigm in frontier communities and provides essential access to ALS resources on and off the road system. This initiative will prove that a unified clinical umbrella, coupled with the proven remote duty paramedic model, creates a more resilient workforce and a vastly more cost-effective healthcare delivery system. We are not just building a better EMS system; we are constructing a primary care safety net for the most remote Alaskans.	Over \$5M	Statewide	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Internal Medicine Associates	Internal Medicine Associates expanded services and improved outcomes	AK	Rural Alaskans face limited access to specialty care, including endocrine and gastrointestinal care, resulting in delayed diagnosis and worsening chronic disease. Fairbanks has only intermittent in-person endocrine & gastrointestinal coverage, and surrounding Interior communities often have no specialty access at all. Patients with thyroid disease, adrenal disorders, GERD, IBS, Crohn’s disease, colitis, celiac disease, and gallstones frequently travel hundreds of miles for routine care, which leads to missed appointments, poor disease control, and preventable complications. The opportunity is to transform this fragmented system into a stable, accessible, and modernized statewide endocrine and gastrointestinal service. By strengthening the Anchorage hub, expanding Fairbanks coverage, and building tele-endocrinology pathways, we can dramatically reduce travel burdens, improve outcomes, and create a sustainable model for specialty care delivery in rural Alaska.	Our approach focuses on three coordinated strategies: workforce stabilization, telehealth expansion, and integrated chronic disease management. 1. Workforce Stabilization We will recruit 1–2 additional gastroenterology providers and 1 additional endocrinology provider or advanced practice clinicians to expand capacity and reduce burnout among the current team. Dedicated travel support will ensure consistent Anchorage-to-Fairbanks rotations. A rural care coordinator will manage referrals, follow-ups, and patient navigation across the Interior. 2. Tele-Gastroenterology & Endocrinology Expansion We will establish a telehealth hub in Anchorage with dedicated scheduling, remote monitoring tools, and EMR integration with Fairbanks and rural clinics. This will enable virtual follow-ups, insulin titration, medication adjustments, and chronic disease management for patients in Delta, Tok, Nenana, Healy, and surrounding communities. Telehealth will also support tribal health partners and reduce weather-related care disruptions. 3. Chronic Disease Management Program We will implement remote virtual education, medication management, and culturally appropriate materials for rural Alaskan patients. Standardized care pathways will improve thyroid, adrenal, GERD, IBS, Crohn’s disease, colitis, and celiac disease management. 4. Infrastructure & Technology Funding will support telehealth equipment, EMR integration, remote monitoring devices, and training for rural clinic partners. Together, these strategies create a reliable, scalable, and sustainable statewide gastrointestinal & endocrine services that aligns with RHTP goals for access, modernization, and improved outcomes.	\$250K-\$1M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Southeast Fairbanks Census Area	Advance to Implementation Application

International SOS Government Medical Services, Inc.	International SOS (Intl.SOS) Health on the Move - Bringing Care to Remote Communities	TX	The Mobile Rural Health Network expands the capacity of Alaska’s rural healthcare system by combining mobile clinical infrastructure with telehealth enabled care delivery. Three Mobile Medical Units will rotate among rural hub communities and surrounding villages, extending the reach of tribal clinics, community health aide programs, and regional hospitals while improving access to care in remote communities. Many rural communities in Alaska face barriers to accessing healthcare services due to geographic isolation, limited transportation infrastructure, and workforce shortages. Approximately 82 percent of Alaska communities are not connected to the road system and rely on air or marine travel to reach healthcare services. More than 90 percent of Alaska’s land area is designated as a Health Professional Shortage Area for primary care. Although Alaska’s healthcare system includes tribal health organizations, critical access hospitals, and federally qualified health centers, many communities still experience limited access to routine medical services. Travel distances for primary care can exceed 60 to 120 miles, contributing to delayed treatment and increased reliance on emergency departments for non urgent conditions. Three Mobile Medical Units supported by telehealth will deliver approximately 36,000 to 45,000 patient encounters annually while strengthening coordination with Alaska’s tribal clinics and rural hospitals.	Intl.SOS proposes a Mobile Rural Health Network that expands the capacity of Alaska’s rural healthcare system through mobile clinical services, telehealth technologies, and integrated health data systems. The program will deploy an initial pilot of three Mobile Medical Units that rotate among rural hub communities and surrounding villages on scheduled service routes. The Mobile Rural Health Network is designed to extend the reach of tribal clinics, community health aide programs, and rural hospitals by providing additional clinical access points in remote communities. This approach strengthens statewide healthcare infrastructure while preserving locally delivered care. Each Mobile Medical Unit functions as a fully equipped mobile clinic capable of delivering primary care, urgent care, preventive screenings, chronic disease management, women’s health services, and behavioral health services. Clinical care will be delivered by Advanced Practice Providers supported by nursing staff and connected through telehealth platforms to physicians and specialists when needed. Electronic health records will document patient encounters and support secure information sharing where appropriate to ensure continuity of care. Telehealth capabilities allow providers to monitor chronic conditions and provide follow up consultations between scheduled site visits. Each Mobile Medical Unit is expected to deliver approximately 12,000 to 15,000 patient encounters annually based on projected clinic operating capacity. The initial pilot of three Mobile Medical Units will deliver approximately 36,000 to 45,000 patient encounters annually across participating regions. The pilot establishes mobile healthcare infrastructure that can expand to additional rural regions, allowing the program to scale statewide while strengthening coordination with tribal health organizations and regional hospitals.	Over \$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Interstate Health Systems, Inc.	Interstate Health Rural Access Network – Alaska	TN	Rural and frontier Alaska faces some of the most severe healthcare access disparities in the US. Geographic accessibility issues mean that many residents often delay treatment until conditions become urgent, contributing to high rates of diabetes, cardiovascular disease, behavioral health conditions, substance use disorders, suicide, and preventable hospital utilization. These barriers worsen health outcomes while increasing the overall cost of care. Large areas of Alaska are designated Health Professional Shortage Areas and Medically Underserved Areas, reflecting persistent shortages of primary care, behavioral health, and specialty providers. Rural healthcare systems must also contend with high operating costs related to staffing, housing, transportation, and medical logistics. Many communities rely heavily on Medicaid, Medicare, Indian Health Service, and uninsured patients, creating financial sustainability challenges for local providers. Many residents must travel long distances or rely on emergency departments for conditions that could be managed through accessible community-based primary care. These gaps highlight the need for flexible, scalable care models. Expanding regional healthcare access hubs supported by telehealth, mobile outreach, and team-based care can bring essential services closer to rural residents while improving care coordination and reducing preventable emergency department use.	Interstate Health will establish a phased network of six rural and frontier clinics across Alaska, each approximately 1,200–2,000 square feet, designed to function together as a coordinated rural access network. Clinics will be located near population hubs, transportation corridors, and ports so they can function as regional healthcare access hubs serving surrounding rural and frontier communities supported by mobile outreach and telehealth connectivity. This scalable model allows Interstate Health to adapt to Alaska’s geographic terrain, transportation limitations, and logistical realities while expanding sustainable access to primary and urgent care services. Initial geographic targeting will prioritize rural and frontier regions with documented Health Professional Shortage Area and Medically Underserved Area designations and limited primary care provider availability, including the regions identified in this application and additional western Alaska regional service hubs that support surrounding rural communities. Clinics will be staffed by Nurse Practitioners and Physician Assistants with physician supervision. Care teams will include Community Health Coaches who function as patient navigators and community health workers, supporting patient education, chronic disease management, care coordination, and follow-up engagement. Telehealth-based physicians and behavioral health specialists will provide clinical consultation and specialty support. Workforce recruitment may include relocation assistance, telehealth-supported supervision, and flexible staffing models. Mobile outreach vehicles will conduct community visits, workplace health services, screenings, and follow-up care in remote communities. Core services will include primary and urgent care services, chronic disease management, preventive screenings, immunizations, diagnostic imaging, and behavioral health services delivered through telehealth and on-site. Clinics will provide occupational health services like DOT physicals, veterans’ medical disability examinations, and evaluation and management of sleep disorders through home-based, virtual, and clinic-supported sleep apnea testing when clinically appropriate. Telemedicine visits and remote patient monitoring will further support ongoing patient care. When patients require specialty or hospital-level services, care teams will coordinate with regional hospitals, tribal health systems, and specialty providers to ensure continuity of care.	Over \$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Intertribal Agriculture Council	Strengthening Tribal Food Systems to Improve Rural Health in Alaska	MT	Many Alaska Tribal communities have received federal investments in food system infrastructure such as cold storage, processing space, and transportation equipment. While these investments are important, infrastructure alone does not ensure reliable access to healthy food in remote communities. Across rural Alaska, long distances, limited road access, and seasonal transportation make healthy foods expensive and inconsistent. Many communities are located 250 to 1,200 air miles from Anchorage and rely on complex supply chains involving barges and small aircraft. Freight costs for food can exceed \$1.50 to \$2.50 per pound, increasing household food costs and contributing to spoilage and supply disruptions. The core challenge is an implementation gap. Prior investments supported infrastructure installation in 12 Alaska Tribal communities, but they did not fully fund the technical assistance, workforce training, operational planning, and market coordination needed to activate and sustain those assets. This project addresses that gap by supporting existing projects while expanding investments to at least three additional Tribal communities. By strengthening the ability to store, process, and distribute locally harvested foods, the project improves food access, reduces waste, and supports healthier rural communities.	Our approach is to close the gap between food infrastructure investment and actual community use. Building on the USDA National Intertribal Food Business Center work already underway in 12 Alaska Tribal communities, this project will provide the operational support needed to turn installed assets into functioning local food systems. This work builds on a successful collaboration between our team and the Alaska Food Policy Council (AFPC), which has helped strengthen coordination, shared learning, and statewide visibility for Tribal food system initiatives. Together, we will continue to support communities in activating existing infrastructure and expanding food access solutions that reflect local conditions across Alaska. Previous funding supported equipment such as cold storage, processing, packaging, and transport capacity, but it did not fully cover the implementation assistance needed to ensure these assets are used effectively. This project focuses on activating those investments while expanding support to additional communities facing similar challenges. The project includes five core components. First, we will confirm participating communities and launch the opportunity through coordinated outreach with Tribal partners and AFPC’s statewide network. Second, we will select three regional Tribal food system implementation awardees in underserved areas, with awards of up to \$100,000 each for the North Slope or Arctic region, Southeast Alaska Panhandle, and Yukon-Kuskokwim Delta. Third, we will support targeted procurement and installation of equipment where critical gaps remain. Investments may include cold storage, small-scale processing equipment, or supply chain delivery capacity that allows communities to safely store and distribute food. Fourth, we will provide on-site technical assistance and workforce development focused on food safety, operations, business planning, and local distribution systems. Fifth, we will work with AFPC and community partners to strengthen connections between producers, Tribal food programs, and buyers so locally harvested foods can move through sustainable local and regional systems. The work will be implemented over an 18-month period, beginning with community confirmation and award selection, followed by procurement and operational training, and concluding with market integration, site visits, evaluation interviews, and an Alaska Food Festival convening to strengthen statewide learning and collaboration.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Isaac Health	Reducing Medical Travel Through a Rural Neurocognitive Specialty Hub	NY	Alaska has an estimated 9,000–11,000 residents living with Alzheimer’s disease and related dementias, with many more experiencing early cognitive impairment that has not yet been formally diagnosed. Due to geographic isolation, workforce shortages, and limited access to neurologists, many Alaskans—particularly those in rural and frontier communities—face long delays in diagnosis and limited access to ongoing specialty care. Isaac Health’s telehealth-enabled neurologist model expands access to cognitive care without requiring patients to travel to urban centers. Within the first year, Isaac Health could serve 1,500–2,500 Alaskans, representing approximately 15–25% of the diagnosed dementia population. Patients receive comprehensive cognitive evaluation, diagnosis, individualized care plans, medication management, behavioral symptom support, and caregiver education. As referral networks grow and partnerships expand with primary care providers and health systems, the model could scale to serve 4,000–6,000 Alaskans annually within three years, reaching 40–60% of the state’s dementia population. By delivering specialist care directly to patients in their homes, Isaac Health reduces costly medical travel, supports local providers in managing complex cognitive conditions, and strengthens access to sustainable dementia care across Alaska’s rural and frontier communities.	Our model is dementia-forward given the epidemiologic reality that Alzheimer’s disease and related dementias (ADRD) are among the leading contributors to neurologic disability among U.S. adults over age 65 (Global Burden of Disease Study 2021). Within Medicare and Medicaid populations, dementia and vascular cognitive impairment account for a substantial share of functional decline, caregiver burden, and downstream health care utilization. These challenges are amplified in rural and frontier communities across Alaska where access to neurologists and geriatric specialists is extremely limited and patients often must travel long distances to urban centers such as Anchorage or Fairbanks for specialty care. Our model expands access to neurologist-led dementia care through a telehealth-enabled specialty approach designed for rural and remote communities. Using a proprietary supervised machine learning model trained on adjudicated claims and pharmacy data, we identify individuals at high risk for neurocognitive disorders with greater than 90 percent diagnostic accuracy. Identified members are proactively engaged and offered comprehensive neurocognitive evaluation by board-certified neurologists, geriatricians, or psychiatrists. Diagnostic evaluations follow evidence-based guidelines and include cognitive testing, functional staging (such as CDR or FAST), medication review, laboratory evaluation, imaging when clinically appropriate, and assessment of vascular risk factors. Diagnoses are coded precisely and aligned with CMS HCC/RAF requirements, enabling accurate identification and management of Alzheimer’s disease, vascular dementia, Lewy body disease, frontotemporal dementia, and mixed etiologies. The model also evaluates vascular cognitive impairment and post-stroke cognitive decline, integrating secondary stroke prevention, cardiometabolic risk optimization, and medication adherence strategies. These interventions support improved outcomes while reducing avoidable hospitalizations and costly medical travel. By combining advanced analytics, telehealth-enabled specialist care, and coordination with local providers and community health workers, the model strengthens the rural health workforce while expanding access to neurologic care. The result is a more sustainable care model that improves early diagnosis, supports caregivers, and allows older Alaskans to remain safely in their homes and communities longer.	\$1M-\$5M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

ISCCO (International Shared Care Community Organization)	Extended Discharge Support	HI	In many cases, individuals with chronic conditions, disabilities, or age-related health challenges rely heavily on family members or informal caregivers who may not have the training or support needed to safely manage complex health needs at home. our vision is for our program/organization to become a widely recognized and trusted resource for individuals who assume caregiving responsibilities for family members. Without adequate caregiver education and support, communities experience higher risks of medication errors, falls, preventable hospitalizations, and worsening health conditions. These challenges place additional pressure on rural hospitals, clinics, and emergency services. This project addresses the opportunity to strengthen community-based health support by equipping caregivers and community members with practical training, education, and resources that improve their ability to safely assist individuals with daily health management. By building caregiver knowledge and confidence, the project helps bridge gaps in healthcare access while improving patient safety and health outcomes. Supporting caregivers as an extension of the healthcare team creates a scalable and sustainable approach to improving health outcomes in rural and frontier communities while helping individuals remain safely in their homes and communities.	Our proposal addresses the challenges through a comprehensive caregiver education and support program designed to improve knowledge, confidence, and access to practical health management tools. The program will provide structured training, accessible resources, and community-based support to individuals who are caring for family members with health needs at home. The project will deliver caregiver education through multiple accessible formats, including in-person community workshops, telehealth-enabled learning sessions, and digital educational materials. These services will focus on practical topics such as chronic disease management, medication safety, fall prevention, nutrition support, mobility assistance, and recognizing early warning signs that require medical attention. By providing clear, practical guidance, caregivers will be better prepared to safely assist their loved ones between medical visits. A key component of the program is collaboration with local healthcare providers, hospitals, tribal health organizations, and community service agencies. These partnerships will help ensure that caregivers receive consistent information that aligns with medical care plans while strengthening coordination between caregivers and healthcare professionals. The program will also provide caregivers with tools such as care planning guides, educational materials, and access to support resources that help them organize and manage care more effectively. By increasing caregiver knowledge and confidence, the project helps reduce preventable health complications and supports individuals in remaining safely in their homes and communities. Through education, collaboration, and accessible support resources, this project strengthens caregiver capacity and creates a sustainable community-based approach to improving health outcomes in rural and remote communities.	\$1M-\$5M	Statewide	Anchorage (Municipality); Juneau (City and Borough); Ketchikan Gateway Borough; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough)	Deferred or Not Advanced

ISCCO (International Shared Care Community Organization)	Short-Time Care	HI	One of the greatest gaps in rural caregiving support is the lack of short-duration relief. Short time care is useful under many circumstances such as immediately after hospital discharge or post surgical assistance. Many persons in need could benefit from a brief period of help to attend medical appointments, run essential errands, or take time for rest. Longer hours are too costly, or require longer scheduling commitments. Without access to even short periods of relief, caregivers may experience burnout, stress, and fatigue, which can affect the quality and safety of care provided to their loved ones or themselves. The Short Time Care program addresses this gap by providing flexible caregiving support visits lasting 1 to 3 hours, allowing caregivers time to manage essential responsibilities while ensuring their loved ones remain safe and supported at home. By offering short, practical relief, the program strengthens caregiver capacity and supports safer home-based care in rural communities.	the Short Time Care program will address the need for short-duration support services in rural, remote, and frontier communities by providing flexible care visits lasting 1 to 3 hours. The program is designed to support individuals who need temporary assistance or supervision, while also providing relief for family caregivers when needed. In many rural communities, individuals may require short periods of assistance but do not need or cannot access traditional full-day care services. Short Time Care fills this gap by offering brief, scheduled visits that provide practical support in the home. These visits may include companionship, mobility assistance, medication reminders, meal preparation, safety supervision, and general support for individuals who may need help during a short period of time. The program will recruit and coordinate trained caregivers who can provide these short-duration services within their communities. Whenever possible, caregivers will be recruited locally to help reduce travel barriers and strengthen community-based support networks. Access to the program will be supported through partnerships with healthcare providers, community organizations, senior service agencies, and local social service programs. These partners will help identify individuals who may benefit from short-term support and assist with referrals and outreach efforts. A simple intake and scheduling system will allow individuals or families to request services for short periods of time, such as when attending medical appointments, running errands, managing personal responsibilities, or during times when temporary assistance is needed for safety and well-being. By providing accessible and flexible short-duration care, the Short Time Care program helps individuals remain safely in their homes and communities while strengthening local support systems. The program also helps reduce caregiver stress, improves continuity of care, and supports the overall resilience of rural families and communities.	\$1M-\$5M	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

J&M Global Solutions LLC	Alaska Rural Health Training Pipeline Mapping Design & Expansion Initiative	VA	Alaska is entering an unprecedented period of investment in rural health transformation through the federal Rural Health Transformation Program (RHTP). Workforce expansion is one of the state’s highest priorities, yet workforce shortages remain especially acute in rural, remote, and frontier communities. While Alaska has numerous training assets, including CHA programs, nursing schools, mobile training initiatives, and rural clinical sites, these assets are not consistently coordinated or strategically aligned across regions. The lack of a comprehensive, data-driven understanding of where training capacity exists, where gaps remain, and how pathways connect limits the state’s ability to scale workforce solutions efficiently. This project presents a strategic opportunity to map, integrate, and redesign Alaska’s statewide health workforce training pipeline. By grounding planning in geospatial analysis and stakeholder engagement, the initiative supports a coordinated, regionally responsive workforce strategy aligned with RHTP goals to grow and support resilient health care teams and strengthen partnerships across the care continuum.	The project will begin with a comprehensive statewide mapping of Alaska’s health workforce training assets using geospatial and programmatic data. This analysis will capture the full landscape of existing training capacity, including Community Health Aide training centers and their affiliated Tribal health organizations, university and community college nursing programs, mobile and satellite training hubs, and rural and frontier sites capable of supporting clinical rotations or residency expansion. By visualizing these assets together, the project will identify geographic gaps, areas of duplication, and opportunities for strategically targeted, regionally tailored investments that strengthen rural training capacity and improve workforce distribution. Building on this foundation, the project will design integrated and connected training pipelines that allow learners to progress smoothly through the workforce continuum while remaining linked to rural practice settings. These pathways will connect entry-level Community Health Aide roles to nursing prerequisites, nursing degree programs, and advanced practice opportunities, while also linking local training opportunities to clinical placements and rural residency sites. Mobile and hybrid training options will be incorporated to ensure that individuals in hard-to-reach communities can access education and advancement opportunities without unnecessary barriers or relocation. To further expand access to training, the project will support the development of mobile or pop-up training hubs that deliver simulation labs, hands-on skills training, and specialty certification courses directly to rural and remote communities. This approach modernizes workforce training delivery, reduces travel and cost burdens for rural providers, and expands access to continuing education critical for workforce retention and quality of care. Finally, the initiative will focus on expanding rural residency and clinical placement opportunities by identifying priority regions and assessing facility readiness. This work will support the expansion of rural primary care residency slots, increase behavioral health and specialty clinical placements, and outline infrastructure and incentive strategies designed to retain trainees in rural communities. Together, these efforts create a coordinated, data-driven approach to building a resilient, locally rooted health workforce aligned with Alaska’s rural health transformation goals.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

J&M Global Solutions LLC	Chronic Disease Risk Mapping Initiative	VA	CDC research shows that American Indian and Alaska Native (AI/AN) populations experience significantly higher rates of smoking, physical inactivity, and obesity than non-Hispanic White populations — all major contributors to chronic disease. These conditions contribute significantly to avoidable hospitalizations, reduced quality of life, and longterm healthcare costs. However, health system leaders and community partners often lack precise, geographically targeted data that identifies where disease burdens are highest and where resources should be prioritized. Geographic Information Systems (GIS) offer a powerful, underutilized opportunity to visualize layered health, demographic, environmental, and service utilization data. By mapping chronic disease hotspots and associated social determinants of health, Alaska’s Rural Health Transformation Projects (RHTP) can better align interventions with the communities most in need. This proposal outlines an approach to implement a GIS-driven Chronic Disease Risk Mapping solution to directly support RHTP’s goal of promoting healthy communities and preventive care.	The proposed approach uses a GIS-driven, multiphase strategy to identify, analyze, and address chronic disease risks across Alaska’s rural and Tribal communities. It begins with data integration and preparation, compiling existing health information, such as hospital claims, screening rates, EMS data, and public health registries, alongside key social and environmental determinants, including transportation access, food availability, socioeconomic factors, and housing conditions. All data are deidentified and aggregated to ensure privacy while retaining analytic value. Next, the project develops interactive GIS maps and spatial models that visualize the prevalence of hypertension, diabetes, COPD, obesity, and behavioral health conditions. Additional layers include locations of critical access hospitals, Tribal and behavioral health facilities, community programs, and indicators of social vulnerability. Spatial analytics identify chronic disease hotspots, gaps in preventive care access, and communities facing overlapping risks, such as high disease burden combined with low primary care availability. The initiative then incorporates stakeholder engagement and validation, engaging Tribal health organizations, rural clinics, EMS leaders, public health nurses, and community partners. These collaborative sessions ensure that mapped insights align with on-the-ground experience and regional priorities, strengthening accuracy and community relevance. Finally, the project produces decision support tools, including user-friendly dashboards and a map library that enable health system leaders to translate GIS insights into actionable strategies. These tools support planning for preventive services, funding proposals, workforce deployment, and community-driven wellness initiatives.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

J&M Global Solutions LLC	Community Resource Dashboards for Alaska	VA	Alaska’s communities—rural, urban, and Tribal—possess a rich network of local assets that support health, resilience, and wellness. These include schools, community centers, tribal health aides, food access sites, wellness hubs, behavioral health supports, and nonprofits delivering prevention services. However, these assets often operate in silos, and community members, agencies, and program planners lack a centralized way to see what resources exist and where service gaps remain. A Community Resource Dashboard presents an opportunity to create a statewide, easyto use mapping tool that visualizes local assets and connects them to prevention programs. This solution would help providers coordinate care, help residents find nearby supports, and give state and tribal decision-makers the data needed to target investments and interventions where they are needed most.	The project will develop a statewide Community Resource Dashboard by following a structured, collaborative, and data driven approach. First, the team will partner with Tribal health organizations, local governments, school districts, community coalitions, and state agencies to gather vetted datasets that represent Alaska’s diverse community assets. Priority resources include schools, youth serving organizations, community centers, cultural hubs, Tribal health aides, village based providers, food access points, wellness hubs, behavioral health services, and prevention programs. Next, the project will build an intuitive, web based dashboard that enables users to view resources by region, community, or service type; filter by target populations such as youth, families, or elders; and identify strengths and service gaps in real time. Integrated GIS mapping and optional heat-mapping will help visualize equity indicators such as food insecurity or behavioral health risks. Community engagement is central to the approach. The project will conduct workshops with Tribal councils, school administrators, and regional coalitions in a pilot region to validate data and ensure culturally grounded representation. Local partners will be able to request updates or submit new resources through a structured review process, strengthening accuracy and community ownership. To ensure longterm sustainability, the project will establish a cross agency steering group responsible for data governance, quality assurance, and maintenance. Training and user guides will help communities adopt and use the dashboard effectively over time.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

J&M Global Solutions LLC	Emergency Response Optimization for Alaska’s Tribal and Rural Communities	VA	Alaska’s rural and tribal communities face some of the most challenging medical transport environments in the United States. Vast distances, limited road infrastructure, harsh weather, and inconsistent connectivity create delays in emergency response, particularly for medevac, EMS, and interfacility transport. These delays translate to increased morbidity and mortality for time sensitive conditions such as trauma, stroke, myocardial infarction, sepsis, and obstetric emergencies. Despite strong regional partnerships, transport pathways across agencies (tribal health organizations, regional hospitals, EMS, state assets, and contracted medevac providers) often remain fragmented. Dispatch protocols differ by region, duplication of effort across call centers is common, and many communities lack a consolidated view of available aircraft, capability (ALS/BLS), landing zones, and real-time route conditions.	The project uses a comprehensive, data driven, and collaborative strategy to strengthen Alaska’s emergency transport system and address delays caused by distance, weather, fragmented dispatch pathways, and inconsistent regional workflows. It begins with a statewide mapping of current medevac, EMS, and tribal transport processes, documenting the full chain of emergency movement, from local first response through dispatch, air and ground transport availability, handoff points, and receiving facilities. This mapping captures regional variation and identifies inefficiencies and gaps across diverse geographies. The team will then conduct data integration and workflow analysis, bringing together information from dispatch centers, air carriers, EMS agencies, and tribal health organizations. This includes analyzing historical response times, seasonal constraints, aircraft capabilities, and communication bottlenecks. Geospatial modeling will be used to identify underserved areas and optimize routing options under various environmental and resource conditions. A robust stakeholder engagement process ensures solutions are aligned with local needs. Tribal health organizations, medevac providers, EMS directors, hospital leaders, and community responders will participate in interviews and co-design workshops. These sessions validate pathway maps, highlight operational realities, and support culturally grounded system improvements. Findings will inform a detailed optimization blueprint that includes standardized dispatch protocols, cross agency coordination templates, and technology enhancements such as real-time routing recommendations and consolidated visibility into available aircraft and landing zones. The blueprint also includes redundancy strategies for weather or resource limitations, and offers actionable recommendations for staffing models, training, and system redesign.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

J&M Global Solutions LLC	Facility Placement Algorithms to Expand Access to Essential Services in Alaska	VA	Alaska’s vast geography, extreme weather conditions, and dispersed rural populations create persistent barriers to accessing timely, essential health services. Communities often rely on limited local resources, long-distance travel, or intermittent visiting providers for care. Health systems and state partners need a more data driven way to determine where new service sites—such as telehealth pods, mobile clinics, community paramedicine hubs, or birthing centers—would have the greatest impact. Currently, placement decisions are often influenced by historical patterns, local advocacy, or limited data snapshots. This can result in investments that are difficult to scale or may not fully align with evolving demographic, workforce, and transportation realities. There is a significant opportunity to use advanced analytics to support more equitable, efficient, and proactive planning. Facility Placement Algorithms present a solution: a systematic, evidence driven approach to identifying optimal locations for new access points that bring care closer to home for rural and Indigenous communities.	The proposed approach uses a systematic, data driven framework to identify the most impactful locations for new health service sites across Alaska’s rural and Indigenous communities. First, the project integrates key datasets (population distribution, health outcomes, unmet service needs, travel barriers, broadband availability, existing facilities, and community infrastructure) to create a comprehensive geospatial model of current access gaps. This statewide map highlights service deserts and regions where residents face long travel times, limited local providers, or inconsistent access to essential care. Using this integrated dataset, the project applies proven facility placement and geospatial optimization algorithms (such as pmedian, location allocation, and coverage models) to test multiple scenarios for placing services like telehealth pods, mobile clinics, community paramedicine hubs, and birthing centers. These models quantify potential improvements in access and identify where new sites would deliver the greatest reduction in travel time and the largest boost in service availability. A critical component of the approach is a structured community and Tribal engagement layer. Local knowledge on cultural considerations, community readiness, workforce availability, and infrastructure capacity is incorporated to ensure recommended placements are feasible, culturally aligned, and supported by local partners. This step ensures the model’s outputs reflect real-world conditions rather than purely mathematical optimization. Finally, the project develops decision support tools (including interactive maps, dashboards, and scenario comparison tools) to make results easy for state and Tribal decision-makers to use. These tools enable leaders to weigh cost, access, and feasibility, and to update plans as populations shift, broadband expands, or new care models emerge.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

J&M Global Solutions LLC	Geospatial Access Modeling to Expand Essential Services Closer to Home	VA	Alaska’s rural and frontier communities experience profound barriers to accessing essential health services due to long travel distances, limited to no road access, limited local providers, variable regional capacity, and reliance on weather-dependent transportation. The Alaska Department of Health emphasizes that the Rural Health Transformation Program (RHTP) is designed to ensure communities across the state can access “a full continuum of care as close to home as possible,” recognizing major geographic and operational challenges across regions. Additionally, federal RHTP investments aim explicitly to “bring care within reach,” reduce unnecessary travel, and strengthen rural clinics and regional care networks. This creates a unique opportunity to deploy geospatial modeling that accurately identifies service gaps, transportation barriers, and opportunities for bringing essential care delivery closer to rural residents.	The project uses a comprehensive geospatial modeling approach to identify and address barriers to essential health care across Alaska’s rural and frontier communities. The model integrates mapping of existing clinic and hospital service areas, multimodal transportation networks—including road, air, marine, seasonal overland, and weather-dependent routes—and travel times to priority health services to identify where geographic isolation and seasonal variability limit access. Using these integrated datasets, the project conducts scenario modeling to evaluate where expanding local services, such as primary care, maternal care, behavioral health, urgent care, diagnostics, or rotating and mobile clinics, would have the greatest impact. It also assesses the feasibility and expected benefits of telehealth expansion, mobile care models, and regional hub-and-spoke service designs, quantifying potential reductions in travel burden and improved continuity of care. The approach includes direct engagement with tribal health organizations, state partners, local clinics, regional hospitals, and community groups to validate model findings and ensure that recommendations reflect region-specific needs, consistent with RHTP’s emphasis on community-driven solutions. The modeling outputs will also directly inform workforce and infrastructure planning, identifying where provider shortages, facility limitations, and telehealth gaps are most constraining access. This supports strategic decisions about new satellite service points, workforce deployment, recruitment priorities, and technology modernization. Overall, the approach provides Alaska with a repeatable, data-driven analytic framework that drives targeted investments, supports value-based and sustainable care models, and accelerates the expansion of essential services closer to home for rural and frontier communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

J&M Global Solutions LLC	Geospatial Support for TeleMFM Expansion	VA	Alaska’s vast geography and extreme rurality create profound challenges for delivering Maternal–Fetal Medicine (MFM) services. Many communities are not connected by road, weather can disrupt transportation, and high-risk pregnant patients often must travel long distances, or even relocate weeks before delivery, to access specialty care. This burden affects maternal and infant health outcomes and increases emotional, financial, and logistical strain on families. As the state expands its TeleMFM capabilities, there is a strategic opportunity to use geospatial analysis to optimize hub-and-spoke routing between MFM specialists and village clinics. By mapping transportation routes, population needs, risk factors, existing facility capabilities, and telehealth capacity, Alaska can better coordinate care, reduce avoidable travel, address provider shortages, and ensure more equitable access to specialty maternal care.	The proposed approach uses geospatial analysis to design an optimized TeleMFM hub-and-spoke system that improves access to high-risk pregnancy care across Alaska’s rural and frontier communities. The project begins with a targeted pilot to validate methods and workflows before expanding statewide. The pilot phase will integrate geospatial data on clinics, hospitals, transportation routes, village locations, MFM hubs, and telehealth capacity to create an initial mapping environment. Maternal health indicators, such as birth volumes, prevalence of highrisk conditions, and referral patterns, will be overlaid to identify priority regions and pinpoint gaps in access. This phase will model preliminary routing pathways between village clinics and MFM specialists, testing methods for minimizing travel burden, increasing reliability, and strengthening continuity of care. Routing optimization will evaluate air, land, and marine travel modes to determine which clinics are most suitable to serve as TeleMFM “nodes,” based on access, population need, and technical readiness. Pilot results will be validated with regional health systems, tribal organizations, and local clinicians to ensure that routing recommendations reflect local conditions, cultural considerations, and existing referral networks. Following the pilot, refined models will be scaled statewide. Full implementation will produce optimized routing configurations, clearer referral pathways, and operational guidance for incorporating geospatial insights into scheduling, triage, and telehealth workflows. This phased approach ensures the system is accurate, locally informed, and operationally feasible before expansion, ultimately enabling more consistent specialist support, reduced patient travel, and strengthened rural clinical capacity across Alaska.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

J&M Global Solutions LLC	GIS Data Infrastructure for Health Interoperability in Alaska	VA	Alaska’s health ecosystem spans state agencies, tribal health organizations, telehealth networks, regional health systems, and emergency response entities. Despite strong individual systems, geographic isolation, bandwidth constraints, and fragmented data environments limit the ability to exchange real-time, place-based health information. Critical datasets, such as patient encounter locations, telehealth service availability, environmental hazards, emergency response zones, and tribal care networks, are often siloed in formats that cannot easily interoperate. There is a significant opportunity to build a modern Geographic Information System (GIS) data infrastructure that integrates spatial layers with Alaska’s Health Information Exchange (HIE), tribal Electronic Health Records (EHRs), and telehealth platforms. A unified spatial data backbone would improve clinical coordination, emergency response, public health analytics, broadband planning, and equitable access to care across rural and tribal communities.	The project will develop a federated, interoperable GIS data infrastructure that unifies spatial and health information across Alaska’s diverse health ecosystem. The first component focuses on building a statewide spatial data repository containing standardized, interoperable layers such as care facility locations, tribal jurisdiction boundaries, patient service areas, telehealth connectivity maps, transportation routes, and environmental risk data. These layers will follow national interoperability standards, including HL7 FHIR, USCDI+, and OGC spatial formats, to ensure seamless integration with Alaska’s Health Information Exchange (HIE), tribal EHRs, telehealth platforms, and emergency response systems. To support real-time information exchange, the project will create APIs enabling bidirectional data flow between GIS databases and clinical, telehealth, public health, and emergency operations systems. This infrastructure will allow providers, tribal organizations, and state agencies to access shared, place-based data essential for coordinating care across remote regions. A dedicated effort will focus on integrating tribal and rural health data through collaboration with Tribal Health Organizations, respecting data sovereignty, governance protocols, and role-based access models. This ensures equitable participation and secure sharing of community specific datasets. The project will also enhance telehealth and broadband mapping by unifying FCC availability data, provider networks, and community-level assessments to produce real-time layers that support digital health planning and broadband expansion efforts. Finally, the project will deploy interactive dashboards and predictive spatial modeling tools to support decision-making. These tools will help identify service gaps, optimize resource allocation, strengthen emergency preparedness, and inform planning for maternal health, chronic disease management, workforce distribution, and mobile or telehealth service deployment.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

J&M Global Solutions LLC	GIS Enabled Maternal Health Access & Hotspot Mapping Initiative	VA	Alaska’s rural and frontier communities face profound maternal health access barriers. Families living off the road system encounter severe provider shortages, must travel long distances for labor and delivery, and often must relocate weeks before birth due to limited local maternal care capacity, causing significant emotional, financial, and logistical strain. These challenges are intensified by weather dependent travel, limited medevac availability, and reliance on air transport. A GIS-based hot spotting and access mapping solution provides a timely, evidence based opportunity to understand exactly where maternal risk, access gaps, and environmental/transportation vulnerabilities intersect.	The project will begin with a focused pilot implementation to validate the approach before scaling statewide. The pilot will integrate geospatial, transportation, environmental, and maternal health data to develop a GIS-based hot spotting and access mapping tool that identifies where high-risk pregnancies, service gaps, and environmental or transportation vulnerabilities intersect. This initial phase will test data ingestion, mapping workflows, and the accuracy of clustering analyses in a limited number of rural or offroad communities. It will also allow early collaboration with tribal health organizations, regional hospitals, and community health aides to ensure that the mapping outputs accurately reflect local realities, cultural context, and existing care pathways. Building on lessons from the pilot, the project will expand to statewide implementation. The full solution will integrate maternal and neonatal care facility locations, referral patterns, transportation routes, medevac landing sites, weather-related risks, social determinants of health, and telehealth availability. This data driven mapping approach will support RHTP’s emphasis on technology enabled decision-making and rural health transformation. Throughout the project, the team will conduct regional engagement sessions to validate local findings, incorporate community priorities, and refine mapping layers to ensure accuracy across Alaska’s diverse tribal and frontier regions. The statewide platform will provide actionable insights to support maternal care expansion, including opportunities for mobile maternity services, facility upgrades, telehealth hubs, and improved evacuation pathways. It will also supply workforce planners with precise geographic data to target recruitment, training, and deployment strategies in areas with limited maternal care capacity. Because the platform is cloud enabled and scalable, it can evolve as new RHTP-funded services come online and will remain useful throughout the 2026–2030 transformation window.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

J&M Global Solutions LLC	Maternal Access Mapping	VA	Alaska’s pregnant and postpartum population faces persistent challenges related to geographic isolation, workforce shortages, fragmented care systems, and limited data visibility into where maternal health access gaps exist. These challenges are particularly acute in rural and remote communities. There is a critical opportunity to improve maternal health outcomes by developing a comprehensive, statewide understanding of service availability, access barriers, and care coordination gaps. Maternal Access Mapping seeks to address this opportunity by creating a structured, data-informed foundation that can guide policy, investment, and program development focused on maternal health equity.	The project will use a structured mapping and analysis approach to assess maternal health access across Alaska. This includes identifying existing maternal health services, referral pathways, workforce capacity, and geographic gaps. The project will integrate quantitative data and stakeholder input to produce a clear picture of where access challenges exist and where targeted interventions could have the greatest impact. Findings will be shared with partners to support coordinated planning, inform future investments, and align maternal health initiatives with statewide rural health transformation goals.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

J&M Global Solutions LLC	Recruitment Targeting Through Workforce Migration & Accessibility Analytics	VA	Alaska’s health care system continues to face persistent workforce shortages driven by geographic isolation, limited local training pipelines, high turnover, and strong competition for clinical and behavioral health professionals. Many rural and remote communities struggle to attract and retain workers due to housing constraints, long or seasonal commutes, and limited data on where potential candidates are most likely to relocate from. A data-driven understanding of workforce migration, commuting accessibility, and housing feasibility presents a significant opportunity. By identifying regions with high outbound migration of health care workers, analyzing commuting friction, and mapping housing availability near care sites, Alaska can more strategically target recruitment efforts and make informed siting and investment decisions. This project addresses not only where health care talent exists today, but where it is most likely to move in the future, supporting more efficient, evidence-based workforce planning and long-term system sustainability.	The project will integrate three core analytic components to inform recruitment targeting and workforce planning: Workforce Migration Analysis: J&M will examine historical and current migration flows into and within Alaska, segmented by health occupation, age, education, and household characteristics. This analysis will identify regions that consistently supply health care workers and reveal untapped recruitment opportunities. Commuting Barrier and Accessibility Assessment: Transportation networks, travel times, and commuting constraints, including seasonal variability, will be analyzed to identify areas where commute burden limits recruitment or retention. Scenario modeling will assess how incentives, housing support, telehealth-enabled hybrid roles, or transportation investments could expand the viable workforce catchment area. Housing Availability and Affordability Mapping: Housing stock near health care sites will be mapped and evaluated for availability, affordability, and suitability for relocating workers. The analysis will identify communities where housing constraints pose a barrier and where targeted investments could unlock sustainable staffing and recruitment pipelines. These analyses will be integrated into interactive dashboards and geographic visualizations that generate workforce siting insights and support decision-making for facility placement, training locations, and rotational workforce hubs.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

JAMHI Health & Wellness, Inc	Advancing Access: JAMHI's Capacity-Building Initiative for Sustainable Rural Care	AK	Although demand for integrated, high-quality care continues to grow, JAMHI faces key infrastructure gaps—such as outdated data systems, limited care-coordination processes, and insufficient workforce and quality-improvement capacity—that restrict its ability to expand services. These challenges directly affect patients in Southeast Alaska’s rural island communities, where limited local clinical resources, weather, and transportation barriers often delay timely care. To meet rising needs, JAMHI must redesign internal systems that coordinate care, integrate behavioral health, and support preventive services more effectively. Current limitations make it difficult to maintain service continuity, address growing behavioral health and chronic disease needs, and ensure reliable care navigation for rural patients. This project strengthens JAMHI’s capacity by building a well-trained workforce, improving workflows, and upgrading operational infrastructure. These improvements will support more timely, reliable, and fully integrated services aligned with the RHTP vision for a sustainable Alaska health system. The project will also improve access for Gustavus, Tenakee Springs, and Elfin Cove through a hub-supported, spoke-based model that enables patients to complete multiple services in a single Juneau visit and ensures coordinated follow-up when they return home.	JAMHI’s approach centers on a structured capacity-building effort to strengthen internal systems, improve care delivery, and expand access for rural residents of Juneau and SE Alaska. With RHT support, JAMHI will modernize its infrastructure, enhance workforce readiness, and build sustainable clinical and operational models that improve outcomes and reduce long-term disparities. JAMHI will launch a coordinated transformation initiative aligning operations, finance, compliance, and data systems around shared goals. Key priorities include strengthening budgeting, modernizing procurement and contract oversight, implementing clear time-and-effort policies, improving staff familiarity with standard operating procedures, reinforcing compliance structures, clarifying privacy and security roles, and improving policy management. JAMHI will engage an experienced FQHC/CCBHC consultant for workflow redesign, revenue-cycle improvements, value-based-care readiness, and data-system assessments, enabling selection of tools to better track quality outcomes, patient progress, and staff training. Operational improvements focus on rebuilding patient access and flow. Centralized scheduling, standardized EHR templates, walk-in flex capacity, and active no-show management will expand access to in-person and telehealth services. Workforce development is a core component. JAMHI will establish a tiered provider model, build a cross-trained staffing bench, and offer competency-based training with protected clinical time. Leadership development and structured change-management practices will standardize warm handoffs, referrals, supervision, and documentation, reducing burnout and strengthening interdisciplinary coordination. Data, reporting, and revenue-cycle functions will improve through unified data governance, standardized KPIs, and automated dashboards for access, quality, productivity, denials and A/R aging. End-to-end revenue-cycle redesign, self-audits, and denial-management loops will support financial stability and compliance. To ensure long-term sustainability, JAMHI will operationalize an on-site pharmacy integrated with care teams, scheduling, and prior-authorization workflows. Strong inventory and compliance controls will support timely medication access for rural patients. These investments will expand access and visit capacity, strengthen revenue integrity, improve staff retention, and create reliable, data-driven operations, meeting the needs of rural SE Alaska.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Hoonah-Angoon Census Area; Juneau (City and Borough)	Advance to Implementation Application

JAMHI Health & Wellness, Inc	JAMHI’s Jordan Avenue Clinic Rural Health Hub: Integrated Facility Modernization Initiative	AK	JAMHI seeks to modernize its Jordan Avenue Clinic to meet rising regional demand for integrated primary care and behavioral health as an FQHC/CCBHC hub. Current access challenges, including limited staffing space, fragmented workflows, and an aging, undersized facility, restrict JAMHI’s ability to provide timely, high quality services to Juneau residents and patients from surrounding rural communities. The layout limits same day access, privacy, warm handoffs, chronic disease management, and telehealth, all essential to delivering care close to home with dignity, comfort, and cultural safety. JAMHI recently renovated the 1st floor to expand primary care, limited behavioral health services, and wellness programs. The 2nd floor and exterior remain outdated and inadequate for fully integrated team based care. This next phase will remodel the 2nd floor to create a comprehensive behavioral health clinic and needed administrative space; complete a first floor pharmacy in existing shell space; add an elevator for ADA compliant access; and implement major exterior upgrades, including new siding, repaired parking and walking surfaces, and rebuilt awning. Without investment, renovations would extend over a decade, delaying critical improvements in privacy, accessibility, trauma informed environments, and integrated service delivery. RHTP funding accelerates this transformation, creating a modern, dignified facility where patients feel safe, respected, and well supported	JAMHI will renovate and modernize the Jordan Avenue Clinic through a phased construction project that transforms the second floor into a comprehensive behavioral health clinic and essential administrative hub, completes a first floor pharmacy, improves vertical circulation with an elevator, and upgrades the building’s exterior to create a safe, dignified, and welcoming care environment. The redesigned second floor will support patient privacy and federal guidelines for confidential behavioral health care, providing 10 behavioral health offices, 11 administrative offices, a flexible conference/group therapy room, a staff break room with kitchen, four restrooms, and badge controlled access on all new and existing doors. On the first floor, JAMHI will build a fully functional pharmacy in existing shell space with secured access. A redesigned main entry stair and a new elevator will provide accessible movement between floors. Updated wayfinding and trauma informed interior design will strengthen culturally safe patient experiences and support integrated care workflows. FFE investments will enhance clinical capabilities: telehealth carts and room mounted screens, monitors in behavioral health offices, a multifuge to support expanded blood testing and faster pharmacy preparation, and consistent, durable furnishings across offices. Exterior upgrades will improve safety and community presence through a full roof replacement, refinished siding, repaired parking and walking surfaces, a rebuilt building awning, and refreshed landscaping. Mechanical, electrical, and plumbing improvements will support long term performance, including new electrical service for the elevator, an oil sensing sump pump, a new HRV with ductwork, new diffusers and grilles, additional heat pump capacity with new refrigerant piping and fan coil units, plumbing upgrades, added data drops, and a new fire alarm and sprinkler system. To maintain access during severe winter weather, JAMHI will purchase a skid steer equipped with a plow and bucket to ensure reliable snow clearing and protect appointment availability for patients traveling from remote communities. Together, these improvements will create a modern, accessible, integrated care hub that expands clinical capacity, strengthens coordination, improves rural access, and aligns JAMHI with RHTP’s statewide transformation goals.	Over \$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Hoonah-Angoon Census Area; Juneau (City and Borough)	Advance to Implementation Application

JAMHI Health & Wellness, Inc	JAMHI's Salmon Creek Clinic Rural Health Hub: Integrated Facility Modernization Initiative	AK	JAMHI seeks to renovate and modernize its Salmon Creek Clinic to meet rising regional demand for integrated primary care and behavioral health as a designated FQHC/CCBHC hub. Current access challenges, including insufficient staffing space, fragmented workflows, and an undersized, outdated facility, limit JAMHI's ability to provide timely, high-quality care to local residents and patients traveling from Southeast communities. The existing clinical wing restricts same-day access, privacy, warm handoffs, chronic disease management, and telehealth, critical components for delivering care close to home with dignity, comfort, and cultural safety. Without investment, JAMHI estimates these renovations would take more than 10 years to complete, delaying essential improvements in privacy, accessibility, trauma-informed environments, and integrated care coordination. RHTP funding will accelerate these upgrades, enhancing patient experience and supporting a welcoming care environment where individuals feel seen, safe, and valued. The project involves a full renovation of the 9,525 sq ft clinical wing to create an integrated model of primary care, behavioral health, and wellness services. Modernized space will expand capacity, reduce delays, improve outcomes, and strengthen workforce retention. This project is mission-critical to meeting demand, serving more children and families, and advancing durable, community-anchored healthcare across rural Alaska.	Character Limit: 2500 JAMHI will use RHTP funding to modernize and renovate the Salmon Creek Clinic, transforming it into a high-performing hub for integrated primary care, behavioral health, and wellness services. Our approach advances the Health Care Access initiative by strengthening rural health infrastructure to improve safety, efficiency, clinical capacity, and the dignity and privacy essential to high-quality care in SE Alaska. Renovations will create 4 primary care exam rooms, 2 family health rooms, 8 behavioral health offices, 2 group rooms, shared provider offices, a lab, restrooms, a break room, a reception/waiting area, a teaching kitchen, and updated mechanical/IT spaces. Spaces are designed to enhance same-day access, warm handoffs, integrated workflows, and trauma-informed care that supports comfort, cultural safety, and dignity. FFE upgrades will further strengthen care delivery, including telehealth carts, consistent furnishings to support clinician well-being, and wellness/primary care equipment that reduces delays. Outdoor wellness areas and a second-floor deck will expand therapeutic and staff respite options, creating calming, dignified settings for patients and families. Renovation requires reconstruction of most non-load-bearing partitions with sound-isolating assemblies to ensure privacy and reduce stress. New fixtures, casework, badge-access doors, and acoustical improvements will modernize workflows and support workforce retention. Mechanical, electrical, and plumbing systems will be fully upgraded, including a new multi-zone air handler, improved filtration, updated coils, an air-water heat pump, and replacement of the oil boiler with an electric system. Electrical work will add LED lighting, CAT 6 cabling, advanced HVAC controls, a new fire alarm, sprinkler coverage, and comprehensive plumbing improvements. JAMHI will also acquire a skid steer to prevent weather-related closures that disrupt patient access. Without RHTP investment, these upgrades would take more than a decade to complete. Funding accelerates critical improvements, expanding access, reducing delays, supporting workforce stability, and delivering high-quality integrated care in an environment that reflects dignity, respect, and community-anchored health for Southeast Alaska.	Over \$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Hoonah-Angoon Census Area; Juneau (City and Borough)	Advance to Implementation Application

JAMHI Health & Wellness, Inc	Developing a Regional Elder-Care Network for Rural Southeast Alaska	AK	Older adults in Juneau and Southeast Alaska face a crisis of unmet needs as chronic illness, dementia, and fall-related injuries rise. Significant barriers—including limited facility capacity and a lack of geriatric and rehabilitation specialists—result in fragmented care and avoidable emergencies. In rural areas, these challenges are magnified by a reliance on intermittent itinerant care and travel hindered by weather and unreliable ferry schedules. Compounding this, Alaska remains one of the few states without a Program of All-Inclusive Care for the Elderly (PACE), largely due to high operational costs and the lack of a state regulatory framework. As a catalyst for regional transformation, JAMHI is uniquely positioned to bridge these gaps by spearheading the state’s first PACE-inspired model. Leveraging 41 years of operational expertise, JAMHI is unifying a coalition of partners to overcome geographic and workforce hurdles. By identifying system gaps and mobilizing interdisciplinary resources, JAMHI aims to expand age-competent primary care, behavioral health, and falls prevention. Our goal is to execute a sustainable, coordinated care network that ensures Southeast Alaska’s aging adults can thrive in place.	With REACH and other Juneau-based social service agencies that serve the elderly, JAMHI will explore addressing critical gaps in elder health by assessing the ability to launch a PACE program to expand age friendly services, strengthening the geriatric workforce, and improving access to preventive, community based support to ensure that older adults in Juneau and surrounding ferry-dependent Southeast Alaska communities can age healthily and safely at home. A comprehensive Elder Care Services Needs Assessment will use mixed methods data analysis, inclusive of publicly available census data, mapping, surveys, and interviews with rural spoke communities to produce a gap analysis, service roadmap, budget scenarios and implementation plan guiding expansion of home based services, respite supports, adult day programs, and dementia friendly pathways. JAMHI will evaluate establishing a Community Wellness Center focused on elders and seniors that will have ADA compliant spaces for group exercise, mobility and balance classes, nutrition workshops, caregiver education, and preventive health programs, equipped with fall safe features, hybrid ready audiovisual systems, and private counseling rooms. To serve rural communities with virtual services, JAMHI will explore if equipping the Center with telehealth-enabled group sessions, CHW navigation, and itinerant elder programming will be viable options. Programming could also include primary care, behavioral health services, OT/PT led mobility sessions, chronic disease self management, culturally relevant meal planning, health promotion and peer led activities to increase participation, improve self reported health, and reduce risk factors. To further support aging in place, the project will explore establishing a PACE (Program of All Inclusive Care for the Elderly) site in Juneau, building on national recommendations that PACE offers a highly effective, integrated model for rural seniors with complex needs and supports aging at home. The HRSA National Advisory Committee highlights PACE’s strong outcomes and its potential to address long term care gaps in rural areas, noting the need for pilot programs, telehealth expansion, shared space partnerships, and workforce incentives to support rural implementation. Plans include multilingual programming, transportation assistance, and outreach to rural communities, with a Community Advisory Group of older adults and caregivers informing design and participation.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Hoonah-Angoon Census Area; Juneau (City and Borough)	Deferred or Not Advanced

JAMHI Health & Wellness, Inc	Strengthening Screening & Care: JAMHI’s Regional Early Childhood Development Screening & Care Hub	AK	Juneau and nearby communities need a stronger, coordinated system to identify developmental needs early and connect young children and families to timely supports. JAMHI routinely see delayed referrals, limited early childhood mental health capacity, and inconsistent pathways for families seeking evaluation or follow-up—challenges intensified by the recent closure of the local child development center. Statewide assessments show that early developmental screening is essential for detecting strengths and potential delays, yet Juneau experiences inconsistent screening rates and uneven access to evaluation. Families face fragmented infant and early childhood mental health (IECMH) services, long waitlists, and a shortage of trained specialists, especially outside population centers, affecting children’s social-emotional development and caregiver well-being. These barriers are even greater in ferry-dependent Southeast communities. JAMHI plans to improve screening, referral, and access to IECMH-informed care through a hub-and-spoke model, expanded workforce pipelines, and better family navigation. The project will help close critical gaps in early identification, mental health supports, and system capacity so Juneau’s youngest children are assessed early, receive appropriate services sooner, and enter school healthier and ready to learn.	To address growing gaps in early childhood developmental (ECD) assessment and follow-up in Juneau and surrounding Southeast communities, JAMHI seeks planning funds to build on JAMHI’s existing child and family services to create a coordinated, clinically integrated early childhood system. The project will develop an ECD clinical service that expands access to autism, FASD, audiology, Early Intervention, and medically complex care, while strengthening referral pathways and reducing delays between screening and evaluation across JAMHI’s primary and behavioral health teams. A central component of the project’s plan is expanding youth behavioral health care through a school-based model. Embedded licensed clinicians in Juneau’s six elementary schools and one middle school removes transportation and scheduling barriers, allow for rapid response to behavioral health concerns, and support early identification and intervention. Collaborating with the Juneau School District improves IEP coordination, and establishes consistent communication between educational and clinical teams, ensuring smoother transitions from early childhood services into the K–12 system. To ensure timely, high-quality assessments, JAMHI train its clinicians in evidence-based protocols, paired with standardized workflows. These investments will support reflective supervision, training costs, and the adoption of consistent evaluation tools so rural families receive the same evidence-based care pathway available in Juneau. The project will also establish Community Health Workers (CHWs) as embedded care coordinators. CHWs will ensure that children ages 0–5 receive timely referrals, completed evaluations, and warm hand-offs to Early Intervention and school-based supports. One CHW will specialize in early childhood referrals, while another will coordinate care for medically complex children, reducing missed appointments and strengthening continuity of care. For rural families, CHWs will manage travel-sensitive scheduling, monitor referral progress, and maintain contact until evaluations and services are in place. Through these strategies, the project advances Healthy Beginnings, Health Care Access, and Strengthen Workforce by creating a reliable, equitable, and coordinated system. This approach increases early identification of developmental delays, expands access to specialty evaluations, and improves long-term outcomes for young children in Juneau and rural Southeast Alaska.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Skagway (Municipality); Yakutat (City and Borough)	Deferred or Not Advanced

Jasper Health	Jasper Health: Driving Access and Sparking Innovation for Cancer Patients in Alaska	ID	With a mission to ease the burden of cancer care, Jasper Health bridges the gap between clinical care and everyday life, improving outcomes and quality of life across the cancer journey. Jasper Health delivers the most comprehensive and scalable patient-centered oncology experience from the suspicion of cancer through survivorship or end-of-life care. Built for seamless partnership with stakeholders across the industry, Jasper takes administrative and clinical care management burden off care teams while improving outcomes and reducing total cancer spend through innovative payment models. The problems we are aiming to address with this project include: the affordability of cancer care, limited access to robust supportive cancer care, and improved outcomes for people with a cancer diagnosis.	Across oncology, providers struggle to connect with patients outside the four walls of the cancer center; this challenge is only exacerbated in vast, rural geographies, such as Alaska. Through our digital platform, we are able to provide tailored, expert support to patients no matter where they live to help them with their psychosocial, financial, transportation, and clinical needs. In addition, with years of experience in oncology value-based payment models, Jasper’s leadership team helps create sustainable, value-based contracts that incentivize providers on quality, evidence-based care, patient satisfaction, and cost efficiency. Jasper’s ability to flexibly participate in a wide range of payment models is essential to implementing or scaling any value-based program in oncology. Jasper’s team has participated and operationalized full sub-capitation contracts, clinical performance case rates, supportive care-only case rates, disease-specific case rates, and chemotherapy and immunotherapy gainsharing. Jasper would serve as a key thought partner and operational subject matter expert to establish alternative payment methodologies in oncology for health plans and the state of Alaska. To support the worsening shortage of oncology providers, including oncologists and certified nurses, Jasper can help providers practice at the top of their license by offloading time-intensive tasks that can be supported virtually, such as finding community resources and delivering emotional support. Jasper works closely with providers to help manage treatment-related symptoms at home or in the outpatient setting as appropriate. Through the use of Jasper’s consumer-facing digital platform, we are able to empower patients to track their symptoms and vitals, to better adhere to their treatment, and to become an active member of their care team. We strive to exceed our patients’ and our partners’ needs by continually improving and evolving our offerings. Jasper is an AI-native oncology platform, leveraging AI to take on manual work that allows our care team and our partners to spend more time delivering value directly to patients. Currently, Jasper uses AI agents to help transcribe patient calls and documentation, to identify evidence-based resources for individual patient needs, and to help standardize the triage and resolution of patient needs. Our AI-powered navigation model is led by a human-in-the-loop framework to ensure clinical safety, traceability, and confidence.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Jilkaat Kwaan Heritage Center	Food as Medicine Traditional & Modern Fusion Cookbook	AK	The proposed project “Food as Medicine” will be addressing concerns of obesity, diabetes, allergies, and nutrition deficiencies. Food security and food sovereignty have been priorities for our community for years. A traditional and modern fusion cookbook would support people with information on how to incorporate important information on how to prepare locally sourced foods. New ways to incorporate traditional ingredients and way to incorporate store bought produce intro a traditional way of cooking. This information would help empower our rural community residents to not rely on prepacked poor nutrient value snacks.	This project would focus on creating a Modern & Traditional fusion cookbook. This cookbook would support community members in incorporating locally sourced nutrient dense foods into their everyday meals. This cookbook would also include suggestions for grocery store sourced substitutes for traditional food ingredients if folks have moved away or the foods are out of season. This project would increase access by raising the baseline of general knowledge of nutritional values and processing information for our local foods.	\$50,000-\$250,000	Single Community	Hoonah-Angoon Census Area	Deferred or Not Advanced
Jilkaat Kwaan Heritage Center	Noise and Impact Study in Chilkat Indian Village (Klukwan)	AK	CIV proposes a baseline health assessment to better understand the impacts of loud and persistent noise on the wellbeing of our rural community. Community members have raised increasing concerns about exposure to noise from aircraft, watercraft, vehicles, and machinery occurring in and around the Village. These concerns include potential risks of hearing damage, tinnitus, hearing loss, mental distress, and related mental health impacts associated with sensory loss. Hearing health is closely tied to overall wellbeing. Hearing loss can contribute to social isolation, communication challenges, anxiety, and depression. In a rural environment like Klukwan, hearing also plays a critical role in personal safety. Reduced hearing ability can increase the risk of wildlife encounters and other environmental hazards where early auditory awareness is important. Village residents include many veterans who may experience heightened stress responses to sudden or persistent noise exposure. For some individuals, loud or unexpected sounds may trigger trauma responses or contribute to mental distress. Despite these concerns, no baseline data currently exists documenting the level, frequency, and duration of noise exposure experienced within the community. The purpose of this effort is to better understand community exposure and its potential implications for hearing health and mental wellbeing so that the Tribe can pursue preventative health strategies and long-term protections for residents.	This project will combine community knowledge with technical monitoring to establish a baseline understanding of noise exposure within Chilkat Indian Village (Klukwan). At key locations across Village lands, audio sensors and recording devices will be installed to measure decibel levels and capture information about the duration and frequency of loud or persistent noise events. These devices will help document how often these events occur, how long they last, and the intensity of sound levels experienced by residents. Monitoring locations will be selected based on community input and observations about where noise disturbances are most frequently experienced. This approach ensures the study reflects the lived experience of residents while producing measurable data. Once compiled, the data will be evaluated against known thresholds associated with hearing loss, sensory damage, and distress caused by prolonged or repeated noise exposure. This analysis will help the Tribe better understand whether the sound levels experienced within the community may pose risks to hearing health or mental wellbeing. Together, the monitoring data and community observations will provide the Tribe with a clearer understanding of noise exposure patterns within Klukwan and establish a baseline dataset that can inform future health planning and preventative care strategies.	\$50,000-\$250,000	Single Community	Hoonah-Angoon Census Area	Deferred or Not Advanced

Juanita Strong Forever Project	Juanita Strong Rural Youth Mentorship and Community Healing Initiative	AK	Youth in Alaska particularly in rural and underserved communities face increasing challenges related to behavioral health, social isolation, and limited access to mentorship and youth development programs. Many communities lack structured support systems that help young people build resilience, develop leadership skills, and maintain healthy lifestyles. Without consistent access to positive mentorship and community engagement opportunities, youth may struggle with emotional wellness, academic engagement, and long-term life planning. These challenges are often compounded in rural areas where access to behavioral health services and youth programming is limited. The Juanita Strong Forever Project seeks to address this gap by creating accessible mentorship networks and youth engagement programs that provide emotional support, leadership development, and healthy lifestyle opportunities. By focusing on prevention, peer support, and community involvement, the project aims to strengthen protective factors that help youth thrive and build stronger, healthier communities across Alaska.	The Juanita Strong Forever Project proposes a community-centered mentorship and wellness initiative designed to address the growing mental health, social isolation, and lack of structured support services for youth in Alaska’s rural and underserved communities. Our approach focuses first on peer-to-peer support, mentorship, and group healing opportunities where youth can safely discuss challenges, build confidence, and develop life skills. Through guided mentorship circles, leadership development workshops, and group discussions led by trained mentors and community leaders, participants will gain tools for emotional resilience, personal responsibility, and healthy decision-making. This initiative also creates safe spaces where youth can build positive relationships with mentors, law enforcement professionals, coaches, and community advocates who serve as trusted role models. As relationships and trust are established, youth will be introduced to structured development opportunities including leadership training, life-skills education, career exposure, and healthy lifestyle programming. Physical activity and team-based athletics such as football training, youth camps, and community sports events will serve as engagement tools that reinforce teamwork, discipline, and accountability while encouraging healthy habits and community pride. By integrating mentorship, emotional wellness support, leadership development, and structured youth engagement activities, the Juanita Strong Forever Project will create a sustainable support system that strengthens rural youth, families, and communities.	\$250K-\$1M	Statewide	Anchorage (Municipality); Bethel Census Area; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Juneau Economic Development Council	St. Ann’s Center for Integrated Care – Redevelopment Project	AK	Southeast Alaska faces a severe and growing shortage of senior-appropriate, accessible housing with coordinated supports. Many older adults—particularly those experiencing mental illness, chronic substance use disorders, developmental disabilities, dementia, or long-term homelessness—struggle to obtain stable housing and safe environments. These challenges often lead to repeated emergency department use, prolonged hospital stays, or unsafe living conditions. Meanwhile, the region’s aging housing stock, limited assisted-living spaces, and workforce shortages further restrict access to dependable long-term support. The St. Ann’s/Crimont Center, originally established in the late 19th century and expanded through multiple decades, now sits mostly vacant despite offering more than 30,774 sq. ft. of usable space across four floors. Longstanding vacancy, vandalism, weather damage, and outdated systems have left the building underutilized and in need of significant repair. Yet its size, location, and existing service-zoned layout make it an ideal candidate for redevelopment into a modern, community-serving senior housing campus. Renovation unlocks the potential for high-need seniors to remain in their home community, surrounded by culturally familiar supports.	The project will transform the existing St. Ann’s/Crimont Center building into a fully modernized, service-integrated independent senior housing facility. Renovation activities include structural stabilization; replacement of mechanical, electrical, and plumbing systems; full fire-suppression and alarm upgrades; ADA accessibility improvements; and modernization of the elevator and egress routes. Interior spaces will be reconfigured to create safe, private living units; accessible communal kitchens and dining rooms; flexible programming areas; and dedicated office and sleeping rooms for partner agencies providing wrap-around services. The renovation will also establish the infrastructure for an onsite geriatric clinic, offering primary care, chronic disease management, assessments, and care coordination for residents and the broader community. Partner agencies—JAMHI, REACH, Polaris House, and St. Vincent de Paul—will each be assigned administrative/clinical offices and staff rooms to enable 24/7 onsite coverage. The facility’s design integrates non-clinical and clinical supports, while this LOI focuses strictly on the building improvements and staffing necessary for opening. The approach includes phased construction and occupancy to allow portions of the facility to be brought online as they are completed.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

Juneau Economic Development Council	Alaska Aging-in-Place Home Modification Infrastructure Initiative	AK	Alaska’s aging population and shortage of trained home-modification providers, especially in rural regions, have created a critical gap in safe, accessible housing for older adults and people with disabilities. Independent living and disability service organizations are preparing for the expansion of Medicaid Environmental Services, but the statewide infrastructure needed to deliver these services does not yet exist. This project addresses these gaps through a coordinated, multi-partner effort led by JEDC to build the statewide infrastructure required for home safety modifications, workforce training, and Medicaid Waiver Environmental Services readiness. SEABIA expands contractor capacity; Rosarium Health contributes workflow expertise; and SAIL and AADD support alignment with disability and Medicaid requirements. The result is a unified, statewide framework for safe aging-in-place and disability-inclusive home modifications.	JEDC will lead a three-year, phased infrastructure initiative to establish Alaska’s first coordinated system for aging-in-place and Medicaid Environmental Service home modifications. 1. Statewide Coordination & Medicaid Infrastructure (Led by JEDC) • Develop referral pathways, data standards, and regional coordination structures. • Establish readiness for a Medicaid Environmental Services pilot under the Medicaid Waiver. • Convene partners across health, disability, tribal, and construction sectors. • Manage fiscal oversight and sub-grant funding to SEABIA to deliver statewide training. 2. Workforce Development (SEABIA, via JEDC sub-grant) • Provide CAPS training, NAHB coursework, and contractor skill development statewide. • Build rural contractor capacity to complete aging-in-place and Medicaid-compliant home modifications. • Support an Educational Coordinator to manage training delivery and contractor support. 3. Clinical & Operational Integration (Rosarium Health, in-kind) • Provide best-practice guidance for assessments, documentation, and workflow design. • Support planning for scalable, coordinated home-modification pathways. 4. Disability & Independent Living Integration (SAIL & AADD) • Advise on accessibility needs and independent living approaches. • Coordinate with regional disability providers to meet Medicaid Environmental Modification criteria. • Support training and assessment processes to ensure modifications align with functional needs. This integrated approach ensures Year 1 builds foundational capacity, Year 2 launches regional pilot work, and Year 3 expands toward a sustainable statewide system.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Juneau Economic Development Council	Community Navigator Connection: Statewide Care Coordination & Resource Navigation Platform	AK	Across Alaska, care navigation is supported by inconsistent tools, ranging from paper files to spreadsheets to isolated referral systems. Navigators, case managers, PCA coordinators, and peer support specialists face daily challenges accessing accurate service information, communicating with partner organizations, and tracking complex care needs—especially in rural and frontier communities where broadband, staffing, and access barriers intensify system fragmentation. The lack of a unified statewide system contributes to delays in services, duplicated assessments, gaps in communication, and a heavy administrative burden. Alaskans often experience slow or incomplete referrals, limited follow-up, and unclear pathways between health, behavioral health, social services, housing, transportation, and employment supports. JEDC has already developed a working prototype, through their programming with the Southeast Regional Eldercare Coalition (SREC) beta navigation website (www.jedc.org/SREC/), which aggregates regional resources and demonstrates a functional foundation for broader statewide development. This project aims to expand that concept into a scalable, HIPAA-compliant platform that meets the needs of diverse providers and communities across Alaska.	The project will follow a deliberate, multi-phase approach to ensure statewide relevance and long-term sustainability. Phase 1: Partnership Formation & Planning JEDC will formalize partnerships with platform vendors such as FindHelp, Unite Us, or United Way of Southeast Alaska and other local IT partners such as Hansen and Gress. These partners bring established systems that can be adapted for Alaska. Collaboration will begin with technical scoping, security alignment, and the use of the JEDC SREC beta platform as a baseline prototype. Phase 2: Needs Assessment & Requirements Development JEDC will engage navigators, care coordinators, and social service providers across multiple regions to identify workflows, documentation needs, referral challenges, and training gaps. These findings will inform a unified set of technical requirements. Phase 3: Prototype Development Using the SREC beta structure, JEDC and technology partners will build an Alaska-specific prototype that includes referral pathways, case tracking, resource directories, billing support, secure messaging, and education libraries. The system will be optimized for rural bandwidth limitations. Phase 4: Training & Pilot Implementation Pilot regions will receive onboarding and training for hands-on testing. JEDC will collect user feedback on workflow improvements, usability, and system performance. Phase 5: Refinement & Sustainability Planning Pilot feedback will guide refinement and expanded directory development. JEDC will create a long-term funding model ensuring the platform remains free for nonprofits and small clinical providers while maintaining vendor-supported infrastructure.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Juneau Economic Development Council	SE Alaska Rural Healthcare Workforce Hubs: CNA, MA, HIM & PCA Pathways	AK	Rural Southeast Alaska faces persistent shortages of CNAs, MAs, HIM technicians, and personal care providers, driven by long travel distances, limited broadband, high training related housing costs, and too few clinical placements. These barriers—felt most by Alaska Native and rural learners—prevent completion of credentialed programs and weaken the healthcare pipeline. Current pathways are fragmented, and Home Maker–based DSDS certification does not create sustainable advancement into higher level health careers. Aligning training with the PCA portion of CNA instruction strengthens competencies and builds a viable entry point into health sciences. The proposed program advances this pipeline by using VR supported hybrid instruction to eliminate geographic and broadband limitations, while Community Support Hubs provide supervised skills practice, proctoring, and reliable technology access. Rising demand for home and community based services further intensifies the need for a trained workforce, yet agencies struggle due to inadequate training infrastructure and required nursing oversight. This project delivers an accessible, community anchored training model that expands local workforce capacity, ensures continuity of care, and supports long term rural health stability.	JEDC will lead the design and launch of Rural Healthcare Workforce Hubs across Southeast Alaska. A Health Workforce Hub Development Specialist will conduct needs assessments, coordinate partners, plan hub infrastructure, and align workforce pathways. Community Support Hubs will provide technology access, VR simulation, tutoring, supervised skills practice, proctored testing, and workforce navigation. The project supports accelerated hybrid training delivered in partnership with UAS for CNA, MA, HIM, and PCA/DSP roles. VR-enabled modules expand training access to remote learners and improve telehealth readiness. Partnerships with regional school boards, employers, SEARHC, tribal health organizations, and DSDS will modernize entry-level care pathways and integrate PCA-based training to replace the Home Maker model. Workforce partnerships will expand internship and experiential learning opportunities.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Juneau Economic Developmen t Council	Thrive Together: Child Health & Provider Support Initiative	AK	Childcare programs across Southeast Alaska routinely serve young children during critical developmental windows yet lack consistent access to pediatric, behavioral-health, and developmental expertise. Providers often observe early warning signs but have no structured mechanism for consultation or referral. Rural and Tribal families face substantial travel barriers and long waits for Autism, FASD, and developmental assessments. Childcare workers themselves—many uninsured or underinsured—lack preventive care access, contributing to instability and turnover. This project addresses these gaps through a coordinated hub-and-spoke model that integrates child development consultants, telehealth diagnostics, clinic-delivered workforce health supports, and statewide navigation tools. These improvements simultaneously strengthen early identification, stabilize the childcare workforce, and enhance care access across rural communities.	The project uses a multi-layered approach integrating onsite childcare consultation, telehealth developmental diagnostics, clinic-led Provider Health Days, community education, and statewide digital access. Visiting specialists deliver developmental screening and case guidance in hub and regional childcare settings. Clinic-led Provider Health Days offer preventive screenings, behavioral-health tools, insurance navigation, and ergonomic support for childcare workers, building sustainable local capacity. A statewide website provides milestones, navigation tools, and specialist information, while the HIE-integrated virtual platform supports e-referrals, tele-assessments, secure communication, and coordinated care plans. Parent and grandparent education enhances community awareness of milestones and behavioral guidance. Together, these components create a cohesive, scalable system designed to improve access, quality, and coordination of early childhood and workforce health supports across rural and remote Alaska.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Juneau Economic Development Council	Thrive Together: Southeast Alaska Child Health & Provider Support Pilot	AK	Childcare programs across Southeast Alaska regularly observe developmental and behavioral concerns but lack reliable access to pediatric, developmental, and behavioral-health expertise and clear referral pathways. Rural and Tribal families often travel long distances and wait months for Autism, FASD, speech-language, or developmental evaluations, delaying intervention during critical windows of neurodevelopment. Childcare workers—many uninsured or underinsured—have limited access to preventive care, driving turnover and instability that reduces available slots for families. JEDC, led by Executive Director Brian Holst, brings decades of regional systems experience, 10 years of service on the Alaska Early Childhood Coordinating Council, 9 years on the Juneau School Board, and leadership in designing Juneau’s childcare subsidy program. This project addresses urgent access and coordination gaps with a Southeast Alaska pilot that embeds specialist consultation in childcare settings, delivers telehealth diagnostics through local clinics, and builds a statewide-ready website and navigation platform for coordinated referrals, family education, and data-informed quality improvement. Replace application Thrive Together: Southeast Alaska Child Health & Provider Support in leu of this proposal.	Year 1 launches a Southeast Alaska-only pilot that integrates clinic-led services, itinerant specialists, and telehealth-enabled diagnostics while building a statewide-ready digital platform. Core components: (1) On-site childcare consultation—screenings, classroom coaching, case conferencing, and referral support in Juneau, Sitka, Ketchikan, Prince of Wales, Wrangell, Petersburg, Yakutat, and Hoonah-Angoon; (2) Telehealth developmental diagnostics—Autism/FASD/developmental evaluations supported by regional clinics to reduce family travel and wait times; (3) Provider Health Days—clinic-delivered preventive screenings, behavioral-health tools, ergonomics, and coverage navigation for childcare workers; (4) Parent/caregiver/grandparent education—practical workshops and culturally responsive materials co-developed with partners; (5) Website + navigation platform—milestone checkers, family self-screener, specialist directory, referral guidance, and secure, HIE-integrated messaging optimized for low bandwidth. Implementation steps: co-design sessions with Tribal health and clinics; workflow mapping for referral and feedback loops; privacy/security training; deployment of tele-assessment kits; and continuous PDSA cycles to refine tools and care pathways. Equity and quality strategies include accessible content, multilingual supports, shared care plans, and closed-loop referrals tracked through the platform. The approach aligns with RHTP by strengthening early childhood health access (Healthy Beginnings), expanding specialty access via telehealth (Health Care Access), supporting workforce wellbeing (Strengthen Workforce), and deploying scalable, interoperable digital tools (Spark Technology & Innovation).	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Juneau Emergency Medical Associates	Emergency Medicine Physicians Access (EMPA) Hub: Telehealth Continuity for Rural Alaska	AK	Long-distance medevac transports in Alaska can exceed \$75,000–\$100,000 per event for patients requiring out-of-state specialty care — and they are happening because over 80% of Alaska’s communities are off the road system, with no access to emergency physician oversight during weather events or medical crises. Data from the Yukon-Kuskokwim Delta shows medevac costs consuming 3% of the entire regional Medicaid budget for a population of just 23,000, a per capita cost forty times the national average. Village clinics and EMS agencies are forced to make high-stakes clinical decisions without real-time specialist backup, driving both preventable patient harm and unsustainable system costs. The RHTP provides a catalytic opportunity to fix this. The EMPA Hub would centralize board-certified emergency medicine expertise statewide, bridging the gap between remote providers and regional trauma centers — so that location is never the reason a patient does not receive timely, appropriate care.	JEMA will establish the EMPA Hub — a 24/7 command center staffed by board-certified emergency physicians. Utilizing low-bandwidth, high-fidelity telehealth stations, the Hub provides synchronous “over-the-shoulder” support to rural health providers. JEMA will integrate its EMR with the healthEconnect Alaska (HIE) to ensure full data interoperability. The initial phase focuses on implementation and relationship-building with Tribal Health Organizations, with five pilot kits deployed to frontier sites. Phase 1: Infrastructure & Staffing Establish a centralized command center in Alaska staffed by a pre-identified cohort of board-certified emergency physicians. This Hub will serve as the specialist nerve center for rural providers across the state. Phase 2: Technical Interoperability Implement a cloud-based, low-bandwidth EMR fully integrated with healthEconnect Alaska (HIE), ensuring that real-time clinical data from village encounters is visible to regional trauma centers and meets federal ASTP/ONC and CMS interoperability standards. Phase 3: Deployment & Triage Deploy ruggedized, high-fidelity telehealth stations to five pilot sites — prioritizing communities off the road system and remote industrial sites in the oil, gas, and mining sectors. Clinical Strategy • Treat-in-Place Protocols: Physician-guided management of stable patients at the local level, avoiding unnecessary transport and preserving patient dignity and community trust. • Medevac Triage Optimization: Real-time specialist assessment to determine true medevac necessity, with a target of reducing preventable evacuations in pilot communities within the first 12–18 months, consistent with outcomes observed in comparable telehealth triage programs nationally.	\$1M-\$5M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Juneau Women's Health	Juneau Women's Health: Point of Care Testing Services	AK	This project aims to reduce testing times and improve outcomes by implementing rapid testing for sexually transmitted infections and chronic conditions. Alaska has the third highest rate of Chlamydia at 697.7 infections per 100,000 and the highest rate of Gonorrhea at 310.9 infections per 100,000 in the US. If left untreated, these infections can lead to infertility and serious pregnancy complications. Chlamydia and gonorrhea are easily curable with antibiotics; the challenges lie in timely identification and treatment to reduce continued transmission. Long turnaround times for test results and high cost are the primary reasons patients decline STI screening. Juneau, Alaska experiences a significant influx of seasonal tourism workers during the summer, including cruise ship crew who may only visit the community briefly. These transient workers often lack the time or health insurance to access traditional lab-based STI screening. Likewise, many Alaskans suffer from chronic conditions can be debilitating if not identified or well-controlled. Patient outcomes can be well managed if closely monitored using routine lab tests, but currently labs must be drawn on-site then sent to LabCorp in Seattle for resulting, at which point we contact the patient and they return for follow-up. This send-out lab testing increases patient financial burden, wait times, and decreases follow-up adherence which ultimately hinders chronic disease management and can lead to poorer health outcomes.	To address these financial and health costs associated with delays in care due to send-out test results we propose the implementation of a small Point of Care (POC) testing lab. This lab would provide in-house screening for Chlamydia and Gonorrhea, lipid panels, and monitoring for blood glucose, hemoglobin A1c, and hemoglobin. Using the binx io chlamydia and gonorrhea assay we will be able to offer patients their test results within 30 minutes, allowing for counseling and treatment (if indicated) to occur during the clinical visit. Point of care analysis for lipid levels, hemoglobin, glucose, and hemoglobin A1c provide results in less than one minute. By providing these lab tests in-house patients would receive timely care and treatment, and lower-cost screening tests. Quick testing for Chlamydia and Gonorrhea specifically would reduce the time to diagnosis and help prevent further infections from asymptomatic patients. For tests requiring a blood sample, in-house labs would minimize patient discomfort and decrease the use of phlebotomy supplies by analyzing specimens obtained from a simple finger-stick, rather than venipuncture. In-house testing would minimize losses to follow-up and increase adherence to medical recommendations. This project would require the purchasing of CLIA-waived POC analysis tools, as well as testing supplies, test controls, staff training, and development and implementation of testing protocols. Cost for testing would be billed directly to the patient or their insurance for reimbursement. For patients who are uninsured this project will include a self-pay option, increasing access to testing. Send-out laboratory testing is billed directly by the lab performing the testing, presenting cost-uncertainty as a barrier for those without insurance. By offering POC testing, we can offer the patient an exact cost for the visit, eliminating the risk for large laboratory bills received by patients months after their testing has been completed.	\$50,000-\$250,000	Family or primary care	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

JVRX, LLC d/b/a Little Big Health Solutions	24/7/365 Nurse Advice Line (NAL)	PA	Many rural and frontier communities face significant barriers to timely healthcare due to geographic isolation, environmental risks, transportation barriers, limited access to healthcare, and healthcare provider shortages. Particularly in Alaska, residents of remote communities who require long travel distances to access medical care face delayed treatment, increased risk of chronic disease, increased morbidity and mortality rates, and increase reliance on emergency services. Our NAL project will address gaps by improving access to timely clinical guidance by providing a 24/7/365 telephonic nurse triage and advice service. By giving residents direct phone-based access to experienced registered nurses who use evidence-based clinical protocols, patients can receive education on managing symptoms, support in determining the appropriate level of care, and guidance on seeking in-person medical attention when necessary. Providing this type of remote support helps individuals make better informed healthcare decisions, reduces unnecessary long travel, decreases the burden on emergency services and departments, and ensures that limited healthcare resources are used more effectively. Our NAL model offers sustainability by eliminating technological barriers, offering an immediate solution that meets patients where they are at, by phone, in their language and with respect for their lived experience. This is especially important in rural communities where broadband access is limited.	Our NAL approach is aimed to immediately implement a scalable telephone-based 24/7/365 nurse triage and clinical guidance service, expanding high quality, timely healthcare access to residents of rural communities. Our service will quickly connect patients with experienced registered nurses who initiate the triage process through a combination of clinical expertise along with the Schmitt-Thompson gold standard evidence-based clinical decision-making support tool. This combined process allows our team of highly qualified registered nurses to evaluate symptoms, provide self-care guidance when appropriate, empower patients to make better-informed healthcare decisions through increased awareness, recommend seeking in-person care when necessary, connect patients to local resources, and pursue urgent or emergency services when appropriate, all in real-time. The service is designed to complement, strengthen and expand existing healthcare systems, not replace them. By instantly answering questions and addressing non-emergency health concerns, our telephonic nurse triage system reduces strain on local clinics, supports limited healthcare workforces, and allows providers to focus on patients who require in-person care. This approach also supports more efficient use of limited healthcare resources by reducing unnecessary travel and avoidable emergency department visits, reducing hospital admissions and readmissions, and limiting the use of emergency transport services to actual emergencies. In remote regions where transportation may require significant time, cost, or coordination, having access to immediate clinical guidance can make a meaningful difference for patients and providers alike. Our model emphasizes clear communication, culturally respectful care, and coordination with local healthcare systems. Call documentation and communication protocols support continuity of care while ensuring the service integrates smoothly with existing providers and healthcare infrastructure. By providing trusted, evidence-based clinical guidance through a scalable telephonic model, this approach helps bridge geographic barriers, improve access to care, and strengthen the sustainability of healthcare delivery for rural and frontier populations.	\$1M-\$5M	Home- and communit y-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Kabo Health LLC DBA Avalia HEALTH	Support for Innovative Outreach and Multidisciplinary Team Services	AK	Many individuals experiencing homelessness in Anchorage are actually are rural residents who suffer from untreated mental illness, substance use disorders, trauma, and chronic health conditions. These individuals frequently interact with emergency services but have limited access to ongoing behavioral health care and coordinated support. Bean’s Café operates one of Anchorage’s largest warming and feeding centers and provides services to hundreds of individuals experiencing homelessness each year, including people who have migrated from rural Alaska for services or opportunity. Despite the presence of multiple service providers, many individuals remain disconnected from treatment due to lack of on-site behavioral health staff able to perform assessments, crisis intervention, and navigation into appropriate care. This project addresses that gap by embedding two outreach LCSWs within the Bean’s Café service model and the Anchorage Multidisciplinary Outreach Team. These clinicians will serve as behavioral health anchors both within the shelter environment and during proactive outreach activities, providing immediate clinical assessment, stabilization, and connection to treatment and housing resources.	The project will fund two full-time Licensed Clinical Social Workers to operate as integrated behavioral health specialists within Bean’s Café and the Anchorage Multidisciplinary Outreach Team and to provide Kabo Health with technical assistance to be able to provide 1115 waiver services. Key functions of the LCSWs will include: • Behavioral health intake assessments for individuals presenting at the warming center or encountered during outreach • Crisis intervention and stabilization for individuals experiencing psychiatric or substance-related crises • Short-term behavioral health counseling and trauma-informed support • Case management and care coordination with medical providers, substance use treatment programs, and housing services • Navigation and referral to appropriate treatment programs including outpatient therapy, residential treatment, medication-assisted treatment, and psychiatric services • Participation in multidisciplinary case conferences with outreach workers, medical providers, and shelter staff • Engagement with unsheltered individuals during outreach activities The LCSWs will operate as integrated members of the Bean’s Café service model and will coordinate with the Anchorage Multidisciplinary Outreach Team to identify individuals in need of behavioral health services. This model places clinical capacity directly within the environment where vulnerable individuals already seek assistance, reducing barriers to care and improving engagement.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Kachemak Bay Family Planning Clinic	Bridging the Distance: Advanced Learning for a Stronger Rural Workforce	AK	Alaskans on the Kenai Peninsula experience several significant barriers to accessing care including rural transportation challenges, high cost of all health care, trouble navigating public assistance enrollment, housing and food insecurity, limited provider expertise in reproductive health, a siloed healthcare system, lack of a medical home, and lack of childcare, among others. Women, including new moms, face compound barriers to care, including geographic isolation, their families’ nontraditional work schedules, past trauma, and social stigma around reproductive healthcare topics such as postpartum depression, maternal deaths, infertility, and contraception for family planning and birth spacing. Additionally, high rates of substance misuse and domestic violence remain leading contributors to maternal morbidity and mortality in Alaska. Rural regions also present unique challenges for healthcare provision due to the vast geography, sociocultural variety, sparse infrastructure, logistical difficulties, limited pool of licensed staff, and high costs associated with providing care in remote areas. As part of the Bridging the Distance program proposal, KBFPC is requesting funds to support current staff pursuing advanced healthcare degrees. As the region’s only dedicated reproductive health provider, KBFPC stands as a critical lifeline for many, particularly in a state where access to care, including for maternal health, is limited and expensive to deliver.	As described in the Bridging the Distance: Remote Maternal and Reproductive Health Services on the Kenai Peninsula LOI, with RHTP programmatic support KBFPC will expand the Remote Services program in reach and in scope – including a new Postpartum Home Visit Program – to improve rural Alaskans’ access to preventative healthcare and reduce the significant social and economic costs of undiagnosed medical conditions for individuals and their families. KBFPC’s work already strengthens and complements regional and statewide public health efforts. The proposed expansion and new service pilot will develop a model built on insights from community-based participatory research and impact assessments to inspire and help scale impactful rural health programs throughout the state and across the country. When all Alaskan women get the care and health information they need to live, work, and play, their families thrive and communities are stronger. RHTP funding will allow KBFPC to set a transformative precedent for rural healthcare delivery, creating lasting impact in a region where reproductive healthcare needs are acute. This funding will build the infrastructure, capacity, and systems necessary to expand the pilot-tested program across the Kenai Peninsula and beyond. Three KBFPC staff members would like to pursue advanced healthcare degrees over the next four years, but are limited by the high cost of education. RHTP funding would support their pursuit of higher education while these staff members remain employed by KBFPC and actively involved in the Bridging the Distance proposal work. These employees understand the needs of rural Alaska and are committed to working in Alaska long-term.	Under \$50,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Kachemak Bay Family Planning Clinic	Bridging the Distance: Clinic Renovations to Support Expanded Access to Care	AK	Alaskans on the Kenai Peninsula experience several significant barriers to accessing care including rural transportation challenges, high cost of all health care, trouble navigating public assistance enrollment, housing and food insecurity, limited provider expertise in reproductive health, a siloed healthcare system, lack of a medical home, and lack of childcare, among others. Women, including new moms, face compound barriers to care, including geographic isolation, their families’ nontraditional work schedules, past trauma, and social stigma around reproductive healthcare topics such as postpartum depression, maternal deaths, infertility, and contraception for family planning and birth spacing. Additionally, high rates of substance misuse and domestic violence remain leading contributors to maternal morbidity and mortality in Alaska. Rural regions also present unique challenges for healthcare provision due to the vast geography, sociocultural variety, sparse infrastructure, logistical difficulties, limited pool of licensed staff, and high costs associated with providing care in remote areas. As part of the broader Bridging the Distance program proposal, KBFPC is requesting funds for overdue clinic renovations to support expanded access to care. As the region’s only dedicated reproductive health provider, KBFPC stands as a critical lifeline for many, particularly in a state where access to care, including for maternal health, is limited and expensive to deliver.	As described in the Bridging the Distance: Remote Maternal and Reproductive Health Services on the Kenai Peninsula LOI, with RHTP programmatic support KBFPC will expand the Remote Services program in reach and in scope – including a new Postpartum Home Visit Program – to improve rural Alaskans’ access to preventative healthcare and reduce the significant social and economic costs of undiagnosed medical conditions for individuals and their families. KBFPC’s work already strengthens and complements regional and statewide public health efforts. The proposed expansion and new service pilot will develop a model built on insights from community-based participatory research and impact assessments to inspire and help scale impactful rural health programs throughout the state and across the country. When all Alaskan women get the care and health information they need to live, work, and play, their families thrive and communities are stronger. RHTP funding will allow KBFPC to set a transformative precedent for rural healthcare delivery, creating lasting impact in a region where reproductive healthcare needs are acute. This funding will build the infrastructure, capacity, and systems necessary to expand the pilot-tested program across the Kenai Peninsula and beyond. Additional funding to support renovations at KBFPC’s already owned clinic building will offer the updated physical infrastructure needed to support this program. Clinic renovations will take place during the initial phase of the 5-year project to help staff focus on caring for Alaskans.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Kachemak Bay Family Planning Clinic	Bridging the Distance: Remote Maternal and Reproductive Health Services on the Kenai Peninsula	AK	Alaskans on the Kenai Peninsula experience several significant barriers to accessing care including rural transportation challenges, high cost of all health care, trouble navigating public assistance enrollment, housing and food insecurity, limited provider expertise in reproductive health, a siloed healthcare system, lack of a medical home, and lack of childcare, among others. Women in the region, including new moms, face compound barriers to care, including geographic isolation, their families’ nontraditional work schedules, past trauma, and social stigma around reproductive healthcare topics such as postpartum depression, maternal deaths, infertility, and contraception for family planning and birth spacing. Additionally, high rates of substance misuse and domestic violence remain leading contributors to maternal morbidity and mortality in Alaska. Rural regions also present unique challenges for healthcare provision due to the vast geography, sociocultural variety, sparse infrastructure, logistical difficulties, limited pool of licensed staff, and high costs associated with providing care in remote areas. KBFPC’s Remote Services Program, with its offered services and responsive model, is essential for overcoming these obstacles. As the only dedicated reproductive health provider in the region, KBFPC and its expert staff stand as a critical lifeline for many, particularly in a state where access to care, including for maternal health, is limited and expensive to deliver.	Traditional healthcare models often fail to meet the needs of rural populations. In response, for over 40 years KBFPC has integrated innovative, community-centered models into its care delivery. In late 2022, KBFPC launched the Remote Services Program to directly address the logistical challenges of accessing care in rural communities. This small-scale initiative combines KBFPC’s expertise and logistical support with regional partners’ physical space for colocation and referrals. A mix of Pop-Up Clinics, outreach education, mail-out services, and telehealth options are used to bring services to where the region’s underserved communities need care the most. The Remote Services Program represents a key model for collaborative and responsive rural healthcare delivery, ensuring that those living in remote areas receive the reproductive and mental health services they need. With RHTP support, KBFPC will expand this program in reach and in scope – including a new Postpartum Home Visit Program – to improve rural Alaskans’ access to preventative healthcare and reduce the significant social and economic costs of undiagnosed medical conditions for individuals and their families. The Postpartum Home Visits will offer new families one-on-one support from a trained clinical provider and postpartum doula; including screening and connection to community resources for mental and physical health conditions associated with birth, as well as interpersonal violence. Because KBFPC already supports women through all stages of their reproductive life, from adolescence through menopause, the addition of this home-visit service is a natural fit for the agency. KBFPC’s work already strengthens and complements regional and statewide public health efforts. The proposed expansion and new service pilot will develop a model built on insights from community-based participatory research and impact assessments to inspire and help scale impactful rural health programs throughout the state and across the country. When all Alaskan women get the care and health information they need to live, work, and play, their families thrive and communities are stronger. RHTP funding will allow KBFPC to set a transformative precedent for rural healthcare delivery, creating lasting impact in a region where reproductive healthcare needs are acute. This funding will build the infrastructure, capacity, and systems necessary to expand the pilot-tested program across the Kenai Peninsula and beyond.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Kachemak Bay Recovery Connection	Expanding and Sustaining Peer Support Services on the Southern Kenai Peninsula	AK	The SKP has a critical lack of available and accessible recovery support services. Since 2008, five Community Health Needs Assessments conducted by the local health improvement coalition have identified substance abuse as a top factor negatively affecting community health. KBRC serves Alaskans at high risk of and most affected by Opioid Use Disorder (OUD) and other Substance Use Disorders (SUDs). Individuals in early recovery are at high risk of relapse; about half relapse within three months after intensive treatment, many more in the first three to five years, and many overdose deaths occur during relapse. RCOs provide proven, evidence-informed recovery support that reduces relapse and overdose risk. Local demand for peer support exceeds KBRC’s current capacity - our two PSS are already serving 40 participants, which is not a sustainable case load. We receive referrals from multiple partners yet we are often unable to fully meet their needs because KBRC lacks sufficient staff and an agency vehicle. Currently, if a participant needs transportation support, we are often unable to meet that need or our facility must temporarily close to provide that transportation. When we do provide transportation, we are using personal vehicles and mileage reimbursement. This approach is neither sustainable nor ideal. A MRU will reduce risk and allow us to reliably meet a high transportation need and added staff will allow us to do that without closing our facility during business hours.	The proposed approach will increase the availability and accessibility of recovery support across the SKP. KBRC is currently the only entity in the region offering peer support to individuals in recovery, and our current staffing level is not sufficient to meet demand. With additional staff, we can better meet local need and strengthen relationships with our partners. We will then have the capacity to keep our facility open to walk-ins during normal business hours while simultaneously supporting participants and partner-referred clients with transportation needs. With increased funding we could also offer full-time positions, which would have a positive impact on both staff recruitment and retention. There is no local public transportation system, and many participants lack a driver’s license and/or a vehicle. In addition to providing local rides, we often need to transport community members 75 miles to the nearest detox facility. Entering detox is a highly vulnerable stage in the recovery process and is safest with a trusted support person, not alone on a shuttle or in a taxi. The ability to provide personalized transportation supports connection and builds trust, two critical aspects of a successful recovery journey. In addition to increasing staff hours, we propose to purchase a MRU. An agency-owned vehicle will have a two-fold benefit: 1. It will allow us to transport participants, whether locally to weekly food pantries or further up the road for detox; and 2. It will allow us to bring our services to various locations throughout the region. The MRU will make regular visits to nearby communities and serve as a highly visible mobile hub where people can access resources and support. Both uses, local transport and regional outreach, will transform how we provide services and fill an unmet community need. Additional staff hours and an MRU will allow us to truly meet people where they are by establishing a regular presence providing services at local food pantries (in Homer, Anchor Point and Ninilchik) and local libraries (in Homer, Anchor Point, Ninilchik, and Seldovia). A regular presence at community food pantries has proven to be an effective engagement strategy, but one we have not been able to staff. Establishing “office hours” at local libraries will further support this approach, as many community members who could benefit from KBRC services frequent libraries as the only warm, free spaces with internet access.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Kachemak Emergency Services	Radio Communications	AK	Due to topography, several locations in Kachemak Emergency Services' area of responsibility have poor or non-existent radio communications. In these locations, EMS units are unable to communicate with their dispatch center or other responding units. As a result, pertinent and time-urgent information is not relayed in a timely manner.	Expand Alaska Land Mobile Radio (ALMR) capability or conventional radio capability to improve coverage at the head of Kachemak Bay. Radio towers on the south side of Kachemak Bay would have visibility to mobile and portable radios on the north side of the Bay.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced
Kachemak Emergency Services	Station 2 volunteer pre-fab quarters	AK	Kachemak Emergency Services (KES) provides fire and EMS coverage across 214 square miles in the Kenai Peninsula Borough, serving roughly 4,500 residents. Station 1, on the eastern side, is staffed with three shifts of two full-time firefighter/EMTs, ensuring reliable district-wide response. Station 2, on Diamond Ridge, houses apparatus but lacks living quarters. Installing a prefabricated modular facility would allow volunteers to take scheduled duty shifts, increasing on-site coverage in the western portion of the district. This project enhances KESA's ability to respond to emergencies where rapid intervention is essential, including severe trauma, cardiac events, and strokes. On-site volunteer quarters also support recruitment and retention, expanding operational capacity and improving timely access to emergency care for residents in this rural service area.	KES proposes installing a prefabricated modular living quarters structure at Station 2, providing bunk rooms, a kitchen, day/living room, and bathroom/shower facilities for volunteers to remain on duty. The unit will be delivered largely complete and installed without a permanent foundation, connecting to existing electrical and septic infrastructure with minimal site preparation. Volunteers could staff Station 2 during scheduled shifts, allowing apparatus to respond directly from that location. This approach expands operational coverage in the western portion of the service area while maintaining readiness from Station 1. On-site living quarters also make scheduled shifts practical, supporting volunteer recruitment and retention.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Kachemak Rapid Care Ambulance	Expanding Rural EMS Access on the Kenai Peninsula	AK	Advanced Life Support (ALS) transport is required for patients needing continuous monitoring and complex interventions, particularly during long-distance transfers. Many transports involve heart attacks, strokes, respiratory failure, severe trauma, or patients requiring cardiac monitoring, ventilator support, intravenous medications, or advanced airway management. Stroke treatment is highly time-sensitive, with the clot-busting drug tPA typically required within 3–4.5 hours of symptom onset, and studies show that each minute of delay results in the loss of approximately 1.9 million brain cells. The Kenai Peninsula Borough spans over 25,000 square miles, and communities outside our service area face no access to long-distance ALS ground transport. Homer and Seward hospitals are not PCI-capable facilities, meaning patients experiencing heart attacks or strokes must often be transported to Anchorage, 200+ miles away, for definitive care. When air transport is grounded due to weather, delays can cause stroke patients to miss the four-hour treatment window, leading to permanent disability. Developing long-distance ALS transport requires significant upfront investment in ambulances, monitors, ventilators, and specialized transport systems. Critical patient monitors alone cost approximately \$30,000, and equipment donations are limited. Currently, there are no dedicated state resources supporting development of this infrastructure.	This project will expand emergency medical transport capacity and improve healthcare access for residents across the Kenai Peninsula by strengthening the region’s only Advanced Life Support (ALS) and long-distance ambulance service. 1. Regional Integration and Service Expansion We will strengthen regional care coordination by establishing formal partnerships with hospitals, Tribal health organizations, fishing industry employers, borough leadership, and EMS partners. Structured outreach will result in hospital MOUs, Tribal health coordination agreements, and integration with regional EMS dispatch systems. These agreements will expand service coverage beyond our current Soldotna base to support communities such as Seward and Homer that lack reliable long-distance ALS transport. This approach improves continuity of care within the Peninsula. 2. Workforce Expansion and Rural Workforce Pipeline The project will fund a dedicated Project Manager responsible for operational expansion, partnership coordination, workforce recruitment, and performance tracking. A targeted recruitment and relocation strategy will attract 1 EMT and 1 Paramedic to support expansion. Staff will also receive training to support specialized transports, including oncology transfers, dialysis patients, hyperbaric-related transfers, and medically complex patients. 3. Community Engagement and System Sustainability A regional communications strategy will position the ambulance service as critical healthcare infrastructure supporting rural access to care. Public education will clarify appropriate EMS utilization and the role of long-distance ALS transport within the regional healthcare system. The project will also produce a five-year sustainability plan including service line break-even analysis, reimbursement optimization strategies, and a capital expansion roadmap to ensure the service remains viable beyond the grant period. 4. Equipment and Infrastructure Investment Grant funding will support acquisition and full ALS outfitting of an additional ambulance based in Seward, enabling expanded service coverage across the Peninsula. Investments include an ambulance vehicle, advanced monitoring and transport equipment, durable medical equipment, medical supplies, IT and dispatch systems, and facility setup required to support safe and reliable emergency medical transport operations.	\$1M-\$5M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Kachemak Swim Club	Kate Kuhns Aquatic and Wellness Center	AK	The community pool currently operated by the Kenai Peninsula Borough School District is facing closure due to the loss of operational funding. This closure would negatively impact youth, families, and seniors who rely on it daily. In rural Alaska, aquatic facilities are essential not only in recreation but also in water safety education, youth development, injury prevention, and chronic disease prevention. The loss of the facility would also significantly reduce opportunities for afterschool programming for children and teens. Kachemak Swim Club (KSC) has the organizational experience and community support to assume operational responsibility for the pool through a nonprofit model that continues to partner with the school district and the Kenai Peninsula Borough. By stabilizing operations and or expanding programming, the facility can continue to be a community health asset that supports youth development, family wellness, rehabilitation, and lifelong physical activity. At this time there is no governing body that has offered to assume operations of the aquatic center and so we anticipate it closing at the end of June 2026. Through support of the RHTP there is an opportunity for KSC to transition oversight. This opportunity aligns with broader rural health priorities by improving access to safe physical activity, strengthening community infrastructure, and expanding prevention-focused programming that supports both physical and mental health across the lifespan.	The proposed project will stabilize the existing aquatic facility and transition operational responsibility from the Kenai Peninsula Borough School District to Kachemak Swim Club through a community-based nonprofit operating model that continues to partner closely with the school district and the Kenai Peninsula Borough. Immediate grant funding would support transition costs, operational planning, and the initial improvements necessary to reposition the facility as a community aquatic wellness center. Once operational stability is achieved, the project will focus on targeted improvements that expand the facility’s ability to serve community health needs. Accessibility upgrades such as pool lifts, family changing rooms, and accessible restrooms and showers will ensure the facility meets the standards of the Americans with Disabilities Act. Operational improvements may include energy-efficient filtration systems, water conservation technology, heat recovery systems, and solar-assisted heating where feasible in order to reduce long-term operating costs. Future planning will explore the feasibility of adding a small warm-water therapy pool, pending engineering feasibility and building approvals. A warmer pool environment would support rehabilitation programs, arthritis exercise classes, and potential partnerships with the local hospital for wellness or physical therapy programming. Additional enhancements may include a zero-entry pool area with modest play elements for young children, as well as a hydrotherapy zone with hot and cold plunge pools to support recovery and therapeutic use. With these improvements the aquatic wellness center will be able to expand programming across the lifespan. Youth swim instruction, afterschool programs, and swim team development will support child and teen wellness and mental health through structured recreation and sports participation. The facility can also host infant swim programs, toddler play groups, aquatic fitness classes, and community wellness activities that support families and seniors. Together, these improvements and programs will transform the pool into a year-round community wellness resource.	\$250K-\$1M	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

Karousel Kidz Learning Center 2 LLC	Karousel Kidz building updates	AK	Our building was build in 1982 and needs some major updating. We need to hire an electrician to rewire some of the classrooms for safety and energy efficiency. The fluorescent light fixtures need replaced with LED fixtures. We would like to upgrade our HVAC units to more energy efficient units. We would like to change out some of the store front windows to egress windows that open to allow natural air flow during the summer. Doors need upgraded as they leak and blow open during our windy days. Floors need upgraded as the carpet has many rips and damage, the hardwood floors are separating and have old drill holes where cables used to be. We would like to install more security systems to have better safety measures for our kiddos. Toilets need upgraded to energy efficient toilets. Sinks need repaired. Walls that are cracked and pulling apart need fixed. The outside of the building needs fixed of random holes and areas that leak water into our walls. The piping in the ceiling leaks condensation. The ceiling tiles need replaced after to get rid of the water marks. It is a very old building that was not kept up very well.	The initial plan is the electrical fixing. I have an electrician available to do the work once we have the funding. I am in close contact with a flooring store for flooring. The HVAC company that maintains our units is also aware of our want to upgrade to better units and is on board. I can upgrade toilets and sinks myself as well as some basic patching of walls and caulking. Steven's glass has given us a quote on upgrading a few windows as well, just waiting for payment to order the windows.	\$250K-\$1M		Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced
Kathy Hurlburt Medical Group LLC	Addressing Metabolic Disease in Rural Alaskans: A Multi-disciplinary Hybrid Care Model	AK	In Dillingham and Naknek, metabolic syndrome—including Type 2 diabetes and hypertension—is a primary driver of premature mortality. While Alaska Native beneficiaries have access to IHS services, a significant population of non-beneficiaries, including the local workforce and seasonal residents, has zero local access to specialized metabolic care. This disparity leads to delayed diagnoses and poor adherence. This project presents an opportunity to create a scalable specialty care bridge for this underserved cohort, preventing the acceleration of costly co-morbidities like stroke and renal failure.	We will implement a three-phase "Fly-In/Tele-Health" model: In-Person Intensives: Quarterly mobile diagnostic hubs in Dillingham and Naknek for high-risk screenings and clinical intake. Clinical Integration: Simultaneous medical management by an Internal Medicine Physician and culturally tailored medical nutrition therapy (MNT) by a Registered Nutritionist. Digital Continuity: Utilization of a HIPAA-compliant telemedicine platform and Remote Patient Monitoring (RPM) to provide monthly follow-ups and real-time coaching, ensuring Anchorage-level care frequency within the rural setting.	\$50,000-\$250,000	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bristol Bay Borough; Dillingham Census Area	Advance to Implementation Application

Kawerak, Inc	Community Led Health and Wellness Program.	AK	The Norton Sound region faces a suicide rate more than twice the national average, driven by deep-seated intergenerational trauma. A primary barrier to healing is the "hub-village gap," where 80% of communities are off the road system and rely on weather-dependent travel. Current reactive models fail because the "golden hour" for emergency response is rarely achievable in frontier Alaska. Domestic violence, sexual assault, and substance abuse often remain siloed or unspoken, preventing rural Alaska Native communities from building the internal accountability necessary for long-term safety. This project transforms regional health by shifting from a reactive, crisis-based model to a proactive, community-led prevention framework. By utilizing an area-specific version of the PC CARES model, we will empower village members to be the primary facilitators of their own wellness. This shifts the burden from a fragile, high-turnover clinical workforce to a stable, village-based social infrastructure, ensuring care remains "close to home". By normalizing difficult conversations and strengthening the Nome/hub wellness forum, we ensure regional resources are directly driven by village-identified needs. Prioritizing internal village-led accountability establishes the stable, relational foundation required to break the cycle of intergenerational trauma and protect our youth.	Our approach utilizes a community-led, trauma-informed framework rooted in strength-based and harm reduction ideologies. By implementing a localized version of the PC CARES model, we move away from deficit-based interventions to activate the inherent resilience and cultural wisdom within our rural Alaska Native communities. Our approach follows a three-part logical framework: Activating Community Assets (Strength-Based): Instead of focusing solely on gaps, we identify and support local leaders to serve as facilitators. This recognizes that our villages already possess the relational knowledge required for healing. By centering the project on community strengths, we ensure the wellness journey is self-determined, which increases the probability of long-term sustainability. Safety through Normalization (Harm Reduction): Facilitators lead "Community Conversations" to break the silence surrounding DV, SA, and SAM. We apply harm reduction principles by meeting the community exactly where they are—reducing the shame and isolation that often lead to crisis. Creating a safe space to discuss these issues provides an immediate layer of protection and an "on-ramp" to support, even when professional resources are distant. Relational Infrastructure: We integrate these village-led strategies into the Nome/hub wellness forum coordination. This ensures regional support is a direct response to local priorities. By formalizing this coordination, we provide the consistent foundation needed to address intergenerational trauma and disrupt repetitive patterns for future generations	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Kawerak, Inc	Expansion of regional Emergency Management capacity for Resilience and Health System Preparedness	AK	Despite ongoing preparedness efforts, significant capacity gaps remain across the Bering Strait Region. The region’s geographic isolation, limited transportation infrastructure, and small local populations create challenges in maintaining sufficient emergency preparedness and response capacity. Many communities rely heavily on volunteer responders and have limited emergency infrastructure or trained personnel available for sustained response operations. Disruptions caused by storms, coastal flooding, or infrastructure failures can quickly affect access to health care, emergency medical response, and essential services that support community health. Currently, a single regional emergency preparedness staff member provides technical assistance and coordination support to fifteen tribal communities. This limited capacity restricts the region’s ability to support mitigation planning, responder training, emergency exercises, and disaster recovery assistance. Expanding regional preparedness capacity represents an important opportunity to strengthen transformative health system resilience, improve coordination among communities, and protect the health and safety of rural residents during emergencies.	This project will strengthen rural health system resilience by expanding regional emergency preparedness capacity and improving coordination across the Bering Strait Region. The initiative will focus on supporting tribal communities in strengthening preparedness planning, improving response coordination, and maintaining continuity of essential services, including health, during disasters and severe weather events. Key activities include: • Expanding regional emergency preparedness staffing to support tribal communities. • Providing technical assistance for local emergency planning and hazard mitigation in all communities. • Supporting responder training, exercises, and coordination with regional partners. • Strengthening collaboration between tribal governments, health providers, and emergency response agencies. • Promoting household and community preparedness to improve resilience during storms and extended disruptions. • Improving communication and coordination systems to support effective emergency response, including injury and other health needs. These activities will strengthen and continue to reinforce the ability of our rural communities to protect residents during emergencies and maintain access to health services when disasters occur.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Kawerak, Inc.	Bering Strait Wellness Initiative Planning Grant	AK	Rates of chronic illness and mental health challenges are high in region, with 75% of adults having at least one chronic condition, and nearly a quarter of Alaska Native youth having considered suicide (19% attempted). The region is not connected by road to the rest of Alaska, requiring food to be flown or barged into communities. Combined with limited food storage capacity in many village stores, these logistical and financial constraints restrict availability of nutritious foods, leaving many residents reliant on cheaper, imported alternatives. The resulting decline in food quality, reduced access to healthy foods, and loss of wellness practices have directly contributed to poor physical and mental health outcomes. Inupiat, St. Lawrence Island Yupik and Yup’ik cultures have thrived in the region for millennia developing systems of wellness grounded in traditional foods, land-based practices, and intergenerational knowledge sharing. However, these systems have been disrupted by historical and structural barriers, including language loss, challenges translating traditional wellness knowledge into Western medical models, and diminished access to traditional foods and harvesting opportunities. Kawerak sees an opportunity to improve regional health outcomes by restoring traditional foodways, expanding access to healthy and locally produced foods, and increasing opportunities for traditional knowledge exchanges to strengthen food sovereignty and cultural wellness.	For the first year of funding, Kawerak proposes to complete the initial planning phase of its five-year Bering Strait Wellness Initiative (BSWI), which aims to reduce chronic illness and expand culturally appropriate, community-based wellness education across the region. During this planning year, project partners – Kawerak’s Pilgrim Hot Springs (PHS), Reindeer Herders Association (RHA) and Environmental (ENV) Programs; the UAF Northwest Campus Cooperative Extension (CES), and the Village of Solomon (VOS) - will collaboratively develop culturally grounded curricula informed by a regional needs assessment. Curriculum development will focus on two core priority areas: traditional foods and nutrition education, and community wellness education. Partners will also establish agreements for shared use of facilities, including the Village of Solomon’s Traditional Foods Processing Facility, the PHS Wellness Center at Pilgrim Hot Springs, UAF NWC Cooperative Extension classrooms and a distribution-focused Bering Strait Food Hub located in Nome. These facilities will serve as central locations for workshops and trainings during the implementation phase. Project partners will collaborate on traditional foods curricula and workshop planning focused on reindeer husbandry, traditional wellness practices, food preserving and preparation, and village-based healthy food trainings. ENV and PHS will also develop curriculum for expanding in-village garden education, building on new agriculture sites recently established in several communities.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Kawerak, Inc.	Remote Health Care Workers Program	AK	There are three problems we would like to address with this project. They are as follows: 1) Itinerate health care workers cycle in and out of rural and remote communities in Alaska on a regular basis. Few stay and make their homes here. Most do not reinvest in the communities they serve. 2) We are facing a severe shortage of health care workers across rural and remote Alaska. 3) Rural communities in Alaska have a very high rate of unemployment. The good news is that the newly enhanced services provided by GCI’s broadband internet and Starlink’s high speed satellite internet make remote work is possible where it never has been before. All three problems can be solved at once by growing our own health care workforce and providing good jobs that pay a living wage in communities like Gambell, where the unemployment rate is 37.8%. Many jobs can be done remotely by rural residents. With the right training programs offered by distance learning, cohorts of students would never have to leave their communities. Employment opportunities in medical coding and billing, health information management and health adjacent roles such as IT support have never been more accessible. We propose to strengthen the health care workforce across the Bering Strait Region by training and certifying our own residents to fill these vital roles.	We propose to recruit and run a cohort of 10 students every six months. The cohorts will receive training in vital health care roles such as Clinical Medical Assistant, Patient Care Technician, Medical Billing and Coding, Electronic Health Records, EKG and Phlebotomy Technician, Pharmacy Technician, Dental Support Assistant, Mental Health Technician, Medical Administrative Assistant, Information Technology Specialist, Cyber Security Professional and roles that require CompTIA Certification. We plan to recruit graduating seniors from high school and retrain adults that may already have work experience. We currently have an existing partnership with MedCertify that students can utilize as they pursue these certifications. All programs listed above are available through Med Certify and can be done remotely. This program will be housed under the Vocational Rehabilitation Department at Kawerak, Inc. Individuals with disabilities will receive priority in the program in the event that we receive more applications then we have spaces available in a given cohort. Case workers, including a vocational rehabilitation case worker, will be on staff to help students and trainees every step of the way. Internet, laptops, necessary office furniture, books and supplies will be provided to students in each cohort. Once graduated, an employment coordinator will assist with a resume, job search, cover letter, LinkedIn profile set up and travel to and from interviews (if required) for each program participant.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Kawerak, Inc.	Early Childhood Education Health, Wellness, and Development	AK	The current federal and State funding that we receive to offer Head Start and childcare services has not kept up with the cost to operate over the years. The intent of this project is to fill in staffing gaps, increase staff hours after our summer of 2025 hour reduction due to budget restraints, and ensure all our programs continue to offer health, wellness, and development for the youngest people in our region. Kawerak, Inc. operates the only comprehensive birth-to-five early childhood education (ECE) program across 11 remote Bering Strait communities, with the exception of one Nome private preschool with limited seats. The qualified applicant pool in our remote region is extremely small, compounding staffing shortages that directly reduce the quality and availability of services for children. Children's needs are greater than ever. Physical health challenges, developmental delays, and social-emotional difficulties are escalating, requiring more staff and specialized support that current funding cannot cover. Six Kawerak-owned Head Start facilities face deferred maintenance that threatens safe, compliant learning environments. Communities are urgently requesting Native language immersion classrooms to combat endangered language loss and strengthen cultural identity among young children, to promote wellness. Without this program, approximately 95 jobs would be lost and parents who depend on our services to maintain employment would face impossible choices.	Through this project, we will: -Restore staff hours -Rehire 9 positions that we recently discontinued due to budget restraints -Create and hire 3 new positions that are desperately needed -Address severe deferred maintenance needs -Continue our language immersion efforts -Continue to grow new teachers through our Teachers in Training program -Continue our Uiivilat Play & Learn Center (UPLC) childcare services without causing undue financial hardship on parents/guardians by keeping the monthly rates within reason	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Kay Brooke Properties, LLC	Interior Alaska Healthcare Workforce Housing Stabilization Initiative	AK	Interior Alaska healthcare facilities rely heavily on temporary, contract, and newly recruited clinicians to sustain services for rural and frontier communities. Fairbanks functions as a regional referral hub, and workforce instability in this community directly impacts access to care across Interior Alaska. A persistent shortage of available, furnished, and short-term rental housing creates delays in provider onboarding, contract acceptance, and assignment stability. Incoming clinicians frequently face extended housing searches, short-notice cancellations, or temporary lodging arrangements that are not sustainable for multi-month contracts. These housing barriers contribute to staffing unpredictability, increased administrative burden for healthcare organizations, and interruptions in care continuity for rural patients who depend on rotating and specialty providers. The lack of dedicated workforce housing represents a structural infrastructure gap rather than an isolated recruitment challenge. Addressing this targeted barrier supports workforce stabilization, improves onboarding reliability, and strengthens rural healthcare sustainability.	Kay Brooke Properties, LLC proposes acquiring and converting 8–10 existing residential units in Fairbanks into dedicated healthcare workforce housing. Units will be fully furnished and reserved for verified healthcare workers, with priority given to temporary, contract, and newly recruited providers serving Interior Alaska communities. Occupancy will require verification of employment or contract status with a licensed healthcare organization to ensure alignment with workforce stabilization goals. The project will be implemented in phases to manage risk and ensure financial stability. Following funding approval, properties will be identified and acquired based on location, condition, and suitability for furnished workforce housing. Light renovations and furnishing will be completed to prepare units for immediate occupancy. Units are anticipated to be operational within approximately 90–120 days of acquisition. A recorded 15-year healthcare-only use restriction will ensure long-term public benefit and prevent diversion to unrelated uses. The program will maintain clear occupancy policies, centralized turnover coordination, and separate financial tracking for transparency and accountability. An advisory committee composed of local healthcare representatives (hospital, clinic, and EMS leadership) will provide workforce insight and periodic review to ensure housing supply aligns with regional demand patterns. The advisory role will strengthen coordination between housing availability and workforce recruitment timelines. This acquisition-based model allows rapid implementation without construction delays, reduces capital risk, and maintains manageable project scale aligned with current organizational capacity. By focusing on existing housing inventory, the initiative addresses an immediate workforce infrastructure gap while ensuring long-term sustainability and operational stability.	\$1M-\$5M	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced

Kay Brooke Properties, LLC	Interior Alaska Rural Healthcare Workforce Infrastructure Stabilization Initiative	AK	Interior Alaska’s rural and frontier communities depend on Fairbanks-based healthcare providers for specialty referrals, outreach clinics, emergency coordination, and rotating clinical coverage. Fairbanks functions as a regional hub, and workforce instability within this hub directly affects access to care across Interior census areas. A persistent barrier to recruitment and retention is the limited availability of workforce-designated housing aligned with healthcare employment timelines. Incoming providers and clinical trainees frequently encounter delays securing appropriate housing, resulting in postponed start dates, shortened assignments, or reduced participation in rural outreach services. These housing constraints increase administrative burden for healthcare employers, contribute to service gaps, and disrupt continuity of care for rural patients who rely on consistent provider availability. The absence of structured healthcare workforce housing represents a system-level infrastructure gap rather than an isolated housing shortage. Addressing this barrier creates an opportunity to strengthen workforce stabilization, improve onboarding reliability, and enhance sustainability of healthcare access for rural and remote communities served through the Interior Alaska hub model. This project addresses a structural barrier to rural health system performance and supports long-term workforce resilience in Interior Alaska.	Kay Brooke Properties, LLC proposes to acquire, renovate, furnish, and activate six residential units within the Fairbanks North Star Borough as dedicated Healthcare Workforce Stabilization Housing. This initiative addresses a structural workforce barrier affecting rural healthcare access by establishing permanent infrastructure that supports recruitment, onboarding, retention, and rural service participation. The project will utilize existing housing inventory to enable rapid deployment. Following anticipated funding release in 2026, properties will be selected based on suitability, location, and workforce demand alignment. All acquisition, renovation, furnishing, and activation activities will be completed by September 2027 per RHTP timelines. Renovations will prioritize safety and workforce-ready standards, including necessary repairs and essential upgrades. Units will be fully furnished to enable immediate occupancy and reduce onboarding delays. A recorded 15-year Healthcare Workforce Use Restriction Covenant will be placed on each property to ensure long-term public benefit. During the covenant period, units will be used exclusively to house licensed healthcare professionals, clinical trainees, and essential healthcare support personnel directly engaged in providing or supporting healthcare services serving rural or frontier communities in Alaska. Eligible occupants may include physicians, advanced practice providers, nurses, behavioral health clinicians, pharmacists, emergency medical personnel, allied health professionals, trainees participating in rural rotations, and operational personnel supporting healthcare service delivery. Occupancy may rotate among qualifying individuals over time in alignment with workforce demand while supporting sustained stabilization. Units will remain restricted to eligible healthcare workforce occupants for the duration of the covenant. Structured eligibility verification will align housing activation with recruitment timelines and rural service needs. Performance tracking will include occupancy rates and provider categories served. Financial sustainability will be supported through structured occupancy fees and reserve planning to preserve workforce designation beyond the RHTP funding period. By establishing permanent workforce infrastructure in the Interior Alaska hub, this approach strengthens recruitment reliability, reduces service disruptions, and enhances rural healthcare access and sustainability.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

KB5 Consulting	KB5 Consulting Rural Health Workforce and Community Capacity Initiative	AK	Rural health organizations in Alaska frequently have the community trust and mission commitment needed to deliver impactful services, but lack the strategic, operational, and workforce capacity to do so effectively or sustainably. This capacity gap is particularly acute for organizations serving individuals with disabilities, who face compounding barriers to care in rural and frontier settings. At the same time, Alaska faces a persistent rural health workforce shortage that undermines the stability of community health programs. KB5 Consulting sees an opportunity to address both challenges simultaneously by providing targeted technical assistance, workforce training, and program development support to rural health organizations. We can strengthen the entire rural health care delivery ecosystem in Alaska.	During the Readiness Grant period, KB5 Consulting will conduct a comprehensive landscape assessment of rural health organizations across Alaska to identify common capacity gaps and priority needs. We will engage rural health organizations, community members, individuals with disabilities, and Tribal partners through interviews, surveys, and community convenings to ensure our program designs are grounded in real need. In parallel, we will develop framework designs for five program components: a technical assistance program for rural health organizations; a workforce training curriculum for rural health and human services workers; a community outreach support model; a disability-inclusive program development guide and consultation service; and a strategic planning and program development consulting model. The Readiness Grant period will culminate in a detailed, fully costed implementation plan and a portfolio of program frameworks, ready for launch in a future RHTP funding cycle.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough	Deferred or Not Advanced

Kenai Local Food Connection	Let's Cook! Program Expansion	AK	Rural residents on Alaska’s Central Kenai Peninsula face overlapping challenges that undermine health: high food prices, limited year-round access to fresh produce, fast-food culture, and a health care system strained by growing demand. Many households—especially low-income families—lack both reliable access to healthy local foods and the practical skills to prepare them in affordable, culturally meaningful ways. At the same time, small local food producers often struggle to connect with consumers, leaving potential health benefits unrealized. These conditions contribute to chronic disease, food insecurity, and preventable use of emergency and specialty care. Regional providers increasingly see health outcomes shaped less by genetics than by what happens in people’s kitchens and communities, yet few sustained, place-based programs link local food access, hands-on nutrition education, and support for small producers. This project positions local food and practical cooking skills as essential rural health infrastructure. By expanding our Let’s Cook! offerings, we will leverage community assets—a local grocer and café, small farms and fishers, schools, health care providers, and Alaska’s traditional culture of harvesting and preserving—to create an integrated, preventive approach. Let's Cook! will help close the gap between what rural Alaskans know they “should” eat and what they can realistically access, afford, and prepare, easing pressure on the health care system.	We will expand Let’s Cook! into a multi-component program that combines access to local foods with practical health education, including: 1) Wellness & Resilience Center: We will build a welcoming teaching kitchen and meeting space within a Soldotna grocer and café. Our Wellness & Resilience Center will host year-round classes, support groups, and events. Co-location with a grocer ensures that skills learned can be immediately applied in a real shopping environment. 2) Targeted Cooking and Wellness Education: - Homeschoolers and within public schools: We will develop and deliver curricula integrating nutrition, cooking, basic gardening, subsistence, and food preservation skills. Lessons will align with educational standards and reflect Alaska’s seasons and food traditions. - Low-income households: We will give a sliding-scale class series focused on cooking with affordable local ingredients, planning balanced menus, and preserving seasonal foods. A child-friendly classroom, classes held in different locations, and collaboration with partnering organizations will help reduce participation barriers. - In-person summer cooking demonstrations across the community with live, virtual versions will extend our reach statewide. - We will develop a nutritionist-approved, Alaska-rooted, weekly menu and shopping guide that features in-season, locally available foods, with recipes that reflect Alaskan tastes, cultures, and realities (limited time, mixed-use of store-bought and harvested foods). Accessible, low-cost memberships will include budget-conscious plans that support chronic disease prevention and management. - We will bring our Local Food Directory online, creating a user-friendly platform where residents can locate nearby farmers, fishers, wild harvesters, and local food retailers. The directory will be integrated into classes and the shopping guide, closing the loop between education and access. Planning for two community gardens, on social service partner sites in Soldotna and Kenai, in collaboration with our Soldotna Seed Library. Throughout the project, we will collaborate with Peninsula health care providers, schools, food producers, and community organizations to refer participants, align messaging with clinical recommendations, and gather feedback. Our evaluation will track participation, changes in knowledge and behavior, increases in (self-reported) consumption of fresh, local foods, and impact on household health and stress.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Kenai Peninsula Borough	Central Peninsula Mobile Integrated Healthcare Community Paramedicine Program	AK	Many Central Kenai Peninsula residents face significant barriers to healthcare access due to long travel distances, limited primary care availability, weather-related transportation challenges and high rates of chronic disease, which often results in reliance on emergency responders and emergency departments for non-emergent medical needs. High-utilizer patients often cycle through emergency medical services and emergency department system with limited follow-up care after discharge due to barriers such as a lack of transportation, housing, substance abuse and medical conditions causing the patients to be homebound. These challenges lead to increased healthcare costs, strain emergency services and reduce quality of life for Alaskans. When low-acuity cases utilize 911, first responders can only provide transport to a hospital, further reducing the hospital's capacity to treat emergency cases. The MIH program can provide transport to walk-in clinics and other non-emergency healthcare facilities for low-acuity cases. MIH programs have already been implemented in several Alaska cities with data clearly demonstrating that MIH programs lead to reduced EMS call volume and emergency department utilization, reduced hospital admissions, improved patient outcomes, and lower healthcare system costs. By providing access to non-emergent care, first responders and emergency department personnel and resources are more readily available to respond to and treat true emergency cases.	Implementing the MIH program through a collaborative partnership between CPH and CES will expand access to healthcare for residents in rural and outlying communities within the hospital service area. Under this model, Community Paramedics will be employed by CPH and operate under hospital medical oversight and clinical protocols, allowing the program to function within the hospital's broader healthcare jurisdiction while leveraging the operational coordination, community relationships, and referral pathways of CES. Together, the hospital and EMS system will identify patients who may benefit from proactive healthcare services, including individuals recently discharged from the hospital, those with chronic medical conditions, and patients who frequently utilize emergency services for non-emergent care. Community Paramedics will conduct scheduled home visits and follow-up services that may include chronic disease monitoring, medication reconciliation, post-discharge assessments, wound care checks, fall risk evaluations, and facilitation of telehealth consultations with healthcare providers. Patients may be referred to the program through hospital providers, emergency department staff, EMS personnel, or primary care providers, allowing for coordinated care across the healthcare system. These services will be appointment-based for non-emergent conditions to ensure that there is no impact on emergency response and resources. CES will provide space within their fire station for a MIH program vehicle, and Community Paramedics, allowing for seamless collaboration between all partners. CPH Partnership with CES will provide clinical oversight, medical direction, shared funding and equipment, referral pathways and data analytics support with the Kenai Peninsula Borough contributing grant oversight, management, compliance with service area boundaries. Upon implementation of the MIH program, residents within the CPH service area will experience improved access to timely healthcare services without the need to travel long distances for routine or follow-up care. This program is expected to increase access to in-home healthcare visits for rural patients, improve continuity of care following hospital discharge, and provide proactive monitoring for individuals with chronic medical conditions within the first 12 months. These early interventions will help patients better manage their health while connecting them more effectively with primary care and hospital services.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Kenai Peninsula Borough	Critical Emergency Medical Service Equipment Replacement	AK	The four ambulances being looked at for replacement are 16,18, 25, and 26 years old and are posing an increased cost in maintenance & repair to ensure the ambulances can remain in operation for emergency response. WES is located between two hospitals- South Peninsula Hospital in Homer & Central Peninsula Hospital in Soldotna. As such, transport times routinely are between 20 minutes and upwards of an hour one way, depending on where in the service area they initiate, contributing to accelerated wear & tear on the emergency vehicles. With all ambulances well past their useful life span, there is an increased risk for an ambulance to require removal from service for an extended period of time in order to complete repairs & maintenance. A reduced ambulance fleet creates an increased response time to critical emergency situations and decreases the department's ability to respond to emergencies within the service area or provide assistance to other departments if needed. Additionally, repair & maintenance costs are exponentially increased with aged, high-mileage vehicles, putting a strain on the department's financial resources & a potential financial impact to taxpayers.	WES intends to replace the four Type-1 ambulances that are 16, 18, 25, and 26 years old that are currently in service and have long surpassed their useful life of 10 years with modern Type-1 ambulances. WES has pursued several other funding opportunities through various grant opportunities, which have not been chosen to be funded. Funding the ambulance upgrades through grant funding is critical to the continued service and operation of WES, as replacing the aged equipment through borough funds will mean implementing a tax (mil) rate increase on property taxes within the service area boundaries, which many residents within the service area are not able to afford. Household incomes in the area range between \$36,700 - \$59,000 with approximately 8.4% to 13.3% of rural Alaskans at or below the federal poverty line, depending on their location. The April 2023 Denali Commission report on Distressed Communities, which includes employment and earnings information, specifically named the communities of Anchor Point, Nikolaevsk, Ninilchik, Happy Valley and Clam Gulch as Distressed Communities. This status is determined by comparing average income to full-time minimum wage earnings, the percent of the population making over minimum wage, and year-round and salaried employment. Additionally, the service area receives a substantial increase in summer population due to world-class sport fishing tourism, placing a significantly increased demand on emergency services. With rural fire districts funded primarily through property taxes, the increased demand in services does not provide an impactful contribution to the costs for these services which leaves increased tax levies as the only option to provide additional funding, placing the cost burden on rural Alaskan community residents. The rural communities within the service area do not have the population to support a significant increase in funding without a substantial mil rate increase. Pursuing grant funding opportunities such as the Rural Health Transformation Program to assist with the critical need to replace WES' aged ambulances prevents rural Alaskans from having to shoulder the burden of increased service demands from seasonal tourism while allowing WES to continue to provide prompt emergency response during the increased service demands of the tourist season.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Kenai Peninsula Borough	Interoperability Communication Upgrades for Eastern Kenai Peninsula Volunteer EMS Responders	AK	The volunteer departments are in need of essential radio communications equipment to replace outdated equipment that is more than 20 years old, is no longer serviced or supported by the manufacturer, experiences a high failure rate and will not be compatible with the Alaska Land Mobile Radio (ALMR) system after December 31, 2026. The VHF digital statewide communications system is used primarily on the road system and southeast Alaska, consisting of over 130 repeater sites and controllers. Partners on the system include the State of Alaska, Alaska Municipal League (Local Government - public safety), Municipality of Anchorage, Federal partners, and the Department of Defense. In 2021, ALMR began a system and equipment upgrade at repeater sites including P25 Phase II TDMA and Dynamic Dual Mode (DDM) repeaters at all the State of Alaska sites. In order to continue to operate effectively, all agencies and subscriber units on the site should have TDMA (Time-Division Multiple Access) capable equipment. This will enable “splitting” of the channels, allowing multiple access on a single channel; effectively doubling the ability of the current system. With additional communication challenges due to the area's geographic topography and limited communication towers, upgraded radio equipment can also address these existing challenges, allowing for prompt emergency response and coordination with neighboring departments.	In order to address the significant expense for these departments to upgrade their radio equipment and to ensure equipment compatibility and standardization across all eastern peninsula departments, EPHESA seeks to further the existing partnership by securing funding to purchase and provide updated radio equipment to the volunteer departments. As a Borough service area, EPHESA has already developed a relationship with a preferred vendor for radio communications equipment for public safety, allowing for a streamlined purchase process and ensuring equipment compatibility across all departments. Additionally, EPHESA has the capacity to assist with coordinating delivery and installation of the radio equipment, easing the financial and logistical burden on these 100% volunteer operated departments with extremely limited budgets. Replacing the departments' outdated radio equipment ensures continued access to emergency response without delay or service interruption for all rural Alaskans within the eastern peninsula and the communities served by these departments.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Kenai Peninsula Borough	River City Academy Behavioral Health and Workforce Integration	AK	Alaska's adolescent mental health crisis is a present emergency. The 2023 Youth Risk Behavior Survey found that 23 percent of Alaska high school students considered suicide in the past year and 19 percent attempted it, more than double the rate from a decade earlier. In rural areas, youth suicide rates are nearly double urban rates. AI/AN people are 91 percent more likely to die by suicide than the U.S. population overall. CDC research identifies school dropout as a public health issue, finding that education is one of the strongest predictors of health. Without upstream intervention, at-risk adolescents become chronic, high-cost users of behavioral health and medical systems. River City Academy is a small, mastery-based alternative school in Soldotna serving 65-100 students in grades 7 through 12 who have disengaged from every other educational option. Of its students, 94 percent carry at least one formal risk flag on the district intervention list, 31 percent have three or more simultaneous risk factors, 23 percent have IEPs, and 12 percent are Indigenous education students. Four students had suicide risk assessments this year after the school counselor position was cut in summer 2025. RCA functions as an upstream behavioral health intervention inside a school. RHTP funding would allow KPBSD to formalize this model with dedicated behavioral health and workforce staff, creating a documented, replicable approach to adolescent mental health intervention for rural Alaska.	RCA's model rests on three evidence-aligned elements that function as behavioral health interventions. First, mastery-based, non-punitive learning allows students to progress at their own pace without penalty, reducing anxiety and removing the primary trigger for students whose trauma or mental health challenges cause them to shut down in traditional graded environments. Second, mentoring and goal-setting are embedded in every school day, with each student assigned a teacher-mentor and engaged in weekly goal review tied to life planning, providing scaffolding that clinical intervention alone cannot offer for students experiencing depression or executive dysfunction. Third, the school's small size of 65-100 students with the same teachers year to year creates the belonging, safety, and known relationships that research identifies as protective factors against disengagement, and that for students with social anxiety, trauma histories, or histories of bullying represent a clinical need rather than a preference. RCA also provides structured independent living and workforce development through career courses, job shadows, personal finance, community service, and student-led enterprises. The Statewide Independent Living Council of Alaska delivers Pre-Employment Transition Services at RCA including youth leadership training, person-centered planning, and First Aid and CPR certification under a formal memorandum of agreement. RHTP funding would add two full-time positions. A Behavioral Health Coordinator would bridge the school and the broader health system, provide direct support for students with documented mental health needs, and coordinate with community providers. This position was cut from RCA in summer 2025, leaving four students with suicide risk assessments this year without consistent mental health access. A Rural Health Workforce Development Coordinator would formalize the existing career and independent living curriculum into intentional health-sector pathways including community health worker certification, elder care, medical administration, and health-supporting trades, building a workforce pipeline from the peninsula's most at-risk adolescent population into its most acute health workforce shortage. A program evaluation framework would document behavioral health indicators, educational engagement, and post-secondary outcomes to demonstrate impact and support replication at other rural Alaska schools.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Kenai Peninsula Homeless Coalition INC	Kenia Peninsula Homelessness Coalition/Shelters of Hope Community Resource Campus	AK	Many of Kenai Peninsula's residents are facing barriers that prevent them from accessing appropriate care. Housing instability, food insecurity, limited transportation, and financial hardship create challenges for individuals already navigating medical and/or behavioral health needs. In rural communities, these barriers are compounded by long travel distances and services spread across multiple agencies and locations. As a result, residents frequently must navigate several organizations just to meet basic needs before they can effectively engage in healthcare. This project represents an important planning and development phase focused on creating a more coordinated approach to these challenges. The coalition will work with community partners to plan a centralized community resource hub that improves access to services supporting health and stability. Planning efforts will focus on strengthening partnerships, identifying service gaps, and developing the operational model for a shared space where multiple providers can work alongside one another. When housing, food, or transportation needs go unmet, people cannot prioritize their health—they are focused on survival. This planning effort will lay the groundwork for a centralized entry point where residents can access housing assistance, food resources, transportation coordination, and connections to healthcare and behavioral health services in one location, improving service navigation and collaboration across providers.	Communities across the Kenai Peninsula have long recognized the need for stronger collaboration among organizations addressing the social determinants of health. While the region benefits from dedicated nonprofits, health providers, and community agencies, services are spread across a large and geographically rural area. Residents experiencing housing instability, food insecurity, transportation barriers, or behavioral health challenges often must navigate multiple systems and travel significant distances to access support. This fragmented structure can delay care and contributes to preventable crises that place additional strain on rural health systems. For many years, Love INC of the Kenai Peninsula has served as a key entry point for residents seeking assistance with housing, utilities, food access, and other essential needs, including programs supported by the Alaska Housing Finance Corporation. As demand for services grows, community partners have identified the need for a more integrated and coordinated model of service delivery. This project proposes establishing a collaborative community resource hub in Soldotna where partner organizations can work alongside one another to improve access to the ten vital services identified by 100% Communities, including food, housing, medical and behavioral health care, transportation, parent supports, education, job training, and youth mentorship. The hub will strengthen care navigation and upstream prevention by allowing residents to access multiple services in one location. The space will support job searches, workforce readiness and GED classes, and provide hygiene resources such as showers and laundry—key supports for individuals seeking employment or housing stability. Designed around a welcoming “living room” model, the hub will also provide a neutral, relationship-centered space where mobile crisis peer support staff can meet with individuals for follow-up engagement and early intervention. By strengthening collaboration among community partners and reducing barriers to essential services, this project improves rural health access, supports prevention-focused care, and builds a more sustainable community-based support system for Kenai Peninsula residents.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Kenai Senior Services - City of Kenai	Enhancing Access and Communication for Rural Senior Services	AK	The current automatic door system at the main entrance has aged and requires frequent maintenance. In addition, several interior areas of the facility would benefit from improved accessibility to allow individuals with mobility limitations to move safely and independently throughout the building. Improving accessibility within the facility will help ensure that seniors can consistently participate in nutrition programs, wellness activities, and other services that promote health and reduce isolation. The Senior Center also operates transportation and meal delivery services throughout the community. Reliable communication between drivers and the center is essential for coordinating routes, responding to changing conditions, and ensuring staff safety while serving rural residents. The Center’s current radios operate on the Alaska Land Mobile Radio system and will become obsolete under new requirements that mandate the removal of non-TDMA radios by December 2026. This project will address these challenges by improving accessibility within the facility and implementing a reliable communication system for staff delivering services throughout the community.	The Kenai Senior Center will address these challenges by improving accessibility throughout the facility and strengthening communication systems that support the delivery of services to rural older adults. The project will replace and upgrade key entryway doors with automatic door openers and improve accessibility at selected interior passageways within the Senior Center. Accessible doorways will be installed at critical locations, including restrooms, the library, and the game room. These improvements will allow individuals using walkers, wheelchairs, or other mobility aids to enter and navigate the building more safely and independently. By reducing physical barriers, these upgrades will help ensure that seniors can consistently participate in congregate meals, wellness activities such as exercise classes, educational opportunities in the library, and social programs in the game room that reduce isolation and support healthy aging. Enhanced accessibility also promotes dignity, independence, and comfort for all participants while encouraging engagement in services that prevent health decline. In addition, the project will provide Rapid Radios for staff operating transportation and meal delivery services. These devices allow instant, reliable communication between drivers and the center without complex programming or licensing. Improved communication will support coordination of routes, allow staff to respond quickly to changes in weather or client needs, and ensure the safety of both staff and clients while traveling throughout rural areas with limited cellular coverage. With the December 2026 ALMR system changes requiring replacement of the Center’s existing radios, Rapid Radios provide a sustainable, cost-effective solution for maintaining essential communication capabilities. Together, these improvements will strengthen the Kenai Senior Center’s capacity to serve rural Alaskans by improving accessibility, increasing participation in health-supporting programs, and ensuring reliable communication for outreach services. By addressing both physical and operational barriers, the project will promote consistent, safe access to programs that enhance health, independence, and quality of life for rural older adults, while supporting the sustainability and effectiveness of essential services across the community.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Kenaitze Indian Tribe	Kenaitze Indian Tribe's Recovery and Transitional Housing Planning Project	AK	Kenaitze is exploring the development of a recovery-oriented housing program to support individuals transitioning from substance use disorder treatment into stable community living. On the Kenai Peninsula, many individuals who complete treatment or detoxification return to environments that lack stability, structure, and recovery support, increasing the risk of relapse and disconnection from ongoing behavioral health services. At the same time, rural geography and limited transportation create additional barriers to maintaining engagement in care. While the Tribe provides a strong continuum of behavioral health services, including mental health and substance use disorder treatment, a gap remains between treatment and long-term recovery. Recovery-supportive housing could help bridge this gap by providing a structured living environment that supports continued participation in treatment, peer recovery support, and culturally grounded wellness practices. By providing a structured environment that supports engagement in care, recovery housing can reduce relapse, decrease avoidable emergency service utilization, and lower the likelihood of involvement in the criminal justice system.	Kenaitze proposes a structured planning process to determine the most appropriate strategy for developing recovery-oriented housing that supports individuals transitioning from substance use disorder treatment into stable community living. The project will focus on three primary areas of planning: community needs assessment, housing model evaluation, and facility feasibility analysis. First, the project will conduct a community needs assessment to better understand the scope and characteristics of recovery housing needs of Alaska Natives on the Peninsula. This work will include analysis of behavioral health service data, consultation with Tribal behavioral health staff, and engagement with community partners involved in treatment, recovery support, and housing services. The goal is to identify gaps in the current continuum of care and determine the types of housing supports most needed for individuals in recovery. Second, the planning process will evaluate a range of recovery housing models to determine which approach best aligns with community need and the Tribe’s behavioral health system. This analysis will include transitional housing, supportive housing, and recovery residence models such as those aligned with National Alliance for Recovery Residences standards. Considerations will include population served, expected length of stay, staffing requirements, service expectations, and integration with behavioral health services. Third, the project will assess potential facilities that could support a recovery housing program. This will include an evaluation of Tribal properties or locations within the community that may be more suitable. The feasibility assessment will examine building configuration, safety considerations, infrastructure needs, transportation access, and operational requirements. Throughout this process, the Tribe will coordinate across all relevant Departments including Behavioral Health, Wellness, Primary Care, Facilities, and Transportation to ensure that planning reflects Tribal priorities and operational realities. The project will also develop preliminary operational frameworks, policies, and sustainability strategies needed for future implementation. The result of these efforts will be a clear recommendation regarding the most appropriate housing model, location, and operational design for a Tribal recovery housing program that strengthens the continuum of behavioral health care and supports long-term recovery in the community.	\$50,000-\$250,000	Clinic	Other	Kenai Peninsula Borough	Advance to Planning

Kenaitze Indian Tribe	Kenaitze Indian Tribe's Dena'ina Wellness Village Concept	AK	Kenaitze has operated the Dena'ina Wellness Center, an Indian Health Service facility, for nearly 30 years and in 2025 opened the local Tuten charter school designed to serve kindergarten through sixth grade. While both of these facilities provide quality services, the Tribe still faces challenges implementing a traditional land-based operational approach including traditional healing services and educational services that utilize traditional healthy living models as their service model. One obstacle is that our current traditional healing integration models fall short because they try to fit traditional healing into Western medicine frameworks instead of rethinking the western model of care from the perspective of indigenous healing priorities and methodologies. The result is traditional healing is underutilized and not well understood by Western medical practitioners. The same situation is felt by our students who experience adverse health effects due to Western education approaches. Our traditional education model is centered around healthy activity, foods, and mental and behavioral health supports. The Dena'ina Wellness Village planning project will help outline the practical steps to create the long-term infrastructure to support these models while addressing the need for locally trained in-house certified practitioners and Tribal educators with well vetted tools who can encourage healthy children and families through our educational programming.	Our approach is to develop a no-nonsense, locally viable plan that takes into consideration the strengths and weaknesses of our current services and community capacity and will set a clear direction for how to increase access to active healthy living opportunities for our community. The plan will articulate how to develop the Dena'ina Wellness Village concept, which can grow and expand with the tribe as community needs shift over time. The planning process will use a multi-phased approach to frame the risk factors, feasibility considerations, and community need. Tribal traditional healers and culture and language educator experts will provide the main development concepts the plan needs to consider for operations, necessary facilities, training program development, and how to implement this plan progressively across related tribal programs. The project will cover campus planning activities such as surveying for land selection needs and architectural design to include: traditional healer practitioner spaces, outdoor education spaces for participants of all ages, and building or expanding on gym and fitness facilities. The planning group will develop a master plan that is ready to be implemented in various stages. Programming planning will follow a similar method with scope and sequence feasibility implementation benchmarks. These benchmarks will be created through community needs assessments, reviewing organizational charts and assessing staffing needs, collaboration across Kenaitze Departments including Health Systems, Culture and Language, Education, and Na'ini Social Services, and developing a Traditional Healer Working Group that would ideally extend beyond Kenaitze to include other Tribes throughout the State. The plan will consider education opportunities for western medicine providers to learn about and understand traditional healing and assessments to better grasp the qualifications or accreditations needed for a traditional healer to be able to move towards billable services, and would also review additional educational supports, including building out high school career pathway development partnerships with healthcare, career technical education, and other future workforce development needs.	\$1M-\$5M	Clinic	Other	Kenai Peninsula Borough	Deferred or Not Advanced

Kenaitze Indian Tribe	Kenaitze Indian Tribe's Naqut'ana Correspondence Support Program	AK	AN/AI correspondence students, particularly those connected to the traditions of the Dena’ina people, face a unique intersection of geographic isolation, limited culturally grounded programming, and reduced access to integrated academic and wellness supports. While correspondence education offers flexibility and autonomy, it can also unintentionally deepen disparities when culturally responsive systems of support are not intentionally built around students and families. Geographic isolation limits access to activities, tutoring, and mental health supports, often delaying identification of mental health needs. For youth experiencing intergenerational trauma, limited access to consistent peer and adult connection increases the risk of anxiety, depression, educational disengagement, substance misuse, and school non-completion. Additionally, most academic models prioritize Western frameworks over Indigenous ways of knowing. This disconnect can weaken cultural identity, which research consistently identifies as a protective factor for Indigenous youth. While these challenges are real, correspondence education also presents a powerful opportunity to integrate a culturally immersive, strengths-based model by embedding social-emotional skill development; physical wellness activities; academic tutoring; and cultural mentorship- all of which strengthen protective factors strongly associated with reduced behavioral health risk and improved long-term outcomes for Alaska Native youth.	To address the identified gaps for AN/AI correspondence students, the proposed approach is to create a structured, culturally grounded enrichment and support model that integrates Dena’ina cultural immersion, place-based physical activity, academic intervention, and social-emotional development into a coordinated system of care. Grounded in the traditions and values of the Dena’ina people, this model centers identity, belonging, and community connection as core drivers of academic and health outcomes. Core components include cultural immersion and identity development, structured social-emotional skill building; outdoor physical activity and wellness promotion; academic support and graduation pathway planning; and integrated community partnerships. These components will be delivered through a three-tiered model— universal, targeted, and intensive supports—ensuring all students receive prevention services while those with greater needs receive additional intervention. This model addresses the root causes of disparity rather than only responding to the symptoms. Ultimately, the Naqut’ana Correspondence Support Program will strengthen protective factors; integrate culture as prevention; reduce isolation; improve academic outcomes; and build community-connected systems. For AN/AI correspondence students, the solution is not simply more services, it is coordinated, culturally grounded, relationship-based support that integrates identity, education, and wellness into one cohesive model.	\$50,000-\$250,000	Clinic	Other	Kenai Peninsula Borough	Deferred or Not Advanced

Kenaitze Indian Tribe	Kenaitze Indian Tribe's Prescription Produce Project	AK	In 2025, the State of Alaska Department of Labor reported that overall price levels of major spending categories— including food, housing, transportation, education, and medical care— have increased by 18 percent since 2020. This sharp rise in costs is placing significant strain on household budgets, weakening food security for many families and increasing reliance on community resources, including food banks, many of which are operating beyond capacity. The burden is especially severe in rural communities where fresh produce and quality proteins are disproportionately expensive and often difficult to access. As a result, many Alaskans are forced to alter their spending habits, often turning to cheaper, ultra-processed foods that contribute to poor long-term health outcomes. It’s estimated that 49% of Alaskan households with children and 35% of households with elders receive SNAP, while more than 8,000 state households receive WIC benefits. While some local farms accept SNAP benefits and the WIC Farmers Market Nutrition Program provides \$45 of electronic food benefits to be used at farmers Markets across the state, the majority of these venders are seasonal, operating June- September, severely limiting access to fresh produce for Alaska’s most vulnerable populations. The proposed project will address food insecurity by planning for the implementation of a produce prescription program and the development of additional infrastructure to support this programming.	Numerous studies have shown associations between food insecurity and poor health outcomes, including hypertension, hyperlipidemia, and diabetes. Often, household responses to food insecurity include reductions in quality food consumption, such as lean proteins and fresh produce, instead relying upon ultra-processed foods (UPFs) which are frequently more accessible and less expensive. Emerging research outlined in the Make America Healthy Again (MAHA) report shows correlations between high levels of consumption of these foods and poor health outcomes including cardiovascular disease, diabetes, hypertension, and obesity. In an effort to address food insecurity and reduce chronic disease among Alaska Native and American Indian (AN/AI) community members throughout the Kenai Peninsula, Kenaitze will undergo extensive planning and research to implement a produce prescription program at the Tribe’s Food Security Campus (FSC), which will include the development of an additional year-round hydroponic unit and a mobile chicken coop. The phased project activities will consist of examining best practices for flock management in the south central region; conducting a community needs assessment for eggs and poultry needs; completing a cost/benefit analysis; undergoing a land survey at the Tribe’s Food Sovereignty Campus (FSC); hiring a hydroponics/greenhouse consultant; completing utility assessments and installation; Developing appropriate procurement and financial policies and procedures; completing a community market analysis for pricing produce; Developing a culturally relevant community education program curriculum; establishing a Tribal food sovereignty working group; participating in local Food Connection group; and collaborating with the ANTHC Tribal Food Sovereignty Network.	\$50,000-\$250,000	Clinic	Other	Kenai Peninsula Borough	Deferred or Not Advanced

Ketchikan Agricultural Producers Association	Ketchikan Shared-Use Kitchen: Community Food Access and Nutrition Hub	AK	Ketchikan faces a significant gap in community food infrastructure. Despite strong local interest in food production and preservation — and a documented need for commercial kitchen access among small food businesses, cottage food producers, and community members — no shared-use commercial kitchen facility currently exists in the region. This gap has real health consequences. Ketchikan is a rural, road-isolated community where fresh, nutritious food is expensive and often scarce. Residents — particularly Alaska Native peoples, elders, and low-income families — rely heavily on imported processed foods, contributing to elevated rates of chronic disease including diabetes, heart disease, and obesity. At the same time, significant community interest exists in producing and preserving local foods: wild-harvested seafood, foraged foods, and value-added products. Without access to a compliant commercial kitchen, this interest cannot be translated into action at scale. A vacant commercial bakery facility in Ketchikan represents an immediate opportunity to address this gap — activating existing infrastructure as a shared-use kitchen and food education hub to expand local food access, support nutrition education, and build long-term community food resilience.	KAPA proposes to lease and renovate a vacant commercial bakery facility in Ketchikan to establish a shared-use kitchen and community food hub. The facility would serve as accessible, affordable, DEC-compliant commercial kitchen space available to community members, small food businesses, and nonprofit food programs on a scheduled-use basis. The project will be implemented in two connected phases: Phase 1 — Facility Activation: KAPA will secure a lease on the existing facility, assess renovation needs, and complete improvements necessary to bring the space into full DEC compliance for shared commercial use. The renovation will leverage existing infrastructure — ovens, prep surfaces, ventilation — to minimize costs and construction complexity. Phase 2 — Programming and Operations: Once operational, the facility will support: - Shared-use kitchen access for cottage food producers, small food businesses, and community members seeking to produce and preserve local foods - Nutrition education and food preservation workshops focused on wild-harvested seafood, foraged foods, and traditional Alaska food practices - Food business development support through KAPA's Technical Assistance Program, including certification training, business basics, and one-on-one consulting - Partnerships with Alaska Native organizations, the Ketchikan Indian Community, local schools, and senior programs to deliver targeted programming for priority populations KAPA brings existing organizational infrastructure, established funder relationships, and a documented pipeline of community interest to this project. The shared-use kitchen will also generate real-world demand data to inform the development of a larger regional food hub facility currently in planning, providing a low-risk proof of concept for community food infrastructure investment in Southeast Alaska.	\$250K-\$1M	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

Ketchikan Gateway Borough	Ketchikan Gateway Borough Recreation Center Expansion	AK	The Ketchikan Gateway Borough proposes to use RHTP planning funds to advance the design and programmatic offerings for a planned expansion of the Gateway Recreation Center, positioning the facility as a cornerstone of community based preventative wellness. Planning funds would support completion of architectural and engineering design work while also retaining a specialized consultant to evaluate how expanded space and facilities could be intentionally programmed to improve rural health outcomes. This analysis would focus on increasing access to preventative wellness services, evidence based fitness and aquatics programming, rehabilitation and injury prevention activities, and inclusive offerings for seniors, low income residents, and individuals with chronic health conditions. The planning effort would also assess opportunities to scale the Borough’s summer camp and youth programming, which provides reliable childcare during non school months and enables parents—particularly those working in healthcare and other essential services—to remain in the workforce. Together, these planning activities will ensure that the Recreation Center expansion is purpose built to function as an integrated, non clinical preventative care asset that aligns with RHTP goals of improving access, population health, and system sustainability in a rural community.	The Ketchikan Gateway Borough’s approach to this RHTP planning effort is to intentionally link facility expansion planning with rural health transformation outcomes. The Borough will pursue a coordinated planning process that integrates architectural and engineering design with programmatic and operational analysis to ensure the expanded Recreation Center is purpose built to function as a preventative health asset. Planning funds will be used to advance design work for a planned facility expansion while engaging a qualified consultant with expertise in community health, recreation based wellness, and rural service delivery. The consultant will work in collaboration with Borough staff, healthcare providers, and community stakeholders to evaluate how expanded space, equipment, and layout could support increased access to evidence based wellness programming, chronic disease prevention, rehabilitation, and inclusive activities for priority populations such as seniors, low income residents, and individuals with limited access to non clinical health services. The planning process will also assess operational models, staffing needs, partnerships, and phased implementation strategies that align with RHTP goals. The outcome will be a shovel ready design and a clearly defined programmatic roadmap that positions the Recreation Center expansion as a scalable, sustainable, and community based solution for improving rural health outcomes.	\$250K-\$1M	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

Ketchikan Gateway Borough School District	Strengthening Community: A Scalable Systemic Model for Rural School-Based Resilience	AK	The Problem: Ketchikan youth face a mental health crisis exacerbated by isolation. Historically, our District relied on a few grant-funded specialists. A 66% reduction in our clinical staff—driven by housing and recruitment barriers—created a critical bottleneck. Needs significantly outpace capacity, leaving high-risk youth on months-long waitlists for overextended community providers. This specialist-dependent model is no longer a viable or safe front line of care. The Opportunity: We will strengthen the local health system by transforming the District into a Universal Tier 1 Health Hub, initiating fundamental care delivery transformation. Our approach drives long-term system-level change by: Workforce Transformation: Shifting from clinical dependency by equipping 200+ permanent staff with mental health literacy for universal prevention and early intervention. Clinical Realignment: Repositioning social workers to focus on high-acuity Tier 3 interventions and systemic consultation, rather than basic triage. Integrated Access: Leveraging the District’s unique position to address Social Determinants of Health, acting as the primary “No Wrong Door” entry for rural health needs. This project converts a staffing crisis into sustainable, community-wide resilience infrastructure designed for Alaska’s unique rural context.	The Multi-Tiered Transformation: Our approach shifts the burden of behavioral health from a shrinking pool of clinical specialists to a district-wide "Resilience Infrastructure." We will implement a three-pillar strategy: 1. Workforce Multiplication (Tier 1 & 2): Instead of the school social worker being the primary point of contact, we will transform our 200+ educators and support staff into a trained "front line." a) Mental Health Literacy: All staff will receive evidence-based training in early intervention, trauma-informed response, and mandated reporting. b) Universal Screening: We will move away from fee-heavy software (such as BIMAS) to a sustainable, staff-led Tier 1 model, identifying student needs before they escalate into clinical crises. c) Direct Support: Educators will be equipped to manage low-acuity behavioral needs in the classroom, preserving specialized clinical time for those in greatest need. 2. Specialized Clinical Excellence (Tier 3): By offloading Tier 1 & 2 tasks to trained staff, our licensed school social workers will transition into "High-Acuity Specialists" and "Clinical Consultants." a) Evidence-Based Interventions: Clinicians will be trained in and deploy high-fidelity interventions including CBT-SP (Cognitive Behavioral Therapy for Suicide Prevention) and DBT (Dialectical Behavior Therapy). b) Clinical Consultation: Social workers will provide "curbside" consultation to teachers, creating a continuous feedback loop that improves the quality of care throughout the school. 3. Technology-Driven Early Warning & Coordination: We will integrate modern technology to bridge the "rural distance" and response-time gaps. Some potential tools might be: a) AI Surveillance: Utilizing tools like Gaggle to monitor school-based digital platforms for indicators of self-harm or ideation, enabling near-instant intervention. b) Data Integration: Using PowerSchool alongside some custom-built data tools (such as our MTSS referral system) to track intervention outcomes and identify community-wide trends. c) No Wrong Door Referrals: Formalizing "warm hand-off" protocols with KIC Behavioral Health, Community Connections, and the Ketchikan Wellness Coalition (KWC) to address Social Determinants of Health (SDOH) such as housing, vision, and food security. These strategies transform the school from a place that simply "hosts" a counselor into a comprehensive community health hub that is resilient to individual staffing vacancies.	\$250K-\$1M	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

Ketchikan Indian Community	Realizing Health Through Partnership (RHTP) – KIC’s Salmon Falls Healing Center	AK	KIC has a real opportunity through the Rural Health Transformation Program to transform how behavioral health and addiction recovery are delivered in rural Alaska. For too long, individuals seeking treatment have been forced to travel far from home, or even leave the state, separating them from the families, culture, and communities that support lasting recovery. For thousands of years, Alaskan communities sustained health and wellness through connection to culture, land, and relationships. KIC’s Salmon Falls Healing Center offers an opportunity to restore these pathways to healing within a modern system of care. KIC is transforming Salmon Falls into a regional Healing and Wellness Campus that integrates residential recovery services, behavioral health care, peer support, and culturally grounded healing practices. Rooted in Alaska Native values, Salmon Falls will incorporate traditional activities, cultural teachings, elder guidance, and sober living to support whole-person healing. By bringing treatment closer to home and integrating Indigenous knowledge with coordinated healthcare services, Salmon Falls will strengthen recovery outcomes while expanding access for rural and remote communities. Salmon Falls represents more than a treatment program: it is a model for how Alaska can build healthier systems of care grounded in culture, community, and resilience. Our goal is not simply to create another program, but to help transform how healing happens across Alaska.	Ketchikan Indian Community’s approach to the Salmon Falls Healing Center is grounded in the understanding that lasting recovery requires more than treatment alone—it requires restoring connection to culture, community, and purpose while strengthening the systems that support health. Salmon Falls will be delivered as a coordinated recovery campus where residential treatment, behavioral health care, cultural healing, and workforce development operate together within KIC’s broader ecosystem of care. At Salmon Falls, individuals will receive residential recovery services integrated with KIC’s outpatient behavioral health programs, medical care, case management, and peer recovery navigation. This coordinated approach allows participants to move seamlessly between levels of care while remaining connected to family and community supports. By emphasizing early stabilization, continuity of care, and long-term recovery planning, the model reduces reliance on crisis-driven responses and supports lasting recovery. Cultural knowledge and Indigenous healing practices will be central to program delivery. Participants will engage in traditional activities, cultural teachings, Alaska Native foods, peer mentorship, and guidance from elders and culture bearers. These practices help restore identity, belonging, and connection to the lands and waters that sustain Alaska Native communities, addressing the deeper drivers of addiction including trauma, disconnection, and loss of cultural continuity. Salmon Falls will also serve as a workforce development hub for rural Alaska. KIC will prioritize local hiring and develop training pathways for Peer Support Specialists, Behavioral Health Aides, and Community Health Aides. Participants advancing in recovery will have opportunities to pursue workforce training and employment, strengthening the behavioral health workforce while creating pathways for individuals with lived experience to support others in their healing journey. Evaluation will begin in Year 1 through partnership with an Indigenous evaluator who will develop culturally relevant measures tracking recovery stability, improved coordination of care, workforce outcomes, and reductions in crisis utilization. Through this integrated approach, Salmon Falls will demonstrate how culturally grounded healing, coordinated healthcare, and workforce development can be delivered together to strengthen recovery systems and improve long-term health outcomes for Alaska communities.	\$1M-\$5M	Clinic	Statewide	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Advance to Implementation Application

Ketchikan Indian Community	Regional Health Talent Pathways (RHTP) -- Ketchikan's Health Workforce Development Program	AK	Southeast Alaska faces a growing healthcare leadership and workforce development crisis. KIC and PeaceHealth collectively employ 500+ people and together form the primary healthcare delivery infrastructure for the greater Ketchikan region—an island community accessible only by air or sea. Both organizations face persistent difficulty recruiting and retaining qualified medical providers and managers, particularly individuals from Alaska. When leadership vacancies occur, they often remain open for months due to Ketchikan’s geographic isolation and limited local talent pool. Recruiting from outside Alaska is costly and uncertain, and many external hires leave within a few years. At the same time, tribal citizens promoted from frontline roles into management frequently receive little structured preparation, contributing to burnout, turnover, and operational disruption. No dedicated healthcare leadership development program currently exists in Ketchikan or Southeast Alaska to prepare local talent for management and executive roles. This gap directly affects the approximately 13K residents of the Ketchikan Gateway Borough and surrounding communities who rely on KIC and PeaceHealth for care. KIC has a unique opportunity to address this challenge by developing the next generation of healthcare leaders locally, building a sustainable workforce that can support the region’s growing healthcare system for years to come.	The Ketchikan Health Workforce Development Program is designed as a five-year leadership and workforce initiative to support the rapid expansion of healthcare services in Ketchikan and across Southeast Alaska. Ketchikan Indian Community (KIC) and PeaceHealth Ketchikan Medical Center maintain a strong collaborative relationship and together employ more than 500 healthcare workers who form the backbone of healthcare delivery in this rural island community. To strengthen this system, the program will recruit up to 12 participants annually (six at each organization), preparing 60+ healthcare leaders over five years. Participants will include Alaska Native and American Indian individuals, non-Native residents, and individuals with disabilities seeking meaningful career pathways in healthcare. Through paid Management Associate positions, leadership training, and structured rotations across KIC and PeaceHealth departments, participants will gain the experience necessary to advance into supervisory and management roles within the regional healthcare system. This program ensures that the healthcare transformation already underway in Ketchikan is supported by a stable and locally rooted workforce. Over the next several years, KIC is expanding services through initiatives such as the Salmon Falls Healing Center, the Rural Family Health Access Center, and KIC’s clinic expansion and transition toward Federally Qualified Health Center (FQHC) readiness. As these programs grow, the need for trained supervisors, program managers, and operational leaders will increase significantly. By building a sustained leadership pipeline over five years, the program will help ensure these roles are filled by individuals from the region who understand the needs of rural communities. The ripple effect of this investment will extend far beyond the program participants themselves. Healthcare managers typically oversee teams of 10–20 staff members, meaning that 60 trained leaders could collectively support and guide 600–1,200 healthcare workers over time. As leadership capacity expands, so does the system’s ability to improve care coordination, strengthen workforce stability, and expand access to culturally responsive healthcare services. In this way, the program will help ensure that the healthcare transformation underway in Ketchikan translates into lasting improvements in health outcomes for rural communities across Southeast Alaska.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Advance to Implementation Application

Ketchikan Indian Community	Regional Health Transformation Project (RHTP) -- KIC's Clinic Expansion & FQHC Readiness Initiative	AK	KIC's Clinic Expansion & FQHC Readiness Initiative will serve as the clinical hub connecting KIC's broader health transformation efforts, including the Salmon Falls Healing Center (residential recovery), the Rural Family Health Access Center (trauma-informed entry point for families), and the Regional Health Talent Pathways workforce program. The expanded clinic will also support aging in place by strengthening access to elder home care services that allow elders to remain safely in their homes while receiving coordinated medical, behavioral health, and supportive services. Investments in care team capacity, quality systems, data infrastructure, and access-enabling services—including care coordination, eligibility support, transportation assistance, and culturally responsive outreach—will expand same-day and next-day access, strengthen continuity of care, and reduce avoidable emergency department utilization. These services align with Alaska's Section 1115 Medicaid waiver, which emphasizes integrated behavioral health and community-based care. KIC is also exploring enhancements to strengthen access and diagnostic capacity, including urgent care services, on-site imaging, expanded telehealth, and patient self-service kiosks. Together, these improvements advance KIC's readiness to serve as the region's future FQHC while strengthening a coordinated system of care that supports recovery, family stability, and healthy aging in Southeast Alaska.	KIC will implement our clinic expansion and FQHC readiness through four operational workstreams: 1) Access & Capacity. KIC will expand team-based primary care by integrating care coordinators, CHAP/BHAs, peer navigators, and panel management support to improve patient flow and continuity of care. Advanced access scheduling will support same-day and next-day appointments, while proactive outreach will prioritize high-risk patients and those transitioning from the Salmon Falls Healing Center and the Rural Family Health Access Center. Standardized care pathways (SUD/ODU, diabetes, maternal/child health) will incorporate culturally responsive elements including elder guidance, traditional healing, and traditional foods. 2) Quality, Safety & Data. KIC will implement a clinic-wide quality system aligned with FQHC expectations, including UDS-style reporting, clinical dashboards, and monitoring of key indicators such as HbA1c control, blood pressure control, depression screening, and SUD/ODU engagement. Closed-loop referrals with PeaceHealth and regional partners will strengthen coordination, while warm handoffs and care gap registries improve continuity and preventive care. 3) Enabling Services & Equity. KIC will expand enabling services that reduce barriers for rural patients, including benefits enrollment, transportation support, care navigation, culturally grounded education, and traditional healing. Stronger linkages with housing, food access, employment, and legal supports will ensure care plans reflect the realities of rural families. 4) Financial Sustainability & Readiness. KIC will advance FQHC readiness through revenue cycle improvements, payer enrollment, compliance systems, and documentation aligned with federal standards. A staffing model aligned with patient demand and a diversified payer strategy—including Medicaid, private insurance, 105(l) lease reimbursement, and grants—will sustain expanded services while the Regional Health Talent Pathways program strengthens the workforce pipeline. KIC is evaluating several enhancements as part of the expansion, including include developing urgent care capacity for same-day needs, integrating on-site imaging, expanding telehealth to improve, and implementing patient self-service kiosks to streamline intake, screenings, eligibility verification, and patient flow. Together, these improvements support efficient team-based care and align with FQHC standards for accessible and equitable healthcare delivery.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Advance to Implementation Application

Ketchikan Indian Community	Rural Health Trauma Prevention (RHTP) -- KIC's Rural Family Health Access Center	AK	KIC recognizes we cannot continue doing the same things and expect different results. Across rural Alaska, trauma and adverse experiences are major drivers of long-term health challenges, including behavioral health conditions, substance use, chronic disease, and family instability. Yet individuals and families experiencing trauma often face significant barriers when seeking care. Geographic isolation, limited providers, and fragmented systems make it difficult to access coordinated support, often forcing families to navigate multiple agencies for medical care, behavioral health services, youth support, and social services while repeating their experiences and missing opportunities for prevention and early intervention. We need a new approach that transforms how rural communities respond to trauma by centering healthcare and weaving supportive services around it. KIC proposes to establish a Rural Family Health Access Center to focus on prevention, trauma recovery, and family stability by creating a coordinated access point where individuals and families can connect to behavioral health services, medical referrals, youth programming, and wraparound supports. No coordinated model like this currently exists in Alaska. By bringing healthcare, prevention, and community partnerships together, the Center will reduce barriers to care, improve provider coordination, and strengthen early intervention, ensuring care is organized around health, healing, and long-term community wellbeing.	KIC's approach is rooted in the understanding that if we want different results, we must take different actions. For too long, individuals and families experiencing trauma have been asked to navigate fragmented systems that treat a single issue or one person at a time. KIC believes meaningful change requires meeting people where they are, operationalizing our community values, and centering healthcare while recognizing that healing must support the entire family. While many models describe “wraparound services,” healthcare is often only one component. At KIC, wraparound services are already integrated across our tribal programs. KIC provides healthcare, behavioral health services, housing support, social services, cultural education, and family programming within one tribal system. The Rural Family Health Access Center builds on this foundation by coordinating these services more intentionally and creating a single access point where families can connect to care. The Center will serve as a coordinated entry point where individuals and families can access behavioral health services, medical referrals, youth programming, and supportive services in one place. Rather than expecting families to navigate multiple agencies and locations, the Center will wrap services around individuals and families by strengthening collaboration among healthcare providers, behavioral health professionals, housing services, social service programs, and community partners. Prevention and early intervention are central to this approach. Modeled in part after the nationally recognized Family Justice Center framework, the Center will emphasize resilience, trauma recovery, and family stability, particularly for children and youth who have experienced adversity. By investing in prevention and family-centered support, KIC aims to interrupt cycles of trauma before they escalate into more serious health challenges. Grounded in Alaska Native values of family, respect, and community wellbeing, this model shifts the burden of navigating services away from families and onto systems of care, ensuring individuals and families can access coordinated support through a single, trusted entry point. KIC is also incorporating workforce and economic development into the approach, such as an Alaska Native artist market, gift shop, or cafe on the first floor of the 306 Building, creating community opportunity while strengthening the long-term sustainability of the center.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

Ketchikan Wellness Coalition	Malasakit Matters: Filipino Health Access Improvement Project	AK	“You’re the doctor.” “You know what’s best, I trust you”. In many Filipino households, particularly those shaped by the cultural value of pakikisama, prioritizing harmony, respect, and group cohesion, health-related decisions are often met with respectful silence or a reluctance to question authority figures. While this can promote social peace, it can discourage open dialogue, limit self-advocacy, and create barriers to culturally responsive care, especially in under-resourced or remote communities. In rural Southeast Alaska, Filipino communities in towns like Ketchikan Gateway Borough and Prince of Wales Island are navigating these cultural dynamics alongside barriers of isolation, underinvestment, and limited access to culturally competent care.	The project evolves the clinical dynamic by engaging youth and storytelling to promote health, wellness, and empowerment. KWC will expand a community health worker (CHW) network that places trained CHWs in a local high school, local hospitals, and public health organizations to serve as trusted cross-generational liaisons. Simultaneously, we will launch a youth-led storytelling initiative that equips Filipino youth to advocate for the health and wellness of their elders. Through interviews, music, dance, and digital storytelling, youth will collect and share narratives that reflect their community’s lived experiences. They will serve as tools for building trust, advancing wellness, and rebalancing power in health communication. Our project is grounded in the hypothesis that activating youth as cultural health advocates can interrupt generational cycles of silence, increase system trust, and generate new pathways for community-defined health knowledge. This project will extend shared resources, knowledge, and outreach strategies throughout KGB and Prince of Wales Island and the surrounding communities. In doing so, we build a regional network of cultural health advocacy, connecting voices, experiences, and solutions across island boundaries. Our goals are threefold 1.Advance intergenerational health equity by training youth to serve as community health storytellers, shifting internal narratives, and strengthening both youth and elders’ confidence to speak openly about health. 2.Expand the CHW workforce in Ketchikan with two new positions embedded in community institutions, schools, and hospitals while serving as a regional hub for outreach to outlying communities. 3.Create a Southeast Alaska community health storytelling archive featuring personal and collective narratives that can inform future health education, clinical interactions, and community dialogue. By combining CHWs with culturally resonant storytelling, this project aims to prototype a future model of rural and island health leadership, one that challenges who holds knowledge, how care is communicated, and what it means to be a health expert within one’s own family and culture. Youth are not just beneficiaries of health education but active co-creators of health knowledge. By equipping young people with storytelling tools rooted in tradition and pairing them with trained CHWs, we are building a community-led model of care that addresses clinical needs, cultural silence, stigma, and disengagement	\$250K-\$1M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Advance to Implementation Application

Ketchikan Wellness Coalition	Community Food Security Planning	AK	KWC’s CFP Project addresses challenges and barriers around food security faced by Ketchikan’s rural residents. The remoteness leads to elevated food prices, periodic shortages, and restricted access to fresh produce, which disproportionately impacts the community’s Indigenous populations, Title I schools, and low-income neighborhoods. Ketchikan’s remote location contributes to high food costs, limited availability of fresh produce, and frequent supply interruptions. High food insecurity rates disproportionately impact children, where nearly 69% of Ketchikan’s children live in households where families are eligible for federal nutrition program assistance. Approximately 420 children in Ketchikan are considered food insecure and at the three key Title I schools, 26-57% of students rely on free or reduced meals. The project will mitigate the impacts of these challenges by creating a reliable source of fresh, nutrient-dense foods within the community in a strategic way that also fosters agricultural education and volunteer-based community models to promote sustainability and growth of food security efforts long term. KWC’s approach focuses on food production, preservation, and waste reduction to transform community reliance on costly imported goods and exported trash logistics by emphasizing agricultural education programming that leads to sustainable local food solutions. This project will include composting practices and use waste minimization strategies within the food forest.	The Community Food Forest will serve as a multi-generational learning hub, strategically situated behind Revilla High School and near Houghtaling Elementary School, which are two Title I schools in the area. Students can easily participate in food production and benefit from food security efforts. Through partnerships with after-school programs and the local recreation center, KWC will expand educational programming to students, providing hands-on opportunities to connect and learn about gardening, harvesting, and food preparation, led by gardening experts in the community. Promoting a youth engagement strategy is essential to support food literacy and understanding of sustainable food practices that carry on into adulthood. KWC’s plan to integrate this food forest with existing educational practices emphasizes self-sufficiency, and community efforts to help bring together youth and other populations that will engage in skill-based knowledge sharing on topics such as growing, preparing, and preserving food – a critical aspect of food security in isolated communities. KWC will minimize food waste and encourage community members to compost food scraps as part of the overall design of the food forest and educational awareness building. This, paired with knowledge that identifies key climate and composting practices in the curriculum, community members will engage in learning and sharing ways to keep resources within the local supply chain and economy, promoting a thriving ecosystem. The produce grown in the food forest will support local feeding programs and supplement low-income families’ access to produce, reducing the community’s dependence on important foods. Furthermore, this will focus on fresh produce, improving dietary health. Community garden members will play a vital role in maintaining the food forest, with plans for a structured volunteer system that encourages local involvement and support during months when school is out of session. The coordination and planning will take place in this phase to ensure the community-driven model is well coordinated to enhance the food forest’s sustainability, while also strengthening social ties and collective responsibility. With targeted educational programs, close alignment with community partners, and a focus on food waste reduction, the project is a timely and relevant response to Ketchikan’s food security challenges.	\$50,000-\$250,000	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

Ketchikan Wellness Coalition	Icelandic Prevention Model - Ketchikan & Community of Practice	AK	The Ketchikan Gateway Borough is geographically isolated from much of the state, not to mention the nation. Getting in and out of the area requires significant personal resources. In Ketchikan, 12.4% of the total population lives at or below poverty. The geographic isolation has been associated with increased substance use among youth with marijuana and alcohol leading in popularity. The most recent Youth Risk Behavior Survey found that 22.4% of Ketchikan High School (K-High) students reported consuming alcohol in the past 30 days. Among alternative school students the rate jumps to 41.6%. This clearly delineates between both high schools, and therefore can have empirical, measurable outcomes. By the time a K-High student graduates, 1 out of 2 will have had at least one drink with a significant number (12.5%) having had that drink before age 13. 8.9% of K-High youth reported current marijuana use; however, it is the most popular choice among Revilla (alternative school) youth with 46.7% reporting having used in the past 30 days and 77.5% reporting using at least once in their lifetime. Youth who consume alcohol and marijuana have higher rates of school absence, lower academic achievement rates, and increased rates of suicide and risky sexual behavior. Additionally, early onset of these problem behaviors has been closely associated with chronic illnesses (heart disease, liver disease, and cancer) in adulthood.	The project would be led and coordinated by two KWC staff, a Program Director and a Prevention and Data Integration Specialist. The approach consists of five inter-operational functions: 1) Applying a primary prevention approach that is designed to enhance the social environment. By working to increase social and environmental protective factors associated with preventing or delaying substance use and decreasing corresponding risk factors, the model prevents substance use by intervening on society itself and across a broad spectrum of opportunities for community intervention. 2) Emphasizing community action and embracing public schools as the natural hub of neighborhood efforts to support child and adolescent health, learning, and life success. The model will apply an ecological approach that addresses family, school, peer, and community social influences and other opportunities from within each neighborhood. 3) Engaging and empowering community members to make practical decisions using local, high-quality, accessible data and diagnostics. The project will utilize local data to (a) capture, focus, and sustain community attention on local factors essential to preventing substance use (b) guide the selection of strategies and the development of community capacity necessary to address the complex problem of substance use. 4) Integrating researchers, policy makers, practitioners, and community members into a unified team dedicated to solving complex, real-world problems. The IPM will convene a team-science-to-practice approach to prevention integrating researchers, policy makers, practitioners, and community members into a coalition that works to solve real-world problems in specific areas or neighborhoods over long periods of time. Partnerships already committed include the Alaska State Division of Population Health Sciences and University of Alaska Anchorage researchers Drs. Travis Hedwig and Alfgeir Kristjansson. 5) Matching the scope of the solution to the scope of the problem, including emphasizing long-term intervention and efforts to marshal adequate community resources. The project will work to improve our society toward one that protects young people from substance abuse, prioritizing creating the community capacity and long-term commitments necessary to achieve our goal.	\$250K-\$1M	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

Ketchikan Wellness Coalition	KGB Community Health Network Planning & Navigators Project	AK	The CHNA Planning & Navigation project presents Ketchikan Gateway Borough with an opportunity to improve access to care and support transitions between care providers by expanding the community health service network into digital domains. Navigators, both in person and via digital user interface, have been shown to improve access and reduce barriers by overcoming challenges like transportation, childcare, and language barriers to name a few. The guided support provided via navigation ensures patients reach necessary appointments, connect with key ancillary services, and elevate the level of coordination between providers. Navigators also serve to educate consumers on a personalized level to better position them to respond proactively to their healthcare needs. Studies have shown that patient navigation leads to higher satisfaction, more timely treatment, and improved outcomes.	Led by Ketchikan Wellness Coalition, the CHNA will facilitate the identification of root causes of chronic illness, barriers to accessing care (affordability, availability, accessibility, accommodation, and acceptability), and take the lead in the development of a comprehensive approach to improving quality of care that is not only easily accessible but also sustainable in perpetuity. A key component to the plan is the application of Health Navigators to facilitate patient access and guide them through the complex healthcare system. The navigation component is designed to provide a centralized virtual navigation system; we aim to simplify access to essential community resources such as mental health services, food security assistance, and housing support, which are often barriers to care for rural communities. The project will actively involve community members in the development and implementation process, ensuring that their voices and needs are prioritized. This inclusive approach will help create culturally competent resources that resonate with rural populations, fostering trust and engagement. Importantly, we will provide navigation with tailored support ensuring that unique individualized barriers do not impede access to necessary services. While the Ketchikan Wellness Coalition will lead the project, its success will depend on the active involvement and input from several key community partners, including PeaceHealth, the Mobile Integrated Healthcare Team (MIH), the Reentry Coalition, SAIL, Community Connections, and SEARHC. Our partners serve as vital direct service providers, and we are committed to incorporating their insights and addressing the needs identified through our collaborative efforts. Together with community stakeholders, the process will proceed through multiple phases including Defining the Community, Data Collection and Analysis, Health Needs Prioritization, and the development of a Health Improvement Plan that will articulate implementation, evaluation, and sustainability strategies. By leveraging the strengths and resources of these partners, we aim to create a comprehensive needs assessment and navigation system that effectively supports both service providers and community members, ensuring a well-coordinated approach to enhancing health access.	\$250K-\$1M	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

Keystone Chiropractic	Ketchikan Integrated Wellness Center and Travel Clinics	AK	Currently the healthcare landscape in rural SE Alaska is reactive acute care rather than preventative care. Rural families often lack conservative options for musculoskeletal health, neurological wellness, and birth support because they are inaccessible or non-existent. 1. Workforce Vitality & Neurological Health: Our regional workforce is the backbone of our economy, yet it is struggling with a dual burden of acute and chronic musculoskeletal injuries. - Physical labor vs sedentary impact: We see a “pinch effect” where half our population suffers from heavy labor injuries, while the other half suffers from neurological and postural decay associated with sedentary lifestyles and heavy technology usage (“Tech Neck”). - Currently, many workers rely on pharmaceutical pain management because they lack consistent access to conservative rehabilitation. 2. The birth crisis and lack of perinatal support: The state faces a high rate of obstetric interventions. There are high rates of C-sections and a lack of specialized support in the birthing room. Mothers often lack access to: - Biomechanical preparations: Without conservative chiropractic care to optimize pelvic alignment, labor often becomes stalled, leading to preventable surgical interventions. - Immediate postpartum continuity: There is a critical shortage of lactation support and Doula/midwifery integration, leaving mothers without “fourth trimester” care necessary for successful breastfeeding and emotional recovery.	We plan to shift our community from reactive to preventative care. Our approach utilizes a hub and spoke delivery system to bridge the geographic gap in healthcare access between Ketchikan, Seattle, and rural underserved communities on POW. 1. The Keystone Chiropractic Wellness Center (The Hub): The physical expansion of our Ketchikan facility serves three strategic purposes: increasing regional clinical capacity, hosting specialized visiting providers, and establishing a community for maternal health. This expansion transforms a traditional practice into a comprehensive multidisciplinary Integrated Wellness Center. This larger footprint allows for: - Diversified conservative care: Integrating pediatric, perinatal, family wellness, nutrition, adding associate positions to train Drs. and staff. - Technical integration: The expansion of evidence-based non-invasive technologies will help arrest biomechanical decay and accelerate tissue repair. - Shockwave Therapy provides a non-surgical, non-pharmacological solution for pain management and functional restoration from overuse injuries. - Low-Level Laser Therapy provides a gentle yet powerful tool for cellular repair and systemic inflammation reduction and expediting healing time. - Digital Infrared Thermal Imaging: Adding training and thermographic imaging will serve as an early-detection and monitoring tool for neurological and vascular dysfunctions and eliminate travel to Seattle for these services. - Our larger footprint will include a dedicated rotational specialist room which allows us to bridge the "specialty gap" by hosting experts from Seattle and larger medical hubs on a periodic basis. - The "village" space: Peer Support and Perinatal Sanctuary. A portion of the new footprint is dedicated to Non-Clinical Peer Support. This is where the "birth crisis" is addressed through community connection: Lactation Peer Groups, Postpartum Resilience Circles, and Workforce Wellness Workshops. 2. Prince of Wales Remote Clinics (The Spokes): We will restore wellness care access to POW through a regular rotation of mobile and remote clinical pop-ups. 3. Workforce Development: The Community Support Network: Recognizing that the “birth crisis” cannot be solved by clinicians alone, we will launch a Community Perinatal Training Initiative. - Lactation & Birth Support Training: We will sponsor and train community members from Ketchikan, POW, and Metlakatla to become Peer Lactation Supporters and Birth Doulas.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Deferred or Not Advanced

Kin Support Program Haa Yaitx'u Saiani	Kinship Navigator Evidence Project: Strengthening Community Wellness	AK	Our everyday work of expanding families' access to social determinants of health is about tangible supports at the surface level, but the core mission is healing from multi-generational trauma, which accounts for many of Alaska's gross health disparities. Our recent development of a formal evaluation plan will help us prove the connection between supportive kinship services and healing from trauma. We designed our culturally-based program utilizing Dr. Jessica Sanigaq Ullrich's Indigenous Connectedness Framework, which emphasizes the importance of spiritual and cultural connectedness in fostering relational well-being. In this framework, reciprocal external relationships with others (including extended family, land, and culture) are connecting forces that support a healthy internal relationship with self. Those external and internal relationships support healing from trauma, resilience, and prevention. Dr. Ullrich and Co-Director Vanessa George conducted focus groups with elder caregivers in Sitka and Petersburg in 2024 to help design our initial measures of intergenerational wellness. Taking this research a step farther through a collaborative program evaluation with Dr. Ullrich and Chapin Hall will: 1. Produce rigorous quantitative data on the intergenerational wellness benefits of services; 2. Complement anecdotal and survey data from clients with objective evidence; and 3. Build credibility for inclusion in evidence-based registries and funding streams.	This approach advances the program's long-term sustainability plan that Stellar Group created for our program through a grant from the Alaska Mental Health Trust Authority. The plan calls for program evaluation as a key element to align with federal prevention funding streams. The evaluation team - consisting of Chapin Hall, Dr. Ullrich, and our staff - have developed an evaluation plan and are ready to start now. Chapin Hall is a research and policy center focused on improving the well-being of children, youth, families, and their communities. Chapin Hall provides rigorous data analysis and achievable solutions to be a partner in improving the lives of people and communities facing adversity. Dr. Ullrich resides in Alaska and serves as Assistant Professor for Washington State University's Institute for Research and Education to Advance Community Health. IREACH is a large research institute that conducts transdisciplinary research devoted to promoting health and health care equity among Indigenous and rural populations. During Evaluation Phase 1, the team will engage internally and with community partners (including health partners) to formally document the program's unique kinship navigation model and rural service delivery context it is operating within. In addition to reviewing all available program documentation, the team will conduct interviews with key partners across the Southeast region and review relevant literature. In addition, the team will facilitate an in-person workshop to co-create the theory of change for our service model. The team will utilize the information already gleaned from our 2024 focus groups and build upon the measures of Intergenerational Wellness developed through that research. Phase 2 will focus on identifying the model's core components and determining how to assess fidelity to the model. The team will develop and refine a business process map for the program that can be replicated with adaptation in other Alaska communities and regions. Throughout this process, the logic model may be refined. During this phase, the team will also develop an evaluability assessment protocol. The evaluability assessment will determine how ready the Kin Support Model is for the next phase of evaluation, identifying where additional information or adjustments may be needed to prepare for the deeper dive into evaluation methodology.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

King Island Native Community	King Island Health Revitalization Plan	AK	Lack of social engagement opportunity for elders. Ensuring elders have access to healthy cultural foods. Hunters and youth that do not have access to hunting equipment. The community of Nome is known for its high rates of alcohol abuse and violence, the King Island Health Revitalization Program aims to organize community members in cultural activities that will improve the health and social outcomes of the community. Elders live in substandard, dilapidated homes. The community hall and carving room do not have an adequate HVAC system for the prevention of communicative airborne disease and risks posed with the dust of ivory carving.	The Ugiuvak Provider Health Program will revitalize the King Island community centered on Native ways of living in relationship with the ocean, land and marine mammals. The goal of this program is to convene experienced hunters and providers with youth to ensure the intergenerational transfer of knowledge of ocean hunting and harvesting methods for the purposes of sharing with elders and members of the community. This program supports healthy living, as local and ocean foods are the most nutrient rich foods. This program aligns with the Healthy Beginnings Initiative by establishing healthy habits for youth, building a foundation for lifelong health, nutritional education, and strengthening mental health. Hunting, harvesting and processing activities require both mental health and physical strength. Working together as hunting crews, as well as in support of the community strengthens social connections to ensure community health and cooperation. This activity will also support the establishment of youth cultural and language camps, to ensure elders and providers are instilling within the next generation a strong cultural foundation. Culture and language camp activities include hunting, harvesting, processing, sharing, sewing, singing, dancing and potluck gathering. As the cycle of each season from spring to fall, it's a busy time of year gathering, processing and sharing with community. This program will provide 6 ocean going aluminum boats, motors and hunting equipment, as well as convene cultural camps. The start-up costs of this program are \$491,200. This program aligns with the Health Care Access Initiative by supporting strong social engagement with elders to improve well-being; as well as provide elders with nutrient rich local foods. This program will serve the 28 elders in the King Island community. This program aligns with promoting healthy lifestyles with culturally appropriate community education focused on nutrition and physical activity, supports local food production and healthy eating initiatives, provides nutrition education support, harvesting knowledge of local foods and convenes the community in wellness programming. The King Island Native Community recognizes the need to install an HVAC system for the indoor environmental health and prevention of communicative airborne disease in the gathering hall and the ivory carving room. The estimated project cost is \$200,000.	\$1M-\$5M	Single Community	Nome Census Area	Deferred or Not Advanced

Knik Tribal Council	Creating a Rural Behavioral Health Access Hub	AK	Mat-Su communities face persistent barriers to timely and comprehensive behavioral health care due to workforce shortages, limited service environments, and the geographic challenges common to rural Alaska. Existing care models are often constrained by facility and infrastructure limitations that prevent organizations from expanding workforce capacity or implementing service delivery approaches such as tele-behavioral health, medication management, substance use treatment, prevention programming, and coordinated care. Our current outpatient services operate in a space-limited setting that restricts clinical staffing growth, group programming, and innovative behavioral health services. As a result, individuals and families in the region may experience delays in care, limited service options, or the need to travel long distances to access specialized behavioral health support. This project addresses the opportunity to prepare and activate a Rural Behavioral Health Access Hub that will transition services from a constrained outpatient model to a scalable system capable of supporting expanded workforce roles and coordinated service delivery. Establishing service-ready environments will enable tele-behavioral health, substance use programming, prevention services, and coordinated intake and care management. By addressing infrastructure barriers, the project strengthens system capacity and positions the region for expanded, sustainable behavioral health access in the Mat-Su Valley	Our proposed approach centers on renovating and equipping an existing facility to establish a Rural Behavioral Health Access Hub that expands service capacity in the Mat-Su Valley. The project responds to Alaska’s behavioral health crisis, including high rates of suicide, substance use disorder, and limited access to timely care in rural communities. Renovation will configure the facility to support a coordinated continuum of behavioral health care. The project will adapt the building to create service-ready environments supporting outpatient care for children and adults, tele-behavioral health access, prevention programming, traditional healing activities, workforce development, crisis response capacity, veteran support services, substance use disorder treatment, and medication management. Renovation will align the layout with operational needs by establishing spaces for individual and group counseling, telehealth delivery, coordinated intake, supervision, and culturally responsive programming. Equipping the facility will ensure clinical, telehealth, and program spaces are functional and able to support expanded workforce roles and integrated, coordinated care delivery. Furnished and technologically equipped areas will support care coordination, early intervention and prevention activities, and workforce training and supervision. By addressing infrastructure limitations that restrict workforce growth and service availability, the project prepares the facility to support expanded services and future workforce recruitment. Improved infrastructure will allow services to be delivered closer to communities through telehealth and coordinated care models that reduce travel barriers and improve continuity of care. This investment creates infrastructure enabling sustainable workforce growth and long-term behavioral health access. Through targeted renovation and equipment investments, the Rural Behavioral Health Access Hub will expand access to coordinated, culturally responsive services and strengthen the region’s response to suicide risk and substance use disorder. This investment advances long-term behavioral health system transformation by creating infrastructure that supports workforce expansion and sustainable rural service capacity. Over time, expanded access to coordinated care will contribute to improved community health outcomes, reduced crisis events, and stronger wellbeing for Mat-Su families.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Knik Tribal Council	Build Healthy Habits for Youth Program	AK	Alaska youth experience major health disparities related to chronic disease risk, behavioral health challenges, and limited access to prevention programming, especially in rural and frontier communities. Geographic isolation, transportation barriers, and limited recreational infrastructure often prevent youth from participating in physical activity, health education, and behavioral health supports. Prevention-focused programming is urgently needed. Alaska has one of the highest suicide rates in the nation, and youth behavioral health indicators remain concerning. According to the Alaska Youth Risk Behavior Survey, 41% of high school students reported persistent feelings of sadness or hopelessness and nearly 24% reported seriously considering suicide. About 16–20% of Alaska youth report attempting suicide. Chronic disease risk factors are also emerging early. Physical inactivity, poor nutrition, tobacco use, and stress contribute to conditions including diabetes, cardiovascular disease, and obesity. Research from the Centers for Disease Control and Prevention shows that Adverse Childhood Experiences (ACEs) increase the risk of chronic disease, mental illness, and substance use later in life. Many rural Alaska communities lack accessible prevention and health education programs. This project will expand youth wellness programs that promote physical activity, nutrition education, behavioral health resilience, and family engagement across underserved Alaska communities.	This project will implement a prevention-focused youth wellness initiative that integrates physical activity, health education, and behavioral health resilience through partnerships with schools, Tribal organizations, and community partners. The project will begin with a community readiness assessment to identify gaps in youth programming, available recreational spaces, and opportunities for prevention program. Community surveys and stakeholder engagement will help identify priority communities, program needs, and culturally appropriate strategies for implementation. Based on these findings, the project will expand youth wellness programming through three integrated strategies. First, the project will increase access to physical activity through school and community fitness programs, including activities modeled on the Presidential Fitness Test and culturally relevant outdoor recreation aligned with Alaska’s subsistence calendar. These activities support national recommendations that youth engage in at least 60 minutes of daily physical activity. Second, the project will expand evidence-based health education and chronic disease prevention program. Programs such as the National Diabetes Prevention Program (CDC) and Alaska’s Fresh Start program will be delivered through digital platforms supported by trained health coaches and community health aides. These programs reduce the risk of developing type 2 diabetes by up to 58% among participants who achieve modest lifestyle changes. Third, the project will strengthen youth mental health resilience through culturally responsive social-emotional learning and leadership development. Youth leadership, peer mentoring, and family engagement will build protective factors linked to positive mental health outcomes. Training in Question Persuade Refer (QPR), Adverse Childhood Experiences (ACE) awareness, and trauma-informed approaches will be provided to educators, families, and community leaders. To support long-term delivery, the project will expand Health Aide Academies that train local community members to deliver prevention programming and health education, increasing capacity and supporting culturally responsive services in rural communities. Through these strategies, the project will create a scalable model for youth health promotion that addresses chronic disease risk while strengthening mental health resilience and community wellness.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Knik Tribal Council	Rural Healthcare Simulation and Workforce Training Center	AK	Alaska faces persistent healthcare workforce shortages, particularly in rural and remote communities where geography, high costs, limited training infrastructure restrict development of local healthcare professionals. Demand continues to grow;estimates indicate Alaska needs 9,400 new healthcare workers annually, including 1,400 registered nurses each yearly. Access disparities are severe in rural regions. Many communities are accessible only by air or water, requiring patients to travel for care. Alaska has 229 Alaska Native villages, where residents face limited provider specialty care. Maternal health access illustrates these challenges:30.1% of births occur among women in rural areas, yet only 14% of maternity providers practice there, creating service gaps. Clinical training opportunities remain concentrated in large cities and very expensive, forcing many students to leave their communities for education and reducing the likelihood they return to practice in rural areas. Rural healthcare systems often rely on traveling staff or experience prolonged vacancies. This project addresses challenges by establishing a Rural Healthcare Simulation and Workforce Training Center with hands-on clinical training offered to youth(sparking early interest) and adults. By increasing regional training capacity, providing experiential learning in primary & emergency care, pediatric care, specialties certificates, the project will strengthen the healthcare workforce pipeline to rural Alaska	This project strengthens rural healthcare access, workforce capacity, and system resilience in Alaska by establishing a Rural Healthcare Simulation and Workforce Training Center that expands clinical training and prepares providers for remote and frontier care. There is nothing similar to this project in Alaska. Workforce → Expanded healthcare training pathways for rural Alaska students and providers Access → More providers trained for rural, remote, and telehealth care System Impact → Stronger regional healthcare workforce pipeline The center will replicate real-world healthcare environments and provide hands-on experiential training across care settings common in rural and frontier systems. The facility will include eight training environments supporting hospital care, emergency trauma response, rural primary care, maternal and pediatric care, clinical skills, telehealth technology, and simulation control/debrief operations. These spaces will use simulation equipment, task trainers, and audiovisual systems that allow instructors to run realistic clinical scenarios while monitoring performance. Training programs will support multiple levels of the workforce pipeline. Early exposure programs will introduce youth and young adults to healthcare careers through simulation demonstrations and exploration. Certification pathways will support training for Certified Nursing Assistants, Community Health Workers, and Emergency Medical Technicians. Clinical training will also support nursing students, Community Health Aide trainees, and other professionals through scenario-based learning in patient assessment, emergency stabilization, maternal and pediatric care, and chronic disease management. Telehealth training is a core component. Because many Alaska communities lack road access and depend on remote consultation systems, providers must deliver care through digital diagnostics and telemedicine platforms. Instruction will emphasize interdisciplinary teamwork, clinical decision-making, and rural emergency preparedness. Simulation scenarios will reflect conditions faced by providers in small clinics, tribal health systems, and remote villages, including limited staffing and delayed transport. By combining simulation technology with workforce training pathways, the project will expand regional training capacity, reduce barriers to healthcare education, and strengthen the pipeline of providers serving rural Alaska communities	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Knot Technology Solutions	Improving Public Health Outcomes Through Integrated Technology Solutions	MD	Through modern cloud platforms, secure data integration, telehealth technologies, and analytics, we help extend healthcare services beyond traditional facilities. These solutions support the Alaska Department of Health in improving access to care, strengthening clinical decision-making, and building sustainable healthcare systems for Alaska’s rural and frontier populations.	Our approach focuses on leveraging secure, scalable technology to extend healthcare services beyond traditional facilities. By implementing telehealth platforms, cloud infrastructure, and interoperable data systems, we help providers deliver care to patients in rural and remote areas. Through collaboration with local stakeholders and the Alaska Department of Health, we enable better care coordination, improve data-driven decision making, and support sustainable healthcare access for underserved communities.	\$250K-\$1M		Statewide	Aleutians East Borough; Bethel Census Area; Dillingham Census Area; Kodiak Island Borough; North Slope Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced
Kodiak Area Native Association	Kodiak In-Home Care Coordination Program	AK	Patients in the Kodiak region who require ongoing support at home often fall into a gap between routine ambulatory outpatient care and higher levels of care such as hospitalization or long-term facility placement. Individuals who need help managing medications, navigating their homes, monitoring and managing chronic conditions, or recovering after a change in health status may not require hospital level care, but they still need more support than periodic clinic visits can provide. Without a structured in-home care coordination model, patients and families are often left to manage these needs on their own or to pursue long swing bed or rehabilitation stays at the local crucial access hospital. This leads to worsening health conditions, increased caregiver strain, and preventable use of emergency or hospital services. This project addresses the opportunity to establish a coordinated in-home care model that provides consistent monitoring, support, and connection to clinical services for patients who need additional care at home. By creating this missing layer of support between clinic visits and hospitalization, the program aims to strengthen continuity of care and improve health outcomes for patients in the Kodiak region.	KANA proposes to develop a coordinated in-home care model that connects patients in their homes with KANA’s existing clinical services. The program would deploy trained home-based care staff to provide routine in-home support for patients who need additional monitoring and assistance between clinic visits. Home-based care staff would provide services such as medication support, monitoring and management of clinical conditions, assistance with basic personal care, and regular nursing and provider check-ins to help identify changes in a patient’s condition. These services would be supported by registered nurse oversight to guide care planning, monitor patient status, and coordinate follow-up care when concerns arise. Clinical providers would maintain medical oversight of the program and would support the care teams with telemedicine and home visits as appropriate. Telehealth technology would allow in-home staff to connect directly with providers for consultation and assessment, allowing changes in a patient’s condition to be addressed quickly without requiring onerous clinic or hospital visits. As the program develops, the model would expand to support a range of patient needs, including individuals with mobility difficulty, managing chronic conditions, patients recovering after hospitalization, and Elders who require additional support to remain safely at home. Over time, the program may incorporate additional services such as remote patient monitoring, mobile phlebotomy support, and coordination with other care team members including nutrition, rehabilitation, and behavioral health services. Through this coordinated approach, the program would create a structured in-home care model that strengthens continuity of care and expands the reach of the regional health system into patients’ homes.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Kodiak Island Borough	Advance to Implementation Application

Kodiak Area Native Association	Cultural Wellness Expansion	AK	Programs serving Alaska Native communities in the Kodiak region recognize the role cultural connection plays in wellbeing. Cultural engagement strengthens protective factors linked to mental health, resilience, and recovery from substance use disorders. KANA programs already incorporate cultural activities within peer support, community services, and other wellness initiatives, but the ability to offer them consistently is limited by program capacity, staff expertise, and challenges of coordinating activities across Kodiak and surrounding villages. As a result, access to culturally grounded wellness opportunities varies across communities, and many programs lack the resources or cultural expertise to sustain cultural activities that support connection and wellbeing. This project will expand cultural wellness programming through partnership with the Alutiiq Museum. By connecting KANA programs and initiatives with museum staff, artists, and cultural bearers, the project will expand access to cultural workshops, instruction, and enrichment opportunities across the Kodiak region. Programming will include in-person activities in Kodiak and the villages, as well as hybrid learning such as recorded instruction or virtual participation, making cultural engagement more accessible across the archipelago. Social media and community outreach will reinforce connections between cultural values, self-care, and health, encouraging community members to support wellbeing and access to care.	KANA will expand cultural wellness opportunities across the Kodiak region through partnership with the Alutiiq Museum, connecting cultural practitioners, artists, and educators with KANA programs and communities. Cultural workshops and enrichment activities will be offered in Kodiak and in surrounding villages, increasing opportunities for residents to engage with cultural knowledge, traditional practices, and language. Programming will include hands-on workshops and artist-led instruction, along with cultural activity kits and learning materials that allow programs and participants to continue activities beyond the workshop setting. To expand access across the archipelago, the project will incorporate hybrid delivery methods that combine in-person activities with virtual participation when possible. Workshops may also be recorded or streamed to reach additional programs and communities when travel is limited. These activities will complement existing KANA wellness, peer support, and behavioral health programs by strengthening culturally grounded approaches that support connection, identity, and community wellbeing.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Kodiak Island Borough	Deferred or Not Advanced

Kodiak Area Native Association	Cultural Workforce Training	AK	Organizations serving Alaska Native communities in the Kodiak region rely on a workforce that is often recruited from outside the region. While these employees bring important professional expertise, many arrive with limited familiarity with Alutiiq culture, regional history, and the cultural values that shape relationships within local communities. At present, there is no coordinated regional approach to preparing employees to work effectively across these cultural contexts. Without meaningful cultural orientation and learning opportunities, staff may struggle to understand the historical and cultural factors that influence how individuals and families engage with health and social services. This gap can affect communication, relationship building, and trust, and may limit the ability of organizations to deliver services in ways that feel respectful and responsive to community priorities. This project will develop a coordinated cultural workforce training program that supports employees across health care, social services, and partner organizations serving Alaska Native communities in the Kodiak region. In partnership with the Alutiiq Museum, the program will create culturally grounded learning opportunities that strengthen workforce readiness and support more effective engagement with the communities they serve.	KANA proposes to develop a coordinated cultural workforce training program in partnership with the Alutiiq Museum to strengthen cultural readiness among employees serving Alaska Native communities in the Kodiak region. The project will focus on creating structured cultural learning opportunities that help employees better understand the history, values, and lived experiences of the communities they serve. The project will begin with development of a cultural workforce training framework in collaboration with the Alutiiq Museum and other cultural knowledge holders. This work will identify priority learning topics, appropriate teaching approaches, and opportunities to incorporate local cultural expertise into workforce development. Training content will be designed to support employees across health care, social services, and other organizations serving Alaska Native communities in the Kodiak region. Building on this framework, the project will implement cultural orientation and workforce learning opportunities that may include structured orientation sessions for new employees, cultural learning workshops, and community-based learning experiences led by cultural practitioners and educators. These opportunities will provide employees with meaningful exposure to regional history, cultural values, and the cultural context that shapes community relationships and engagement with services. The project will also focus on integrating cultural learning into ongoing workforce development practices. By establishing partnerships, training materials, and delivery models that can continue beyond the initial project period, the program will help create a sustainable cultural workforce training model that strengthens the ability of organizations serving the Kodiak region to deliver services in culturally responsive ways. Through this approach, the project will help build a workforce that is better prepared to engage with Alaska Native communities and support services that affect health and wellbeing in rural communities.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Kodiak Island Borough	Deferred or Not Advanced

Kodiak Area Native Association	Kodiak Regional Village Wellness Center Development	AK	Remote villages in the Kodiak region have limited infrastructure designed to support community wellness activities outside of clinical care. While KANA operates village clinics that provide primary and behavioral health services, many communities lack dedicated spaces where prevention programming, cultural activities, behavioral health groups, and other wellness-focused programs can occur consistently. Existing community spaces are often shared facilities not designed for health-related programming, which can make scheduling difficult and limit opportunities for regular activities that promote wellbeing. This project addresses the opportunity to develop regional village wellness centers that provide flexible, community-centered spaces for prevention, cultural programming, and wellness activities. Through a planning and development process, KANA will work with village communities and local partners to evaluate facility options, including renovation of existing structures or development of new space. These centers will strengthen local infrastructure that supports prevention, cultural engagement, and community-based wellness activities that complement clinical services in rural Alaska.	KANA will lead a community-centered planning and development process to establish village-based wellness centers that support prevention, behavioral health, and community wellness programming. The process will begin with engagement with village communities, tribal governments, and local partners to identify priorities and assess potential locations. Planning efforts will evaluate options to renovate existing facilities or develop new multipurpose wellness spaces based on community needs and available infrastructure. KANA will work with planning and design professionals to assess site considerations, develop conceptual designs, and identify feasible development pathways. The project will also examine operational considerations such as facility management, scheduling, and coordination with visiting providers, peer support staff, and community partners. These spaces are intended to support health education, behavioral health activities, cultural programming, and telehealth connections. Given the logistical realities of rural Alaska, including transportation constraints and short construction seasons, the planning process will follow a phased approach that supports realistic timelines for development and future implementation.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Kodiak Island Borough	Deferred or Not Advanced

Kodiak Area Native Association	Kodiak Workforce Housing Planning and Design Project	AK	Health care organizations in rural Alaska face ongoing challenges recruiting and retaining qualified staff. In the Kodiak region, limited housing availability and high housing costs create significant barriers for health professionals considering employment in the community. These housing constraints can delay recruitment, shorten the length of time staff remain in rural positions, and contribute to ongoing workforce instability. For organizations responsible for delivering health services across multiple rural communities, these workforce challenges directly affect the ability to maintain consistent service delivery and meet community health needs. This project addresses the opportunity to plan and design workforce housing solutions that reduce housing barriers for health professionals serving the Kodiak region. By developing well-designed staff housing options, KANA can strengthen recruitment and retention of the health workforce needed to support rural health care delivery.	KANA proposes to undertake a planning and design process to develop workforce housing solutions that support recruitment and retention of health professionals serving the Kodiak region. The project will assess current housing barriers affecting recruitment and retention and identify appropriate housing models that meet the needs of clinical providers, behavioral health staff, and other health professionals working in rural communities. The planning process will include evaluation of potential housing configurations, site considerations, and design concepts that support safe, functional, and sustainable staff housing. This may include staff quarters designed to support permanent employees, rotational staff, and visiting providers who travel to rural communities to deliver care. KANA will work with appropriate planning and design professionals to develop conceptual designs, cost estimates, and implementation options that can support future development of workforce housing. The planning process will also evaluate operational considerations such as housing management, maintenance needs, and long-term sustainability. By developing well-designed workforce housing plans, the project will position KANA to address one of the most significant barriers to rural workforce recruitment and retention and support long-term stability of health services across the Kodiak region.	\$50,000-\$250,000	Federally qualified health center	Single Community	Kodiak Island Borough	Deferred or Not Advanced

Kodiak Area Native Association	School-Based Health Support in the Koniag Region	AK	Children and youth in the Kodiak region spend much of their day in school settings, where health concerns are often first noticed by teachers or school staff. However, schools and the local health system are not currently structured to work together as part of a coordinated approach to pediatric health support. When health concerns arise during the school day, there is often no clear pathway connecting those observations to timely clinical evaluation or care coordination. Recent reductions in school nursing capacity within the Kodiak Island Borough School District (KIBSD) further highlight this gap and increase the risk that emerging health concerns may go unidentified or unaddressed during the school day. This project addresses the opportunity to strengthen the connection between school settings and the regional health system so that health concerns identified in schools can be more consistently connected to clinical care, improving early identification and coordination of pediatric health needs in the Kodiak region.	KANA proposes to develop a coordinated school-based pediatric health support model that connects school settings with KANA’s clinical services. Through a partnership with the KIBSD, KANA would place registered nurses in participating Kodiak schools to serve as a direct link between students, families, school staff, and health providers. School-based RNs would support student health needs during the school day, assist with screenings and health monitoring, and help identify emerging health concerns that may affect a child’s health, attendance, or ability to participate fully in school. When health needs are identified, nursing staff would coordinate with families and KANA providers to connect students with appropriate clinical care and follow-up services. A central component of the model is strengthening coordination between schools and the regional health system. School-based nurses would serve as care coordinators who help translate school-based observations into appropriate clinical follow-up. This creates a more consistent pathway between the education and health care systems serving children in the Kodiak region and allows health concerns identified during the school day to be addressed earlier. Over time, the program would expand beyond basic nursing support to include enhanced care coordination and stronger integration with KANA’s clinical services. The model may incorporate telehealth connections between school settings and KANA providers when appropriate, periodic provider engagement in schools, and improved coordination for students with acute or chronic health needs. By linking school-based health observations, screenings, and care coordination with KANA’s clinical services, the project aims to establish a more proactive pediatric health support system in the Kodiak region, one that identifies needs earlier, improves communication between families and providers, and strengthens coordination between the education and health care systems serving children and youth.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Kodiak Island Borough	Deferred or Not Advanced

Kodiak Community Health Center	Bidirectional Exchange of Radiology and Laboratory Orders and Results with Providence	AK	Our clinic relies on radiology and laboratory services provided through our hospital partner. While these services are essential to patient care, the exchange of diagnostic orders and results between systems can still involve manual steps or delayed information transfer. These processes can create inefficiencies for staff and increase the risk of transcription errors or incomplete patient records. When providers do not receive results quickly, it can also delay follow-up care and clinical decision-making. Implementing a bidirectional interface will allow radiology and laboratory orders to be transmitted electronically and results to return directly into the patient’s electronic health record. Improving interoperability between systems will streamline diagnostic workflows and ensure providers have timely access to the information they need to care for patients.	This project will design and implement a secure, standards-based bidirectional interface to support the electronic exchange of radiology and laboratory orders and results between our clinic and PKIMC. The interface will allow providers to submit orders electronically and automatically receive completed results directly within the patient’s electronic health record. Using established health information exchange standards will ensure reliable and secure transmission of diagnostic data between the two organizations. Implementation activities will include interface development, system configuration, testing, and workflow integration to ensure the technology supports clinical operations. Staff training will also be provided so providers and administrative teams can fully utilize the new system. By improving interoperability between healthcare systems, this project will help ensure our providers have faster access to diagnostic information and can coordinate patient care more effectively.	\$50,000-\$250,000	Federally qualified health center	Single Community	Kodiak Island Borough	Advance to Implementation Application
Kodiak Community Health Center	Improving Patient Access and Clinical Workflow Through a Real-Time Care Coordination Platform	AK	Efficient communication and coordination among clinic staff are essential to maintaining smooth patient flow and timely access to care. In many healthcare settings, communication about patient movement, room availability, and provider status still relies on verbal updates or manual processes. Our clinic currently uses several manual methods to coordinate patient flow and communicate changes throughout the day. While these methods work, they can make it difficult for the entire care team to quickly see patient status, staff availability, and appointment progress across the clinic. A real-time clinic coordination platform provides an opportunity to improve these processes by giving staff a shared view of clinic operations throughout the day. The system provides visibility into patient location, appointment progress, and room utilization while allowing staff to communicate updates quickly. Improving clinic-wide visibility and communication helps reduce delays, improve coordination among staff, and support a more efficient patient experience.	Grant funding would support the implementation of a real-time care coordination platform that improves communication and visibility across clinic operations. The system uses tablets and digital displays inside and outside exam rooms to provide real-time updates about patient status, staff location, and appointment progress. Care team members can quickly see which patients are ready, which rooms are available, and where providers or staff may be needed. The platform also includes communication tools that allow staff to send quick updates and alerts across the clinic. These features help streamline communication, improve handoffs between staff, and allow the care team to respond more quickly to changing clinic needs. Additional features support clinic safety and operational awareness, including the ability to quickly signal alerts or safety concerns when needed. By replacing manual coordination processes with automated communication and real-time visibility, the system helps improve patient flow, reduce wait times, and support better coordination among the care team.	\$50,000-\$250,000	Federally qualified health center	Single Community	Kodiak Island Borough	Advance to Implementation Application

Kodiak Community Health Center	KCHC Health IT Service Management & EHR Support Initiative	AK	Health information systems play a central role in how we deliver care and manage clinic operations. As new features, reporting requirements, and care programs are introduced, staff frequently require technical assistance, system enhancements, or additional training to effectively use the EHR. Without a structured system for managing support requests, it can be difficult to track incoming issues, prioritize system improvements, or identify common areas where additional training may be beneficial. We see an opportunity to strengthen how our clinic manages Health IT support by implementing a centralized system for submitting, tracking, and responding to requests related to the EHR and other health information systems. Improving how these requests are managed will help ensure staff receive timely support while allowing leadership to better understand system needs and prioritize improvements that support patient care.	Through this initiative, we will implement a centralized Health IT service management platform designed to organize and track requests related to the EHR and other clinical information systems used throughout the clinic. The platform will allow staff to submit support requests, report system issues, request enhancements, and ask for training through a single structured system. Requests will be categorized and tracked, allowing our Electronic Health Systems Analyst to manage workload more efficiently and communicate progress transparently. The system will also provide leadership visibility into request trends and recurring issues. These insights will help identify opportunities for targeted staff training, workflow improvements, and system enhancements. Using this data-driven approach, we will strengthen how our clinic manages technology support while improving the efficiency and usability of the EHR and related systems.	Under \$50,000	Federally qualified health center	Single Community	Kodiak Island Borough	Advance to Implementation Application

Kodiak Community Health Center	KCHC Patient Access & Capacity Optimization Initiative	AK	Our clinic continually works to ensure that available provider time is structured in a way that best supports patient access to care. As services evolve and patient needs change, scheduling systems and appointment templates benefit from periodic evaluation to ensure they remain aligned with current demand. We have already begun reviewing scheduling guidelines, visit lengths, and clinical workflows to better understand how appointment structures support patient access. Through this process, we have identified an opportunity to take a deeper look at how appointment utilization, visit types, and provider scheduling templates function across our clinic. Working with a healthcare access and operations consultant will allow us to analyze scheduling data, appointment utilization patterns, and provider templates in greater depth. This analysis will help validate and refine the changes we are exploring and identify opportunities to improve appointment utilization while maintaining high-quality patient care.	Through this initiative, we will work with an experienced healthcare access and operations consultant to conduct a comprehensive assessment of patient demand, appointment utilization, scheduling guidelines, and provider templates. The consultant will analyze scheduling data, appointment utilization patterns, and provider templates to better understand how available provider capacity aligns with patient demand. This work will help validate and refine scheduling adjustments our clinic has begun exploring, including potential changes to visit lengths, scheduling guidelines, and appointment structures. The consultant will also review scheduling workflows and patient outreach practices to determine whether adjustments to scheduling processes or communication strategies could further improve access to appointments. Using these findings, our clinic will work with the consultant to implement refined scheduling structures and improved access strategies designed to better align provider capacity with patient demand. We will also monitor scheduling utilization and patient access metrics to evaluate the effectiveness of these improvements and ensure the changes result in measurable gains in appointment access and provider capacity utilization.	\$50,000-\$250,000	Federally qualified health center	Single Community	Kodiak Island Borough	Advance to Implementation Application
Kodiak Community Health Center	Reducing Provider Documentation Burden Through AI-Supported Clinical Documentation	AK	Clinical documentation is necessary to support safe patient care, regulatory compliance, and healthcare reimbursement. However, the time required to complete documentation can create additional workload for providers and reduce the time available for patient engagement. AI-supported clinical documentation tools can assist providers by capturing and organizing documentation during patient encounters, reducing the time required to complete clinical notes while maintaining accuracy and compliance. This project presents an opportunity to support the continued implementation and adoption of an AI-supported clinical documentation platform across our clinical teams. Supporting this continued rollout will help ensure providers are able to fully integrate the technology into their workflows and realize the benefits of improved documentation efficiency.	Through this initiative, our clinic will implement and expand the use of an AI-supported clinical documentation platform across primary care and behavioral health providers. The platform captures patient-provider conversations during clinical visits and generates draft clinical documentation that providers can review and finalize within the electronic health record. This approach helps reduce the time required to complete documentation while supporting accurate and structured clinical notes. Funding would support continued implementation, provider onboarding, workflow integration, and training as the platform is rolled out across our primary care and behavioral health providers. These activities will help ensure the technology is effectively integrated into clinical workflows and supports improvements in documentation efficiency.	\$50,000-\$250,000	Federally qualified health center	Single Community	Kodiak Island Borough	Advance to Implementation Application

Kodiak Community Health Center	Remote Patient Monitoring for Diabetes Management and Chronic Disease Care	AK	Diabetes remains one of the most common chronic conditions managed within our clinic, and effective glucose monitoring is essential to preventing complications and improving long-term outcomes. Traditional diabetes management relies heavily on periodic clinic visits and intermittent glucose readings, which can make it difficult for providers to identify patterns of unstable glucose levels between appointments. Patients who experience rapid fluctuations or who require insulin adjustments may benefit from more consistent monitoring and clinical support. Remote Patient Monitoring using Continuous Glucose Monitoring technology provides an opportunity to strengthen diabetes management by giving providers access to continuous glucose data and enabling earlier intervention when concerning trends emerge. Expanding RPM with a CGM focus will allow our clinic to proactively support patients with higher-risk diabetes, improve care coordination between visits, and strengthen chronic disease management through technology-enabled care.	Kodiak Community Health Center will implement a Remote Patient Monitoring program with an initial focus on Continuous Glucose Monitoring for patients with diabetes who would benefit from closer monitoring and support. Patients with higher-risk diabetes will be identified and enrolled in the program. Participants will receive CGM onboarding, education on device use, and guidance on how glucose data will be shared with care teams. Clinical workflows will be established to support routine CGM data review, patient outreach, and follow-up when concerning glucose trends are identified. Providers will use CGM data to support medication adjustments, reinforce diabetes self-management education, and help prevent complications associated with unstable glucose levels. The program will establish structured RPM workflows that integrate monitoring data into clinical care processes. While CGM will serve as the initial focus, the program is designed to support future expansion of RPM to additional chronic conditions such as hypertension or other monitoring needs. This staged approach allows the clinic to begin with a high-impact diabetes initiative while building a scalable RPM infrastructure that can support broader chronic disease management over time.	\$50,000-\$250,000	Federally qualified health center	Single Community	Kodiak Island Borough	Advance to Implementation Application

Kodiak Community Health Center	Strengthening Financial Systems to Support Sustainable Rural Healthcare Services	AK	Healthcare organizations operate in a complex financial and regulatory environment. Rural health centers often manage these responsibilities with limited administrative capacity while still meeting the same financial oversight expectations as larger healthcare systems. We currently have a part-time Chief Financial Officer and internal financial staff who manage day-to-day financial operations. However, situations regularly arise where additional financial expertise can help evaluate financial systems, review procedures, or provide guidance on complex financial questions related to healthcare operations. Access to experienced financial professionals allows us to strengthen internal financial systems and ensure our financial practices remain aligned with regulatory and program requirements. This type of support is especially valuable when reviewing financial reporting practices, strengthening internal controls, evaluating reimbursement structures, or analyzing financial considerations related to service expansion. Strengthening financial infrastructure helps ensure the resources supporting patient care are managed responsibly and supports the long-term sustainability of healthcare services.	Grant funding would allow us to access external financial expertise that can support our leadership and financial staff in strengthening financial systems and processes. External financial professionals would provide guidance on financial reporting practices, review internal financial procedures, and assist with questions related to regulatory requirements and healthcare financial management. This support would complement the work of our internal staff and help ensure our financial systems remain well aligned with program requirements. Financial expertise can also assist with evaluating reimbursement structures, reviewing payer contracts, and providing financial analysis when considering new or expanded services. This type of support helps ensure financial decisions related to clinic operations and service development are based on sound analysis. Strengthening financial systems and planning capacity supports responsible management of healthcare funding and helps position our clinic to sustain existing services while exploring opportunities to expand care for the patients we serve.	\$50,000-\$250,000	Federally qualified health center	Single Community	Kodiak Island Borough	Advance to Implementation Application

Kodiak Community Health Center	Technology Integration to Strengthen Patient Outreach and Preventive Care	AK	Our clinic currently uses HealthTalk AI to support patient outreach; however, the platform is not integrated with our OCHIN-hosted Epic electronic health record. Outreach workflows require manual list generation, data uploads, and response tracking outside of the EHR environment. These manual processes create inefficiencies and limit our ability to consistently manage preventive care gaps, chronic disease follow-up, and missed appointments across patient populations. Staff time spent managing outreach lists and tracking responses also reduces the capacity available for direct patient engagement and care coordination. Integrating HealthTalk AI directly with Epic presents an opportunity to streamline these workflows and embed automated outreach within our population health infrastructure. With real-time data exchange between systems, patient identification, outreach, and documentation can occur automatically within the EHR. This integration will allow our clinic to expand proactive outreach, strengthen preventive care completion, improve chronic disease follow-up, and make more effective use of workforce resources.	This project will establish a direct integration between HealthTalk AI and our OCHIN-hosted Epic electronic health record to automate patient outreach, documentation, and reporting workflows that support population health management. Working with OCHIN and HealthTalk AI technical teams, our clinic will configure a secure interface that allows data to move between the two platforms. Automated workflows will identify patients who are due for preventive services, chronic disease monitoring, or follow-up appointments and initiate outreach through the HealthTalk AI platform. Patient responses will be captured and documented directly within the Epic EHR, allowing care teams to view outreach outcomes and coordinate follow-up care when needed. The integration will also strengthen reporting and analytics capabilities so our clinic can better monitor care gaps, evaluate outreach effectiveness, and guide population health strategies. By embedding these workflows within the EHR, this project will strengthen care coordination, improve preventive care outreach, and support more efficient population health management.	\$50,000-\$250,000	Federally qualified health center	Single Community	Kodiak Island Borough	Advance to Implementation Application

Kodiak Community Health Center	KCHC Workforce Sustainability & Operational Transformation Initiative	AK	In recent years, our administrative structure has evolved as leadership roles and departmental responsibilities have shifted. Functions that support patient care — including scheduling, front desk operations, billing coordination, and provider documentation support — now involve multiple departments working closely together. While our teams collaborate regularly, many workflows developed over time as responsibilities shifted between departments. This has created an opportunity to review how these functions interact, improve communication across teams, and ensure roles and processes are clearly aligned. Strengthening coordination between operations, finance, billing, and clinical support functions will help ensure scheduling systems, documentation workflows, and care coordination activities operate efficiently. Improved coordination between operations and billing functions will also support more efficient revenue cycle processes and reduce administrative burden across teams. Improving these connections allows staff to work more effectively together while supporting timely patient access to care.	This project will engage an experienced healthcare practice transformation consultant with expertise in rural health systems and federally qualified health centers. The consultant will work with our leadership and staff to conduct a comprehensive assessment of current administrative roles, workflows, and coordination across departments. This process will include leadership discussions, staff interviews, and workflow mapping across operations, finance, billing coordination, and quality improvement functions. The assessment will also examine how workflows move between departments, such as front desk operations, billing coordination, provider documentation support, and quality improvement activities to ensure these processes are clearly aligned. Based on this assessment, the consultant will work with clinic leadership to redesign key workflows, clarify roles and responsibilities, and develop implementation plans to improve coordination across departments. The project will also include facilitated workshops and staff training to support implementation of the redesigned processes. By improving communication and operational alignment across departments, this initiative will strengthen the systems that support patient access to care while creating a more sustainable and coordinated work environment for our staff.	\$50,000-\$250,000	Federally qualified health center	Single Community	Kodiak Island Borough	Deferred or Not Advanced

Kodiak Community Health Center	Kodiak Community Health Center Capital Expansion – Architectural and Engineering Design Phase	AK	Our health center faces an immediate opportunity to expand clinical capacity to meet growing demand for care in our rural community, but progress is constrained by required pre-development design work. Kodiak Island’s geographic isolation, limited healthcare infrastructure, and increasing population have placed sustained pressure on existing clinic space, limiting appointment availability and the ability to add services. We have received CDS funding to support clinic expansion, however, completion of full architectural and engineering design, beginning with schematic drawings, is a key prerequisite to advancing the project. While multiple predevelopment requirements must be addressed, this design work is foundational and directly informs subsequent project steps, including final budgeting, timelines, and required environmental and historic requirements. Until this design phase is completed, progress on the remaining components of the expansion remains constrained. By investing in this critical pre-construction phase, we can advance the project toward construction readiness and position our health center to better serve our community.	Our approach is to complete the required architectural and engineering design through construction documents needed to advance our clinic expansion and move the project to implementation readiness. This project will focus exclusively on preconstruction planning activities that support an existing federal capital award and enable future expansion of essential health services. We will engage qualified architectural and engineering professionals to complete full architectural and engineering design, including schematic, design development, and construction documents that meet applicable requirements and align with the overall scope of the planned expansion. This work will be coordinated with our leadership team to ensure consistency with project goals, timelines, and anticipated service needs. Completion of the full architectural and engineering design phase will establish the technical foundation needed to move forward with remaining pre-development steps, including refinement of project costs, scheduling, and required reviews. Advancing the full design phase allows the broader expansion effort to proceed efficiently toward construction readiness and supports future increases in patient capacity. This focused planning approach supports health care access by enabling timely expansion of clinic space, reducing delays that limit service availability, and ensuring prior federal investment can be fully realized. Advancing this work positions our health center to better meet growing demand for primary and preventive care for our community.	\$1M-\$5M	Federally qualified health center	Single Community	Kodiak Island Borough	Deferred or Not Advanced

Kodiak Community Health Center	Modernizing Payroll and Workforce Systems to Support Rural Healthcare Workforce Stability	AK	Our organization currently operates payroll and workforce management through a legacy configuration that was originally built more than a decade ago. As our workforce and services have grown, this system has become increasingly inefficient and difficult to manage. Although we currently use Paycom, we are not fully utilizing the platform’s integrated capabilities. Many employee status changes, including hiring, terminations, compensation updates, and benefits changes, require manual entry across multiple systems and workflows. This creates unnecessary administrative workload, increases the potential for payroll errors, and requires significant staff time to maintain accuracy and compliance. For a rural health center with limited administrative capacity, inefficient internal systems can divert staff time away from critical workforce support activities such as recruitment, onboarding, and employee support. This project presents an opportunity to modernize our payroll and workforce management system, reduce administrative burden, and strengthen the operational infrastructure needed to support a stable healthcare workforce.	Our approach is to complete the modernization and full implementation of our Paycom Human Resources Information System so that payroll, human resources, and benefits administration function as an integrated system. We will transition from our current legacy payroll configuration to Paycom’s updated payroll infrastructure and fully implement the platform’s integrated modules. This will allow employee data to automatically synchronize across payroll, HR, and benefits functions instead of requiring manual updates in multiple systems. The project will include system configuration, migration of existing workflows, testing of automated processes, and staff training to ensure the system is used effectively. Once implemented, employee status changes such as new hires, compensation adjustments, and benefit updates will flow automatically through the system, reducing manual data entry and administrative errors. Modernizing this system will streamline onboarding processes, strengthen payroll accuracy, improve internal controls, and provide leadership with more reliable workforce data to support planning and compliance.	\$50,000-\$250,000	Federally qualified health center	Single Community	Kodiak Island Borough	Deferred or Not Advanced

Kodiak Community Health Center	Strengthening Grant Development Capacity to Support Rural Healthcare Services	AK	Grant funding plays an important role in supporting healthcare programs and service expansion for non-profit FQHCs. Identifying relevant funding opportunities and managing multiple application timelines can be difficult when those processes are handled manually. Currently, one staff member manages grant research, proposal development, and reporting responsibilities. While this allows us to pursue funding opportunities, it limits how many opportunities we can realistically identify and apply for. Many healthcare grants have short application windows and complex requirements. Without a centralized system for identifying opportunities and organizing materials, maintaining a consistent strategy for pursuing funding that supports expanded healthcare services can be challenging. Implementing a grant discovery and management platform will help us strengthen our ability to identify relevant funding opportunities and organize the grant development process. Strengthening this capacity supports our goal of expanding services and sustaining programs that benefit our patients.	Grant funding will support the implementation of a centralized grant discovery and management platform that improves how we identify and organize funding opportunities. The platform will allow us to search for relevant funding opportunities, track application deadlines, organize proposal materials, and manage grant workflows within one system. Many of these activities are currently managed manually across spreadsheets and individual documents, which makes maintaining a consistent process more difficult. With a centralized platform, we will be able to organize funding opportunities more efficiently and spend more time developing strong proposals that support expanded patient services. Because the platform is cloud-based, implementation can occur quickly. Once the system is in place we will begin using it to identify funding opportunities, organize application timelines, and strengthen our overall grant development process. Improving our ability to pursue grant funding supports the sustainability of healthcare programs and allows us to continue exploring opportunities to expand services for our patients.	Under \$50,000	Federally qualified health center	Single Community	Kodiak Island Borough	Deferred or Not Advanced

Kodiak Community Health Center	Sustaining Community Pharmacy Services Through Workforce Support	AK	Kodiak’s rural island community faces persistent pharmacy workforce instability that threatens reliable access to medications and continuity of care. Recruitment challenges, staff turnover, and a limited local workforce have resulted in reduced hours and service disruptions. Because the pharmacy is open to the public and serves both clinic patients and the broader community, these disruptions directly impact medication access, treatment adherence, and patient outcomes. Operational strain is compounded by rising supply costs, increasing demand for medication delivery and curbside services, and limited internal training infrastructure. Reliance on external trainers to onboard new pharmacy staff is costly and inefficient, slowing workforce stabilization and increasing operational risk. This project presents an opportunity to strengthen workforce recruitment and retention, build internal training capacity, and improve pharmacy operations so that services can remain reliable and accessible. By investing in workforce stability, structured training programs, and operational improvements, the pharmacy can maintain consistent medication access and support high-quality care for patients throughout the Kodiak region.	This project will implement a comprehensive workforce stabilization and operational improvement strategy focused on recruitment, structured training, retention, and workflow optimization. Recruitment incentives and targeted hiring strategies will be implemented to attract qualified pharmacy professionals to our geographically isolated community and reduce vacancy timelines that contribute to service disruptions. Streamlined hiring processes and improved recruitment outreach will strengthen our ability to secure long-term staff. The project will establish a structured onboarding and training program supported by standardized operating procedures, competency-based training checklists, and leadership oversight. Developing internal training capacity will reduce reliance on external trainers, accelerate staff proficiency, and ensure consistent pharmacy practices that support medication safety and patient counseling. Retention strategies will include workflow redesign, improved role clarity, and workload monitoring to reduce burnout and improve staff engagement. Operational improvements will focus on enhanced inventory management, improved forecasting and ordering practices, and optimization of pharmacy management technology to strengthen documentation, reporting, and workflow efficiency. Stabilized staffing will also allow expansion of patient-centered services such as medication delivery and curbside support for individuals facing transportation or mobility barriers. Additionally, expanding billable pharmacy services such as medication therapy management and adherence support will improve provider efficiency and contribute to long-term financial sustainability. Together, these strategies will strengthen workforce stability, modernize pharmacy operations, and improve access to medications and pharmacy services for rural patients.	\$250K-\$1M	Federally qualified health center	Single Community	Kodiak Island Borough	Deferred or Not Advanced

Kodiak Island Borough	Kodiak Island Hospital Chiller Replacement to Ensure Access to Care	AK	The current chiller system serves both Providence Kodiak Island Medical Center (PKIMC) and the Kodiak Community Health Center, which are co-located within the Kodiak Island hospital facility. It operates at approximately 35% capacity and requires continual repairs, leading to repeated service disruptions. These interruptions force patients—many of whom require time-sensitive or critical care—to travel off-island, or postpone care, creating significant barriers for families, providers, and the broader community. A replacement chiller is vital to the safe operation of the Sterile Processing Department, which directly supports the Emergency, Surgical, and Obstetrics departments. Without a reliable chiller system, these essential services remain vulnerable to shutdowns. The chiller is also critical for infection prevention protocols for environmental controls that limit the spread of infectious organisms, crucial to a larger public health landscape.	We propose to solve this challenge by replacing the chiller system. Engineering design for the new system is 95% complete and has been reviewed and approved by the Kodiak Island Borough Architectural Review Board, positioning the project for timely construction.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Kodiak Island Borough	Advance to Implementation Application

Kodiak Island Borough School District	KIBSD Health Documentation System Upgrade	AK	The Kodiak Island Borough School District (KIBSD) serves 2,000 students in a remote region where the district is often the primary point of healthcare access. Currently, our school nurses, counselors, and psychologists rely on SchoolCare, an obsolete platform with significant data privacy risks and operational silos. This system’s failure to update has caused unreliable immunization forecasting and a lack of secure parent engagement tools. Most critically, it lacks interoperability; nurses, counselors, and psychologists cannot collaborate within a single record. This fragmentation leads to a "documentation gap" where support plans for vulnerable students—particularly those without formal IEPs or 504s—are lost during school transitions. Modernizing our EHR with August Schools allows KIBSD to implement a secure, mobile-responsive "Whole-Child" model of care. This project ensures HIPAA-compliant data sovereignty and eliminates third-party data monetization. The transition will bridge linguistic barriers through automated translation (supporting our large Tagalog and Spanish-speaking communities), automate immunization safety via Alaska VacTrAK integration, and ensure seamless continuity of care across buildings. Finally, this platform introduces sustainable Medicaid reimbursement potential, turning our health infrastructure from a cost center into a self-sustaining resource for the Kodiak community.	Proposed Approach: Integrated Health Modernization KIBSD will address the current health infrastructure crisis by transitioning from a stagnant, third-party-monetized system to August Schools, a modern, comprehensive EHR designed for school-based health ecosystems. Our approach focuses on four key pillars: 1. Implementing a Unified "Whole-Child" Care Team We will deploy a multidisciplinary platform that integrates school nurses, counselors, and psychologists into a single secure environment. This approach replaces siloed email threads with role-based data segmentation, ensuring privacy while allowing for critical cross-referrals. For example, a nurse documenting frequent somatic complaints (stomach aches) can seamlessly flag the pattern for a counselor to investigate underlying academic or home-life anxiety, ensuring no student's needs go unaddressed. 2. Enhancing Rural Access through Frictionless Engagement Recognizing the unique barriers in remote Alaska, we will utilize August Schools’ "Magic Link" authentication and mobile-responsive portal. This eliminates the barrier of forgotten passwords for parents. To ensure equity across our diverse population, we will leverage automated translation features to communicate with families in their primary languages, specifically Tagalog and Spanish, moving beyond basic email to inclusive, real-time text and portal messaging. 3. Clinical Efficiency and Safety Upgrades We will modernize frontline care through: Safety Automation: Using integrated Medication Administration Records (MAR) and automated inventory/expiration alerts to eliminate manual errors. State Alignment: Direct integration with the Alaska VacTrAK registry to ensure compliance with state immunization mandates. Emergency Readiness: Implementing QR-code-based data sharing to provide EMTs and hospitals with vital health information instantly during a crisis. 4. Building a Sustainable Financial Foundation A core component of our approach is long-term fiscal sustainability. Unlike our current system, August Schools provides Medicaid reimbursement reporting utilizing ICD-10 codes. By capturing and documenting billable procedures, KIBSD will be positioned to leverage shifting Alaska legislation to generate revenue. Our goal is for the system’s reimbursement potential to eventually offset its operational costs, ensuring this transformation remains sustainable long after the 5-year grant period.	Under \$50,000	Single Community	Kodiak Island Borough	Deferred or Not Advanced

Koniag, Inc.	Alaska Native Partnership for Rural Health Innovation and Enablement	AK	Fragmented health data and limited interoperability across providers, health organizations, and partners make it difficult to coordinate care, manage chronic disease, and support population health across the Alaska rural health system. Limited access to user-centered digital tools for patients, providers, and community partners, reducing the ability to navigate services and coordinate care. Limited digital infrastructure, outdated legacy software, and insufficient cybersecurity protections that leave rural health systems vulnerable to cyber threats and data breaches, while restricting the ability to support modern analytics, AI, and telehealth-enabled care. Underutilization of health data, analytics, and artificial intelligence to identify risks earlier, strengthen care coordination, and support more proactive, value-based health management. Technology barriers in remote and frontier communities, where deploying and maintaining networks, devices, and secure digital systems is challenging due to geography, connectivity limits, and scarce local technical resources. Operational inefficiencies from outdated technology environments, which limit the ability to scale modern digital capabilities statewide. Technology and workflow inefficiencies which increase administrative burden on providers. Cybersecurity and data protection risks as health systems increasingly rely on digital tools, shared data infrastructure, and telehealth platforms to support care delivery.	Working in partnership with Tribal health organizations, providers, and technology partners which already support Alaska Rural Health needs, Koniag will identify, plan, and deliver: Human-centered digital tools to improve patient navigation, provider workflows, and care coordination across Alaska’s rural health system. Modernization of legacy health technology systems that support rural health programs and services. Data, analytics, and AI capabilities to strengthen population health management, supported by secure data pipelines, identity and access management, and protections for sensitive health data. Deployment of secure technology infrastructure in central and remote communities, including networks, devices, cloud-enabled platforms, and cybersecurity architecture designed for rural environments. Managed services and technical support to sustain modern digital health capabilities statewide, including cybersecurity monitoring, vulnerability management, and system protection. Cybersecurity protections to safeguard health data and critical health infrastructure, including threat monitoring, incident response readiness, and compliance with healthcare security standards. By combining secure technology deployment with long-term operational support, Koniag will help create a sustainable digital health backbone and ecosystem that strengthens access to care, supports rural providers, and enables coordinated care delivery across village clinics, regional hospitals, and statewide health partners. Koniag will establish a dedicated RHTP team in Anchorage partnering with the Alaska Department of Health, Tribal health organizations, providers, and technology partners. This team will include these roles: Rural Health Director – coordinates with DOH, Tribal partners, providers, and RHTP leadership Infrastructure Technology Director – network and infrastructure planning and deployment Software Solutions Technology Director – digital solutions, data, analytics, and AI-enabled solutions. Program / Engagement Director – program delivery, coordination with RHTP teams, and oversight of budget, personnel, and risks. Koniag's extensive teams throughout the U.S. will also support the effort. Koniag is uniquely qualified to provide hands-on technology implementation at all 600+ Alaska communities. Koniag will leverage our many years of Value-Added-Reseller experience to ensure competitive pricing and service on technology equipment.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Koniag, Inc.	Groundwork Alaska: Community Water & Sanitation Infrastructure Program	AK	Rural Alaska faces a water and sanitation infrastructure crisis that directly drives preventable illness and increases health care demand in the state's most remote communities. Over 200 rural communities lack adequate water and sanitation access; more than 3,300 year-round homes have no piped water. Alaska's RHTP Project Narrative documents the direct health consequences: severe skin infections, gastrointestinal illness, and systemic disease burden tied directly to absent basic sanitation. Washaterias, the primary hygiene resource in many communities, are mechanically fragile and are operated without dedicated technical staff. Failures leave communities without safe water for extended periods, triggering costly emergency responses. Existing water infrastructure, where present, largely lacks remote monitoring, so failures go undetected until service is fully lost. No scalable Alaska-based team currently closes this gap by combining licensed water treatment system engineering with SCADA-enabled automation and Alaska field deployment capacity purpose-built for remote, off-grid operation. This project addresses that gap directly under Initiative #3 - Healthy Communities.	Working in alignment with Tribal health organizations, community partners, and Alaska DOH, Koniag, through KEW, will deploy and operationalize water treatment and sanitation infrastructure in rural Alaska communities currently lacking adequate access, in partnership with licensed Alaska engineering firms providing water treatment system design. KEW delivers: water treatment system installation, automation, and controls; SCADA and remote monitoring with automated alerting, remote diagnostics, and predictive maintenance for washaterias and water delivery systems; electrical and mechanical systems integration; custom NRTL-listed control panels designed and fabricated in KEW's Wasilla facility; and field deployment by Alaska-based crews with logistics capacity for remote, fly-in, and off-road communities. Post-installation, KEW provides commissioning, operator training, and remote monitoring setup so communities can manage systems with limited on-site technical presence. All manufacturing occurs in Alaska, reducing supply chain dependencies and supporting Alaska workforce. Koniag aligns with Tribal health organizations and regional partners who identify infrastructure needs, secure their own RHTP awards, and engage KEW as the Alaska-based implementation partner. As a Regional Alaska Native Corporation, Koniag combines a mission-driven commitment to Alaska Native communities under ANCSA with proven infrastructure delivery experience across Alaska's most demanding environments. Licensed engineering partners are engaged for water treatment system design, ensuring each installation meets applicable regulatory standards and is appropriate for the community's specific water source and site conditions. KEW's installation and controls team executes against those designs, maintaining clear scope discipline and accountability across each project.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Koniag, Inc.	Secure Foundations: Rural Health Facility Infrastructure Modernization Pilot	AK	Rural clinics in Alaska's Kodiak Archipelago and off-road-system Interior communities face a physical and operational infrastructure deficit that directly limits care quality and access. Many facilities operate with electrical systems that cannot support modern telehealth and diagnostic equipment, mechanical systems that are unreliable and difficult to maintain remotely, and no meaningful OT or physical security posture. Emerging health technologies - advanced remote monitoring, telehealth platforms, require physical installation and building system integration that most vendors cannot provide in Alaska's remote operating environment. Simultaneously, rural health facilities increasingly rely on networked SCADA and building automation for operational continuity, creating OT security vulnerabilities. A compromised or failed building control system in a remote clinic can disable climate control, power management, or access control - directly interrupting care delivery. No scalable Alaska-based provider currently offers the combined electrical contracting, controls integration, physical security, OT security, and emerging technology commissioning that rural health facilities require. This project addresses that gap through a focused pilot.	Koniag, through KEW, executes a defined rural clinic infrastructure modernization pilot in the Kodiak Island Borough, in partnership with Kodiak Area Native Association (KANA). KANA serves as the Tribal health partner identifying clinic facilities with priority infrastructure needs; KEW delivers physical and operational infrastructure work. Engineering partners include DOWL (water treatment system design), CRW Engineering (civil/environmental), and EDC Alaska (electrical/controls). ACEP/UAF provides academic partnership and research credibility for remote energy and water system integration. Vervint and Koniag Cyber are named partners across the Koniag RHTP portfolio. Year 1 scope is deliberately bounded to build a replicable model. Working alongside KANA to confirm site access and facility priorities, KEW will: (1) conduct facility assessments at KANA-affiliated rural clinic sites in the Kodiak region, documenting electrical capacity, mechanical condition, building automation status, and OT/physical security posture - the number of sites will be determined jointly with KANA based on confirmed access and facility readiness; (2) complete ICS/OT security assessments at priority sites identified through the assessment phase, with a hardening roadmap for each; (3) install physical security systems - access control, surveillance, perimeter security at priority clinic locations; (4) initiate electrical and controls upgrades at priority facilities to support telehealth and remote monitoring equipment load. KEW's combined capabilities cover: electrical, mechanical, and controls upgrades to existing rural clinic buildings (upgrades to existing infrastructure only, no new construction per RHTP requirements); custom NRTL-listed control panel fabrication built at KEW's Wasilla facility; physical security system design and installation appropriate for remote Alaska environments; ICS/OT security assessment and hardening of industrial control systems and building automation; and physical installation and commissioning of emerging health delivery technologies. As a Regional Alaska Native Corporation, Koniag brings both a mission-driven commitment to Alaska Native communities and a proven track record of technical delivery across Alaska's most demanding environments. Bristol Bay Area Health Corporation is actively being engaged in the same manner.	\$1M-\$5M	Statewide	Bristol Bay Borough; Dillingham Census Area; Kodiak Island Borough; Lake and Peninsula Borough	Deferred or Not Advanced

Kooth	Alaska Upstream Child and Youth Behavioral Health Hub	IL	Alaska’s geography, limited behavioral health workforce, and fragmented service pathways make it difficult for children and youth ages 0–25 to find the right support at the right time. Rural & frontier communities often rely on a small number of providers across vast distances, resulting in long wait times, unclear referral routes, duplicated intake and assessments, and avoidable escalation to crisis care. Many young people fall into an “in-between” gap as they transition out of school-based supports, face stigma in small communities, and struggle to access timely, confidential care. Families and referring partners often lack a clear, consistent way to identify acuity, know what options exist, and miss the prevention window. This fragmentation makes accessing care and resources challenging for Alaskans, increases administrative burden on providers, contributes to preventable crises, and limits Alaska’s ability to measure engagement and outcomes across regions. The opportunity is to strengthen Alaska’s youth behavioral health ecosystem with a coordinated, prevention-first, measurement-driven digital front door that standardizes screening, clarifies pathways, improves navigation and follow-through, and tracks outcomes consistently statewide to improve rural access while preserving clinical capacity for higher-acuity needs.	This project will implement a statewide, measurement-based digital front door for children and youth ages 0–25 that standardizes how care and resources are found, matches support to acuity, and closes the loop on referrals. The approach combines (1) a single entry experience available by self-referral or by referral community partners (2) validated screening at intake to identify needs and risk; (3) proven stepped-care, prevention-first pathway that preserves clinical capacity; and (4) ongoing measurement to track outcomes and continuously improve the system statewide. Digital front door + measurement backbone by Greenspace expanding on their current footprint in the state. On entry, users complete a brief assessment using validated tools. Greenspace serves as the shared assessment, navigation, and outcomes layer: bi-weekly check-ins track progress over time and power real-time dashboards for providers and state leaders (reach, engagement, symptom change, and pathway flow) so Alaska can see what’s working and where gaps persist. Immediate prevention support by Soluna by Kooth. Users matched to low-to-high need can immediately access clinically informed, stigma-free digital supports, self-guided tools, moderated peer support, and 1:1 single session coaching for parents and youth through text, call or video via the Kismet telehealth platform with an average wait time of 3 minutes outside school/work hours, regardless of geography. This absorbs demand upstream and reduces preventable escalation. Step-up and safety. Screening and ongoing check-ins trigger defined escalation pathways for higher acuity needs. For imminent risk, the platform routes to crisis services (e.g., 988) and local emergency pathways. For non-imminent but high acuity, the front door supports warm handoffs to local services. Alaska alignment + implementation: ABHA serves as strategic advisor to align workflows with the local landscape, regional resource routing, and define quality measures. The Hub will include a curated, continuously updated local resource and service directory to ensure support recommendations remain locally and relevant. Implementation will phase: (1) workflow configuration, assessment battery determination, resources curation and development; (2) pilot with priority regions/partners; (3) iterate based on youth/parent/provider feedback; (4) scale statewide with usage and outcome reporting to continuous quality improvement and sustainability beyond grant funding.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Kooth	Kismet- Alaska’s Digital Front Door for Pediatric Behavioral Health Access and Care Coordination	IL	Alaska’s pediatric & young adult behavioral health system faces significant structural gaps that limit early access to care and contribute to preventable crises. Youth and young adults ages 16–25 represent approximately 110,000 Alaskans, yet the system remains largely oriented around crisis response rather than prevention or early intervention. The consequences are visible across the system. In 2025, Alaska’s only state psychiatric hospital had just 10 dedicated youth beds statewide. North Star Behavioral Health reported 440 inpatient admissions and 184 youth requiring psychiatric residential treatment, including 49 who were sent out of state due to insufficient in-state capacity. These numbers reflect a system that often intervenes only after needs escalate to the highest levels of care. Earlier access points are limited and fragmented. Families struggle to navigate multiple providers and referral pathways, and providers lack shared infrastructure to coordinate care across organizations. The behavioral Health Roadmap identifies limited technology infrastructure, gaps services & lack coordination as key barriers to improving outcomes. This project addresses those gaps by building technology infrastructure that strengthens early identification of b.h. needs, improves referral and care coordination pathways, and supports collaboration across providers.	This project proposes the deployment of a statewide technology platform that strengthens coordination, access, and continuity of care across Alaska’s pediatric behavioral health system. The platform will support earlier identification of behavioral health needs, improve referral pathways, and enable providers to collaborate more effectively across organizations and geographic regions. The approach focuses on three key capabilities. 1st the project will expand access to services through a digital entry point that complements existing access channels such as Help Me Grow Alaska’s Centralized Access Point. Families, caregivers, and providers will be able to initiate referrals, access care coordination support, and connect more quickly to appropriate behavioral health services. This capability is particularly important in rural and frontier communities where families often struggle to navigate multiple providers and fragmented referral systems. Second, the platform will strengthen care coordination across providers and levels of care. Behavioral health providers, hospitals, care coordinators, and community organizations will be able to collaborate through shared workflows, secure communication, and coordinated referral management. This infrastructure will improve transitions when children move between inpatient care, outpatient services, and community supports, helping reduce gaps in care following hospitalization or crisis events. Third, the platform will support remote behavioral health services delivered directly to families in their homes. Providers will be able to conduct telehealth therapy sessions, family counseling, and care coordination visits with children and caregivers regardless of location. This approach helps address workforce shortages and geographic barriers that often prevent rural families from accessing timely care. The project will also support secure documentation sharing and patient participation through a caregiver portal that allows families to access services and share relevant records with their care teams. Integration planning with Alaska’s Health Information Exchange will help ensure alignment with the state’s broader health data infrastructure. Implementation will begin with a collaborative planning and integration phase with Alaska partners to configure the platform, establish data-sharing agreements, and align workflows with existing programs and provider needs.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Kusilvak Rising, Inc.	Kusilvak Regional Resilience & Workforce Development Initiative	AK	Communities in the Kusilvak Census Area face persistent economic instability, limited local employment opportunities, and geographic isolation that contribute to housing insecurity, behavioral health crises, and disrupted continuity of care. Residents often relocate to urban areas for employment, education, or access to services without coordinated transition planning, increasing vulnerability to homelessness, untreated behavioral health conditions, and long-term instability. At the same time, rural villages experience workforce shortages and limited local capacity to support economic resilience, youth engagement, and culturally grounded opportunity. These structural challenges are closely linked to preventable health disparities and crisis-level service utilization. There is a significant opportunity to strengthen regional stability by integrating workforce development, transition navigation, and coordinated referral systems into a unified regional resilience model. By addressing economic capacity and transition stabilization as foundational determinants of health, the region can reduce avoidable crises, improve care continuity, and build sustainable community-based infrastructure that supports long-term well-being.	Communities in the Kusilvak Census Area face persistent economic instability, limited local employment pathways, and geographic isolation that contribute to housing insecurity, behavioral health crises, and disrupted continuity of care. Residents often relocate to urban areas for employment, education, or access to services without coordinated transition planning, increasing vulnerability to homelessness, untreated behavioral health conditions, and long-term instability. At the same time, rural villages possess strong cultural knowledge systems, subsistence practices, and intergenerational leadership that remain under-resourced as formal workforce pathways. There is significant opportunity to strengthen regional resilience by creating culturally grounded employment opportunities, including language nests, carving and artisan apprenticeships, subsistence and food security initiatives, community gardening, youth mentorship, and peer transition support roles, while integrating coordinated referral pathways for health and behavioral health access. By aligning economic development, cultural workforce creation, and transition stabilization into a unified regional model, this project addresses foundational determinants of health. Strengthening employment, cultural continuity, and coordinated access to services reduces crisis-level interventions and builds sustainable community-based infrastructure that supports long-term well-being across rural and urban settings for residents of Kusilvak origin.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Kusilvak Census Area	Deferred or Not Advanced

Kuspuk School District	Kuspuk Care Network: School-Based Wellness and Health Access	AK	Spanning nearly 12,000 square miles across western Alaska, Kuspuk School District is comprised of nine schools located in seven villages accessible only by air or river travel. According to the 2020 census, about 1,391 people live in the district’s villages. More than 96% of KSD students are Alaska Native, primarily Yup’ik and Athabascan. All schools qualify as Title I, with family income surveys indicating more than 96% of the district’s students are economically disadvantaged. Families rely on a health care system severely impacted by distance, weather, and staffing shortages that keep care episodic and crisis-driven rather than preventive. These barriers hit hardest in behavioral health and early intervention, where delays and missed follow-up care contribute to student disengagement, chronic absenteeism, and family stress. Kuspuk has begun redesigning student supports through Kuspuk Empowers, integrating trauma-engaged culturally responsive practices, tele-mental health access, and stronger partnerships with families and tribes. Kuspuk seeks to convert this momentum into a durable school-based access ecosystem that reaches children, caregivers, and staff where they already gather: schools and community spaces. The goal is to close three gaps: reliable private spaces for wellness supports and telehealth, predictable preventive wellness and health opportunities, and stronger coordination among schools, Tribes, families, and providers to ensure services reach all students.	Our approach is to build the Kuspuk Care Network, a ready-to-operate, school-based prevention and health access system that uses schools as stable village hubs, aligns with regional providers, and leverages nationally recognized supports. Funding will support multi-site wellness hub buildout across all seven communities, plus the coordination, training, and evaluation needed for immediate execution. The backbone of the system is a calendar-embedded, all-staff professional development convening where health professionals and staff build shared practice across a high-turnover, multi-village district. Workstream 1: Wellness hub buildout (space plus IT). In each school, we will create or upgrade a private, telehealth-ready wellness space with clear privacy and consent procedures, a calm/regulation area, secure storage for basic screening tools, and a playbook for staff (mandatory reporting, documentation, and referral steps). Workstream 2: Predictable access and navigation. Establish a yearly Wellness Access Calendar synced to the school calendars, so families and partners can plan for access. On scheduled access days, partners deliver screenings, education, and consults using mobile or itinerant teams and telehealth. A site-based Wellness Navigator will manage consent packets, scheduling, student data, and closed-loop referral follow-through (referral to first contact and completion). Workstream 3: Workforce training and continuous improvement, built around Kuspuk Empowers. Each year, Kuspuk Empowers, the district’s three-day October in-service, will serve as an Implementation Summit where school staff, school board members, and Tribal and community partners review district wellness data, strengthen shared understanding of student needs, and coordinate how village systems will respond. Staff leave with practical tools grounded in trauma-engaged and culturally responsive practices to support student regulation, strengthen relationships, and recognize early behavioral health needs. School board members gain a clearer understanding of the conditions affecting student wellness and the district systems being implemented to support students and families. Tribal and community partners participate as collaborators, ensuring village knowledge, cultural values, and family priorities shape the work. The summit strengthens coordination among schools, Tribes, and regional providers so student and family supports function as a connected village system.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area	Deferred or Not Advanced

Landsick Media	Alaska Midlife Initiative: Building a Permanent Alaska Rural Health Media Library	AK	Midlife health represents a critical but often overlooked opportunity to improve long-term health in Alaska. Women ages 35–65+ frequently experience hormonal, metabolic, and sleep health changes that influence risks for chronic disease, mental health challenges, and decreased quality of life. In rural Alaska, access to reliable health information and specialized care addressing midlife health is limited. Many communities lack clinicians with training in menopause management, metabolic health, and lifestyle medicine, leaving both patients and providers without accessible educational resources or culturally relevant guidance. Midlife women also serve as central health decision-makers within families and communities. Improving midlife health literacy can influence preventive health behaviors for entire households and support healthier aging across communities. This project addresses this opportunity by developing a statewide platform focused on midlife health in rural Alaska. Through community-informed storytelling, including a documentary highlighting voices of women across rural and Alaska Native communities, the initiative will translate medical knowledge into accessible educational resources for patients, families, and healthcare providers. By combining documentary storytelling, educational media, and provider training resources, the initiative aims to improve health literacy and strengthen the capacity of rural healthcare providers to address midlife health concerns.	This initiative will create a statewide health education platform designed to improve midlife health literacy and support rural health care providers serving women ages 35–65+. The project will be implemented by Landsick Media in collaboration with Dr. Jillian Woodruff, a board-certified gynecologic surgeon who will serve as Medical Director and clinical advisor. Dr. Woodruff is the founder of Modern Gynecology & Skin in Anchorage and specializes in women’s midlife health, hormone optimization, and preventive care. She also hosts Line One: Your Health Connection on Alaska Public Media, a statewide call-in program where Alaskans seek medical information. Her clinical expertise will ensure project materials are evidence-based and medically accurate. Media production will be led by Landsick Media producer Jaybird Oliver, a lifelong Alaskan multimedia artist who grew up in rural communities across Alaska. Oliver has produced culturally relevant media, including medical training videos for Southwest Senior Services focused on caring for Indigenous elders, helping ensure project content reflects the perspectives of rural and Alaska Native communities. The project will begin with community listening sessions conducted in partnership with rural communities, tribal health organizations, and health care providers. These sessions will prioritize Alaska Native voices and rural perspectives to identify gaps in midlife health education and guide development of culturally relevant resources. Landsick Media will also produce a feature documentary exploring midlife health through the voices and experiences of women across Alaska, including rural and Alaska Native communities. The film will help open a broader public conversation about menopause and healthy aging. Insights from listening sessions will guide development of educational media addressing hormonal changes, menopause, metabolic health, sleep health, mental health, and preventive care. Landsick Media will produce short educational videos and provider training modules with medical oversight from Dr. Woodruff. Educational resources will be shared through rural clinics, tribal health organizations, Community Health Aide networks, community gatherings, and digital access through the Alaska Rural Health Media Library. This permanent library will house project materials and could expand into a statewide platform supporting education on chronic disease prevention, behavioral health, maternal health, and aging.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Launch AK, LLC	Rural Futures AK: Creating Career Pathways from High School to Healthcare and Related Professions	AK	State data shows rural areas have significantly lower graduation rates and postsecondary attainment—including certifications and degrees—than urban areas, limiting locally trained professionals. In the last five years, rural Alaska graduation rates were at 75%.:The Alaska Hospital and Healthcare Association estimates the state must add more than 9,400 healthcare workers annually to meet demand and Native Alaskans are a a small fraction of the medical workforce. Current training pipelines produce far fewer workers than needed, particularly in nursing and community health roles. The most critical shortages occur in villages in Northwest Alaska, Bethel, and the North Slope, where medical emergency rates coincide with limited services. This initiative will strengthen a rural workforce by addressing academic gaps while connecting secondary education with healthcare career pathways. It will prepare students for careers in community health while equipping educators with tools to support executive functioning, self-advocacy, career planning, and transitions into healthcare training programs. High school graduates can pursue healthcare certificates (e.g., medical assistant, licensed practical nurse) through training programs. Individuals with caregiver certifications can work in skilled care units or provide home services for elderly and medically fragile residents. Those with some college but no degree could complete associate degrees or industry credentials with targeted support.	The Rural Futures AK project will implement a five-year strategic plan to address educational gaps and the healthcare workforce shortage in rural Northwestern Alaska, the Northern Slope, by focusing on academic learning, career skill development, and professional growth for educators. Yr 1– Needs Assessment & Goal Setting Engage rural community members, Native corporations, educators, and healthcare providers to identify current educational and healthcare gaps. Conduct surveys, focus groups, and community forums to gather data to determine critical need communities. Establish measurable goals for student outcomes, workforce development, and service delivery. Begin forming university and healthcare partnerships; hire 2 educators to oversee initiatives. Yr 2–Resource Development Develop professional development programs for educators focused on academic interventions and career pathway advising. Create structured tutoring, credit-recovery programs, and parent workshops. Build an online hub of curriculum and instructional materials for educators. Formalize partnerships with universities (e.g., UAF, UAA) and healthcare providers to support training programs. Yr 3– Pilot Implementation Launch pilot tutoring, credit recovery, and parent workshops in selected rural communities. Begin professional development programs for teachers and counselors. Introduce initial online healthcare certification courses and job shadowing opportunities. Start internships and community-healthcare collaborations with local providers. Collect baseline data on student academic progress and participation. Yr 4-Full Implementation & Expansion Expand tutoring, parent workshops, and professional development to additional communities. Broaden healthcare certification courses, job shadowing, and internships to more students. Strengthen community initiatives, involving families, Native corporations, and healthcare partners. Monitor student graduation rates, workforce participation, and program effectiveness. Year 5 – Evaluation, Refinement & Sustainability Conduct an evaluation of academic outcomes, workforce engagement, and healthcare training success. Refine programs based on data, community feedback, and lessons learned. Establish long-term sustainability plans, including continued university partnerships, ongoing professional development, and expanded community-healthcare networks.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough	Deferred or Not Advanced

Disseminate best practices for rural education and healthcare workforce development across Alaska.



LAUNCH ALASKA	Alaska Rural Health Technology Accelerator: Advancing Frontier-Ready Health Access and Innovation	AK	Alaska’s rural, remote, and frontier communities face structural barriers that limit access to timely, high-quality, and financially sustainable health care. More than 80 percent of communities are off the road system, requiring air or water transport for specialty services, diagnostics, and even routine care. Limited broadband, aging infrastructure, workforce shortages, and fragmented data systems further constrain care delivery. Patients often travel hundreds of miles for specialty consultations, behavioral health services, pharmacy access, and chronic disease management, resulting in high costs, delayed treatment, and avoidable medevacs. At the same time, Alaska presents a unique opportunity to leapfrog traditional infrastructure constraints by deploying technology-enabled care models designed for frontier conditions. Telehealth, remote patient monitoring, AI-enabled workflows, interoperable health IT systems, mobile diagnostics, and emerging delivery tools such as unmanned aerial systems can expand access, improve care coordination, and reduce costs. However, rural providers often lack the technical capacity, capital, and implementation support to procure, integrate, and sustain these solutions. This project addresses that gap by creating a structured pathway to recruit, test, deploy, and scale frontier-ready health technologies statewide, ensuring rural Alaskans receive secure, efficient, high-quality care closer to home.	Launch Alaska will address this challenge by establishing a statewide Rural Health Technology Accelerator that recruits, tests, and deploys frontier-ready health technologies in partnership with rural providers, Tribal Health Organizations (THOs), and community stakeholders. First, we will recruit a cohort of health technology companies whose solutions directly address rural access gaps, including telehealth platforms, remote patient monitoring systems, AI-enabled clinical documentation tools, mobile diagnostics, pharmacy automation, cybersecurity solutions, and emerging transportation and delivery technologies such as unmanned aerial systems. Companies will be screened for interoperability, alignment with CMS Health Technology Ecosystem standards, cybersecurity readiness, and applicability to frontier conditions. Second, the accelerator will provide structured technical assistance to rural clinics, hospitals, and THOs to support procurement, integration, and implementation. This includes workflow redesign, workforce training, cybersecurity compliance, HIE integration, and evaluation planning. Rather than simply introducing new tools, Launch Alaska will ensure that technologies are embedded into clinical operations in ways that strengthen care coordination, reduce administrative burden, and improve patient outcomes. Third, we will establish a Rural Technology Catalyst Fund to competitively pilot promising solutions in roadless and remote communities. These pilots will focus on operational feasibility, cost-effectiveness, clinical impact, and scalability. Evaluation frameworks will measure improvements in access (e.g., reduced travel or medevacs), quality (e.g., improved chronic disease monitoring, behavioral health follow-up), and system performance (e.g., interoperability and value-based readiness). Finally, Launch Alaska will convene state agencies, providers, technology partners, broadband entities, and private investors to align funding streams and scale successful models. As an independent, non-provider organization, Launch Alaska can serve as a neutral convener to reduce duplication and accelerate coordinated implementation statewide. Through this structured model, the accelerator will create a durable pathway for expanding technology-enabled, community-based care across Alaska’s rural and frontier health system.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Laux, LLC	Adult mental health residential step-down from acute psychiatric placement	AK	Alaska has never had a complete mental health system of care. The state has long lacked mental health residential step-down capacity, resulting in high recidivism rates for acute care admittees as they fall off the cliff and direct-discharge to home rather than stepping down in a more therapeutic and clinically appropriate fashion. The Department of Health has attempted to fill this void in the behavioral health system of care by adding adult mental health residential services, rendered in licensed assisted living homes, as a service available under the 1115 Medicaid waiver. To date, few assisted living homes have seized an opportunity to render adult mental health residential services, very likely due to the competing differences between what is historically an assisted living home service and what is a behavioral health residential treatment service. This project seeks to stand-up a 15 bed facility specifically intended to treat adult mental health clients in a post-acute step-down residential level of care without blurring the populations of mental health clients and, say, the physically disabled, who are the more traditional recipient of assisted living. This facility would work with, or perhaps partner with, acute levels of care throughout the state, e.g. Alaska Psychiatric Institute, Providence, Mat Su Regional, or many of rural access hospitals in the state that have to routinely flex a medical/surgical bed to accept a patient in an acute psychiatric episode.	Modeled after best practice standards for adult mental health residential treatment services as set forth in healthcare accreditation standards such as The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), a highly structured adult mental health residential treatment program could be launched in any suitable facility. Alaskan healthcare has long been brick-and-mortar infrastructure poor, thus such a facility need be constructed, or more likely renovated to suit from another pre-existing building or facility. Real estate acquisition, local permitting, and renovation to suit are the most time and resource consuming parts of this project, with programmatic launch being a relatively straight forward process once there is an appropriate residential facility to work from.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Laux, LLC	Adult psychiatric residential step-down services	AK	Currently Alaska faces high recidivism rates among clients admitted to acute psychiatric facilities being readmitted due to lacking capacity to step-down in a more clinically effective and appropriate manner to transition back home. The Department of Health's current strategy for addressing this is to increase the number of assisted living homes in Alaska that are capable of rendering adult residential mental health treatment services under the Medicaid 1115 waiver. Assisted living home operation, and behavioral health services delivery are very different types of service and business. The state has struggled with expertise and technical assistance resources capable of successfully encouraging and assisting ALHs to navigate the 1115 process, or behavioral health providers to move into the area of assisted living home licensing. This project aims to remedy this issue.	Once funded, such an educational and consulting service could be promoted to potential ALH or BH entities that may be interested in moving more into the area of mental health residential services. This promotion could progress via means of professional association engagements such as the Alaska Behavioral Health Association, or the Assisted Living Association of Alaska. Further publicized by engagement with key foundations or philanthropic entities such as the Alaska Mental Health Trust, United Way organizations, or the Rasmussen and Foraker foundations. Direct engagement with potential clients is also possible, as the information of currently existing ALHs and BH providers is already publicly available, thus direct engagement could progress by moving down the list of ALHs not yet 1115 mental health residential approved, or behavioral health entities whose business lines and treatment models would align with further providing residential services but with whom have never operated or stood-up a licensed assisted living home.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Laux, LLC	Trauma-Informed Assisted Living Workforce Initiative for Behavioral Health Populations	AK	Anchorage's assisted living facilities serve a population with extraordinarily high rates of serious mental illness, yet staff lack standardized training to provide trauma-informed, behaviorally appropriate care. The prevalence of serious mental illness in US assisted living communities increased by 54% between 2007 and 2017, rising from 7.4% to 11.4%. Three-quarters of assisted living residents have a cognitive disorder, and 26% have a psychiatric disorder, yet 25% of dementia cases remain unrecognized by staff and only 43% of psychiatric disorders receive complete treatment. Residents of Medicaid-funded assisted living facilities report significant unmet mental health needs, including depression, anxiety, and substance use, accompanied by barriers to accessing care such as loss of autonomy, mistrust of organizational support, and isolation. Staff are expected to manage psychiatric crises, behavioral symptoms, and complex trauma without adequate training, tools, or clinical backup. A VA study of nursing home staff found that respondents identified lack of training of front-line staff as a key challenge in providing high-quality care to residents with serious mental illness, specifically noting needs to increase staff knowledge about SMI symptoms and diagnoses, improve staff communication and interactions with residents, and decrease mental illness stigma among staff.[12]	A. Establish Mandatory Training Standards All Anchorage assisted living facilities serving mental health populations will adopt standardized training requirements including: - Trauma-informed care principles (residents' need for safety, respect, and acceptance while minimizing retraumatization) - Mental Health First Aid and serious mental illness training - Crisis de-escalation and behavioral management - Person-centered communication using evidence-based curricula - Suicide prevention and overdose response B. Train and Certify All Frontline Staff Training will reach all staff members, including direct care and non-direct care staff (housekeeping, dietary), using a team-based approach. The OASIS curriculum model demonstrates that this comprehensive approach reduces antipsychotic use and improves resident outcomes.[5] Internet-based training modules will supplement in-person sessions, as research shows this approach produces significant positive effects on knowledge, attitudes, self-efficacy, and behavioral intention with medium-to-large effect sizes. Staff training will incorporate structured protocols, person-centered approaches, and communication techniques—elements associated with better staff and resident outcomes in dementia care settings. Training combined with external clinical support results in sustained improvements in both staff and resident variables, including reductions in challenging behaviors and improvements in staff self-efficacy. C. Implement Train-the-Trainer Model Each participating facility will designate an OASIS-style program coordinator and internal champion who will attend intensive training sessions and return to deliver staff training programs. The train-the-trainer model addresses sustainability by creating local educators who can continue training as staff turn over. A 12-year longitudinal study demonstrated that this approach produces sustained gains and substantial cascading effects.[6] D. Create Clinical Linkages Formalized linkages will connect assisted living facilities with: - Anchorage Health Department behavioral health services - Mobile crisis teams for real-time consultation - Emergency departments for coordinated crisis response - Community behavioral health providers for ongoing treatment Cross-sector partnerships that include shared personnel or resources and written agreements with mental health providers are associated with higher odds of participation in population-based mental health activities.[19]	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Learning Point Alaska	Katurrvik - The Gathering Place	AK	Katurrvik addresses the behavioral health crisis affecting Alaskan villages. Remote villages face disproportionately high rates of trauma, including suicide, domestic violence, child abuse, and historical wounds. Suicide alone is the second leading cause of death for Native youth aged 10-34, with rates significantly higher than those of other populations. Despite these challenges, culturally relevant mental health services are often unavailable, leaving many without support. Katurrvik leverages the proven "Healing the Wounds of Trauma" curriculum, which combines place-based healing with mental health best practices to foster personal resilience. This program is accessible and culturally sensitive, addressing the unique needs of Alaska Native villages. The project focuses on group healing sessions, where participants engage in discussions, lament, and forgiveness, while also training local leaders to sustain the program. The project overcomes logistical barriers by centralizing training and offering remote access for isolated villages. With a focus on spiritual restoration, Katurrvik not only helps individuals process trauma but also fosters long-term community healing by empowering local leaders to lead locally grounded trauma recovery efforts. This approach ensures both immediate relief and sustainable, culturally relevant care, bringing hope and renewal to Alaska Native communities.	The Katurrvik Project addresses the severe behavioral health challenges facing Alaska Native and American Indian communities, focusing on trauma healing through culturally relevant, place-based approaches. Our proposed solution builds on the proven "Healing the Wounds of Trauma" curriculum, which integrates spiritual principles with mental health practices to restore individuals and communities. Utilizing small group settings, the program provides a safe space for participants to explore trauma, grief, forgiveness, and resilience while engaging deeply with cultural identity. The healing process emphasizes lament, pain processing, and restoration, fostering mental health and emotional well-being. The project will strategically host events in central hubs like Anchorage or Fairbanks, allowing for cost-effective planning and access for participants from remote villages. Sessions will be tailored to address the unique challenges of these communities, including the stigma of sharing personal stories in close-knit settings. We will balance the needs of village participants through considerations like airfare and lodging, ensuring accessibility. To amplify the program's impact and sustainability, local leaders will undergo intensive training to facilitate future healing groups. This training equips leaders with the skills to continue trauma healing efforts within their own communities, ensuring cultural relevance and long-term cost-effective support. By addressing trauma as both a cultural and emotional wound, the program fills a critical gap in existing behavioral health services, which often lack a place-based component. The project strives to make villages hubs of healing and hope, equipped to meet community mental health needs. Through this approach, the Katurrvik Project creates a sustainable, community-centered model of trauma recovery, empowering Alaska Native communities to thrive emotionally, spiritually, and culturally.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; North Slope Borough	Deferred or Not Advanced

Let Every Woman Know-Alaska	Comfort Touch at Alaska Native Medical Center Oncology & Hematology Clinic Infusion Center	AK	Many cancer and infusion patients experience added stress to their disease simply by the delivery of often toxic intravenous treatments. The Comfort Touch program seeks to decrease many of common cancer treatment side effects, provide comfort to the patient, and improve the patient’s outlook for undergoing infusion treatment. This project aims to address two health care problems: 1. It will improve parity of care between Anchorage’s primary non-Native medical center and the Alaska Native Medical Center. 2. It will deliver a relaxation technique to ANMC infusion patients that could establish a more positive patient treatment experience and potentially improve longer-term outcomes. According to the Institute of Integrative Oncology based in California, therapeutic massage is a safe, noninvasive method of touch that is often recommended as a non-pharmacological adjunct for pain and stress management. Oncology Massage is the adaptation of massage techniques to safely nurture the body of someone affected by cancer and its treatments. Therapeutic oncology massage with a comfort-oriented touch is called “Comfort Touch”. Comfort Touch is available in Anchorage at the Providence Hospital Infusion Center. It is NOT currently available to the Alaska Native patients at the ANMC Infusion Center. This service is a reminder that the body and mind can find relief, comfort, and relaxation despite the emotional stress and physical discomfort experienced during treatment.	The Comfort Touch program is based on the “Greet the Day” Infusion Center Massage Program, which began in 2006 in California and has provided oncology massage to more than 56,000 intravenous patients. Visits to the Infusion Center can be numerous and time consuming, lasting between 1-6 hours. The high level of tension of a cancer diagnosis and the side effects often present during treatment add further anxiety to an already onerous situation. This initiative will provide inpatient Therapeutic Massage (“Comfort Touch”) sessions at the ANMC Oncology & Hematology Clinic - Infusion Center at no cost to the patients. Borealis Massage Therapy (BMT) is based in Anchorage and certified in the extensive “Greet the Day” protocols. BMT will provide licensed and accredited Comfort Touch to patients on request and with approval from the infusion nurse. Brief massage will occur at the patient chair or bed during their infusion. The program will offer 2-hour shifts in the Infusion Clinic, 3 days a week, as a standard of care through the therapists of BMT. Comfort Touch is performed on the lower legs/feet, and lower arms/hands of infusion patients. A non-greasy, no-fragrance lotion called Biotone is lightly used. At patient request, massage can be applied to target areas like neck/shoulders. Also at patient request, Comfort Touch can be offered over clothing with no lotion used. BMT will also offer the massage on a one-time basis to the infusion nurses to familiarize them with Comfort Touch therapy that their patients will experience. The BMT therapists are trained for oncology / hematology standards to perform Comfort Touch: - They observe the 3 Bs of patient care by confirming with the infusion nurse that: the Red Blood Count, the White Blood Count, and absence of Blood Clots are all adequate for physical stimulation of Comfort Touch. - They are thoroughly trained in the 3 Ps of patient massage therapy: applying the correct Positioning, Pressure, and Pace to make Comfort Touch a pleasant and beneficial experience. Cancer Patients receiving infusion treatments at the ANMC Infusion Center are the primary target. In 2025, the Infusion Center completed 17,608 appointments. Two therapists from BMT have been allocated a total of 312 Comfort Touch massage hours under this proposal, which allows for 3-7 patients per hour depending on volume of requests. A range of 1,000 – 2,000 patient Comfort Touch encounters per year are possible through this program.	Under \$50,000	Other	Anchorage (Municipality)	Deferred or Not Advanced

LetsGetChecked, Inc.	LetsGetChecked: Improving Biometrics and Diabetes Screening Rates With Education & At Home Testing	GA	Identify at risk populations early in the disease progression process. There is an opportunity to expand access to routine services closer to home to promote healthy communities and general health status knowledge. - 30% of Alaska adults did not have a routine checkup in the past year. - Approximately 33% of Alaska adults have not had a blood sugar test in the last three years creating the undiagnosed risk. - About 9% of Alaskans are living with diagnosed diabetes, but the state has seen a rise in prediabetes, with many residents unaware of their status. - 75% of Alaskans live with at least one chronic disease or a behavior (like smoking or obesity) that significantly increases their risk. The low screening rates directly correlate with Alaska’s high mortality in preventable areas. By offering free at-home kits, the state can bypass the key reasons for these low numbers: 1) Logistical challenges with limited road access: Residents wait for emergencies rather than prevention. 2) Systemic with workforce shortages: 50% adequacy of health care coverage means clinics prioritize sick people over healthy ones. Cost Travel Tax: The out-of-pocket cost of the travel to a physician’s office often exceeds the cost of the tests. Additionally, Alaska has the 4th highest uninsured rate in the US. 3) Psychological: Fear and a desire to avoid the risk of bad news when there is not an immediate feeling of being “sick”.	The lifecycle of care: 1) Announcement Campaign: Deploy a multi media campaign to rural populations & a targeted campaign to the local provider/ community resources to raise awareness of the new, no cost services available. 2) Ordering/ Enrollment: Residents self-enroll via a co-branded order page or a dedicated 1-800 call center. Providers, local Community Health Workers & other resources can order kits in bulk to have available for direct distribution to residents. 3) Ensuring Program Eligibility: LetsGetChecked uses a questionnaire to screen patients for eligibility based on: Demographic/ Age Verification: Residents confirm residency in a target county Clinical Triage: Residents answer basic questions to ensure suitability; those with high-risk factors are redirected to appropriate diagnostic care. 4) Taking the Test: Direct-to-Home Delivery: Kits are shipped with multilingual instructions, collection tips, & video tutorials. 2 drops of blood are collected on an ADX card. 5) Seamless Return: Residents use a pre-paid, trackable label to send samples to our CLIA-certified & CAP-accredited lab. 6) Support: A clinical care team and our digital platform are available 24/7 to assist with sample collection questions. 7) Engaging Patients to Take Action: Timely Reminders: Automated SMS and email remind patients to complete and return their kits. 8) Result delivery: Lab results are mailed to the patient’s home address and available on our Digital Dashboard. This allows participants to track sample status, view historical results, and download lab reports. Results And Clinical Support: Normal Results: Released via the patient dashboard and mailed to the home address. Abnormal Result Outreach: Our clinical team conducts high-touch outreach for all positive findings to explain results and discuss next steps prior to releasing findings digitally. 8) Provider Integration: We do a warm hand-off by providing result letters and clinical documentation to local practitioners to ensure continuity of care. 9) PatientsLikeMe: Peer- Led Empowerment by Fuze Health- a premier digital health community where residents can manage chronic conditions through real-world evidence and peer connection, reducing the common stressor of social isolation common in rural communities. 10) Real-time Reporting: EMR platform Halo, we maintain a comprehensive record of all activity that can be shared with the state to support their reporting requirements.	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

LetsGetChecked, Inc.	LetsGetChecked: Improving Screening Rates & Treatment to Reduce Impact of Chlamydia & Gonorrhea	GA	There is an opportunity to expand access to essential sexual health screening services closer to home and promote healthy communities through increased detection and treatment. Alaska continues to face some of the highest STI rates in the United States, frequently ranking in the top three for both Chlamydia and Gonorrhea, particularly in rural and "frontier" regions. Alaska currently ranks 3rd in the U.S. for Chlamydia rates with high prevalence in Anchorage, and the Yukon-Kuskokwim (Y-K) Delta in Southwest Alaska. Of additional note, the highest incidence is found among young adults (ages 15–29) and Alaska Native populations. Alaska has recently ranked 1st in the U.S. for Gonorrhea rates and has seen a recent surge in "invasive" cases that can potentially require hospitalization. The solution requires a program to be able to address the three concepts that have compounded the population health crisis. 1) Lack of Testing Access: In remote villages, the "travel tax" often prevents routine screening, meaning infections go untreated and continue to spread. 2) Clinical Staff Shortages: Rural regions often lack the consistent presence of specialized STI clinicians, OBGYN's or public health workers for contact tracing. 3) Social Factors: Socioeconomic disparities, stigma of sexual activity, lack of insurance, privacy concerns, high rates of substance misuse, and concentrated sexual networks in isolated communities contribute to the "persistence" of these high rates.	Program Lifecycle: - Announcement Campaign: Deploy a multi media campaign to rural populations and a targeted campaign to the local provider/ OBGYN's, community resources to raise awareness of the new, no cost, in-home- discreet screening services. . - Ordering/ Enrollment: Residents self-enroll via a co-branded order page or a dedicated 1-800 call center. Providers, local CHW's, OBGYN's and other resources can order kits in bulk to have available for direct distribution to residents - Program Eligibility: We use a questionnaire to screen patients for eligibility based on: Demographic/ Age Verification: Residents confirm age and residency in a target area Clinical Triage: Residents answer basic questions to ensure suitability for the kit - Taking the Test: Direct-to-Home: Kits are shipped with multilingual instructions, collection tips, and video tutorials. The test only requires a urine sample. - Seamless Return: Residents use a pre-paid, trackable label to send samples to our CLIA-certified and CAP-accredited lab. - Support: A clinical care team and our digital platform are available 24/7 to assist with questions. Engaging Patients to Take Action - Timely Reminders: Automated SMS and email remind patients to complete and return their kits. - Result delivery: Lab results are mailed to the home address and available on our Digital Dashboard. Participants can track sample status, view historical results, and download lab reports. - Results And Clinical Support: Normal Results: Released via the patient dashboard and mailed to the home address. Abnormal Result Outreach: Our clinical team conducts high-touch outreach for all positive findings to explain results and discuss next steps. A focus of these discussions is the education around th indeed for partner testing. Telehealth capabilities: As requested, patients can also be transferred to a telehealth provider for a full consultation and where appropriate e-prescribe services to a local pharmacy. - Provider Integration: We also offer warm hand-off by providing result letters and clinical documentation to local practitioners to ensure continuity of care. - PatientsLikeMe: Peer- Led Empowerment: To complement clinical care, we offer access to PatientsLikeMe powered by Fuze Health, a digital health community where users can manage chronic conditions through real-world evidence and peer connection, reducing the barriers of stigma and social isolation common in rural communities. .	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

LetsGetChecked, Inc.	LetsGetChecked: Improving Screening Rates for Colorectal Cancer With Education and At Home Testing	GA	There is an opportunity to expand access to essential screening services closer to home and promote healthy communities through increased preventative care and early detection. Despite being preventable, Alaska's colorectal cancer (CRC) screening rate is only 63.8%. Alaska Native populations face the world's highest CRC incidence (exceeding 60 per 100,000), with screening recommended to begin at age 40. With only 43 GI specialists (1.5 per 100,000 residents), Alaska ranks last in the U.S. with a 50% adequacy rate. The reasons why people avoid screenings are generally categorized into three main "walls": psychological, logistical, and systemic. To overcome psychological, logistical, and systemic barriers, we propose: 1) Psychological: An awareness plan to bridge the education gap and drive action. 2) Logistical: At-home kits via our dedicated user portal or customer service team, eliminate the need for provider visits, orders, or lab travel for sample evaluation and screening. 3) Systemic: A FIT-based triage model. By identifying the broader population for abnormal biomarkers first, clinicians can prioritize high-risk patients for limited time with GI specialists and colonoscopy slots, ensuring those most at risk move to the front of the line. While our solutions are designed to be accessed by individual residents, we also partner with the local provider community for test kits distribution and to ensure communication of all testing results.	The lifecycle of care: - Announcement Campaign: Deploy a multi media campaign to rural populations and a targeted campaign to the local provider/ community resources to raise awareness of the new, no cost services available. - Ordering and Enrollment: Residents self-enroll via a co-branded order page or a dedicated 1-800 call center. Providers, local CHWs, and other resources can order kits in bulk to have available for direct distribution to residents. - Program Eligibility: LetsGetChecked uses a questionnaire to screen patients for eligibility based on: Demographic/ Age Verification/ Target Location: Clinical Triage: Basic questions to ensure suitability; those with high-risk factors, such as a hx. of colon cancer, are redirected to appropriate care. - Taking the Test: Direct-to-Home Delivery: Kits are shipped with multilingual instructions, collection tips, and video tutorials. The FIT test only requires a Q- tip size stool sample. - Seamless Return: Residents use a pre-paid, trackable label to send samples to our CLIA-certified and CAP-accredited lab. - Support: A clinical care team and our digital platform are available 24/7 to assist with sample collection questions. - Engaging Patients to Take Action: Timely Reminders: Automated SMS and email remind patients to complete and return their kits. - Result delivery: Lab results are mailed to the patient's home address and available on our Digital Dashboard. This allows participants to track sample status, view historical results, and download lab reports. - Results And Clinical Support: - Normal Results: Released via the patient dashboard and mailed to the home address. - Abnormal Result Outreach: Our clinical team conducts high-touch outreach for all positive findings to explain results and discuss next steps prior to releasing findings digitally. - Provider Integration: We do a warm hand-off by providing result letters and clinical documentation to local practitioners to ensure continuity of care. - PatientsLikeMe: Peer- Led Empowerment: To complement clinical care, we offer integrated access to PatientsLikeMe powered by Fuze Health, a premier digital health community where residents can manage chronic conditions through real-world evidence and peer connection, reducing the common stressor of social isolation common in rural communities. . - Real-time Reporting: EMR platform Halo, we maintain a record of activity that can be shared with the state to support reporting requirements.	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Level 3 Communica tions, LLC, A Lumen Technologie s company	Internet Connectivity to Support Health in Rural and Frontier Alaska	CO	Rural, remote, and frontier communities across Alaska face ongoing challenges accessing reliable internet connectivity necessary to support health care delivery and health workforce training. Geographic isolation, extreme weather conditions, limited terrestrial infrastructure, and high connectivity costs restrict the effective use of telehealth, distance education, electronic health records, and real-time clinical consultation. These barriers contribute to gaps in care access, training opportunities, and long-term workforce sustainability. This project addresses the opportunity to strengthen rural health care and training capacity by enabling resilient, secure connectivity in locations where traditional broadband solutions are unavailable or unreliable. By improving access to dependable internet connectivity, the project supports expanded use of telehealth services, remote clinical supervision, and virtual training models that are essential for improving health outcomes and sustaining Alaska’s rural and frontier health workforce.	Proposed Approach (Phased Delivery) We will address connectivity barriers in rural, remote, and frontier Alaska by deploying Lumen Managed Multi Connect to provide resilient, secure internet access that supports telehealth, distance learning, remote supervision, and access to clinical systems for RHTP-supported training and care settings. The solution uses bonded multi-satellite and wireless connectivity, leveraging multiple network paths to maintain reliable service in environments affected by extreme weather, geographic isolation, and limited terrestrial infrastructure. Phase 1 – Planning & Site Readiness: We will identify and prioritize RHTP training and care sites based on connectivity gaps and workforce impact, confirm satellite and wireless coverage options, establish performance requirements, and coordinate with clinical, training, and IT stakeholders to ensure alignment with care delivery and training schedules. Phase 2 – Pilot Deployment & Validation: A pilot deployment at select rural and frontier sites will validate performance for telehealth visits, virtual training sessions, remote supervision, and secure access to clinical systems. User feedback and performance data will be used to refine configurations and support processes. Phase 3 – Scaled Expansion: Based on pilot results, the solution will be expanded in waves to additional communities, prioritizing sites with the greatest training and clinical impact. Standardized configurations and centralized monitoring will support consistent delivery while allowing flexibility for local conditions. Phase 4 – Operationalization & Sustainability: Sites will transition to steady-state operations with proactive monitoring, ongoing optimization, and basic user training to support long-term use. This phased approach enables rapid impact, minimizes risk, and supports sustainable rural health training and care delivery across Alaska’s frontier communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

LifeMed Alaska	Bridging Distance to Care: Rural Access and Clinical Capability Expansion Across Alaska	AK	LifeMed is a medivac company serving the entire state of Alaska, where geography, weather, long transport distances, and limited local clinical resources can delay access to higher-acuity care. In the Yukon-Kuskokwim region, these challenges are compounded by the operational limitations of our damaged Bethel hangar door, which prevents timely aircraft access during common wind conditions and reduces our ability to launch quickly for medically necessary transports. In a region where communities are not connected by road, this creates a direct barrier to care. Rural Alaska needs stronger emergency-care capability, more reliable transport resuscitation tools, and more opportunities to train clinicians who practice in low-volume but high-consequence settings. This project addresses both needs: removing an infrastructure barrier to patient access and builds regional clinical capability through specialized equipment, simulation training resources, and workforce development. We already have an established education department and staff who teach not only our own nurses and paramedics, but community partners. This creates a significant opportunity to expand a proven platform. With additional simulation medical equipment and educators dedicated to this effort, we can help deliver training and clinical support across the state. Because we operate our own airplanes and helicopters, we can reach communities statewide and bring training directly to them wherever there is runway access.	Our proposed approach is a coordinated rural access, workforce, and technology project with two connected components. First, we will reinforce and replace the Bethel hangar door so aircraft can be accessed and launched more reliably in routine regional wind conditions, reducing avoidable barriers to patient transport from the Yukon-Kuskokwim region. This will improve access to higher-acuity care for patients who must be flown to Anchorage or other locations for services unavailable locally. Second, we will strengthen clinical capability through targeted equipment, training, and implementation support. Requested investments include additional simulation medical equipment, advanced blood-product transport coolers with integrated temperature monitoring, mechanical CPR devices, blood and fluid warmers, and point-of-care ultrasound. These tools will improve diagnostics, resuscitation, transport safety, blood-product reliability, and patient stabilization during prolonged rural transports and care in austere settings. This project is designed not only for LifeMed crews, but for broader rural benefit. LifeMed Alaska already has its own education department and staff with the expertise and structure to teach our nurses and paramedics and to provide training to other clinicians and community members. To make this program successful at the statewide level, we would also need to hire additional educators who can expand outreach delivery, support recurring training, and help sustain implementation over time. Using our own airplanes and helicopters, LifeMed can deliver training and support directly to communities across Alaska. As long as a village has a runway, we can access it and bring education closer to the point of need. We will pair the equipment investments with standardized training, simulation-based instruction, competency validation, outreach education, implementation protocols, and quality monitoring for rural clinicians, including EMS agencies, nurses, and community-based providers. This approach aligns with RHTP priorities by improving access, strengthening workforce capacity, and deploying practical technology through a sustainable statewide model.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

LifeStance Health, Inc.	Rural Mental Health Access Program	AZ	The Rural Mental Health Access Program (RMHAP) is focused on bringing the benefits of integrated care to rural communities providing early identification of and rapid intervention for behavioral health conditions that commonly present in the primary care setting consistence with LifeStance’s experience implanting programs with primary care groups and health systems in a variety of states and build on LifeStance’s experience providing mental health care for chronically ill patients in Alaska under existing CMMI innovation projects. The principal goals are to make it easier for individuals in access mental health care, both therapy and psychiatry, in their community and through their primary providers and, once care is accesses, bring the benefits of tight coordination between primary care and mental health providers in managing underlying conditions.	Elements of the RMHAP are anticipated to include * A LifeStance collaborative care clinician (CCC) embedded, physically or virtually in rural PCP offices, rural health systems or critical access hospitals supported by a consulting psychiatrist to support on-site mental health screening, provide brief, evidence-based treatment and medication management, * LifeStance will work with primary care providers and health systems to implement regularly screening for mental health issues when patients present for annual or other physical health appointments supported by clear referral pathways when issues are identified, * LifeStance will integrate its EHR system with local health providers’ EHRs to provide direct scheduling, bilateral data exchange and care coordination between physical and mental health, • The embedded LifeStance CCC is supported by psychiatric clinicians (psychiatrist and registered nurses) who support patients whose conditions required medication for effective management. LifeStance psychiatric providers delivering regular case consultation and treatment recommendations for patients who are not improving as expected, allowing local primary care providers to confidently prescribe medication or directly manage the patient medications depending on local needs. *LifeStance tracks treatment progress via a dedicated registry platform to ensure patients are engaged and improving with measurement based outcome tracking shared with local treating physicians through the EHR integration. •LifeStance intends to deploy technology tools to connect patients with providers between appointments and support clinical goals, measure progress and provide digital therapeutic support. •Care navigator overseeing patients’ journeys in the RMHAP to ensure strong connections with providers. The care navigator focused on capturing underlying data for metric informed care, reporting to providers to support clinical decision-making and ensuring patients are connected with additional care where necessary to support the underlying diagnosis. • LifeStance will provide periodical community-based mental health screenings to engage with community members that may not have a regular physician to identify mental health issues and connect them with providers. •As part of the RMHAP, LifeStance intends to recruit providers to be physically located in and deliver care within rural communities on either a full time or rotating basis depending on community needs.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Lightbeam Health Solutions	Population Health & Care Management Platform	TX	Lightbeam addresses the issue of patient data fragmentation across disperse provider organizations. Patient data is siloed into various systems ranging from insurance claims, electronic health record data (often not shared across provider/hospital groups) to social determinants of health information. This creates inequities in how patients are cared for as well as fosters patients falling through the cracks and not receiving the care they need. Additionally, there simply aren't enough resources available to adequately proactively engage these patients in their care. Lightbeam aggregates data across this fragmented ecosystem, enriches patient data with social determinants of health information, applies predictive analytics to call out patients who need help now, and has a powerful rules engine that enables automated workflows to activate based on desired outcomes. These workflows include, but are not limited to provider engagement via EHR overlays, automated reporting as well as patient engagement via automated phone calls, text messaging and agentic AI. Lightbeam illuminates care gaps, provides predictive analytics to stratify the population and then has automation tools to engage patients and drive action at scale.	Lightbeam will address fragmented patient data and limited care-management capacity by creating a unified, actionable data foundation and automating workflows that drive care-gap closure and targeted outreach. - Unify fragmented data into a single platform: Lightbeam aggregates data from multiple sources—including EMRs, clinical data, lab results, HIE data, post-adjudicated claims, billing, pharmacy, and social determinants of health (SDOH)—into a single integrated solution to create a comprehensive patient view. - Enable interoperability across systems: The platform supports interoperability standards to integrate diverse feeds and reduce silos. - Identify risk and prioritize interventions: Lightbeam applies multiple risk stratification models (e.g., Johns Hopkins ACG, Charlson Comorbidity Index, Area Deprivation Index) and AI/ML (including Lightbeam’s Ability to Impact (ATI) score) to identify high-risk patients and predict avoidable events, ED visits, and admissions. - Illuminate and close care gaps with automation: The platform identifies non-compliant patients and creates actionable, trackable Gap-in-Care Tasks that can be satisfied based on daily incremental clinical data. It can also automatically close quality measure gaps by integrating with EHR data (noting an average of 57% closed without manual intervention), and routes remaining gaps to the appropriate users for completion - Activate workflows at the point of care: Lightbeam pushes care opportunities into clinical workflows via point-of-care tools such as the “Lightbeam Ribbon” overlay within the EMR, displaying open care gaps and coding opportunities during the encounter. - Support segmentation and rules-based workflows: The Cohort Builder enables configurable, rules-based monitoring to automatically identify patients meeting cohort criteria and group them for assignment, tasking, outreach, and reporting; the rules engine also drives workflow actions such as assigning patients to care management resources and care plans. - Deliver actionable reporting and provider insights: Lightbeam provides dashboards, quality reporting down to the patient level where available, provider scorecards, and automated report distribution to drive accountability and performance improvement. - Enable timely interventions via real-time alerts: Lightbeam supports real-time notifications based on events such as ED/inpatient admissions and ADT feeds to prompt rapid follow-up and care coordination.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

LilyLink	Alaska Remote-First Maternal Diabetes Program	CA	Alaska sees approximately 9,000 births annually, with 60% or more from mothers outside of Anchorage who face significant travel burdens for care and delivery. Prevalence of gestational or pre-existing diabetes can be as high as 1 in 5 pregnancies, due to higher risk among Alaska Native/American Indian women. Diabetes is one of the most common and modifiable contributors to maternal and neonatal complications, including cesarean delivery and NICU admission. In rural and frontier communities, diabetes education, weekly glucose monitoring, and specialist oversight are difficult to access. Specialist maternal-fetal medicine (MFM) physicians are concentrated in urban centers, and often local providers manage high-risk pregnancies without structured co-management support. Traditional reimbursement models do not consistently cover frequent remote data review and care coordination, creating a gap in ongoing diabetes management. This project addresses that gap by implementing a remote-first maternal diabetes program that delivers continuous glucose monitoring, weekly clinical review, and structured MFM oversight without requiring travel to urban hubs. It represents an implementation-ready opportunity to improve maternal outcomes, reduce avoidable complications, and extend limited specialty workforce capacity across rural Alaska.	LilyLink will implement a structured, remote-first maternal diabetes care model in partnership with Alaska-based Maternal-Fetal Medicine (MFM) physicians to support rural prenatal providers across the state. Initially, our project management lead will engage providers that see patients in rural areas such as OBs, FQHCs, tribal health, and critical access hospitals, offering a streamlined referral pathway for gestational or pre-existing diabetes. Clinicians can easily refer directly to LilyLink’s monitoring platform. Patients receive 1:1 onboarding and education from a RD/CDCES clinician within five days and a connected glucose monitor as needed. The platform supports secure data transmission from home, allowing continuous monitoring without requiring travel. A dedicated telehealth clinical team (RD/CDCES) will review 100% of patient glucose data weekly. The team will provide ongoing nutrition counseling, medication recommendations, and proactive outreach when trends are concerning. Automated reminders and patient education tools will support adherence throughout pregnancy. Clearly defined escalation thresholds will trigger MFM review. MFM collaborators will provide structured oversight for high-risk or complex cases, including therapy recommendations and consultative support to referring providers. This ensures timely specialist involvement while allowing primary prenatal providers to remain central to care delivery. Implementation is designed for rapid deployment. The platform is fully operational, clinical protocols are established, and referral workflows can be activated immediately on award. No construction or major infrastructure buildout is required. Device inventory and staffing can be scaled in alignment with enrollment targets. The model will initially target 200 rural pregnancies in Year 1, followed by phased expansion. Performance metrics will include enrollment times, data review compliance, reduced in-person visits, and maternal/neonatal outcome tracking. This approach transforms care delivery by shifting from episodic, visit-based management to continuous, proactive monitoring with specialist-backed oversight. It strengthens rural provider capacity, extends limited MFM resources across frontier communities, and establishes durable digital infrastructure to support long-term maternal health improvement in Alaska.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

LINKS Mat-Su Parent Resource Center	Alaska Intensive Community Navigation Program	AK	Frequent emergency department (ED) use in rural Alaska reflects untreated behavioral health conditions, unmanaged chronic disease, and social determinant barriers that make routine care hard to access. In the Mat Su region, the High Utilizer Mat Su (HUMS) program was created to address these gaps for adults with multiple ED visits, providing transportation, appointment accompaniment/advocacy, benefits navigation, and linkage to behavioral health and basic needs supports. HUMS’ track record shows clear system impact - participants engaged two years or longer have driven more than \$7.25 million in ED related savings at Mat Su Regional - demonstrating a strong base for expansion. The opportunity now is to pair HUMS’ community rooted model with CBCS’s proven national playbook to scale outcomes in Mat-Su and replicate them in Anchorage. Across multi state implementations, CBCS’s trauma informed, boots on the ground navigation has achieved ~60% reductions in ED visits, ~a targeted 50% reductions in hospital admissions, and about \$40,000 annual cost avoidance per enrollee, with other programs showing 2:1 ROI and dramatic declines in psychiatric readmissions. Anchorage faces similar pressures. By integrating CBCS training, operational supports, and data driven workflows with HUMS’ frontline engagement, the project can targeted to enroll about 300 additional Mat-Su residents and about 600–700 Anchorage residents, reduce dependence on EDs, and strengthen rural care pathways at scale.	HUMS and CBCS will jointly expand a high impact model built on reducing ED overuse by addressing medical, behavioral health, and social needs among high utilizing adults. HUMS will remain the boots on the ground outreach team, continuing to meet participants at the point of care and in the community while providing transportation, appointment accompaniment, referrals, and support with housing, benefits, and behavioral health access. CBCS will supply training, operational structure, and growth support, strengthening HUMS’ existing model through standardized engagement protocols, advanced trauma informed training, interdisciplinary care planning practices, and consistent data tracking workflows. Mat Su Expansion: CBCS will help HUMS enroll about 300 additional high utilizers, leveraging HUMS’ demonstrated ability to reduce ED utilization and generate significant cost savings (over \$7.25M for long term participants). CBCS will refine referral pathways (ED alerts, EMS, provider and payer feeds), enhance real time communication loops, and support quality improvement cycles. HUMS staff will continue addressing immediate needs - behavioral health referrals, detox linkage, utility and housing assistance, food resources, and transportation - ensuring stability and improved outpatient follow through. Anchorage Expansion: CBCS/HUMS will replicate the Mat Su model by building a HUMS-aligned Anchorage team to engage projected 600–700 residents experiencing frequent ED or crisis-system use. Expansion is aligned with Anchorage’ growing behavioral health system needs and crisis response development, including increasing Mobile Crisis Team activity and rising monthly call volume. CBCS/HUMS will build team capacity, implement structured training, and support existing mobile crisis, establish referral workflows with hospitals, EMS/MCT, behavioral health providers, and housing programs. Core Methods: 1. Identify & Engage: Real time ED/EMS alerts and community referrals. 2. Enroll & Assess: Individualized care plans integrating behavioral health, medical needs, and SDOH. 3. Coordinate & Accompany: Appointment support, advocacy, and consistent follow up. 4. Stabilize: Rapid resolution of transportation, benefits, housing, and basic needs barriers. 5. Track & Improve: Joint dashboards monitoring utilization, linkage, SDOH resolution, and outcomes. This integrated approach strengthens HUMS’ operational capacity while enabling scalable replication across rural Alaska.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Matanuska-Susitna Borough	Advance to Implementation Application

LINKS Mat-Su Parent Resource Center	Maternal & Early Childhood System Stabilization Initiative	AK	The first five years of life are critical to lifelong health, development, and educational stability. In rural and frontier areas of the Matanuska-Susitna Borough, services supporting mothers, infants, and young children operate across multiple systems, including pediatric and maternal health providers, MSBSD Child Find, the Infant Learning Program, licensed childcare programs, Early Head Start and Head Start, preschool and kindergarten programs, and pediatric therapy providers. While these systems provide essential support, coordination between healthcare, early childhood programs, and education systems is often fragmented. Referral pathways and follow-up processes are not always aligned across systems. As a result, families frequently navigate multiple programs during periods of heightened stress, particularly when developmental delays or behavioral concerns emerge. Gaps in early identification and cross-system coordination can lead to delays in evaluation and services, increased maternal stress, disrupted transitions between programs, and missed opportunities for early intervention during critical developmental stages. Strengthening coordination during the prenatal-to-five period offers a key opportunity to improve early identification, stabilize family systems, and promote more coordinated support for young children and families in rural communities.	LINKS Community Parent Resource Center proposes a Rural Healthy Beginnings Initiative to strengthen maternal and early childhood systems during the critical prenatal-to-five period. Project leadership serves as an Ambassador for the Division for Early Childhood (DEC) Recommended Practices, nationally recognized, research-based standards guiding high-quality early childhood and early intervention services. These practices emphasize family engagement, early identification, social-emotional development, coordinated transitions, and interdisciplinary collaboration. This initiative will apply these standards to strengthen rural maternal-child systems through the following strategies: Early Identification Alignment Strengthening collaboration between MSBSD Child Find, the Infant Learning Program, childcare providers, and pediatric healthcare providers to streamline referral pathways and reduce delays between developmental concerns and evaluation. Birth-to-Five Transition Stabilization Developing a standardized framework to support smoother transitions from early intervention to preschool and kindergarten, reducing service gaps and caregiver stress. Maternal Mental Health & Family Stabilization Improving provider awareness of maternal mental health indicators and strengthening referral coordination to appropriate supports. Evidence-Based Workforce Development Delivering workforce development sessions grounded in DEC Recommended Practices to improve provider competency in family-centered care, early identification, and cross-system collaboration. Rural Reflective Practice Cohorts Establishing small peer learning groups to reduce professional isolation and strengthen collaboration across rural communities. Workforce development will serve as the primary mechanism for improving maternal-child system coordination and stabilizing early childhood services across the region. At least 50% of workforce activities will be delivered virtually to ensure access for rural and frontier communities.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Little Bears Playhouse	Creating a Community Outdoor Play Space to Support the Physical and Mental Health of Our Community.	AK	Like many states across the U.S., Alaska faces an obesity epidemic among children. Most communities across Alaska are rural, frontier, or remote, making the delivery of essential needs challenging. The rural nature of our communities results in increased consumption of processed and shelf-stable foods; harsh winters contribute to sedentary behaviors; and lack of sunlight during winters affects mental health. Little Bears Playhouse is committed to assisting Girdwood, AK, and the other communities of Turnagain Arm on the journey to mitigate childhood obesity and improve healthy living. In Fall 2026, Little Bears will open in a new 8,000 sq ft facility providing childcare and after-school programming with three outdoor playgrounds to meet the needs of our community. The lack of inclusive outdoor spaces for children to explore, with the mentorship of skilled educators, leads to a more secluded environment, sedentary lifestyles, mental health concerns, and a lack of a sense of belonging. Open spaces with intentional features allow children to experiment and learn with other children of all ages and ability types, fostering inclusivity, collaboration, and cooperation, all of which are essential to instill healthy lifelong behaviors and combat the ongoing fight against chronic disease, such as obesity, diabetes, and cardiovascular disease. Little Bears’ consistent dedication to our community’s youth stimulates respect and development for a foundation for healthy living.	Little Bears Playhouse commits to Girdwood and Turnagain Arm’s youth to create the foundation for healthy futures. These communities are passionate about outdoor engagement and community involvement. The greatest supports lacking in our community are ample developmentally appropriate childcare, after-school care, and outdoor spaces allowing children to be active in all weather environments. Little Bears took action to meet our communities’ needs through the expansion of our facility and increased capacity. Little Bears Playhouse designed three developmentally appropriate open play spaces to welcome youth from our communities to explore, develop, and build healthy physical activity habits. Engaging in outdoor play spaces encourages the acquisition of gross motor skills, social engagement, and diverse sensory skills. Through a variety of play experiences, children develop the skills necessary to engage in the world around them. Our inclusive design ensures all children, regardless of ability or skill level, can explore the space. The construction of our facility's playgrounds is crucial to instill healthy lifestyles in our youth. Playgrounds foster social interaction, team problem-solving, cooperation, and conflict resolution. Studies show that engaging in active play in outdoor play spaces reduces symptoms of anxiety and depression, improves mood, and increases self-esteem. The outdoor setting promotes exposure to natural light and fresh air, an important factor supporting mental well-being. Little Bears’ new playgrounds lay the foundation for social development, enhance confidence and self-esteem, and contribute to the emotional and physical health of the youth in our community. A substantial benefit of developing and constructing our outdoor play spaces is the sense of belonging and community engagement. These playgrounds will serve as social hubs, bringing our diverse community together to build friendships, reduce isolation, and assist families in creating a village of support within our community. This vital social infrastructure encourages regular interactions and community pride, an essential component of a strong neighborhood and community.	\$250K-\$1M	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Little Bears Playhouse	Providing Afterschool Care for an Isolated Community to Support Our Youth	AK	Girdwood, Alaska, is a remote town approximately 40 miles south of Anchorage along the Seward Highway. This distance creates many barriers for our community and the surrounding communities of Indian, Bird, and Portage. Critical infrastructure is lacking, which would support the only medical service, Turnagain Community Health Clinic, Girdwood Fire Department, Whittier Police Department (who serve Girdwood), and the many medical professionals who call Girdwood home. One identified critical need for our community is after-school programming and child care. Our local school, Girdwood K-8, has no official after-school programming. This lack of programming leaves many children on their own from 2:30-6:00 pm. The lack of reliable and accessible after-school programming has led many families to leave our community. After-school care is a lifeline for working parents, providing an absolutely essential service that does not exist in our community. Little Bears Playhouse is expanding to a new 8,000 sq ft facility in Fall 2026. As part of this expansion, Little Bears Playhouse has developed the Girdwood Afterschool Program (GAP). Through the creation of GAP, Little Bears Playhouse offers a solution to meet this essential infrastructure need for Girdwood and the other Turnagain Arm communities.	Little Bears Playhouse will open its doors to the new Girdwood Afterschool Program on August 19, 2026. In our new facility, we have constructed an 800 sq foot multipurpose room designed to support 20 school-aged children from 2:30 pm to 6:00 pm for after-school programming. This program, led by 3 education professionals, will provide academic support, physical activity, and social connectedness to these students in our secluded town. GAP will provide a space for community youth to receive after-school tutoring and one-on-one academic support. The program curriculum will engage in Science, Technology, Engineering, Arts, & Mathematics (STEAM) focused activities to align with our educational philosophy. The integration of STEAM supports a hands-on approach, bridging the gap between classroom theory and real-world application. The ability to have dedicated, supervised time for physical activity in our outdoor play spaces or through teacher-led activities (cross-country skiing, hiking, etc.) allows our students to meet the national health benchmarks for moderate-to-vigorous activity. GAP will serve as a critical protective factor for our youth's mental and physical health. Our structured, safe environment will provide a spectrum of support, from basic emotional safety to intensive social-emotional learning. The primary mental health benefits will be a reduction in risky behaviors, a buffer to toxic stress, development of self-esteem, and behavioral improvements. GAP will allow students to engage with their peers, reducing the likelihood of developing problem behaviors associated with social isolation. Additional anticipated benefits include reduction in parental stress, use of trauma-informed care to assist our youth in navigating traumatic events, and building healthy coping mechanisms. Since reliable childcare and after-school care are a primary drive of stable parental employment, benefits of our after-school programming include improved workforce participation, parental job stability, and peace of mind. This program will support Girdwood's remote community health clinic by enabling recruitment, retention, and improved sustainability for current and new healthcare workers, to allow for the expansion of services, and improve healthcare access. Our broader community will see positive impacts, as engaged youth lead to a safer neighborhood and a decrease in risky behaviors, chronic disease, mental health conditions, and substance use.	\$50,000-\$250,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Little Bears Playhouse	Workforce Housing for our Early Childhood Educators to Support Our Healthcare Workers	AK	The healthcare industry in Alaska faces ongoing challenges with recruiting and retaining healthcare workers, who are vital to a strong workforce. A major factor is the lack of reliable childcare. In Girdwood, Alaska, supporting and expanding healthcare services is also challenging due to childcare workforce shortages. Girdwood, located within the Municipality of Anchorage, has pursued independence and self-sufficiency since its incorporation. The town has established its own volunteer fire department, the Turnagain Community Health Clinic (the only medical service within a 45-minute drive), police coverage (supported by Whittier Police Department), a library, a community center, a post office, and a small mercantile. Little Bears Playhouse, previously too small to meet community needs, has built a new 8,000 sq ft early learning center opening Fall 2026. This expansion will increase capacity from 29 to 110 children and add much-needed infant care and afterschool programs. These additions will substantially improve childcare access for the 75-150 healthcare workers and first responders who live and work in Girdwood. Employers will benefit from reduced absenteeism and lower staff stress. By collaborating with existing healthcare infrastructure, Little Bears Playhouse will also provide early development interventions and screenings, further supporting the community's broader health. Increased childcare capacity directly benefits healthcare employee recruitment and retention.	Little Bears Playhouse identified a community need and set to work to solve the lack of affordable, accessible, and reliable childcare for our healthcare workers and first responders in the town of Girdwood with our new facility, increased capacity, and expanded childcare services as outlined above. To enroll our new early learning center to the maximum capacity needed by our community, Little Bears Playhouse will increase its number of early childhood educators by at least 6 employees to maintain adequate ratios. To recruit new, qualified childcare workers to support our community, we need to provide adequate housing, which is scarce in our remote town. Little Bears has begun our hiring campaign to support the opening of the expanded early learning center. To continue finding the most reliable, qualified, and intentional early childhood educators, we seek to provide housing during their employment. Little Bears has established two partnerships to provide housing for our new and potential early childcare workers. The first partnership is with a private owner of multiple rental properties in Girdwood, AK. This private owner has agreed to contract with Little Bears Playhouse to allow us to rent out 4 of their rental units beginning June 2026. Little Bears has a Memorandum of Agreement with Alyeska Resort, owned by Pomeroy Lodging, to lease at fair market value and sublet 6 of its housing units, upon the completion of their new workforce housing development. Little Bears will manage these properties and have a contract set in place that ties an educator's residence to their employment at Little Bears Playhouse. As a recruitment incentive, Little Bears will cover 50% of the rent for the first year of employment for our early childhood educators, beginning in June 2026. This support will allow qualified educators to relocate to our secluded town and provide the highest-quality education to our youngest community members. This financial support will provide relocation assistance for our educators, in turn enabling our early learning center to enroll to capacity.	\$50,000-\$250,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Little Rock Early Learning Center	Outfitting Little Rock Early Learning Center (Little Rock), a New Daycare and Preschool in Homer	AK	Little Rock ELC addresses the severe shortage of licensed childcare slots in Homer and surrounding area. Rising costs of living, which require many families to have two working parents, and access for parents who are fiscally challenged are extremely troubling. Little Rock is undergoing the process of becoming a fully licensed childcare facility able to qualify for state, military and tribal subsidies, which will help directly resource many of these families. Our long-term goal is to have a healthy scholarship fund which would provide tuition subsidies for those who are in a median income bracket. Workforce challenges faced by local employers are high due to limited childcare availability. Little Rock will provide opportunity for training in a variety of positions and skill-levels, bolstering the workforce and longevity in the childcare field. Individuals will be well equipped and trained, providing space to for passion to grow under good leadership and support. Awareness of childhood development and access to intervention is limited in our small community. Little Rock Early Learning Center will support and increase access for our rural hub community to the long-term benefits of early childhood education, including improved school readiness, social-emotional development, and lifelong learning outcomes. Down the road, we plan to incorporate therapy services and support for childhood development, across a scope of unique needs.	Being deeply rooted in the Homer community, our leadership team began asking how we could tangibly support families “where they are.” Through conversations with parents, educators, business owners, and civic leaders, it became increasingly clear that early childhood education was one of the most urgent and unmet needs. We have used data from South Peninsula Hospital, acute observations of their own childcare center and the MAPP steering committee findings from the Homer Community Health Needs Assessment in 2022 to accurately identify the need and scope of support. The decision to pursue Little Rock ELC grew out of years of curiosity, strategic planning, and community observation. Families throughout the greater Homer area have consistently expressed the difficulty of finding reliable, high-quality childcare. We are excited to invest in as many as sixty children ages three months to five years old as a fully-licensed, year-round establishment working to strengthen families, support the workforce and serve our community in practical and sustainable ways. Year-round childcare is extremely limited in Homer: Little Rock will have full-time, year-round staff, able to provide consistency, predictability, and continually strengthen families without an extended break for summer. This enables both children to have continued care and childhood development support, the parents to continue in the workforce, and the staff of Little Rock to continue in their goals.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Loon Medical LLC	MamaBear Health: Consumer Digital Tool for Right-Sized Pediatric Follow-Up in Rural & Tribal AK	MN	Rural and frontier Alaska needs a practical way to make timely care decisions for young children when symptoms change outside a scheduled encounter. In the village clinic system, children under five account for approximately 25% of CHA/P visits, and respiratory/ENT illness is the dominant workload—40.8% of diagnosed encounters—including URI, bronchiolitis, wheezing/reactive airway disease, and pneumonia follow-up. Care decisions for these low-acuity cases depend on trajectory: is the child improving, stable, or deteriorating? Alaska's eCHAM guidance reflects that reassessment is core to sick-child care: some pathways call for daily rechecks until improvement criteria are met, while others direct rechecks only if symptoms worsen or a caregiver is concerned. This creates decision-critical touchpoints after the child returns home—when symptoms may be intermittent, hard to describe, or absent at the time of evaluation. Repeat rechecks impose a disproportionate burden where distance, weather, staffing, and connectivity limit access. Alaska has strong store-and-forward infrastructure, but workflows are clinic-initiated and optimized for provider-to-provider consultations—not for follow-ups for low-acuity & sick-child illnesses. The opportunity is to establish a low-bandwidth pathway to collect and store meaningful clinical change between encounters, enabling right-sized decisions—home care, local evaluation, or escalation—to be made with better information and less travel/time.	MamaBear will be deployed as a consumer-facing, store-and-forward pediatric reassessment tool within existing rural Alaska care workflows (tribal organizations, RHCs, and FQHCs). The project does not create a new service line or 24/7 triage channel; it standardizes and documents existing non-urgent sick-child check-in processes. Rollout is designed for 30–60 days per site. Year 1: implement and evaluate in 1–3 sites; Years 2–3: scale based on results and partner demand. Partner recruitment (Months 1–2). With Alaska DOH RHTP facilitation and APCA support, recruit initial partners and confirm readiness: a clinical champion, a workflow owner, a privacy/security review path, and agreed-upon metrics. Initial focus: Kenai Peninsula and Mat-Su, with expansion to frontier/village settings (YK Delta/YKHC) in Years 2–3. Workflow integration & training (Months 2–4). MamaBear is triggered by a sick-child follow-up requested by a CHA/P at the conclusion of an in-clinic visit. At home, caregivers submit structured inputs aligned with eCHAM recheck domains—activity, hydration/urination, breathing, and medication response—plus a brief, quality-controlled video. Staff training is lightweight (≤2 hours via Zoom & conducted by a licensed pediatric pulmonologist) and includes job aids and safety-net scripting. Clinical review & documentation (Months 3–12). Clinicians and CHA/Ps review submissions during defined workflows—not continuous monitoring—and document next steps: home care with safety-net guidance, local evaluation, or escalation. Reports are delivered via secure link to a secure email or via EHR integration, where available, but not required. Family education (Months 3–12). Clinician-reviewed "what to watch for" guidance is tied to logged symptoms, reinforcing when to seek urgent care. Alaska-specific content will be co-developed with partners. Sustainability (Months 4–12). Where appropriate, establish compliant store-and-forward billing workflows. Track time-to-review, staff time per reassessment, and recheck substitution to inform ROI scenarios rather than assuming uniform billing uptake. Evaluation (Months 6–12; Years 2–3). Phase 1 metrics: adoption rates, recheck substitution, review time, time-to-response, travel-burden avoidance, and safety signals (escalations, short-interval return visits). Years 2–3 will scale to additional sites and add de-identified aggregate trend reporting.	\$50,000-\$250,000	Statewide	Kenai Peninsula Borough; Kusilvak Census Area	Deferred or Not Advanced

Love Alaska	Online Exploitation Prevention and Digital Safety Training for Alaska Communities	AK	Across Alaska, communities are increasingly encountering the realities of exploitation, particularly the rapidly growing issue of online exploitation and digital grooming. Social media platforms, messaging applications, and online gaming environments have dramatically expanded the ways predators can access and manipulate vulnerable youth. In many cases, exploitation now begins online long before it becomes visible in a community. Rural communities are particularly vulnerable because access to prevention education and specialized training is often limited. Parents, educators, and community leaders may not be aware of the tactics used by traffickers and predators or the warning signs that exploitation may be occurring. At the same time, online exploitation can result in significant trauma and long-term behavioral health impacts for victims. There is a clear need for prevention-focused training that equips communities with practical knowledge to recognize online risks early and respond effectively before exploitation escalates. Our organization has an established history of doing this work in Alaska. We have partnered with Homeland Security and the FBI on victim-focused operations, we have worked with Tlingit & Haida, Knik Tribe, and the Alaska Native Women's Resource Center for indigenous-focused trainings, we have trained students at UAF, Sitka Public Schools, Mt. Edgecumbe, and Job Corps, along with hundreds of other Alaskans who have been equipped through our trainings.	Love Alaska proposes to expand a statewide training initiative focused on online exploitation prevention, digital safety, trauma awareness, and community response. The project will deliver community-based trainings designed for educators, youth workers, parents, service providers, and community leaders. These trainings will focus on recognizing grooming behaviors used by traffickers, understanding how exploitation occurs through digital platforms, identifying warning signs that youth may be experiencing online exploitation, and strengthening early intervention strategies. Participants will also learn practical tools for supporting youth who may be at risk and connecting individuals with appropriate resources. The project will prioritize rural and underserved communities where access to this type of training is often limited. Trainings will be delivered through partnerships with local organizations including tribal entities, schools, universities, healthcare providers, and social service agencies. In addition to professional trainings, youth-focused workshops will provide young people with practical information about digital safety, healthy online boundaries, and how to recognize manipulation tactics used by predators. By equipping communities with prevention tools and trauma-informed knowledge, this initiative strengthens protective factors that reduce vulnerability to exploitation and improve overall community wellness.	\$50,000-\$250,000	Statewide	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Sitka (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Lowell Point Volunteer Fire Department	Ambulance/Rescue vehicle for the Lowell Point Community and Lowell Point Volunteer Fire Department.	AK	The Lowell Point Volunteer Fire Department currently offers fire, first responder medical care and rescue services. The fire and rescue vehicles owned and operated by the department are old, 42 and 53 years old. The vehicles lack adequate storage space and compartmentation to stock and transport a variety of medical and rescue equipment. Responder often have to make decisions about what equipment to bring and what to leave behind. The department currently has no ambulance or rescue truck and responds in one of our two Tanker/Pumper that cannot transport patients. Some medical and most rescue equipment is staged at the station and brought to the incident in Private Operated Vehicle because it does not fit on either Tanker/Pumper. Since the current units are too small to be stocked with a variety of rescue equipment, volunteer members must make decisions about which rescue equipment might be needed for the incident. Volunteers then take the time to load and stow the rescue equipment, if it fits, in the unit prior to departure. This decision making, loading and stowing delays incident response times. These old vehicles are difficult to retrofit with modern systems. The new vehicle would have integrated modern communication systems directing drivers to locations and allowing drivers to communicate in real-time with other members. Given the age of the vehicles, they require constant tinkering to maintain which cost money and depletes our limited budget.	Since the Lowell Point Volunteer Fire Department currently offers fire, first responder medical care and rescue services and has two tanker/pumpers the ideal vehicle would be a Type 1-AD (Additional Duty) Ambulance/walk in Rescue with transport capability. It will include a medium duty chassis with a modular, 14-foot ambulance/rescue body for both medical care and transport and to carry rescue equipment needed for vehicle accidents and back country rescue. This would be about 2 feet longer than the average Ambulance and has extra compartment space for medical and rescue equipment. It will have seating for two in the cab and three in the body/patient care area. Our fire station has an open heated bay for this vehicle. This ambulance will be for emergencies and to help evacuate patients to the hospital in Seward for advanced medical care. The addition of an ambulance to our fleet will provide both medical care and rescue services in one platform and will replace one of our Tanker/Pumper trucks. We will still own, maintain and operate two vehicles keeping our overall costs similar or less. Lowell Point wishes to be more self-sustaining since the road access to the community can periodically be cut off. The community and the Fire Department are three miles south of Seward and can only be reached by a dirt road or boat. The single access road is known for its landslides, rock fall and snow avalanches. Morning commuters often have to wait for avalanches to be cleared before going to work. On Saturday, May 7, 2022, a large landside occurred on the access road with an estimated 40,000 cubic yards of debris blocking the only road into the community for 17 days. Having our own ambulance will improve response times and improve patient care but is particularly important when access to Lowell Point is cut-off. The ambulance will allow our members to provide medical assistance, stabilize the patient and transport the patient to our dirt helicopter landing pad. The department aided in coordinating evacuation of visitors and aided community members during the landslide. Since the slide occurred on a Mother’s Day weekend at about 3 pm and the weather was beautiful, the community was full of numerous tourist and day adventures. The department worked with local businesses to offer water taxis to transport passengers and supplies in and out of Lowell Point from Seward. Fortunately, during this three-week period we did not experience any fire or medical emergencies.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

LTS/testand go	Expanding Testing and Medication Access Across Alaska Through Dispensing and Pharmacy Kiosks	VA	Rural and remote communities across Alaska continue to face barriers to timely access to prescription medications, health products, and diagnostic testing. Long travel distances, weather-related disruptions, transportation challenges, workforce shortages, and limited local pharmacy or health access points can delay care and make it harder for patients to follow through on treatment and testing recommendations. In many cases, patients may leave a care encounter with a prescription or recommended test but still face significant obstacles to obtaining medications, supplies, or testing in a timely and reliable way. This project addresses that gap by enabling organizations to expand access through prescription kiosks, dispensing kiosks, and self-collected diagnostic test kits that can be deployed to reflect local needs, care models, and operating environments. These solutions can help reduce barriers between diagnosis, prescribing, dispensing, and follow-up, while giving providers more flexible tools to improve access closer to home. For LTS, the opportunity is to serve as a scalable implementation partner for multiple Alaska entities seeking practical, technology-enabled solutions to strengthen access and continuity of care. Through this project, LTS would support participating organizations with the infrastructure, implementation planning, and deployment support needed to expand access in a way that is sustainable, adaptable, and responsive to rural service delivery in Alaska.	LTS’s proposed approach is to work with participating Alaska organizations to plan, configure, and deploy the access model that best fits each setting. Depending on the organization’s needs, that may include a prescription kiosk, a dispensing kiosk, self-collected diagnostic test kits, or a combination of these tools. The project would be implemented through a phased process designed to move from planning to deployment in a structured and operationally sound way. Initial work would focus on identifying participating sites, confirming pharmacy and provider partners, defining priority use cases, and determining the appropriate deployment model for each organization. LTS would then support site assessment, workflow design, product or formulary planning, connectivity and infrastructure review, and any needed integration with pharmacy systems or electronic health records. This phase would also include coordination around oversight requirements, security, testing protocols, staff training, and patient-facing education. Once implementation requirements are defined, LTS would support system configuration, installation, testing, and go-live preparation. After launch, the project would include early monitoring of utilization, workflow performance, and operational issues so that participating organizations can make adjustments and strengthen long-term performance. This approach is intended to give Alaska entities a practical implementation pathway, not just access to technology. LTS’s role would be to provide the equipment, planning support, integration coordination, and deployment assistance needed to help multiple organizations put these solutions into operation successfully.	\$1M-\$5M	Statewide	Anchorage (Municipality); Bethel Census Area; Copper River Census Area; Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Lumeris Companies	AI-Enabled Primary Care Infrastructure: Integrated Virtual, Remote & Community Care Orchestration	MO	Rural Alaskan communities face persistent barriers to timely care due to geographic isolation, workforce shortages, and limited service capacity. Long travel distances, severe weather, and uneven connectivity make it difficult for patients to access preventive services, manage chronic disease, and maintain continuity of care. Rural providers also face growing administrative burden and difficulty recruiting and retaining clinical staff. These challenges create an opportunity to strengthen care delivery through AI-enabled primary care infrastructure that expands access, strengthens prevention, and supports workforce capacity. By embedding advanced analytics and autonomous care orchestration within existing clinical workflows, providers can proactively identify care gaps, monitor rising-risk patients, and coordinate preventive outreach across dispersed communities. Tom™, Lumeris’ AI-enabled primary care platform, integrates directly with existing EMRs and health information exchanges while preserving local data governance. It also integrates with complementary technologies such as remote patient monitoring and digital health tools, strengthening the impact of existing investments and enabling coordinated care across solutions already used by Alaska providers. This approach helps providers modernize care coordination, strengthen continuity, and expand access to primary and preventive services while maintaining community-based care models essential to rural Alaska.	The proposed approach is to make Tom™, an AI-enabled rural primary care infrastructure platform, available to Alaska providers and Tribal health organizations that elect to deploy the platform, expanding care coordination capacity while integrating directly into existing clinical systems and workflows. Rather than replacing local technology or care models, Tom is designed to embed within provider EMRs and health information exchanges using standards-based interoperability (e.g., HL7 and FHIR), allowing organizations to strengthen care coordination while preserving local data governance and operational autonomy. Tom functions as an AI-enabled care orchestration layer anchored in primary care. By continuously analyzing clinical, claims, and patient-reported data, the platform identifies care gaps, rising-risk patients, and preventive needs. Using evidence-based clinical protocols, Tom can initiate outreach and care coordination actions across multiple communication channels—including text, voice, and landline—ensuring patients in low-bandwidth rural environments can still be reached reliably. The platform is designed to strengthen the impact of existing health system and community investments by integrating with complementary technologies already used by providers, such as remote patient monitoring and other digital health solutions. By coordinating across these systems, Tom amplifies the effectiveness of existing tools while reducing fragmentation across care teams and settings. For rural providers facing workforce shortages and increasing administrative demands, Tom functions as a force multiplier for care teams. By surfacing actionable insights, coordinating and autonomously executing routine outreach and follow-up activities, the platform helps clinicians practice at the top of their license while mitigating the need for additional staffing investments in hard-to-fill coordination roles. Implementation will emphasize thoughtful integration and clinician engagement, working with Alaska providers and Tribal health organizations to ensure AI-enabled tools are introduced in ways that build trust and familiarity among care teams and patients. Tom establishes AI-enabled primary care infrastructure that allows Alaska providers to adopt emerging capabilities without repeatedly rebuilding underlying systems.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

LumiCare, Inc.	LumiCare's LumiLink Nurse Connect: Improving Rural Access Through 24/7 Remote Nursing	PA	Rural, remote, and frontier communities face persistent barriers to timely, high-quality clinical care. Long travel distances, severe weather, limited nursing capacity, and chronic workforce shortages frequently lead to delayed interventions, preventable hospitalizations, and fragmented care. Traditional site-based nursing models cannot adequately support communities where skilled clinicians are scarce and where health concerns often go unaddressed for extended periods. This project aims to close that gap by introducing a remote nursing and real-time health monitoring model that expands clinical access and reduces avoidable emergencies. Through 24/7 Registered Nurse availability, proactive monitoring with medical-grade devices, and integrated dashboards, individuals can receive immediate triage, early intervention, and ongoing support regardless of location. The opportunity is to strengthen Alaska’s rural health system with a scalable, person-centered solution that improves access, enhances care quality, and eases pressure on an overstretched workforce. By extending clinical reach and enabling earlier, more consistent support, the project helps ensure that even the most isolated residents receive timely, reliable, and responsive care.	The project introduces a remote nursing and real-time health monitoring model that expands access to reliable clinical support for individuals living in Alaska’s rural, remote, and frontier communities. It is designed to address barriers that routinely delay care, limited on-site nursing capacity, long travel distances, severe weather, and seasonal disruptions. By establishing a centralized virtual nursing hub supported by medical-grade remote monitoring technology, the model strengthens local care systems while reducing the burden on overstretched providers. Participants and caregivers gain 24/7 access to Registered Nurses through a secure telehealth platform. Nurses deliver real-time assessment, triage, coaching, and care coordination, enabling concerns to be addressed early and often preventing escalation. Because many issues can be resolved safely at home, the model reduces avoidable emergency visits and ensures residents in isolated communities receive immediate support without waiting for in-person services. Bluetooth-enabled medical devices feed vital signs and symptom data into an integrated clinical dashboard. This allows the nursing team to identify trends, detect early warning signs, and intervene quickly, improving outcomes for individuals with chronic or complex needs. The standardized monitoring approach also supports providers who may lack access to a full clinical team. The model is built to integrate with partner workflows. Documentation and encounter summaries are shared in interoperable formats, and escalation pathways are customized to align with local protocols and available resources. When in-person care is required, the virtual nursing team coordinates directly with local providers or emergency responders to ensure smooth handoffs. By reducing travel demands and enabling limited staff to prioritize high-acuity needs, the model helps stabilize the rural workforce and reduce burnout. Caregivers and local staff also receive training and ongoing coaching, increasing confidence in managing lower-acuity concerns with remote clinical support. Together, continuous clinical access, proactive monitoring, and strong care coordination create a scalable, sustainable approach that improves access, strengthens care quality, and ensures individuals in Alaska’s most isolated communities receive timely, dependable support.	\$50,000-\$250,000	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Managing Me Enterprises	The PENNI Project: A Project Database Matching Platform for Creating Partnerships	AK	"Partnership is the foundation for transforming care in rural AK"(AKCMSRHTP, pg.17). Challenges include limited public health authority, infrastructure gaps, system modernization needs, and rural service reductions(pg 6,8,10). RHTP funds target improving access/outcomes through tech and collaboration(pg 12-14,17). The cost of siloing/uncoordinated projects is high but hard to quantify. AK spends more per capita than the US in 5/9 health cat., with care coordination failures ID'd as a top wasteful spending area(AKHCTPRoadmap, pg.23). National collab. resources don't meet AK's needs. Successful local partnerships demonstrate the power of coordination. The AK Rural Utility Collab., our CEO's CommCare work, and Stone Soup/Southcentral collab. increased access by leveraging synergies, coordination pathways, and workflow integration. But these required slow, heavy investment/had a narrow focus. The RHTP presents an opportunity to build on these lessons. By quantifying siloing costs, defining collab. enablers/inhibitors/automating their identification, a tech platform could reduce service gaps/duplication and increase access beyond the RHTP. The RHTP will already have the data on AK's most innovative initiatives and provide motivation/direction for specific partnerships. Now is the chance to build a centralized, automated, collaborative platform that replicates past collaborative successes in a scalable, tech-driven, efficient way that outlasts the RHTP funds that establishes it	PENNI is a statewide project matching platform that helps organizations find overlapping work and connect with the right partners. PENNI takes a searchable database to the next level by giving the option to automatically generate match scores with plain-language explanations based on partner-defined factors, so teams can quickly decide when to coordinate. In PENNI, “project” is a broad term that includes programs, initiatives, research efforts, current studies, pilots, evaluations, and other organized work happening across AK. PENNI is more than a searchable list: organizations can maintain project information, control what is shared publicly, and use match suggestions to coordinate early and reduce duplicated effort, especially in rural and remote communities where capacity is limited. Our approach is partnership-first and designed to strengthen collaboration within the RHTP ecosystem. In partnership with DOH/Alaska Community Foundation’s RHTP, PENNI will support DOH’s goals around efficient use of funding and improved project coordination starting in Year 1 by helping identify overlap, reduce duplication, and surface collaboration opportunities across awarded work. Year 1 focuses on validating collaboration needs and “fit factors” through structured Voice of Customer, facilitated workgroups, and mapping how projects are created, managed, and closed. Outputs include VoC-verified mind maps and workflow diagrams, a usable set of matching factors, an explainable match approach, and a baseline of the cost of siloed work (duplication and survey fatigue), resulting in a research paper and practitioner-oriented white paper. Subsequent phases build and pilot the platform with RHTP recipients and additional AK organizations, refine matching through real usage, strengthen governance and onboarding, and mature operations for sustainability. Over time, the platform will automate matching and coordination processes initially done by hand, reducing workload while improving efficiency and enabling more precise program and funding planning. Once fully launched in Alaska, we will extend our user base to the lower 48 as part of our sustainability plan. This will allow user fees outside the state to fuel in-state free use of the platform.After the organization-facing proof of concept is established, a later phase may include an optional public view of public projects and resources so community members and patients can discover opportunities and sign up for relevant updates	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Maniilaq Association	Maniilaq Association Behavioral Health AI Clinical Documentation and EmPATH Design Planning	AK	Our rural residents of the Maniilaq service (MSA) area face significant barriers to behavioral health care, including geographic isolation, limited crisis stabilization infrastructure, and Behavioral health (BH) workforce shortages. BH providers serving the MSA must manage high caseloads while meeting complex documentation requirements associated with Medicaid billing, accreditation standards, and regulatory compliance. These administrative demands reduce time available for direct patient care and contribute to clinician burnout. At the same time, the region lacks dedicated psychiatric crisis stabilization facilities. Individuals experiencing behavioral health crises often present to emergency departments or law enforcement settings that are not designed to provide therapeutic stabilization. This project addresses these challenges by implementing AI-enabled clinical documentation tools that reduce administrative burden while simultaneously designing a rural Emergency Psychiatric Assessment, Treatment and Healing (EmPATH) crisis stabilization unit. By addressing both challenges together, these efforts will strengthen Maniilaq's Behavioral Health service delivery, improve workforce sustainability, and expand access to crisis care across a geographically remote region of Alaska.	The Maniilaq Behavioral Health AI Clinical Documentation and EmPATH Design Planning project will improve the quality, efficiency, and accessibility of behavioral health services across the Maniilaq Service Area through the implementation of AI-supported clinical documentation and the design of a rural Emergency Psychiatric Assessment, Treatment and Healing (EmPATH) crisis stabilization unit. This project will implement two coordinated strategies to improve behavioral health care delivery in the Maniilaq Service Area. First, the project will deploy an AI-enabled clinical documentation and compliance platform to support approximately 50 behavioral health providers. The system will assist clinicians in generating compliant documentation for assessments, treatment plans, and progress notes while aligning documentation with payer requirements, regulatory standards, and accreditation expectations. Real-time compliance auditing will help identify documentation gaps before submission, reducing administrative rework and strengthening audit readiness. Second, the project will complete operational and architectural planning for a rural Emergency Psychiatric Assessment, Treatment and Healing (EmPATH) crisis stabilization unit. EmPATH units provide rapid psychiatric assessment and short-term stabilization in a therapeutic environment designed specifically for behavioral health crises. Planning activities will include workflow development, space design, staffing models, and integration with existing crisis response systems. The design will consider the unique conditions of rural Alaska, including transportation challenges, cultural considerations, and coordination with tribal health services. By combining workforce support through AI-enabled documentation with crisis stabilization infrastructure planning, the project will advance a comprehensive approach to improving behavioral health care access and system performance in rural Alaska.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Northwest Arctic Borough	Advance to Implementation Application

Maniilaq Association	Maniilaq Association Health IT Modernize End-User Access	AK	The Maniilaq Health Center (MHC) and our 11 rural village clinics must replace and upgrade our current aging health systems' computer workstations to take advantage of new technologies to improve both access and enhanced quality of care for our patients. Providing health services to a rural population, Maniilaq and our patients need better access to essential telehealth services, enhanced cybersecurity against growing and constant threats, ensure timely Electronic Health Record (EHR) interoperability, and ensure patient care continuity. Additionally, by replacing and upgrading our MHC and village clinic health system computer workstations, we will improve operational efficiency and be better able to attract future providers who expect advanced, digital capabilities. Other current challenges with our aging Health Computer workstations: 1. Need for better Healthcare Cyber Specific Security. Like other health providers, Maniilaq has seen an increase in cyber attacks. 2. Faster EHR access for our providers and health support staff is critical for improving our rural patient outcomes, decreasing errors, and reducing clinician burnout. 3. Reducing costly travel burdens on our rural patients by accessing more medical appointments through Telehealth. 4. Our health providers being able to access new Health AI Tools for better documentation and diagnosis of our patients. 5. Maniilaq Health computer workstations have either warranties about to expire or have expired.	Maniilaq Health IT Modernize End-User Access project will purchase new health computer workstations for the Maniilaq Health Center and the 11 village clinics in the Maniilaq service area. Within the first month of the grant award, the Maniilaq IT Director and CIO will put in order for the new health computer workstations. This will include a mix of both fixed and movable workstations. Maniilaq has a quote for \$675,909.20 from CDWG for a mix of Lenovo ThinkPad workstations with ThinkSystem infrastructure. Maniilaq IT and Health Services have already done both assessment and planning for this project to ensure the right equipment is ordered. They have concluded that these more modern workstations will help our rural hospitals and village clinics improve patient care by providing reliable, high-performance, and cyber-secure technology. They will enhance efficiency for our healthcare providers and support staff through fast access to digital health records, support advanced medical imaging, enable telehealth, reduce IT downtime, and provide dedicated support services. Additionally, Maniilaq IT Department will work with ANTHC to ensure all new health computer workstations have proper integration into the Tribal health shared Electronic Health Record (EHR) system. After the procurement in the first month, Maniilaq IT will start on the replacement and configuration of all new health workstations and ensure all have the right software, security software, and health-related access and tools to support all providers and health support staff. The last phase will be both the implementation and training of the provider and health support staff on the proper use of all new health workstations. This will be done in partnership with the vendor and Maniilaq IT staff. As Maniilaq Health Services is very large, implementation and training will be done by department covering all 11 Village clinics in the Maniilaq service area, and at the Kotzebue Maniilaq Health Center, the departments of Long-term Care, PHN, ER, Medical Inpatient and Outpatients, Radiology, Dental, Behavioral Health, PT, Eye clinic, Tribal Doctor, Pharmacy, and other health support services.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Northwest Arctic Borough	Advance to Implementation Application

Maniilaq Association	Maniilaq Association Medical Village Home Visit Starlink	AK	In the Maniilaq service area, our village Community Health Aides/Practitioners (CHA/Ps) perform rural home visits in our villages for patients who are unable to walk or make their way to the clinics without Electronic Health Record (EHR) access, which can create significant challenges that impair the quality, safety, and efficiency of our patient care. Challenges this project will address: 1. Without CHA/Ps having access to shared EHR, health providers doing home visits are unable to seamlessly share information with primary care physicians or specialists, leading to fragmented or delayed care 2. Inaccurate documentation due to relying on paper records can increase the likelihood of losing patient data, recording errors, or struggling to read handwriting. 2. Workflow Disruption due to CHA/Ps needing to "double-document" by writing notes by hand during the visit and later entering them into a computer system, which is time-consuming and inefficient. 3. Without patients or CHA/Ps having instant access to patient histories, recent lab results, or medication lists, clinicians cannot make informed, real-time decisions. 4. Increased risk of error with medication management, especially with patients taking multiple medications or managing several chronic medical conditions. 5. Delays in being able to submit 3rd party billing as paper-based or non-integrated documentation can slow down the submission of billing, which can impact the financial stability.	Maniilaq IT Department, working with our CHA/P program, will order 11 Portable Starlink dishes that can be used in all our villages in the Maniilaq service area. Within the first month of the grant award, the Maniilaq IT Director and CIO will put in order for the new 11 Portable Starlink dish units. Maniilaq has a quote for \$99,000.0 from Starlink for the equipment and 1st year of service. Future years to be covered by Maniilaq. These Portable Starlink units will be used by our village clinic CHA/Ps to give them secure high-speed during home visits. This technology enables real-time EHR access, video consultations, and remote diagnostics, bridging the digital divide where mobile and cellular infrastructure is unreliable. Maniilaq IT and Health Services have already done both assessment and planning for this project to ensure the right equipment is ordered. They have concluded that these Portable Starlink dish units will help our rural village clinic CHA/Ps have the needed access to our EHR during home visits. The Starlink dish units will be set up at the village clinics. CHA/Ps will be trained on their use and how to align them with LEO satellites to provide immediate broadband access for EHR access. Additionally, Maniilaq IT Department will work with ANTHC to ensure all new health computer workstations have proper integration into the Tribal health shared Electronic Health Record (EHR) system. After the procurement in the first month, Maniilaq IT will start testing and ensuring all new Portable Starlink dish units are working and configured so that all village CHA/Ps have the right EHR and other health-related access and tools to support performing home visits to patients who are unable to walk or make their way to the clinics. The last phase will be both the implementation and training of the provider and health support staff on the proper use of all new health workstations. This will be done in partnership with the vendor and Maniilaq IT staff. As Maniilaq Health Services has 11 village clinics, implementation and training will be done at one village clinic at a time in the Maniilaq service area.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Northwest Arctic Borough	Advance to Implementation Application

Maniilaq Association	Maniilaq Association Modernizing of Health IT Infrastructure	AK	The Maniilaq Health Center and Village Clinics' current Health IT infrastructure systems are nearing the end of life (end of support) and need to be replaced to allow for bridging significant health disparity gaps, improving rural access to care through improved telemedicine, and ensuring cybersecurity. These Health IT replacements/upgrades of core switches and IT infrastructure will allow Maniilaq Health Services to provide better coordination among health providers across vast distances, reduce travel burdens on patients, and support the integration of electronic health records (EHR) to improve patient outcomes. Additionally, Maniilaq's Health IT infrastructure is critical for our rural Arctic Alaska population to overcome geographical isolation to ensuring seamless care coordination through telehealth services, and ensure healthcare professionals maintain access through Electronic Health Records (EHR's) data for patients moving between remote villages and urban centers. Lastly, Health IT upgrades will allow for newer technologies to improve provider efficiency and help manage chronic diseases.	Maniilaq Association's IT department will purchase new core switch, infrastructure switches, and compute/storage platforms, which will be implemented side-by-side while the current Health IT systems are in operation. Based on our years of experience in providing Health IT services in rural Arctic Alaska, Maniilaq's proposed approach for this project will be to prioritize high-reliability IT upgrades made to deal with the extreme rural Arctic environment we provide services in, and that are equipment that is resilient and has low maintenance needs, so we are not dependent on outsourced support. Additionally, our Maniilaq Health IT team and Healthcare providers will review all potential upgrades and replacements to ensure the infrastructure supports improved telemedicine, high-definition imaging, and future AI-enabled diagnostic tools. Lastly, Maniilaq's IT team will ensure all upgrades and replacements will have the storage platforms to handle future potential data growth, reducing the need for frequent and difficult hardware refreshes. Maniilaq Health IT will be working with a proven vendor, and contracted support will be leveraged as needed to ensure the new systems are implemented following industry best practices. This method will allow for minimal downtime, clear progress tracking, and the ability to fall back to the current system if necessary. Once the migration is complete, the old Health IT systems can be taken offline (but powered on) until the new system is verified to be fully operational.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Northwest Arctic Borough	Advance to Implementation Application

Maniilaq Association	Maniilaq Association Pharmacy Modernization Project	AK	Our village patients often experience reduced medication access due to frequent medication shipment interruptions. Vulnerable patients with medication management difficulties do not have enough support for enhancing medication adherence through pill box/medication cassette utilization. The Maniilaq Pharmacy modernization project will address these and other current challenges, including the fact that pharmacy space is limiting program growth, and expansion is needed to enhance operational efficiency in response to growing service demands. Maniilaq Pharmacy Modernization Project (Three-part) Part 1: Medication management technology modernization for our 11 village clinics to address the multiple systems that are being used to manage village clinic medications, which are cumbersome, inefficient, and prone to errors. Our current system of PickPoints + Knoxware lockboxes + provider boxes does not have enough space for pharmacy products needed in our village clinics, and the 3 different medication storage/security methods are time-consuming and confusing to manage. Part 2: Pharmacy design will address the need for expansion to enhance both patient safety and operational efficiency in response to growing service demands. Part 3: Initiation of medication adherence, vulnerable patients with medication management difficulties do not have enough support for enhancing medication adherence through pill box/medication cassette utilization, known as a “Mediset” program.	As stated above, the intent of this pharmacy modernization project is to address challenges through a three-part, multi-faceted manner, to provide expanded access to pharmacy care to all of our patients and clinics. The Maniilaq Health Center (MHC) Pharmacy modernization project has three parts: Part 1: Medication management technology modernization for our 11 village clinics, through automated dispensing cabinet (ADC) upgrading and expansion. The project will cost an estimated \$1M for new equipment and setup, which would be performed by the vendor and MHC staff. Maniilaq Pharmacy's village medication management need for new ADC is absolutely necessary as the current systems have reached end-of-life and are no longer serving our needs due to size and reporting limitations. The new ADC system will be much more seamless for village clinic staff to manage, and MHC pharmacists to oversee and support. These remote automated dispensing cabinets will improve medication oversight capacity and faster/more efficient management and shipping of stock items; increased medication stocking capacity in village clinics will lessen the medication shipment delay impact on patients when weather interferes with shipping schedules; enhanced reporting capability with these cabinets will result in better adherence with documentation requirements, and improved visibility of what patients are receiving. Part 2: MHC pharmacy department remodel design project, to expand workspace and create more patient counseling/visit rooms, improve workflow, and add space for new pharmacy automation. The project will cost an estimated \$150,000 for design. The combining of the current 3 different systems into one comprehensive Automated Dispensing Cabinet system in each village clinic would enable MHC pharmacy to efficiently manage those remote stocks and reduce clinic staff time doing medication management. Part 3: Initiation of a medication adherence packaging system and program (Mediset) to improve medication adherence for patients with medication management difficulties. The project will cost an estimated \$50,000. Our identified patients needing extra assistance will be connected to licensed pharmacists via secure technology. Our in region Pharmacy technicians handle on-site dispensing, provide counseling, verify prescriptions, and manage care via video and phone. The Mediset program will support vulnerable patients with medication management difficulties across the entire rural region	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Northwest Arctic Borough	Advance to Implementation Application

Maniilaq Association	Maniilaq Association Portable X-Ray Units for Rural Arctic Village Clinics	AK	X-ray imaging is not available in our 11 rural off-road village clinics in the Maniilaq service area, and patients with injuries or illnesses in our villages have to fly to Kotzebue (Hub) to have imaging studies. Travel costs for both patients and Maniilaq Health are very expensive, as an round trip ticket can cost between \$405 - \$600 to travel to Kotzebue from our villages. This project would cut down on our travel expenses by being able to diagnose or rule out simple fractures, dislocations, pneumonia, or other issues in the villages. The benefits for the patients in our villages are that they can be treated more quickly and possibly not have to travel to Kotzebue, depending on the outcome of their exam. Currently, more than 2,000 exams annually require village patients to fly to Kotzebue for an X-ray. These delays of timely diagnosis and treatment can often add to the significantly high cost of healthcare in our rural area. Additionally, severe weather and the vast geography of our rural Arctic service area result in frequent flight cancellations cause additional delays in providing proper care. Large fixed X-ray units are not feasible in our small and crowded village clinics, which makes these portable X-ray units a perfect fit for our rural Arctic Village clinics. Maniilaq Health Center's existing integrated specialist radiologist partners are available 24/7 via remote data connection to interpret and diagnose digital radiographs from off-road village clinics.	The investment in this project to provide portable X-ray units for our rural village clinics will significantly transform the healthcare delivery in our rural isolated villages, and will provide immediate and clear improvement in our paitents albility to access this needed healthcare service. Additionally, this targeted investment in radiologic technology and strategic staffing integration to increase local village provider capacity to deliver secure, timely, high-quality care as close to home as possible, and to extend the reach of our specialist services. The Fuji AQRO has been used in other rural areas in Alaska by other Tribal Health Organizations. Moreover, by installing Fuji AQRO compact portable mobile digital x-ray units in our village clinics, the AQRO’s small footprint, light weight, mobile design, and digital technology solve three problems we currently face: • Can be used and stored in our small crowded village clinics. • Light enough to be transported by a small plane for service in rural Alaska. • Digitally integrates with our existing PACS and EHR radiology systems, allowing for remote virtual integration of specialty care providers and hospital-based radiology technicians. Historically, a secondary barrier to village-based x-ray is maintaining village medical staff competencies to operate x-ray units. However, our Maniilaq hospital-based Radiology Team will remotely guide every X-ray exam conducted in village clinics via live, multi-camera, two-way video interface. By the Maniilaq Radiology team, providing live remote video guidance from highly qualified hospital radiology technicians will: • Improve the quality of X-ray images for diagnosis for our rural patients. • Increase utilization of village X-ray units by giving village medical staff the support needed to conduct X-ray exams.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Northwest Arctic Borough	Advance to Implementation Application

Maniilaq Association	Maniilaq Association Arctic Hub Health Transportation	AK	The Maniilaq Arctic Hub Health Transportation project will address challenges our underserved populations, including low-income, elderly, patients with disabilities, and patients flying in from rural villages, face in getting to medical appointments and picking up medications at the Maniilaq Health Center. Currently, Maniilaq sees a high rate of missed appointments due to challenges of a lack of transportation from the airport or for our patients unable to walk to our health center. The hub community of Kotzebue faces significant barriers to accessing healthcare due to a lack of personal transportation, reliable taxi cab services, long winters making it dangerous to walk, high cost of fuel, and no public transit system. These and other challenges often lead to many of our patients having high rates of missed medical appointments, particularly among the elderly, the disabled, and those with chronic conditions. These missed appointments can led to worsened chronic conditions, delayed diagnoses, increased mortality risk, and higher rates of hospitalization Other challenges: 1. Medication loss during long winter months, as temperatures are low enough to cause medication to freeze in transport without heat. 2. High risk of patient slips and falls, as winter months can create dangerous walking conditions that significantly increase the risk of falls, resulting in broken bones, sprained ankles, or even TABI and create 3. Financial barriers to accessing healthcare appointments.	The Maniilaq Association (MA) Arctic Hub Health Transportation project will address challenges our underserved populations (low-income, elderly, patients with disabilities, and patients flying in from villages), face in trying to arrange transportation to or just getting to medical appointments and picking up medications, as well as the high rate of patients missing appointments at the Maniilaq Health Center (MHC). The Maniilaq Facilities Department, working with Health Services and NANA NMS, will purchase and provide a dedicated shuttle bus service to address these transportation challenges. MHC will offer a proactive and coordinated transportation service aligned with current health appointment scheduling. This shifts from the current unreliable or no option patient transportation model for many of our rural patients, to a much more managed component of MA healthcare delivery. The Maniilaq Arctic Hub Health Transportation project is a targeted intervention designed specifically to address this documented barrier. By aligning shuttle routes and scheduling with clinic operations, the project offers a practical and community-informed solution that directly responds to identified needs. The main activity of this proposal is expected to take 6-7 months and will be completed in the RHTP 1st year: I: The MA Transportation project will purchase a Health transportation shuttle bus. This will be done by the MA Facility Department, which oversees all vehicle purchases at Maniilaq to ensure staff can provide proper maintenance of the vehicle. (Month 1) II: MA will sign an agreement with NANA NMS to provide the operation of the Health transportation shuttle bus. This project has already been discussed with NMS. This phase will include policy refinement and scheduling coordination. Month 1-2) III: will start advertising the new shuttle service through the Maniilaq Communication Department on social media, local radio PSA, and mailing out fliers. MA will also have health staff attend community meetings to share information about the program. (Months 3-6) IV: MA, working with NANA NMS, will begin providing health transportation services in Kotzebue from the airport and other identified areas to the MA Health Center. This will include data tracking, as well as performance and route optimization review. (Months 6-7) Cost: \$375,000 (Bus \$160k, Shipping \$15k, Operation \$200k). Seattle to Kotzebue (barge) will be arranged to save on transportation costs.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Northwest Arctic Borough	Deferred or Not Advanced

Maniilaq Association	Maniilaq Association Employee Health Activity Center	AK	This project will prioritize the retention of staff in high-need areas of healthcare and behavioral health. Maniilaq Association (MA) faces many challenges in the recruitment and retention of its healthcare workforce. Some of the many challenges, are dealing with the recruitment and retention of critical health workers as talked about above include long winters, extreme cold, long periods of darkness, geographic isolation, and high costs. Moreover, MA is dealing with very high burnout rates and high turnover rates among our healthcare workforce. This high turnover rate has forced MA to rely on high-cost private temporary duty staff (TDYs) to cover our needed health positions. From our employee surveys and health studies, the MA Employee Activity Center is a strong employee recruitment and retention tool and is seen as a high-value perk. This MA Employee Health Activity Center project will purchase new fitness equipment to both upgrade aging equipment and expand the number of exercise equipment options for our healthcare workers and their families to use. Upgrading and expanding the MA Employee activity center will help health workers by providing safe and convenient access to exercise, which reduces stress, lowers burnout, and improves mental health. This MA on-site center has been shown to boost our health staff morale, energy levels, and enhance overall well-being, while offering a safe, accessible environment for physical health, particularly during long winter months.	This project's proposed approach is aimed at prioritizing the retention of critical staff in high-need areas, including healthcare workers in our Community Health Center, Emergency Department, Long-Term Care, Community Behavioral Health, and other needed health services. Maniilaq Facilities Department, which will oversee the project, has worked with and received input from all of Maniilaq's critical departments on the need and benefits of this project to improve the Employee Activity Center. Having a workout activity center located near the hospital is a strategic tool that aids in the recruitment and retention of health workers by addressing high burnout rates, promoting work-life balance, and fostering a supportive, health-focused culture. This Maniilaq on-site facilities provide our staff with a safe, convenient, 24-hour, and easily accessible space that helps staff manage stress, reduce fatigue, and improve overall well-being, directly impacting turnover rates, which we hope to decrease by 25%. In the first month of the award, all equipment will be ordered through our Facilities department, with input from Maniilaq staff from all critical departments. Using the barge season and service to save on shipping cost, the equipment installations will be done over multiple phases due to the shipping schedule associated with our remote location & short barge season. The project will be completed in the 1st year of the RHTP award. The project will modernize and upgrade the Maniilaq Employee Activity Center, which promotes mental and physical recovery along with healthy physical activity. 1. Upgrade and expand the number of treadmills and ellipticals for an employee workout center that provides a "no-impact" workout that minimizes stress on knees and back, provides a full-body workout that engages both upper and lower body simultaneously, and features adjustable resistance and incline to target different muscle groups. 2. Upgrade and expand the number of new heavy, static strength machines to offer more durability, safety, and ease of use, while promoting consistent strength training for all fitness levels. These new machines, which can be fixed resistance machines and also multi-station units, will enhance employee health and reduce injury risks at the same time. 3. Upgrade the types of versatile strength training tools to facilitate diverse and full-body workouts that can provide for high-intensity interval training.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Northwest Arctic Borough	Deferred or Not Advanced

Maniilaq Association	Maniilaq Association Modernizing EMS transportation and training in rural Northwest Alaska	AK	An inventory of ambulances used by Maniilaq village health clinics revealed the poor status and condition of 4 village clinic ambulances. The rural communities of Ambler (pop.274), Kobuk (pop.191), Shungnak (pop.272), and Noatak (pop.570) all have ambulances older than 23 years, are in various states of disrepair, have become operationally unreliable, present patient safety issues (lack of heat), and would not meet the minimum Medicaid standards for a certified/billable EMS provider. To illustrate, Shungnak’s ambulance is an old Suzuki mini-truck with Japanese instrumentation, a driver’s wheel on the right side, a stick shift on the left, has cramped space for an average adult, and a cracked windshield. Currently, Maniilaq’s rural village health clinics perform all emergency patient transportation at no cost to the patient and without any revenue collection. Even if Maniilaq wanted to establish certified/billable EMS provider services in these communities, we currently do not have ambulances in a condition that would support that future development. Village clinic ambulances are not well organized and do not have emergency equipment and supplies stocked at the ready. Despite all our rural health care workforce’s EMS training and certifications, there is a knowledge gap, a lack of attention, and a lack of ownership to assume a scope of work that includes ambulance readiness. This RHTP is our opportunity to drive the transformation of rural EMS systems of care.	Within 5 business days of being awarded, Maniilaq would place the order for five (5) ASAP 911 MedStat 500s UTV ambulances costing \$435,875 and spending 87% of the amount requested in this proposal. We anticipate 12-18 months for the ASAP 911 order to be fulfilled. These modern ambulances have been Alaska-bush tested and support minimum Medicaid billing standards. Replacing the 4 dilapidated ambulances in Ambler, Kobuk, Shungnak, and Noatak will have an immediate and direct impact on EMS response reliability and quality of pre-facility patient care and transport. Freight booking confirmations of the ambulances to Seattle (truck) and then Seattle to Kotzebue (barge) would be arranged in close coordination with ASAP 911. Within 18-24 mo, we would spend the remaining \$63,710 in freight transportation to Kotzebue. Upon receipt of the ambulances in Kotzebue, each ambulance would be internally processed and reviewed by Extended Facilities who maintains our corporation’s vehicle fleet. Each ambulance would be tagged, registered with our insurance provider, and retrofitted with any outstanding items needed to ensure each vehicle is ready for village clinic deployment. Then Maniilaq will arrange distribution to the Ambler, Kobuk, Shungnak, and Noatak village health clinics. The EMS Program would then provide on-site orientation and training with village clinic staff to include daily ambulance checks and electronic reporting. Having modern ambulances also allows us to consider becoming a certified/billable EMS provider in the future. The 5th ambulance would be kept by the Maniilaq EMS Program in Kotzebue, where it will be incorporated into the routine/regular EMS trainings for CHA/Ps, village-based APPs, and volunteer EMS responders throughout the region. Currently, EMS certifications have not translated into the knowledge or empowerment where responders organize and maintain ambulance readiness. The training ambulance kept in Kotzebue would also serve as a spare replacement ambulance in the case that a village clinic becomes unserviceable. Maniilaq will arrange and cover additional costs to get new ambulances to the village health clinics. Maniilaq EMS Program would provide on-site ambulance orientation and training of village clinic staff. Later, CHAP, EMS Program, EMS Medical Director, and Maniilaq leadership would evaluate local economies to determine whether to move forward with developing certified EMS providers and Medicaid billability in the 4 communities.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Northwest Arctic Borough	Deferred or Not Advanced

Maniilaq Association	Maniilaq Association Northwest Arctic Regional EMS Workforce Training & Simulation Hub	AK	Maniilaq's service area is a rural area in the Northwest Arctic region that has a critical need for emergency medical services (EMS) training due to remoteness, limited infrastructure, and often long weather-dependent transport times to the Maniilaq Hospital. However, while we have this need for EMS training, this region faces significant challenges in maintaining a trained EMS workforce. Rural location, high travel costs, severe weather, no connecting roads, and limited training infrastructure restrict access to certification courses, continuing education, and hands-on skills training required for responders to maintain competency. These barriers are particularly significant in roadless communities where local EMS responders often serve as the first and only line of emergency care. This limited access to training contributes to workforce shortages, inconsistent training opportunities, and difficulty maintaining clinical skills for low-frequency, high-acuity emergencies. Many responders must travel long distances to participate in required education or are unable to attend training at all due to cost, staffing constraints, or transportation barriers. This creates gaps in workforce development and reduces system capacity in communities where timely emergency response is critical. There is a clear opportunity to strengthen rural emergency care by expanding access to workforce training and modernizing regional training infrastructure to support responders in remote communities.	The Maniilaq Northwest Arctic Regional EMS Workforce Training & Simulation Hub project will address these challenges by establishing a Northwest Arctic Regional EMS Workforce Training and Simulation Hub, a technology-enabled training environment designed to strengthen access to high-quality EMS education for responders serving rural and frontier communities. The project will modernize an existing training space by installing integrated audiovisual and instructional systems that support hands-on clinical training, scenario-based exercises, and hybrid instruction. Instructors will be able to deliver certification courses, continuing medical education, and skills training while also connecting with remote participants when appropriate. While certain portions of EMS education (such as hands-on skills verification and scenario-based assessments) will continue to require in-person participation, the technology will allow didactic instruction, case review, and portions of coursework to be delivered through a reliable hybrid format. Training scenarios conducted in the classroom can also be captured and used to develop reusable instructional materials. These materials will be distributed through the existing regional learning management system, allowing responders in remote communities to access continuing education modules, case reviews, and instructional content outside of scheduled classes. This approach supports flexible learning while maintaining the in-person training components necessary for high-quality clinical education. By strengthening regional training infrastructure and leveraging technology to support hybrid instruction, this project will expand access to workforce development opportunities, reduce unnecessary travel burdens, and support the development and retention of a skilled rural EMS workforce capable of responding to medical emergencies close to home.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough; Northwest Arctic Borough	Deferred or Not Advanced

MAPHABIT INC	ANCHOR: Aging & Neurodivergent Care through Health, Outreach, and Remote Support	AK	Alaska’s healthcare system is facing growing pressure from workforce shortages and increasing demand for home- and community-based services (HCBS). The state’s direct support workforce is projected to face significant shortages over the coming decade, making it difficult to provide consistent support for individuals with complex needs. At the same time, Alaska is experiencing rising prevalence of Alzheimer’s disease and related dementias (ADRD), traumatic brain injury (TBI), intellectual and developmental disabilities (IDD), and fall-related injuries among older adults. Many individuals lack access to structured preventive supports that maintain independence and reduce health risks. Traditional service delivery models rely heavily on in-person visits and are difficult to sustain across Alaska’s rural and frontier geography. Long travel distances, weather conditions, and limited workforce availability restrict access to services for many communities. These conditions create an opportunity to implement new care models that help individuals manage daily activities more independently while enabling caregivers and providers to extend their reach. MapHabit & Vivo are technology-enabled supports that reinforce daily routines, utilize preventive health programming, and can improve outcomes while strengthening Alaska’s community-based care system.	The MapHabit + Vivo initiative (ANCHOR) will deploy a statewide model integrating assistive technology, preventive health programming, and provider partnerships to strengthen home- and community-based services (HCBS) across Alaska. The program includes four complementary components. Digital Habit-Building Supports Participants receive a MapHabit-managed tablet and personalized onboarding with a coach. Using MapHabit’s library of more than 1,000 visual maps, or customized maps created with user-specific text/photos/videos, participants follow step-by-step guidance for daily routines. These routines support medication adherence, hygiene, meal preparation, and other activities essential for independent living. This neuroscience-based approach helps individuals with cognitive or functional challenges complete tasks more consistently while reducing reliance on constant caregiver supervision. Participants may also receive therapist-curated cognitive engagement kits designed for neurodivergent populations that reinforce routines, stimulate cognitive activity, and promote independence. Preventive Mobility and Strength Programming Participants engage in live virtual strength and balance classes delivered by Vivo using MapHabit tablets or their own computers/mobile devices. These classes are designed for older adults and individuals with mobility limitations and focus on improving balance, mobility, and functional strength. Regular assessments track progress and help identify improvements in mobility and fall risk. Caregiver and Provider Enablement Caregivers and direct support professionals incorporate digital routines and preventive exercises into daily care activities. Embedding these structured supports into existing care workflows enables providers to maintain consistent support for individuals across Alaska’s geographically dispersed communities. Outcome Measurement and Program Evaluation The platform captures engagement data and mobility metrics that measure improvements in independence, participation, and health outcomes. These analytics support program evaluation and provide evidence for long-term sustainability through Medicaid and HCBS programs. ANCHOR will launch through partnerships with Alaska organizations including the Association on Developmental Disabilities, Peninsula Independent Living Center, and Daybreak Inc., to complement existing community-based services while expanding access to preventive supports and independence-building tools.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Maserculig Incorporated	Marshall Community Telehealth & Meeting Hub	AK	Access to alcohol/drug rehabilitation in rural Alaska is currently underserved and difficult to access. Mas Inc has been planning to create a safe/secure space in Marshall with access to telehealth (i.e. two independent/private computer stations) and also create a space for group interactions as well with video access. Mas Inc currently owns a 16 bed residential & outpatient alcohol/drug rehab facility in Casper, Wyoming. Our senior therapist is currently in the last phase of licensing for the State of Alaska. Mas Inc currently has a successful telehealth IOP (intensive outpatient) operating in the lower 48. There is a need & desire in Marshall for secure/safe access to rehab services. What is lacking is a facility of any type where clients can have the necessary privacy and technology to receive that care. Because Marshall has "gone wet" there is a growing need for these services. Additionally this facility would be available for residents of Marshall, St Marys & the surrounding area for other healthcare telehealth services. The village is asking for help and we believe we can provide it due to the experience and staff we have at our Wyoming facility.	1) Awareness of the problem. Letting the community know that we are aware, that we care & that we are here to help. 2) Assistance with insurance, payments, continuing care, step up care to outlying facilities if necessary. 3) Providing safe/secure/private space for community members to be able to access professional help. 4) Providing a group space where community members can meet to join together in the process of healing (including 12 step type programs and cultural healing exercises). 5) Access to Alaska licensed professionals via safe & secure electronic connections. 6) Outreach to the youth of the community through telehealth meetings, introduction to family support groups and education concerning addiction. 7) The availability of currently available technology to other residents within the community for other healthcare issues.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kusilvak Census Area	Deferred or Not Advanced

MASH Property Managemen t	Build behavioral health workforce to deliver Medicaid-eligible shelter services-2 of 4 projects	AK	We aspire to create an integrated health model for Anchorage’s shelter system, but workforce capacity across the industry is currently insufficient. Staff serving individuals with co-occurring behavioral health, substance use, and medical needs lack access to formalized clinical training pathways, recognized credentials, or the administrative skills required for Medicaid billing compliance. This gap is structural, not individual. High-intensity service environments like shelters attract mission-driven staff but often struggle to offer professional development pathways. The result is high turnover and credential gaps that prevent Medicaid billing, and service quality inconsistencies that undermine clinical outcomes. Training will include Peer Support Specialist certification, Behavioral Health Technician training, trauma-informed care, motivational interviewing, and Medicaid documentation, and will emphasize evidence-based approaches widely used in homeless service systems. Administrative staff will also receive training in Medicaid documentation, billing procedures, and compliance standards to support accurate claims submission. Investing in workforce development addresses all three dimensions simultaneously: credentialed staff deliver better services, satisfy Medicaid supervision requirements, and are more likely to remain in their roles, improving continuity of care.	Professional Certification Staff will receive training and certification through recognized programs including Peer Support Specialist (PSS) certification and Behavioral Health Technician (BHT) training. PSS and BHT credentials enable staff to deliver Medicaid-billable services and meet Alaska’s supervision and documentation requirements under the 1115 Waiver service model. Clinical Skills Development Training will emphasize evidence-based approaches with strong applicability in homeless services: trauma-informed care, motivational interviewing, behavioral health screening tools (PHQ-9, AUDIT, DAST), recovery-oriented service delivery, and harm reduction practices. Both local training partners and nationally recognized online programs will be utilized. Administrative and Billing Competency Administrative staff will receive targeted training in Medicaid documentation standards, billing procedures, and compliance requirements to support accurate claims submission and audit readiness. This training is directly coordinated with the billing infrastructure development in Request 1. Operational Continuity Because shelters operate 24/7, training participation requires temporary staffing coverage to prevent service disruption. Grant funds will support temporary backfill staffing during training periods, ensuring both workforce development goals and shelter operations can proceed simultaneously.	\$50,000- \$250,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

MASH Property Managemen t	Buy Linda’s Place shelter to ensure long- term stability of integrated care delivery-4 of 4 Projects	AK	Linda’s Place is structurally essential to the MOA’s homelessness response. It is one of two year-round MOA-funded congregate shelters. It is the only facility with segregated space for men and women, which is critical for certain individuals that may have experienced trauma in their past. The facility’s lease structure creates ongoing financial and operational risk that is incompatible with the long-term investments in clinical integration, workforce development, and capital infrastructure that MASH is pursuing. The MOA’s shelter system has experienced significant instability since its establishment in 2020, with multiple facilities opening, operating briefly, and closing—disrupting services and displacing vulnerable residents. Ownership provides permanence. A permanently-owned facility can receive capital investment in clinical space (Project 3), serve as the platform for Medicaid-enrolled service delivery (Project 1), and provide the stable employment base that supports workforce development and retention (Project 2). The acquisition also enhances financial efficiency: the annual rental expense currently paid to a private owner can be redirected toward services. This internal cost savings is a sustainable, non-grant funding source for expanded behavioral health programming.	Property Acquisition Grant funds will be used to acquire the Linda’s Place property. MASH is working to establish a 501(c)(3) nonprofit entity to hold title, ensuring the facility remains permanently available for shelter use regardless of future operational changes. This structure protects the public investment by preserving the facility’s mission-restricted use. MOA Partnership MASH will negotiate a revised operational agreement with the Municipality of Anchorage that maintains MOA funding for shelter operations while transitioning property ownership to the MASH-affiliated nonprofit. Facility Stewardship MASH will maintain and improve the facility to sustain its suitability for integrated care delivery, including planned clinical space enhancements (Project 3) and technology and documentation infrastructure supporting Medicaid billing (Project 1).	\$1M-\$5M	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

MASH Property Managemen t	Create Medicaid billing infrastructure for shelter-based behavioral health services-1 of 4 projects	AK	Despite serving one of Alaska’s highest-acuity homeless populations—individuals managing co-occurring behavioral health, substance use, and medical conditions—The MOA’s shelter system operates entirely outside the Medicaid billing system. Shelter services are funded as emergency housing, not as health care, even when the services provided are clinically substantive and would qualify for Medicaid reimbursement under other settings. Nationally, shelter-based Medicaid billing models have demonstrated both clinical and fiscal impact. States and localities that have successfully enrolled shelters as Medicaid providers report increased behavioral health engagement, reduced emergency department utilization, and improved care transitions. Alaska’s 1115 Behavioral Health Demonstration Waiver creates explicit authorization for expanding community-based behavioral health services and supports innovative service delivery models for high-need populations. By building provider enrollment, compliance, documentation, and billing infrastructure, MASH will create the administrative foundation required to transition shelter-based care from a purely municipal-funded emergency function to a sustainable, Medicaid-supported integrated care model. This project will build the Medicaid billing infrastructure that makes all other components of MASH’s integrated care strategy financially sustainable and not entirely dependent on municipal appropriations subject to annual budget cycles.	Medicaid Provider Enrollment and Compliance MASH will engage a consultant with demonstrated experience implementing Medicaid billing for safety-net providers. The consultant will guide provider enrollment application preparation, compliance framework development, clinical documentation standards, supervision structure design, and credentialing requirements. MASH has begun preliminary outreach to potential consultants and has engaged peer agencies that have successfully implemented Medicaid billing to learn from their experience. Service Model Design Working with the consultant, MASH will design a shelter-based service model aligned with Alaska Medicaid billing requirements and the 1115 Waiver. Target services include: behavioral health screening and assessment, peer recovery support, Substance Abuse Care Coordination (SACC), recovery coaching, relapse prevention, daily living skills training, adult day services, chronic disease monitoring, and post-hospitalization transition support. Service model design will be coordinated with the workforce development initiative (our second request) to ensure staff credentials align with billable service types. Billing and Data Infrastructure MASH will establish billing workflows, electronic documentation systems, and financial management procedures necessary to submit and track Medicaid claims, meet documentation standards, and support compliance monitoring. Implementation Phasing Year 1 Provider enrollment preparation, consultant engagement, compliance framework development, documentation system build. Year 2: Initial Medicaid billing launch for core service types. Years 3–4: Service expansion, utilization review, and ongoing optimization.	\$50,000- \$250,000	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

MASH Property Management	Install relocatable clinical buildings to expand on-site behavioral health services-3 of 4 projects	AK	Linda’s Place is a critical facility in Anchorage’s homelessness response system, but its physical layout was not designed for integrated health service delivery. The shelter’s shared spaces constrain the type, volume, and confidentiality of clinical services that can be offered. Partners such as Anchorage Neighborhood Health Center, Alaska Behavioral Health, Beans Cafe, and Team One are engaged with shelter residents but are limited by available space. Relocatable modular buildings offer a pragmatic solution: they are available through federal surplus property programs at substantially reduced cost, can be installed with minimal site modifications using existing utility connections, and remain available for shelter use regardless of future operational or ownership changes. Installing dedicated clinical space transforms Linda’s Place from a facility that provides shelter to a facility that provides care—consistent with national best practice models for health-supportive shelter environments. This Project is independently fundable and does not require completion of Projects 1 or 2. However, clinical space expansion amplifies the impact of both workforce development and Medicaid billing by creating the physical environment in which credentialed services can be delivered to a greater number of residents.	Building Acquisition MASH will acquire relocatable modular buildings through federal surplus property programs, significantly reducing capital costs compared to new construction. Preliminary review confirms available structures suitable for clinical use. Site Preparation and Installation Buildings will be sited adjacent to Linda’s Place and connected to existing utilities. MASH has reviewed zoning requirements and utility access and will coordinate closely with the Municipality of Anchorage on permitting, safety, and building compliance throughout the process. Dedicated Clinical Use Areas Installed spaces will support on-site paramedic and primary care services, Anchorage Neighborhood Health Center clinical visits, confidential behavioral health consultations, peer recovery support and counseling sessions, care coordination and case management meetings, small-group recovery programming and daily living skills, post-hospitalization transition services, and adult day services for elder residents. Partner Integration Existing clinical partners—Anchorage Neighborhood Health Center, Alaska Behavioral Health, and Team One—will be invited to expand on-site service hours using the new spaces. Additional partners will be recruited as capacity allows.	\$250K-\$1M	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Mat Su Jewish Center	ARK Program	AK	Rural Alaska faces critical healthcare challenges from geographic isolation, limited clinical resources, and workforce shortages, compounded by social isolation that prevents people from noticing needs and supporting one another. For the past ten years, the Mat-Su Jewish Center has piloted the ARK program, testing ways to build community networks that strengthen early support, engagement, and pathways to care. Now is the time to scale this work in the Mat-Su Valley, where community interest is strong and the need is clear. By turning everyday interactions and community engagement into opportunities to contribute, ARK (Acts of Routine Kindness) creates a sustainable network where belonging, meaningful participation, and shared responsibility embed health and wellbeing into daily life, extending care beyond clinics into the fabric of the community.	Rural Alaska faces healthcare challenges from geographic isolation, limited services, workforce shortages, and social isolation that prevents people from noticing needs and supporting one another. The ARK program, Acts of Routine Kindness, strengthens the social fabric by cultivating belonging, participation, and shared responsibility, turning everyday interactions into pathways for health. Through giving-centered programs, home chefs share knowledge while families exchange trusted pediatrician referrals and learn to stretch food budgets and eat healthier. Seniors pass on skills and passions to younger generations, maintaining social connections across age groups. Children and families connect through shared activities, and adults with disabilities model inclusion and the value of every person. In these interactions, the community itself becomes a frontline of care, helping neighbors notice when someone is struggling, reach out, and connect each other to medical and behavioral health resources. By activating the entire community, ARK emphasizes that health is a collective responsibility, not just an individual one. Scaling a ten-year pilot, the program strengthens resilience, improves wellbeing, and builds a sustainable, community-driven model of care that extends far beyond any building. We will track outcomes through surveys, focus groups, and participant interviews, as well as monitoring program engagement and community-led initiatives, to measure changes in social connection, sense of belonging, resource-sharing, and access to care. Through these strategies, Acts of Routine Kindness transforms everyday interactions into pathways for health, creating a model of community-driven care that can be sustained and replicated across rural Alaska.	\$50,000-\$250,000	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Matanuska-Susitna Borough	Mat-Su Borough EMS Clinical Simulation Hub — Station 3-9	AK	Rural EMS systems develop clinical competency through repetition, but repetition requires access to training infrastructure that most rural systems have never had. Mat-Su Borough EMS serves 25,000 square miles from a network of geographically dispersed stations, and for the first time in the agency's history, a dedicated training facility is under construction. Station 3-9 will provide classroom space, a control room, and a dedicated simulation room — the physical shell for a high-fidelity clinical simulation program. The shell, however, will arrive empty. Without simulation equipment, the facility cannot deliver the high-fidelity, scenario-based clinical training it was designed for. A control room without an AV debrief system is a closet. A simulation room without a manikin is a storage space. The investment already made in constructing Station 3-9 is only realized when the facility can function as intended — as a hub for clinical simulation training serving MSB EMS personnel and the broader Mat-Su provider community. This project equips the Station 3-9 simulation center to fulfill that purpose, completing the investment already underway and activating a training infrastructure that rural Alaska EMS has never had access to before.	MSB EMS proposes to equip the Station 3-9 Clinical Simulation Hub with high-fidelity simulation technology, control room infrastructure, and supporting task trainers and consumables, activating the facility as a functional clinical training center for EMS personnel across the Mat-Su Borough system. The simulation center is purpose-built for flexibility. The control room features dual access; one side runs a dedicated simulation room. The other side is an adjacent classroom, allowing the simulation environment to be configured in either direction depending on training objectives. This design supports both controlled high-fidelity scenario runs and classroom-integrated simulation exercises without requiring fixed equipment placement. Core equipment will center on a high-fidelity, tetherless patient simulator. This letter highlights a platform-class equivalent to the Gaumard HAL S3201 — selected for its wireless, battery-powered portability, pre-hospital and EMS-specific scenario capability, and the absence of annual licensing fees that would create ongoing grant dependency. The manikin's tetherless design allows it to be moved between the simulation room and classroom, supports transport simulation scenarios, and is compatible with real clinical devices, including defibrillators, airway equipment, and monitoring systems. The final decision would rest on the appropriate decision process. Supporting equipment will include task trainers for advanced airway management, vascular access, and wound care; a high-fidelity wearable trauma simulation system for hemorrhage control and penetrating trauma scenarios; control room AV and debriefing infrastructure; a scenario software library tailored to rural EMS and frontier practice; and a consumables and maintenance package ensuring multi-year operational sustainability without immediate resupply costs. The Station 3-9 simulation hub serves as the fixed, high-fidelity anchor of a broader MSB EMS simulation training ecosystem. Distributed XR simulation capability at rural stations, addressed in a companion LOI, provides asynchronous, station-level training. The Station 3-9 hub provides a centralized, hands-on, high-fidelity simulation environment for skills and scenarios requiring physical manikins, real clinical devices, and structured debriefing. Together, they form a complete training infrastructure for a frontier EMS system.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Matanuska-Susitna Borough	Mat-Su Borough EMS Mobile Health Infrastructure Modernization Initiative	AK	Mat-Su Borough EMS operates across 25,000 square miles of frontier Alaska with a fleet and infrastructure designed for a previous era of emergency medical response. Over the past five years, call volume has increased 21% with no proportional expansion of fleet capacity or operational infrastructure. The existing ambulance fleet has never been redesigned; all units are remounts on aging configurations that predate modern telehealth capability, ergonomic standards, and frontier-optimized design. The result is a response system that is operationally capable but technologically constrained. Paramedics responding to frontier communities cannot initiate telehealth consultations from the unit. Treat-in-place decisions lack diagnostic support infrastructure. Extended transport times, a defining characteristic of frontier EMS, occur in vehicles not designed to support the clinical complexity that those transports increasingly demand. Modernizing mobile response infrastructure is not a luxury upgrade. It is the platform layer that enables every advanced clinical capability the EMS system needs to deliver — telehealth consultation, remote diagnostics, treat-in-place protocols, and mobile integrated health operations across one of the largest and most challenging municipal service areas in the United States.	MSB EMS proposes a phased mobile infrastructure modernization program comprising two integrated components: deployment of purpose-built quick-response vehicles for frontier and mobile health operations, and a ground-up redesign and pilot build of telehealth-optimized ambulances, establishing a replication template for fleet-wide modernization. Quick Response Vehicles. Procurement and deployment of two to four heavy-duty 4WD SUVs or utility body vehicles, platforms such as the Chevrolet Tahoe or Ford Expedition, configured for rural medical response, mobile integrated health operations, and behavioral crisis co-response. Vehicles will be equipped with medical response capability, Starlink connectivity, and telehealth infrastructure. QRVs provide flexible, fuel-efficient response capacity for non-transport MIH visits, frontier outreach, and behavioral health co-response without committing full ambulance assets to non-emergency deployments. Telehealth-Optimized Ambulance Program. A two-phase ambulance modernization initiative beginning with a dedicated design year, followed by pilot construction of two sets of two ambulances built to the new template. Year one design phase will produce a comprehensive ambulance specification that incorporates ergonomic overhaul, austere-condition optimization, thermal management, sound attenuation, integrated Starlink and AV wiring for telehealth consultations, diagnostic equipment mounts, and FLIR driver-assistance technology. The design year produces a replicable template applicable to the entire 18-unit fleet over subsequent RHTP cycles. Years two and three deliver four ambulances built to the new specifications, two units per build cycle, consistent with MSB EMS procurement and deployment practice. These pilot units validate the design template, establish supply chain relationships, and demonstrate telehealth-enabled ambulance capability in operational frontier conditions before fleet-wide commitment.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Matanuska-Susitna Borough	Mat-Su Community Health Response System	AK	The Matanuska-Susitna Borough faces a convergence of accelerating behavioral health crises, growing frontier healthcare access gaps, and an emergency medical system absorbing demand that should never reach 911 in the first place. Over the past five years, MSB EMS has absorbed a 21% increase in 911 call volume with no proportional increase in fleet or staffing. That trajectory is unsustainable without meaningful demand-side intervention. The behavioral health component of that demand is accelerating fastest. In 2025, Mat-Su residents generated 4,691 behavioral health crisis calls across community channels — including 786 calls directly to 911 — while the Mobile Crisis Team completed 476 visits against a backdrop of worsening indicators across every measured behavioral health category. Alaska Careline/988 calls from Mat-Su residents increased 65% in a single year, from 1,673 in 2024 to 2,753 in 2025. No indicator is trending downward. Simultaneously, frontier residents in communities like Meadow Lakes, Willow, and Glacier View lack reliable access to primary care, face transport distances that make routine medical needs into logistical crises, and depend on 911 as their default healthcare access point — not because of preference, but because no alternative exists. Mat-Su Borough EMS is already in those homes. This project builds the infrastructure to make those contacts count.	MSB EMS proposes to establish the Mat-Su Community Health Response System, a telehealth-enabled, hub-and-spoke mobile integrated health program designed to reduce avoidable emergency department visits, improve access to frontier healthcare, and build a sustainable community-based care model across the Borough's 25,000-square-mile service area. The program operates across three integrated service lines delivered from a single EMS operational hub: Urban High-Utilizer Stabilization. Intensive case management, ED diversion, post-discharge follow-up, medication reconciliation, and social service coordination for high-frequency 911 users in the urban core. Targeting the highest-cost, highest-acuity repeat utilizers reduces system burden while improving individual health trajectories. Frontier Outreach Spokes. Mobile response units equipped with Starlink-enabled telehealth and point-of-care diagnostics are deployed to remote communities for treat-in-place services, remote physician consultation, and social determinants of health intervention. Frontier residents receive hospital-grade clinical assessment without transport. Behavioral Crisis Response. Paramedic and peer support co-response model for behavioral health 911 calls, with tele-clinician backup and ED diversion protocols. Designed to absorb growing behavioral health demand documented in Mat-Su's crisis system utilization data and integrate with the existing Mobile Crisis Team infrastructure. Year one establishes program foundation: hiring a dedicated MIH Program Coordinator, acquiring initial point-of-care diagnostic equipment, obtaining CLIA waiver, developing clinical protocols and medical oversight agreements, executing partner MOUs, and completing benchmarking visits to five established community paramedicine programs. Direct service delivery begins in year two.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Matanuska-Susitna Borough	MSB EMS CORE Program — Clinical Operations and Rural Exchange	AK	Rural EMS providers in frontier Alaska face a structural clinical competency gap that geography alone creates and geography alone prevents from being solved locally. Extended transport intervals, low call volume, and geographic isolation mean that paramedics in frontier communities may go months without performing advanced airway management procedures — including endotracheal intubation and RSI — that define the ceiling of prehospital clinical capability. Clinical skills decay silently in low-volume environments, and the critical patient does not announce their arrival in advance. The inverse problem exists in urban EMS. High-volume systems produce clinically aggressive providers with limited exposure to resource-constrained, long-interval, autonomous practice. A paramedic who has never managed a patient more than fifteen minutes from definitive care has a fundamentally different (and incomplete) clinical posture for frontier operations. Neither system, in isolation, produces a complete provider. Rural Alaska needs access to the clinical volume it cannot generate. Urban EMS needs exposure to operational conditions it cannot replicate. A structured bilateral exchange directly addresses both gaps simultaneously, at pilot scale, with measurable outcomes and a replication framework designed from the outset.	The CORE Program (Clinical Operations and Rural Exchange) is a structured bilateral provider exchange between Mat-Su Borough EMS and University Hospital EMS in Newark, New Jersey, one of the highest-acuity municipal EMS systems in the United States. The program places one to two providers from each agency in a supervised two-week rotation within the operating environment of the other, creating reciprocal, documented competency gains in both directions. Both agencies operate under the National Registry of Emergency Medical Technicians certification standards, providing a common clinical framework that supports cross-state deployment without requiring scope-of-practice modifications or state licensure compacts. Alaska Provider → Newark Rotation. Mat-Su providers gain supervised exposure to advanced airway management volume, including live intubation, RSI, and video laryngoscopy; high-acuity trauma and medical volume; behavioral health emergencies at scale; and observation of urban EMS command structure and MCI operations. Rotations are conducted under the supervision of Newark EMS preceptors using a jointly developed standardized evaluation tool. Newark Provider → Alaska Rotation. University Hospital providers gain supervised exposure to prolonged field care, resource-limited autonomous clinical decision-making, aeromedical coordination, cold-weather operations, terrain-specific patient packaging, and communication failure contingencies. Rotations are conducted under Mat-Su EMS preceptors using the same standardized evaluation tool. Program administration, grant compliance, and reporting are managed by Mat-Su Borough EMS as the lead applicant. Newark participation is structured as a sub-award or direct reimbursement. A bilateral MOU will be executed prior to the first rotation. University Hospital EMS has provided a signed Letter of Intent confirming partnership commitment. The pilot is intentionally limited to 4-6 total participants in year one — a proof-of-concept scale designed to validate the model, generate outcome data, and produce a replication framework applicable across Alaska's seven EMS regions.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Matanuska-Susitna Borough	Mat-Su Borough EMS Rural Station Simulation Training Initiative	AK	Matanuska-Susitna Borough EMS provides emergency medical services across 25,000 square miles from a network of geographically dispersed stations. Maintaining consistent clinical training across that network is a persistent operational challenge. In-person training requires personnel to travel to centralized locations, pulling staff from rural posts and creating coverage gaps. Seasonal operational demands, including summer surge staffing that suspends formal training cycles, further compress the training calendar. Severe weather events routinely cancel scheduled sessions entirely. The result is an inequitable training experience across the system. Providers at rural stations receive less frequent access to high-fidelity simulation and scenario-based training than their counterparts at centralized facilities — not because of organizational intent, but because of geography and operational tempo. Over time, inconsistent access to training contributes to clinical skill degradation, reduced confidence in low-frequency, high-acuity events, and weakened workforce retention in rural posts, where professional development opportunities are already limited. Immersive extended reality simulation technology offers a proven solution: high-fidelity, scenario-based clinical training that can be delivered at any station, without travel, without centralized infrastructure, and without suspending operations.	MSB EMS proposes to deploy an immersive extended reality simulation platform across its rural station network, creating a decentralized, technology-enabled training infrastructure that delivers consistent, high-fidelity clinical education regardless of geography, season, or weather conditions. The project has three integrated components: Hardware Deployment. Procure and deploy XR simulation headsets and supporting equipment to four to five rural MSB EMS stations. Hardware will be selected through competitive procurement for portability, offline functionality, and operational durability in Alaska's environmental conditions. Offline-capable systems are a technical requirement given connectivity limitations across rural Mat-Su. Scenario Library Development. Develop a library of clinical simulation scenarios tailored to the high-acuity, low-frequency events most critical to rural EMS competency: including trauma, obstetric emergencies, pediatric resuscitation, and medical emergencies with extended transport times. Scenarios will be developed in partnership with the selected platform vendor and MSB EMS training personnel, ensuring clinical accuracy and operational relevance to frontier practice conditions. Training Program Integration. Integrate XR simulation into MSB EMS continuing education and competency verification programs. The Borough's existing training team will facilitate scenario delivery, debriefs, and competency tracking at rural stations, eliminating travel requirements for routine training cycles. This infrastructure is designed for expansion. The scenario library and deployment model are directly applicable to MSB's rural fire and first-responder network, creating a scalable hub-and-spoke training system across Borough public safety services in a future phase.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Matanuska-Susitna Borough	Mat-Su Borough EMS Transport Infrastructure and Workforce Protection Initiative	AK	Rural EMS systems across Alaska face a compounding workforce crisis: a shrinking pool of qualified candidates, extended recruitment timelines, and an aging, increasingly vulnerable workforce that is bearing the cumulative physical toll of EMS work. In a system where a single experienced paramedic may represent years of investment in training and field competency, a career-ending musculoskeletal injury is not just a personnel loss. It is a gap in emergency coverage across thousands of square miles that cannot be quickly filled. Nationally, musculoskeletal injuries are the leading cause of occupational injury and lost work time in EMS, with patient loading and unloading consistently identified as the highest-risk activity in routine operations. Powered stretcher and auto-load systems are a proven, evidence-based intervention that directly reduces this risk, yet deployment remains inconsistent across rural systems where capital equipment budgets are constrained and competing priorities are significant. This project addresses that gap for Mat-Su Borough EMS, protecting an experienced rural workforce, modernizing fleet infrastructure, and sustaining emergency access across one of the largest and most challenging service areas in the United States.	Matanuska-Susitna Borough EMS proposes to equip its operational ambulance fleet with powered stretcher systems and integrated automatic loading systems, eliminating the manual lifting forces associated with ambulance loading and unloading operations across the entire Borough fleet. The project scope includes deployment of 22 powered stretchers and 22 auto-load systems across the operational fleet, retrofit of 18 ambulances with compatible loading system infrastructure, procurement of additional units to ensure operational continuity during maintenance cycles, and fleet-wide maintenance contracts, extended warranties, and staff training. Powered stretcher systems reduce spinal loading forces during the most injury-prone phase of patient handling by automating the lift-and-load sequence. Auto-load systems eliminate the manual push-and-lock mechanism that transfers significant force to personnel during ambulance loading. Together, these systems allow EMS clinicians to focus on patient care and monitoring during loading operations rather than manual lifting mechanics, a meaningful safety improvement in Alaska's environmental conditions, where snow, ice, and uneven terrain increase the risk of loss of footing during patient movement. Implementation will proceed immediately upon award. Procurement will begin in Fall 2026, with installation and retrofits completed in Winter 2026 through Spring 2027, staff training and deployment in Spring through Summer 2027, and full operational deployment before September 30, 2027. The project is shovel-ready, with defined equipment specifications, confirmed vendor availability, and implementation infrastructure in place.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Matanuska-Susitna Borough	Mat-Su CLEANS Program: Neighborhood Cleanup, Clinical Outreach & Recovery Support Expansion	AK	The Mat-Su Borough’s CLEAN Program (Community, Lands, Enforcement, Abatement & Neighborhood Support) has conducted numerous cleanups across the community. The Mat-Su Borough is a second-class Borough and lacks the health and policing powers, so we have to think outside the box to get things done. We want to build on this program, and this is a wildly unique "ask" we're making. We want to transform neighborhoods visually and partner with nonprofits to address mental, behavioral, and substance abuse issues that plague many neighborhoods. We conducted a successful cleanup in the Williwaw area of Wasilla and left a huge transformation; however, we noticed that many of the issues are complex mental/substance/behavioral health issues. Coming to the neighborhood, transforming it visually, and bringing support to the residents would be a game-changer. Government is not fixing things; this is the community rallying together to make their home better.	We want to clean up neighborhoods, transform them, and partner with mental health and substance abuse professionals to provide wraparound support. Addressing environmental disorder directly aligns with this goal because it targets conditions that contribute to mental health strain, substance-use risk, and reduced engagement with care rather than waiting for crises to occur. Rather than punitive enforcement, it should be reframed as a public-health and recovery-support strategy. By removing hazardous debris, stabilizing properties, and restoring neighborhood order, while simultaneously embedding behavioral health and substance-use clinicians, CLEANS addresses both the environmental and human health impacts of disorder. We are a second-class Borough and lack the health powers, so this helps to bridge that gap. In this way, CLEANS operationalizes the health-relevant insights of Broken Windows Theory in a trauma-informed, non-punitive, and community-centered model, making it a strong fit for RHTP’s focus on sustainable, rural health transformation. We want to purchase the equipment to do these cleanups more effective and minimize people getting hurt and actually pay nonprofits to come in and provide all the professional mental/substance/behavioral health services that will be needed for the immediate care and long-term care. News Coverage https://matsugov.us/news/msb-program-supports-clean-up-in-williwaw https://www.frontiersman.com/news/the-williwaw-project-hopes-to-revitalize-community-de-incentivize-crime/article_85338238-c262-4555-85f9-18ac2a0465bd.html https://www.alaskasnewssource.com/2025/09/13/blessing-volunteers-remove-tons-trash-wasilla-neighborhoods/	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Matanuska-Susitna Borough	Northern Valley Ski & Snowboard Bus to Skeetawk	AK	Rural communities in Alaska experience persistent disparities in health outcomes driven by geographic isolation, limited transportation options, fewer structured recreational opportunities, and reduced access to prevention focused programs. These challenges are especially acute during winter months, when limited daylight and severe weather restrict safe and affordable physical activity. For many families in the communities of Trapper Creek, Talkeetna, Willow, Houston, and Big Lake, distance, cost, and transportation barriers make organized wellness activities unattainable. While the Mat-Su region contains strong recreational assets, access is uneven, without transportation. Families outside core population centers often lack reliable transportation or financial resources to access structured recreation. As a result, rural youth experience lower physical activity levels, increased winter isolation, and elevated risk factors for chronic disease later in life. The RHTP recognizes that improving health outcomes for rural Alaskans requires addressing upstream drivers of health outside clinical settings. Prevention, community wellness, and reduction of access barriers are central to improving access to care. This project responds directly by addressing one of the most persistent barriers to wellness in rural Alaska, transportation and focuses on youth gaining access to positive healthy choices that can lead to a lifelong active pursuit.	Mat-Su Ski and Snowboard Club has agreed to serve as the host organization for this project and brings established systems, policies, and experience in delivering this type of programming. The Club has a successful track record managing transportation logistics, coordinating with ski areas, enrolling families, and ensuring participant safety. Leveraging an existing organization with proven capacity reduces start up risk and allows the project to focus resources on expanding access rather than building new systems from scratch. In the first year of implementation, starting January 2027, the program will operate one coach bus and serve at least 50 youth from communities including Trapper Creek, Talkeetna, Willow, Houston, and Big Lake. After the first season, an evaluation of the program will be conducted to refine process and procedures and gauge interest to expand to two coaches for 2028. The hub based model also creates an opportunity to reach youth who have not previously participated in downhill skiing or snowboarding. By bundling transportation with access to rental equipment and instruction at Skeetawk, the program lowers the entry barrier for families who may lack equipment, experience, or familiarity with winter sports. This inclusive approach supports skill development, confidence, and sustained participation, increasing the likelihood that youth will continue engaging in physical activity beyond a single season. Expanding a proven model into remote communities represents a scalable and sustainable approach to improving access to prevention focused wellness opportunities. By adapting an existing system to new geographies and partnering with Skeetawk, the project maximizes impact while minimizing operational risk. This approach strengthens community wellness, supports positive youth development, and creates meaningful access to healthy choices that can become lifelong active pursuits for rural youth.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Matanuska-Susitna Borough	Northern Valley Youth Swim and Skate Summer Program	AK	Rural youth in communities such as Trapper Creek, Talkeetna, Willow, Houston, and Big Lake face limited access to structured summer recreation due to long distances, limited transportation options, and the cost of travel. Although the Wasilla Pool and Brett Memorial Ice Arena provide high quality opportunities for physical activity, many families in remote areas are unable to access these facilities consistently. As a result, youth have fewer opportunities for supervised physical activity, skill development, and social connection during the summer months. This project addresses that gap by combining reliable transportation with intentional, partner-led programming. Borough Recreation Facility staff will coordinate closely with nonprofit partner Youth360 to design and deliver swim and skate programming tailored to the needs of this targeted population. This partnership brings together facility expertise, youth development experience, and trusted community relationships to ensure programming is inclusive, developmentally appropriate, and responsive to youth who may have limited prior access to organized recreation. Through this coordinated approach, the project expands equitable access, strengthens community wellness, and provides positive opportunities that support physical health, social connection, and lifelong active habits for rural youth.	Youth360 has agreed to serve as the host organization for this project and brings established systems, policies, and experience in delivering youth focused programming for rural and underserved populations. Youth360 has a strong track record of coordinating logistics, engaging families, and creating safe, inclusive, and supportive environments for youth participation. Leveraging an existing nonprofit partner with proven capacity reduces start up risk and allows project resources to focus on expanding access rather than developing new administrative systems. Youth360 will work in close coordination with Mat-Su Borough Recreation Facility staff to plan and deliver structured summer swim and skate programming at the Wasilla Pool and Brett Memorial Ice Arena. This partnership combines Youth360’s expertise in youth development with the Borough’s facility operations, instructional capacity, and safety protocols, ensuring programming is well coordinated, developmentally appropriate, and responsive to the needs of the targeted population. The program will operate during the summer season for at least eight sessions, and at least one day per week, and will serve youth from remote communities including Trapper Creek, Talkeetna, Willow, Houston, and Big Lake. Organized and supervised transportation will be provided using a hub based model, allowing youth from multiple communities to access programming safely and consistently. The hub based approach creates an opportunity to reach youth who have not previously participated in swimming or skating due to transportation, cost, or lack of access. By bundling transportation with facility access and instruction, the program lowers entry barriers for families who may lack experience, resources, or familiarity with these activities. This inclusive approach supports skill development, confidence, and sustained engagement in physical activity. By adapting a proven access model to summer programming and partnering with Youth360 and Mat-Su Borough Recreation Facilities, the project offers a scalable and sustainable approach to improving access to prevention focused wellness opportunities. The approach strengthens community wellness, supports positive youth development, and provides meaningful opportunities for rural youth to build healthy habits that can become lifelong active pursuits.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Matanuska-Susitna Borough School District	Building the Mat-Su Healthcare Workforce: High School Pathways for Rural Alaska	AK	Communities across Alaska experience persistent healthcare workforce shortages that limit access to care and place increasing pressure on existing providers. Recruitment from outside the state is difficult and expensive, and many healthcare workers do not remain long term in remote communities. At the same time, many Alaskan students lack early exposure to healthcare careers or clear pathways into the healthcare workforce, coupled with a limited network of local testing centers for health career certifications. The Mat-Su Borough School District has an opportunity to address these challenges by refining our current CTE Healthcare programs and developing a high school-based healthcare workforce training network that prepares students for healthcare careers while they are still in school. By embedding healthcare training pathways within local high schools, the district can increase early career exploration opportunities, provide industry-recognized training, and connect students with regional healthcare employers. This approach builds a locally rooted workforce pipeline, allowing students to see healthcare as an attainable and meaningful career while helping communities cultivate the next generation of providers. With Mat-Su’s growing population and increasing healthcare demand, developing local talent is a critical opportunity to strengthen the region’s healthcare system and support rural communities throughout Alaska.	This project will establish a Healthcare Workforce Development Training Network across Mat-Su Borough School District high schools, with each participating school offering a specialized healthcare career program aligned with regional workforce needs. Rather than replicating identical programs, each high school will focus on a distinct health pathway, such as pre-nursing, emergency medicine, behavioral health, medical assisting, dental assisting, pharmacy technician, sports medicine, physical therapy, healthcare technology, or biomedical science. This network model allows all schools to offer similar foundational healthcare courses that lead to a specific program emphasis. The district can collectively offer a broad range of healthcare career preparation opportunities while maximizing available resources and partnerships. Students will participate in a combination of classroom instruction, hands-on skill development, career exploration, and real-world learning experiences. Training opportunities may include industry certifications such as Certified Nursing Assistant, emergency trauma technician, wilderness first aide/responder, registered behavioral health technician, or other entry-level healthcare credentials. The program will also build strong partnerships with regional hospitals, clinics, tribal health organizations, emergency services agencies, and postsecondary institutions to support internships, job shadowing, mentorship, and dual-credit opportunities. These partnerships will help students transition smoothly into employment or advanced training after graduation. Additionally, students will receive exposure to telehealth systems, community health outreach, and culturally responsive care practices, preparing them to work effectively in Alaska’s rural healthcare environments. By building a coordinated training network across high schools, the project will create a sustainable pipeline of students entering healthcare education programs and the regional workforce.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Matanuska-Susitna Borough School District	Growing Together in the MSBSD: Providing Resources and Connections for Families with Young Children	AK	Families with young children benefit from early support, parenting education, and opportunities to build strong relationships that support healthy development. However, many families have limited access to programs that provide practical parenting strategies, social connection, and early learning experiences. In our region, educators have reported a significant increase in disruptive behaviors among students entering kindergarten, and families have expressed a need for additional support in understanding how to help their children develop key social, emotional, and self-regulation skills. Young children learn best through play-based experiences that support language, social, emotional, and cognitive development. Programs that allow parents and children to learn together give caregivers the opportunity to observe effective strategies, practice new skills, and strengthen relationships that support early development and school readiness. This project will address these needs through community events, parenting classes, and parent–child workshops offered in partnership with MSBSD. These activities will build caregiver skills, increase awareness of developmental milestones and ready-to-learn behaviors, and connect families with local resources. By strengthening early supports for families, the project promotes healthy child development and helps reduce the need for more intensive behavioral and mental health services later.	This project will provide accessible, family-centered programming that supports parents and young children learning together while strengthening connections to the school district and community resources. The program will offer a combination of structured learning opportunities and community-based activities designed to build parenting confidence, support early childhood development, and foster social connection among families. A core component of the project will be weekly parent–child workshops facilitated by an early childhood educator. These sessions will provide play-based learning experiences for children while modeling effective strategies for parents to support development at home. Parents will have opportunities to observe, practice, and reflect on practical parenting approaches while engaging alongside their children. Activities will focus on building language, social-emotional skills, early literacy, and positive parent–child interaction. In addition to weekly workshops, the program will host a calendar of family social events designed to reduce isolation and build community connections. These events will be organized in partnership with local organizations such as libraries, small businesses, and outdoor recreation spaces. Activities may include family story times, community play events, and outdoor exploration opportunities at local state parks and trails. These gatherings will create welcoming spaces for families to connect with one another while strengthening ties between families and community partners. Families will also have the option to participate in evidence based parenting classes that provide more focused instruction on topics such as child development, positive discipline, communication, and supporting learning at home. These classes will offer practical tools and guidance while allowing parents to ask questions and share experiences with peers. Throughout all programming, families will be introduced to local resources and services that support child development and family well-being. By combining parent education, play-based learning, and community engagement, this project will create supportive opportunities for families and children to grow, learn, and build healthy beginnings together.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Matanuska-Susitna Borough School District	Health Facility HVAC Modernization for Safe Care Environments	AK	Several school facilities currently rely on outdated pneumatic HVAC control systems that limit the district’s ability to effectively manage ventilation, temperature, and indoor air quality. These aging systems are increasingly difficult to maintain, offer limited operational control, and contribute to higher energy use and inconsistent indoor environments. In rural Alaska communities where schools serve as important public facilities, maintaining safe and healthy indoor conditions is critical. This project will support the design of modern direct digital control (DDC) system upgrades at Colony Middle School, Colony High School, Palmer High School, and Sutton Elementary School. Developing these designs will position the district to replace aging pneumatic controls with advanced digital systems that enable precise, programmable control of heating and ventilation systems. The completed designs will support future implementation that improves indoor air quality, enhances system reliability, reduces energy consumption, and enables integration with centralized building automation systems for long-term facility management and sustainability.	This project will develop detailed engineering designs to modernize building control systems at four school facilities: Colony Middle School, Colony High School, Palmer High School, and Sutton Elementary School. The work will begin with a comprehensive assessment of existing pneumatic HVAC control systems, including site audits and evaluation of current mechanical equipment, control components, and building conditions. This assessment will identify system limitations, maintenance challenges, and opportunities to improve ventilation control and energy efficiency. Based on these findings, engineering consultants will develop facility-specific designs to transition from pneumatic controls to modern direct digital control (DDC) systems. The design phase will include development of control architecture, equipment specifications, integration requirements for centralized building automation systems, and preparation of construction-ready plans and specifications. The completed designs will position the district to implement future upgrades that replace aging pneumatic components with modern electronic controllers, sensors, and communication interfaces. These improvements will enable more precise monitoring and programmable control of ventilation, heating, and temperature regulation throughout the buildings. By advancing these facilities to a construction-ready stage, the project will support future implementation that improves indoor air quality, enhances system reliability, reduces energy consumption, and strengthens long-term building management for safe and healthy learning environments.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Matanuska-Susitna Borough School District	Rural Health Cybersecurity & Continuity Infrastructure Upgrade	AK	The district’s disaster recovery (DR) site backs up and protects critical systems and data that support school operations, safety systems, and services used by students and staff. The network firewall currently protecting this infrastructure is aging and approaching the end of its useful life, creating increased cybersecurity risk and limiting the district’s ability to defend against evolving cyber threats. Modern cybersecurity threats continue to grow in sophistication and frequency, making reliable network protection essential to maintaining secure and resilient systems. Without modern security infrastructure, critical data backups and recovery systems could be vulnerable to cyber incidents that disrupt essential services. This project will replace the existing firewall with modern cybersecurity infrastructure designed to provide advanced threat detection, stronger network protection, and improved system reliability. Upgrading this critical component of the disaster recovery environment will strengthen the district’s ability to protect sensitive data and ensure continuity of operations in the event of a cybersecurity incident or system disruption.	This project will replace the existing network firewall at the district’s disaster recovery (DR) location with modern cybersecurity infrastructure designed to strengthen network protection and system resilience. The project will begin with a review of the current network architecture and disaster recovery environment to ensure the replacement firewall is properly sized and configured to support the district’s backup and recovery operations. Technical staff and cybersecurity specialists will evaluate existing network traffic, system dependencies, and security requirements to determine the appropriate firewall solution. Once the appropriate system is identified, the district will procure and install the new firewall hardware and associated security software. Configuration will include implementation of updated security policies, network segmentation, threat detection capabilities, and secure access controls designed to protect replicated data and backup systems. Following installation, the system will undergo testing and validation to ensure that backup operations, network monitoring, and security protections function as intended. The new firewall will then be integrated into the district’s disaster recovery and cybersecurity management processes to support ongoing monitoring and system protection. Upgrading the firewall at the disaster recovery site will strengthen the district’s ability to protect critical systems and maintain secure backups, ensuring that essential systems can be quickly restored in the event of a cyber incident or other disruption.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Matanuska-Susitna Borough School District	Safe Routes Youth Activity & Community Wellness Infrastructure	AK	Many students in rural Alaska communities lack safe pedestrian routes to travel between neighborhoods and local schools. Limited sidewalks, pathways, and pedestrian infrastructure can create safety concerns for students walking or biking to school and accessing community recreation spaces located on school grounds. This project will focus on the design of infrastructure improvements located on school property that are necessary to complete safe routes to school campuses. While route planning and design for areas outside school grounds are being addressed by partner organizations, this project will ensure that safe pedestrian connections continue onto school campuses through appropriate pathway design and site improvements. Through the district’s Safe Routes to School ranking process, the Matanuska-Susitna Borough School District has identified approximately 30 potential on-campus projects that address safety needs and infrastructure gaps near school facilities. Design costs vary by location and complexity but are estimated to range from approximately \$30,000 to \$50,000 or more per project. Funding received through this project will allow the district to advance design work for as many prioritized projects as possible, creating construction-ready plans that support future implementation of safe routes improvements.	Projects have been evaluated and prioritized through the Safe Routes to School Rankings process based on safety needs and infrastructure gaps near school facilities. The district is coordinating with the Matanuska-Susitna Borough Safe Routes to Schools Committee to align project priorities and ensure that on-campus improvements complement planned off-campus route development led by community partners. Through this project, the district will advance engineering design for on-campus infrastructure improvements that support safe pedestrian access to school campuses. Design activities will include site assessments, development of pathway alignments, accessibility considerations, and preparation of construction-ready plans and specifications. The Matanuska-Susitna Borough School District has identified approximately 30 potential prioritized projects through its ranking process. Design funding will be used to advance as many of these projects as possible based on available resources, creating construction-ready plans that can support future implementation of Safe Routes to School improvements connecting surrounding neighborhoods with school facilities.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Matanuska-Susitna Borough School District	Youth Wellness Infrastructure Upgrade for Healthy Communities	AK	Many playgrounds across the district contain equipment that is aging and approaching the end of its useful life. While the existing equipment remains safe and operational, proactive planning is needed to ensure continued safe use and to prepare for future replacement as components age out. In many rural Alaska communities, school playgrounds serve as shared recreation spaces for students and the broader community outside school hours, making them an important part of local wellness infrastructure. This project will support a district-wide assessment of existing playground equipment to identify infrastructure nearing the end of its service life and develop plans for modern, safe, and inclusive replacements. The resulting designs and replacement strategies will position the district to pursue future funding opportunities for playground upgrades that support youth wellness and maintain safe, accessible recreational spaces for rural communities.	The district will conduct a district-wide assessment of playground equipment at up to 20 elementary schools to identify infrastructure that has reached or is approaching the end of its useful life. This effort will be completed in partnership with a qualified playground manufacturer that will provide technical expertise in equipment evaluation, safety standards, accessibility, and modern playground design. Design and assessment costs are estimated at approximately \$10,000–\$12,000 per playground, allowing the district to advance planning and conceptual replacement designs for multiple sites depending on the level of funding available. Together, the district and partner will review equipment age, condition, and compliance with current safety guidelines to identify priority locations for future upgrades. Based on this assessment, conceptual designs and replacement plans will be developed for modern, safe, and inclusive playground equipment. These plans will guide future implementation and position the district to pursue funding for playground upgrades that support youth wellness and community recreation in rural Alaska communities.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

MatSu Food Bank aka Food Pantry of Wasilla Food4Kids	A Hand Up: Building Food Independence and Nutrition Health in the MatSu Valley	AK	Food insecurity remains a significant challenge across Alaska, particularly in rural communities such as the Matanuska-Susitna Borough. High food costs, long travel distances to grocery stores, and limited access to fresh foods make it difficult for many households to maintain consistent access to nutritious food. As a result, many families rely on inexpensive processed foods or emergency food assistance, increasing the risk of chronic diseases such as diabetes, heart disease, and obesity. While food banks provide essential short-term relief, many households lack the knowledge, tools, and resources needed to build long-term food stability. Families often struggle with managing food budgets, growing food in Alaska’s climate, preparing healthy meals, and preserving food for future use. The MatSu Food Bank’s “A Hand Up, Not Just a Handout” program addresses this gap by providing practical education and tools that help families move from short-term food assistance toward greater food independence. Through training in financial stability, home food production, healthy cooking, and food preservation, the program helps families improve nutrition, strengthen household resilience, and reduce long-term reliance on emergency food assistance.	While food banks provide essential emergency relief, long-term food insecurity is often driven by a lack of practical knowledge and tools that help families manage food budgets, grow food in Alaska’s climate, prepare healthy meals, and preserve seasonal foods. While food banks provide essential emergency relief, long-term food insecurity is often driven by a lack of practical knowledge and tools that help families manage food budgets, grow food in Alaska’s climate, prepare healthy meals, and preserve seasonal foods. The MatSu Food Bank’s “A Hand Up, Not Just a Handout” program addresses this gap by providing hands-on education and practical tools that help families build food independence. The program focuses on four key areas: financial stability and budgeting, growing food through small hydroponic systems, preparing nutritious meals, and preserving food for year-round use. By combining education with practical tools participants can use at home, the program helps families improve nutrition, strengthen household stability, and reduce long-term reliance on emergency food assistance.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced
MatSu Food Bank aka Food Pantry of Wasilla Food4Kids	Food4Kids Mobile Summer Nutrition Program Expansion	AK	Food insecurity remains a persistent challenge for families across the Matanuska-Susitna Borough, particularly for children during the summer months when school meal programs are unavailable. The Food4Kids program provides meals directly to children in neighborhoods where families face transportation barriers and high food costs. Demand continues to grow. In 2025 the program served 30% more meals than in 2024. The MatSu Food Bank proposes expanding the program through the purchase of two dedicated mobile delivery vans to support reliable transportation of meals and milk to community distribution sites.	The Food4Kids Summer Nutrition Program distributes meals through neighborhood locations designed to reduce barriers to food access. The project includes three components: 1. Purchase two cargo vans dedicated to the Food4Kids program to safely transport meals and milk to distribution sites. 2. Operate three summer meal distribution locations in Wasilla serving approximately 13,000 meals during the summer months. 3. Expand the program beginning in 2026 to include one Saturday distribution per month to increase access for families unable to attend weekday distributions.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

MatSu Food Bank aka Food Pantry of Wasilla Food4Kids	MatSu Valley Grocery Rescue Program	AK	Food insecurity remains a significant challenge across Alaska, where approximately 1 in 7 residents experience food insecurity. At the same time, large amounts of edible food are discarded each year by grocery stores, restaurants, and food retailers. In the Matanuska-Susitna Borough alone, an estimated 36 million pounds of food may be wasted annually. A portion of this food remains safe and nutritious and could be rescued and redistributed to families in need. The MatSu Food Bank proposes establishing a coordinated Grocery Rescue Program to recover surplus food from grocery stores, restaurants, and food retailers across the MatSu Valley. This program will significantly increase the amount of rescued food available to families experiencing food insecurity while reducing waste sent to landfill.	The MatSu Valley Grocery Rescue Program will establish a dedicated food recovery system designed to capture surplus food that would otherwise be discarded. The program will include: • Hiring one full-time employee dedicated to food rescue coordination and partner outreach • Purchasing a dedicated box truck under 26,000 GVW to collect and transport rescued food • Full vehicle insurance and operating expenses • Purchase of a forklift and pallet jack to safely move palletized food • Development of scheduled pickup routes for restaurants and grocery stores • Expansion of food distribution to partner agencies across the MatSu Valley The MatSu Food Bank has recently begun partnering with the Knik Tribe through the use of their composting Connex system. This partnership allows any food that cannot be rescued for human consumption to be composted rather than sent to the landfill. Through this partnership and expanded food recovery infrastructure, the MatSu Food Bank has established a goal of achieving zero food waste by 2026, ensuring that no food handled by the organization enters the landfill waste stream.	\$50,000-\$250,000		Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Health Services, Inc.	Mat-Su Health Services RHTP Phase I	AK	Rural communities across Alaska face persistent barriers to accessing timely comprehensive health care, including workforce shortages, geographic isolation, and limited access to specialty services. These challenges are particularly evident in the Matanuska-Susitna Valley, where rapid population growth has increased demand for primary care, behavioral health, and specialty services. In contrast, the health care workforce has struggled to keep pace. Mat-Su Health Services (MSHS), a Federally Qualified Health Center and regional behavioral health provider, currently operates on an aging on-premises server infrastructure that limits system reliability, interoperability, and the ability to leverage telehealth and modern care delivery tools fully. Upgrading to a cloud-based electronic health record environment will modernize care delivery, improve connectivity with health system partners, and strengthen telehealth capacity for rural patients. At the same time, access to specialty services such as vision care remains limited in many communities. Tele-optometry technology offers the opportunity to provide remote eye care services at MSHS clinics without requiring on-site specialists. This project will modernize technology infrastructure, introduce tele-optometry services, and build workforce capacity through a Rural Health Transformation Program Coordinator and Community Health Worker, creating the foundation for a scalable model to expand integrated care to rural Alaskans.	Mat-Su Health Services (MSHS) will implement a phased approach to modernize technology infrastructure, expand service delivery capabilities, and build workforce capacity to improve access to care for rural Alaskans. Phase I will focus on foundational technology upgrades necessary to support modern health care delivery. MSHS will transition its electronic health record system from on-premises servers to a secure cloud-hosted environment through NextGen’s AWS-based platform, improving system reliability, cybersecurity, interoperability, and telehealth functionality. During this phase, MSHS will also upgrade its behavioral health technology suite to the newest available platform and enhance connectivity across clinical sites to improve coordination between primary care, behavioral health, and specialty services. In addition, MSHS will implement tele-optometry technology through Digital Optometrics at its three medical clinics, allowing patients to receive comprehensive eye exams supported by remote optometrists using advanced diagnostic equipment. This model will expand access to vision care, reduce wait times and eliminate the need for on-site specialty providers in rural settings. Phase I will also establish key staffing infrastructure by hiring a Rural Health Transformation Program Coordinator responsible for project management, data reporting, and partnership development, and a Community Health Worker who will begin training to support patient navigation, outreach, and care coordination. In Phase II, MSHS will build on this infrastructure through its Behavioral Health Modernization initiative, “Momentum,” integrating behavioral health clinicians, case managers, and support staff within primary care teams to improve whole-person care for patients with complex needs. Once this integrated model is fully operational within the Mat-Su region, Phase III will focus on expanding telehealth-enabled services to additional rural and frontier communities in Alaska that currently lack access to integrated behavioral health and primary care services. By combining modern cloud-based technology, innovative care models, and workforce development, this project will create a scalable platform that can expand high-quality care to rural communities across Alaska.	\$1M-\$5M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Advance to Implementation Application

Mat-Su Health Services, Inc.	Alaska Behavioral Health Population Management PMPM	AK	Behavioral health providers across Alaska operate in a system where the majority of patients are covered by Medicaid, yet reimbursement structures are largely built around fee-for-service encounters that do not fully support the level of coordination, outreach, and stabilization services required for individuals with complex behavioral health conditions. Recent statewide analyses, including the Guidehouse behavioral health rate study, have highlighted the ongoing gap between Medicaid reimbursement and the true cost of delivering comprehensive behavioral health services. This misalignment creates significant sustainability challenges for community providers and limits the ability of the system to invest in proactive, community-based interventions that can prevent crises and reduce costly downstream utilization such as ED visits, inpatient admissions, and out-of-region care. This project will explore the development of a sustainable care model that supports individuals through a flexible, population-based approach. Rather than relying solely on billable visits, the model would support wraparound services including care coordination, crisis prevention, and community-based stabilization designed to keep individuals connected to care within their communities. The project will initially focus on designing and piloting the model in the MSB, with the goal of developing a scalable framework across Alaska and strengthen the long-term sustainability of the state’s behavioral health system.	This project will design and pilot a sustainable care model that supports individuals with complex behavioral health needs through a flexible, population-based approach. The model will draw upon proven care management and value-based behavioral health systems implemented in other states, including Oregon’s Coordinated Care Organizations, Colorado’s Regional Accountable Entities, and New York’s Medicaid Health Home program. These models demonstrate that proactive care coordination, community-based stabilization services, and population-level care management can improve outcomes while reducing avoidable hospitalizations and emergency department utilization. While these models provide a strong evidence base, Alaska presents unique challenges that require adaptation. The state’s geographic size, rural and frontier communities, workforce shortages, transportation barriers, and limited access to psychiatric specialty care require a care model that can operate effectively across vast distances and support smaller community providers. During Years 1–2, Mat-Su Health Services will lead the design and pilot phase in the Mat-Su Borough. This phase will include development of the care model framework, identification of target patient populations, evaluation design, and collaboration with behavioral health providers and system partners to ensure the model is practical and scalable in Alaska’s rural environment. The pilot will test strategies such as enhanced care coordination, crisis prevention services, telehealth-enabled psychiatric consultation, and community-based stabilization supports designed to help individuals remain engaged in care and avoid behavioral health crises that lead to emergency department visits or hospitalization. Years 3–5 will focus on refining the model based on pilot results and developing a scalable framework that can be implemented by behavioral health providers across Alaska. The project will emphasize collaboration with rural providers, training and technical assistance, and the use of telehealth to extend specialty expertise to underserved communities. By adapting proven population-based behavioral health models to Alaska’s unique environment, this project aims to strengthen provider sustainability, expand access to coordinated behavioral health services, and reduce costly downstream utilization while allowing Alaskans to receive care within their own communities.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Mat-Su Regional Medical Center	AI-Assisted EEG: Bridging the Neurological Assessment Gap with AI	AK	When MSRMC Emergency Room or Intensive Care Unit patients present with unclassified seizure-like activity - to include altered mental status or subtle, unclassified movements (which may or may not be non-convulsive seizures or status epilepticus) - the hospital lacks on-site neurological monitoring required for definitive diagnosis. This includes limited in-house capability to provide neurology and electroencephalogram (EEG) interpretations. Therefore, MSRMC frequently transfers these patients to an Anchorage facility with the requisite capabilities. The transfer process introduces significant delays in diagnosis and treatment that are particularly dangerous in cases of ongoing, non-convulsive seizures that can cause irreversible brain damage. Therefore, MSRMC is requesting RHTP funding to procure an AI-enabled EEG system from a vendor such as Ceribell that will enable its in-house clinicians to diagnose, treat and avoid transfer of patients experiencing these symptoms.	MSRMC's approach to address the challenge of diagnosing and treating patients who present with seizure-like activity is to procure an AI-assisted EEG system along with an annual supply of the disposable headbands required for system use of such systems. An AI-assisted EEG system, like the Ceribell system, reduces the need for specialized training and lengthy electrode placement required for traditional EEG. An AI-assisted EEG system then enables physicians to quickly determine if a patient is experiencing status epilepticus. This rapid identification is crucial for making emergent treatment decisions prompting appropriate care locally and potentially avoiding the need for a costly, time-sensitive transfer that may contribute to negative outcomes. MSRMC's approach includes procurement of an AI-assisted EEG system along with an annual supply of the headbands required for use. Attributes specific to the Ceribell system identified by MSRMC include the following: 1. Objective Data at the Bedside: The portable, battery-powered Ceribell device captures and processes the brain electrical activity immediately. 2. AI-Driven Interpretation: Crucially, Ceribell provides a proprietary Brain Stethoscope feature, which is an auditory representation of brain activity, and utilizes AI-powered software to help the clinician identify seizures within minutes. The software provides quantitative metrics and assists in flagging patterns consistent with status epilepticus. 3. Immediate Local Decision Making: By providing immediate, objective confirmation (or exclusion) of seizure activity, Ceribell empowers MSRMC physicians—emergency medicine and critical care specialists—to initiate appropriate, life-saving anticonvulsant therapy at the bedside. This ability to "rule in" or "rule out" a neurological emergency locally prevents unnecessary patient transfers and helps patients who are seizing receive treatment when every minute counts. For patients who are not seizing, it rapidly directs the diagnostic path toward other causes of altered mental status, saving time and resources. This immediate diagnostic capability transforms the MSRMC standard of care from one of transfer-for-diagnosis to one of local-diagnosis-and-treatment, vastly improving critical neurological care access for the Mat-Su Borough.	\$50,000-\$250,000	Hospital	Single Community	Matanuska-Susitna Borough	Advance to Implementation Application

Mat-Su Regional Medical Center	Expanding neonatal critical care access by converting existing space into a Level II NICU.	AK	MSRMC currently provides neonatal care within existing space; however, limitations of the hospital's infrastructure and clinical capability require transfers for infants who need Level II monitoring or short-term intensive support. These transfers create significant logistical and emotional burdens for families, disrupt maternal-newborn continuity, and place additional strain on receiving facilities in Anchorage. According to Alaska Hospital Association data for 2024, at least 48 Level II–appropriate neonatal discharges for Mat-Su residents occurred at Anchorage hospitals, indicating that a meaningful number of infants are transferred primarily due to facility capability constraints rather than clinical necessity. This represents a clear (and widening) access gap within the region. Upgrading neonatal services within MSRMC’s existing footprint to achieve Level II capability presents an opportunity to reduce avoidable transfers, improve timeliness of care, and strengthen local maternal-child health capacity for rural and frontier families.	MSRMC will implement a phased approach to achieve Level II NICU capability within its existing footprint, without adding new square footage. Step 1: Clinical and Regulatory Gap Assessment - MSRMC will finalize its detailed review of current neonatal services against Level II standards to identify required infrastructure, equipment, workflow, and staffing enhancements. This assessment will guide design specifications and support compliance with regulatory and accreditation requirements. Step 2: Targeted Renovation and Equipment Upgrades - The project will renovate existing space to support appropriate patient care configuration and enhanced monitoring capacity. This approach aligns with RHTP allowable uses for targeted capital improvements that strengthen maternal and newborn care facilities, including conversion or updating of existing suites and installation of technology that expands appropriate care availability. Step 3: Workflow Integration and Implementation - Clinical protocols, interdisciplinary coordination processes, and staff training will be updated to align with Level II standards. Following completion, MSRMC will monitor transfer rates and neonatal outcomes to evaluate impact.	\$1M-\$5M	Hospital	Single Community	Matanuska-Susitna Borough	Advance to Implementation Application

Mat-Su Regional Medical Center	Strengthening the Mat-Su specialty workforce to promote sustainability	AK	The Mat-Su region faces sustained shortages across primary care and key specialties essential for rural and frontier populations. Rapid growth—40,000 additional residents since 2005—has intensified access challenges. Statewide, HRSA reports 338 primary care HPSA designations, with only 26.58% of need met. By 2029, Mat-Su is projected to face deficits of 28 family medicine physicians, 28 internal medicine physicians, 11 gastroenterologists, 7 nephrologists, 6 pulmonologists, and 6 neurologists. Behavioral health access is strained, with 342 residents per mental health provider—worse than the national average. Recruitment is further complicated by housing and childcare constraints; 43% of children under 5 rely on unlicensed care. Within this environment, MSRMC’s workforce data reflect ongoing instability. Among employed providers, 32% of those active one year ago and 55% of those active three years ago are no longer practicing at MSRMC. Recruitment yield remains limited: cardiology has produced 0 hires from 8 candidates in 10 months; family and internal medicine each yielded 1 hire despite 15–20 candidates; psychiatry 5 hires from 60 candidates over nearly six years. MSRMC currently has 8 multi-year provider vacancies and 2 unfilled therapist roles. The average third next available new PCP appointment is approximately 20 days. This project advances a coordinated regional strategy to improve recruitment yield, strengthen retention, and stabilize long-term workforce capacity.	MSRMC will implement a structured, outcome-driven recruitment and retention strategy to stabilize the highest-need primary care and specialty service lines and measurably improve patient access across the Mat-Su region. This initiative establishes a coordinated workforce stabilization framework aligned with the RHTP Strengthen Workforce initiative. Step 1: Data-Guided Prioritization. MSRMC will identify priority roles based on vacancy duration, patient access delays, service-line instability, and transfer patterns. Baseline metrics (including vacancy rates, time-to-fill, contract labor utilization, and appointment wait times) will establish performance targets. Step 2: Performance-Based Recruitment Incentives. RHTP funds will support time-limited recruitment incentives tied to multi-year service commitments, with staged payments linked to retention milestones. This approach is designed to shorten time-to-fill, improve multi-year retention rates, and reduce recurring vacancy cycles. Funds will not subsidize routine salaries. Step 3: Barrier Mitigation Supports. To address rural relocation challenges, MSRMC will provide wraparound supports such as housing navigation, time-limited housing assistance where appropriate, childcare coordination, and structured onboarding. Reducing these practical barriers increases the likelihood of long-term retention and workforce stability. Step 4: Professional Integration and Retention Infrastructure. MSRMC will strengthen mentorship, continuing education access, and specialty collaboration networks to reduce professional isolation and burnout—key drivers of rural attrition. Step 5: Ongoing Performance Monitoring. Progress will be tracked through recruited provider counts, retention rates, vacancy trends, contract labor reduction, and changes in appointment availability and wait times. By reducing persistent vacancies and strengthening long-term retention, MSRMC expects to improve continuity of care, decrease delays in access, reduce reliance on premium temporary staffing, and create durable workforce capacity serving rural and frontier patients.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Mat-Su Regional Medical Center	Upgrade surgical robotics platform to enhance surgical quality and access for Mat-Su Borough.	AK	Mat-Su Regional Medical Center currently operates two surgical robots as part of its surgical robotics program. The program began in 2018 when MSRMC procured its first robotic surgical system. These systems are based on a platform originally introduced in 2014 and, while they have served the community well, they reflect technology that is now more than a decade old. Last year alone, nearly 650 surgeries were performed using these robotic systems, demonstrating the program’s strong utilization and importance to the region. In 2025, a new and more advanced soft-tissue surgical robotic platform was released and other competitor products are becoming available, offering substantial benefits to patients, surgeons, and operating room teams compared to MSRMC’s current systems. These advancements include improved imaging, advanced instrumentation, and expanded capabilities that support better clinical outcomes and workflow efficiency. Hospitals in Anchorage, AK, are already utilizing this latest generation technology. As a result, patients and surgeons in the Mat-Su Borough who wish to access these advanced capabilities must currently travel to Anchorage. MSRMC seeks to upgrade its existing surgical robotic systems to the latest platform released in 2025 to help the community it serves has the same level of access to state-of-the-art surgical robotics technology as patients treated in Anchorage.	MSRMC proposes purchasing two of the latest-generation surgical robotic systems, along with the necessary equipment, to upgrade its surgical robotics platform to the most advanced technology currently available. These two new systems will replace the existing robots and significantly enhance surgical quality, clinical capabilities, and access to advanced robotic surgery for patients in the Mat-Su Borough. MSRMC will select its vendor and coordinate with the vendor to have the new robotic systems shipped and installed within three months. After installation, current surgeons and operating room staff will complete required training on the new platform, which is expected to take approximately one month. Upon completion of training, MSRMC will fully transition to the upgraded systems and will be prepared to offer the most advanced surgical robotics technology available to patients and providers in the Mat-Su Borough.	\$1M-\$5M	Hospital	Single Community	Matanuska-Susitna Borough	Advance to Implementation Application

Mat-Su Regional Medical Center	Building Automation System and Cooling Plant Upgrade & Innovation	AK	MSRMC’s building automation system is 20+ years old and is now obsolete, unsupported, and unable to meet current IT and operational needs. The legacy system limits the hospital’s ability to analyze building performance and maintain reliable control of critical clinical environments. It lacks secure remote monitoring and cannot integrate with modern IT systems, making upgrades in other areas of the facility costly and complex. MSRMC, Community Health Systems (CHS) [MSRMC's parent], Facility Diagnostics, and Trane Technologies have developed a BAS modernization plan that incorporates innovative, cloud-based, autonomous AI technology to optimize building operations in real time. This upgraded platform enables secure remote monitoring, centralized management, and improved system reliability—capabilities essential for healthcare facilities serving Alaska’s growing and geographically dispersed communities. As part of the BAS modernization project, MSRMC also proposes to upgrade the hospital’s cooling plant utilizing modern equipment and controls. This plant services critical maternal care rooms and wellness centers throughout the facility. Finally, MSRMC proposes to train facility engineers and staff on these new systems. These efforts are expected to improve patient and staff comfort, support better clinical outcomes, and increase operational resilience.	The proposed project will modernize MSRMC’s building automatic system by replacing legacy controllers with network capable units fully integrated into the Trane Ensemble platform, enabling secure remote access, advanced analytics, and centralized management. It also includes the opportunity to pilot Trane's BrainBox AI, an artificial intelligence–driven building optimization platform that uses real-time operational data and predictive analytics to autonomously adjust HVAC systems for improved performance and efficiency. BrainBox AI was acquired by Trane Technologies and is now integrated into Trane’s building automation ecosystem, strengthening platform compatibility and long-term support. MSRMC also plans for the cooling plant effort to include a modernized chiller and upgraded plant controls. This will extend equipment life, improve serviceability, and reduce maintenance disruptions.	\$1M-\$5M	Hospital	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Regional Medical Center	Enhance endoscopy recovery and throughput with renovation.	AK	MSRMC faces a significant throughput bottleneck in its endoscopy program driven by limited recovery space. The existing endoscopy recovery area has reached physical capacity, creating a constraint that directly limits procedural volume and overall efficiency. Compared with typical Facility Guidelines Institute (FGI) planning expectations for a hospital of this size and service profile, MSRMC’s recovery capacity is undersized, currently operating with only two recovery bays where a larger complement is generally anticipated. Because recovery bay availability dictates the pace of procedures, insufficient recovery slots create a “stop-start” dynamic that delays cases, restricts daily throughput, and underutilizes specialized staff and equipment. This limitation could contribute to extended patient wait times for essential diagnostic and preventive procedures, thereby compromising timely access to care for rural residents. In some cases, patients must instead travel long distances to Anchorage, AK to receive needed endoscopy services. The constrained recovery environment also impacts workflow, patient experience, and safety. Crowded conditions reduce optimal post-sedation monitoring space and strain nursing operations. In summary, inadequate endoscopy recovery capacity restricts program growth, lengthens wait times, and places pressure on the clinical environment, necessitating a comprehensive solution to provide efficiency and access.	The solution employs an approach focused on strategic relocation and targeted renovation to lessen the capacity constraint in the endoscopy recovery area. This first move prepares the site by creating the necessary space to relocate the offices to minimize disruption to current clinical operations. This space will be across the hall from the OR area in the admin department. Once this is complete the inhabitants of the two offices will relocate. After the relocation occurs, the now-empty office and storage area will undergo a full clinical renovation that includes the following: Capacity Expansion: The renovation will be designed and executed to construct two new, fully equipped, modern endoscopy recovery bays. Clinical Goal Attainment: The new bays will immediately increase the unit's total capacity, reduce the current throughput bottleneck, and allow MSRMC to schedule the optimal number of daily procedures. This staged approach supports the needed capacity expansion with minimal, non-clinical displacement, adding two recovery bays that improve patient access and quality of care.	\$1M-\$5M	Hospital	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Regional Medical Center	Enhancing rural hospital capabilities with AI assisted biorobotics aquablation surgery for BPH	AK	Benign Prostatic Hyperplasia (BPH) is the leading cause of urologist visits for men. The condition affects one in two men aged 51 to 60, and its prevalence increases with age. Ninety-nine percent of men with BPH report that their symptoms negatively affect their quality of life. Despite the commonality of BPH, there is still a considerable unmet need in BPH treatment. This is primarily due to the side effects associated with current surgical procedures, patient reluctance to commit to long-term medication, and a general acceptance of quality-of-life impacts like frequent urination and incontinence. Side effects also include erectile and ejaculatory dysfunction. The rates of these side effects can be quite high and are often irreversible. Ejaculatory dysfunction can result in up to 89-90% during a simple prostatectomy. MSRMC plans to help solve this problem by improving access to state-of-the art care enabled by the AI-assisted biorobotic aquablation system. In the case of the Procept Hydros AI-assisted biorobotic aquablation system, the incidence of BPH side effects drops to under 11%, erectile dysfunction to 0%, and incontinence is 0.5%, according to the vendor. With these dramatically improved outcomes in mind, MSRMC anticipates that more men will seek the appropriate interventional care using an AI-assisted biorobotic aquablation system to stop the progression of disease so that more severe complications are avoided.	MSRMC proposes to address the problem of men with BPH avoiding care and experiencing a high degree of negative side effects by purchasing an AI-assisted biorobotic aquablation system. Procept Hydros has been identified as a potential vendor partner. This proposed purchase aligns to Alaska's Health Care Access initiative and the stated potential use of funds to increase access to high-quality, specialized services. The selected vendor will provide training to MSRMC's nephrologist to effectively use the system and begin serving patients.	\$250K-\$1M	Hospital	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Regional Medical Center	Expand Intensivist Coverage with Tele Health Technology	AK	MSRMC is the only full-service acute care hospital serving geographically expansive rural and frontier region larger than many U.S. states. Despite being the fastest-growing community in Alaska, the Mat-Su Valley and its surrounding frontier service area face critical specialist access gaps that place lives at risk and drive unsustainable costs. For example, MARMC sees the following challenges: Specialist access gaps: frontier communities typically do not have local specialist access. Patients requiring intensivist or critical care expertise face medevac transport at average costs of \$15,000–\$20,000 per flight. After-hours coverage strain: Reaching Mat-Su specialists after hours requires physical transport, causing preventable delays in time-sensitive conditions including sepsis, acute kidney injury, and other complex care cases. Workforce attrition: Clinical isolation — operating without specialist backup — is a primary driver of provider burnout and departure in frontier Alaskan settings. This initiative is designed specifically to strengthen specialty and critical care for rural, remote, and frontier communities across the Mat-Su region. By enabling real-time specialist collaboration between MSRMC and community health sites, the project expands the reach of advanced clinical expertise.	MSRMC proposes to partner with Omnicure Inc. and SickBay AI-enabled inpatient monitoring, to establish this hub-and-spoke telehealth network that extends Mat-Su’s intensivist capabilities to frontier communities across its service area. The model has three components: Component 1 — Tele-ICU & Critical Care Augmentation at Mat-Su: The project will deploy a tele-critical care platform that supplements Mat-Su’s existing intensivist program, providing 24/7 on-demand board-certified intensivist coverage for complex cases, overnight gaps, and surge periods. Paired with SickBay’s AI-enabled continuous monitoring in Mat-Su’s 14-bed ICU and 22-bed ED, this creates an always-on critical care safety net that reduces transfers to Anchorage and improves outcomes for the region’s highest-acuity rural patients. Component 2 — Virtual Specialist Access for Frontier Communities: Via Omnicure’s platform, community health aides, nurses, and clinic providers across the Glenn Highway corridor and Susitna Valley gain real-time access to Mat-Su-backed intensivists and specialists. This enables stabilization in community and avoids medevac transport for conditions manageable with specialist guidance. Component 3 — Virtual Nursing & Chronic Disease Management: Omnicure’s virtual nursing program supports post-discharge follow-up and chronic disease management for high-risk patients — particularly Alaska Native patients with ESKD, diabetes, and hypertension — reducing avoidable readmissions and emergency presentations. MSRMC notes that Omnicure’s platform integrates with major EHR systems via Rhapsody, typically requires no custom IT build, and typically deploys within 45–60 days of award. Satellite connectivity options are compatible with Alaska’s rural internet environment. This model enables rural clinicians to stabilize and manage more patients locally while maintaining immediate access to specialist consultation when needed. By strengthening MSRMC’s role as a regional hub, the program reduces unnecessary transfers and allows patients to remain closer to their families and communities whenever clinically appropriate. MSRMC will coordinate with regional clinics, community health aides, and Alaska Native health organizations to align the telehealth network with existing rural care delivery systems.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Regional Medical Center	Expanding access to Oncology services for the Mat-Su and surrounding populations	AK	Residents of the Mat-Su face growing demand for cancer services but limited access to coordinated oncology care within their community. Cancer incidence is highest in Alaska’s interior and rural regions, but most oncology services—including chemotherapy, radiation therapy, diagnostics, surgical oncology, and multidisciplinary care planning—are concentrated in Anchorage. Many rural, remote and frontier patients must travel long distances for treatment. Healthcare claims data show that 54% of Alaska cancer patients travel to Anchorage for chemotherapy and 36% for radiation therapy. Because cancer incidence increases with age, Mat-Su’s growth—combined with an aging population—means cancer cases will rise over the next decade. MSRMC estimates that the borough likely sees 500–700 new cancer diagnoses per year - a sufficient volume to support a regional oncology program. Within the borough, existing cancer services are limited and dispersed across multiple facilities. Patients must navigate separate locations for screening, diagnostics and treatment, creating fragmented care pathways that delay care and increase travel burden. These challenges are compounded by gaps in early detection. Alaska ranks among the bottom states for preventive cancer screenings, contributing to later diagnoses and poorer outcomes, and the state’s cancer mortality rate exceeds the national average. There is a clear need to improve access to coordinated cancer care services closer to where patients live.	In support of Alaska's RHTP goals to improve access to care—particularly access to specialty services in rural hub communities and including age appropriate cancer screenings—our vision is to develop a cancer center in the Mat-Su Borough with a full spectrum of cancer care services, from screenings through treatment and into survivorship that will improve the health of thousands of Alaskans. This cancer center would bridge the care gap between Mat-Su's growing population and the specialized oncology services concentrated in Anchorage. Today's cancer care landscape in the borough is fragmented, with individual physician practices delivering medical oncology and hematology, radiation therapy and surgical care at separate, disparate locations. The geographic challenge is one of several straining cancer care in Alaska, including provider shortages, cost barriers and SDOH constraints. Research shows that multidisciplinary, co-located cancer programs improve speed to treatment, quality of care, adherence to clinical guidelines, and patient satisfaction. Coordinated centers also operate more efficiently by reducing duplicative testing, strengthening communication among providers, and centralizing medical records. Most importantly, a cancer center shifts the focus from treating a disease in isolation to caring for the whole person. MSRMC proposes a feasibility study as the first responsible step in evaluating whether and how to develop a hospital-based cancer center in the Mat-Su Borough. Cancer care continues to evolve rapidly, and any long-term investment must be grounded in solid data and a clear understanding of community need. The study will evaluate current and projected demand, review the existing provider landscape, assess which clinical programs can be sustainably supported locally, and analyze facility, equipment, workforce, and technology requirements. It will also include financial modeling to outline capital needs, operating projections, phased development options, and long-term sustainability. Partnership opportunities and strategies to reduce patient outmigration will also be examined as part of the analysis. By the conclusion of the study, leaders will have an implementation roadmap that outlines scope, cost, timeline, and measurable outcomes. This roadmap is expected to provide a practical path forward for strengthening cancer care in the Mat-Su Borough.	\$250K-\$1M	Hospital	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Regional Medical Center	Improve immediate use sterilization capacity for surgeries	AK	The two Amsco immediate use autoclaves are essential for the daily operations of the operating rooms at MSRMC. They serve as a critical backup and specialized sterilization method when standard pre-packaged instrument sets are compromised, or when unique, one-of-a-kind surgical instruments are needed quickly. Specifically, if a sterile, pre-packaged set is accidentally dropped or otherwise contaminated mid-procedure, the contaminated instruments can be rapidly processed through the immediate use autoclave to be safely returned to use with minimal delay to the surgery. Similarly, for highly specialized or expensive instruments that do not have duplicates, this capacity allows for their immediate reprocessing and availability for subsequent cases, maximizing equipment utilization and preventing surgical bottlenecks that would arise if the team had to wait for a full, centralized sterilization cycle.	MSRMC proposes to use RHTP funds to replace its aging sterilization units by procuring two new Amsco 400 series immediate use autoclaves. This will directly resolve the critical capacity issue currently faced by MSRMC. The Amsco 400s are current-generation, high-speed sterilizers known for their reliability, efficiency, and compliance with the latest sterilization standards. By installing these new units, MSRMC will reduce the looming risk of catastrophic failure associated with the existing, near end-of-life machines, thereby increasing continuous immediate use sterilization capacity. This proactive replacement helps the operating rooms maintain optimal throughput, respond quickly to unexpected contamination events, and promptly reprocess specialized surgical instruments—supporting continued access to essential surgical services across the Mat-Su Borough while reducing the risk of delays or cancellations due to equipment failure.	\$50,000-\$250,000	Hospital	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced
Mat-Su Regional Medical Center	Nurse call system replacement	AK	The MSRMC nurse call system is nearing its end of life. The estimated end of life is December 2027. After this time, the current vendor will no longer support the system. Parts will be unavailable and only "best efforts" will be made for repairs. As expected with many systems nearing end of life, MSRMC is already facing challenges with the system. Specifically, aging system hardware is beginning to fail, to include failures of two staff consoles in the past year. The current system hardware is also incompatible with newer technologies implemented by MSRMC, resulting in the inability for the nurse call system to integrate with the hospital's wireless phone system. In addition, calls between patients, physicians and nursing staff are sometimes difficult to hear and are dropped before conversations are complete. These challenges ultimately diminish the quality of care MSRMC is able to provide its patients and adversely impacts nurse, doctor and patient satisfaction. Finally, the current system is not able to work with the modern technologies, including AI, that are essential to improving care delivery for rural, remote and frontier Alaskans at Mat-Su.	MSRMC proposes to use RHTP funds to procure and integrate a new Nurse Call System, such as the leading system offered by Ascom, to replace its current system that is approaching its end of life. MSRMC is currently working to determine an integration timeline that accomodates integration of the nurse call system along with the hospital's wireless phone system, clinical devices, workflows and the EHR for documentation support. We expect that this timeframe will be several months. During this time, MSRMC plans to work collaboratively with the selected vendor to deliver an on-time integration.	\$250K-\$1M	Hospital	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Regional Medical Center	Renovate clinic to make outpatient cardiac imaging department	AK	The Mat-Su Borough currently faces a significant bottleneck in local cardiology healthcare access, primarily driven by substantial waitlists for critical diagnostic tests, particularly cardiac stress tests. This backlog results in delayed diagnoses and postponed treatment initiation for patients with potential cardiac conditions. The existing infrastructure is unable to meet the growing demand for these essential services. MSRMC has identified this capacity gap and will be purchasing an additional nuclear medicine camera and echocardiography machine on its own. However, the clinic currently lacks adequate space to house this equipment. The absence of an integrated and consolidated cardiology imaging suite further exacerbates workflow inefficiencies and limits diagnostic throughput. As a result, patients requiring non-invasive cardiac evaluation are experiencing prolonged wait times or must travel to Anchorage for testing, delaying definitive diagnosis of conditions such as coronary artery disease. In some cases, patients wait weeks for necessary screening, directly impacting the timeliness of intervention. These delays in diagnostic services represent a significant barrier to access and jeopardize the continuity, quality, and effectiveness of advanced cardiac care for residents of the Mat-Su Borough.	This proposal reflects MSRMC's plan to solve the cardiology bottleneck problem by renovating and optimizing existing space at the Mat-Su Heart Clinic into a dedicated cardiology imaging suite. This suite will house the newly purchased diagnostic equipment. This will be accomplished in the following ways: Design and Planning: Assess clinic space, create architectural plans to accommodate the nuclear medicine camera, Echo machine, stress test treadmill, and EKG equipment, optimize patient and technician workflow. Construction and Installation: Renovate the space (including structural, power, and necessary shielding/lead-lining), professionally install and calibrate the nuclear medicine camera, Echo machine, and stress test equipment, and integrate the systems. Operational Launch: Train staff on new workflow and safety protocols, finalize scheduling to maximize use of the two nuclear medicine cameras and Echo machines to reduce the patient backlog, and initiate a phased rollout. This focused approach uses existing MSRMC real estate and equipment, offering a rapid, cost-effective solution to the critical diagnostic bottleneck. RHTP funds will be used to fund the renovation only.	\$250K-\$1M	Hospital	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Senior Services	Palmer Area Senior Meals and Services	AK	This project addresses the critical intersection of food insecurity, social isolation, and mobility limitations among adults aged 60+, aiming to strengthen access to home delivered meals, congregate dining, and reliable transportation. Addressing this issue is urgent due to four key challenges: rising unmet needs and service waitlists, significant transportation barriers, high rates of isolation leading to poor health outcomes, and most importantly the rising cost of food. To combat these challenges, the project focuses on several key opportunities. A "More Than a Meal" (Meals on Wheels America initiative) model will be implemented, which combines nutritious meals containing a balanced diet of fruit, vegetables and protein, and it will include regular safety checks, social engagement, and wellness activities. Additionally, the project will expand upon our door through door services where drivers are trained in Passenger and Sensitivity Safety (PASS) training. PASS trained drivers will not only transport seniors to and from medical and non-medical appointments, but will also accompany them into and out of all structures. Mat-Su Senior Services (MSSS) integrated transportation solutions will bring seniors to a congregate setting five days a week, reducing isolation and fostering community. Finally, the project aims to bridge the gap by utilizing technology and community partnerships to identify at risk, low-income, vulnerable seniors who are not currently receiving services.	Mat-Su Senior Services is prepared to restart the evidence-based More Than a Meal model, a transformative initiative that evolves traditional home-delivered meal programs into a high-impact platform for senior health, safety, and social connectivity. This comprehensive approach leverages daily nutritional visits as a critical touchpoint for wellness checks, effectively combatting social isolation while delivering well-balanced meals designed to improve long-term health outcomes for our community's most vulnerable seniors. To ensure the highest nutritional quality while addressing food insecurity, we will directly recover unsold, high-quality perishable food—including fresh produce, meat, and dairy—from the Palmer Carrs location to prevent waste and immediately redirect nutritious food to local tables. Recognizing that limited mobility serves as a primary barrier to health equity, the program will integrate specialized, “door-through-door” transportation solutions. These services go beyond standard transit by providing the physical assistance necessary to restore senior access to the community center and essential services. To maximize the program's efficacy, the project will specifically target underserved populations by conducting rigorous assessments of nutritional needs, Activities of Daily Living (ADLs), and Instrumental Activities of Daily Living (IADLs). By leveraging existing partnerships with the Food Bank of Alaska and Palmer Safeway (Carrs), both of which helped to offset overhead costs with their food donations, we will rebuild a robust support network that addresses food insecurity and promotes healthy aging in place with dignity.	\$1M-\$5M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Services for Children & Adults, Inc.	Increasing Available ABA Service in the Mat-Su Valley	AK	The Mat-Su Valley currently faces a critical behavioral health infrastructure gap, with families experiencing a 24-month waitlist for essential Applied Behavior Analysis (ABA) services. This delay occurs during crucial developmental windows, forcing families to choose between forgoing care or managing the severe logistical burden of traveling to Anchorage for multi-hour therapy sessions. Our agency has the opportunity to bridge this gap by expanding our established service network. We currently operate both an Infant Learning Program and Home and Community-Based Waiver services. By integrating ABA into this existing framework, we can provide a cohesive, life-course continuum of care that allows children to transition seamlessly between services within their own community. This project transforms the regional care model from one of exported services to a sustainable, local system that directly addresses the health equity challenges of our population.	To address the Applied Behavior Analysis (ABA) service gap in the Mat-Su Valley, our proposed approach focuses on the strategic expansion of our existing infrastructure to create a cohesive, life-course care model. We will utilize RHTP funding to recruit, onboard, and train a specialized team of ABA providers to operate directly within the Mat-Su Valley, effectively reducing the geographic barrier that currently forces families to commute to Anchorage. This local presence is essential for maintaining the treatment consistency required for ABA, ensuring that therapy sessions are not disrupted by weather, road conditions, or the logistical strain of long-distance travel. Our agency is uniquely positioned to bridge the divide between early and adult services, as we currently provide Infant Learning Program (ILP) services for children and Home and Community-Based Waiver services for adults. By introducing ABA as a specialized service line, we complete the continuum of care, allowing for a seamless transition for children graduating from ILP who require continued behavioral support, but are still on the waitlist for their waiver. This integration ensures that the developmental gains made during early childhood are not lost due to service fragmentation.	\$250K-\$1M	Home- and community-based services provider	Single Community	Matanuska-Susitna Borough	Advance to Implementation Application

Mat-Su Services for Children & Adults, Inc.	Behavioral Health Services for Individuals with Intellectual and Developmental Disabilities	AK	Data indicates that 30% to 70% of individuals with IDD also carry a mental health diagnosis. However, traditional BH agencies in Alaska are primarily designed to address trauma and substance use. Consequently, clinical staff across the state are often not equipped with the specialized training required to effectively treat individuals with IDD. This leads to a cycle of crisis: complex mental health behaviors in group homes or family settings go undertreated, often resulting in emergency room visits, out-of-state placements, or a complete breakdown of the home environment.	We will operationalize a continuum of care that embeds behavioral health into every stage of life: Early Intervention & Family Support: We will embed BH services within our Infant Learning Program (ILP), providing immediate family therapy and postpartum depression support to parents of children ages 0-3 that have been identified as having a development delay. Home-Based Family Services (HBFS): For children ages 4–17, our mobile clinical teams provide intensive, in-home behavioral support. This will allow us to address complex mental health behaviors in the child's natural environment, stabilizing the family unit, and preventing the need for more restrictive out-of-home placements. High-Intensity Adult Services: We will launch an IDD-specific Assertive Community Treatment (ACT) Team to support adults experiencing complex mental health behaviors in community or group home settings, alongside Individual Placement and Support (IPS) to integrate mental health care with meaningful employment for individuals with serious mental illness.	\$250K-\$1M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Mat-Su Services for Children and Adults	Babies Can't Wait	AK	The Mat-Su Services for Children and Adults (MSSCA) serves individuals and families caring for young children from birth through 2-years with developmental delays and disabilities. Mat-Su families face significant barriers to accessing Infant Learning Program (ILP), health, and family services. Alaska has the highest eligibility thresholds in the country for ILP services, limiting access for families with children whose developmental delays are lower than 50%. National data shows that children with 25 – 49% delays also need ILP services for best outcomes and to reach maximum potential. The 2025 Community Health Needs Assessment (CHNA) published by the Mat-Su Health Foundation (MSHF) shows the number of children meeting most goals for kindergarten readiness has been declining in the Mat-Su since 2020. Through Babies Can’t Wait, families whose children do not meet the ILP eligibility criteria but fall within the 25 -49% delay range will be offered services, to include developmental guidance, family coaching, and coordinated resource navigation in home, community, and virtual environments, ensuring reliable, equitable services in all Mat-Su Borough communities. This project will expand targeted support for young children and their caregivers while promoting healthy starts, reducing future risk, and supporting resilient, thriving families in a thoughtful and sustainable manner.	Babies Can’t Wait will use a family centered model that tailors supports to best fit each family’s needs. While this is similar to ILP, services for children with milder delays are expected to have a lower frequency and shorter duration. This program will also have less, more streamlined paperwork and processes. Trained staff will partner with families to identify targets for their children’s development, provide coaching and strategies, track progress, and offer resources and connections to further support them.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Services for Children and Adults	Family Foundations	AK	Mat-Su Services for Children and Adults (MSSCA) supports individuals with developmental and intellectual disabilities and delays and their families and caregivers. The Infant, Child, and Family Supports Department specifically visits families caring for young children throughout the Mat-Su Valley from Chickaloon to Talkeetna/Trapper Creek, and out to Point Mackenzie, as well as the entireties of Wasilla and Palmer. According to the 2025 Community Health Needs Assessment (CHNA) recently published by the Mat-Su Health Foundation (MSHF), only 26% of the Mat-Su’s 8,999 children under six-years-old were served in licensed or approved early childhood education services, public pre-k programs, Head Start or Early Head Start programs, or military early childhood education services. The number of children meeting most goals for kindergarten readiness has been declining in the Mat-Su over the past ten years. Families enrolled in our programs frequently ask for child development training, parenting groups, and playgroup connections. Partner agencies often call to ask when we might be able to fill some of these gaps in supporting families as well. This project addresses these gaps directly by creating a program dedicated to providing ongoing Circle of Security Parenting Groups, community child development training (to cover both general development and special circumstances), and high-quality playgroup opportunities with built in access to child development experts.	Family Foundations will create a part-time position dedicated to organizing and scheduling groups and training events at locations across the Mat-Su Borough. We have current staff with expertise and certification across a variety of child development topics and who are certified facilitators of Circle of Security Parenting. A rotating scheduling system and close work with community partners to vary locations (to include virtual options) will allow more caregivers to access training, parenting groups, and playgroups more frequently.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Services for Children and Adults	Hello BABY Programmatic Build-out	AK	Mat-Su families face difficulties locating and accessing healthcare, mental health care, and specialized services, contributing to high rates of child abuse, neglect, and maltreatment. Challenges include transportation barriers, heating costs, adequate housing, and food insecurity. The 2025 Community Health Needs Assessment (CHNA) published by the Mat-Su Health Foundation (MSHF), shows that 30% of caregiver respondents were unlikely or very unlikely to ask for help childcare for medical appointments or school pick-ups. Hello BABY, a R.O.C.K. Mat-Su initiative designed to strengthen coordination across early childhood and family support systems for pregnant people and families with young children, connects families to information, referrals, and resources while building stronger relationships between community partners to reduce fragmentation in the service system. Hello BABY is piloting a shared data system to track referrals and identify service gaps, deploying a Family Support Fund across the region to provide rapid assistance for basic needs, and developing an information and referral website to improve family access to information and services. Proactive family check-ins and the development of a family- to-family support network also strengthen community connections and prevent crises before they occur. This work, grounded in Early Relational Health (ERH) principles, aims to transform system collaboration to support families with young children.	This project builds on existing infrastructure developed by the Hello BABY team. RHTP support would propel the project from structured collaboration to sustainable systems transformation and program implementation. Key components include: · Assessing, refining, optimizing, and scaling coordinated referral and follow-up systems through shared data infrastructure and cross-sector workflows. · Integrating ERH principles into maternal, pediatric, and community-facing systems through shared training, facilitation, and messaging. · Deploying a prevention-focused framework that supports families before crises emerge. · Contributing to development, launch and oversight of a dedicated Hello BABY website or webpage to include learning materials, information on resources, and methods for contacting the Hello BABY team. · Participation in guiding the initiative alongside the Steering Committee comprised of balanced representation from early childhood and community systems, families and family leaders, and health systems/child health champions. · Building a long-term sustainability strategy that blends philanthropic, community, and public investment.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Mat-Su Services for Children and Adults	ILP Integrated EHR System	AK	Mat-Su Services for Children and Adults (MSSCA) Infant Learning Program (ILP) serves families caring for children from birth through 2-years. Child records are kept in physical charts with many documents scanned and saved in an agency Shared Drive system. Information is entered into a State ILP database as well as the Medicaid billing system. Multiple reviews and duplicative data entry happens daily to ensure that records match between the multiple spaces and across the multiple media in which they are stored. We have been engaging in discussion sessions with other ILP programs across Alaska to explore adoption of an integrated Electronic Health Record (EHR) platform designed specifically for ILP that we could all use in partnership. There are systems used in other states which allow programs to collect data, interface with the state database and other ILP providers, produce forms, complete casework, template reports, report for oversight, bill public and private insurance, and transfer across the State smoothly when a family moves.	MSSCA ILP’s proposed approach leans into partnerships with other ILP agencies across Alaska to put as many of us as possible onto a complete EHR platform designed specifically for the nuances of Early Intervention work, including reporting and billing requirements. A key piece of the approach is for agencies to explore and evaluate platforms together, discussing the ways in which they could support or hinder work in each region and across the state as a collective. The EHR platform chosen as a best fit for Alaska will be implemented by MSSCA ILP and we will serve as a pilot, along with other willing ILP agencies, to work out systematic glitches and as a liaison for other agencies interested in implementing the platform next. Implementation will be phased in with newly enrolled children and families being the first to enter the system. We will expand the number of children and families within the system each month until the full program is held within the EHR.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Maxim Healthcare	Expanding Alaska's Workforce through the Novice Nurse Program	AK	Maxim's Novice Nurse Program will allow us to train, hire and assign nurses to provide patient care who have less than one year of experience in rural Alaska. Today, home health agencies in Alaska are challenged by regulatory barriers that prevent the hiring and placement of nurses with less than one year of experience (7 AK Admin Code 12.650). The mission of the Novice Nurse Program is to better facilitate and support Novice Nurses by developing critical thinking skills, increasing nursing knowledge, and providing quality care to patients and their families in the home setting. It is a particularly important intervention for serving rural populations. The Novice Nurse Program addresses the policy dilemma of meeting federal program mandates affected by the shortage of trained skilled nurses in our community, while providing meaningful, structured employment to new nurses.	Maxim Healthcare is committed to collaborative, holistic training and support of our Novice Nurse population. Our experienced clinical team works in collaboration with operational, scheduling, and credentialing teams to facilitate successful completion of the Novice Nurse program. Maxim's Clinical Team is responsible for the following tasks under the Novice Nurse Program: • Collaboration with academic, vocational and community-based partners to support our Novice Nurse Program • Assistance with recruitment and hiring, and job placement of Novice Nurses • Maintenance of a comprehensive in-office skills lab to facilitate hands on training and competency of our Novice Nurses • Developing individualized training plans through initial needs and knowledge assessments with on-going monitoring and evaluation • Facilitating Maxim's Tracheostomy Management, Ventilator Management, and Pediatric Skills Advancement programs to support the advanced training needs of the novice nurse population • Performing final quality assurance and assessment audits of required competencies prior to independent nurse placement in patient homes Recruitment To recruit a cohort of rural-based Novice Nurses, Maxim Healthcare will conduct outreach with: schools of nursing, onsite job fairs, posters and other marketing materials, an unemployment office partnership, job board advertisement and email blasts. We will work with the Rural Alaska Community Action Program (RurAL CAP), Alaska Area Health Education Centers Program (Alaska AHEC), Alaska Center for Rural Health and Health Workforce (ACRH-HW), and the Alaska Native Health Board (ANHB). Our target training population consists of local Centrus-employed RNs and LPNs who are interested in learning new homecare patient care skills to include. All trainees/participants must be a RN or LPN license in good standing. RNs and LPNs will be focused on expanding their capability to fill nurse shifts and referrals to address critical healthcare workforce shortages for current patients, as well as becoming an RN/LPN for a dedicated patient at home. Readiness Maxim Healthcare currently operates the Novice Nurse program in a dozen states, including in Alaska. Dedicated funding allows us to scale our expertise and training program and robustly recruit caregivers in rural areas.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Matanuska-Susitna Borough; Sitka (City and Borough)	Deferred or Not Advanced

Maxim Healthcare	Travel Nurse to Permanent Alaskan: Expanding the Alaska Nursing Workforce	AK	Rural Alaska continues to face a persistent shortage of long-term, community-based healthcare providers, especially in home-based and person-centered care. Many communities rely heavily on travel nurses, which creates high turnover, inconsistent continuity of care, and significant financial strain on the system. At the same time, a subset of travel nurses are actively seeking meaningful, place-based work and are open to relocation when supported effectively. This project creates an opportunity to convert interested travel nurses into permanent Alaska residents by offering targeted recruitment, relocation incentives, seasonal support, and community integration. By pairing new residents with local welcome committees and providing structured bonuses for moving and winter retention, the project aims to build a stable, committed workforce that strengthens care quality, reduces reliance on temporary staffing, and supports the long-term vitality of rural communities. Currently, travel nurses make up 20 percent of Maxim Healthcare's overall nursing hours.	The proposed approach focuses on converting travel nurses into long-term residents who can provide stable, relationship-based care in rural Alaska. The strategy begins with targeted recruitment of nurses already interested in home-based, person-centered care and open to practicing in remote environments. By emphasizing the meaningful impact of rural nursing, the opportunity for deeper community relationships, and the unique lifestyle Alaska offers, the project aims to attract candidates motivated by purpose as well as professional opportunity. Recruitment will prioritize nurses with prior Alaska experience, backgrounds in similar rural settings, or a desire for continuity of care rather than short-term assignments. Once candidates are identified, the project offers a structured incentive package to reduce relocation barriers and support long-term retention. Moving bonuses will offset the financial burden of relocating, while winter bonuses acknowledge the challenges of the first year and encourage nurses to remain through the most difficult season. Incentives will be tied to milestones—such as six-month, one-year, and two-year commitments—to reinforce stability and help nurses build roots in their new communities. These incentives are designed as part of a broader strategy to make permanent relocation both feasible and appealing. A key component of the approach is intentional community integration. Each relocating nurse will be paired with a local welcome committee made up of community members, elders, and healthcare staff. This committee will provide practical support, such as help navigating housing, transportation, and local resources, as well as social and cultural connection. By introducing nurses to community events, traditions, and networks, the welcome committee helps reduce isolation and fosters a sense of belonging, increasing the likelihood that nurses will remain long term. To ensure nurses feel confident and supported in their new roles, the project includes a structured onboarding process tailored to rural practice. This includes training in home-based care protocols, safety considerations for remote environments, and culturally responsive care. Mentorship from experienced Alaska-based clinicians will provide ongoing guidance, while professional development opportunities will reinforce skills and strengthen long-term engagement. Together, these supports help nurses feel prepared, valued, and connected to their work.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Matanuska-Susitna Borough; Sitka (City and Borough)	Deferred or Not Advanced

McCarthy Emergency Services	Frontier Clinic Completion: Primary Care Access for McCarthy-Kennecott, Alaska	AK	The population of our remote community and medical needs are steadily rising, but our healthcare infrastructure has not kept pace. The closest advanced life support provider and primary care clinic is four hours away. The nearest hospital is six hours away. In 2025, our volunteers responded to 27 emergency calls and coordinated 6 air evacuations. Each flight costs \$35,000 - \$60,000. Many of these responses could have been prevented with earlier access to primary care. U.S. Census data shows our population increased 155% from 2000 to 2020. Peak seasonal population exceeds 1000, driven by visitation to Wrangell-St. Elias National Park and Preserve. Park visitation increased from 65,236 in 2022 to 81,635 in 2024. In 2022, McCarthy Emergency Services completed construction of a medical services building, the first healthcare facility in our community since 1938. The building is active, operational, and stages our ambulance. It hosts community meetings and events that generate rental income supporting our operating budget. However, its clinic space remains unfinished. This LOI requests RHTP support to complete and equip this space, enabling a frontier clinic that reduces delayed care, avoidable evacuations, and system costs. The building exists. The community need is acute and documented. What is missing is the final investment to make it real.	We're implementing a rural healthcare delivery model that integrates EMS, primary care, and telehealth. McCarthy-Kennecott sits at a rare convergence of readiness and need. A committed physician partner has been identified and helped design the clinic space to meet clinical and patient stabilization requirements. Our volunteer general contractor, a licensed professional and board member who oversaw original construction, is ready to lead the fit-out. Our organization is experienced, financially disciplined, and trusted by the community we serve. This project funds the interior medical fit-out of the existing north clinic wing of our medical services building. The building envelope is structurally complete. No new construction is required. Scope of work includes: interior insulation and drywall, flooring, medical-grade electrical and lighting, plumbing fixtures and connections, examination room cabinetry, telehealth infrastructure and connectivity infrastructure, and diagnostic equipment. We anticipate interior fit-out completion and expenditure of all first year funding before October 1st 2027. Initial clinic operations are planned for spring 2028. Our identified physician partner, who collaborated on the design of this space, has expressed intent to provide scheduled clinic days upon completion. A formal letter of intent is in progress and will accompany the full application. The clinic will operate on a rotating provider model supported by telehealth, enabling both in-person and remote care. EMS responders will coordinate with providers to stabilize patients, creating a continuum of care not currently available in the region. As facility landlord, McCarthy Emergency Services will charge cost-covering fees for clinic use, which will also support EMS operations, creating a financially sustainable operating model. Workforce capacity will be expanded through visiting providers participating in short-term service, sabbatical, or volunteer placements. This model addresses provider burnout while expanding access, a replicable approach for similarly isolated communities.	\$250K-\$1M	Home- and communit y-based services provider	Multi- Community or Participating in Regional Hub-and- Spoke	Copper River Census Area	Advance to Implementati on Application
McKinley Imaging LLC	Digital X-Ray System Upgrade for Rural Diagnostic Access	AK	The current X-ray system is aging and lacks the capabilities of modern digital radiography technology. This limits the quality of imaging and the range of exams we can provide. Upgrading the system will improve diagnostic accuracy and expand imaging services available to rural patients who otherwise may need to travel to Anchorage or other distant facilities.	Grant funds will be used to purchase and install a new digital radiography (DR) X-ray system with upgraded imaging software and detectors. The system will integrate with our existing imaging workflow and PACS environment. Vendors have already been identified, allowing for rapid procurement, installation, and staff training.	\$50,000- \$250,000	Clinic	Multi- Community or Participating in Regional Hub-and- Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

McKinley Imaging LLC	MRI Upgrade to Improve Advanced Diagnostic Access for Interior Alaska	AK	The current MRI system at McKinley Imaging Center is an older 1.5T unit with limitations in patient comfort, scan speed, and advanced imaging capabilities. These limitations reduce throughput and restrict our ability to perform newer imaging protocols that are becoming standard in many parts of the country. Patients from rural Alaska often must travel long distances or wait extended periods for advanced imaging exams. There is an opportunity to improve diagnostic access in Interior Alaska by upgrading to a modern wide-bore MRI platform with advanced software and hardware capabilities.	McKinley Imaging Center will upgrade its existing MRI system to a wide-bore 1.5T MRI platform with updated hardware and advanced imaging software. The upgrade will include improved gradient performance, faster imaging sequences, and expanded exam capabilities. The project will include: Replacement or upgrade of the current MRI system to a wide-bore platform, Installation of upgraded imaging software and advanced diagnostic protocols, Hardware improvements to allow faster scan times and higher image quality, Staff training to implement new imaging capabilities The upgraded MRI system will allow us to provide more detailed diagnostic imaging, faster exam times, and additional specialized exams not currently available locally.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced
McKinley Orthopedic and Sports Medicine	McKinley Orthopedic Patient Safety Project	AK	McKinley Orthopedic and Sports Medicine provide orthopedic and musculoskeletal care for patients across Fairbanks, North Pole, and many rural and frontier communities throughout Interior Alaska. A key component of our non-operative treatment approach is Osteopathic Manipulative Treatment (OMT), which helps reduce pain, restore mobility, and return patients to full function without surgery. However, our current treatment tables limit our ability to provide care to a growing portion of our patient population. The existing tables only support between 200–250 pounds, which does not safely accommodate many patients in our community. In addition, the lack of electronically adjustable tables makes it difficult for patients with limited mobility or disabilities to safely access treatment surfaces. These equipment limitations also contribute to inefficiencies in clinic workflow and have resulted in a backlog of more than 90 days for OMT appointments. This project presents an opportunity to improve accessibility, expand the clinic’s ability to treat patients of all body types and mobility levels, and increase the efficiency of delivering essential non-operative orthopedic care to patients across Interior Alaska.	To address these challenges, McKinley Orthopedic and Sports Medicine, proposes to improve both facility accessibility and clinical equipment used to deliver Osteopathic Manipulative Treatment (OMT). The project will include upgrades to the clinic’s building to enhance handicap accessibility and the purchase of modern OMT treatment tables designed to better accommodate a broader range of patients. The new OMT tables will have a significantly higher weight capacity than the clinic’s current tables and will include electronic height adjustment features. These improvements will allow providers to safely treat patients who exceed the weight limits of the current equipment and make it easier for patients with limited mobility to safely access treatment surfaces. The electronic adjustment capability will also improve provider ergonomics and workflow efficiency during treatment. By improving both accessibility and treatment equipment, the clinic will be able to expand its ability to provide OMT services, increase patient throughput, and reduce the current backlog of patients waiting for care. This approach will allow the clinic to deliver more timely non-operative musculoskeletal care while improving safety and comfort for patients across Fairbanks, North Pole, and surrounding rural Interior Alaska communities	Under \$50,000	Clinic	Statewide	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

McKinley Orthopedic and Sports Medicine	McKinley Orthopedic X-Ray Enhancement	AK	McKinley Orthopedic and Sports Medicine currently utilize an aging X-ray system that limits our ability to efficiently evaluate certain orthopedic patients. The existing equipment struggles to adequately image larger patients and does not reliably produce full-length radiographs required for lower extremity alignment studies and spine evaluations. These limitations reduce diagnostic efficiency and can delay treatment planning for patients requiring orthopedic care. In addition, limited imaging availability within the clinic creates workflow bottlenecks that restrict patient throughput and access to timely evaluation. These challenges are particularly impactful for patients undergoing joint replacement procedures, where accurate imaging is essential for preoperative templating and the development of patient-specific surgical guides. Upgrading the X-ray system presents an opportunity to improve imaging capability, reduce radiation exposure, enhance diagnostic accuracy, and expand access to timely orthopedic care for patients in Fairbanks, North Pole, and surrounding rural Interior Alaska communities. New X-Rays technicians also struggle with the older system. As we move into a new generation of employees an updated machine is essential based on their training in machines that now do a lot of the exposures and set up automatically.	To address these challenges, McKinley Orthopedic and Sports Medicine proposes to upgrade its current X-ray system to a modern digital radiography platform capable of producing high-quality images across a wider range of patient sizes and imaging needs. The upgraded system will allow the clinic to reliably obtain full-length radiographs required for lower extremity alignment studies and scoliosis studies and improve imaging resolution for larger patients. The new imaging system will provide enhanced image clarity while reducing radiation exposure for patients. It will also increase imaging efficiency and capacity within the clinic, allowing providers to obtain necessary diagnostic imaging more quickly during patient visits. This will reduce workflow bottlenecks and improve the ability to evaluate and treat orthopedic patients in a timely manner. Improved imaging capabilities will also support more accurate preoperative planning for joint replacement procedures. Enhanced full-length imaging will allow surgeons to better template implants and develop patient-specific surgical guides, improving surgical precision and patient outcomes. Through this equipment upgrade, the clinic will strengthen its ability to deliver high-quality orthopedic care to patients in Fairbanks, North Pole, and surrounding rural Interior Alaska communities.	\$50,000-\$250,000	Clinic	Statewide	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

McKinley Sports Medicine, LLC	McKinley Sports Medicine Concussion Awareness	AK	McKinley Sports Medicine provides care for student athletes throughout the Fairbanks region. The clinic currently works with six athletic trainers who provide coverage for local high schools and athletes at University of Alaska Fairbanks. These trainers frequently serve as the first point of contact for sports-related injuries, including concussions. As awareness of concussion risks has increased, the management of these injuries has become more complex. Return-to-learn and return-to-play protocols now require careful monitoring, repeated follow-up, and coordination with schools, families, and healthcare providers. Staffing limits the clinic’s ability to provide the level of follow-up needed to appropriately monitor these athletes during recovery. Unfortunately, many athletes don’t get the follow up they need because of lack of resources. Evaluating concussions is time consuming and requires a high level of patient and parent education that does not reimburse well. This challenge is amplified by the geographic realities of Alaska. Fairbanks teams regularly compete with schools from rural and frontier communities where access to specialized concussion care may be limited. As a result, student athletes from across the region may experience delays in evaluation, monitoring, and clearance to safely return to school and sports. This project presents an opportunity to expand concussion care capacity and improve support for athletic trainers managing these injuries at schools.	To address these challenges, McKinley Sports Medicine proposes to add a dedicated concussion specialist to support the clinic’s sports medicine program and its network of athletic trainers serving local schools. This position would likely be filled by a mid-level provider or an additional athletic trainer with specialized training in concussion management. The concussion specialist would work closely with the six athletic trainers currently providing coverage for local high schools and athletes throughout the community. Their role would include evaluating athletes following suspected concussions, providing ongoing symptom monitoring, coordinating return-to-learn and return-to-play protocols, and ensuring appropriate follow-up care throughout recovery. Too many patients now are injured on the field and lost to follow up because there is not enough support in the community. This additional clinical support would allow injured athletes to receive more timely evaluations and consistent monitoring after injury. It would also provide athletic trainers with direct medical support when managing concussions in the field. By expanding staffing capacity focused specifically on concussion management, the clinic will improve care coordination, reduce delays in follow-up, and provide safer return-to-play guidance for student athletes throughout Fairbanks and surrounding rural communities.	\$50,000-\$250,000	Clinic	Statewide	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

McKinley Sports Medicine, LLC	McKinley Sports Medicine Trainer Support Program	AK	McKinley Sports Medicine provides sports medicine coverage and athletic training support for student athletes participating in Fairbanks North Star Borough School District athletics. Our team regularly provides medical coverage for practices and sporting events; however, many of the school training rooms currently lack adequate medical supplies and equipment to properly support injury evaluation and management. Essential items such as athletic tape, braces, crutches, and automated external defibrillators (AEDs) are limited or outdated in several training rooms. Without consistent access to these supplies, athletic trainers may face challenges providing immediate care for injured athletes during practices and competitions. This project presents an opportunity to strengthen the medical readiness of school athletic programs by equipping training rooms with the supplies and equipment necessary to properly evaluate and stabilize injuries. Improving these resources will allow athletic trainers and medical providers to deliver safer, more effective care for student athletes participating in sports throughout the Fairbanks area and for visiting teams traveling from rural and remote communities across Alaska.	To address these challenges, McKinley Sports Medicine proposes to expand and standardize the medical supplies and equipment available in athletic training rooms across schools within the Fairbanks North Star Borough School District. The project will focus on ensuring that each school’s training room is equipped with the essential tools necessary for athletic trainers and medical providers to properly evaluate and manage injuries during practices and competitions. Grant funding will be used to purchase and distribute key medical supplies and equipment such as athletic tape, braces, crutches, and automated external defibrillators (AEDs). These items will allow athletic trainers to stabilize injuries, support injured athletes, and respond quickly to medical emergencies when they occur on the field or in the training room. By improving the availability and consistency of medical supplies across schools, this project will strengthen the ability of athletic trainers and sports medicine providers to deliver immediate, high-quality care for student athletes. This approach will improve safety during athletic participation and ensure that both local and visiting athletes receive appropriate injury management when competing in Fairbanks.	Under \$50,000	Clinic	Statewide	Anchorage (Municipality); Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

McKinley Surgery Center, LLC	McKinley EHR Upgrade	AK	McKinley Surgery Center currently relies on a paper-based charting system to document patient care and manage surgical workflows. While this system has supported operations to date, it limits efficiency, makes coordination with referring providers more challenging, and does not fully support modern healthcare data management standards. As the surgery center continues to serve patients from Fairbanks and surrounding rural and frontier communities across Interior Alaska, the limitations of paper records create challenges in communication, documentation, and timely access to patient information. These inefficiencies can slow administrative processes and make it more difficult to coordinate care with referring clinics that often serve patients traveling long distances for surgical treatment. This project represents an opportunity to modernize the center’s clinical infrastructure by implementing an electronic medical record (EMR) system. Transitioning to an EMR will improve documentation, streamline workflows, enhance communication with referring providers, and support more efficient delivery of surgical care for patients throughout the region.	To address these challenges, McKinley Surgery Center proposes to transition from its current paper-based charting system to a comprehensive electronic medical record (EMR) platform designed to support ambulatory surgical care. The project will involve selecting and implementing an EMR system that integrates patient documentation, scheduling, clinical workflows, and communication with referring providers. The implementation process will include evaluating EMR vendors, selecting a system that meets the operational needs of the surgery center, and completing system installation and configuration. Staff and providers will receive training to ensure the system is integrated smoothly into daily clinical workflows. Once implemented, the EMR will allow providers and staff to access patient information more efficiently, improve documentation accuracy, and streamline coordination with referring clinics and providers. This transition will modernize the surgery center’s clinical infrastructure and support more efficient delivery of surgical care for patients traveling from Fairbanks and surrounding rural communities across Interior Alaska.	Under \$50,000	Specialist	Statewide	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

McKinley Surgery Center, LLC	McKinley Precision Surgical Capacity Expansion	AK	Since receiving ambulatory surgery center license on 10/25/2023, Mckinley Surgery Center (MSC) has continued to increase its volume every quarter since its inception. McKinley is the only interior surgery center dedicated to only orthopedics and spine patients. This dedication enables us to be more efficiency and reduce cost and complications. We consider our team the best at this specialized surgery because it is all that they do. Entering 2026 the number of operating rooms will be the limiting factor in providing patient care. We have started to see wait time for elective surgeries reach 90 days and the necessity of canceling elective surgeries for more urgent cases. All of these restraints would be mitigated by an additional operating room. Expanding McKinley Surgery Center from one operating room to two operating rooms will address this limitation by increasing surgical capacity and improving scheduling flexibility. This project will allow the center to treat more patients in a timely manner, reduce wait times for procedures, and better accommodate patients traveling from rural and frontier areas of Alaska who often face significant logistical and financial barriers to accessing care. By increasing surgical capacity within a high quality outpatient surgery center, the project represents an opportunity to improve access to cost effective specialty care while strengthening the regional health care system serving Interior Alaska.	Just over three years McKinly Surgery Center was founded. Within a year time frame, we were able to have a fully functional operating room. McKinley Surgery Center will address current surgical capacity limitations by expanding from one operating room to two fully functional operating rooms. We will use a similar plan to the creation of the surgery center expanding the footprint to include an additional operating room. This expansion will increase the number of procedures that can be performed each day and provide greater flexibility in scheduling patients, particularly those traveling from rural and frontier communities throughout Interior Alaska. The project will involve the build out and equipping of a second operating room, including surgical equipment, anesthesia capabilities, and necessary support infrastructure. Once operational, the additional operating room will allow surgical teams to perform procedures more efficiently while reducing delays caused by limited operating room availability. By increasing surgical capacity, McKinley Surgery Center will be able to accommodate more orthopedic and spine cases, reduce patient wait times, and improve access for patients who travel long distances for specialty surgical care. The additional operating room will also allow the center to better coordinate surgical schedules for visiting surgeons and patients arriving from remote communities who often face significant travel and lodging challenges. For example, we currently host the Shriners Hospital surgeons from Spokane, Washington. Their presence he enables complex pediatric cases to be done in Fairbanks. In the past these patients were travelling to Portland Oregon for care. Their outreach touches rural children throughout Alaska and giving them more surgical time and rooms would extend that outreach. This is just one of many patient populations that would benefit if this grant were awarded. This expansion will strengthen the ability of McKinley Surgery Center to provide timely, high quality outpatient surgical care while improving access for rural and frontier patients who rely on Interior Alaska’s limited specialty surgical resources.	\$1M-\$5M	Specialist	Statewide	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

McKinley Surgery Center, LLC	McKinley Surgery Center Enhancement	AK	McKinley Surgery Center serves patients from Interior Alaska and surrounding rural and frontier communities where access to specialty orthopedic and spine surgical care is limited. To maintain safe, efficient, and high quality surgical services for these patients, it is critical that operating room equipment and sterilization infrastructure remain modern, reliable, and capable of supporting current surgical standards. Some of the center’s existing equipment including arthroscopy systems, operating room beds, patient stretchers, and components of the sterilization area are aging and due for replacement or upgrade. Outdated equipment can reduce efficiency in the operating room, increase procedure times, and place additional strain on staff and clinical workflows. In rural regions where surgical resources are limited, maintaining dependable equipment is essential to ensure patients can receive timely care without delays or cancellations. This project presents an opportunity to upgrade key operating room and sterilization infrastructure to improve efficiency, support modern minimally invasive orthopedic procedures, and maintain the high standards of safety and quality required for outpatient surgical care. These improvements will help ensure that McKinley Surgery Center can continue serving patients from rural and frontier communities with reliable, high quality surgical services close to home.	McKinley Surgery Center will address the need for updated clinical infrastructure by upgrading key operating room and sterilization equipment that supports safe and efficient surgical care. The project will focus on replacing aging arthroscopy equipment, upgrading the operating room bed and patient stretchers, and improving the functionality and efficiency of the sterilization room. New arthroscopy equipment will enhance visualization and precision during minimally invasive orthopedic procedures, allowing surgeons to perform procedures more efficiently and with improved clinical outcomes. Upgraded operating room beds and patient stretchers will improve patient safety, support proper positioning during surgery, and allow for smoother patient movement throughout the surgical process. In addition, improvements to the sterilization room will strengthen the center’s ability to properly clean, process, and sterilize surgical instruments in a timely and reliable manner. Enhanced sterilization capacity will help ensure consistent infection prevention practices while supporting efficient surgical case turnover. By modernizing these critical components of the surgical environment, McKinley Surgery Center will improve the quality, safety, and efficiency of outpatient surgical care. These upgrades will allow the center to continue providing reliable orthopedic and spine surgical services for patients traveling from rural and frontier communities across Interior Alaska.	\$250K-\$1M	Specialist	Statewide	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

McKinley Surgery Center, LLC	Spine Surgery Enhancement	AK	Patients in Alaska who require spine surgery often face limited access to advanced minimally invasive surgical options within the state. Many procedures are still performed using traditional open or larger-incision techniques, which can lead to longer recovery times, greater postoperative pain, and increased time away from home for patients who travel from rural and frontier communities for care. McKinley Surgery Center has the opportunity to expand spine care services by introducing arthroscopic spine surgery techniques. Arthroscopic spine procedures use specialized instruments and small incisions to treat certain spinal conditions in a minimally invasive manner. This approach can reduce surgical risk, shorten recovery time, and allow patients to return to normal activity more quickly. Expanding access to arthroscopic spine surgery would represent a significant advancement in spine care for Alaskans. By offering these procedures locally, the project will provide patients with access to state-of-the-art surgical options within Alaska and reduce the need for patients to travel outside the state to receive advanced spine treatment.	To address this opportunity, McKinley Surgery Center proposes to expand its surgical capabilities to support arthroscopic spine procedures. This will involve acquiring specialized surgical equipment and technology required to perform minimally invasive endoscopic and arthroscopic spine surgeries. The project will include procurement of advanced visualization systems, specialized surgical instruments, and supporting technology designed specifically for arthroscopic spine procedures. In addition, surgical staff and operating room personnel will receive training to ensure the equipment is integrated effectively into existing surgical workflows and patient care protocols. By equipping the surgery center with the technology necessary to perform arthroscopic spine procedures, the facility will be able to offer patients a minimally invasive alternative to traditional spine surgery. This approach will allow the surgical team to treat appropriate spine conditions with smaller incisions, reduced tissue disruption, and faster recovery times, expanding access to advanced spine care for patients across Fairbanks and rural communities throughout Alaska.	\$250K-\$1M	Specialist	Statewide	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced
MD, Inc dba Alaska Premier Health	Optimization of Metabolic and Preventive Medical Care delivery via technology and AI innovation	AK	Our clinic has served Alaskans for over 34 years. We have seen and experienced the benefits and results of individualized, patient focused, realistic, and flexible preventive care. We have seen repeatedly how individuals (and their families and coworkers) sieze the fundamentals of healthy living through medical oversight and coaching. Multiple health issues are improved and patients learn to take personal responsibilty for their health vs being a "patient for life." They become happier, more productive and significantly healthier. Because we are medical providers with intensive training in nutrition, physical activity and primary care, we can address the person as a whole, providing them a pathway to reduction of chronic disease.	Our entire staff will have access and training in the most current and evidence-based science regarding nutrition and chronic disease management and, where possible, reversal of chronic disease. Staff will become certified and participate in ongoing training so that we can stay on the leading edge of Metabolic Health care delivery. Our EHR will be upgraded to engage the power of AI in the development of programs and impactful quality improvement measures. Additional AI capacities will help us administer performance driven outcomes that will allow patient feedback and support in real time. As a result, our clinic will have capacity to hire more practitioners who can focus on specific patient groups (children, disabled, etc.).	\$1M-\$5M	Clinic	Statewide	Anchorage (Municipality); Chugach Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; North Slope Borough	Deferred or Not Advanced

Me-2-We, Inc	Day Courts+ Active Aging Program	AK	Project Concept Opportunity The Mat-Su Valley’s senior population is growing rapidly, yet many older adults have limited access to regular opportunities for movement, structured physical activity, and meaningful social connection. In rural communities such as Big Lake, Houston, and Sutton, limited local programming and long winter seasons often restrict seniors’ ability to stay active and engaged. As a result, many older adults spend extended periods isolated at home with few opportunities to participate in safe, guided physical activity or community-based programs. This lack of accessible programming contributes to significant health risks. Reduced physical activity can lead to declining mobility, loss of strength and balance, and an increased risk of falls and chronic health conditions. Social isolation and limited community engagement can also negatively affect mental health, contributing to loneliness, depression, and anxiety. In addition, prolonged isolation and inactivity can accelerate cognitive decline, increasing the risk of memory loss and conditions such as dementia. Without accessible spaces that encourage both movement and connection, these challenges can compound over time, reducing independence and overall quality of life. The Valley’s growing senior population highlights the urgent need for welcoming, community-based programs that support physical activity, cognitive health, and social connection for older adults.	Project Concept Approach Me-2-We’s Day Court+ Active Aging Program will address senior isolation and declining physical health by providing structured, guided daytime programming in a safe and welcoming environment. The program will include low-impact group exercise, strength and balance training, guided fitness classes, indoor track walking, and pickleball, along with light recreational activities and intentional social engagement opportunities designed specifically for older adults. These activities encourage participants to remain active while building meaningful connections with others in their community. All activities will be guided to ensure safety, proper movement mechanics, and accessibility for varying ability levels. Programming will be adaptable so that participants with different mobility levels can participate comfortably and confidently. Participants will be encouraged to progress at their own pace, gradually building strength, balance, coordination, and endurance over time. As these skills develop, seniors gain greater confidence in their ability to move safely in their daily lives, whether walking longer distances, navigating uneven terrain, carrying groceries, or participating in other community activities. Regular movement and social engagement will also support cognitive health. Physical activity, mental stimulation, and social interaction are important factors in maintaining brain health and may help slow cognitive decline associated with aging and conditions such as dementia. By offering consistent scheduling and affordable participation options, the program reduces common barriers faced by rural seniors. Outreach efforts, including community partnerships and text-based communication, will help increase awareness and encourage consistent participation. Through regular guided activity, social connection, and access to pickleball, indoor track use, and senior-focused classes, Day Court+ will promote mobility, improve balance and strength, reduce fall risk, and support chronic disease prevention. As participants build and maintain these physical skills, they are better able to apply them in everyday life, supporting independence, confidence, and overall well-being. By creating a reliable and welcoming place for seniors to gather and stay active, the program will help older adults lead richer, more connected lives across the Mat-Su Valley.	\$250K-\$1M	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Me-2-We, Inc	Night Courts+	AK	The Mat-Su Valley is a rapidly growing rural region with limited community-based wellness infrastructure and increasing strain on behavioral health and primary care systems. Youth and families face reduced access to affordable, structured recreation — particularly during late-night and weekend hours when risk for substance use, violence, isolation, and other harmful behaviors increases. The region lacks a YMCA and recently lost its Boys & Girls Club presence, leaving a significant gap in preventive, supervised youth engagement. At the same time, rural healthcare providers continue to experience high demand for services related to preventable behavioral health crises and chronic disease risk factors such as physical inactivity and obesity. Night Courts+ addresses this gap by expanding structured, supervised physical activity during high-risk hours. Sunday Family Courts access reduces financial barriers for families. This project represents an opportunity to strengthen upstream prevention, increase protective factors for youth, promote family wellness, and reduce avoidable strain on limited healthcare infrastructure.	Me-2-We will implement a dual prevention model: 1) Late-night youth engagement (weekly, 9:00 p.m.–midnight) with structured supervision, clear conduct standards, and trained adult mentors. 2) Sunday Family Courts providing no-cost facility access to entire households. Night Courts+ operates weekly from 9:00 p.m. to midnight, providing supervised, structured physical activity during hours associated with increased youth risk behavior. Trained adult supervisors and volunteer mentors ensure a safe, substance-free environment while building protective factors such as belonging, accountability, and positive peer interaction. The program includes access to basketball/volleyball/pickleball courts, weight training areas, cardio equipment, indoor track use, and turf training spaces, promoting strength, cardiovascular health, and healthy lifestyle habits. To further reduce barriers to preventive wellness, the project will add Sunday Family Courts (4:00–7:00 p.m.), allowing families to access the facility at no cost. This component increases whole-household participation in physical activity, strengthens family cohesion, and expands equitable access to health-promoting resources in the Mat-Su Valley. The approach focuses on upstream prevention by increasing protective factors and physical activity before behavioral or chronic health issues require clinical intervention. By operating during high-risk hours and removing financial barriers, Night Courts+ strengthens the rural health ecosystem and supports long-term sustainability of limited healthcare resources in the Mat-Su Valley.	\$250K-\$1M	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Me-2-We, Inc	Wellness Facility Acquisition	AK	The Mat-Su Valley is one of the fastest growing regions in Alaska yet lacks sufficient indoor recreation and wellness infrastructure to support community health. The region has no YMCA and has lost other youth-centered recreation resources such as the Boys & Girls Club. As a result, there are limited year-round facilities that provide accessible opportunities for physical activity, youth engagement, and preventive health programming. Grizzly Family Fitness is one of the largest indoor recreation and wellness facilities in Alaska and serves thousands of residents each year through fitness memberships, youth sports, and community programming. However, as a privately owned facility, its long-term role as a community wellness resource is not guaranteed as there's great potential for it to be sold as warehouse space or other business ventures. Me-2-We plans to enter into a five-year lease with an option to purchase the Grizzly Family Fitness facility for \$10,000,000, transitioning the property into nonprofit ownership and establishing it as a permanent community wellness hub. The building is valued at approximately \$18,000,000. Nonprofit ownership would eliminate mortgage and property tax obligations, allowing roughly \$500,000 annually to be reinvested into expanded wellness and youth programming and strengthening long-term access to preventive health resources for Mat-Su residents.	Me-2-We proposes to address this problem by transitioning Grizzly Family Fitness from private ownership into a nonprofit community wellness hub that expands access to preventive health and recreation programming in the Mat-Su Valley. Under the proposed approach, Me-2-We will enter into a five-year lease agreement with an option to purchase the facility for \$10,000,000. During the lease period, the facility will continue operating as a full-service fitness and recreation center while gradually expanding nonprofit programming and community partnerships. This structure allows the facility to maintain financial stability while transitioning toward long-term nonprofit ownership. The facility will serve as a central hub for community wellness by providing year-round access to indoor recreation, fitness facilities, youth sports, and health-promoting activities. Existing amenities—including 5 full-sized basketball courts, indoor running track, strength and cardio equipment, and training space—provide immediate capacity to expand preventive health and youth-focused programming. Me-2-We will expand programming to include: additional senior programming, low-moderate income persons, mental health, and youth/teen activities. Nonprofit ownership will also allow Me-2-We to expand partnerships with schools, health providers, community organizations, and other nonprofits to increase participation in programs that support physical activity, behavioral health, and healthy lifestyles. Additional programming may include expanded youth recreation, community wellness initiatives, and partnerships that promote preventive health and social connection. Me-2-We's Board will hire the current staff at the facility to maintain operations in order to ensure continuation of services and then oversee the growth of new services. This ensures a smooth transition. Through this approach, the project preserves an important wellness facility while expanding access to preventive health resources and strengthening the long-term sustainability of community health infrastructure in the Mat-Su Valley.	Over \$5M	Statewide	Matanuska-Susitna Borough	Deferred or Not Advanced

MedCerts, LLC.	Strengthening Rural and Tribal Allied Health Workforce Pipelines in Alaska	MI	Rural and tribal health providers across Alaska face persistent workforce shortages in allied health and administrative roles that are essential to care delivery. Geographic isolation limited local training infrastructure, high recruitment costs, and workforce turnover create ongoing vacancies that disrupt access to care and strain existing staff. Many rural hospitals, community clinics, and tribal health organizations rely on temporary staffing models or operate below optimal capacity due to credential gaps in roles such as Surgical Technology, Medical Billing and Coding, Dental Assisting, Behavioral Health, Healthcare Administration, and IT support. At the same time, rural and Alaska Native communities have residents seeking stable career pathways in health care but face limited access to industry-recognized training aligned to local employer demand. There is a clear opportunity to expand flexible credential pathways that allow providers to upskill incumbent staff, create entry points for residents, and strengthen internal workforce pipelines without requiring relocation or long academic buildouts. This project addresses the gap between employer workforce demand and accessible training pathways, strengthening rural and tribal health system sustainability through targeted allied health workforce expansion.	This project expands access to flexible, employer-aligned allied health credential pathways in partnership with hospitals, clinics, and tribal healthcare systems, and other rural providers. Building on existing enrollments and established partnerships across multiple boroughs, the approach focuses on scaling a proven workforce model rather than launching a new pilot. MedCerts will collaborate with partner organizations to identify high-demand roles, prioritize incumbent worker upskilling and entry-level career pathways, and align credential offerings to employer workforce plans. Programs such as Surgical Technology, Medical Billing and Coding, Dental Assisting, Healthcare Administration, and IT Helpdesk, roles essential to maintaining clinical operations and access to care in rural settings, will be delivered through flexible online and employer-supported models that allow rural residents to train without leaving their communities. The approach emphasizes three core strategies: Employer-Aligned Credential Expansion: Work directly with participating hospitals, clinics, and tribal health organizations to align credential pathways with documented vacancy data, workforce shortages, and employer demand. Rural-Ready Delivery Model: Provide flexible online coursework combined with employer engagement to reduce geographic barriers and support completion for learners in remote settings. Workforce Retention and Career Mobility: Support incumbent worker advancement and create local career pathways that strengthen long-term workforce sustainability and reduce reliance on contract labor. Data tracking and employer engagement will inform continuous improvement and alignment with RHTP workforce and access goals. By expanding credential pathways already in use across Alaska providers, this project strengthens health system capacity while creating economic opportunity in rural and tribal communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

MEDEVAC ALASKA	Rural Healthcare Prevention and Emergent Services	AK	Timeline/continuity of care and shortage of healthcare staff and equipment in rural communities of Alaska	Medevac Alaska proposes to address the critical shortage of health care providers in rural communities by deploying qualified health care personnel directly to remote locations and equipping them with modern medical technology. Through this initiative, trained providers will deliver essential medical services while utilizing telehealth systems and other digital health tools to connect with physicians, specialists, and larger medical facilities when advanced consultation is needed. This approach will help bridge the gap between isolated communities and comprehensive health care networks, allowing rural Alaskans to receive timely diagnoses, treatment, and follow-up care without the significant delays and travel burdens that often accompany remote living. By combining on-site medical support with advanced communication technologies, Medevac Alaska aims to improve access to quality health care, enhance patient outcomes, and strengthen the overall health infrastructure serving rural populations.	Over \$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah- Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska- Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

MedExpert International	INSIGHT: Integrated Network for System Intelligence, Guidance & Health Transformation by MedExpert	CA	Alaska’s healthcare system operates across one of the most geographically challenging environments in the world. Care delivery frequently occurs within a hub-and-spoke structure where rural clinics, community health aides, and EMS responders must practice at the top of their license while specialty services may be hundreds of miles away and reachable only by air. In these circumstances, critical clinical decisions are often made with limited access to reliable patient history or system context. The absence of timely information can lead to delayed escalation of care, fragmented coordination, avoidable transports, and strain on already limited rural health resources. At the same time, Alaska possesses valuable health data across hospitals, Medicaid programs, clinics, and other providers. However, these data sources remain fragmented across systems and are rarely available to individuals making decisions in the field. INSIGHT enables the State to provision role-based access to State-approved health information for EMS responders, rural clinicians, and other authorized professionals. Access to meaningful indicators such as recent utilization patterns, medication history, care coordination activity, and prior points of care strengthens clinical judgment at the moment decisions must be made. By connecting existing health information to frontline decision makers, Alaska can improve the quality of care delivered in rural and frontier communities.	Improving frontline decision-making in Alaska’s rural and frontier environments requires more than access to data—it requires a secure operational platform that delivers relevant information to the right responder at the moment care decisions are made. INSIGHT will be implemented as a State-governed operational intelligence platform that converts State-approved health data into role-based visibility for authorized rural providers and first responders. INSIGHT is powered by MedExpert with multiple years of experience assisting Alaska across the State including in frontier environments. The program was designed based on our experience in Alaska and in conversation with providers and first responders in the State. The system will be deployed across phones, tablets, and web interfaces, allowing frontline personnel to securely access operational dashboards tailored to their responsibilities. The State will define governance, data use policies, and role-based access permissions so that appropriate information is provisioned to authorized users while maintaining privacy and security protections. Initial deployment will focus on frontline response environments where timely context is most critical, including Community Health Aide Providers (CHAPs), EMS responders, fire departments, paramedics, and medevac coordination teams. When responding to a patient, authorized users may view relevant information such as recent emergency utilization patterns, admission history, known diagnoses, medication indicators, prior points of care, and active care coordination pathways. This operational context supports safer clinical judgment regarding treatment-in-place, local referral, or transport when clinically appropriate. Role-based dashboards will be configured collaboratively with State leadership to support operational needs. CHAPs may view patient care patterns that inform treatment protocols; EMS responders may access concise emergency utilization and clinical indicators to support field decisions; State health officials may view aggregated insights that strengthen oversight and resource planning. Transportation partners may use utilization and geographic patterns to better coordinate travel resources in remote regions. This approach advances Rural Health Transformation Program priorities by strengthening rural access to care, supporting value-based resource stewardship, modernizing EMS decision support, and enabling sustainable state-operated health system intelligence.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

MedExpert International	REACH-AI: Rural Engagement, Alignment & Coordinated Health powered by Advanced Intelligence	CA	Across rural settings, medical decisions are often made without timely access to current evidence-based knowledge. Providers and patients frequently operate in fragmented systems where information is difficult to access when decisions are required. Even when the correct clinical pathway is known, implementing that care can be difficult for patients and time-consuming for providers. REACH-AI addresses this gap by delivering current medical knowledge at the moment decisions are made while helping patients and providers navigate the healthcare system. The platform combines expert-system AI with human care coordination so the right information reaches the right person at the right time. REACH-AI addresses several healthcare challenges in Alaska: • Improved access to and quality of care by extending expert guidance and navigation into rural homes and clinics. • Prevention of avoidable escalation leading to emergency visits or transport. • Improved maternal and child health education/support when local obstetric capacity is limited. • Behavioral health support; our prior work in Alaska reduced opioid prescribing and use by ~33% annually. • Workforce sustainability improves as clinicians receive reliable decision support and reduced administrative burden. By improving access to medical knowledge and strengthening care coordination, REACH-AI helps patients navigate care more effectively while supporting better outcomes and responsible resource use across Alaska.	Across rural and urban healthcare systems, medical decisions are often made without timely access to current evidence-based knowledge. Providers and patients frequently operate within fragmented systems where information is difficult to access or disconnected from the moment decisions must be made. Even when the appropriate clinical pathway is known, navigating the healthcare system to implement that care can be difficult for patients and time-consuming for providers. REACH-AI addresses this gap by delivering current medical knowledge at the moment decisions are made while helping patients and providers navigate the healthcare system. The platform combines expert-system AI with coordinated care support so the right information reaches the right person at the right time and recommended care can be successfully implemented. REACH-AI addresses several critical healthcare challenges in Alaska: • Access to care improves by extending evidence-based decision support and care navigation directly into rural homes and clinics, helping determine when travel is necessary and when care can be safely managed locally. • Care quality improves through individualized guidance and proactive navigation that helps prevent avoidable escalation leading to emergency visits, hospital admissions, or transport. • Maternal and child health support improves through pregnancy and postpartum education and navigation when local obstetric capacity is limited in rural or frontier communities. • Behavioral health support expands through ongoing education, decision guidance, and care navigation; prior Alaska programs reduced opioid prescribing and morphine equivalents by approximately 33 percent annually. • Healthcare workforce sustainability improves as clinicians receive reliable decision support and navigation assistance, helping reduce administrative burden and avoidable utilization. By improving access to current medical knowledge and strengthening care coordination, REACH-AI helps patients navigate care more effectively while improving outcomes and supporting responsible stewardship of healthcare resources across Alaska.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

MedExpert International	SUMMIT: Statewide Utilization & Multi-payer Metrics for Integrated Transparency by MedExpert	CA	Healthcare in Alaska is among the most expensive in the nation, placing significant pressure on employers and on the state budget. Simultaneously, Alaska lacks reliable, timely, and comprehensive statewide information needed to determine whether healthcare spending is producing value for rural and frontier residents. Although substantial data exists within individual systems—including Medicaid, Medicare, Tribal health programs, commercial insurers, and state employee plans—these datasets remain fragmented and largely unavailable for meaningful cross-payer analysis. No single entity maintains a comprehensive and timely cross-payer view of how healthcare services are delivered across Alaska. As a result, policymakers and stakeholders often rely on delayed datasets that do not fully reflect Alaska’s unique geography, healthcare market, or population characteristics. More than 20 states have attempted to build All-Payer Claims Databases, yet few remain operational due to governance challenges, inconsistent data quality, or delayed reporting. SUMMIT addresses these limitations by establishing a disciplined, state-governed APCD that integrates multi-payer claims data into a secure, policy-ready analytic environment. This unified cross-payer visibility will strengthen cost transparency, support rural access planning, and provide the timely intelligence needed to guide modernization, accountability, and long-term healthcare sustainability across Alaska.	SUMMIT will belong to the State of Alaska and will be anchored within the Alaska Division of Insurance in coordination with the Department of Health and Medicaid. Governance will clearly separate regulatory authority, lead organization oversight, and data management vendor technical operations. MedExpert will build and manage the technical environment during implementation while state personnel are trained to oversee governance, vendor performance, and data access workflows to ensure long-term operational independence. MedExpert’s experience in large-scale medical data movement allows SUMMIT to transform raw claims submissions into validated analytic datasets rapidly, enabling administrators to receive updated policy intelligence within days of data ingestion rather than the extended delays typical of traditional APCD environments. SUMMIT will incorporate nationally recognized APCD best practices. Standardized submission specifications will align with established multi-state data layouts to reduce payer burden and promote interoperability. Claims, eligibility, and provider data will be normalized across payers, with structured reconciliation of Medicare–Medicaid dual eligibles to prevent double counting. Consistent with leading privacy approaches, SUMMIT will isolate individual identifiers within a secure identity management environment. Identifiable data will be segregated from analytic files and replaced with encrypted, tokenized identifiers to preserve linkage capability without exposing protected health information. This structure protects privacy while preserving advanced analytic integrity. The system will include a secure submission portal with audit logging, Azure-hosted encrypted infrastructure, network security, and strict single-role enforcement of role-based access. A life cycle data quality framework, covering intake validation, processing validation, enhancement testing, and fitness-for-use review, will ensure reliability for all reporting. Finally, SUMMIT will implement a disciplined tiered reporting roadmap tied to documented data readiness thresholds. By carefully sequencing governance, validation, and analytic complexity, SUMMIT will avoid common APCD pitfalls, such as premature advanced modeling or inconsistent data quality, and instead produce meaningful, policy-ready intelligence that supports modernization, accountability, and durable rural health system stability.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Medical Decision Logic, Inc. (dba mdlogix)	Bringing Innovation & Technology into Anchorage for Suicidality Treatment, Collaboration, & Synergy	MD	We will address the problem of harms and deaths from suicidality, a major problem in Alaska. Reducing suicidality across the connected continuum of different types of suffering, losing hope, thoughts of death, considering suicide, forming a suicide plan, and attempting suicide, is a complex challenge, and overlaps with drug overdoses, violence, and “accidents”. Alaska data show 1,186 suicide attempts in 2024, mostly ages 11-24. Federal data suggest for every suicide attempt, 25-50 people have developed a suicide plan. From this, we estimate 25-50,000 at-risk individuals in Alaska, and 10-20,000 in Anchorage (40% of the Alaska population). Two problems hinder suicide prevention efforts: 1) lack of data technology tools including a scalable infrastructure for multi-sector collaborative prevention, early intervention, and treatment referral; and 2) lack of effective, safe treatment of suicidality. A third problem 3) is resistance to new ways of doing things, related to previous failed reforms and cultural barriers. Adoption of new technology elicits concerns about data privacy and security, as well as the efforts needed to learn, understand, and develop confidence with use of new technology. Innovative treatment elicits resistance to changing local treatment practices. We plan to address these problems by deliberately building trust through education, availability, and transparency.	Building trust is our first step. We will work to understand the organizational priorities and problem perceptions of Anchorage regional urban and rural community, to engage with them to identify and support solutions with use of bhworks and participation of youth and adults with THI treatment. With guidance from Mr. Bernitz, and other advisors, we will engage with Anchorage School District, Department of Juvenile Justice, local hospitals, outpatient providers of mental and behavioral health services, and other social services. As part of this in-person engagement, we plan to open a physical office in Anchorage that will host a bhworks technology education, training, support, and career development center, and a THI center for outpatient treatment of suicidality. We will hire and train local residents to staff this office, and support them virtually from our primary offices. We will convene workshops to build community awareness and participation. bhworks offers a large set of off-the-shelf tools and features. Initial configuration for school or clinic use to screen and assess students or clients, and go live, can be accomplished in a week or two. To enable users to quickly grow benefit from use of bhworks, our Client Services team has developed a standard implementation approach, which entails putting in place a local user governance, such as a Steering Committee, with representation of all major roles. Weekly meetings are convened to introduce bhworks capabilities, and to listen to community members and potential bhworks users to learn what their work is, how they do their work, what their constraints and other problems are, what other tools they use or are considering using, and then how bhworks can be configured to support their work, overcome constraints, and solve other identified problems. This becomes an ongoing cycle of measurement-based experience, learning, articulating problems, solving them, generation of new knowledge, and collective learning. The implementation approach for a new THI site typically takes 8-12 months. The main reason for this length of time is the work needed to obtain Medicaid reimbursement approval in a new state. However, with support from RHTP we can start providing suicidality treatment services sooner. Recruiting and training clinical staff such as social workers, counselors, psychologists will take time, but once our THI site is established, Dr. Lee and his team can provide virtual services immediately.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Medical Decision Logic, Inc. (dba mdlogix)	Bringing Innovation & Technology into Kodiak for Suicidality Treatment, Collaboration, & Synergy	MD	The public mental health problem we aim to address is the high rate of harms and deaths from suicidality, especially among Alaskan youth. Preventing suicidality across the continuum—from loss of hope and suicidal thoughts to planning and attempts—is complex and often overlaps with prevention of drug overdoses, violence, and accidental deaths. In Kodiak, based on 2016-2019 data, the suicide mortality rate for Alaska Native people in the Kodiak region is 90.3 per 100,000. The state wide overage is 28.1 per 100,000. k12 schools play a central role via Multi-Tier System of Supports (MTSS), emphasizing universal screening, data-driven decision-making, progress monitoring, and multi-level prevention. Three major challenges hinder progress: (1) limited data technology and scalable infrastructure for multi-sector collaboration and early intervention; (2) lack of effective, evidence-based treatment for suicidality; and (3) resistance to adopting new approaches. Rural communities, in particular, may be cautious about new technologies and treatment models due to concerns about privacy, security, and the effort required to build trust and confidence in unfamiliar systems. Our project addresses these barriers by integrating accessible technology, evidence-based treatment, and local capacity building to strengthen suicide prevention and care in rural Alaska. A structured evaluation component will support continuous learning, measure outcomes, and guide improvement and sustainability.	Our first step is to build trust and understanding with Kodiak-area villages, tribal organizations, and schools. Schools are often the most consistent point of contact for youth and families, making them essential partners in identifying behavioral health needs and connecting students to care. Guided by Mr. Bernitz and other advisors, we will visit villages, meet with tribal and school leaders, and hold community town halls to listen, learn, and co-develop solutions that reflect local priorities and values. We will establish a physical office in Kodiak as a hub for education, training, and support for the bhworks™ technology platform, and as The Hope Institute (THI) center for outpatient treatment of suicidality. Local residents will be hired and trained to staff the office, supported virtually by mdlogix and THI teams. This approach builds local capacity and ensures sustainability. Kodiak Schools have a two year project addressing suicidality. They have trained 195 volunteers to spot and help high school peers. We will will approach them to help expand and support their current project. Use of bhworks increases efficiencies and the number of people helped, and THI provides effectiveness. bhworks provides a web-based infrastructure for screening, referral, and care coordination across schools, clinics, and community organizations. Implementation begins with a local Steering Committee representing these sectors. In Months 1-2, weekly meetings introduce bhworks capabilities and gather input to understand workflows, constraints, and goals. The system is then configured to support school-based screening, early intervention, and referral to THI treatment, while strengthening collaboration with clinics and social services. In Months 3-4, school and clinic personnel will start using bhworks for assessment, consent, referral, intake, monitoring, and reporting. This becomes an ongoing cycle of measurement-based experience, learning, articulating problems, solving them, generating new knowledge, and collective learning. Evaluation is embedded throughout this process to measure progress, outcomes, and community impact, and to guide adaptation of bhworks and THI to local needs. Implementation of a new THI site typically takes 8–12 months, largely due to Medicaid reimbursement setup and clinical staff recruitment. With RHTP support, we can accelerate service delivery by initiating virtual treatment led by Dr. Lee and his team while local staff are trained.	\$1M-\$5M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Kodiak Island Borough	Deferred or Not Advanced

Medical Decision Logic, Inc. (dba mdlogix)	Bringing New Technology & Innovative Suicidality Treatment Into Bethel	MD	The public mental health problem we aim to address is the high rate of harms and deaths from suicidality, especially among Alaskan youth. Preventing suicidality across the continuum—from loss of hope and suicidal thoughts to planning and attempts—is complex and often overlaps with prevention of drug overdoses, violence, and accidental deaths. k12 schools play a central role in prevention through Multi-Tier System of Supports (MTSS), which emphasizes universal screening, data-driven decision-making, progress monitoring, and multi-level prevention. However, three major challenges hinder progress: (1) limited data technology and scalable infrastructure for multi-sector collaboration and early intervention; (2) lack of effective, evidence-based treatment for suicidality; and (3) resistance to adopting new approaches. Rural communities, in particular, may be cautious about new technologies and treatment models due to concerns about privacy, security, and the effort required to build trust and confidence in unfamiliar systems. Our project addresses these barriers by integrating accessible technology, evidence-based treatment, and local capacity building to strengthen suicide prevention and care in rural Alaska. A structured evaluation component will support continuous learning, measure outcomes, and guide improvement and sustainability.	Our first step is to build trust and understanding with Bethel-area villages, tribal organizations, and schools. Schools are often the most consistent point of contact for youth and families, making them essential partners in identifying suicidality and other behavioral health needs and connecting students to care. Guided by Mr. Bernitz and other advisors, we will visit villages, meet with tribal and school leaders, and hold community town halls to listen, learn, and co-develop solutions that reflect local priorities and values. We will establish a physical office in Bethel as a hub for education, training, and support for the bhworks™ technology platform, and as a The Hope Institute (THI) center for outpatient treatment of suicidality. Local residents will be hired and trained to staff the office, supported virtually by mdlogix and THI teams. This approach builds local workforce capacity, ensures sustainability, and grows our social network for diffusion of innovation. bhworks provides a web-based infrastructure for screening, referral, coordination, and collaboration across schools, clinics, and other community organizations. Implementation begins with a local Steering Committee representing these sectors. The Committee will include multi-generation family members and cultural leaders. In Months 1-2, weekly meetings introduce bhworks capabilities and gather input to understand workflows, constraints, and goals. The system is then configured to support school-based screening, early intervention, and referral to THI treatment, while strengthening collaboration with clinics and social services. We will start with the villages that have high-speed web access. In Months 3-4, school and clinic personnel will start using bhworks for assessment, consent, referral, intake, monitoring, and reporting. This becomes an ongoing cycle of measurement-based experience, learning, articulating problems, solving them, generating new knowledge, and collective learning. Evaluation and reporting, with methods and expertise from our RAND partners, is embedded throughout this process to measure progress, outcomes, and community impact, and to guide adaptation of bhworks and THI to local needs. Implementation of a new THI site typically takes 8–12 months, largely due to Medicaid reimbursement setup and clinical staff recruitment. With RHTP support, we can accelerate service delivery by initiating virtual treatment led by Dr. Lee and his team while local staff are trained.	\$1M-\$5M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area	Deferred or Not Advanced

Medical Decision Logic, Inc. (dba mdlogix)	Building Regional Behavioral Health Coordination & School Partnerships in Bristol Bay	MD	Led by Shannon Harvilla, former Superintendent of the Bristol Bay Borough School District, we will establish a coordinated behavioral health infrastructure connecting schools, healthcare providers, tribal organizations, and community partners across the Bristol Bay region of Southwest Alaska. The initiative will deploy the mdlogix bhworks™ technology alongside evidence-based innovative suicidality treatment services provided through The Hope Institute to strengthen prevention, early identification, referral coordination, and treatment access for youth experiencing suicidality and behavioral health challenges. Communities across the Bristol Bay Area Health Corporation service region face extraordinary barriers to care. Most communities lack road access and depend on aircraft transportation to reach regional hubs for basic services such as medical care, dental services, and behavioral health treatment. Schools frequently become the first place where behavioral health concerns affecting youth are identified, yet coordination between education systems and healthcare providers remains fragmented. This project will address these challenges by implementing shared behavioral health screening, referral management, case coordination, telehealth workflows, and regional reporting tools through the bhworks platform. We will center our project and its sustainability with a new physical office serving as a bhworks technology support center and the physical center of The Hope Institute.	The first step in implementing this initiative will be building trust and engaging communities across the Bristol Bay Area Health Corporation service region. With leadership from Shannon Harvilla, former Superintendent of the Bristol Bay Borough School District, the project will begin with outreach to tribal leaders, school districts, healthcare providers, and community organizations to understand local priorities and identify opportunities for problem-solving collaboration. Initial engagement will include meetings with school staff, tribal organizations, health providers, and regional partners to introduce the project and gather input on local needs. Community discussions will help ensure that the system reflects the priorities of participating communities and supports existing prevention and behavioral health initiatives. Coordination and collaboration are fundamental. Following this engagement phase, the project will establish regional coordination secure and scalable data and workflow infrastructure using the mdlogix bhworks™ behavioral health platform. The system will support behavioral health screening, consent management, referral coordination, case management, telehealth integration, and regional reporting. Schools will use the platform to strengthen behavioral health support systems aligned with Multi-Tiered Systems of Support (MTSS), so educators and community providers can identify concerns earlier and coordinate interventions. bhworks includes a comprehensive school nurse module. The initiative will support development of local treatment capacity through collaboration with The Hope Institute, which provides evidence-based outpatient and telehealth treatment for suicidality using the Collaborative Assessment and Management of Suicidality (CAMS) model and related clinical practices. As part of implementation, the project will establish regional training and coordination capacity in Naknek or Dillingham to support partner onboarding, technology training, and collaboration among participating organizations. Local staff will be hired and trained to support system adoption, community engagement, workforce careers, and long-term sustainability. Through phased implementation across participating communities, the initiative will create a coordinated regional network connecting schools, healthcare providers, and community partners to strengthen behavioral health prevention, early intervention, and treatment services across the Bristol Bay region.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Deferred or Not Advanced

Medical Decision Logic, Inc. (dba mdlogix)	We R H.O.P.E. for Anchorage Youth, A Full-Spectrum Behavioral Health Innovation and Technology Model	MD	Underserved youth are a priority population. Behavioral health access is among the most urgent unmet needs. We R H.O.P.E. is that model. Deployed five days per week, We R H.O.P.E. coaches deliver one-on-one brain health and wellness coaching to students in 30-minute sessions over structured 60-90 day cycles. Sessions focus on anxiety reduction, emotional regulation, and coping skill development, grounded in neuroscience to help students build new neural pathways through consistent, structured coaching practice. Coaches work with bhworks screening data, receiving referrals from the platform and documenting outcomes back into it, creating a closed-loop data system from identification through intervention. In parallel, We R H.O.P.E. deploys mental health literacy education to families and community members, building shared language and reducing stigma. We R H.O.P.E. trains community members in eCPR (emotional CPR), equipping them with skills to support others in emotional distress, and delivers early mental health awareness training for educators and school staff, ensuring they can recognize warning signs and coordinate with coaches before problems escalate. These layers create a whole-community approach that amplifies the impact of every coaching session. Based on data from 3,000 students across five states, We R H.O.P.E. consistently produces 35-66% reductions in anxiety and depressive symptoms within 60-90 days, tracked using validated instruments integrated into bhworks.	The mdlogix and We R H.O.P.E. partnership delivers to Alaska's RHTP vision with three integrated components: Component 1: mdlogix Population Screening and Data Infrastructure. bhworks deploys universal behavioral health screening across Anchorage School District schools and community sites, identifying students at risk and generating population-level data that drives all clinical and coaching decisions. bhworks readily connects with other systems, such as healthEconnect, directly advancing the Spark Technology and Innovation initiative goal of building interoperable, data-driven community health infrastructure. Component 2: We R H.O.P.E. School-Based Brain Health and Wellness Coaching. We R H.O.P.E. embeds trained Brain Health and Wellness Coaches in ASD schools beginning with 3-5 sites in Year 1. Each coach serves up to 12 students per day in 30-minute sessions over structured 60-90 day cycles. Coaches receive student referrals directly from bhworks screening workflows and document session outcomes within the platform, enabling real-time cross-system visibility into student progress. All coaches complete We R H.O.P.E.'s Brain Health and Wellness Coach certification program, a neuroscience-grounded, evidence-informed curriculum developed and refined across nine years of school-based practice. Consistent with Alaska's Strengthen Workforce initiative, We R H.O.P.E. will prioritize hiring coaches from within the Anchorage community, creating local behavioral health career pathways for community members without prior clinical credentials. Component 3: We R H.O.P.E. extends its reach beyond the coaching session through three interconnected programs, Mental Health Literacy, eCPR, and Educator Training. Mental Health Literacy is delivered to families and community members in ASD communities, building shared language around brain health and reducing the stigma that delays help-seeking. eCPR (emotional CPR) training equips staff at schools and other settings with evidence-based skills to connect with, empower, and support youth experiencing emotional distress, creating a network of supporters around every student. Educator Training is delivered to teachers and other school staff, ensuring they can recognize warning signs, respond appropriately, and coordinate effectively with embedded coaches. Together, these programs ensure that coaching services are embedded in a community that is informed, equipped, and engaged as an active partner in student brain health.	\$1M-\$5M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Medical Park Family Care	Workforce Development - Healthcare Providers (Physicians, Nurse Practitioners, Physician Assistants)	AK	The key to caring, is caring. Medical Park Family Care has been voted Best in Alaska for Family Health Clinics for the last 17-years straight because our staff and Providers develop long term relationships with our patients and care for their whole being even if it's "just a cold". Recruitment and retention is increasingly difficult as there is a shortage of family medicine providers across the U.S. As an independent practice, we can not compete with large healthcare entities with significantly more resources or have access to supplemental government subsidies and funding. In the last four years, we have had two Physicians and three Advanced Practice Providers (APPs) leave Medical Park to work at larger healthcare entities and compensation was a major factor. Additionally, several candidates have declined employment offers, citing other opportunities that offer more compensation through tuition reimbursement or significantly greater relocation and sign-on bonuses. Funding through RHTP is requested to help ensure we can recruit and retain the right providers in order to achieve our goal of serving Alaskans across the State for the next 50-years and beyond.	Funding from RHTP will be used towards a sign-on bonus for new providers and a retention bonus for current providers. We are requesting \$50,000 for physicians and \$30,000 for APPs with a minimum commitment of 3-years in order to receive these funds. Having a stable medical staff is critical in developing long-term relationships with patients and will help us achieve our overall goal of transforming Medical Park for the next 50-years as outlined in our other LOIs.	\$250K-\$1M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough)	Advance to Implementation Application

Medical Park Family Care	Pay for Value - Alternative Payment Models	AK	Primary care and preventive services are the keys to the overall health of a community and lowering the total cost of health care. There are many studies that support this. However, payment for medical care in Alaska favor high cost specialty services. Insurance companies have stated that their insurance rates have risen significantly due to the increasing cost of health care, more specifically, specialty care. Primary care, on the other hand has seen little or no change in reimbursement. Medical Park's largest insurance payer has not increased their reimbursement rates to us in 10 years. During this same period, preventive services covered at 100% have decreased, resulting in patients paying more for the same services as in prior years. This has forced our providers and patients to decide what care to provide based on cost and not on what is best for the patient's health. There are other payment models that exist or perhaps a new innovative approach can be taken to put the focus back to where it should be - primary care. Medical Park's goal is to explore different options and implement payment models that focus on and reward primary care and preventive services. A payment model that reimburses health care providers fairly for services rendered, does not burden the patient and results in improved health and lowers overall health care costs.	We have begun analyzing our data to identify groups that can be potential partners (employers, insurance companies or programs within insurance companies). Once identified we will begin discussions on program design, one that promotes preventive care and healthy habits. There are many examples across the U.S. of "pay for value" or "pay for quality care" with shared savings. For patients, the cost barrier to care should be minimal to encourage participation instead of hesitation or refusal because of cost. Payment to Medical Park can be designed to provide fair reimbursement to encourage customizing care based on the patient's needs, and not simply to get paid more for doing more. On an annual basis, an evaluation of health outcomes and overall costs will help determine success of the program with any overall cost savings shared between the participating entities. Medical Park has participated in some limited scope "value based contracts" with insurance companies. These programs have had some success but there is still a lack of trust and misaligned incentives that prevent us from greater success. Preventive care and screenings are still defined by the insurance company. Prior Authorizations, arbitrary down coding reimbursement all add barriers that work against achieving greater success. An ideal program would put trust in the Provider to determine what screenings and care are needed based on the patient. In turn, the Provider takes on the responsibility for the patient's care managing their overall health. A patient incentive, from their employer or insurance company or both depending on who's participating in this program helps ensure that the patient will follow through on the recommended screenings and care. By incorporating all of these factors into this program there is a tremendous opportunity to have a program that compensates Primary Care Providers fairly, promotes health and wellness and results in less overall health care costs.	\$50,000-\$250,000	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough)	Advance to Planning

Medical Park Family Care	Health Care Access - Expanding Specialty Care	AK	Alaska is remote and with a relatively small population there is often not enough health care providers in certain medical specialties. Primary Care Providers are the focal point for a patient's care and it's up to these providers to determine when a patient's medical care requires a specialist. Due to the shortage of some specialties, care may be delayed or require the patient to travel out of state for care. Endocrinology is one example of a specialty with a lack of providers in Alaska. Diabetes is a endocrine disease and according to Diabetes.org, over 42,000 Alaskans are affected by diabetes. Medical Park Family Care has two providers who specialize in and only care for patients with diabetes. They each have over 10-years of experience in diabetes management, however, they are family medicine providers and lack the training of an Endocrinologist. There are many endocrinologists in the US with the training and experience who can support our providers. Our goal is to facilitate this connection effectively and efficiently to ensure our providers and ultimately our patients receive the specialty care they need when they need it.	Medical Park seeks to partner with Picasso MD, a network of specialists across the U.S. who can provide on-demand, online medical consults. This service would provide our diabetes providers with the necessary resources and support to continue to provide excellent and timely care to our patients. This support can occur in several ways. During a patient visit, our providers can connect real-time to a specialist to discuss a patient's medical needs. The specialist can provide their assessment and recommendations and following the consult send a summary note that is included in the patient's medical record. Secondly, these specialists can be consulted to discuss long-term care management, helping to ensure patients are on track towards their health goals. These specialists can also provide recommendations when out of State care is necessary and who to refer the patient to. This service could also benefit our general family medicine providers who also care for diabetic patients, many of whom are not as complex as those seen by our diabetes providers but for whom would still benefit from having a specialist consult. The success of this project could also lead to additional collaboration with Picasso MD for other medical specialties and further improve care for all our patients.	\$50,000-\$250,000	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough)	Deferred or Not Advanced

Medical Park Family Care	Health Care Access - Facility Remodel and Infrastructure Upgrades	AK	Medical Park has operated in the same location for over 50-years. The infrastructure is outdated and does not promote safety for our team or facilitate efficient and effective care for our patients. Space heaters are needed in almost room during the winter and at times during the summer. There is not enough electrical power for our existing equipment and we often have to move equipment so as to not exceed electrical capacity. Network cabling is split and "daisy chained" resulting in sub-optimal IT performance. We do not have a back-up generator and risk losing tens of thousands of dollars in refrigerated vaccines and lab reagents in the event of a prolonged power outage. The fire suppression system is limited to the basement and does not cover the first or second floor. Our elevator is small and wheelchairs barely fit and EMS stretchers must be configured with the patient in a seated position to fit. Our physical layout also hinders our ability to care for patients or expand access to rural Alaskans. Separated suites introduce physical barriers to staff and provider collaborating with each other. There are not enough areas for support staff and what is available is poorly designed, cramped or originally intended for other usage such as storage closets. There have been some renovations over the years but primary care is essentially a break-even business so without the necessary monetary resources we cannot commit to the necessary physical and infrastructure upgrades.	Medical Park has been planning for a significant renovation and infrastructure upgrade that creates a "clinic for the future." Key concepts include clinical pods that group patient exam rooms and clinical teams to facilitate collaboration between providers and staff and allow for flexible use. Incorporating patient flow models to determine the optimal number and design of exam rooms and clinical space. Space and infrastructure design will also take into consideration a growing percentage of virtual patient visits and care management via telemedicine or other technologies. Staff and Provider space will also be more efficiently and effectively designed to facilitate collaboration while also providing space for independent or focus work. Multi-use space can also be used for group gatherings or quiet space. In addition to physical space renovations, infrastructure upgrades will include meeting current life and safety requirements, installing a back-up generator, upgrading the electrical and IT network infrastructure with capacity to expand or adapt to future needs. We anticipate that these renovations will actually reduce the total square footage needed for our clinic. We intend to repurpose the excess space and invite community partners to co-locate with us. We have not identified a specific partner but our intent would be to consider partners that would supplement or complement the services we provide to our patients - physical therapy, behavioral health, dieticians and nutritionists, pharmaceuticals, care coordinators or other community resource organizations - creating a health care hub for our patients.	Over \$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough)	Deferred or Not Advanced

Medical Park Family Care	Workforce Development - X-ray Training Program	AK	Medical Park has it's own Radiology department, performing X-ray and Ultrasound studies and Dexa scans to help diagnosis injuries and illnesses. We have one certified X-ray technologist and access to X-ray studies is limited based on their schedule. Training select staff to perform a limited number of X-ray studies will expand access when our technologist is unavailable and provides professional growth and development for our staff in learning additional skills. Expanded access will help minimize delays in diagnosis our patients or unnecessary referrals to more costly dedicated imaging centers.	Alaska regulations do not require a certified X-ray technologist to operate an X-ray machine, however, proper training is essential for patient and staff safety and to ensure a high quality image is produced so that proper diagnoses can be made. We are in the process of reviewing training programs from other clinics that have implemented such a program to mirror and fit to our needs. Key criteria will be in selected the right staff to be trained, adequate training time and a regular review of skill and competency. During the initial implementation we will select one to two current staff members and provide dedicated time away from their primary roles to properly learn and train to perform a set number of X-ray studies. These studies will be selected based on the most commonly performed and at a relatively low complexity. After meeting competency requirements, they will enter a phase of proctored mentorship where they will perform actual studies under the direct supervision of our technologist. Upon completion of this phase these staff members will be allowed to perform these studies unsupervised. We anticipate the first phase will take up to two or three months, the proctoring phase another two based on the volume of studies performed, bring the total timeframe to about six months from start to finish. A periodic review will occur to ensure competency is maintained with the possibility of future training to perform additional studies. This budget for this project is approximately 1 FTE of total time commitment from those being trained and the trainer and a total cost of approximately \$75K	\$50,000-\$250,000	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough)	Deferred or Not Advanced

Medicine by Movement Wellness and PT	Healthy communities with a focus on preventative and proactive health care for the aging population	AK	There is a significant gap in transitional services for the elderly population after they complete physical therapy (PT). Once patients no longer require “skilled services,” they are typically discharged, even though many do not yet feel confident or functional enough to safely continue progressing on their own. I have practiced physical therapy for over 20 years, the majority of that time in Alaska. One of the most common concerns I hear from our aging population is that they do not feel ready at the time of discharge. Outpatient physical therapy clinics are generally structured to treat the specific injury that brought the patient in. Care continues until the patient either achieves their primary goals or stops making measurable progress. However, many patients reach a plateau after making meaningful improvements, yet still lack the confidence, strength, or knowledge to independently continue advancing their exercise programs at home. As a result, these individuals frequently return to the clinic in the near future with the same injury or with new complications related to the original issue. This problem is even more pronounced in rural areas, where consistent one-on-one care and follow-up resources are limited. At the same time, the majority of Americans are overweight and do not meet recommended weekly exercise guidelines. This further complicates their overall health and places an increasing burden on the healthcare system.	I am providing a safe place for these individuals to continue to exercise, strengthen and work on balance and mobility activities that have been proven to decrease hospital visits, minimize medical issues, and improve longevity. It provides a sense of place, motivation in a group setting, but also instructed by a doctor of physical therapy where I can offer modifications and keep each client safe. I have started to offer this outside of Sitka with classes being offered via zoom and recordings. Traditional PT does not always work, nor do patients in rural communities always have access. I also offer specific low back pain, knee and hip osteoarthritis, and plan to continue to expand 6-week educational and exercise classes specific to this to help treat, prevent, and empower the patient to have the knowledge to treat themselves. Anyone who attends these classes live or via recordings have the ability to communicate with their PT without charge at any time, which eases the burden on other health care providers, and offers help in facilitation of appropriate care when needed. These classes will be offered live via zoom, but also in a pre-recorded fashion that can be an excellent resource for patients in rural areas with limited access.	\$50,000-\$250,000	Private practitioner	Statewide	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Meetopolis	Meetopolis: Peer Support	AZ	Alaska faces some of the most significant behavioral health access challenges in the United States. Vast geographic distances make consistent access to mental health and substance use services difficult—particularly in rural and tribal communities. Many regions have few or no licensed behavioral health providers, and workforce shortages continue to strain existing systems of care. Individuals often experience long wait times, limited follow-up support after discharge, and gaps between crisis intervention and ongoing recovery services. Alaska also experiences high rates of substance use disorder, suicide, trauma exposure, and co-occurring mental health conditions. Social isolation, stigma, and cultural barriers further prevent individuals from seeking help early. After treatment, reentry from incarceration, or hospital discharge, many individuals lack consistent peer support and community connection—key protective factors against relapse and crisis recurrence. Meetopolis addresses these gaps by providing secure, virtual peer support communities that extend access beyond brick-and-mortar services. The platform connects individuals with lived-experience peer supporters, offers daily engagement tools and check-ins, and supports continuity of care during high-risk transition periods. By leveraging technology, Meetopolis reduces geographic barriers, strengthens community connection, and complements Alaska’s existing behavioral health infrastructure without replacing clinical care.	Our proposed approach is to deploy Meetopolis as a secure, technology-enabled peer support platform designed specifically to address Alaska’s unique geographic and workforce challenges. Alaska’s rural and frontier communities face extreme isolation, weather-related transportation barriers, limited broadband infrastructure, and significant shortages of behavioral health providers. These factors often result in delayed care, fragmented treatment, and high vulnerability during transitions such as post-discharge or reentry. Meetopolis would be implemented as a scalable digital extension of existing providers, tribal health systems, and community organizations. The platform enables structured peer support groups, one-to-one peer engagement, relapse prevention check-ins, and between-session accountability — all accessible remotely via mobile devices. The platform is designed to function in low-bandwidth environments and can be integrated into telehealth workflows already in use across Alaska. Our approach prioritizes collaboration with local partners to ensure cultural responsiveness, including coordination with tribal health entities and community-based behavioral health providers. Peer leaders can be recruited locally to support culturally grounded engagement while expanding reach across remote regions. By embedding Meetopolis into discharge planning, outpatient services, and community recovery programs, we will create continuous recovery touchpoints that reduce isolation, increase early intervention, and strengthen long-term engagement. This approach enhances care quality, supports provider sustainability, and reduces costly readmissions while respecting Alaska’s diverse and geographically dispersed populations.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Mercury Healthcare, Inc.	WebMD Ignite's Health Education & Access for Rural Transformations (HEART)	NJ	WebMD Ignite seeks to close the growing gaps in access, prevention, and care coordination for rural, remote, and frontier Alaskans, who face disproportionate burdens of chronic disease, behavioral health conditions, and preventable hospital use amid severe workforce and service shortages. Small clinics, Tribal health partners, and critical access hospitals struggle to reliably reach patients across vast distances, extreme weather, and inconsistent broadband, limiting their ability to deliver timely education, follow-up, and navigation support beyond brief, episodic encounters. At the same time, Alaska’s RHTP prioritizes investments that harness technology, reinforce hub-and-spoke care models, and build a durable foundation for prevention and chronic disease management in every community. In response, we aim to establish a shared, culturally attuned digital health education and engagement infrastructure that local providers and care teams can use to extend their reach, deliver consistent, high-quality information, and activate patients and families between visits, while generating actionable data to complement existing infrastructure.	We will implement a shared education and engagement backbone that rural providers and care teams across Alaska can plug into with minimal lift. WebMD Ignite, through its HEART for Rural Transformation framework, will partner with selected rural, Tribal, and critical access hospital sites to align digital health education and outreach strategies with RHTP priorities, and support the deployment of a configurable hub that surfaces trusted, plain-language health education across web, mobile, print, and point-of-care channels. Collaboration with Tribal, local, and rural partners will drive alignment and ensure the approach reflects Alaska’s diverse cultural and community contexts. A branded digital health education hub can then be linked from existing websites, portals, and patient communications, offering communities a simple, always-available front door for Alaska-relevant health resources. Content can be integrated into existing workflows such as care coordination, management, outreach, and follow-up, enabling staff to share consistent, culturally sensitive education across multiple formats, including print materials when digital access is limited. This collaborative approach may also help partners identify relevant priority areas, such as chronic disease, behavioral health, substance use, and maternal health, while engagement and utilization insights provide complementary data that enhance existing systems without duplicating or replacing them. Throughout the project, WebMD Ignite will provide implementation support, training, and technical assistance to help build a sustainable, low-burden infrastructure that Alaska providers and care teams can continue to use and adapt beyond the grant period. As part of this continuing support, content is regularly reviewed and updated through WebMD Ignite’s established content development process, ensuring accuracy, relevance, and alignment with evolving partner needs.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Metlakatla Indian Community	Strengthening the Behavioral Health Workforce and Expanding Access to Care in Remote Metlakatla	AK	Wil la Mootk Counseling Center faces significant workforce recruitment and retention challenges due to the extreme geographic isolation of Metlakatla and the unique governance structure of the Metlakatla Indian Community. The community is accessible only by ferry or float plane from Ketchikan, Alaska. Travel to and from the island is frequently influenced by weather conditions and limited transportation schedules. These factors make relocation and long-term employment in the community difficult for many behavioral health professionals. In addition, individuals who are not members of the Metlakatla Indian Community must obtain work and residency permits in order to live and work on the island. Together, these geographic and administrative barriers create persistent workforce shortages that impact the stability of behavioral health services and continuity of care for residents. This project seeks to strengthen the behavioral health workforce pipeline and improve infrastructure supporting care delivery through recruitment incentives, telehealth expansion, and transportation improvements.	Wil la Mootk Counseling Center proposes a comprehensive approach to strengthening behavioral health workforce stability and improving access to care in Metlakatla. The project will focus on three primary strategies: workforce recruitment and retention, expansion of telehealth service capacity, and improvements to transportation access that allow community members to more reliably connect with behavioral health services. To address workforce shortages, the project will implement targeted recruitment and retention incentives designed to attract qualified behavioral health professionals to the community. These incentives will be tied to two- to three-year service commitments to support workforce continuity and reduce the frequent turnover that disrupts service delivery in rural and remote areas. Recruitment efforts will focus on licensed clinicians, behavioral health aides, and support staff who can provide culturally responsive care within the community. The project will also expand telehealth infrastructure to supplement local service capacity and ensure that individuals can access behavioral health providers even when travel conditions or workforce shortages limit in-person availability. Telehealth services will support clinical consultation, therapy sessions, and care coordination, allowing Wil la Mootk Counseling Center to maintain continuity of care during transportation disruptions that are common in Southeast Alaska. Finally, the project will strengthen transportation support for behavioral health services. Because travel delays and limited transportation options often prevent individuals from attending appointments, the project will explore solutions that improve access to services both within the community and when travel to regional providers is necessary. Together, these strategies will stabilize the behavioral health workforce, improve reliability of service delivery, and increase access to care for residents of Metlakatla. By addressing both workforce and infrastructure barriers simultaneously, the project will create a more sustainable behavioral health service system capable of meeting community needs over the long term.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Single Community	Prince of Wales-Hyder Census Area	Advance to Implementation Application

Metlakatla Indian Community	Installation of Float and Pilings at Annette Bay Boat Launch	AK	The Metlakatla Indian Community, Annette Islands Reserve in southeast Alaska is home to over 1464 residents who live and work on AIR. The Annette Bay Small Boat Launch was installed in 2023, and needs the float and pilings to complete this facility. The launch is concrete and vessels can safely be launched, however, without the pilings and floats, boarding the vessels becomes difficult, even more so if weather conditions are bad. The rocks and area around the concrete launch are slippery and uneven. The risk of slipping and falling is greatly increased. With the float in place, passengers could step safely on board the vessel and can travel to Ketchikan for services not available in Metlakatla. The cost to install the pilings and floats is known as the full project went out to bid in 2023 and MIC was faced with the difficult decision to reduce the scale of the project. The goal to install the pilings and floats is a priority project for the community.	MIC will post the project out for competitive bid, select the most qualified, and cost-effective bidder to install the float and pilings using approved materials. The bidder will follow the existing US Army Corps Permit to meet all regulations and environmental considerations. Once the float and pilings are installed, they will be inspected by the City Manager and the engineer of record. Once approved the project will be opened officially, acknowledgement of the contributions from funders will be announced and the site will be a safe fully useable Small Boat Launch in Annette Bay.	\$1M-\$5M	Single Community	Prince of Wales-Hyder Census Area	Deferred or Not Advanced
Metlakatla Indian Community	Wil Maamxsga Pts’aan- Totem Park Children's Playground	AK	The Metlakatla Indian Community, Annette Islands Reserve in southeast Alaska is home to over 1464 residents who live and work on AIR. There are over 600 persons under the age of 18 according to the last census. The primary playground equipment is located on the school grounds and not always open to the public. The playground also lacks accessible options for those with mobility challenges. MIC began construction of the Totem Park located near the harbor in 2024. The park is co-located with a small skate park, community forestry project and a growing totem pole park. To increase the use and enjoyment of the park, MIC applied for and was funded by LWCF grant funds to install a pavilion for covered seating, benches, picnic tables and bbq pits. The second year, MIC applied and was funded for the addition of a children's playground at the site. The equipment was selected using community feedback from surveys and public outreach. As MIC is a tribal fishing community, the equipment will resemble a commercial salmon fishing vessel and incorporate native art forms where possible. The estimated cost for shipping and installation is greater than the grant funds, therefore MIC is pursuing optional ways to fund this project.	The Wil Maamxsga Pts’aan-Totem Park project has been collaborative with the community, especially the Mom’s on a Mission community-based organization and tribal leadership. Planning for the playground engaged the community on all levels and this anticipated children's playground will provide a safe, accessible outdoor play area for ages 2-12. MIC applied for funding from LWCF for the playground equipment and was awarded funds in 2025. Grant funds will cover the cost to purchase the equipment. The costs associated with rural Alaska shipping and transportation are so great that professional installation of the equipment will cost nearly as much as the equipment itself. To ensure the project will be installed in such a manner that it will last for decades, benefit the youth, children, elders and all Metlakatla families, the equipment needs to be installed professionally. This will increase the value and lifetime of the equipment. It is possible to install it using local labor, and we will employ local members. The warranty will be valid and extended if the professional, certified installing team is engaged.	\$50,000-\$250,000	Single Community	Prince of Wales-Hyder Census Area	Deferred or Not Advanced

Micah Hahn	Climate and Health Integration Blueprint to Strengthen Alaska’s Rural Health Transformation	AK	Climate-driven environmental change is already affecting the health of Alaskans in measurable and growing ways, including increasing wildfire smoke exposure, emerging extreme heat events, and disruptions to subsistence food resources. These changes are worsening chronic disease and increasing stress on mental and behavioral health. These pressures are also compounding challenges for rural health care delivery. Climate-related disruptions to travel - changing winter conditions, wildfire smoke, and extreme weather - are creating new barriers to care. Permafrost thaw, flooding, and erosion threaten facility stability and the water and sanitation systems that support care delivery. Surges in demand from extreme weather events are adding workload pressure to an already stretched rural workforce. Taken together, these trends are increasing health needs, complicating access to care, and straining the infrastructure that supports rural health delivery. As they intensify, the costs of maintaining rural health services will grow. The RHTP presents an unprecedented opportunity to modernize Alaska's rural health system. Integrating climate resilience from the start will help ensure new investments in workforce, technology, and care delivery function reliably under conditions Alaskans are already experiencing. Alaska is uniquely positioned to develop and test climate-resilient strategies, and to become a national leader in building rural health systems prepared for a changing climate.	This project will be led by Micah Hahn, PhD, MPH, an Alaska-based epidemiologist with 19 years of applied research at the intersection of climate and public health. Dr. Hahn has worked with Alaska Tribal health organizations and federal, state, and local agencies to develop surveillance systems for emerging climate-related risks, translate climate and health research into decision-relevant tools, educate veterinary, clinical, and public health partners, and support public-facing communication. Through this project, Dr. Hahn will develop a Climate and Health Integration Blueprint for the RHTP that identifies practical integration options to strengthen effectiveness, durability, and financial sustainability of current and planned investments across RHTP initiative areas under changing environmental conditions. The Blueprint will be developed through three core activities. First, a structured review of Year 1 RHTP-funded projects will identify where climate-related risks may affect proposed work and where existing investments can be strengthened through targeted integration of climate-informed approaches. Second, a scan of national and international efforts will identify implementation models that can be adapted to strengthen care delivery, system reliability, and long-term financial sustainability. Third, consultation with national leaders in climate and health system integration and technology partners will identify practical implementation pathways, partnership opportunities, and infrastructure needs relevant to Alaska’s rural health system. This work will be organized around three cross-cutting domains that support long-term success of RHTP investments: workforce preparedness; integration of climate/environmental data into care delivery and operations; and coordinated communication infrastructure to support timely response to seasonal and emerging risks. The primary Year 1 deliverable will be a Climate and Health Integration Blueprint identifying integration opportunities, key partnerships, infrastructure and data needs, and financing pathways to support sustained implementation. The Blueprint will include a menu of implementation options aligned with RHTP initiatives and a phased action plan to guide adoption over time. Together, these elements will provide a practical guide that strengthens current investments, supports coordinated system-level integration, and improves the long-term effectiveness and sustainability of Alaska’s rural health system.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Microbion Corporation	Phase 3 Clinical Study Preparations for Topical Pravibismane to treat DFI in Rural/Frontier Alaska	MT	Diabetic foot ulcers (DFUs) and lower-extremity amputations (LEAs) represent major complications of diabetes, a significant public health concern among rural Alaska communities. Epidemiologic surveillance from Alaska indicates that the prevalence of diagnosed diabetes among Alaska Native adults increased from approximately 5.2% in 2009 to 6.3% in 2019, representing a 21% increase in disease burden and expanding the population at risk for complications including diabetic foot ulcers (DFU) and diabetic foot ulcer infections (DFI), and resulting limb amputations. As diabetes prevalence increases in the rural Alaska population, complications related to diabetic foot disease are also expected to rise. Research using Medicare cohorts of individuals hospitalized with DFI shows that approximately 7.7% of patients undergo major leg amputation within 30 days, and racial and ethnic disparities persist, with minority populations—including Alaska Native individuals—represented among patients experiencing adverse outcomes. Similarly, national analyses examining racial disparities in DFI outcomes report that native and rural patients with DFI have significantly higher risk of major amputations compared with White or urban patients, even after adjustment for clinical and demographic factors. Many rural Alaska residents have limited access to vascular surgery, podiatry services, and wound-care programs, necessitating innovative trouble-free approaches for self-administered home care.	Current clinical treatments for DFI frequently leads to lower-extremity amputations (LEA), and to a devastating 70% five-year mortality rate following major LEA. Leveraging our 25-year history which started in Alaska and continues to this day in Alaska, our existing Investigational New Drug application (IND) which is maintained with FDA, our completed Phase 1 and Phase 2 clinical studies; and our FDA Fast Track and QIDP designations, Microbion is ready to initiate Phase 3 Pivotal Clinical Study preparations. These preparations comprise the first year of this project, include finalization of our draft Phase 3 clinical protocol, completing necessary meetings with FDA, completing necessary preparatory CMC (chemistry, manufacturing and controls) activities, ensuring quality and adherence to Good Clinical Practices (GCP) guidelines, and manufacture of regulatory and clinical drug product batches for advanced Phase 3 clinical studies in Alaska. This project is ready for implementation, with clear scope, objectives, budget, and sustainability plan. In this project, we are ensuring adherence to required quality standards, as well as readiness for Phase 3 clinical studies for our limb-saving, and potentially life-saving, topical pravibismane drug product. Pravibismane continues to demonstrate potency against all tested antibiotic-resistant and multidrug-resistant (MDR) bacterial and fungal infectious pathogens. This project provides a "Made in Alaska" solution that targets the root causes of limb loss in rural Alaska and the Tribal Health System. This clinical drug development program focuses on development of topical pravibismane, which uniquely and effectively addresses many of the key challenges facing diabetic patients in rural Alaska. This innovative, clinical-stage, targeted locally-administered drug product is a patient-facing therapeutic tool that has demonstrated 100% median patient compliance to date in a Phase 2 clinical study (funded by the U.S. Navy MTEC program), and in which the majority of treatments were administered at home by the DFI patients themselves, or their home-based family caregiver; it does not require healthcare doctors or nurses to administer. It has consistently been demonstrated safe and well-tolerated in 6 distinct human clinical studies. Topical pravibismane is not absorbed into systemic circulation, and does not present risk of drug-drug interactions or off-target organ effects. It does not require cold chain transport or storage.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Microsoft	Rural Healthcare Hub	WA	Rural, remote, and frontier communities face persistent barriers to accessing high quality health care due to geographic isolation, workforce shortages, fragmented technology, and financial instability among critical access hospitals and clinics. Many providers operate with limited IT capacity and must independently procure, secure, integrate, and maintain clinical and administrative systems. This results in uneven adoption of telehealth, poor data sharing, administrative burden on clinicians, and delayed access to care for patients. At the same time, significant public investment and advances in digital health create an opportunity to transform rural care delivery. However, without a coordinated approach, rural providers risk duplicative costs, inconsistent standards, and unsustainable technology investments that strain already limited resources. This project addresses the opportunity to establish a centralized, standardized approach to onboarding and managing health care technology for rural providers. By reducing complexity, lowering total cost of ownership, and ensuring consistent access to interoperable, secure digital tools, the project enables rural organizations to focus on patient care rather than infrastructure. The result is improved access to services, higher quality and more coordinated care, and a sustainable foundation that strengthens rural health systems over time.	The proposed approach addresses this problem by establishing a centralized and standardized model for onboarding, managing, and supporting health care technology across rural, remote, and frontier providers. Rather than requiring each hospital or clinic to independently procure, integrate, secure, and maintain digital systems, the project creates a shared platform with common governance, security controls, interoperability standards, and operational support. This reduces complexity for individual providers while ensuring consistency and reliability across the rural health ecosystem. Through this central approach, participating providers gain rapid access to preconfigured and interoperable solutions such as telehealth, health information exchange, analytics, and administrative automation. Centralized onboarding shortens implementation timelines, lowers total cost of ownership, and ensures that privacy, cybersecurity, and regulatory requirements are applied consistently from the start. Standardized configurations and shared vendor management prevent duplication of effort and allow small rural organizations to benefit from the same level of technical rigor typically available only to larger systems. The approach also includes shared training, technical assistance, and change management to support adoption by clinical and administrative staff. By reducing reliance on scarce local IT resources, rural providers can focus their limited workforce capacity on patient care rather than infrastructure maintenance. Centralized support helps reduce clinician burnout by streamlining workflows, automating administrative tasks, and embedding digital tools directly into existing clinical processes. Scalability and sustainability are core design principles. Shared infrastructure and standardized workflows create economies of scale that make ongoing operations more affordable over time. Secure aggregation of data across participating providers supports care coordination, population health insights, and program evaluation while preserving local clinical autonomy and data governance. As efficiency gains are realized, savings can be reinvested into workforce development, expanded services, and continued technology modernization. By pairing centralized technology enablement with locally delivered care, this approach improves access to services, strengthens quality and coordination, and builds a durable foundation that rural health systems can sustain and evolve over time.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Midsouth Medicine	Scaling Multi-Modality Technology-Enabled Chronic Care to Improve Rural Health and Quality of Life	MS	Rural communities often face limited access to consistent care for chronic illnesses due to provider shortages, long travel distances, and geographic isolation. Many patients must travel hours for specialty care or delay treatment, which can lead to worsening health outcomes, preventable complications, and higher long term health costs. This project addresses that challenge by leveraging a patient care model that has already proven effective in rural settings for managing chronic conditions such as diabetes, cardiovascular disease, and other long term illnesses. By combining this established care approach with the expanding capabilities of telemedicine, the project can extend physician expertise into remote communities while allowing patients to receive care closer to home. Telehealth technologies enable regular follow-up visits, specialist consultations, and coordinated care with local providers without requiring frequent travel. Remote monitoring tools and virtual consultations also allow clinicians to track patient progress more consistently and intervene earlier when problems arise. Building on a model that has already demonstrated success in rural environments, the project creates an opportunity to scale access to high-quality chronic disease management while supporting the sustainability and capacity of rural health systems and strengthening care delivery for underserved populations.	Our approach combines modern health technology with established models of chronic disease management to create a care system tailored to the needs of rural and remote populations. Rather than building an entirely new framework, the project leverages proven approaches to managing chronic illness while adapting them to rural environments through the use of telemedicine and digital health tools. At the center of the approach is a hybrid care infrastructure that integrates telehealth consultations, remote patient monitoring, and collaboration with local health providers. Telemedicine allows patients in remote communities to connect regularly with physicians and specialists without the need for frequent long-distance travel. Remote monitoring tools can track key health indicators such as blood pressure, glucose levels, and other chronic disease markers, allowing clinicians to identify changes early and adjust treatment plans quickly. The care model emphasizes coordinated, patient-centered management of chronic conditions while also promoting overall health and prevention. Patients receive regular follow-up care, education, and support that help them better manage their conditions and maintain healthier lifestyles. By focusing on prevention, early intervention, and continuous care, the model aims to reduce hospitalizations and complications related to chronic disease. This infrastructure is designed specifically with rural populations in mind. It recognizes the realities of geographic isolation, limited provider availability, and smaller local health systems. By extending specialist expertise through technology while supporting local clinics and providers, the approach strengthens existing health services rather than replacing them. Ultimately, the project creates a scalable system that combines technology, established clinical models, and community-based care to improve access, strengthen chronic disease management, and promote long-term health in rural communities.	\$1M-\$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Mo On the Go Transport LLC	Rural Care Access Transportation Coordination for the Kenai Peninsula	AK	Rural communities across the Kenai Peninsula face significant barriers accessing timely healthcare due to long travel distances, limited transportation infrastructure, weather challenges, and gaps in coordinated non-emergency medical transportation. These barriers contribute to missed appointments, delayed specialty care, prolonged hospital stays, and avoidable emergency department utilization. Many Medicaid beneficiaries, Veterans, elders, and individuals with mobility limitations rely on consistent transportation to maintain continuity of care, yet rural options remain limited and fragmented. This project addresses the opportunity to strengthen transportation as a key component of rural healthcare delivery by improving coordination between transportation providers, healthcare organizations, and community partners. By expanding reliable ambulatory and wheelchair transportation and integrating transportation into discharge planning and care coordination processes, the project aims to reduce access gaps, improve preventative care utilization, and support more sustainable healthcare access for rural Alaskans.	The proposed approach focuses on strengthening coordinated non-emergency medical transportation (NEMT) as a core component of rural healthcare access across the Kenai Peninsula. The project will expand reliable ambulatory and wheelchair transportation while improving coordination with hospitals, clinics, case managers, and community partners. Key activities include developing consistent referral pathways, supporting discharge planning, and improving communication between transportation services and healthcare providers to reduce missed appointments and delays in care. The project emphasizes a flexible, locally based transportation model that integrates into existing healthcare workflows rather than operating separately from them. By supporting preventative care visits, follow-up appointments, and access to specialty services outside the region when needed, the project aims to improve continuity of care and reduce avoidable strain on emergency services. Early implementation will focus on strengthening partnerships, refining scheduling and coordination processes, and building a scalable approach that can expand as community needs grow.	\$50,000-\$250,000		Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough	Deferred or Not Advanced

Mobilizing for Action Through Planning and Partnership	Regional RHTP Planning Project	AK	The opportunity is for MAPP to lead a coordinated, local convening process on the SKP over the next year. This will position our region to be more coordinated, efficient, and effective during the next four years of RHTP funding. Two key developments over the last year prepared MAPP to realize this opportunity: 1. MAPP engaged Bridges as a fiscal sponsor. 2. The MAPP Steering Committee (SC) adopted a new 2026–2029 Strategic Plan. In fall 2025, formally established as a project under Bridges, MAPP first secured a grant from the Homer Foundation to support a strategic planning process for the MAPP SC. That process produced three core strategies: 1. Expand the reach of MAPP. 2. Strengthen the community culture of collaboration. 3. Define and steward data collection and action processes. This Regional RHTP Planning Project is perfectly aligned with that second strategy. That strategy was further defined to “Support a “next-level” collaboration opportunity that includes partners within and outside of existing MAPP network”. As part of strategic planning, the MAPP SC defined “next level” collaboration as proactive, community centered, inclusive, replicable, and capacity building. This reflects our belief that the region is ready to scale collaboration to achieve deeper, more equitable health impacts. The SC set a specific goal “to identify and support one new community collaboration opportunity to pursue.” The RHTP Planning Project is that opportunity.	MAPP has already begun groundwork around the RHTP opportunity. MAPP hosted a local convening on January 28, and the MAPP Coalition Coordinator, along with partner organizations, attended the regional convening on February 13 at Central Peninsula Hospital hosted by 100% Communities. As a result of these early convenings, partners determined that, given the short initial timeline, organizations would pursue individual projects and funding in this first round. While there was intention toward alignment, no large, shared initiative was ready. This highlighted a clear gap, and opportunity, for more deliberate, regional planning and collaboration before subsequent RHTP funding cycles. Over the next year, MAPP will lead a structured planning process to: • Convene a broad set of community stakeholders (health care providers, Tribal entities, behavioral health, social services agencies, local government, and community based organizations). • Use existing and emerging data (including MAPP’s 2023 Community Health Needs Assessment South Peninsula Hospital’s forthcoming 2026 Community Health Needs Assessment), respond to key findings, and identify health improvement initiatives. • Co design one or more “next level” collaborative initiative that can be implemented and scaled during the remaining RHTP funding periods. MAPP has a long, successful history of facilitating community collaborations and systems change across the SKP and maintains a strong, active coalition. The Steering Committee represents a broad cross section of the community, including: Bunnell Street Arts Center; Church on the Rock; Homer Public Health; Homer United Methodist Church; Hospice of Homer; Kachemak Bay Family Planning Clinic; Kenai Peninsula College, Kachemak Bay Campus; Pratt Museum; Sprout Family Services; South Peninsula Haven House; South Peninsula Behavioral Health Services; South Peninsula Hospital; and SVT Health & Wellness. Beyond the Steering Committee, the MAPP Coordinator has engaged additional partners in this first RHTP round, including: Homer Cycling Club; Homer Hockey Association; Homer OPUS; Homer Senior Center; Independent Living Center; Kachemak Bay Recovery Connection; and Kachemak Swim Club. Through this inclusive, data informed convening and planning process, MAPP will move the region from loosely aligned efforts to a coordinated, rural health collaboration that can leverage future RHTP resources for maximum impact.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Moda	Advancing Value-based Payment Readiness through PCMH Implementation on the Kenai Peninsula	OR	Moda Health, Central Peninsula Hospital, and South Peninsula Hospital propose partnering with the Alaska Department of Health to establish a Medicaid coordinated care demonstration project on the Kenai Peninsula. While the Alaska Department of Health determines a path forward for a CMS 1115 waiver, this project will prepare both hospital partners to operate within a Medicaid coordinated care model and participate in advanced value-based payment arrangements. Additionally, drawing on Moda’s experience implementing Medicaid coordinated care models in other states, the project will help CPH and SPH transition away from fee-for-service and support the state in managing Medicaid cost growth in the region. This initiative brings together Moda Health, as state-wide Alaska payer with experience designing VBPs across commercial and Medicaid programs, and two essential rural hospitals that provide emergency, primary, and specialty care in the Kenai Peninsula. Together, partners will design and test new VBP models that will strengthen foundational quality improvement infrastructure, expand reporting capacity, and support practice transformation through implementation of the NCQA Patient-Centered Medical Home (PCMH) model, which has been shown to improve quality of care, support chronic disease management, increase patient and provider satisfaction, improve quality metric performance, and lower overall cost of care (ncqa.org).	The proposed project supports Goal 2: Building Sustainable Outcomes-Driven Health Systems through the Pay for Value Initiative by advancing pay-for-value readiness on the Kenai Peninsula through implementation of the NCQA Patient Centered Medical Home (PCMH) model at Central Peninsula Hospital and South Peninsula Hospital’s primary care clinics. Moda Health will serve as the project convener, payer partner, technical assistance provider, and grant administrator, and will leverage extensive experience designing and implementing VBPs across multiple markets. Both hospital partners will receive upfront foundational capacity building payments to support PCMH implementation and develop the infrastructure needed to participate in more advanced value based payment arrangements over time. This proposal aligns with Alaska’s proposed use of funds to launch transitional grants to support the adoption of VBP arrangements, support VBP infrastructure, and provide TA to support Pay for Value projects. All project activities are designed to strengthen the foundational capabilities required for long term financial stability of rural providers and to support the transition to alternative payment models that support improved care coordination, behavioral health integration, chronic disease management, and quality improvement activities. The project is structured around the nationally recognized Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework, which provides a clear, phased roadmap of participation in advanced VBP pathways (https://hcp-lan.org/apm-framework/). This progression aligns with and will help partners prepare for Alaska’s planned 1115 Medicaid Waiver. In Year 1, Category 2A foundational payments and more advanced per-member-per-month (PMPM) payments will support PCMH implementation and three critical focus areas: behavioral health integration (BHI), community health worker (CHW) integration, and development of robust quality improvement (QI) infrastructure. Together, these investments will strengthen care coordination, expand community clinical linkages, enhance quality reporting capacity, and build the operational readiness required to move from foundational payments toward more advanced pay for performance arrangements, allowing partners to participate in more advanced VBPs based on readiness.	Over \$5M	Other	Kenai Peninsula Borough	Advance to Implementation Application

Montis Corporation	Every Flight Matters: Improving Rural Health Outcomes in Alaska with Real-Time Weather Visibility	AK	Alaska’s aviation system is crucial to providing quality, affordable health care to rural communities across the state. However, frequent flight delays and cancelations limit patient and provider access, delay medication deliveries, and impose high costs on those seeking routine, urgent, and emergency health services. AWOS/ASOS outages are a leading cause of flight delays and cancellations. Less than half of all public-use airports in Alaska have adequate weather coverage, hindering pilots’ ability to fly under instrument flight rules. As FAA logs show, on an average day, one in three stations suffer an outage. As the Alaska Legislature found in 2024: “Station outages disrupt the critical flow of passengers and goods, create risks to human life and health in medical emergencies, and delay essential medication deliveries.” Despite multiple efforts to address the problem, missing weather data remains the single greatest challenge to Alaska’s aviation system. That is largely due to cost. An AWOS/ASOS costs \$2 million and takes 2-3 years to install in Alaska due to complex siting requirements. With only 2-3 stations built per year, it will take more than \$500 million and 100+ years for the FAA to install stations at the 257 airfields without coverage in Alaska. Meanwhile, rural Alaskans seeking access to quality, affordable health care continue to suffer. Improving rural air service thus presents one of the best opportunities to improve health outcomes statewide.	"Every Flight Matters" advances a commercial approach to aviation weather—as Congress encouraged in the FAA Reauthorization Act of 2024. In partnership with the State of Alaska, regional organizations, air carriers, and local communities, Montis Corp will install and maintain low-cost, ultra-reliable weather stations in tough-to-reach places, thus fixing a known problem in Alaska’s aviation system that directly contributes to poor health outcomes statewide. Our approach is built on the MWOS. Designed by Walter Combs, a 27-year FAA veteran, the MWOS is a self-contained system providing real-time visibility and weather data to pilots, flight dispatchers, healthcare providers, and community members at 1/100th the cost of an AWOS/ASOS. With minimal power requirements and 24/7 satellite or cellular (LTE) connectivity, it can be installed and online in less than 8 hours. In partnership with the State of Alaska, regional organizations, air carriers, and local communities, we propose to identify and install MWOS units at high-priority locations where missing weather data contributes to frequent flight cancellations and delays. That is, airports without existing weather coverage but also rural clinics, community centers, and even remote mountain passes—all places where government-owned stations are unlikely or unable to go in the coming years. Priority sites will be selected based on input from our partners, with an emphasis on communities served by tribal health organizations, medevac operators, and Essential Air Service carriers. For each site, we will collect baseline flight data prior to installation so that improvements can be measured over the lifetime of the project. During installation, we will work with community members to ensure the purpose of the MWOS is understood and supported by the people it serves. We named this project Every Flight Matters because in rural Alaska, every flight does. Even a single cancelled or delayed flight can mean a missed diagnosis or treatment, an expired medication, or a patient who doesn’t reach the hospital in time. As outlined above, our approach puts field-tested, affordable technology where it is needed most – in the hands of pilots, providers, and community members who will use it every day.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Mountain Pacific Quality Health	Transform Cardiometabolic Care for Alaskans Via Interoperable Systems & Pharmacy Enabled Prevention	MT	Through partnerships with the Alaska Pharmacy Association, the American Pharmacists Association Foundation, the Alaska Hospital and Health Association, and healthEconnect, this initiative will implement a proven model for cardiometabolic risk reduction across the state. By expanding clinical pharmacy services, the project will support high risk, dual eligible individuals through prevention, early detection, and enhanced transitions of care interventions. These efforts will strengthen Alaska’s rural health ecosystem by improving care coordination and communication between primary care providers and an underutilized but highly accessible healthcare resource—rural pharmacists. These partners have been intentionally convened to drive broader, system level improvements that include: • Increased patient access to care through expanded telehealth capabilities and pharmacist provided clinical services. • Greater use of accurate, up to date medication lists across care settings to improve safety and continuity of care. • Higher patient engagement with interoperable electronic health record (iEHR) portals, ensuring patients and care teams have reliable access to essential health information. Together, these coordinated efforts will advance a more connected, efficient, and patient centered healthcare system for rural Alaskans.	Mountain Pacific will serve as the primary administrator and project manager for the program to ensure alignment of priorities, collaboration and quick action throughout the state. Mountain Pacific will partner with the Alaska Pharmacy Association, the American Pharmacists Association Foundation, Alaska Hospital and Health Association, and healthEconnect to launch the IMPACT Cardiometabolic Risk Reduction initiative which will implement a population health, patient-centered, team-based care model to include pharmacists to enhance primary care in rural geographies throughout Alaska. Our goal is to engage over 60 community pharmacies across Alaska, ensuring broad, statewide impact. Technologies will be leveraged to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes as well as to promote sustainable access to high quality rural health care services. The American Pharmacists Association Foundation and Alaska Pharmacy Association will deploy established implementation-ready programs that have demonstrated benefit in cardiometabolic risk reduction. Services will expand access in medically underserved rural communities by providing pharmacist led cardiovascular, prediabetes, and diabetes care. Participating pharmacies will serve as access points for screening, detection, referral, prescribing, prevention, and collaborative patient care management. Activities include screening for Social Determinants of Health (SDOH), atrial fibrillation, and stroke risk, with patients enrolled into one or more tracks: • Atrial fibrillation and stroke risk referral: Pharmacist screening plus a comprehensive medication review to identify cardiovascular related medication problems. • Continuous Glucose Monitoring (CGM): Support obtaining devices, applying sensors, interpreting patterns, preventing hypoglycemia, and understanding food, medication, and activity impacts. • Medication Therapy Management (MTM): Comprehensive medication reviews shared with primary care providers. • Transitions of Care (TOC): Post discharge medication reconciliation to resolve issues common during care transitions. • Lifestyle change program: Enrollment in the CDC recognized National Diabetes Prevention Program through the American Pharmacists Association Foundation’s Umbrella Hub Organization, enabling pharmacies to deliver services with centralized administrative support.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Mountain Pacific Quality Health	Building Sustainable Health Outcomes Through Provider Incentives and Technical Assistance	MT	Participation in Alaska’s Fresh Start program offers significant benefits including improved health outcomes such as meaningful weight loss, blood pressure reduction, and better blood sugar control. By pairing stipends with robust technical assistance (TA), providers are better positioned to connect their communities to these proven benefits while sustaining high-quality program delivery over time. However, community clinics, primary care practices and other providers often face major barriers when adopting new health-support programs, including limited staff capacity, onboarding time, data reporting demands, and workflow integration challenges. Providing stipends or site funding helps reduce these burdens by compensating providers for time spent on training, implementation, outreach, and reporting, while also offsetting operational costs such as staff hours, IT needs, and participant engagement activities. This financial support makes participation more feasible for small or rural sites and encourages early adoption and long-term involvement. The role of TA equips providers with the skills, guidance, and operational support necessary to implement programs effectively, improving confidence, smoothing workflow integration, and reducing uncertainty. By offering hands-on training, implementation support, technology and data guidance, and ongoing quality-improvement coaching, TA strengthens program fidelity and builds lasting provider capacity.	To expand the reach and impact of the Fresh Start program across Alaska this project will combine provider stipends/site funding with comprehensive, hands-on technical assistance (TA). Our project is designed to lower participation barriers, strengthen provider capacity, and ensure long-term sustainability in delivering evidence-based chronic disease prevention and management programs. Provider stipends/site-based funding will offset the time, staffing, and administrative effort required for onboarding, outreach, participant engagement, and data reporting. By reducing the financial burden on clinics these stipends make participation feasible, especially for rural and smaller organizations. Funding allows providers to dedicate staff time, integrate workflows, adopt necessary tools, and maintain steady engagement throughout the program cycle. Alongside this financial support, our organization will deliver technical assistance that ensures providers have the knowledge, resources, and support necessary for high-quality implementation. TA will begin with thorough onboarding and training, orienting providers to program goals, workflows, and best practices while offering both live and virtual options to accommodate varying schedules and bandwidth. During implementation, we will provide site-specific support to align program activities with each provider’s capacity and operational structure. This includes troubleshooting enrollment challenges, adjusting workflows, and helping integrate Fresh Start activities into existing systems in a way that is realistic and sustainable. We will also offer technology and data assistance, ensuring providers can effectively use digital platforms, reporting tools, and participant-tracking systems. Templates, streamlined data processes, office hours, and rapid-response help will make reporting more manageable and improve data quality. To maintain strong outcomes over time, providers will benefit from ongoing quality improvement and coaching, including regular check-ins, barrier assessment, problem-solving support, and access to best-practice guidance and toolkits. This continuous improvement process strengthens fidelity and builds long-term capacity within each site. Together, this integrated approach ensures providers have the financial resources, operational supports, and expert guidance needed to deliver Fresh Start programming effectively and sustainably ultimately improving health outcomes across Alaska.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Mountain View Community Mental Health and Recovery Center LLC	Low-Barrier Clubhouse & Integrated Behavioral Health Program	AK	Alaska continues to experience some of the highest rates of suicide, addiction, and untreated mental illness in the nation, yet many residents are unable to access timely, coordinated care. Individuals in both urban and rural communities frequently fall through gaps created by transportation barriers, limited psychiatric availability, stigma, and fragmented service systems. This project addresses that opportunity by creating a low-barrier, integrated behavioral health program that offers walk-in access, Nurse Practitioner -led clinical services, peer-driven recovery support, and a clubhouse model that fosters community, purpose, and long-term stability. By reducing structural barriers and providing a welcoming, coordinated point of care. The program also aims to reach individuals who are currently underserved and at high risk for crisis, hospitalization, or homelessness.	Our approach centers on delivering accessible, person-centered behavioral health care that meets individuals where they are. The program combines outpatient therapy, case management, recovery support, and emerging services such as group therapy, medication management, and individual psychotherapy to create a comprehensive continuum of care. All services are grounded in trauma-informed and culturally responsive practices, ensuring that clients feel safe, respected, and empowered throughout their treatment. To strengthen coordination and reduce gaps in care requires to maintain strong partnerships with community providers, enabling warm handoffs, shared care planning, and integrated support for individuals with complex needs. This collaborative, whole-person approach allows the program to address mental health and substance use challenges simultaneously, improve engagement, and promote long-term recovery and stability.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Mountain View Health Services	Mountain View Health Services Mobile Health Services and Sustainability Project	AK	Mountain View Health Services (MVHS) has served as the healthcare access point for integrated primary care, urgent care, behavioral health for people experiencing barriers that prevent access to traditional health care for many years. We have experienced sustained financial losses after COVID due to: high overhead (lease, utilities, insurance), under-reimbursement with a high percentage of self-pay population, highly -complex patient population, uncompensated care, and workforce recruitment and retention challenges. The continuation of the current model is not financially sustainable and we anticipate closing our physical clinic location at the end of this month.	1. To preserve access to care for Mountain View and surrounding high-need populations—including individuals experiencing homelessness, serious mental illness, and substance use disorders—MVHS plans to close its clinic location and transition to a fully mobile and home-based integrated health care model. MVHS requests technical assistance, planning support, and funding to help us transition from a high-overhead fixed-site clinic to a low-overhead 100% mobile health and home-based delivery model offering integrated medical care and behavioral health. RHTP funding is requested to support: salaries and protected time for MVHS staff to conduct the planning and redesign work, start-up costs associated with mobile health infrastructure, financial modeling and sustainability planning, and operating expenses during transition. 2. To address the underlying issue of lack of viability of the clinic, we need help with developing a sustainable financial strategy, exploring partnerships and alternative payment models, and right-size services for long-term sustainability of a "brick and mortar" clinic.	\$250K-\$1M	Clinic	Single Community	Anchorage (Municipality)	Advance to Implementation Application

Mountain View Health Services	Mountain View Health Services Early Life Wellness Pilot	AK	Underserved communities like the Mountain View neighborhood experience disproportionately high rates of maternal tobacco and substance use, perinatal depression, housing instability, food insecurity, and early childhood developmental delays. Yet preventive services during pregnancy and the first five years of life remain fragmented, grant-funded, and workforce-limited. Many communities lack consistent access to behavioral health providers, pediatric specialists, and home visiting programs. As a result, risks go unidentified until crisis points child welfare involvement, emergency behavioral health care, and preventable chronic disease. Existing systems (tribal health, public health nursing, early intervention, WIC, schools) may often operate in silos and are often not structurally able to deliver Medicaid-billable prevention services. There is an opportunity to redesign the system by creating a Medicaid-enrolled Early Life Community Health Worker (Home-visitor) provider type to deliver evidence-based perinatal and early childhood prevention services under clinical supervision. This pilot would demonstrate a way to expand the rural workforce, integrate services across sectors, and establish a sustainable financing model that shifts Alaska’s maternal and early childhood health system from crisis response to prevention and early intervention.	Our project will pilot a new Medicaid-enrolled Home-Visitor: the Early Life Community Health Worker (EL-CHW). This paraprofessional workforce will be specially trained in maternal and early childhood health from conception through age five and will deliver structured, evidence-based prevention home-visit and community-based services under clinical supervision from a local healthcare organizations. The project will work with the State to establish a Medicaid enrollment category, fee schedule, supervision standards, and regulatory framework to support billing for defined preventive services. EL-CHWs may bill independently once accredited or operate within a Medicaid-enrolled healthcare group. A standardized education and credentialing pathway will prepare EL-CHWs in human development, perinatal depression screening, SBIRT, substance use and tobacco cessation counseling, nutrition education, trauma-informed care, and Medicaid documentation compliance. The pilot EL-CHWs will deliver Medicaid-billable services in homes, shelters, schools, and community settings. Services will include home visiting for prevention and early education, behavioral health screening and brief intervention, recovery and drug-use prevention counseling, care coordination, goal-setting, transportation and housing support coordination, Medicaid enrollment assistance, and warm handoffs to medical and behavioral health professionals. Services will be tied to measurable outcomes and aligned with evidence-based practices. The model is designed to integrate into existing systems rather than duplicate them. EL-CHWs can be embedded within existing organizations like schools and non-profits serving people experiencing homelessness.. This strengthens cross-sector coordination while allowing communities to tailor services from a defined menu of reimbursable interventions based on local needs. Financial sustainability is central to the approach. By establishing a Medicaid-financed prevention model, this pilot shifts early life services from grant dependence to a durable reimbursement structure. Over time, early identification and intervention are expected to reduce high-cost utilization, including neonatal intensive care, behavioral health crises, and child welfare involvement. This approach builds a scalable, community-based prevention infrastructure that improves maternal and early childhood outcomes while creating a sustainable financing pathway for rural, remote, and frontier Alaska.	\$250K-\$1M	Clinic	Statewide	Anchorage (Municipality)	Advance to Implementation Application

Mountain View Health Services	Mountain View Health Services Youth Prevention Health Worker (YPHW) Pilot	AK	Rural Alaskan communities are home to resilient and healthy populations that thrive in remote and extreme environments. Despite the general health and resilience of the population, many Alaskan youths suffer from the same lifestyle afflictions of obesity, prediabetes, cardiovascular risk factors, depression, anxiety, and substance use as other youth nation-wide. Yet broad societal forces and remote locations have limited some communities' (and neighborhoods') access to health-specific mentors and role models as well as access to structured physical activity, nutrition education, and behavioral health programming and supports. Schools often lack year-round prevention capacity, homeschool families have fewer organized wellness resources, and many communities lack dual-purpose spaces to host extracurricular recreation and resilience-building programs. Many components of our current healthcare systems are still largely reactive, addressing disease after onset rather than building lifelong habits early.	We propose establishing a workforce of Youth Prevention Health Workers that are embedded across healthcare organizations, school districts, homeschool networks, Tribal communities, and community organizations. The program is modeled after Alaska’s CHAP system and incorporates evidence-based home-visiting and CHW models, with broad adaptability based on community input. Tribal organizations and community organizations hire YPHWs and with the support of a state-wide TA network, and create unique community-based youth prevention programs. The project creates a new Medicaid billing provider, a menu of billable preventative services, and a training and support network with input from Tribal health experts as well as national and local experts. There is a priority given to input from local, rural communities. YPHWs will be trained in a variety of evidence-based prevention services including: physical activity programming (including Presidential Fitness metrics and strength/endurance training); nutrition education; family-based behavior change strategies; cardiovascular and metabolic screening (BMI percentile, blood pressure, risk assessment); evidence-based resilience and social-emotional skill building; and family engagement and motivational interviewing. YPHWs will not be tied to school employment, ensuring year-round availability and broader community reach. Programming will integrate in-school modules, after-school and homeschool programming (sports and employment conditioning, healthy meal opportunities, family fitness nights), home-visiting, and culturally-appropriate family-based prevention interventions adapted from evidence-based programs. Workforce will prioritize local hire, but include itinerant workers from non-rural areas as needed to support workforce needs and prioritize rural delivery. Minor modifications to community centers or gyms may be needed to create dual-purpose spaces. Mental and behavioral health prevention services and supports will include structured resilience curricula, peer connection activities, screening for depression/anxiety, and warm handoffs to clinical services when needed. Supervision by Tribal entities will ensure cultural relevance and local control. Supervision will combine digital tools, regular coaching, and quality improvement processes. The project intersects with Healthy Communities by linking youth programming to community-wide physical activity infrastructure, food systems access, and behavioral health supports.	\$250K-\$1M	Clinic	Statewide	Anchorage (Municipality)	Deferred or Not Advanced

Mountain View Hope Covenant Church	Mountain View Hope Center: A Community Hub for Health, Stability and Connection	AK	Mountain View is a diverse neighborhood in Anchorage where many residents face significant barriers to stability and well-being, including food insecurity, housing instability, behavioral health challenges, and social isolation. Despite the strength and resilience of the community, there are few consistent, low-barrier spaces where neighbors can gather, access basic needs, and connect with supportive services. Anchorage also serves as a regional hub for Alaskans traveling from rural communities to access medical care, behavioral health services, and other supports that may not be available in their home communities. For some individuals, these trips become complicated by housing instability, behavioral health challenges, or lack of resources to safely return home, leaving them without strong support networks while navigating care in the city. The Mountain View Hope Center is a space that strengthens community health by establishing a welcoming neighborhood hub where individuals can access basic needs, build relationships, and connect with the services and support systems that contribute to long-term well-being.	The Mountain View Hope Center will establish a welcoming, community-centered hub in the Mountain View neighborhood where residents and visitors can access meals, gather in a safe and dignified space, and connect with supportive services. The project will focus on creating a consistent place of belonging where people can build relationships and access resources that support health and stability. Initially, the Hope Center will focus on meeting basic needs by providing community meals, snacks, and a safe, warm gathering space where neighbors can connect and find support. The center will work in partnership with local food providers and community organizations to ensure reliable access to meals and essential resources while avoiding duplication of existing services. Over time, the Hope Center will expand partnerships with local service providers to offer additional supports such as resource navigation, connections to behavioral health services, financial coaching, and educational opportunities. By providing a consistent place for connection and early support, the Hope Center also has the potential to reduce reliance on strained systems such as crisis care, emergency departments, shelters, and law enforcement. Community-based gathering spaces that address basic needs and support social determinants of health can help stabilize individuals earlier and improve engagement with health and behavioral health services. In this way, the Hope Center contributes to a stronger, more robust and coordinated community health ecosystem.	\$250K-\$1M	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

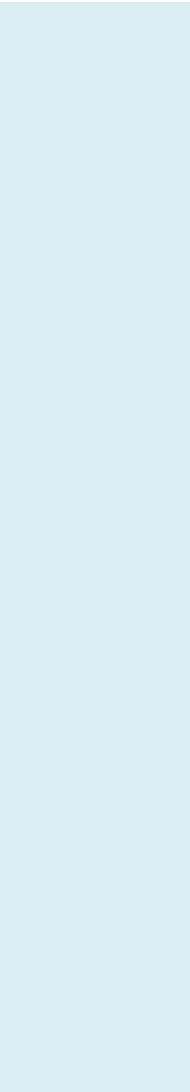
Mountain View Lions Club Foundation	Lions Club Free Health Clinic	AK	The largest obstacles in Alaska are the cost of healthcare and the accessibility of it. A single person qualifies for Medicaid if they make less than \$23,000/year. Someone who works a full-time job at minimum wage in Alaska is over that limit. As public healthcare options require \$700 premiums (now that subsidies have lapsed) and \$7,000 deductible at the cheapest program, healthcare costs at 10% of annual income (according to IRS affordability measures by the Affordable Care Act) means that someone must make \$154,000 to have their public insurance option deemed as "affordable". There is a huge gap of people who simply cannot afford care, deferring treatment and causing climbing costs. That is dependent on whether finding a clinic accepting new patients is plausible in a timely manner, or one who accepts insurance at all. As of 2021, our state ranks last in individuals accessing preventative clinical services and having a dedicated health care provider. We are 31st in avoiding care due to cost. Only six states have a higher percentage of uninsured residents. The US Institute of Medicine issued several reports in the early 2000s concluding that being uninsured is seriously hazardous to American health outcomes. A more recent (2014–2018) Commonwealth Fund survey discovered almost half of underinsured adults report medical bill and debt problems and 41% delay necessary care because of costs.	The goal of the proposed free healthcare clinic is directed toward Alaskans who: 1. Are “insured” yet cannot afford to access services because of high deductibles/copays. 2. Do not qualify for health care because they fall outside income or age thresholds. 3. Avoid the hassle of engaging with the healthcare system unless they are in acute need. Our approach is through multiple nonprofit and clinical partnerships to provide free popup clinics at various times of the year. Through various groups like Mobile Medics International and Remote Area Medical, we will host the largest multidisciplinary free pop-up health services clinics ever held in the state. These 2-day events in Anchorage and Fairbanks will provide hundreds of Alaskans with free, proactive health care services (dental, vision, mental, medical) by volunteer clinicians so they can get help now with undiagnosed, debilitating or life-threatening physical/behavioral health issues — regardless of ability to pay. This has proven immensely beneficial. Since 2023, these Alaskan pop-up clinics have provided almost a half million dollars of free healthcare, glasses, labwork, and medications for over a thousand Alaskans. Federally Qualified Health Clinics offer low-obstacle sliding fee services, but Alaskan FQHCs are overwhelmed and often have up to a 9-month waitlist for care. Our unique clinic model completely removes all barriers that stop so many Alaskans from accessing care — in particular 1) high deductibles/copays, 2) falling outside income/age thresholds for free coverage, and 3) “powering through” without preventive care until issues become intolerable. Our free clinics offer pro bono care — for all. Without funding these pop-up clinics for labs, disposables, venues, logistics, and lodging, dependence on expensive reactive treatments such as ER visits for urgent complications will remain a statewide trend. By addressing the acute need for free proactive health services to identify and treat issues early, we can improve health outcomes for hundreds of our friends, families, and neighbors. Due to extraordinary in-kind community and partner support, we will deliver these clinics for only one-fifteenth of the total cost. Today’s health care system is largely reactive and avoids addressing issues until a crisis situation demands an immediate response. These clinics are a pressure relief valve — care that changes things for struggling people NOW.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough	Deferred or Not Advanced

MPS Enterprises, LLC	Nome Nugget Inn Rural Health Housing Conversion (Planning Phase)	AK	The opportunity is to convert an existing, centrally located hotel into dedicated rural health lodging at a moment when Nome’s housing market cannot meet health-system demand. The Nome Nugget Inn is a known facility that underwent significant renovations in 2024, yet it has been closed since early 2025 and is not currently serving the public. Without intervention, this asset will remain underutilized while the regional health system and traveling patients continue to compete for scarce short-term rentals and limited hotel rooms. The problem is straightforward and urgent: lack of safe, consistent, and affordable lodging is a binding constraint on rural health care delivery in the Bering Strait/Norton Sound region. It limits recruitment and retention of temporary and permanent clinical staff, increases travel-related costs for providers and health organizations, and creates a barrier to care for patients who must travel for services that often require multi-day stays, including specialty consults, infusion, wound care, prenatal monitoring, imaging, and post-operative follow-up. This LOI proposes owner-led planning to reposition the Nugget as dedicated workforce and patient/escort lodging. The project leverages an existing structure to address an identified regional bottleneck and aligns with RHTP’s purpose by strengthening access to needed services, improving continuity and quality of care for rural residents, and increasing sustainability of the regional workforce pipeline.	We are requesting RHTP Planning Grant support to complete the due diligence and predevelopment work needed to renovate and reopen the Nome Nugget Inn as dedicated lodging for the rural health workforce and for traveling patients and escorts. The planning phase will deliver a feasible, code-compliant, partner-informed package that is ready for an RHTP implementation application. As the property owners, we can provide immediate building access, coordinate directly with qualified contractors and regulators, and ensure planning decisions support long-term stewardship. Planning will confirm technical feasibility, scope, cost, and operating requirements. We will complete engineering review and architectural programming to adapt the building from short-stay hotel use to longer-term workforce and patient-stay needs, including privacy, accessibility, durable finishes, storage, and practical shared amenities. We will obtain contractor assessments and detailed estimates for priority mechanical work, with emphasis on comprehensive plumbing repairs needed for reliable year-round operations. We will also complete life-safety and accessibility planning, including design requirements for a unified fire alarm and fire suppression system, egress, and permitting steps, coordinating early with the City of Nome to reduce redesign risk. In parallel, we will work with Norton Sound Health Corporation and other stakeholders to define an operating model that is workable in Nome, including referral and eligibility criteria, booking processes, safety policies, staffing and management needs, and an affordable, sustainable rate structure. Planning will culminate in an implementation-ready scope, budget, schedule, and business plan/pro forma (including utilization assumptions and a maintenance/capital reserve strategy) that reduces risk for funders and partners and positions the project to improve rural access and workforce stability.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Mt Edgecumbe Preschool Inc	Mt. Edgecumbe Preschool and Sitka Pioneer Home Strengthening Workforce	AK	The Sitka Pioneer Home is an assisted living program. Situated in rural Sitka, Alaska, the Pioneer Home employs nurses, doctors, and other medical specialists, as well as administrative staff, activities coordinators, janitorial workers, kitchen employees, maintenance workers, and more. All of these positions allow the Sitka Pioneer Home to function well in order to appropriately care for all of its residents. However, it has been challenging to find qualified applicants to fill all the positions at the Sitka Pioneer Home, and one barrier to finding quality healthy care employees to work at the Sitka Pioneer Home has been the lack of available childcare in Sitka. Additionally, Mt. Edgecumbe Preschool, a 501(c)3 nonprofit preschool residing on the Sitka Pioneer Home campus, struggles to retain high quality teachers due to the high cost of living in Sitka and the inability to increase wages without increasing tuition. A Memorandum of Agreement already exists between the two organizations. An opportunity exists for Mt. Edgecumbe Preschool to give preferential preschool placement for the children of Sitka Pioneer Home employees, as well as to increase the wages and professional development for teachers to keep offering high quality early childhood education, ensuring this preschool is a desirable place for parents to send their kids. These measures would strengthen the workforce at both organizations and improve quality of health care for Sitka Pioneer Home residents.	Mt. Edgecumbe Preschool and Pioneer Home have an existing Memorandum of Agreement allowing Mt. Edgecumbe Preschool to use the building in exchange for regular positive interaction with Pioneer Home residents. The preschool resides on the Sitka Pioneer Home campus, allowing easy access for parents to drop their children off and pick them up from preschool. Mt. Edgecumbe Preschool could give preferential placement of preschool-aged children of Sitka Pioneer Home employees, with spaces reserved for children of Sitka Pioneer Home staff. Administrators from both organizations would meet to discuss logistics, create a plan, and take steps to implement the plan. Ideally, the plan would be put into action by the beginning of the coming school year. Funds would be put toward administrators' time planning and coordinating this partnership; increasing Mt. Edgecumbe Preschool teachers' wages and professional development compensation to ensure a high quality of early childhood education is provided; expanding the Mt. Edgecumbe Preschool scholarship fund to decrease the financial barrier of tuition and improve access to care; and potentially hiring another preschool teacher to expand preschool hours so as to align with the medical staff shifts at the Sitka Pioneer Home.	\$50,000-\$250,000	Single Community	Sitka (City and Borough)	Advance to Implementation Application

Mt. Sanford Tribal Consortium	Securing Fiscally Sustainable Healthcare For Future Generations of Upper Ahtna Indigenous People	AK	Mt Sanford Tribal Health Consortium - located 4 hours northeast of Anchorage - serves an Alaska Native (AN) frontier community that has declined from 200 residents to approximately 60 in two decades. The current population is primarily elderly. We face structural fiscal instability driven by low patient volume and a fee-for-service reimbursement model that does not function in ultra-low-density settings. Annual revenue has averaged ~\$120,000 and only reached break-even when supplemented by itinerant provider services. Medicaid reimbursement is capped by provider type. When the Consortium had a Nurse Practitioner on staff, billing capacity ranged from approximately \$100,000 to \$120,000 annually. Following the loss of the NP, the clinic now relies on two CHAs, who generate approximately \$41,000 each per year under current billing rules, reducing total billing capacity to roughly \$82,000. In addition, elders who are not Medicaid-eligible require uncompensated care, creating further financial pressure. The Consortium lacks third-party insurance contracts, diversified payer sources, and operating reserves, leaving no margin for recruitment, infrastructure investment, or service expansion. Rural health policy literature consistently notes that the current model is poorly suited to very small or frontier providers with low patient volume. Without a structural redesign, the Consortium risks losing its ability to maintain even basic healthcare access for residents.	Following RHTP Initiative 4, this project will protect healthcare access by transitioning Mt. Sanford Tribal Health Consortium from a fragile encounter-based billing model toward a sustainable value-based care approach supported by APMs. 1. Fiscal Solvency and Care Model Realignment We will conduct a comprehensive fiscal sustainability and care delivery assessment to determine the most viable long-term operating model. This analysis will evaluate whether Mt. Sanford should function as: (1) a direct primary care provider with limited on-site services; (2) a coordinated access and transportation hub connecting residents to Anchorage or regional providers; or (3) a hybrid model combining local stabilization services with structured referral and care coordination. Financial modeling will assess the sustainability of each option under alternative payment pathways, including population-based payments, care coordination reimbursement, and access-based payments designed for low-volume frontier systems. Engage with regional Tribal Health Organizations and referral partners ensuring the selected model strengthens integration with the broader Alaska Tribal Health System. 2. Alternative Payment Model Development Working with technical advisors and payer partners, the project will complete a formal APM Readiness Assessment evaluating payer mix, cost structure, service capacity, and eligibility for participation in value-based or CMS-aligned arrangements. Based on this, the project will produce an APM Implementation Plan outlining how the Consortium can transition to voluntary alternative payment models beginning in Year 2. Potential payment structures include per-member-per-month payments for defined populations, bundled reimbursement for chronic disease management, care coordination payments tied to referral management, and value-based reimbursement supporting transportation-enabled specialty and behavioral health access. 3. Workforce Sustainability Aligned to the Care Model We will align staffing with the redesigned care and fiscal models to ensure long-term sustainability. This includes evaluating CHA and BHA roles, developing financially viable recruitment and advancement	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area	Advance to Planning

pathways, and strengthening attraction and retention strategies through employer branding and workforce planning. Aligning workforce structure with stabilized reimbursement pathways will reduce burnout risk and ensure staffing models match the realities of serving a small frontier population.



Municipality of Anchorage	Municipality of Anchorage: Connecting Crisis Care and Safety Net System to Rural Healthcare	AK	The Municipality of Anchorage (MOA) has a significant population of individuals and families with complex health and social needs including trauma histories, behavioral, physical, cognitive and functional impairments, high risk of infectious disease, and food and housing insecurity. This includes a high proportion of people from rural Alaska and Alaska Native individuals and families who come to Anchorage for health care and other services. The MOA is a healthcare hub that serves individuals from all regions. MOA’s Crisis Care and Safety Net System serves this priority population through coordinated emergency dispatch, crisis response, relentless engagement, low-barrier shelter, mobile and facility-based behavioral and physical health care, WIC nutrition support, infectious disease screening and treatment, and supportive housing. Our teams often serve the same individuals without the basic tools to coordinate care, improve outcomes, sustain services, capture data, or connect with each other, Tribal health organizations, healthcare providers, and partners. We have No shared client records No enhanced triage or assessment No bed registry for treatment or shelter No electronic referral or intake No billing or other revenue generation to sustain services No care coordination or secure communication among teams or with providers No ability to identify and track individuals in need of or receiving infectious disease screening and treatment No accurate data monitoring	MOA will procure and implement appropriate technology and test pilot approaches to integrate health and social supports to coordinate care, improve outcomes, sustain services, capture data, and connect clinical teams with local healthcare providers, rural Tribal health organizations, and other partners. Objectives: I. Enhance triage and emergency dispatch to identify alternative destinations and referrals where EMS ambulance response is not appropriate II. Establish interoperable client records for dispatch and clinical teams at MOA departments: Police (APD), Fire (AFD), and Health (AHD) -Procure and implement technology for screening and assessment tool connected to client records -Facilitate referrals, care coordination, and secure communication, between dispatch, clinical teams, physical and behavioral healthcare, and shelter, assisted living and housing providers III. Establish real time registry of treatment and shelter beds, and shared referral and intake for shelter, treatment, and housing options IV. Develop internal capacity to provide clinical oversight, documentation, and billing for reimbursable services to sustain and grow services to meet demand V. Launch and evaluate pilot projects to fill critical gaps in care for potential addition to Medicaid waiver services -Fully implement Mobile Integrated Health with dispatch of Advanced Practice Provider to calls for service and follow-up to reduce EMS utilization (AFD) -Pilot communicable disease testing and treatment care model with integrated behavioral healthcare, case management and supportive housing (AHD) -Pilot non-emergency transportation for individuals with physical mobility issues and other challenging behaviors (AFD) -Fully implement Medication-Assisted Treatment (MAT) for Opioid Use Disorder following positive screen with mobile clinic access (AHD/AFD) -Fully implement pre-arrest deflection from criminal justice system for eligible individuals to behavioral health treatment (APD) -Pilot a WIC-integrated maternal health model with embedded behavioral health support (AHD) -Increase supply of appropriate assisted living and other supportive housing to serve people with complex health and social needs (AHD) -Replicate existing pilot project of behavioral health treatment paired with microunits or other modular housing type (AHD)	\$1M-\$5M	Other	Statewide	Anchorage (Municipality)	Advance to Implementation Application

Municipality of Anchorage	Municipality of Anchorage: Alaska Rural Health Innovation Accelerator & Deployment Program	AK	Rural AK healthcare providers face persistent challenges related to workforce shortages, geographic isolation, limited resources, and disproportionate rates of chronic disease and other health conditions. At the same time, many promising health technologies and care delivery innovations are being developed across the US that could help address these challenges. However, AK lacks a structured mechanism to connect emerging healthcare companies with rural providers and move promising solutions into real world pilots or deployment within AK’s healthcare system. Without an organized pathway to identify, vet, pilot, and deploy new technologies, rural providers often struggle to evaluate emerging solutions or assume the risks of early adoption. As a result, many promising tools, such as remote monitoring tech, digital care coordination platforms, workforce support tools, and medical devices, remain underutilized in rural healthcare settings. This project seeks to address that gap by creating a structured accelerator and pilot deployment program that connects healthcare startups with AK providers to support testing and implementation of solutions aligned with AK’s priority healthcare needs. From 2020 to 2025, Health TIE (HT) was a healthcare hub that linked healthcare entrepreneurs and changemakers with health and human services organizations. This project will build on and incorporate learnings from HT – deploying and testing scalable solutions in AK and supporting their growth.	The proposed AK Rural Health Innovation Accelerator & Deployment Program (RHAD) will be a partnership between 49th State Angel Fund (49SAF), Municipality of Anchorage (MOA)’s venture capital arm, University of Alaska Center for Economic Development (UACED), and ecosVC, a scalable tech startup accelerator operator. RHAD will support early-stage companies developing solutions aligned with AK’s healthcare priorities, e.g. chronic disease management, telehealth expansion, emergency medical services modernization, and behavioral health access. Some healthtech startups in AK include: CallDr, a novel telehealth platform, and OpiAID, a wearable device for opioid misuse recovery patients. Similar to Launch Alaska, AK’s energy accelerator, RHAD will be a structured pathway linking promising healthcare startups with AK providers and pilot deployment opportunities. National Startup Recruitment RHAD will recruit AK and US startups whose solutions could improve healthcare access and outcomes in AK. Selection will be based on alignment with AK’s priority health needs and potential to deploy solutions in partnership with rural providers. Structured Commercialization Accelerator 8 startups will participate in a 3 month accelerator delivered with ecosVC, using the Lens of the Market Accelerated curriculum, which helps validate a business case, refine a business model, and develop realistic go to market strategies. The curriculum includes 4 sprints, 2 held in AK and 2 virtual, with mentorship and support between sessions. Direct Engagement with AK Healthcare Providers AK healthcare providers and organizations, e.g. rural systems, tribal health organizations, community providers, and HT's existing network of advisors will serve as mentors and advisors. They will help startups refine solutions based on AK’s healthcare realities while building early customer relationships and pilot opportunities. Deployment and Pilot Projects A pilot deployment fund will support 4 down-selected startups testing and launching solutions in AK. Providers will help identify solutions that align with their operational needs. Pilot awards will support early implementation costs in rural communities. Rural Health Innovation Investor Network RHAD will begin building an investor network interested in healthcare innovations addressing rural health challenges. Demo events and targeted outreach will connect selected startups with AK and national investors to support growth beyond initial pilots.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Municipality of Anchorage	Municipality of Anchorage: Child Care Needs Assessment and Infrastructure	AK	Access to safe, reliable, and licensed child care is a foundational component of healthy communities and a stable workforce. Across Alaska, families face significant barriers to finding affordable, high-quality child care. These challenges are particularly acute for the health care and essential workforce that supports both urban and rural communities. MOA aims to strengthen the connection between child care infrastructure and health system stability. Through a comprehensive early childhood needs assessment and the development of employer-supported child care cost-sharing models, this project will identify scalable strategies to expand licensed child care capacity and improve access for working families. Importantly, the project will generate insights and models that can inform similar efforts in rural Alaska, where child care shortages are even more severe and workforce challenges directly affect access to health care and other essential services. By strengthening child care infrastructure and exploring new partnerships between employers and early childhood providers, this project seeks to improve workforce stability, support family well-being, and contribute to healthier communities throughout Alaska. This project will focus on two complementary strategies designed to strengthen early childhood infrastructure while supporting the workforce needs of health care and related industries.	Develop a comprehensive assessment of child care supply, demand, and infrastructure needs in Anchorage and surrounding communities that influence the regional workforce, examining: • The current supply and capacity of licensed child care programs • Gaps in access for working families, including health care workers • Barriers to opening or expanding licensed child care programs • Workforce challenges within the early childhood sector • Infrastructure needs such as facilities, start-up capital, and workforce development • Opportunities for cross-sector partnerships between employers and early childhood providers The assessment will result in a strategic planning framework that identifies priority investments and scalable strategies for strengthening licensed child care capacity in the MOA and examine the ways in which child care infrastructure in regional hubs can support the recruitment and retention of professionals serving rural Alaska. Lessons learned from this process will be shared with partners working in rural communities and will help inform broader statewide conversations about child care infrastructure and workforce stability. The second component of the project will explore and pilot employer-supported child care cost-sharing models designed to expand access to licensed child care for working families. Employer-supported child care models represent an opportunity to leverage public-private partnerships while improving affordability and stability for families and providers. This work will: • Assess employer demand and workforce child care needs • Engage health care employers and other major industries in identifying potential partnership models • Design cost-sharing structures that support both family affordability and provider sustainability • Identify opportunities for collaborative pilot programs between employers and licensed child care providers These models may include shared cost arrangements, employer contributions to child care slots, or collaborative investments that support the expansion of licensed child care programs. Because health care employers play a critical role in serving both urban and rural populations, employer-supported child care partnerships have the potential to strengthen recruitment and retention of health professionals whose work supports communities across Alaska.	\$250K-\$1M	Statewide	Anchorage (Municipality)	Deferred or Not Advanced

MUSKEG Wellness	Peer Support Professional Development Project	AK	There are currently at least 40 community-based orgs and agencies utilizing Peer Supports to provide peer support, navigation, mentoring and/or advocacy in Alaska. While some (such as True North or Set Free) have had the impressive success expected from national peer support studies and have reported high staff morale, peer staff capacity, and efficiently achieved excellent client outcomes, others fall short. Many AK BH Providers experience high turnover rates in their Peer Support Teams, associated with burnout, lack of role clarity, inability to hold clear boundaries, inadequate supervision, and lack of new skills support. Additionally, agencies experience unacceptable levels of Medicaid billing losses. In this project, we will help address the drastic impacts on Alaska’s Peer Support workforce, protect Peer Staff retention, and provide our Alaskan Peer Supports with the continuing coaching and attention that they need to be safe and confident in their very demanding positions. There are now over 2,000 Peer Supports trained in Alaska, at great expense to the state. It is unknown how many are employed providing peer support and navigation services, but only 200 have actually received AK certification. This project is designed to both provide quality control and protect the State’s investment in this invaluable behavioral health workforce, as well as expand the number of qualified Peers trained up and certified in the state, by 100 each year.	Providing effective Peer Support can be challenging as we move beyond current limiting beliefs and support others through often very difficult or sad circumstances. By partnering with MUSKEG to help keep their staff skills and morale high, our 6 partnering agencies hope to find that productivity increases, thereby achieving more positive outcomes for clients, stability for the agencies, and cost savings for Alaska. Maximum effectiveness and efficiency can be achieved by: 1) Providing regular, culturally appropriate, professional training & coaching to new Peer Support Professionals. 2) Supporting supervisors with expert consultation and with best practice policies that combine flexibility with accountability. 3) Electronic records and documentation practice with Pear Suites (dialed in for Alaska’s medicaid systems with oversight from an in-state billing and compliance expert). 4) Providing a permanent, personal professional development records portal for each student. This is a multi-agency project designed in Alaska for our Behavioral Health Providers’ Peer Support Teams. We will provide at each site: a) An in-person State-approved training for both Peer Support Associates (38 hours) and EITHER Traditional Peer Support Associates (an additional 8 hours) OR a YES! Youth Empowerment & Support Workshop for Youth Mentors b) The 12 hrs of Extra Required Classes for Alaska PS Certification c) Personalized assistance to help each graduate go through the State certification process, to ensure success and track outcomes. d) Access to 38 Team Coaching sessions with our Peer Support Coach e) Key Authentic Cultural trainings for Alaskan Indigenous Peer Supports f) Private student portal into an innovative professional development platform, specially created for us by Opus EHR g) 8 hrs of professional consults for Supervisors of Peers h) 5 hrs of training in best-practice policies for agencies hiring Peer Support teams i) Six months of access to Medicaid compliance, billing & claims training with the innovative team at Pear Suites. j) Exclusive employment opportunities, statewide. Our training teams are a highly experienced, diverse mix of experts. We will work to expand the Alaska PS workforce by 100 yearly, improving retention rates, so that we have a larger pool of Peer Supports, Traditional Peer Supports, and Youth Mentors working statewide, accountable to national best practices and Alaska’s Core Competencies for Peer Workers.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

MY House	Jeffs Path Exspansion	AK	MY House intends to increase capacity for Youth face unnecessary risk factors when paired with older adults in treatment cohorts and are often negatively influenced, making their recovery that much more difficult. We often see young adults in groups and residential living situations with those older individuals who have a much longer and intense use history which creates an unhealthy social connection for young adults early in recovery. It is also safe to say that youth in 12-step meetings across Alaska are building potentially unhealthy social connections due to mentorships being developed that lead to negative consequences for the young adult. Examples of this are risky sexual relationships and an increase of level of use as well as more dangerous drugs being used. This population will benefit from holistic care to include Mental health service that address, the whole person, focusing on SAMHSA eight dimensions of wellness. • Emotional: Coping effectively with life and creating satisfying relationships. • Environmental: Living in a clean and safe environment. • Financial: Managing financial resources effectively. • Intellectual: Engaging in creative and stimulating activities. • Occupational: Finding personal satisfaction and enrichment in one’s work. • Physical: Maintaining a healthy body and seeking medical care when needed. • Social: Developing a sense of connection and belonging with others. • Spiritual: Expanding a sense of purpose and meaning in life.	To address the shortage of residential behavioral health services for young adults ages 18–25 MY House will expand our ASAM 3.1 to include 3.5 residential programs from 8 beds to 16 beds. This expansion combines targeted facility renovations, workforce development, evidence-based clinical programming, care coordination, and quality improvement to increase access, strengthen care, and ensure long-term sustainability. Facility Renovation and Expansion: We will renovate our existing residential home to safely accommodate 16 young adults while maintaining a safe therapeutic, structured, and youth-centered environment. Renovations include reconfiguring bedrooms, expanding shared living and treatment spaces, and upgrading safety features. These improvements support a recovery-oriented environment where young adults feel secure, engaged, and supported in their treatment, including spaces for group therapy, individual counseling, and life-skills development. Workforce Development and Training: A well-trained and stable workforce is essential to high-quality care. We will recruit, train, and retain clinicians and residential staff, emphasizing trauma-informed, evidence-based, and culturally responsive practices. Staff will receive ongoing clinical supervision and professional development, ensuring fidelity to ASAM guidelines and sustainable staffing to meet the increased capacity. Clinical Programming and Individualized Care: Residents will receive individualized treatment plans that integrate ASAM 3.1 and 3.5 levels of care to match clinical need. Programming includes structured daily schedules, evidence-based therapeutic interventions, skill-building, and psychoeducation. This ensures that young adults with varying levels of need receive timely, appropriate, and intensive support, reducing risks of crisis, justice system involvement, and long-term instability. Care Coordination and Rural Access: We will coordinate with community providers, tribal health organizations, and telehealth resources to ensure seamless admissions, discharge planning, and post-residential follow-up. Expanding in-state capacity allows young adults to remain connected to family, community, and cultural supports while receiving care, reducing the need for out-of-state placement and strengthening continuity of care for rural communities. .	\$250K-\$1M	Statewide	Matanuska-Susitna Borough	Advance to Implementation Application

MY House	Redemption Services	AK	Geographic isolation, limited access to behavioral health and social services, systemic inequities, and trafficking networks along transportation routes create a high-risk environment for youth exploitation. Traffickers increasingly target vulnerable youth through social media, online games, and highways, often recruiting youth within 72 hours of displacement. Many victims are homeless, involved with the child welfare or juvenile justice systems, or have experienced family violence or substance use challenges, placing them at heightened risk of sex or labor trafficking. The opportunity lies in expanding community-based, evidence-informed residential and behavioral health services that are trauma-informed and culturally responsive. By increasing the capacity of ASAM 3.1 and 3.5 programs and providing targeted, survivor-centered interventions, this project will improve access to care, stabilize youth, and reduce their vulnerability to exploitation. Workforce training for rural providers, schools, law enforcement, and tribal organizations will strengthen early identification, response, and prevention of trafficking, while formal referral pathways will ensure youth receive timely support across systems.	The MY House Redemption Program addresses the urgent risk of human trafficking among youth and young adults in Alaska’s rural Mat-Su Valley through a trauma-informed, survivor-centered approach. We combine residential and outpatient care, behavioral health services, workforce development, and cross-system collaboration to reduce vulnerability, stabilize youth, and build lasting capacity in the community. Youth in rural areas often face long travel distances, isolation, and limited local resources, which can delay access to care and increase risk of exploitation, homelessness, or unsafe living situations. By expanding residential and outpatient services at the Carson Cottle Center (CCC), youth ages 10–26 can access intensive, trauma-informed support without leaving their families or communities. Residential and Outpatient Care: Our ASAM 3.1 and 3.5 programs provide structured, evidence-based care in a safe, supportive environment. Youth receive individualized treatment plans, trauma-focused therapy, life skills development, and culturally responsive interventions. Outpatient services allow youth to continue care after discharge or receive intensive therapy while living at home, ensuring continuity and reducing gaps in support. Centralizing these services locally gives youth timely access to the level of care they need, when they need it, without traveling long distances. Workforce Development: CCC staff are trained in human trafficking identification, survivor-centered support, and evidence-based behavioral health care. Training extends to partner organizations—including schools, law enforcement, tribal entities, and domestic violence/sexual assault programs—to strengthen early recognition, referral, and follow-up, building rural capacity and ensuring consistent care. Cross-System Collaboration and Referral Pathways: Warm referral pathways link law enforcement, child welfare, tribal organizations, schools, shelters, and outpatient providers. These partnerships create a protective network in regions where trafficking services are scarce, ensuring youth are identified early, connected quickly to care, and supported through both immediate safety and longer-term behavioral health needs. By integrating residential and outpatient services at the CCC with workforce development MY House improves access to safe, trauma-informed, care for youth in Alaska, strengthens networks, and creates sustainable, long-term impact for vulnerable youth in the Mat-Su Valley.	\$250K-\$1M	Statewide	Matanuska-Susitna Borough	Advance to Implementation Application

MY House	Compensation Scale	AK	MY House is currently operating without a comprehensive, agency-wide pay scale, which creates significant challenges in maintaining equitable, consistent, and competitive hiring practices. Because multiple hiring managers are responsible for bringing new staff into different programs, salary decisions can vary widely from one department to another. Without a standardized framework, pay offers are sometimes determined by immediate staffing needs, individual negotiation skills, or budget pressures rather than a clear, equitable compensation structure. This inconsistency increases the risk of unintentional wage disparities between employees who hold similar positions or carry equivalent responsibilities, which can negatively impact morale, trust, and staff cohesion. A pay scale also creates a clearer path for professional growth. When MY House can publicly list competitive, well-structured wage ranges, it strengthens its ability to attract qualified candidates in behavioral health, case management, peer support, administrative roles, and program operations. This is particularly important because MY House does not currently offer fringe benefits, such as health insurance or retirement contributions. In the absence of those benefits, a well-designed pay scale becomes one of the most powerful tools available to remain competitive and appealing to prospective staff.	To address workforce instability and ensure equitable compensation across all MY House programs, we propose hiring an experienced human-resources compensation contractor to design and implement a comprehensive agency-wide pay scale. The contractor will conduct a full compensation analysis, including reviewing current salaries, comparing regional and statewide benchmarks, assessing job responsibilities, and identifying inequities created by having multiple hiring managers without a unified structure. They will develop standardized wage ranges for every position, create a clear advancement ladder, and produce guidance for future salary adjustments and promotions based on experience, performance, and training. This will provide MY House with a consistent, transparent, and competitive compensation system especially critical given our rural location and the absence of fringe benefits. Implementing this pay scale will strengthen recruitment by offering predictable salary ranges, and it will improve retention by giving staff a clear understanding of their growth pathways. With the contractor’s support, MY House will establish a sustainable compensation framework that supports workforce stability, enhances internal equity, and allows the organization to remain competitive within the rural health and social-service labor market. In addition to our current workforce this pay scall will be scaled for My House's new Carson Cottle Center to include night and weekend differentials.	Under \$50,000	Statewide	Matanuska-Susitna Borough	Deferred or Not Advanced

MY House	Leadership Training (Middle Management)	AK	MY House has an incredible opportunity to build leadership from within. We employ a large number of staff who are in recovery, as well as several individuals who have successfully completed our programs and now serve as valued employees. This lived experience is one of our greatest strengths. In addition, our Youth Board includes three MY House graduates, creating another meaningful pathway for developing leadership capacity internally. As our organization grows, many dedicated and experienced team members are eager to step into supervisory and management roles that would greatly benefit from formal middle management training. By investing in structured leadership development, MY House can intentionally cultivate the skills needed to guide teams effectively through expansion. Research consistently shows that when managers receive proper training, organizations perform more cohesively and efficiently. Strong middle managers foster communication, accountability, and collaboration, ensuring that the agency moves forward as one unified team rather than operating in silos. This project builds on the strengths already present within MY House, creating clear leadership pathways, strengthening team alignment, and positioning the organization for sustainable growth and high-quality service delivery.	MY House Middle Management Training Approach MY House proposes to contract with an experienced leadership development consultant or group to design and implement a structured middle management training program. The contractor will bring specialized expertise, provide neutral and objective facilitation, reduce the burden on executive leadership, create professional and structured training, build systems rather than informal practices, and help position MY House for long-term sustainability. While the exact steps will be finalized collaboratively with the contractor, the proposed approach includes four phases. Phase 1: Assessment & Planning (1–2 months) The contractor will assess organizational leadership readiness, identify skill gaps, and evaluate management and supervisory capacity. This phase will ensure that the training aligns with MY House’s goals and addresses the full range of management and supervisory needs. Phase 2: Core Management Training (3–6 months) Schedules sessions will provide training in supervisory skills, including accountability, communication, conflict resolution, trauma-informed leadership, managing staff in recovery, performance management, preventing burnout, team cohesion, and change management during organizational growth. Phase 3: Coaching & Mentorship (6–12 months) Emerging supervisors will receive 1X1 coaching to address challenges and apply leadership skills to day-to-day operations. Support will also be provided for Youth Board leadership development to strengthen pathways for young leaders. Phase 4: Integration of Internal Strengths (6–12 months) The contractor will help build a leadership model that leverages employees in recovery, program graduates, and Youth Board members. This will include developing peer leadership pathways, creating structured advancement tracks, training managers to supervise staff with shared lived experience, and formalizing internal promotion pipelines, further strengthening sustainability and reinforcing MY House’s mission-driven culture. Measurable Outcomes (12–18 months) The impact of the program will be tracked using metrics such as staff retention, supervisory turnover, staff satisfaction, communication effectiveness, internal promotions, and improved service capacity utilization. This data will demonstrate how structured middle management training directly supports organizational growth, team cohesion, and high-quality behavioral health services for rural communities.	Under \$50,000	Statewide	Matanuska-Susitna Borough	Deferred or Not Advanced

MY House	Peer Support Expansion	AK	MY House has an opportunity to partner with the hospital to strengthen staff skills while simultaneously supporting clients in workforce development. Many individuals with behavioral health needs face significant barriers to maintaining employment. Without stable income and workplace support, they are at increased risk of returning to homelessness, engaging in illegal activity for survival, or becoming vulnerable to exploitation and trafficking. Sustainable employment is not just an economic issue; it is a critical component of recovery and long-term stability. Through an employment-focused peer support model, clients can receive real-time feedback, coaching, and structured skill development within an actual work environment. This hands-on experience allows them to build practical job skills, improve workplace behaviors, and develop confidence in a supportive and supervised setting. Immediate feedback and guided accountability help reinforce positive habits that can be transferred to long-term employment opportunities, increasing job retention and overall stability. By partnering with the hospital, MY House will enhance skills that lead to certification and a stronger workforce. In addition, this collaboration can expand opportunities for peer work therapy sessions, creating employment pathways for clients who have progressed in their recovery and are prepared to move to full time employment.	We are proposing two coordinated but independent initiatives: A Hospital Workforce Development Partnership and developing a peer work therapy work force. While both projects support employment stability for individuals with behavioral health needs, each operates within a different setting and structure. Project 1: Hospital Workforce Development Partnership This initiative establishes a formal partnership with the hospital to strengthen staff capacity while creating supported employment pathways for individuals in recovery. The hospital-based project will create structured, supervised employment placements within hospital departments. Once placed, participants will: Work in designated peer rolls within the hospital as well as the MY House Carson Cottle Center. Receive real-time supervision and performance feedback Participate in structured training session that provide needed skills to work with individuals beginning a recovery journey Work toward industry-recognized certifications relevant to their assigned roles The hospital as well as MY House benefits from an expanded workforce pipeline and enhanced staff skill development, while participants gain transferable skills, work history, certifications, and increased job retention capacity. Project 2: Create a peer workforce that focuses on providing work therapy to individuals in recovery. The MY House Work Therapy initiative is a therapeutic employment program operating within our organization. This program integrates work-based learning with behavioral health support in a controlled, recovery-oriented environment. The Work Therapy Department will: Provide structured, in-house job assignments Integrate therapeutic goals into daily work activities Provide immediate coaching and behavioral feedback Prepare participants for transition into external employment opportunities Unlike the hospital-based placements, this program serves as a therapeutic steppingstone for individuals who may not yet be ready for competitive employment. It allows clients to practice consistency, accountability, teamwork, and task completion in a supportive setting. Participants who demonstrate readiness may transition into: Hospital partnership roles, Community-based employment, Certified peer support positions	\$250K-\$1M	Statewide	Matanuska-Susitna Borough	Deferred or Not Advanced

My House	Project to Coordinate Youth Behavioral Health Service Continuum	AK	We would like to coordinate services to support the youth continuum of care in the Mat Su - which actually serves the entire State of Alaska. We have started a group, called Jacobs Ladder, to identify and fill gaps for youth services in our area and are working to fill the gaps to create a smooth continuum to support youth coming from rural areas. MY House is leading the "Jacobs Ladder Project" and would like support for planning a program that offers transportation, education and shared staff to help our programs and our partner programs have warm handoffs to step-down services and continuing care for youth age 14-25. We have a great partnership with Mat Su Regional Medical Center, with a Behavioral Health expansion pending that will increase capacity and expand services to Alaskan youth from rural areas. We would like to be coordinated and prepared to support youth through a strong continuum of care as they exit hospital programs and move through recovery. Without partnerships and a solid continuum, the risks of relapse, arrest, incarceration and for many, homelessness, is inevitable. We would like to be prepared for the Hospital to have a key role, working together to coordinate a robust continuum that supports youth through to healthy adulthood with sobriety, managed behavioral health and job skills that help them to live here in the Valley or return to remote areas and thrive.	Our concept is to work with community providers to provide transportation from a youth/young adult hospital program discharge to safe housing and continued care for behavioral health and substance use disorder treatment. We would like to offer peer support and navigation/outreach services that connect with hospital staff to pick up patients at discharge to transport them to their next level of care. This may be a lower-level residential program, outpatient services, sober housing or supported housing. The goal being to insure that patients are not discharged without a treatment plan for continuing care and support, safe housing and wrap around services. We would also build a partnership for an education program that MSRMC and Behavioral Health staff would host that could offer training for certificates and tech positions that would elevate entry level staff to better wages, greater capacity and provide expanded workforce for the Region. We have consistent shortages in behavioral health workers at the levels of care we are building and would greatly benefit from a training program partnership where staff from all partner organizations can receive benefits for hours worked/internships, college credits and CDC or Behavioral Health training certificates as part of their work in our Continuum of Care. We would benefit from some technical assistance to develop this program out, but it offers entry level people in long term recovery pathways to better pay and elevated job status as a function of joining one of the service providers. It also lets partners support training programs through a variety of pathways, with Hospital-based accreditation backing the learning journey. This is an exciting way to empower staff and fill gaps in our Valley employment and labor sector. Lastly, we want to have a partnership with MSRMC that would allow them to share professional staff to keep our programs operating at top levels as we build our workforce here in the Valley. Mat Su Regional leads the State in many patient satisfaction areas and having qualified staff is a cornerstone of this achievement. Making some of these staff available to programs just starting up, or who experience a lack of clinical supervision, medication management staff and medical oversight for residential programs is a way for the Hospital to support the step-down services, create a community safety net and remain connected to partners on a "care" platform that serves patients and community very well.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

My House	Upstream Prevention Through Digital Media	AK	MY House is uniquely positioned to be the leader in Alaska for upstream video prevention work. We have access to a large number of young people in recovery with lived experience in homelessness, addiction, domestic violence, trauma and other related experiences. These youth will be essential for connecting with our primary target audience of at-risk youth and young adults from across rural Alaska. MY House also has a fully functional recording studio that includes professional grade cameras, lighting, microphones and editing equipment and has staff well trained on how to produce all manner of professional level content. Because of this, the cost of producing prevention materials is significantly lessened because we sidestep the cost of equipment rental, studio time or outside contracted video and audio editing staff. The funding in this request would be used to distribute the prevention materials that MY House has the staff and equipment to create. MY House also offers a unique job training opportunity for youth to engage in production, recording, voice over and editing in a working recording studio. We have several years of training interns and have placed them in jobs both in-house and across the community. This job training effort is popular among our clients and clients of our partner organizations like True North Recovery and the Mat Su School District. These interns would be helping produce the prevention and recovery themed content that is going across Alaska.	Our approach is utilizing our funding in the first year of the Rural Health Transformation Initiative to immediately and effectively fill a critical gap in the previously mentioned prevention messaging across the State of Alaska. MY House’s communications team will produce the following content, designed to provide upstream messaging to youth and young adults. Themes will be focused around recovery, prevention, treatment, suicide prevention, etc. Four short films with former clients (one a quarter) Limited Run “Prevention Podcast” with Sandy Snodgrass/other community partners “Wellness Wednesday’s” weekly shorts (similar to current program – Motivational Monday” 30 sec prevention advertisements distributed across social media, streaming services, music apps, YouTube and local television/radio (updated once a quarter) 15 sec prevention advertisements distributed across social media, streaming services, music apps, YouTube and local television/radio (updated once a quarter) Print ads in local newspapers (Updated once a quarter) This is the communication prevention base that we want to build on in the second year. Additionally, we are requesting funding for planning a physical expansion of our current communication department capacity to continue to produce and distribute recovery and prevention materials across the State, utilizing treatment and recovery partnerships for bigger and more in-depth projects. We need expanded space to increase our capacity to serve clients, staff and community. We have plans to continue to host panel discussions, Youth Mental and Behavioral Health Task Force meetings, empowerment and life skills classes and community engagement initiatives and due to the large number of attendees we have outgrown the current space. This would include architect, engineering, design and building permit costs with the intention of having additional renovation funding in year two.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

My3Tech, Inc	Alaska Healthy Communities Population Based Digital Care and Rural Health Insights Program	SD	Rural Alaska has a significant opportunity to improve health outcomes by strengthening chronic disease management, care coordination, and community-based support for residents who face barriers to consistent care. Many rural and frontier communities experience fragmented care, provider shortages, limited visibility into patient needs between visits, and limited tools to support chronic disease self-management. These challenges can lead to delayed interventions, worsening outcomes, avoidable hospitalizations, and additional strain on limited rural healthcare capacity. This project addresses that opportunity by deploying a Healthy Communities digital care model that combines mobile patient engagement tools, care and case management workflows, and interoperable data and analytics. The solution will help rural providers, care teams, and community partners identify high-risk individuals, monitor health status, coordinate services, and support self-management. The opportunity is to create a scalable, technology-enabled approach that helps rural communities move from reactive, episodic care to more proactive, coordinated, and community-centered health management. By combining patient-facing tools with provider workflows and analytics, the project will improve continuity of care, strengthen coordination, and support healthier rural communities over time.	Our proposed approach is to implement a Healthy Communities population-based digital care model that combines mobile patient engagement, structured care and case management workflows, and interoperable data and analytics to improve chronic disease management, care coordination, and community-based support in rural and frontier Alaska. The project is designed to help providers, care teams, and community partners move from fragmented, reactive care to a more proactive, data-informed model. In the first phase, we will work with rural providers, Tribal organizations, and community partners to identify pilot communities, priority populations, and care coordination needs. The solution will be configured to support patient engagement, care planning, outreach, follow-up, and reporting workflows while establishing the core data and operational requirements needed for implementation and future scale. In the second phase, providers and care teams will use mobile and patient-facing tools to support individuals between visits. Patients will access education, track symptoms, receive reminders, and communicate with care teams. Providers and care coordinators will use dashboards, alerts, and structured workflows to identify high-risk individuals, monitor follow-up needs, and intervene earlier. The project will also establish an interoperable analytics layer to support rural health insights, population health monitoring, and reporting, with pilot deployments validating the model for broader expansion.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

My3Tech, Inc	Rural Care Access and Mobile Health Enablement Program for Members, Providers, and Families	SD	Alaska’s rural and frontier communities face ongoing barriers to timely, coordinated healthcare due to geographic isolation, transportation limitations, provider shortages, and limited local healthcare infrastructure. Many residents must travel long distances for routine care, specialty services, and chronic disease management, often resulting in delayed treatment and increased health risks. These challenges are especially severe for older adults, individuals with chronic conditions, and those who need continuous monitoring and care coordination. This project will address those gaps by deploying mobile-enabled digital health tools, telehealth services, and coordinated care management tailored for rural settings. Through mobile applications, remote patient monitoring, and secure virtual care connections, providers can extend services beyond traditional clinical sites and reach patients in remote communities more effectively. The initiative will allow care teams to conduct virtual visits, monitor patient health remotely, coordinate services across providers, and respond earlier when risks are identified. These capabilities will reduce delays in care, improve chronic disease management, and strengthen continuity of care. The overall goal is to create a scalable, technology-enabled care access model that expands healthcare availability, supports rural providers, and delivers more proactive, connected care across Alaska’s rural and frontier communities.	The proposed approach is to implement a mobile-first, technology-enabled care access model that expands healthcare delivery to rural and frontier communities through telehealth services, remote patient monitoring, and coordinated care management tools. The initiative will leverage secure cloud-based digital health platforms designed to connect patients, providers, and care teams across Alaska’s geographically dispersed communities. In the first phase, the project will establish partnerships with participating rural healthcare providers, tribal health organizations, and community partners to identify pilot communities and priority populations. During this phase, the technology platform will be configured to support mobile patient engagement, telehealth consultations, and remote monitoring workflows aligned with existing provider and care coordination processes. The second phase will focus on deploying mobile health applications and telehealth capabilities that allow patients to access virtual visits, communicate with care teams, receive health education, and monitor chronic conditions from their homes or community locations. Remote patient monitoring devices and connected health tools will enable healthcare providers to track key health indicators and intervene earlier when health risks are identified. Care teams will use integrated care coordination dashboards and workflow tools to manage patient outreach, follow-up care, and coordination between providers. These tools will support proactive management of chronic conditions, care transitions, and ongoing monitoring of high-risk individuals. Pilot deployments will initially focus on selected rural communities to validate operational workflows, technology integration, and patient engagement approaches. Based on pilot outcomes, the program can expand to additional regions through a hub-and-spoke model that connects rural providers, community organizations, and care teams through shared digital infrastructure. This phased approach ensures rapid implementation, measurable outcomes during the first year, and a scalable model that can support long-term improvements in healthcare access for rural Alaskan populations.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

My3Tech, Inc	Spark Digital Health Innovation and Remote Monitoring Program	SD	Rural and frontier communities across Alaska can improve health care delivery through digital health tools, remote patient monitoring, and interoperable clinical data exchange. Geographic isolation, transportation barriers, provider shortages, and limited specialty access often make timely follow-up, ongoing monitoring, and consistent communication difficult, especially for people with chronic conditions or complex care needs. This project will deploy a Spark Technology & Innovation model that combines mobile health apps, patient-facing tools, remote monitoring workflows, and integration with HIE and other clinical systems. These capabilities will help rural residents track symptoms, stay connected with care teams, receive timely support, and remain engaged in care between visits. Providers will gain better visibility into patient risk, status, and follow-up needs, enabling earlier intervention and better care coordination. Interoperability is central to the project’s value. By connecting EHR, claims, pharmacy, HIE, and related systems, the solution will reduce data silos, support more complete longitudinal patient records, and enable faster, better-informed decisions across care settings. The result is a scalable, sustainable model that improves access, strengthens continuity of care, and supports technology-enabled health care delivery across Alaska’s remote and frontier communities.	Our approach is to implement a Spark Technology & Innovation model that combines consumer-facing digital health tools, remote patient monitoring, patient communication capabilities, and interoperable clinical and Population Health data exchange to improve healthcare delivery in rural and frontier Alaska. The project will follow a phased, pilot-first approach so participating providers and communities can validate workflows, demonstrate early outcomes, and scale successful practices over time. This aligns with My3Tech’s eHealth, care management, and integration capabilities, supporting mobile engagement, CCM, RPM, TCM, and real-time connectivity across clinical and administrative systems. In the first phase, we will work with participating rural providers, Tribal organizations, community providers, and partners to identify pilot communities, priority populations, and the most suitable digital health use cases. We will configure the solution to support mobile patient engagement, symptom tracking, alerts, communication with care teams, and remote monitoring workflows, while defining the technical and operational requirements for integration with existing systems such as EHRs, HIE connections, and other relevant clinical or program data sources. In the second phase, participating organizations will launch pilot deployments of mobile apps, patient-facing tools, and remote monitoring-enabled workflows that help patients stay connected with care teams between visits and enable more timely intervention when risks emerge. Providers and care coordinators will use dashboards, alerts, and integrated workflows to monitor patient status, respond to changes, and improve continuity of care. This model is designed to reduce delays in follow-up, improve engagement, and strengthen care quality for people in remote communities. The project will also establish an interoperable innovation layer connecting digital tools with HIE and other clinical data systems to support real-time monitoring, provider and patient alerts, and more coordinated care delivery. Initial pilots in selected rural communities will validate workflow effectiveness, patient adoption, and reporting approaches. Based on pilot results, the project can expand through a scalable hub-and-spoke model to additional communities and provider partners across Alaska. This phased approach supports Alaska’s RHTP priorities around technology innovation, rural impact, measurable outcomes, and sustainable transformation.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Nakaani Technologies, LLC	Digital Health Innovation to Strengthen Rural Access, Workforce, and Care Coordination	AK	Rural and frontier communities in rural Alaska face significant barriers to timely, coordinated health care. Geographic isolation across dispersed island communities often requires costly, weather-dependent travel for specialty care, diagnostics, and follow-up. Limited workforce capacity, high provider turnover, and reliance on Community Health Aides/Practitioners can contribute to care delays, fragmented referrals, and challenges managing chronic conditions, behavioral health needs, and prevention. Health systems serving the region, although robust, are often complex or built as a "one-size-fits-all" model, which often overlooks the need to meet growing administrative and reporting demands while operating with constrained infrastructure, uneven broadband reliability in some locations, and aging health IT systems that may not fully support coordinated, team-based care. These factors can contribute to avoidable medevac use, gaps in continuity when patients travel outside their home community, and difficulty tracking outcomes across providers. This project addresses the opportunity to deploy culturally aligned, entry-level, tribal-ready digital health tools to strengthen care coordination, improve referral visibility, support workforce efficiency, and enable proactive population health management—helping improve access, quality, and long-term sustainability of rural health delivery across rural Alaska.	Nakaani would like to pilot ALEX across one or more independent or tribal health organizations. ALEX is a healthtech platform designed to support all areas of operation of healthcare provider type, with networked care as a native principle of the platform. Currently covered healthcare providers include hospitals, clinics, pharmacies, labs, and imaging centers. For healthcare providers, the platform covers clinical care including telemedicine, billing, accounting, inventory management, procurement, lab order tracking, imaging order tracking, pharmacy management, queue management, patient relationship management connected to clinical care operations, and enterprise configuration/data governance. For patients, the platform’s free patient app provides access to patient health data, appointment booking, and telemedicine with providers using ALEX. Additionally, ALEX is a continuously improving platform that is designed to be flexible enough to keep up with modern technology. Soon, ALEX will add a fully comprehensive HR module to support workforce payroll, staff learning and compliance, attendance, and benefits management. ALEX also plans to add a claims management module that reduces claims error and improves claims adjudication to shorten revenue cycle. Today, these functionalities are spread across multiple legacy systems, which limits the contextual data analysis that organizations can use to generate insights that improve care operations. ALEX is also significantly cheaper than legacy systems since it is priced on a pay per use model, which is more aligned with the principles of value based care. ALEX does not charge for maintenance or any upgrades that would benefit all healthcare providers on its platform. This prevents vendor lock-in and ensures the team behind ALEX is bought in to continuously support healthcare. Altogether, ALEX would save healthcare organizations 30-40% in TCO of health IT systems over 5 years, which is capital that can be used to reinvest into delivering better care. ALEX is currently in use by a psychiatric hospital in India and over a dozen aesthetic clinics in Thailand. However, since ALEX is new technology to US healthcare, it is difficult to immediately onboard all clinics in a tribal health organization’s network. Currently, ALEX has planned to add claims processing electronically to IHS/CMS for Q4/Q1 2026/27. Furthermore, prior to a wider rollout, ALEX must validate its workflows to ensure buy in from all stakeholders.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Northwest Arctic Borough; Yakutat (City and Borough)	Deferred or Not Advanced

NAMI Alaska Incorporated	Hands Across Alaska - Rural Alaska Mental Health Outreach and Wellness Initiative	AK	Alaska faces persistent behavioral health disparities driven by geography, workforce shortages, transportation barriers, and limited service availability in rural and remote communities. Many Alaskans—particularly those living in small, isolated communities and Alaska Native communities—lack access to timely mental health education, early intervention supports, and peer-driven resources. Financial barriers and limited local services often leave individuals and families with few options until challenges escalate. As a result, many Alaskans encounter the behavioral health system only during periods of crisis, placing increased strain on emergency services, clinical providers, and public safety systems. Expanding access to community-based mental health education and peer support provides an important prevention-focused opportunity to address these challenges. Evidence-based education and peer-led support programs equip individuals and families with knowledge, coping skills, and supportive networks that help people recognize mental health concerns earlier, support loved ones, and navigate available resources. Providing accessible mental health wellness resources and peer-led support groups offers an upstream lifeline for Alaskans across the state—particularly in rural and underserved communities—helping individuals and families manage challenges before they escalate and strengthening Alaska’s community-based behavioral health continuum.	This project will strengthen statewide coordination and outreach to expand access to preventive, community-based mental health supports, with particular focus on rural and Alaska Native communities. By enhancing education, peer support, and connection, the initiative seeks to reduce reliance on crisis-driven services and advance recovery-oriented systems of care. Through partnerships with communities, behavioral health organizations, providers, and tribal governments, the project will ensure that more Alaskans—regardless of geography or circumstance—receive timely resources, guidance, and support. This approach not only strengthens the state’s behavioral health continuum but also empowers individuals, families, and communities to take an active role in promoting mental well-being and resilience. This also includes promotion of evidence-based mental health education, including family engagement practices, in rural school settings and/or youth-based organizations utilizing our NAMI educational programs addressing youth mental health.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

NAMI Fairbanks	Strengthening Community with Mental Health Advocacy	AK	As a local behavioral health and social service nonprofit deeply rooted in Interior Alaska, we are committed to advancing Alaska led strategies that build in state capacity, expand access to community-based behavioral health services, and ensure that infrastructure and value remain in Alaska. Our work naturally aligns with the State’s priorities for strengthening rural health systems, and the proposed initiatives of this grant directly support our mission.	Our peer support groups, crisis navigation services, and community trainings are already among the few behavioral health support options easily accessible to rural Interior residents. NAMI Fairbanks’ public education, stigma reduction initiatives, and early-intervention programs strengthen community resilience and reduce the likelihood of behavioral health crises. By expanding preventative mental health programming in schools, Tribal communities, and rural hubs, we will help build a proactive culture of well being across the region.	\$50,000-\$250,000	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced
NAMI Juneau	Juneau place-based crisis stabilization feasibility study	AK	The State of Alaska, communities and providers statewide have invested many resources to learn from, adapt and implement the Crisis Now framework into local settings. The Juneau Crisis Now Workgroup eagerly anticipated local implementation of all three essential Crisis Now elements into their community. Juneau residents in a behavioral health crisis can access two out of three essential components: ‘Someone to Contact’ and ‘Someone to Respond’. The Juneau community sees a remaining need for access to place-based behavioral health crisis care (‘A Safe Place for Help’) outside of the hospital setting. The Juneau Crisis Now Workgroup believe the community has the necessary resources to implement a place-based crisis stabilization program for adults, and possibly youth. The primary barrier to developing place-based crisis stabilization has been the lack of an operator to access and maximize readily available community resources to develop a program. The Juneau Crisis Now Workgroup, with lead applicant support from NAMI Juneau, desire to conduct a feasibility study to explore potential place-based stabilization programs in Juneau. The study would provide updated and realistic information on the needs, opportunities and fiscal impacts of program operations so the community understands what is feasible and realistic for Juneau. The feasibility study can then be used by the Workgroup and other community partners to have more informed, focused conversations with potential operators.	NAMI Juneau will serve as fiscal agent on behalf of the Juneau Crisis Now Workgroup for any fund awards and plans to contract with Agnew::Beck Consulting for their experience with place-based crisis stabilization program feasibility studies and the Juneau community. Phase 1-Market Research: The market research will include 1)Up to 20 interviews with community partners, including: Tribal and non-Tribal behavioral health, housing and homelessness service providers, Bartlett Regional Hospital ED and MHU staff, peer support and behavioral health advocates, first responders and City and Borough of Juneau staff. 2)Data collection and analysis, including but not limited to: First responder data, Bartlett Regional Hospital ED and MHU data, community behavioral health provider utilization data, Alaska’s Hospital Discharge Database and healthcare workforce reports. Findings will be summarized in a written memo and PowerPoint presentation for review with the Juneau Crisis Now Workgroup. Findings will be mapped to SAMHSA’s continuum of place-based crisis care models to identify areas of alignment between community gaps and possible care models. Juneau Crisis Now Workgroup will guide selection of up to three place-based crisis stabilization concepts for further analysis. Phase 2-Financial, Technical and Operational Feasibility: Conceptual staffing plans and billable revenue streams will be developed for each selected concept. The financial feasibility study will develop a three-year operating pro forma to identify the most likely financially viable model. Technical feasibility will examine whether the model is defined in licensing or regulation and with existing or potential Medicaid-billable services. Operational feasibility will review conceptual staffing models and proposed operating hours to examine alignment with workforce capacity and community need. The Juneau Crisis Now Workgroup and other key partners will provide feedback on assumptions included in the study throughout the process. Phase 1 & 2 will findings be summarized in a publicly available written report. Phase 3-Concept Selection and Next Steps: Within one year from project start the Juneau Crisis Now Workgroup will review feasibility study findings and select the most impactful, sustainable concept for the community. This phase may include creation and presentation of materials to different audiences and identify next steps for project implementation, including proposal development for future funds.	\$50,000-\$250,000	Single Community	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

NAMI Juneau	OPEN: Outpatient Planning and Exploration at NAMI Juneau	AK	Patients seeking mental health treatment in Alaska face significant barriers to receiving outpatient treatment, including long waitlists and lack of Medicaid-accepting private practice therapists. Alaska's 2023 Scorecard from the Department of Health acknowledges that barriers to accessing mental health and substance use treatment include a lack of available treatment options, lack of insurance or funds to pay for services, and long waitlists. The 2024 Milliman report commissioned by Alaska's Division of Behavioral Health notes that Alaska faces increased service demand, workforce shortages, and care delivery barriers. These challenges are particularly complicated by the state's size, geography, and diverse demographics. NAMI Juneau's Juneau Mental Health directory lists private practice mental health providers in Juneau and shows that none accept Medicaid. Insurance options include Aetna, Premera/BCBS, Cigna, Optum, Tricare, EBMS, ComPsych, and self-pay, but not Medicaid. Juneau's community mental health organizations that do accept Medicaid are the primary access points for Medicaid recipients, creating concentrated demand on a small number of providers and contributing to the waitlist problem. NAMI Juneau proposes conducting a study that would assess the feasibility of including outpatient treatment as a NAMI Juneau offering, reducing wait times and increasing access to quality care.	NAMI Juneau proposes to address the shortage of Medicaid-accepting outpatient mental health providers in Juneau by conducting a feasibility study to assess the viability of adding outpatient therapy services as a core NAMI Juneau program offering. This planning phase would be led by a contracted consultant with expertise in behavioral health program development and nonprofit service delivery. The timing of this study is particularly opportune: Alaska Medicaid State Plan Amendment 25-0005, effective July 1, 2025, removes prior authorization requirements for rehabilitative behavioral health services, reducing a significant administrative barrier to outpatient mental health service delivery. The consultant would produce a comprehensive report examining three primary areas of inquiry. First, the study would assess workforce and employment models, exploring how NAMI Juneau could structure the employment or contracting of licensed therapists, including considerations around compensation, supervision requirements, licensure, and retention in a high cost-of-living community. This would include a review of comparable models that have successfully integrated outpatient services, and recommendations for NAMI Juneau structures. Second, the study would examine billing and sustainability, analyzing the financial infrastructure needed to bill Medicaid and other insurance providers, including credentialing requirements, billing systems, reimbursement rates, intake and assessment, and the administrative capacity required to manage a clinical billing operation. This analysis would identify what startup investment would be needed and what an ongoing sustainable revenue model could look like. Third, the study would evaluate mission alignment, assessing how an outpatient therapy program would complement NAMI Juneau's existing education, advocacy, and peer support work. This would potentially include community input and stakeholder engagement to ensure that any new services reflect the values and priorities of those NAMI Juneau serves. The completed feasibility report would give NAMI Juneau's leadership and board the information needed to make an informed decision about whether and how to move forward with implementation, and would serve as the foundation for future funding requests for that next phase of work.	\$50,000-\$250,000	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

NAMI Juneau	Together We Are Strong(er)	AK	NAMI Juneau has developed four behavioral health training programs tailored specifically to Alaska communities, addressing gaps that national programs fail to fill: Suicide Safety Planning, Social Emotional Health Education (SEHE),Peer Support Associate, and Together We Are Strong. At the top of this list is Together We Are Strong, a two-day suicide prevention training with integrated indigenous values specific to local cultures developed in partnership with the Central Council of Tlingit and Haida, in which participants practice direct conversations with someone who is suicidal. In rural Alaska, where crisis response often means involuntary hospitalization hours away, community members trained to support someone through a suicidal crisis can be lifesaving. Because these programs are relatively new, they lack the formal evaluation needed to assess effectiveness, capture participant feedback, and identify areas for improvement. Without evaluation, these programs cannot pursue evidence-based designation, a credential that determines whether funders, employers, and partner organizations will invest in or require a training. This project would develop a rigorous evaluation framework for NAMI Juneau's locally developed programs, measuring participant outcomes, satisfaction, and skill retention to produce the data needed to pursue formal evidence-based status and expand access to these critical trainings across Alaska.	Evaluation is the foundation of effective, credible programming. For training programs to be trusted by participants, partners, and funders, they must be grounded in data that demonstrates what is working and what needs improvement. Formal evaluation also opens the door to evidence-based designation, which signals to schools, employers, and health organizations that a program meets a recognized standard of quality. For NAMI Juneau's locally developed programs, evaluation is the critical next step toward becoming a more official, widely respected, and broadly adopted resource for Alaska communities. With NAMI Juneau will contract with an external evaluator to design and implement a formal evaluation process for its locally developed behavioral health training programs. This approach will strengthen program quality, build credibility with funders and partner organizations, and ultimately position NAMI Juneau's trainings for recognition on the Suicide Prevention Resource Center (SPRC) Best Practices Registry, a nationally recognized standard for suicide prevention programming. In Year 1, the evaluator will develop a participant survey tool to measure outcomes, skill retention, and satisfaction among training attendees. Data collection will begin as trainings are delivered, establishing a baseline for program performance. In Year 2, data collected from participants will be reviewed and used to refine program content and delivery as needed. Data collection will continue, building a stronger evidence base. In Year 3, findings will be compiled and submitted to the SPRC Best Practices Registry for formal recognition. Alongside the evaluation of participant outcomes, the evaluator will also assess training methods and delivery procedures. As part of this work, NAMI Juneau will hire someone to develop detailed program manuals covering both the evaluation process and a train-the-trainer model. Currently, only the staff who developed these trainings can deliver them, which limits how often they can be offered each year. Without a documented manual, training new facilitators means simply telling them to repeat the content word for word, which is an inadequate foundation for a train-the-trainer program. Thorough documentation of training methods is a natural outcome of evaluating how programs are taught, and will make NAMI Juneau's programs more transferable, scalable, and sustainable over time.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

NAMI Juneau	Transformation of Juneaumentalhealth.org	AK	Navigating behavioral health services in Juneau is a well-documented challenge for residents and providers alike. NAMI Juneau's Juneau Mental Health directory (juneaumentalhealth.org) opens with the acknowledgment that "mental health resources can be difficult to navigate," and offers direct navigation assistance by phone and email. Research shows that for every one day of wait time, one percent of patients give up seeking care altogether. Community-based coordination and referral is an evidence-supported strategy for reducing long periods of untreated mental illness and preventing negative outcomes. Over 13 years ago, NAMI Juneau created juneaumentalhealth.org as a centralized directory of behavioral health providers, used by primary care providers, social service agencies, and community members alike. The site already draws significant traffic: over 2,000 unique visitors and 4,000 sessions in the past year, with users spending an average of five minutes searching the provider directory, which is accessed over 2,700 times annually. Despite this demand, the site's technology has not kept pace: only one of its tabs is searchable, and staff cannot embed hyperlinks in provider matrices. No mobile app currently exists, further limiting accessibility. NAMI Juneau proposes to upgrade the Juneau Mental Health website and develop a companion mobile app, making behavioral health resources more easily navigable for both the general public and the providers who serve them.	NAMI Juneau proposes to address the challenge of navigating behavioral health services in Juneau through two related technology upgrades: a significant rebuild of the existing Juneau Mental Health website (juneaumentalhealth.org) and the development of a companion mobile app. NAMI Juneau has already identified developers for both the website and the app, positioning this project for timely execution. The upgraded website will serve as the backbone of the project, providing a more robust, user-friendly platform for both community members seeking services and providers making referrals. The rebuild will make all tabs and directories fully searchable and allow hyperlinks to be embedded directly in provider matrices while preserving print functionality. A modern, well-structured website also creates the foundation upon which additional features can be more easily integrated over time, such as multilingual access or other evidence-supported strategies for reducing barriers to care for our Juneau community members. Unlike national directories such as Psychology Today, juneaumentalhealth.org is specifically designed for Juneau's behavioral health landscape. Without duplicating existing resources, the site fills gaps that national platforms do not: it lists community mental health organizations by the specific services they provide, includes free support groups, and maintains an active therapist listserv used regularly by local providers to coordinate referrals and share continuing education opportunities. The directory is also actively maintained through annual outreach and ongoing updates, ensuring accuracy in a way that self-reported national directories cannot replicate. The companion mobile app will extend the reach of the directory to users who rely on mobile technology to find and access services. The app would provide a variety of behavioral health tools including a searchable provider directory with filters for insurance type, specialty, and availability, prominent crisis resources and hotlines, and referral support functionality for primary care and social service providers. Research shows that up to 40 percent of behavioral health referrals fail due to missed appointments or lack of follow-up; a well-designed navigation tool directly addresses this gap. Together, the upgraded website and app will make Juneau's behavioral health resources more accessible, more current, and easier to use for the individuals who need them most.	Under \$50,000	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Nancy Morgan Wound Care LLC	HealthForce One: Rural Healthcare Workforce and Clinical Support for Alaska	NV	Rural Alaska faces significant barriers to specialty healthcare access due to geographic isolation, workforce shortages, and limited access to advanced clinical training. Many patients must travel long distances to receive specialized care, creating delays in treatment and increasing healthcare costs. At the same time, many local healthcare providers are capable of managing more complex conditions if they have access to specialized training, clinical decision support, and remote consultation with experienced specialists. This project addresses the opportunity to strengthen Alaska’s healthcare system by expanding the capabilities of the existing workforce. By providing targeted education, workforce coordination, and remote specialist support, HealthForce One enables local clinicians to manage more advanced care within their own communities.	HealthForce One proposes a workforce-centered model designed to strengthen rural healthcare capacity through training, clinical support, and workforce coordination. The project will provide specialized education programs designed for clinicians practicing in rural and remote settings. These programs focus on practical clinical skills, decision support tools, and protocols that enable providers to manage complex cases safely within their scope of practice. In addition to training, the project establishes a remote specialist support network composed of U.S.-based physicians and advanced clinicians who can provide consultation, case review, and clinical guidance when local providers encounter complex situations. The project operates through a hub-and-spoke model that connects regional health systems with rural clinics and community providers. This structure ensures that care remains locally delivered while clinicians have access to the expertise and support needed to manage challenging cases. By strengthening local workforce capacity and providing access to remote specialist support, the model expands access to care, reduces unnecessary patient travel, and improves clinical confidence among rural healthcare providers.	\$1M-\$5M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Napakiak Rural Health Solutions, LLC	Project NORTHSTAR: ARPA-H PARADIGM Innovation Delivering Hospital Care to Rural Alaska	AK	Alaska’s rural health system operates under conditions unlike any other state. Advanced care, diagnostics, specialty consultation, and obstetrics, often require air, river, or seasonal travel. These realities limit local diagnostic capacity, strain workforce availability, and force reliance on transporting patients rather than delivering appropriate care closer to home. The human cost is significant. Rural Alaskans experience high rates of chronic disease, poor maternal and infant outcomes, behavioral health crises, and substance misuse. Many communities lack reliable access to emergency departments, intensive care, dental services, or behavioral health. Community Health Aides/Practitioners (CHA/Ps) and EMS providers shoulder extraordinary responsibility, yet 64% of rural hospital staff report difficulty securing timely specialty referrals. The result is delayed care, preventable escalations, and families separated during critical moments. Project NORTHSTAR addresses this diagnostic and access gap by deploying the GOHOSPITAL Care Delivery Platform (CDP), integrated with Tribal and regional health partners to bring hospital-level diagnostics, maternal monitoring, chronic disease management, and tele-specialty support directly into villages. This disciplined, regionally governed model strengthens local workforce capacity, reduces avoidable transport, and builds a more sustainable rural health architecture that keeps care closer to home.	Our proposed approach is Project NORTHSTAR: a disciplined, regionally governed mobile care model that deploys the GOHOSPITAL mobile CDP as a seamless extension of Alaska’s existing THOs and regional hospital hubs. GOHOSPITAL, developed under the ARPA-H Platform Accelerating Rural Access to Distributed and Integrated Medical Care (PARADIGM) program, is a rugged, modular, Arctic-hardened mobile unit equipped with point-of-care laboratory, diagnostic imaging, telehealth connectivity, and restorative dental capability. It delivers hospital-level services directly to rural Alaskans while operating as a true extension of existing hubs. Rather than building parallel systems, we strengthen the hub-and-spoke architecture already serving rural Alaska. In Year 1, NRHS will partner with the ANTHC, FHP, and FMH to activate the Interior hub serving the Fairbanks to Delta Junction region. If success is clear, expansion into the Anchorage area may be considered. GOHOSPITAL units operate on data-driven rotational routes integrated with hospital EHRs and informed by regional disease prevalence, Medicaid transport patterns, and referral gaps. Services focus on high-impact areas: maternal monitoring, chronic disease management, behavioral health continuity, point-of-care diagnostics, preventive dental services (Year 3), and real-time tele-specialty consultation. All deployment, clinical scope, and data governance protocols operate under the authority of participating Tribal Health Organizations. Leveraging Homeward Health’s AI-native rural platform, Homeward supports patient engagement, route optimization, care navigation, and clinical workflows that enhance local health workers through tele-supervision. Combined with AI-powered Revenue Cycle Management (RCM) and alternative payment models such as maternal bundles, these tools ensure long-term viability without new subsidies. The approach aligns with Alaska’s six RHTP initiatives: Healthy Beginnings, Health Care Access, Healthy Communities, Strengthen Workforce, Spark Technology & Innovation, and Pay for Value. Year 1 is focused on the Interior hub to ensure operational stability and compliance with federal timelines. Future expansion occurs after documented performance in reducing avoidable travel, increasing in early detection of diseases, and strengthening reimbursement integrity. Project NORTHSTAR is designed to endure beyond the grant period through sustainable reimbursement and strengthened local capacity.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Juneau (City and Borough)	Deferred or Not Advanced

National Alliance for Drug Endangered Children	Mat-Su Valley Drug Endangered Children Help Rural Heath Transformation Program	CO	Rural communities within the Mat-Su Borough face increasing healthcare access challenges due to population growth, workforce shortages, and limited healthcare infrastructure. Many residents must travel to Anchorage or other urban centers to receive behavioral health, specialty, and preventive services. These barriers disproportionately impact children, families, individuals experiencing substance use disorders, and residents with complex health needs. At the same time, Mat-Su communities have strong local networks of healthcare providers, community organizations, and public safety partners who are working independently to address these challenges. However, coordination between systems remains limited, and many residents struggle to navigate available services. This project represents an opportunity to transform how rural health services are delivered in the Mat-Su region by strengthening coordination among healthcare providers and expanding innovative service delivery models. By building a collaborative regional approach that integrates primary care, behavioral health, and community-based services, the project will improve access to care and better support the health and wellbeing of rural residents.	The proposed initiative will create a coordinated rural health network for the Mat-Su region that improves access to care through collaboration, innovative service delivery models, and expanded use of technology. Key strategies will include strengthening partnerships between healthcare providers, behavioral health services, community organizations, and public safety partners to improve coordination of care and referrals. By utilizing the information and data that has been gathered over the last several years, we can improve system gaps and services. A central component of the project will be improving access to behavioral health and substance use disorder services, which remain significant needs across the region. Through coordinated screening, referral pathways, and integrated care models, residents will be better connected to the services they need. The initiative will also focus on supporting children, youth, and families who are impacted by substance misuse and related health challenges. By identifying individuals earlier and connecting them to community-based services, the project will help prevent long-term health consequences and strengthen overall community wellbeing. Through a regional hub-and-spoke model, healthcare providers and community organizations will work collaboratively to deliver services closer to home while improving care coordination across the Mat-Su region.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced
Native Village of Chenega	Clinic planning and design for future health care in Chenega	AK	Since the Chenega Clinic was built in 2006, there have been changes in both the community demographics and how health care can be delivered to rural areas. As residents and health care providers consider the future of care delivery in Chenega, we want to ensure that any future remodel or construction aligns with community needs, best practices, and offers flexibility as both evolve over time. This project will proactively capture community planning for future design of the health clinic in Chenega. Through community surveys and other outreach activities, this project will also kickstart dialogue with health care organizations about future workforce needs, technology upgrades and community-informed priorities in addition to a concept design of the physical clinic building.	The Native Village of Chenega will work with community planning and design professionals to collect information on health care needs of residents and synthesize the information into a report that can be used to create architectural drawings of a new health clinic. Our hope is that each step of the process will be a collaboration between Chenega residents, health care providers and space planning experts to create a final design that anticipates the health goals and objectives important to the Chenega community.	\$50,000-\$250,000	Single Community	Chugach Census Area	Advance to Planning

Native Village of Chenega	Emergency services ambulance for Chenega	AK	In Chenega, a small island village in Prince William Sound without a full-service hospital, emergency medical service is a critical part of health care that requires access to specialized equipment for adequate pre-hospital assessment, care and stabilization before air transport to the nearest hospital. An upgraded ambulance with emergency supplies and wireless or cellular equipped connectivity will allow local community health aides and trained volunteers to provide continuous care and connection to remote specialists in a medical emergency, even while waiting for an air carrier at the airport, which is more than a mile from the Chenega health clinic on gravel roads. With an upgraded ambulance, all Chenega residents from youth to Elder will have expanded access to a higher level of local first-response care that can improve their health outcomes and potentially decrease costly hospital stay lengths due to adequate care and guidance from the start of medical response. The current community ambulance is outdated, unreliable and insufficient for use in rural Alaska. A new ambulance will ensure that local health aides and trained volunteers can safely provide care and be connected to remote specialists that are familiar with the emergency equipment onboard. Being able to provide top-notch care is a key part of a healthcare provider's job satisfaction and may inspire volunteers to continue training with potential for advancement.	The Native Village of Chenega is the local government and community service provider. Through a partnership with Chugachmiut, our region's Tribal health organization, and their EMS specialist staff, we will identify an appropriate ambulance replacement for use in Chenega. The ambulance will also be equipped with wireless or cellular communications devices that will allow local first responders to connect with remote specialists that can guide them through appropriate medical care and stay connected to air carriers enroute to Chenega for transport to the nearest hospital. Chenega is less than an hour by air to Anchorage where Alaska's highest rated trauma hospitals are located. Chugachmiut currently hires and trains a community health aide practitioner who works at the local clinic and will be able to identify further training for the new ambulance equipment. Chenega also works with Chugachmiut to provide training for local EMS volunteers on a regular basis. Once a new ambulance is procured and delivered, we will work with our partners in the Tribal health system to ensure ongoing maintenance and equipment training standards are established. This will allow long-term use of the equipment as well as creating a pipeline of backup and future care providers. The Native Village of Chenega is prepared to support ongoing maintenance of the ambulance and any administrative functions necessary to ensure safe and continued use.	\$250K-\$1M	Single Community	Chugach Census Area	Deferred or Not Advanced

Native Village of Chitina	Native Village of Chitina CHAP Training and Support	AK	The NVC’s proposal addresses several critical challenges affecting access to consistent, high-quality healthcare in its rural community. Chitina is geographically isolated, with limited on-site medical services and significant barriers to timely care, including long travel distances to regional health facilities, harsh weather conditions, and transportation costs. These barriers often delay diagnosis and treatment, contributing to poorer health outcomes and increasing reliance on emergency services. One key problem is the shortage of trained healthcare providers available within the community. The current Community Health Aide/Practitioner (CHAP) cannot meet local needs, particularly when providers are not trained to higher CHAP certification levels that allow them to deliver a broader scope of care. Without advanced CHAP-level training, NVC must rely heavily on distant clinics or hospitals. The proposal also addresses workforce sustainability. By training an existing CHAP provider to reach CHAP 4 level—the highest certification in the CHAP program—the community would gain a more experienced practitioner capable of handling complex cases, mentoring other aides, and providing expanded clinical services. Additionally, training a local resident to become a CHAP strengthens culturally responsive care, since local providers are more likely to remain in the community. This proposal also addresses the need to provide a CHAP locum when the CHAP 3 attends training.	The Native Village of Chitina (NVC) proposes strengthening its Community Health Aide Program (CHAP) to improve healthcare access, quality, and sustainability for residents of rural Chitina. The project focuses on expanding local clinical capacity and strengthening the healthcare workforce. First, NVC will support advancing an existing provider from CHAP Level 3 to Level 4. This upgrade will enable the clinic to diagnose and manage more complex conditions locally, reducing the need for patients to travel long distances for care. Second, the project will train a local resident to become a new Community Health Aide, increasing staffing capacity while fostering a workforce rooted in the community. Training a local provider promotes cultural familiarity, continuity of care, and long-term retention in the clinic. Together, these efforts will enhance service delivery, strengthen the rural healthcare workforce, and ensure that residents of Chitina have more reliable access to timely, high-quality healthcare close to home.	\$250K-\$1M	Clinic	Single Community	Copper River Census Area	Advance to Implementation Application

Native Village of Chitina	Native Village of Chitina Elder Care Services Project	AK	The Native Village of Chitina faces a growing challenge: ensuring that local Elders can age safely in their homes while receiving consistent, culturally responsive care. Currently, the elder services NVC provides are not billable, are paid for from the NVC's general fund, and are not sustainable. In a remote community like Chitina, access to health services is limited by distance, weather, transportation barriers, and workforce shortages. Training eight Elder Service Care Providers to become Certified Personal Care Assistants (PCAs) directly addresses these barriers by building local capacity and strengthening continuity of care. By earning PCA certification, these caregivers would be qualified to provide essential daily living supports such as personal hygiene assistance, medication reminders, mobility support, meal preparation, and basic health monitoring. Because they are members of the community, they offer culturally grounded care, speak the local language, and understand traditional values—factors that increase trust, compliance, and overall well-being among Elders.	This project strengthens healthcare access in the remote Alaska Native community of Chitina by training eight Elder Service Care Providers to become Certified Personal Care Assistants (PCAs). Due to geographic isolation, limited local providers, transportation barriers, and the high cost of traveling to regional healthcare hubs, residents—especially Elders—often struggle to obtain consistent care. The Native Village of Chitina (NVC) will address these challenges by building a locally trained workforce capable of delivering in-home and community-based services. By certifying existing caregivers as PCAs, the project expands the community’s ability to provide routine health support, assistance with daily living activities, and monitoring for vulnerable residents. This approach ensures that care is delivered by trusted community members who understand local culture, language, and traditions, improving both comfort and quality of care. Developing local capacity also reduces reliance on distant providers, strengthens long-term healthcare sustainability, and supports healthier aging in place for Chitina’s Elders.	\$50,000-\$250,000	Clinic	Single Community	Copper River Census Area	Advance to Implementation Application

Native Village of Chitina	Native Village of Chitina Telehealth Capability Improvement Project	AK	The NVC proposes expanding telehealth capabilities in the community by upgrading broadband connectivity, installing a Starlink satellite system, and purchasing modern telehealth equipment including monitoring digital stethoscopes, and kits for patients, such as blood pressure monitors, glucose meters, and pulse oximeters. These improvements will strengthen access to healthcare in this remote Alaska community where travel to regional hospitals can be difficult, expensive, and weather-dependent. Upgrading broadband infrastructure will provide the reliable internet speeds required for secure video consultations, electronic health records, and data transmission between the Chitina Tribal Clinic and regional healthcare providers. Installing a Starlink satellite system will ensure redundant, high-speed connectivity even when traditional internet service is disrupted, allowing telehealth services to continue during emergencies or severe weather. The project also includes purchasing telehealth devices for the clinic and portable remote monitoring kits. These tools may include digital stethoscopes, blood pressure monitors, pulse oximeters, and other diagnostic equipment that allow healthcare professionals to assess patients remotely with greater accuracy. Remote monitoring kits will enable patients with chronic conditions to track vital signs from home and transmit data directly to providers.	The Native Village of Chitina (NVC) proposes expanding telehealth capabilities at the Chitina Tribal Clinic to address longstanding barriers to healthcare access caused by geographic isolation and limited transportation infrastructure. Residents of Chitina often face lengthy and costly travel to reach regional medical centers, which can delay care and discourage routine visits. Strengthening telehealth systems offers a practical and sustainable solution by enabling patients to connect remotely with physicians, specialists, and behavioral health providers. The proposed approach focuses on improving the clinic’s telehealth infrastructure, including reliable broadband connectivity, modern telemedicine equipment, and secure digital platforms that support virtual consultations. By integrating these tools into routine clinic operations, healthcare providers can deliver timely diagnoses, treatment recommendations, and follow-up care without requiring patients to travel long distances. Telehealth will also support behavioral health services, which are particularly important in rural communities where access to specialists is limited.	\$250K-\$1M	Clinic	Single Community	Copper River Census Area	Advance to Implementation Application

Native Village of Chitina	Native Village of Chitina Healthy Nutrition Project	AK	The NVC’s plan to complete its community kitchen with commercial-grade equipment addresses a critical challenge in providing safe, nutritious, and culturally relevant meals for residents. Currently, the tribal office’s kitchen's outdated and limited appliances constrain the village's ability to efficiently prepare large quantities of food, making it difficult to support community events, elder programs, and youth initiatives. By installing commercial-grade ovens, stoves, refrigerators, and prep stations, the Multi-Purpose Building kitchen will be able to handle larger meal volumes safely and more efficiently, ensuring food is prepared in accordance with health standards. This upgrade also supports community health by enabling the preparation of traditional foods in ways that preserve nutrition and cultural practices. Improved equipment reduces food spoilage, lowers the risk of contamination, and allows for consistent meal service during emergencies or public gatherings. Additionally, a modern kitchen enhances the village's ability to offer food-based programs that teach cooking skills, nutrition, and cultural traditions to younger generations. Overall, completing the kitchen strengthens food security, promotes health, and supports cultural continuity. It transforms the kitchen into a reliable hub for community gatherings, education, and wellness, addressing both practical and social needs while empowering the NVC to serve its residents better.	The Native Village of Chitina will complete and equip its 622-square-foot community kitchen with commercial-grade appliances to expand reliable, culturally appropriate food preparation for the community. The approach focuses on installing safe, modern equipment, training local staff and volunteers, and establishing regular meal programs that prioritize nutritious, locally sourced foods when possible. The kitchen will support elders, children, and residents recovering from illness while strengthening food safety and preparation capacity. By improving access to healthy meals and nutrition education, the project addresses diet-related chronic diseases common in rural Alaska. The completed kitchen will serve as a sustainable hub for community health and community.	\$50,000-\$250,000	Clinic	Single Community	Copper River Census Area	Deferred or Not Advanced

Native Village of Chitina	Native Village of Chitina Medevac Access & Safety	AK	The Native Village of Chitina’s (NVC) goal is to improve medevac by adding runway lighting and a 5000-gallon fuel tank at the 2,850 ft x 75 ft Chitina Airport. The lack of aviation fuel and runway lighting at the Chitina Airport significantly affects access to health care for residents of the small rural community. Because Chitina has no hospital and only limited primary medical services available at its local clinic, residents often rely on air transportation to reach larger health care facilities in Anchorage during emergencies. Because the airport lacks reliable fuel supplies, aircraft transporting patients, medical personnel, or supplies must carefully plan routes or avoid landing in Chitina altogether, creating delays and reducing flight availability. The absence of runway lighting further compounds the problem by restricting aircraft operations to daylight hours. This limitation can force patients to wait until morning for transport, potentially worsening medical outcomes in situations such as trauma, cardiac events, or severe illness. For Chitina, where aviation is the primary link to advanced medical services, basic airport infrastructure is closely tied to public health. The improvements described above will strengthen the overall health care safety net for Chitina residents, and for the 7,000 to 10,000 fishermen drawn to the Chitina dipnet fishery each summer, and the 20,000 to 80,000 tourists drawn to Wrangell-St. Elias National Park.	Phase I: Design, Permissions, and Approvals: Develop a design for the 5000-gallon tank through a qualified engineer. Enter into a lease with the landowner, Ultima Thule Lodge, for the site of a 5000-gallon fuel tank. Obtain approval for the plan from the state fire marshal. Phase II: Regulatory Compliance. Develop a Spill Prevention, Control, and Countermeasure Plan developed by a registered professional engineer. Develop a secondary containment system using a double-walled design. Ensure adherence to Alaska Department of Environmental standards for leak detection and spill prevention. Phase III: Site Preparation and Installation. Have a qualified engineer build a monolithic concrete support pad that is at least 1 foot beyond the tank's exterior on all sides. Level the tank, installing atmospheric venting with a weatherization cap, complete fencing, and security measures. Phase IV: Train operators in spill prevention, containment, and emergency response. Complete inspections and release detection testing as required by EPA and state regulators.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area	Deferred or Not Advanced

Native Village of Chitina	Native Village of Chitina Patient Transport Project	AK	The NVC's proposal would replace its three aging patient transport vehicles with a new Chrysler Pacifica, a Ford Transit Van, and a 4WD or AWD Ford Explorer. These vehicles would significantly improve patient transportation in Chitina by providing safer, more reliable travel between the community and the regional medical hub in Anchorage. Chitina residents must often travel long distances for specialty care, diagnostic testing, and follow-up appointments that are not available locally. Reliable ground transportation is, therefore, critical to maintaining consistent access to healthcare. An AWD or 4WD Ford Explorer would provide a dependable option for transporting individual patients or small groups, particularly elders or patients with mobility limitations. Its four-wheel-drive or all-wheel-drive capability and durability make it well-suited for Alaska's challenging road conditions, including winter snow, ice, and rough rural highways. The 33-mile Edgerton Highway from Chitina to the Richardson Highway, and the 180-mile Glenn Highway to Anchorage, particularly the Long Lake section, are among the most dangerous winter roads in Alaska – and the country. It is not unusual for 20 accidents to occur in a day along the Glenn Highway, according to ADOT and Anchorage Police Department statistics. The vehicle would allow health staff or community representatives to safely escort patients on long trips while ensuring comfort during extended travel.	The Native Village of Chitina (NVC) will improve access to healthcare by replacing three aging patient transport vehicles with a Chrysler Pacifica, a Ford Transit Van, and a 4WD or AWD Ford Explorer. These vehicles will support safe, reliable transportation for residents traveling from Chitina to Anchorage for medical services that are not available locally. Because community members must travel long distances for specialty care, diagnostic testing, and follow-up appointments, dependable transportation is essential for maintaining consistent healthcare access. The AWD or 4WD Ford Explorer will be used for individual patients or small groups, especially elders and individuals with mobility limitations. Its durability and enhanced traction will allow drivers to navigate Alaska’s hazardous winter road conditions more safely, including snow, ice, and rough rural highways. Health staff or trained community representatives will use the vehicle to escort patients on long-distance trips, ensuring both safety and comfort during travel.	\$250K-\$1M	Clinic	Single Community	Copper River Census Area	Deferred or Not Advanced

Native Village of Chitina	Native Village of Chitina Recovery and Healing Camp Feasibility Project	AK	The NVC faces significant challenges related to alcohol and substance abuse, which have profound impacts on the health, safety, and cultural continuity of its community members. Rates of substance misuse in rural Alaska often exceed statewide averages, and limited access to healthcare and treatment services exacerbates the problem. Establishing a seasonal cultural recovery camp could directly address these challenges by providing a holistic, culturally grounded approach to healing. Such a camp would integrate traditional practices, language, and subsistence activities—such as fishing, hunting, and crafts—into recovery programs. Engaging participants in culturally meaningful activities strengthens identity, fosters resilience, and builds community support, which are critical protective factors against relapse. By combining cultural engagement with evidence-based treatment strategies, the camp would fill a gap left by standard treatment facilities that may be geographically distant or culturally disconnected.	This project will conduct a feasibility study for a seasonal Cultural Recovery Camp led by the Native Village of Chitina (NVC) to support individuals experiencing alcohol and substance use challenges. The approach centers on integrating culturally grounded healing practices with practical planning and community engagement. Project activities will include consultations with tribal leadership, Elders, and community members to identify culturally appropriate program elements such as land-based activities, traditional knowledge sharing, and mentorship. The study will assess potential camp locations, evaluate infrastructure and transportation needs, and examine staffing models that incorporate both clinical and cultural support roles. Researchers will also review successful Indigenous recovery models and regional service gaps to inform program design. Findings will guide the development of an operational framework outlining seasonal programming, safety protocols, partnerships, and estimated costs. The feasibility assessment will determine whether a seasonal camp can effectively support recovery outcomes and whether the model could expand into a year-round cultural wellness and recovery center.	\$50,000-\$250,000	Clinic	Single Community	Copper River Census Area	Deferred or Not Advanced
Native Village of Eklutna	Expansion of the Eklutna Health Clinic	AK	The Eklutna Community Clinic has consistently seen increasing numbers of patients and appointments since opening in 2019, and is now well-positioned to plan an expansion to accommodate the needs of our community and increase the options and opportunity of services.	The proposed plan is to acquire funds to support planning a strategic expansion of the Eklutna Community Clinic so that the facility can continue to operate at full capacity and meet community needs. This would include the increase in medical treatment rooms, spaces designed for behavioral health appointments, wellness and physical therapy space, traditional healing, and office/administrative spaces. Strategically planning for expansion would ensure that the Native Village of Eklutna’s clinic will be ready to provide access to essential and meaningful services to the public in a thoughtful and fiscally responsible manner.	\$50,000-\$250,000		Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Advance to Planning

Native Village of Eklutna	Emergency Generator Backup	AK	Currently, if the power goes out the Clinic would have to close and would not be able to continue to provide health care. Also, there would be a risk of losing valuable medication, vaccines, and potential patient supplied samples/specimens. This would be a cost saving initiative as it will help prevent the damage of consumable medical inventory that are on hand during a power outage.	Our proposed approach would be to purchase and install an appropriately sized backup generation system to ensure that if there was a power outage the system would automatically kick on and provide the necessary power to keep our clinic doors open, health care provided, and refrigeration units up and running, so nothing would be lost or wasted.	\$50,000-\$250,000		Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced
Native Village of Eyak- Ilanka Community Health Center	ICHC and CCMC Exploratory/Planning Phases for One Healthcare System in Cordova	AK	The Native Village of Eyak (NVE) and the City of Cordova have begun open discussions to identify best practices and determine the next steps needed to preserve and expand essential medical services including maintaining access to a critical access hospital, which include exploring a potential merger between ICHC and CCMC. As noted earlier, rural communities face a wide range of ongoing and emerging challenges that make it difficult for smaller healthcare organizations to enhance and expand local medical services. ICHC and CCMC are seeking the resources and support needed to begin the initial exploratory steps of a potential merger, including evaluating how combining services could strengthen financial stability, improve operational efficiency, and ultimately enhance care for the Cordova community. In addition, ICHC and CCMC both meet challenges when it comes to aging healthcare facilities and ensuring compliance with current medical standards. Due to no other alternatives for continuing services, NVE purchased the current ICHC building in 2023, despite its dilapidated condition. As the Cordova community considers the possibility of transitioning to a single healthcare entity, it is important to explore what additional opportunities and needs exist for co locating services and improving infrastructure to ensure adequate, modern, and efficient medical space for both patients and staff.	While local City and Tribal governments have come together to review the next steps and continued medical needs for the community, additional information, resources, and experts are needed to ensure an accurate and informed discussion can be made on the possibility of one healthcare entity for the community. This includes the hiring of a project manager, completing financial and operational assessments, fair market appraisals, legal support, and structural/engineering assessments. This process would allow all parties to assess the needs and strengths each healthcare facility brings to a potential merger and determine the most effective path toward financial and operational sustainability, ensuring the long term delivery of healthcare services to the community under a unified provider. In addition, if a merger was feasible, it would help facilitate the needs and opportunities for expanded services such as specialty clinics, expanding outpatient services such as pharmacy etc. It will also help identify opportunities for advancement in services such as the need for new medical equipment and the use of AI and new technology in current and future services.	\$1M-\$5M	Clinic	Single Community	Chugach Census Area	Advance to Implementation Application

Native Village of Kotzebue	Kotzebue Tribal Family Wellness and Behavioral Health Prevention Initiative	AK	Rural Alaska communities continue to experience significant health disparities related to behavioral health challenges, substance misuse, suicide risk, and family stress. In communities such as Kotzebue, limited access to preventative services means that many families only receive support once issues have escalated into crisis. While regional health providers deliver essential clinical services, there is a gap in community-based prevention, early intervention, and culturally grounded wellness programs that help families build resilience before serious health challenges develop. The Native Village of Kotzebue seeks to expand its Healthy Families and Community Wellness Program to address this gap by strengthening preventative services that support youth, parents, and families. Evidence across Alaska Native communities shows that strong cultural identity, connection to Elders, language, and community engagement serve as powerful protective factors for mental health and overall wellness. Expanding culturally grounded wellness programming can play a critical role in preventing behavioral health crises, reducing suicide risk among youth, and improving long-term health outcomes in rural communities.	The Native Village of Kotzebue proposes to expand its Healthy Families and Community Wellness Initiative to strengthen community-based prevention and early support for families and youth. The initiative will focus on several core strategies: Family Wellness and Parenting Support Expanding family support programming that provides parenting education, family engagement activities, and early assistance for households experiencing stress or instability. These activities help address Adverse Childhood Experiences (ACEs) by strengthening family stability, reducing trauma exposure, and supporting healthy childhood development. Youth Engagement and Mentorship Developing youth-centered wellness activities that connect young people with positive mentors, cultural teachings, and safe spaces for healthy development. Cultural Identity as a Health Protective Factor Integrating Iñupiaq cultural knowledge, language exposure, and intergenerational learning opportunities into wellness programming. Cultural identity and connection to Elders are recognized protective factors that strengthen resilience and support long-term mental health. Community-Based Behavioral Health Prevention Creating opportunities for early engagement that address risk factors related to substance misuse, suicide risk, and mental health challenges before they require clinical or emergency intervention. Coordination with Regional Health Providers Strengthening coordination between community wellness programs and regional health providers so families can be connected to appropriate services when needed.	\$50,000-\$250,000	Single Community	Northwest Arctic Borough	Advance to Implementation Application

Native Village of Kotzebue	Iglut Senior Apartments Healthy Aging Renovation Project	AK	The Native Village of Kotzebue seeks to renovate the Iglut Senior Apartments, an Elder housing facility built in the early 2000s that has not received significant upgrades since construction. As the building ages, infrastructure systems such as heating, ventilation, plumbing, and interior fixtures require modernization to maintain safe and healthy living conditions for residents. In rural Alaska communities like Kotzebue, limited housing options for Elders can create health and social challenges. Safe and accessible housing plays a critical role in supporting independence, reducing injury risk, and maintaining connections to family and community support networks. Renovating the Iglut Senior Apartments presents an opportunity to strengthen community health by improving the living environment for senior residents. The project will address aging infrastructure, improve accessibility for residents with mobility limitations, and enhance the overall safety and comfort of the building. Investing in these improvements supports long-term community health by allowing Elders to remain in stable housing in their home community rather than relocating to distant care facilities or regional hubs.	The Native Village of Kotzebue proposes to conduct a comprehensive assessment and phased renovation of the Iglut Senior Apartments to improve building infrastructure, accessibility, and overall living conditions for Elder residents. The project will focus on building upgrades that directly support healthy aging, including improvements to heating and ventilation systems, plumbing infrastructure, accessibility modifications, and modernization of interior spaces such as kitchens, bathrooms, flooring, and lighting. These upgrades will improve safety and reduce environmental risks for residents with mobility limitations or chronic health conditions. Energy efficiency improvements will also be evaluated to improve indoor environmental conditions while reducing long-term operating costs. Renovations will be planned carefully to minimize disruption to residents while ensuring the facility remains a safe and comfortable place to live during the improvement process. The Native Village of Kotzebue has experience managing housing programs and coordinating infrastructure projects and will work with regional partners, contractors, and housing professionals to implement the renovations.	\$250K-\$1M	Single Community	Northwest Arctic Borough	Deferred or Not Advanced

Native Village of Kotzebue	KOTZ Radio Rural Health and Emergency Communication Infrastructure Initiative	AK	Rural communities in Northwest Alaska face significant barriers to accessing timely health information and emergency communications due to geographic isolation, limited transportation infrastructure, and inconsistent internet connectivity. For decades, KOTZ Radio has served as a trusted regional communication platform providing emergency alerts, community announcements, and health information to residents across the Northwest Arctic region. Recent changes to national public broadcasting funding and increasing operational costs threaten the sustainability of rural radio stations that provide these essential services. Without reliable local broadcasting capacity, rural communities risk losing a critical communication system that supports emergency response, health awareness, and public safety. This project seeks to strengthen the operational stability of KOTZ Radio so it can continue serving as a vital communication infrastructure for rural communities	The Native Village of Kotzebue will support the continued operation of KOTZ Radio to ensure the station remains a reliable communication platform for emergency alerts and public health messaging across the Northwest Arctic region. Funding will support core operational capacity including broadcast infrastructure, technical equipment, staffing, and programming that delivers critical health information and emergency communications to rural communities. KOTZ Radio will continue broadcasting public health messaging, behavioral health awareness information, emergency alerts, and community wellness programming that reaches residents across the region. The station will also strengthen coordination with Tribal programs, regional health providers, emergency responders, and community organizations to ensure timely dissemination of health and safety information during emergencies and public health events. By strengthening rural communication infrastructure that supports health awareness, emergency preparedness, and behavioral health outreach, this project contributes to Alaska’s broader efforts to improve health outcomes, reduce health disparities, and strengthen community resilience in rural and Alaska Native communities.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Northwest Arctic Borough	Deferred or Not Advanced

Native Village of Kotzebue	Kotzebue Rural Environmental Health & Community Cleanup Initiative	AK	The community of Kotzebue faces ongoing environmental challenges related to accumulated debris, abandoned materials, and environmental hazards within residential areas, public spaces, and surrounding subsistence-use areas. Limited infrastructure for waste management and the high cost of cleanup in remote communities contribute to these conditions. Environmental hazards can impact public safety, environmental quality, and community wellbeing. Addressing these issues through coordinated cleanup efforts provides an opportunity to improve environmental health while strengthening community engagement. This project seeks to organize a community-driven environmental cleanup initiative that improves the overall health and safety of Kotzebue while promoting environmental stewardship consistent with Iñupiaq values.	The Native Village of Kotzebue proposes to coordinate a community-wide environmental cleanup and restoration initiative that focuses on reducing environmental hazards and improving community health. Key activities may include: • Organizing community cleanup events and debris removal efforts • Identifying environmental hazards in residential areas and public spaces • Supporting proper disposal of waste and hazardous materials • Engaging youth and community volunteers in environmental stewardship activities • Coordinating with local partners to improve long-term environmental management The project will be led by the Tribe and implemented through collaboration with local organizations and community volunteers. Outreach and education will also be included to strengthen community awareness of environmental health and stewardship.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Northwest Arctic Borough	Deferred or Not Advanced

Native Village of Tanana	Tanana Step-Down Substance Use Treatment Program	AK	Alaska lacks adequate step-down care options for adults leaving intensive residential substance use treatment programs. While high-intensity programs provide essential initial care, there is a critical gap in transitional support for those who need to step down into lower-intensity care while continuing to receive structured support in a real community setting. Existing recovery residences and sober living homes are concentrated in road-accessible hubs such as Fairbanks, Anchorage, Wasilla, and Kenai, leaving rural and off-road regions without culturally grounded step-down programs. This gap most affects Alaska Native individuals from rural and remote communities who, after residential treatment, often return home without the ongoing supports needed to sustain recover. For individuals with chronic or long-term addictions, the lack of supportive transitional care dramatically increases the risk of relapse and prevents successful reintegration into family and community life. To address this gap, we will establish a step-down residential program in Tanana that provides continued recovery support, life skills development, and community-based living in a culturally grounded environment. Supported by Tanana’s new health clinic, the program will expand access to care and advance RHTP goals by adding a new level of rural, tribally led step-down care that reduces avoidable relapse and repeat treatment episodes.	We will establish the Tanana Step-Down Substance Use Treatment Program through three overlapping phases: facility renovation, program development, and staged implementation. Phase 1 (Years 1–2): Facility Renovation The project will renovate the east wing of Tanana’s Elders building to create a six-bed residential space for step-down treatment. Renovations will include resident rooms, office space, and shared program areas, with kitchen facilities jointly used by the Elders program to support operational efficiencies. Design planning will balance integration and separation between Elder and recovery services while ensuring safety, privacy, accessibility, and cultural appropriateness. Phase 2 (Year 2): Program Planning and Development In partnership with Tanana Chiefs Conference (TCC), this phase will establish the clinical, cultural, and operational foundations of the program. Key activities include defining eligibility, developing individualized treatment planning, staffing and referral pathways, and structuring Medicaid and tribal billing processes. The program will integrate Alaska Native cultural practices, Elder mentorship, family engagement, life skills, and employment readiness supports. Partnership agreements, data systems, evaluation tools, and staff training will be completed. The program design will align closely with services provided through the new Tanana clinic, ensuring access to telebehavioral health, on-site counseling, and group services. Phase 3 (Years 3–4): Staged Implementation Beginning in Year 3, the program will open at reduced capacity and scale up to full operation. It will serve individuals completing intensive residential treatment—including those from court-involved programs—who require structured, community-based recovery support. Residents will engage in life skills practice, cultural activities, and employment opportunities consistent with individualized treatment plans and recovery goals. Lengths of stay will range from one month to one year. Continuous quality improvement, evaluation, and participant feedback will guide program refinement. The program’s long-term sustainability will be supported by Tanana Tribal Council health funds, Medicaid billing coordinated through TCC, and other braided revenue sources, ensuring continued operation beyond the initial project period.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Yukon-Koyukuk Census Area	Advance to Implementation Application

Native Village of Tanana	Tanana Dental Health Aide Therapist (DHAT) and Provider Housing Renovation Project	AK	Rural Interior Alaska communities face persistent gaps in access to basic dental and primary care due to provider shortages, distance, and harsh travel conditions. The Native Village of Tanana (NVT) is completing a new 6,575-square-foot health clinic in June 2026 with a full dental suite and multipurpose exam room for dental, optical, and consultation services, creating a hub for improved oral health and primary care in Tanana and nearby villages. During clinic planning, NVT and Tanana Chiefs Conference identified placement of a Dental Health Aide Therapist (DHAT) in Tanana as an opportunity to expand access to continuous, community-based dental care. DHATs are trained to live and work in rural communities, providing preventive and restorative services that reduce reliance on infrequent itinerant dentist visits. However, recruitment and retention of DHATs and other clinical staff are constrained by the lack of safe, affordable housing. The limited local rental market consists mainly of older, inefficient units with high costs, and few suitable options exist for permanent or itinerant professionals. To address this barrier, NVT will renovate a former Indian Health Service duplex, now used as office space, back to its original purpose as dedicated provider housing.	Over a two-year period, NVT will renovate a office space to provide dedicated provider housing. Phase 1: Design and Pre-Construction (Months 1–6) During the initial phase, NVT will issue a design-build Request for Proposals (RFP), select a qualified contractor and design firm, and finalize designs and renovations plans. Working with the designer and contractor, NVT will develop detailed plans to convert the building into safe, code-compliant housing suited to clinical providers. Design work will prioritize privacy, soundproofing, accessibility, and energy efficiency, while identifying needed structural repairs such as roof and exterior improvements, electrical and plumbing upgrades, ventilation and indoor air quality enhancements, and insulation and heating system improvements to reduce operating costs. Permitting and pre-construction logistics will be completed so that construction can commence at the start of Phase 2. Phase 2: Renovation Work (Months 7–20) Renovation will transform the former facility into two durable housing units for the Dental Health Aide Therapist (DHAT) and other clinical staff, including itinerant providers. Work will include roof and siding replacement, new windows, updated electrical and plumbing systems, installation of high-efficiency heating and ventilation, and reconfiguration of interior layouts to create comfortable, functional living spaces. Finishes and furnishings will meet long-term professional housing standards and include reliable internet and workspace. NVT will prioritize local workforce participation where feasible and ensure quality through use of licensed contractors experienced in remote Alaska construction. As renovation milestones are completed, inspections will be conducted, with final inspection and certification for occupancy near the end of this phase. Phase 3: Occupancy and Integration (Months 21–24) The renovated units will then serve as dedicated quarters for the DHAT stationed in Tanana and other rotating providers supporting the new clinic and nearby communities. NVT will establish policies governing use of the units and coordinate with Tanana Chiefs Conference to house supervising dentists, primary care clinicians, and visiting specialists. By providing stable, proximate housing, the project will make it feasible for a DHAT to live and work in Tanana, strengthen provider recruitment and retention, and improve the continuity and reliability of care across the region.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Yukon-Koyukuk Census Area	Deferred or Not Advanced

Native Village of Tyonek	Native Village of Tyonek-Indian Creek Health Clinic Renovation	AK	The Native Village of Tyonek seeks to renovate the Tyonek Indian Creek Health Clinic to address aging infrastructure that affects the delivery of healthcare services in a remote rural community. The clinic building is approximately 2,500 square feet and houses Community Health Aide services, exam rooms, behavioral health space, dental space for visiting providers, laboratory services, and staff offices. The lower level of the building houses the Indian Creek Health Department, which provides public health and community wellness programs. Due to the age of the building, several structural and mechanical systems require repair and modernization, including exterior siding, sidewalks, interior ceiling and sheet rock repairs from water damage, lighting systems, doors, plumbing fixtures, and installation of a reliable furnace system. Renovating the clinic will improve safety, protect medical equipment and vaccine storage, and ensure the facility remains capable of supporting healthcare services for the Tyonek community	The Native Village of Tyonek will address aging infrastructure at the Tyonek Indian Creek Health Clinic through targeted facility renovations that improve safety, functionality, and sustainability of the building. The project will focus on repairing exterior siding and sidewalks, replacing damaged ceiling tiles and sheetrock from water damage, upgrading lighting systems, doors, and plumbing fixtures, and installing a reliable furnace to ensure consistent heating during winter months. Improvements will also address building safety systems and interior workspaces to support healthcare staff and patient services. Renovations will be coordinated to minimize disruption to clinic operations and maintain access to care for residents. These improvements will help ensure the clinic remains a safe and reliable facility capable of supporting primary care and public health services for the Tyonek community.	\$250K-\$1M	Clinic	Single Community	Kenai Peninsula Borough	Advance to Implementation Application

Native Village of Tyonek	Tyonek EMS Program Strengthening	AK	The Native Village of Tyonek seeks to strengthen its local emergency medical response system to ensure residents have reliable emergency care in this remote rural community. Tyonek is accessible primarily by small aircraft and seasonal boat travel, and residents requiring advanced medical care must be transported to regional hospitals in Anchorage or Kenai. During medical emergencies, local responders play a critical role in stabilizing patients until medevac transport is available. The Tyonek community currently faces challenges maintaining a stable EMS workforce due to a small population, limited volunteer availability, and the absence of a dedicated EMS program coordinator. Without trained responders available, delays in emergency response can place residents at increased risk during medical events such as trauma, cardiac emergencies, or respiratory distress. This project will establish a sustainable rural EMS response model that supports recruitment and retention of up to six community EMS volunteers, development of an EMS coordinator role, and ongoing training opportunities for responders. By strengthening the local EMS workforce and ensuring responders are properly equipped and trained, the project will improve emergency response readiness and protect the health and safety of Tyonek residents.	The Native Village of Tyonek will implement a rural EMS response program designed to meet the needs of small and remote Alaska communities. The program will recruit and support a team of up to six community EMS volunteers who will participate in a responder rotation to ensure emergency coverage within the community. To support participation and retention, EMS volunteers will receive stipends that recognize their commitment to emergency readiness, training, and response activities. Example stipend structure may include a monthly participation stipend of approximately \$300–\$400 for active responders, an on-call stipend of approximately \$150–\$200 per scheduled response week, and a per-call response stipend of approximately \$75–\$100 when responders participate in emergency calls. The project will also establish an EMS Coordinator role responsible for program oversight, responder scheduling, training coordination, equipment maintenance, and coordination with regional healthcare providers and medevac services. Training and professional development will be a key component of the program. EMS volunteers will participate in certification courses, continuing education programs, and regional training opportunities necessary to maintain EMS credentials. This may include participation in events such as the Alaska EMS Symposium to obtain continuing education hours required for certification. Because Tyonek is a remote community, the project may support travel, lodging, and registration costs when responders must travel to attend these educational events.	\$50,000-\$250,000	Clinic	Single Community	Kenai Peninsula Borough	Advance to Implementation Application

Native Village of Tyonek	Tyonek Community Wellness and recreation Center Assessment and Renovation	AK	Tyonek is a remote Alaska community located on the west side of Cook Inlet in the Kenai Peninsula Borough. Residents face barriers to health and wellness services due to geographic isolation and limited access to community gathering and recreation facilities. Travel to larger service centers such as Anchorage is often required for many services and activities that support healthy living. The proposed project will assess an existing building that would be renovated and transformed into Tyonek's Community Wellness and Recreation Center. While the facility will provide a strong focus on supporting elders and elder meal programs, the recreation and wellness spaces will be open and accessible to the entire community, creating a shared location where youth, adults, and elders can gather, participate in activities, and strengthen community relationships. The center will serve multiple purposes including: • A daily gathering place for Elder Lunch Programs and elder wellness activities • A community recreation space open to all residents • A venue for cultural programs and traditional knowledge sharing • A location for community health education and prevention programs • A central gathering space that encourages positive social interaction and healthy activities The design of the building will support flexible use of space so that elders, youth, families, and community organizations can all utilize the facility.	The approach to developing a Community Wellness and Recreation Center in the Native Village of Tyonek will begin with a comprehensive assessment of an existing building to determine the improvements necessary to safely renovate and bring the structure up to current building and safety codes. This initial phase will include a professional building condition assessment conducted by qualified engineers or architects. The assessment will evaluate structural integrity, electrical and mechanical systems, plumbing, accessibility, fire safety, and general life-safety requirements. The goal of this evaluation is to identify deficiencies, determine the scope of necessary upgrades, and develop a clear renovation plan that ensures the building is safe, compliant, and suitable for community use. Following the assessment, project partners will develop renovation designs and cost estimates based on the findings. This phase will include planning upgrades to meet applicable building codes and accessibility standards, as well as improvements needed to support the building's intended uses as a wellness and recreation center. Potential improvements may include electrical and lighting upgrades, heating and ventilation improvements, accessibility upgrades such as ADA-compliant entrances and restrooms, safety improvements, and interior modifications to create functional spaces for recreation and community gatherings. The renovated facility will be designed to include a flexible recreational space where youth, adults, and elders can gather for activities and exercise. Planned amenities may include workout equipment, table tennis, pool tables, foosball, and other recreational activities that encourage participation and social engagement. The facility will be designed to serve elementary-aged children through adults, creating an inclusive space that supports healthy lifestyles and positive youth engagement. Community input will play an important role throughout the planning and implementation process to ensure the facility meets local needs and reflects community priorities. By starting with a thorough building assessment and following a phased renovation approach, the project will transform an existing structure into a safe, functional, and welcoming Community Wellness and Recreation Center that promotes physical activity, social connection, and improved well-being for residents of Tyonek.	\$250K-\$1M	Clinic	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

Native Village of Tyonek	Tyonek MedEvac Helipad	AK	The Native Village of Tyonek is a remote Alaska Native community that is not connected to the road system. Access to advanced medical care often requires emergency medical evacuation (MEDEVAC) by helicopter to hospitals in the Anchorage region. Currently, Tyonek relies on a gravel airstrip with operational limitations and no dedicated helicopter landing infrastructure, which can create safety concerns and delays during emergencies, particularly in poor weather or during nighttime operations. These limitations can affect response times for medical evacuations, trauma care, and other urgent health situations where rapid transport is critical. In rural and frontier communities such as Tyonek, timely access to higher levels of care is an essential component of the healthcare system. Establishing a dedicated helipad will improve the reliability, safety, and efficiency of medical evacuation services. The helipad will provide a designated landing location designed for helicopter operations, reducing delays and improving response times for emergency medical transport. This project presents an opportunity to strengthen emergency medical access for Tyonek residents while improving overall safety and logistical support for healthcare delivery in the community.	The Native Village of Tyonek proposes to develop a dedicated helicopter landing facility to support emergency medical evacuation, healthcare access, and essential logistics for this remote community. The project will begin with evaluation and confirmation of a suitable site within or near the village that provides safe helicopter access, minimal environmental impact, and proximity to village infrastructure and emergency response services. The selected location will consider terrain, prevailing winds, and potential obstacles such as trees, powerlines, and coastal bluffs. The helipad will be designed in accordance with Federal Aviation Administration (FAA) heliport guidance, including appropriate dimensions for touchdown and liftoff areas, safety zones, and clear approach paths. The project will include site preparation, surface construction, markings, and safety features such as a clearly marked landing surface and wind cone. Lighting and other safety enhancements may be incorporated where feasible to support operations during low-light conditions. Coordination with the FAA and other regulatory agencies will occur as needed to ensure compliance with aviation safety requirements, including notification of landing area development and evaluation of potential airspace impacts. The completed helipad will provide a reliable location for medical evacuation helicopters to safely land near the village. This will improve emergency response capability and strengthen the community’s healthcare access infrastructure. The project supports the RHTP goal of sustainable access to healthcare by improving emergency transport infrastructure that connects rural residents to higher levels of care when needed. It also supports innovative care delivery by strengthening the emergency medical response network that rural communities depend on to access specialized healthcare services.	\$250K-\$1M	Clinic	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

Nenana City School District	Nenana Trauma-Engaged Workforce and Student Support (TEWSS) Project	AK	NCS is located in Nenana, Alaska, and serves preschool through 12th grade students at NCS as well as high school students residing at the NSLC. The proposed initiative focuses on the 215 students attending Nenana City School, including students boarding from across the State. Students at NCS experience disproportionately high rates of poverty and adverse childhood experiences (ACEs). Nenana’s poverty rate is 27.6%, more than double the state average, with a child poverty rate of 39%. Boarding students also come from villages with high poverty rates. Between 2021 and 2023, NCS and the LC experienced four student suicide attempts. 12 students required safety plans during the 24–25 school year. Youth Risk Behavior Survey data show that 63% of students reported feelings of hopelessness in the past year, and 33% seriously considered suicide, well above state averages. 47% of students report they do not feel they belong at school, 19% cannot name a single trusted adult in the school, and only 20% report being able to regulate their emotions. In 24–25, NCS recorded 246 disciplinary referrals, including 38 suspensions or expulsions due to violence and 11 related to substance use. Bullying, harassment, and substance misuse remain persistent concerns, particularly among boarding students navigating separation from family and community supports.	During the summer implementation period, two Trauma-Informed Paraprofessionals (TIPs) will be hired and begin structured training in trauma-engaged practices. This training period will focus on building foundational skills and ensuring a supported transition into school-based roles. Once the academic year begins, TIPs will staff the school Wellness Room; support emotional regulation and de-escalation; assist students experiencing distress; and coordinate supports among the school and community partners. Paraprofessionals will operate as part of a multidisciplinary support system aligned with the District’s existing tiered behavioral health framework. These entry-level positions are intentionally designed to support a “grow-our-own” workforce strategy, enabling staff to build skills, complete training and certification pathways, and advance into higher-level human services roles over time. To support implementation and workforce stabilization, a school-based social worker will provide implementation support and mentorship. This role will model and teach trauma-responsive strategies, support the integration of social-emotional learning (SEL) within classrooms, and assist with coordination of school-based supports. The social worker will build internal capacity by coaching educators to confidently embed social-emotional learning (SEL) and trauma-engaged practices into daily instruction and school operations, while mentoring peers to gradually apply these approaches independently over time. This creates a sustainable train-the-trainer model within NCS that strengthens long-term workforce capacity. This position functions as a bridge to reinforce internal systems and does not replace clinical counseling services. Implementation also includes trauma-engaged staff training, including crisis response and de-escalation, cultural humility, SEL integration, and peer support principles where applicable. Staff training stipends and paid education pathways for the TIP’s will support workforce retention and advancement. To support early intervention and reduce disruption to learning, onsite contracted counseling services will be available to students as needed. These services will be coordinated with existing community providers and will not duplicate Medicaid-reimbursable services. This approach aligns with best practices for a multi-tiered system of supports (MTSS) by providing timely, targeted intervention while preserving continuity of care.	\$50,000-\$250,000	Statewide	Yukon-Koyukuk Census Area	Deferred or Not Advanced

Nenana Volunteer Fire/EMS Department	Nenana Mobile Crisis Team	AK	Nenana is a rural Interior Alaska community with approximately 350 year-round residents and about 100 students who reside at the Nenana Student Living Center during the academic year, serving youth from across Alaska. The community also supports surrounding Denali Borough areas by providing emergency medical transport and response services. Nenana is experiencing a growing need for coordinated responses to behavioral health crises, yet emergency systems are often required. Behavioral health crises account for approximately 33% of all emergency calls responded to by the Nenana Volunteer Fire Department (NVFD), many involving youth. NVFD currently responds to these calls as part of its emergency role but does so without a mobile crisis structure, standardized protocols, or specialized behavioral health crisis training. As a result, emergency medical services, fire personnel, and law enforcement often serve as the first point of contact for crises that are not medical in nature. Nenana has completed preliminary readiness work and demonstrated strong commitment to developing a Mobile Crisis Team (MCT). This project focuses on intentionally planning the design and operational structure of an MCT within NVFD prior to implementation. The planning phase will develop operational plans, policies and procedures, workforce and training strategies, funding pathways, and phased implementation timelines to ensure the model is coordinated, sustainable, and responsive to community needs.	The proposed approach focuses on a structured planning phase to design and operationalize a Mobile Crisis Team (MCT) that will be housed within the Nenana Volunteer Fire Department (NVFD), ensuring the model is ready for safe, coordinated, and sustainable implementation. Planning activities will begin with confirming the scope and design of the MCT, including response criteria, hours of coverage, and coordination with existing emergency response operations. The planning process will align the MCT with NVFD’s structure while clearly defining how crisis response integrates with behavioral health partners, emergency medical services, and other community resources. The approach emphasizes cross-agency coordination and role clarity. Key partners, including behavioral health providers, schools, healthcare, and regional response partners, will be engaged to formalize referral pathways, communication protocols, and aftercare coordination. This ensures the MCT complements existing services and avoids duplication or system strain. A central component of the planning phase will be the development of policies, procedures, and safety protocols specific to mobile crisis response within NVFD. This includes response criteria, escalation guidelines, supervision structures, and alignment with state guidance and best practices. Workforce and training planning will identify appropriate staffing and volunteer models, training and certification requirements, supervision and clinical oversight needs, and a phased training plan tied to implementation milestones. The planning phase will also address funding and sustainability, including identification of potential Medicaid billing pathways, grant opportunities, and braided funding strategies to support long-term operations. Legal, risk, and compliance considerations will be reviewed to ensure the model is viable prior to launch. The planning process will conclude with a phased implementation roadmap that outlines next steps, timelines, and decision points for NVFD leadership and board approval. This approach ensures that any transition to full implementation is intentional, coordinated, and aligned with NVFD’s capacity and mission.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Yukon-Koyukuk Census Area	Advance to Planning

Nenana Volunteer Fire/EMS Department	Nenana EMS Planning Project	AK	Nenana is a rural Interior Alaska community of approximately 350 year-round residents located along the Parks Highway corridor between Fairbanks and Anchorage. Because this highway is the primary route connecting major Interior communities, Nenana experiences seasonal fluctuations in travel, tourism, and recreation that increase demand for emergency response. The Nenana Volunteer Fire Department (NVFD) provides the community’s primary emergency medical response across approximately 37 miles of roadway and surrounding remote areas. The community is situated between the Nenana and Tanana Rivers and serves as a hub for hunting, boating, and outdoor recreation, often requiring responders to operate in remote environments with extended response times. Like many rural EMS agencies, NVFD faces increasing call complexity, limited workforce capacity, volunteer fatigue, and constrained funding and billing infrastructure. The nearest emergency department is approximately 55 miles away, making many transports lengthy and resource intensive. Many 911 calls could be safely addressed through on-scene assessment, treat-in-place care, telehealth consultation, or referral to community-based services. A structured planning process will allow NVFD to assess readiness for community paramedicine, mobile integrated health, advanced certifications, and alternate care models that improve patient outcomes while strengthening workforce sustainability and rural EMS capacity.	The proposed project will support the Nenana Volunteer Fire Department in conducting a structured planning and readiness phase to guide the thoughtful expansion and modernization of emergency medical response services. This approach prioritizes feasibility, workforce sustainability, and alignment with statewide EMS best practices before implementation. The planning phase will begin with a comprehensive program readiness and feasibility assessment to evaluate NVFD’s current operational capacity, staffing levels, volunteer availability, and burnout risk. This assessment will clarify which emergency medical service models, such as treat-in-place, community paramedicine, mobile integrated health (MIH), telehealth consultations, and alternate destination transport, are realistic and appropriate for Nenana’s geography, call volume, and workforce structure. Workforce development planning will focus on mapping EMS career pathways from EMT-Basic through A-EMT and Paramedic, including assessing readiness to standardize certifications and phase out legacy EMT levels. The project will identify training timelines, certification requirements, local instructional capacity, and Train-the-Trainer opportunities, while planning tuition and support pathways for students entering a Paramedicine A.A.S. program. Recruitment and retention strategies will be developed to strengthen volunteer and paid responder pipelines, reduce burnout, and improve coverage depth. The approach will also include assessments of training and instructional capacity, technology and data infrastructure, and equipment and facility needs. This includes evaluating readiness for Patient Care Reporting (PCR), NERIS/ImageTrend reporting, billing documentation, and secure storage for medications and equipment. EMS billing practices, Medicaid and IHS reimbursement structures, and alternative payment models will be reviewed to support long-term financial sustainability. Throughout the planning phase, clear governance, coordination, and evaluation structures will be established. A phased implementation roadmap, performance metrics, and sustainability strategies will be developed to ensure alignment across workforce, technology, and billing systems. This approach positions NVFD to responsibly advance toward a modern, community-centered rural EMS system that improves patient outcomes while reinforcing operational and workforce stability.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

New Hope Counseling Center	Counseling Services for Uninsured	AK	Mental health challenges have been a long term concern in AK as many struggle with substance abuse, depression, anxiety disorders and suffer from traumatic experiences. Unfortunately sexual abuse is rampant in our state which can cause multi-faceted devastation for generations to come, not only personally, but on families and communities as well. At New Hope Counseling Center, we want to be resources of hope, change and restoration for people who struggle with substance abuse and mental health challenges and have suffered from traumatic experiences. Through our time as a counseling center, however, we have found that access to treatment can be hindered by financial constraints. While we bill most insurances and offer a 25% administrative discount for those who are uninsured, many who are uninsured are still not able to seek services due to cost. We are hoping that this grant can help subsidize services for those who are uninsured so that some of the most vulnerable populations will be able to seek services to assist them toward a pathway of recovery and restoration and flourishing.	Through this grant, we hope to be able to increase access to our services both locally and state wide. For those who are uninsured, they will be able to acquire services at a significantly discounted rate as the grant subsidizes their fee, making services accessible and cost effective for the client as well as New Hope Counseling Center. We will be able to market our services in rural communities in Western AK and Southeast AK thru tele-behavioral health where access to services is often very limited. We will also be able to market our services locally, communicating subsidized rates for those without insurance. Making services more affordable to clients without insurance will offer the hope and resources needed to address the challenges that hinder individuals from progressing in life.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Statewide	Anchorage (Municipality); Bethel Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Nome Census Area; Sitka (City and Borough)	Deferred or Not Advanced

New Life Perinatal Support Services	Implementing Integrated Home-Based Perinatal Support to Improve Maternal and Neonatal Outcomes	AK	Alaska’s rural and frontier communities experience persistent disparities in maternal and neonatal outcomes and preventable morbidity. These disparities are driven by geographic isolation, limited access to postpartum follow-up care, gaps in perinatal health education, cultural barriers, limited provider time for patient education, fragmented care coordination and the absence of a trained perinatal support workforce. In Northern and Southwestern Alaska, one-third of postpartum women report not receiving a postpartum checkup (Alaska PRAMS), increasing the risk of delayed identification of maternal and neonatal warning signs, preventable complications, and avoidable emergency department use. In remote communities, delayed care may result in costly aeromedical transport exceeding \$30,000 per flight, illustrating the high cost of delayed identification of complications. These challenges are not limited to specific regions but reflect systemic barriers to perinatal care access across Alaska’s rural and frontier communities. There is a significant opportunity to improve maternal and neonatal outcomes and strengthen continuity between clinical care and home recovery by expanding community-based perinatal workforce capacity, improving early risk identification in the home setting, and enhancing coordination between families and providers across the peripartum period.	This project establishes a scalable, community-based workforce that delivers structured, individualized, home based, health education and support to peripartum families. Designed for rural and frontier communities with limited maternal and neonatal infrastructure, the model embeds locally recruited Perinatal Support Professionals (PSPs) within each community to function as a bridge between families and the formal healthcare system. This non-clinical role operates within a defined scope of practice, focused on patient education, preventive care, early intervention, screening, care coordination and maternal recovery support. PSPs will complete an evidence based, standardized training and credentialing program, with cyclical competency requirements and ongoing supervision. This will establish a scalable, competent, localized workforce model capable of serving rural and remote communities. An initial regional capacity and needs assessment will identify existing infrastructure, key referral and escalation partnerships, baseline data (including emergency transfers, readmissions, priority outcome disparities and workforce capacity) and priority regions for implementation. Each enrolled family will receive a structured package of approximately 20–40 hours of support during the peripartum period, with duration adjusted based on risk stratification and family need. This duration reflects the clinical reality that the highest-risk window for maternal and neonatal complications occurs in the weeks following hospital discharge, when feeding patterns, weight trends, jaundice progression, maternal blood pressure changes, mood instability, infection, wound recovery and family adaptation to newborn care, evolve over days—not minutes. Extended shifts allow opportunity for longitudinal observation and support, enabling real-time lactation and newborn care coaching; offering practical support that stabilizes the families transition, fostering maternal-newborn bonding and reducing maternal strain during recovery, reinforcing peripartum education and enabling early identification of subtle warning signs that brief visits may miss. A secure, HIPAA-compliant, app-based EMR will standardize documentation, trigger escalation alerts, facilitate provider communication, and enable continuous data collection to evaluate outcomes and workforce utilization.	\$250K-\$1M	Maternal health	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

NextGen Dx, Inc	AI technology-enabled maternal-fetal care for healthy beginnings across Alaska	CA	Congenital heart disease (CHD)—the most common, serious, and costly birth defect—is missed by screening ultrasound more than half the time. Despite universal recommendation for prenatal ultrasound screening (the standard second-trimester ultrasound), a third of the world lacks ultrasound, including in Alaska where half of the counties are maternity care deserts. Scalable, accurate fetal screening—both hardware and software—is urgently needed for fetal heart and every problem and organ system that is evaluating using fetal ultrasound.	NextGen Dx delivers affordable, AI-enabled, full-stack fetal screening and monitoring. NextGen Dx addresses all causes for poor fetal ultrasound: Lack of ultrasound machines >> We provide an affordable, portable, easy-to-use ultrasound system. Required anatomic views are missed or are poor-quality unsuitable for diagnosis >> NextGen's on-board AI identifies and optimizes images in real time. Fetal biometric measurements are laborious and error-prone >> AI automates accurate biometric measurements. Inexperienced image interpretation >> AI provides screening diagnosis at the point of care. Lack of access to image storage/PACS >> System sends imaging securely to cloud PACS for review, sharing, telemedicine and quality improvement (supporting healthcare IT infrastructure).	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Nightingale College	Rural Nursing Education in AK	UT	Rural, remote, and frontier Alaska communities face a compounding crisis: severe nursing shortages, insufficient access to nursing education, and a revolving door of imported providers who lack the cultural understanding and trust essential to effective care. Traditional nursing education requires relocation to urban centers—a barrier that disproportionately excludes Alaska Native, rural, and underserved community members who are often the most motivated to serve. The result is a workforce that doesn't reflect the people it treats, and communities that remain underserved generation after generation. Nightingale College has partnered in Alaska for over five years because we believe geography should never determine who becomes a nurse—or who gets quality care. Our blended distance-learning model serves both the optimal student and those from underserved communities needing flexible, accessible pathways. Students complete accredited programs (LPN through MSN) without leaving home, training in facilities where they'll practice alongside people they already know. This is workforce architecture rooted in a simple truth: like people caring for like people produces better outcomes. RHTP investment will expand proven Alaska enrollment from 121 to 300 students by September 2026, building a sustainable pipeline that reflects our shared mission: better humanity through healthcare access for every Alaskan, in every region.	This concept scales enrollment from 121 to approximately 300 students within the first program year using Nightingale's existing curriculum, faculty recruitment capacity, technology platform, and clinical agreements—minimizing startup risk while maximizing speed to impact. Nightingale College leverages a proven blended distance-learning model that has operated successfully in Alaska for five years, combining three core elements: accessible online education, embedded local clinical training, and comprehensive learner support designed for students from underserved and rural communities. Phase 1 — Partnership Expansion & Student Recruitment (Months 1–6): Working with existing Alaska partners to identify prospective nursing students already employed or residing in rural communities. Recruitment will prioritize Alaska Native, rural, and frontier community members through partnerships with AHHA, the Alaska Health Workforce Coalition, AK DOL, and the Alaska Federation of Natives. Phase 2 — Blended Education Delivery (Ongoing): Students complete didactic coursework online from their home communities, supported by Nightingale's dedicated Learner Support Services team providing academic coaching, tutoring, and wrap-around services recognized with a Beacon Award from NWCCU for our 73% diverse student population. Learning follows a three-step model: individual study with learner support, faculty-led online verification of knowledge, and in-person clinical validation of skills at local healthcare facilities. Internet access through community centers in rural areas eliminates connectivity barriers. Phase 3 — Clinical Integration & Workforce Placement (Ongoing): Clinical education is embedded within partnering hospitals, Tribal health organizations, community clinics, and Critical Access Hospitals. Students train where they will practice, building relationships and institutional knowledge that accelerate readiness and retention. Clinical partnerships are already established across multiple Alaska regions with capacity to expand. Phase 4 — Service Commitment & Retention (Post-Graduation): All RHTP scholarship recipients enter five-year formal service agreements with participating healthcare employers, ensuring graduates remain in rural Alaska communities. Because students never left their communities to train, retention is organic rather than incentivized—they're already home.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Nine Star Education and Employment Services	Development of Healthcare Workforce Development Pipeline to Improve Outcomes for Community Partners	AK	Nine Star requests a grant to provide RHTP Employment Readiness Services to provide coordinated workforce development support for regional nonprofit tribal consortiums, community based workforce development programs and rural health agencies, with the goal of recruiting, advancing and retaining employees, as well as providing access and placement in remote and on-site jobs. Nine Star has a successful track record of providing strong workforce development services for the last 50 years, including our academic skills training, WorkKeys training and assessments, digital literacy training and certifications, financial literacy training, soft skills training, and job placement services. Nine Star is actively developing partnerships in Nome, Kotzebue, and Nuiqsut, and is exploring the needs in Bethel, Yakutat and Talkeetna to upskill, train and place rural residents in healthcare-related roles, such as Community Health Aides, Community Behavioral Health Aides, and Dental Health Aides. The culturally-sensitive services Nine Star provides would be customized to meet the specific needs of the communities inviting us in, and would help to create ready employees.	Our approach focuses on 4 rural Alaskan communities with an acute need for well-trained and prepared health care workers. Nine Star’s goal is to establish strong partnerships with local regional nonprofit tribal entities, existing community workforce development programs and healthcare organizations to provide workforce development training and education services that expand Nine Star’s successful job training curriculum, emphasize the unique cultural identities of the region, provide new job opportunities within the region and avoid outmigration. Through our partnerships with community leaders we hope to ensure that every person is well prepared for healthcare jobs in Alaska and we have established a local employment services model benefiting aspiring job seekers, the community and employment partners. Nine Star would serve as the training agency to ‘fill in the gaps’ assessed by our partners to help upskill existing employees, prepare jobseekers for long-term success, and to utilize our extensive course offerings and services to customize our approach to ensure employers have a strong roster of job candidates, and that local job seekers have access to remote jobs. Robust partnerships require a local presence to facilitate recruitment, training, and job placement. In 2025, Nine Star obtained limited grant funding to plan for development of distance-delivery training hubs to create a workforce pipeline for Bethel, Nome, Kotzebue, and Yakutat. Courses available from Nine Star would include GED preparation, financial literacy, resilience development, digital literacy, soft skills, and some hard skills focused on health care. In future project years, additional rural communities would be added to fully address employment needs and serve Network members. As part of the partnership with each community, we would collectively hire an Outreach Coordinator to help create strong relationship with our healthcare employment partners to map out employment needs and skills and provide a steady pipeline of prepared and aspiring candidates. IT upgrades at Nine Star’s main office would facilitate Network projects, including mapping available health care training and wraparound services; defining measurable Network objectives; establishing data sharing to monitor recruitment, outcomes, placement, retention, and certifications; evaluating results; and modifying strategies to meet employers’ needs.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced

Nine Star Education and Employment Services	Interagency Workforce Development Network	AK	Nine Star requests a grant to create an Interagency Workforce Development Network that convenes workforce training providers, Tribal consortiums, career services agencies, & health care providers with the shared goal of increasing the pool of candidates for rural health careers. The Network would reduce costs by eliminating silos that prevent data sharing, redundancies in recruitment & job placement services. Nine Star envisions a cohesive Network to transform workforce development into a seamless, statewide effort focused on increasing the number of CHA/Ps, BHA/Ps, DHATs, CHWs, RNs, and Peer Support Specialists. With 50 years of experience in Alaska workforce development, Nine Star is well-qualified to guide development of the Network and facilitate streamlining training, pre-employment & placement services to reduce the administrative burden on training providers and employers. Recruiting for health careers requires culturally sensitive relationships with the rural communities to be served. Nine Star is evaluating connectivity for 4 new educational hubs that provide career services and training in soft skills to serve Yakutat’s Community Health Center, Bethel’s YKHC, and Kotzebue’s Maniilaq Medical Center. Enhanced rural broadband connectivity will support distance-delivery education with connectivity to Anchorage. Each rural hub would be staffed by an Outreach Coordinator to maintain an ongoing Network presence and sustain relationships in each community.	The most acute need for health care workers is found in Alaska’s remote communities with their unique cultural identities distinct from multicultural urban communities on road systems. Nine Star believes that successfully increasing the rural workforce for these areas requires a transformational approach to eliminate the system of workforce silos operating in Anchorage, Juneau & Fairbanks. The current system hinders collaboration among training providers, employers, and career services providers. Establishing an Interagency Workforce Development Network comprised of all agencies in workforce development would reduce duplicative efforts, streamline workforce development, and align training with market demand. Nine Star would serve as the Network’s convener to assemble educational institutions, training providers, career services agencies, State of Alaska, Tribal entities, and health care providers. Network members would map current training programs, analyze gaps, define Network goals, and build partnerships that focus on rural employers’ specific needs. Nine Star adds value to the Network by providing training in soft skills that improve retention and career development; maintaining ongoing communication with rural partners; and sharing a digital platform to track progress and evaluate services. In the villages, robust partnerships require a local presence to facilitate recruitment, training, and job placement. In 2025, Nine Star obtained limited grant funding to plan for development of distance-delivery training hubs to develop a workforce pipeline pilot for Bethel, Kotzebue, and Yakutat. Hub equipment, which will be optimized for synchronous instruction and virtual collaboration, has the potential to serve the entire Network. Courses available from Nine Star would include GED preparation and soft skills focused on health care. In future project years, additional rural communities would be added to fully address employment needs and serve Network members. IT upgrades at Nine Star’s Anchorage office would facilitate Network projects, including mapping available health care training and wraparound services; defining measurable Network objectives; establishing data sharing to monitor recruitment, outcomes, placement, retention, and certifications; evaluating results; and modifying strategies to meet employers’ needs. The Rasmuson Foundation recently invited Nine Star to apply for a grant of \$200,000 that would support IT upgrades.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Yakutat (City and Borough)	Deferred or Not Advanced

Ninilchik Traditional Council	ADA-Accessible Mobile Integrated Health Expansion for Frontier Communities	AK	Despite long-standing health services in the region, critical access gaps persist: Kasilof Service Gap: Kasilof lies within NTC tribal boundaries yet lacks any permanent health services. Residents travel significant distances for primary care, behavioral health, and urgent services. Mobile pop-up clinics have demonstrated strong demand for recurring care. Mobile Infrastructure Limitations: NTC’s current mobile unit lacks ADA accessibility and sufficient space, limiting access for elders, individuals with disabilities, and patients with complex needs.	The LOI proposes a system-level rural health transformation that redesigns how care is delivered across the southern Kenai Peninsula by integrating our current mobile care, from substance use treatment to urgent care, and co-located primary and behavioral health services into one coordinated access corridor, rather than expanding isolated services. Core Approach Shift from fragmented, site-based care → to an integrated, hub-and-spoke access model led by the Ninilchik Traditional Council and aligned with the Rural Health Transformation Program. How the Concept Works: Mobile Integrated Health as the Front Door: We are a currently licensed Mobile Integrated Health program (with an additional ADA-accessible unit) brings care directly to unserved and underserved communities (especially Kasilof). Focus on prevention, early intervention, chronic disease management, behavioral health, and MOUD. Reduces travel burden and delays in care. Workforce + Technology Enablement Team-based staffing model (PCP, behavioral health, RN, MIH paramedic, care coordination). Telehealth and data integration connect all components into one system. What Makes This a “Transformation” (Not an Expansion) Uses existing licensure → high readiness, low startup risk Closes a tribal-boundary service gap (Kasilof) Integrates prevention + urgent + chronic care into one model Builds sustainable workforce pathways Reduces downstream costs (ED, medevac, delayed care) Creates a replicable rural model, not a one-off project.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementati on Application

Ninilchik Traditional Council	Anchor Point Rural Urgent Care and Integrated Access Stabilization	AK	The LOI proposes a system-level rural health transformation that redesigns how care is delivered across the southern Kenai Peninsula by integrating urgent care, and co-located primary and behavioral health services into one coordinated access corridor, rather than expanding isolated services. This project transforms fragmented rural services into a coordinated, tribally led health access corridor that delivers urgent, and integrated primary and behavioral health care close to home for Alaska Native / American Indian children, adults, and Elders, underserved children and adolescents, including those with limited access to preventive, behavioral, and primary care services, adults at risk for or living with chronic disease, including diabetes, cardiovascular disease, respiratory illness, and related conditions Individuals with behavioral health and substance use disorders, individuals with complex medical, behavioral, and social needs, older adults and individuals with mobility limitations or disabilities. Low-income and geographically isolated rural residents These populations experience disproportionate barriers to timely, coordinated care due to distance, workforce shortages, disability access limitations, and fragmented service delivery. The proposed initiative is designed to reduce these inequities by expanding integrated, culturally responsive, and accessible care close to home.	Shift from fragmented, site-based care → to an integrated, hub-and-spoke access model led by the Ninilchik Traditional Council and aligned with the Rural Health Transformation Program. Anchor Point as the Stabilization Hub: Existing building redesigned as a rural urgent care access point. Handles same-day needs, prevents avoidable ED use, and connects patients back to ongoing care. Integrated Care Center for Continuity Repurposed tribally owned property becomes a seven-day integrated urgent care and 5 day week primary care + behavioral health clinic. Multidisciplinary teams manage high-risk patients, underserved children, and adults at risk for chronic disease. Ensures continuity after urgent visits. Workforce + Technology Enablement Team-based staffing model (PCP, behavioral health, RN, medical assistant, care coordination). Telehealth and data integration connect all components into one system.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Nisma Therapy Services	Interior Alaska Multidisciplinary Rehabilitation & Telehealth Expansion	AK	Interior Alaska faces a severe shortage of rehabilitation providers, including speech-language pathologists, occupational therapists, and physical therapists. This workforce gap creates major barriers to care, forcing many individuals and families to wait months for services or travel long distances to access therapy. Rural communities are especially affected, where specialized rehabilitation services are limited or unavailable. Our clinic currently maintains a waiting list of approximately one year, demonstrating the significant unmet need for rehabilitation services across the region. Delays in care can negatively impact communication, learning, mobility, independence, and overall quality of life. Rehabilitation services are essential for children with developmental delays and autism, individuals with dyslexia and learning disorders, adults recovering from traumatic brain injury or stroke, and older adults experiencing neurological or mobility challenges. This project will expand access to multidisciplinary rehabilitation services by strengthening workforce capacity, expanding telehealth services statewide, improving clinical infrastructure, and adding physical therapy to our existing speech-language pathology and occupational therapy programs.	This project will expand multidisciplinary rehabilitation services across Alaska through workforce development, facility improvements, telehealth expansion, and rural outreach. Funding will support critical facility upgrades to increase therapy capacity and accessibility, ensuring the clinic can safely serve individuals with disabilities and complex medical needs. Improvements will create safe, functional spaces for children, adults, and older adults requiring specialized care. The project will also fund the purchase of specialized therapy equipment and diagnostic materials for conditions including developmental delays, dyslexia, traumatic brain injury, autism spectrum disorder, and neurological disorders. Funding will support development of Activities of Daily Living (ADL) therapy environments, including adaptive kitchen equipment such as a stove and dishwasher, to help patients practice independent living skills. Expansion of telehealth infrastructure will allow clinicians to serve patients throughout the state, particularly in rural and remote communities with limited access to rehabilitation services. Funding will support recruitment, retention, and training of rehabilitation professionals, including speech-language pathologists, occupational therapists, physical therapists, therapy assistants, and clinical support staff. These efforts will strengthen workforce capacity, reduce wait times, and improve access to timely, high-quality care. Together, these investments will allow the clinic to function as a comprehensive, multidisciplinary rehabilitation center, providing essential services to children, adults, and older adults across Alaska and addressing the critical unmet need for rehabilitation care statewide.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Matanuska-Susitna Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Nolan Davis DDS LLC	Frontier Aviation Dental Access & Safety Initiative	AK	The Problem Yakutat faces ongoing oral health disparities due to: • No resident full-time dentist • High untreated decay rates • Expensive and weather-dependent travel • Emergency dental evacuations Currently, Dr. Davis uses an older (1969) VFR aircraft that is not optimally equipped for Southeast Alaska’s challenging weather patterns. If weather does not allow for a VFR landing at the destination airport (Yakutat or Juneau), the plane does not carry enough fuel to return to the airport of origin. The 200 mile flight is usually executed at a very low altitude along the coastline below a low cloud ceiling and often through showers. Limited weather capability results in canceled or delayed clinics. Compounding the problem: • Commercial jet service is infrequent • FAA ground-based equipment outages have disrupted reliability numerous times • Potential reductions in federal airline subsidies threaten further flight reductions • Decreased airline service would significantly reduce healthcare access • The weather between Juneau and Yakutat around Mt Fairweather and Glacier Bay can be deadly Without intervention, Yakutat’s access to dental services may become even more unstable. The Opportunity The opportunity is to stabilize and strengthen an existing, proven care model by investing in a safer, more weather-capable aircraft. This ensures healthcare delivery remains independent of commercial airline vulnerabilities.	Phase 1: Aircraft Acquisition • Purchase a safer, IFR-certified aircraft with deicing or anti-icing equipment that is appropriate for Alaska conditions • Ensure enhanced avionics and terrain/weather safety features • Complete FAA registration and insurance underwriting Phase 2: Service Stabilization • Establish consistent monthly or bi-monthly dental rotations • Coordinate scheduling with Yakutat Community Health Center • Expand school-based preventive programs • Strengthen recall systems for ongoing treatment Clinical Services • Preventive care (cleanings, fluoride, sealants) • Restorative care (fillings, crowns, dentures) • Extractions • Emergency stabilization • Pediatric services • Oral health education Portable equipment will continue to be used within local clinic infrastructure.	\$250K-\$1M	Dental	Single Community	Yakutat (City and Borough)	Deferred or Not Advanced

Nolan Davis DDS LLC	Mobile Marine Dental Clinic for Gustavus, Pelican, Elfin Cove, Tenakee and Baranoff Springs	AK	Residents of Gustavus, Pelican, Elfin Cove, Tenakee and Baranoff Springs face profound barriers to oral health care: • No dental clinic or dental provider in Gustavus, Elfin Cove, Baranoff Springs or Tenakee Springs • No health clinic in Elfin Cove or Baranoff Springs • Limited, intermittent dental availability and limited services in Pelican (by Dr. Davis) • No airport in Pelican, Elfin Cove, Tenakee or Baranoff Springs • Travel to Juneau costs hundreds of dollars per visit in transportation and lodging • Weather conditions frequently delay or cancel travel • High rates of untreated decay and periodontal disease • Increased emergency department use for preventable dental issues These conditions contribute to: • Chronic pain and infection • Missed school and work • Higher long-term healthcare costs • Disproportionate oral health inequities in frontier communities The small population of each community does not warrant full time dental provider presence. Fixed-site clinic structures, if constructed, would sit unused the majority of the time and equipment, supplies and materials would be multiplied and wasted. This project addresses a clear opportunity: using Alaska’s marine transportation reality to create a maritime-based healthcare delivery model tailored to Southeast Alaska’s geography.	Phase 1: Vessel Acquisition and Retrofit • Purchase a seaworthy catamaran (for stability) vessel capable of operating safely in Southeast Alaska waters. • Retrofit the vessel with a fully functional mobile dental clinic including: - o Fully functional dental operatory (or two) - o Digital X-ray - o Modern equipment including CAD/CAM crown mill - o Sterilization area - o Accessible patient entrance - o Secure medical storage Phase 2: Staffing and Scheduling • Recruit a licensed dental hygienist and dental assistant (Excellent Staff has been identified) and a Coast Guard certified Captain (already identified if needed) • The dentist submitting this proposal will be the Staff Dentist • Establish a recurring service schedule • Coordinate with community leadership to ensure appointment access • Coordinate with Harbor Masters and the National Park Service (in process) for dock space Phase 3: Community Integration • Partner with local clinics and health aides • Conduct preventive education sessions • Implement telehealth consultation capabilities for specialty referrals Services Provided • Preventive care (cleanings, fluoride, sealants) • Restorative care (fillings, crowns) • Extractions • Emergency stabilization • Pediatric services This approach ensures both urgent and preventive care are addressed consistently.	\$1M-\$5M	Dental	Multi-Community or Participating in Regional Hub-and-Spoke	Hoonah-Angoon Census Area	Deferred or Not Advanced

Nome Community Center Inc	Improving Health Through Food Access in Nome	AK	Residents of Nome and surrounding villages face significant barriers to accessing affordable, nutritious food, which directly impacts health outcomes. The cost of groceries in rural Alaska is among the highest in the nation due to transportation challenges, limited supply chains, and geographic isolation. Many households must rely on infrequent shipments and small local stores where healthy foods are often expensive or unavailable. Food insecurity is a growing concern in the region and contributes to higher rates of chronic health conditions such as diabetes, cardiovascular disease, and obesity. When individuals and families cannot consistently access nutritious foods, it becomes more difficult to manage healthy lifestyles, maintain reliable attendance at school or work, and sustain mental and physical wellness. For many residents, the local Food Bank, Community Garden, Nome Emergency Shelter (NEST), and XYZ Senior Center serves as critical safety nets for people during times of financial hardship and need for support. With the increase in expenses and unreliable SNAP and Medicaid benefits, the demand for services and support has increased significantly.	Initial phase of the project will entail increased food distribution through the Nome Food Bank, Nome Emergency Shelter (NEST), XYZ Senior Center, and the Community Garden. During this phase, education will demonstrate the importance of nutrition and healthy lifestyle choices. Partnerships with local entities will ensure wholistic support and services. The second phase of the project will focus on long-term solutions and sustainability. Education on gardening, subsistence, and financial management will be offered during this phase. Supplies will be distributed to support local subsistence, such as fishing poles and preservation supplies.	\$50,000-\$250,000	Single Community	Nome Census Area	Deferred or Not Advanced

North Slope Borough	North Slope Rural Clinic Upgrades	AK	Health clinics across the North Slope Borough serve as the primary access point for medical, behavioral health, emergency stabilization, prevention, and chronic disease management services in some of the most remote communities in the United States. Clinics in: • Atqasuk • Anaktuvuk Pass • Kaktovik • Nuiqsut • Point Hope • Point Lay • Wainwright • Utqiagvik operate in extreme Arctic conditions where power disruptions, aging infrastructure, and equipment limitations pose risks to patient safety and continuity of care. Many existing clinic facilities require infrastructure upgrades, and several rely on aging generators that have exceeded their operational lifespan. Power interruptions in these environments can: • Disrupt emergency stabilization and trauma response • Interrupt vaccine refrigeration and medication storage • Disable electronic health systems and telehealth services • Compromise behavioral health service continuity • Increase risk to patients and staff This project addresses a critical rural health transformation need: strengthening capital infrastructure and resiliency to ensure uninterrupted access to care in remote communities.	The North Slope Borough Health Department proposes to support clinic facility upgrades and generator replacement across all North Slope communities. 1. Generator Replacement • Purchase and installation of new, appropriately sized backup generators for each village clinic. • Integration with existing electrical systems. • Weather-resistant housing and Arctic-rated equipment. • Compliance with safety and regulatory standards. 2. Targeted Facility Infrastructure Upgrades • Electrical system improvements to support modern medical equipment. • Structural or interior repairs necessary to maintain safe operations. • Energy efficiency enhancements where feasible. • Protection of IT and telecommunications infrastructure. • Improvements that ensure compliance with health and safety standards.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Advance to Implementation Application

North Slope Borough	Health Impact Assessment & Cultural Practice Healing Model Research	AK	Rural communities in the North Slope Borough experience disproportionate rates of chronic disease, behavioral health challenges, and limited access to culturally aligned services. Health planning and infrastructure investments often occur without a formal Health Impact Assessment (HIA) process grounded in both epidemiological data and Indigenous knowledge systems. This project addresses a critical rural health transformation opportunity: establishing a data-driven and culturally informed foundation for improving access, quality, coordination, and long-term fiscal sustainability of health care in rural Alaska. Specifically, this initiative will: • Strengthen appropriate care availability by identifying service gaps and barriers. • Advance prevention and chronic disease strategies through upstream health impact analysis. • Integrate behavioral health considerations into community planning. • Foster collaboration across Tribal, local government, and health system partners. • Develop an innovative care framework rooted in cultural healing practices to improve trust and engagement in care delivery.	The North Slope Borough Health Department proposes to request \$450,000 to procure qualified contractors to implement two coordinated and transformative efforts for health care in Alaska. 1.) Rural Health Impact Assessment (HIA) A contracted public health and evaluation team will: • Conduct cross-sector stakeholder engagement across rural communities. • Analyze epidemiological, behavioral health, environmental, and social determinant data. • Assess projected health impacts of economy, policy, infrastructure, and system-level decisions. • Identify gaps in appropriate care availability and service coordination. • Develop actionable, evidence-based recommendations to improve quality, access, and cost-efficiency. The HIA will inform rural health transformation planning and strengthen long-term fiscal sustainability by guiding strategic investments toward high-impact prevention and care coordination strategies. 2.) Cultural Practice Healing Model Development A culturally competent facilitation and planning team will: • Conduct structured engagement with Elders, cultural knowledge bearers, and community stakeholders. • Identify protective cultural practices that support prevention, resilience, and behavioral health. • Develop a formal Cultural Practice Healing Model framework. • Provide implementation guidance and workforce training recommendations. • Produce a scalable framework adaptable across rural communities. This initiative will strengthen workforce capacity by equipping providers with culturally responsive tools and supporting trauma-informed approaches. It advances innovative care delivery models that integrate traditional healing and public health systems.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

North Slope Borough	North Slope Borough Medical Billing Implementation	AK	The North Slope Borough Health Department delivers prevention, behavioral health, clinic-based, and community health services across some of the most remote communities in Alaska. While services are expanding to meet community need, revenue cycle infrastructure has not been fully developed to maximize third-party reimbursement opportunities. Limited internal billing capacity and the absence of a dedicated medical billing structure restrict the Department’s ability to: • Capture eligible Medicaid and insurance reimbursements • Sustain workforce and service expansion • Support prevention and behavioral health program growth • Improve fiscal forecasting and financial transparency To advance rural health transformation, strengthening revenue cycle management is essential to improving fiscal sustainability and reducing reliance on short-term or uncertain funding streams. This project addresses a critical system-level transformation opportunity: building durable medical billing infrastructure to align financial operations with service delivery and ensure long-term sustainability.	The North Slope Borough Health Department proposes to request RHTP funding to either: 1. Hire a full-time Medical Billing Agent (including wages and benefits), or 2. Procure a qualified contractor to provide comprehensive medical billing and revenue cycle management services. Key Project Components: 1. Revenue Cycle Development • Establish billing workflows for eligible services. • Ensure compliance with Medicaid, Medicare (where applicable), and third-party payer requirements. • Develop documentation and coding standards aligned with reimbursable services. • Improve claims submission, tracking, and denial management processes. 2. Workforce & Administrative Capacity Building • Train clinical and prevention staff on documentation requirements. • Strengthen internal processes to support accurate coding. • Establish financial monitoring and reporting dashboards. 3. Contractor Option (if selected) • Solicit and contract with an experienced rural medical billing vendor. • Integrate billing services with electronic health record systems. • Provide ongoing revenue cycle oversight and optimization.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

North Slope Borough	North Slope Land Based Youth Adventure & Prevention Program	AK	Youth across the North Slope Borough face increasing risks related to behavioral health challenges, substance misuse, social isolation, and limited access to structured extracurricular opportunities. Rural isolation and harsh environmental conditions can limit opportunities for positive youth engagement, physical activity, and leadership development outside of school settings. At the same time, the Arctic environment provides unique opportunities for culturally relevant, land-based learning experiences that strengthen resilience, connection to place, and protective social supports. This project addresses a critical prevention opportunity: expanding land-based wellness and leadership programming that promotes physical health, behavioral health resilience, and youth engagement through structured outdoor adventure experiences. By combining expedition-style outdoor learning with ongoing after-school programming, the initiative strengthens prevention infrastructure and builds long-term protective factors among youth across the North Slope.	The North Slope Borough Health Department proposes to implement a land-based youth adventure and prevention program consisting of two complementary components: • multi-day outdoor expeditions led by professional instructors from the National Outdoor Leadership School (NOLS), and • weekly after-school adventure programming in North Slope communities. This initiative aligns directly with RHTP allowable uses including: • Prevention and chronic disease • Behavioral health • Healthy Communities • Workforce and leadership development • Training and technical assistance • Fostering collaboration 1. Land-Based Youth Expedition Program Partnering with NOLS instructors, youth participants will engage in structured outdoor expeditions focused on: • leadership development • teamwork and communication skills • resilience and stress management • environmental awareness and land stewardship • physical activity and healthy lifestyle development • confidence building and goal setting Expeditions will incorporate culturally respectful land-based experiences that encourage youth to build meaningful connections with the Arctic environment while developing leadership and life skills. 2. Weekly After-School Adventure Programming In addition to expedition programming, the project will establish recurring after-school adventure activities designed to maintain engagement throughout the year. Activities may include: • hiking and outdoor exploration • winter survival and safety skills • team-based adventure challenges • outdoor physical fitness activities • leadership and confidence-building exercises • culturally informed land-based learning opportunities These activities will provide safe, structured alternatives to risk-taking behaviors and create consistent engagement opportunities for youth across communities.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

North Slope Borough	North Slope Prevention & Community Wellness Outreach Initiative	AK	Communities across the North Slope Borough experience elevated rates of chronic disease, substance misuse, suicide risk, trauma exposure, and preventable health conditions. Geographic isolation, limited behavioral health access, and high travel costs create barriers to consistent prevention engagement. There is a critical opportunity to expand community-driven, culturally responsive prevention initiatives that engage both youth and adults, strengthen protective factors, and integrate behavioral and physical health education into accessible community-based programming. This project advances rural health transformation by strengthening prevention infrastructure, expanding behavioral health engagement, and improving access to high-quality, community-centered wellness initiatives across all North Slope communities.	The North Slope Borough Health Department proposes to implement a coordinated suite of prevention-focused outreach initiatives designed to increase access, engagement, and sustainability of prevention services across the region. Core Project Components: 1. Youth Wellness Camp Initiative - A structured, culturally grounded wellness camp for youth focused on: • Behavioral health awareness and resilience building • Substance misuse prevention • Physical activity and nutrition education • Cultural identity strengthening and protective factors • Leadership development and peer mentorship The camp will incorporate trauma-informed approaches, evidence-informed prevention curricula, and engagement from community role models and Elders. 2. Men’s Health Prevention Outreach (Travel to All North Slope Communities) Prevention staff will travel to: • Atqasuk • Anaktuvuk Pass • Kaktovik • Nuiqsut • Point Hope • Point Lay • Wainwright • Utqiagvik to conduct targeted men’s health engagement sessions focused on: • Chronic disease prevention (heart disease, diabetes, hypertension) • Cancer screening awareness • Behavioral health and suicide prevention • Substance misuse prevention • Healthy coping strategies and stress management • Increasing engagement in primary care and preventative screenings This outreach reduces barriers to access by bringing prevention services directly into communities. 3. North Slope Behavioral & Physical Health Conference A regional conference designed to: • Integrate behavioral health and physical health education. • Provide prevention training and continuing education. • Foster cross-sector collaboration between providers, Tribal partners, schools, and community leaders. • Strengthen community knowledge of available services. • Promote culturally responsive and trauma-informed prevention practices. The conference will enhance local workforce capacity and strengthen coordination across systems of care.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

North Slope Borough	North Slope Rural Health Technology Modernization	AK	Health facilities and clinics across the North Slope Borough operate in an environment where aging technology infrastructure, limited broadband stability, and outdated hardware reduce efficiency, compromise data security, and limit coordination of care. Many rural clinics rely on aging computers, unsupported software systems, limited network redundancy, and insufficient data storage capacity. These limitations directly affect: • Timely documentation and reporting • Secure transmission of patient information • Telehealth capabilities • Care coordination across providers • Workforce productivity • Regulatory compliance and cybersecurity readiness To advance rural health transformation, technology infrastructure must support secure, reliable, and scalable service delivery. Modernized IT systems are foundational to improving appropriate care availability, strengthening behavioral health integration, enhancing prevention services, and ensuring fiscal sustainability.	The North Slope Borough Health Department proposes to secure RHTP funding to modernize and standardize technology infrastructure across health facilities and clinics in all North Slope communities. Technology Upgrades Will Include: Hardware Modernization • New desktop and laptop PCs • Monitors and dual-screen workstations • Printers and multifunction copy machines • Handheld radios • Secure servers and backup systems • Network switches and structured cabling • Data storage systems Network Infrastructure • Upgraded network connections • Enterprise-grade Wi-Fi routers • Wi-Fi extenders for clinic coverage • Network redundancy and failover equipment • Secure VPN access capability Cybersecurity & Software • Updated operating systems and licensed software • Virus protection and endpoint security • Firewall upgrades • Encrypted storage solutions • Multi-factor authentication systems • Data backup and disaster recovery systems These upgrades will create standardized, secure, and resilient infrastructure across rural clinic sites.	\$1M-\$5M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

North Slope Borough	North Slope Rural Workforce Training	AK	Rural communities in the North Slope Borough face significant workforce shortages across prevention services, behavioral health, and the Community Health Aide Program (CHAP). Geographic isolation, high travel costs, limited local training availability, and credentialing requirements create barriers to maintaining a qualified and sustainable workforce. Retention and advancement of local providers is essential to improving appropriate care availability, strengthening behavioral health systems, advancing prevention strategies, and ensuring long-term fiscal sustainability of rural health services. This project addresses a critical transformation need: investing in workforce certification, advancement, and retention to strengthen rural health system capacity and improve access, quality, and continuity of care.	The North Slope Borough Health Department proposes to secure RHTP funding to support airfare, training registration, certification, and credentialing costs for frontline health personnel in prevention, behavioral health, and CHAP programs. This initiative aligns directly with RHTP allowable uses including: • Workforce • Behavioral health • Training and technical assistance • Appropriate care availability • Prevention and chronic disease • Fostering collaboration Funding will support participation in the following training and certification activities: Community Health Aide Program (CHAP) • CHAP Session Training • CHAP State Board Certification • Emergency Trauma Technician (ETT) Training • Advanced CHAP certifications • Appropriate care availability across seven rural communities Behavioral Health Workforce • Behavioral Health Aide Certification • Counselor and Clinician License Renewals • Advanced Clinical Certifications • Continuing Education Units (CEUs) required for licensure Prevention & Community Health • Prevention Specialist Certification • Mental Health First Aid (MHFA) • CPR / Basic Life Support • Supervisory or Leadership Certifications • Advanced Trainer Credential • Continuing Education Units (CEUs) required for licensure • Advanced public health or prevention credentials Due to the remote location of the North Slope Borough, airfare and technology limitations represent substantial barriers to workforce development. RHTP investment will directly remove barriers to access training infrastructure not locally available.	\$50,000-\$250,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

North Slope Borough Fire Department	Foundations for Regional EMS Training	AK	All communities in the North Slope Borough are geographically isolated, requiring expensive air travel to provide training opportunities for certification, skills and continuing medical education. Improvements to video conferencing and internet connectivity have begun to create additional training opportunities, but the cost of training equipment, particularly that geared toward at risk populations in the states RHTP proposal, is cost prohibitive to full realization of this opportunity. Medical care in village clinics is limited to first responder service and village Community Health Aide/Practitioners. Access to higher levels of medical care, such as that in Barrow or Anchorage, requires medevac assets that may have limited availability or difficulties of access created by geography and/or weather. This project seeks to improve the quality of local BLS and potential limited ALS care, supporting the ability for local first responder services to seek licensure as full-fledged ambulance services, and enhancing the local knowledge and skills of local EMS and health providers, to support them in patient care when delays to patient access to higher levels of care exist. Other EMS regions have a similar problem, and there is early discussion of collaboration on similar and compatible projects among the EMS regions state wide.	This project seeks to take a hub and spoke approach to regional EMS training, purchasing identical training equipment for a regional center in Barrow, and satellite sites in each village. This will allow for decentralization of training, while allowing remote students to follow along with with skills and training with identical equipment in their home communities. For more specialized equipment, such as OB trainers and ALS equipment, the intent is to create a central cache in Barrow that can be sent as needed to specific communities. A preliminary equipment list to support this approach included adult and pediatric airway mannikin for each village, baby CPR mannikins, trauma training equipment, iSimulates to allow for remote scenarios for each village and a central set in Barrow to support teaching. Additional equipment for a regional basis includes birthing simulators that can simulate common delivery problems, a low-medium fidelity trauma mannikin to support ALS skills and Barrow and the training needs of the fire department medevac service, and additional ALS training equipment to eventually support the local delivery of ALS certification classes in Barrow like EMT-II, EMT-III and AEMT. This would also allow the long term opportunity to collaborate with the Arctic Slope Native Association in simulation and scenarios. The hospital, in partnership with a local university, supports a nursing school program in Barrow. This equipment would allow for collaboration that could include simulation of full continuity of care between initial assessment, stabilization and transport in the field, to village clinic and/or medevac and/or ambulance to the Samuel Simmonds Memorial Hospital. As SSMH seeks to expand their capabilities to include an operating room and seeking certification as a level III trauma center, this will allow the fire department and health department to both take enhance and take advantage of these capabilities for area residents and better support the capabilities in the transfer of patients from SSMH to other specialty centers in Anchorage by the fire department aeromedical division.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Advance to Implementation Application

North Slope Borough Fire Department	Regional EMS training for vulnerable populations and long-term sustainment	AK	Access to quality training is impacted by remoteness in NSB villages due to remote geography and the costs associated with airfare. Weather or limited resources can also mean that sick patients requiring medevac may wait hours or days for transfer to an appropriate facility. In small villages, one incident might significantly strain the resources or morale of local responders, especially in the case of fatalities that might have close community connections to responders within the community. This project is the first step in a multi-year plan to improve the training of villages, Barrow and the NSBFD medevac division to incrementally increase the level of care provided to RHTP target populations relative to the existing capabilities of each entity. This project also seeks funds to create additional instructors to improve long term training sustainability, supporting a separate RHTP proposal for purchasing equipment for a regional hub and spoke EMS training center approach. Last, this proposal seeks to improve responder resilience by ensuring each community has access to at least one person trained in psychological first aid and critical incident stress debriefings.	This project takes consists of three separate tracks to improve training. The first divides the fire department into loose functional areas with similar capabilities: village fire departments, Barrow Fire Department, and the Aeromedical Division. This track seeks to incrementally improve the capabilities of each functional area relative to their existing capability in support of RHTP target populations through funds allocated to specific classes, with a first year focus on pediatrics. The second track is to improve long term sustainability of the training program by seeking funds for instructor training to support the separate RHTP proposal seeking equipment to create a regional EMS training center on a hub and spoke model. Last, the third track seeks to funds to send personnel from each community to training in psychological first aid and critical incident stress debriefing.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Advance to Implementation Application
North Slope Borough Fire Department	EMS equipment for vulnerable populations	AK	Currently, the village ambulances do not have a method of properly securing infants and small children to a stretcher and limited pediatric trauma equipment, like size appropriate backboard or vacuum mattresses. Additionally, NSB villages do not have the appropriate equipment or training to care for patients requiring manual or mechanical ventilation for sustained periods of time. This proposal addresses both of these problems by purchasing ETT/EMT level appropriate equipment to fill this void.	Pediatric transport needs will be met by using RHTP funds to purchase a pediatric vacuum mattress and commercially available pediatric securing device, like a pedimate, for each NSB community ambulance. For manual ventilation support, the proposal seeks funds to purchase an Archeon EoLife for each ambulance. This device provides feedback on the rate and volume of manual ventilations administered using a bag, valve mask device, providing feedback on the quality of breaths as well as proper mask seal. This device directly supports American Heart Association resuscitation guidelines which emphasize the importance of delivery of proper volume breaths during resuscitative efforts.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

North Star Behavioral Health	North Star Cerner EHR Implementation Project	AK	Behavioral health hospitals, particularly Institutions for Mental Diseases (IMDs), were excluded from federal Meaningful Use incentives, resulting in dated systems that lack interoperability with rural and Tribal providers. Rural Alaskans face long travel times, limited local services, and fragmented transitions of care, which can cause delays, safety risks, and readmissions. North Star’s statewide role, including the only acute inpatient program for children under 12 and specialized services for veterans and first responders, makes it a critical hub for rural patients. However, current technology limits real-time coordination with referring and returning providers, schools, and community behavioral health organizations. The proposed modernization of the Cerner EHR aims to create a secure, interoperable infrastructure that supports seamless data exchange, expanded telehealth (including rural IOP with Starlink), earlier intervention through school and community partnerships, and improved workforce satisfaction and retention. These enhancements will improve access, quality, and sustainability of rural behavioral health care in line with RHTP priorities.	Behavioral health hospitals, particularly (IMDs), were excluded from federal Meaningful Use incentives, leaving many facilities with outdated systems that cannot reliably share information with rural and Tribal providers. For rural Alaskans—who often face long travel distances, limited local treatment options, and fragmented care transitions—these gaps create delays, safety risks, and avoidable readmissions. North Star serves as a statewide behavioral health hub, including Alaska’s only acute inpatient program for children under 12 and specialized services for veterans and first responders, yet current technology limits real-time coordination with rural clinics, schools, Tribal health organizations, and community behavioral health agencies. Implementing the Cerner EHR will create a secure, interoperable infrastructure that supports timely data exchange and expands telehealth options. These changes directly advance RHTP’s goals around access, care coordination, and system sustainability. North Star will implement the Cerner Electronic Health Record as the core infrastructure for modernizing behavioral health care delivery across Alaska. This includes full system build, interface development, data migration, workflow redesign, staff training, and cybersecurity enhancements. Once live, Cerner will support real-time exchange of clinical information—admissions, discharges, medications, safety plans—with Tribal partners, rural hospitals and clinics, and statewide data networks. The platform will integrate with North Star’s Quality Assurance and Performance Improvement (QAPI) processes, enabling stronger outcome monitoring, safer medication practices, equity tracking, and enhanced reporting for value-based care. Beyond inpatient modernization, Cerner will serve as the technological backbone for expanding future telehealth-based Intensive Outpatient Program (IOP) services. North Star aims to broaden partnerships with schools, community agencies, and Tribal organizations to create virtual step-down pathways for youth and adults returning home.	\$1M-\$5M	Behavioral health/su bstance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

North Star Volunteer Fire Department	Frontier EMS Rapid Access and Patient Extrication Program	AK	The North Star Volunteer Fire Department serves a rural and frontier area where many residents build homes off established road systems, down long driveways, on seasonal trails, or in areas with limited infrastructure. As a result, emergency vehicles cannot always directly access patients. During winter months, the problem intensifies due to heavy snow loads, narrowed roadways, drifting, and reduced street widths. Standard ambulances and fire apparatus often cannot safely navigate these conditions, delaying emergency medical response. In addition, our service area hosts numerous outdoor activities and events such as dog sledding and snowmachining across trail systems and remote terrain. When injuries occur during these events, responders face significant challenges reaching patients quickly and safely. Without specialized off-road equipment, accessing and transporting injured individuals from these locations is time-consuming and resource intensive. This lack of reliable off-road access directly impacts response times and patient outcomes. Addressing this gap is critical to ensuring timely, equitable emergency medical care for residents and visitors in our rural community.	Our proposed approach is to modernize and expand our off-road emergency response capabilities by replacing outdated equipment and acquiring purpose-built all-terrain and winter response assets. Through this grant, we will purchase Side-by-Side vehicles, snowmachines, trailers, updated rescue equipment, cold weather PPE, and patient transport systems specifically designed for rugged terrain and extreme winter conditions. This investment will allow us to remove aging, unreliable equipment currently used in limited off-road responses and replace it with safer, more dependable, and medically appropriate transport platforms. The new equipment will be configured to support patient packaging, stabilization, and secure transport from remote locations to the established road system where ambulances can assume care. By improving the transfer point between off-road response and traditional EMS transport, we will reduce delays in definitive care and improve patient outcomes. The equipment will be integrated into our existing response plans, training programs, and maintenance systems to ensure long-term sustainability. Personnel are already trained in wilderness EMS, cold weather operations, and technical rescue, allowing immediate operational deployment upon acquisition. Standard operating guidelines will be updated to formalize activation criteria, response protocols, and safety procedures. In addition to improving service within our own jurisdiction, this project strengthens regional response capacity. The upgraded equipment will be available for mutual aid when requested, allowing us to assist surrounding departments that lack specialized off-road or winter rescue capabilities. This collaborative approach enhances overall emergency preparedness across our region and ensures consistent access to emergency medical care for rural residents and visitors. By upgrading equipment, improving reliability, and enhancing patient transport capability from remote areas to the road system, this project directly addresses current response gaps and creates a sustainable, modern solution for rural emergency access challenges.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough	Deferred or Not Advanced

North Star Volunteer Fire Department	Rural EMS Workforce Development and Simulation Training Initiative	AK	Advancements in medical simulation technology have significantly improved the way EMS personnel are trained to respond to real-world emergencies. However, many rural departments, including ours, lack access to modern training equipment due to limited funding. Without advanced training aids, responders must rely on basic or outdated training tools that cannot fully replicate the complexity and stress of real patient care situations. This project addresses the need for more realistic, hands-on training opportunities for our EMS providers. By acquiring a modern EMS training manikin, our department will be able to conduct high-quality scenario-based training that closely mirrors real medical emergencies. This type of training allows responders to practice patient assessment, airway management, cardiac care, trauma treatment, and other critical interventions in a controlled environment before encountering these situations in the field. Improving the realism and quality of training directly strengthens the skills, confidence, and decision-making ability of our EMS personnel. In rural communities where emergency responders may be the first and only medical providers for extended periods of time, strong training is essential. By investing in better training tools, we can ensure our providers are better prepared to deliver effective care, ultimately leading to improved patient outcomes in the communities we serve.	Our approach is to enhance the quality and realism of EMS training by acquiring an advanced medical simulation manikin capable of replicating a wide range of emergency medical conditions. This training device will allow our department to conduct scenario-based simulations that mirror real-world incidents commonly encountered by rural EMS providers. The advanced manikin will enable training in critical areas such as cardiac arrest management, airway interventions, respiratory emergencies, trauma care, patient assessment, and other life-threatening medical conditions. Unlike traditional training tools, modern simulation manikins provide real-time feedback on key interventions such as chest compressions, ventilation quality, airway placement, and other lifesaving skills. This feedback allows students and instructors to evaluate performance, identify areas for improvement, and reinforce correct techniques during training exercises. By incorporating this technology into our training program, we will be able to create more realistic and challenging scenarios that strengthen both individual clinical skills and team-based response coordination. Personnel will have the opportunity to repeatedly practice complex medical scenarios in a controlled environment, improving confidence, decision-making, and patient care skills before responding to actual emergencies. This equipment will support training for paid staff, scholarship firefighters, and volunteer members within our department. Additionally, the manikin will allow us to expand training opportunities by conducting regular skills sessions, continuing education programs, and scenario-based drills designed to maintain clinical competency. Ultimately, this approach strengthens our EMS training infrastructure and ensures responders are better prepared to deliver high-quality patient care in the field. By improving training realism and providing measurable performance feedback, the project directly supports improved emergency medical response and better patient outcomes for the rural communities we serve.	Under \$50,000	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced

Northern Hope Center	Northern Hope Center Integrated Drop-In and Peer Crisis Pathway	AK	Northern Hope Center operates a drop-in center in Fairbanks that provides low-barrier support to individuals experiencing behavioral health challenges throughout Interior Alaska. While the drop-in model has proven effective, our current capacity is limited, and we lack the peer crisis infrastructure needed to serve individuals in acute crisis, divert them from emergency departments and contact with law enforcement, and connect them to sustained clinical care. There is a critical and unmet need for peer-delivered crisis support in Interior Alaska, a region where behavioral health provider shortages are severe, emergency departments are overburdened, and community-based crisis alternatives are virtually nonexistent. RHTP funding represents an opportunity to build on a working foundation and close this gap.	Northern Hope Center will expand its existing drop-in center and launch a new peer crisis component, creating a five-part Integrated Drop-In and Peer Crisis Pathway. First, we will expand drop-in hours, staffing, and on-site supports to serve more individuals and increase the depth of care available at walk-in. Second, we will hire and train Peer Support Specialists with lived experience of recovery to provide direct support, crisis accompaniment, and system navigation. Third, we will launch crisis stabilization services as a community-based alternative to emergency department visits, allowing individuals to de-escalate safely and connect to follow-up care. Fourth, we will establish warm handoff protocols with clinical partners to ensure continuity of care beyond the initial crisis contact. Fifth, we will deploy a mobile outreach team to extend services beyond our Fairbanks site to encampments, shelters, and rural communities throughout the region. This integrated model addresses the full continuum from outreach to stabilization to clinical connection, built on an operational foundation that is ready to scale.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough	Deferred or Not Advanced
Northern Hope Center	Northern Hope Center Reentry Peer Support and Community Integration Initiative	AK	There is no health-centered group home in Fairbanks designed to support adults navigating reentry, recovery, and health stabilization. Individuals reentering the community face compounding barriers, such as mental health disorders, substance use histories, trauma, and profound disconnection from health care, with almost no specialized support available. Without stable housing and consistent peer support during the critical reentry period, individuals cycle through emergency departments, crisis services, and incarceration at enormous cost. Northern Hope Center has the organizational foundation, community relationships, and behavioral health expertise to establish this resource. RHTP Readiness Grant funding will support the planning and design work needed to ensure it is done right.	Northern Hope Center will use Readiness Grant funding to plan a new health-centered group home across four workstreams: (1) feasibility and licensing assessment covering regulatory requirements, site options, and operational cost modeling; (2) peer support program design, including recruitment strategy, certification pathways, supervision frameworks, and peer-delivered service protocols co-designed with individuals with lived reentry experience; (3) health care integration planning, including provider mapping, warm handoff protocols, and telehealth options; and (4) community engagement and partner development with reentry-experienced community members, Tribal partners, law enforcement, and service providers. The Readiness phase will culminate in a detailed implementation plan and budget for a future RHTP Implementation Grant application.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough	Deferred or Not Advanced

Northern Hope Center	Northern Hope Center Telehealth and Digital Access Initiative	AK	Northern Hope Center currently has no telehealth capability. While our in-person drop-in and behavioral health services are effective for individuals who can reach our Fairbanks site, we are unable to serve the many rural and remote Interior Alaskans who need behavioral health support but cannot travel to access it. Telehealth represents the single greatest opportunity to extend our reach across this region, but building it responsibly requires planning. Without proper feasibility assessment, community engagement, and technology design work, telehealth investments risk producing platforms that don't work in low-bandwidth environments, don't meet client needs, or don't integrate with clinical workflows. This Readiness Grant will fund foundational planning to design a telehealth and digital access program purpose-built for Northern Hope Center's population and the realities of Interior Alaska.	Northern Hope Center will use Readiness Grant funding to conduct three parallel planning workstreams. First, we will assess the feasibility of a telehealth video counseling platform by reviewing HIPAA-compliant vendor options, evaluating bandwidth and device requirements in target rural communities, and consulting with clinical staff on workflow integration. Second, we will engage current and prospective Peer Support Specialists and community members to design a virtual peer support model that extends peer services remotely and to identify training needs and technology requirements specific to virtual peer work. Third, we will research consumer-facing digital tools appropriate for our client population, assess digital literacy and device access, and conduct community engagement to understand client needs and preferences. Across all three workstreams, we will partner with Tribal organizations and rural community members to ensure the design is culturally grounded and technically appropriate for Interior Alaska. The planning process will culminate in a detailed, fully costed implementation plan, ready for submission in a future RHTP funding cycle.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough	Deferred or Not Advanced

Northgate Alaska	Mat-Su Young Adult Catalyst: Strengthening the Transition to Healthy Adulthood	AK	Northgate Alaska through the iAMSOMEBODY program has partnered closely with the Thrive Coalition to strengthen youth engagement across the Mat-Su Valley. Together with schools, prevention organizations, and community partners, these efforts create events and programs that connect youth with positive organizations and mentorship. Through this collaboration, partners identified a significant gap. Once students graduate from high school, few coordinated opportunities support their transition into adulthood. While education and some work opportunities exist, social spaces for young adults are limited and often center around substance-use environments. The Mat-Su Valley has strong community networks, including a large faith community and civic organizations committed to supporting young people. However, there is no coordinating role focused on connecting these resources and creating consistent opportunities for young adults. This gap increases the risk of isolation, substance misuse, and behavioral health challenges during a critical stage of life. The opportunity is to extend the youth ecosystem already present in the Mat-Su Valley into young adulthood by creating clean, dry, and sober opportunities for connection, mentorship, leadership development, and community engagement. Early conversations have explored the potential for a gap-year style leadership experience that could provide a meaningful pathway for growth and service as young adults launch into adulthood.	This project will establish a dedicated Young Adult Catalyst role to strengthen the transition from youth engagement into healthy young adulthood across the Mat-Su Valley. The Catalyst will collaborate closely with partners in Thrive Coalition, including schools, prevention organizations, faith-based youth networks, and community groups. The role is not to duplicate existing programs but to connect partners, identify opportunities, and coordinate consistent activities that support young adults after high school. The initiative will begin by convening partners and mapping existing opportunities serving young adults. This process will identify gaps, align resources, and build shared ownership across organizations already invested in youth and community development. Through this collaboration, partners will explore solutions that leverage each organization’s strengths. This includes using the population-to-relationship funnel model already used in Thrive and iAMSOMEBODY initiatives— from large clean, dry, and sober community gatherings to mentorship, leadership development, and personal growth. The Catalyst will also pilot clean, dry, and sober gatherings that provide welcoming social environments where young adults can build relationships, develop leadership skills, and connect with mentorship and service opportunities. These gatherings will emphasize belonging, personal development, and civic engagement while strengthening partnerships among organizations serving youth in the region. The Catalyst will also participate in existing Thrive opportunities and leadership development activities to ensure this work dovetails with the regional youth ecosystem and creates a clear runway into young adulthood. As the effort develops, the initiative will explore whether a central hub could support young adults through a gap-year style leadership experience. Drawing from international models familiar within the faith community, this concept could provide a structured year focused on leadership development, community engagement, and service. Within this hub, sub-communities could form around interests such as faith, creative arts, nature and adventure, or vocational exploration, allowing multiple organizations to contribute expertise while maintaining a unified ecosystem of support. The first year will focus on convening partners, piloting gatherings, and learning from participants to refine a sustainable model that strengthens the transition into adulthood.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

NorthStar Gaming	Guiding youth when they feel lost	AK	Youth living in rural and remote communities across Alaska often face significant barriers to accessing mental health support. Geographic isolation, limited availability of behavioral health providers, stigma surrounding mental health, and lack of transportation can prevent young people from receiving help when they are struggling. Many rural youth experience feelings of loneliness and disconnection, which can increase the risk of depression, substance misuse, and suicide. At the same time, many youth regularly connect through online gaming and digital platforms. This presents an opportunity to meet youth in a space where they already feel comfortable and engaged. By creating a supportive online community where someone is always available to listen, encourage positive interaction, and promote kindness, this project aims to reduce isolation, increase access to support, and create a safe environment where youth feel seen, heard, and valued.	Our proposed approach is to create a safe, supportive online community designed specifically for youth in rural and remote communities across Alaska. The program will utilize an online gaming and communication platform where youth can connect with peers, participate in positive activities, and engage with trained mentors who are available to provide encouragement and support. By meeting youth in a familiar and comfortable digital environment, the program removes many of the barriers associated with accessing traditional mental health services. A key component of the program is ensuring that someone is always available online to interact with youth, whether they want to play games, participate in activities, or simply talk. This consistent presence helps create a reliable support system and ensures youth never feel alone when they are struggling. Mentors will help guide conversations, promote healthy coping strategies, and encourage positive peer-to-peer interactions. The program will also incorporate structured activities such as online games, challenges, and community events that promote teamwork, communication, and relationship-building. Youth will be encouraged to participate in tracking and sharing random acts of kindness, which will be recognized through fun incentives and prizes. This approach helps build a culture of empathy, positivity, and mutual support. To ensure equitable participation, the program will work to make sure youth have access to reliable internet so they can fully engage in the program regardless of their geographic location. By combining technology, positive engagement, and consistent mentorship, the project aims to reduce isolation, strengthen connections, and provide an accessible support network for youth who may otherwise have limited resources available to them.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Northway Village	Northway Community Wellness and Cultural Learning Center	AK	Northway is a remote Upper Tanana community where long winters, extreme temperatures, and limited indoor facilities make it difficult for residents to stay physically active and socially connected for much of the year. Currently, there are very few dedicated spaces where youth, families, and Elders can gather for wellness activities, cultural learning, and community connection. This lack of indoor wellness infrastructure creates challenges for supporting prevention-focused health activities, youth engagement, and opportunities for Elders to stay active during the winter months. Social isolation and limited recreational opportunities can contribute to behavioral health challenges and reduced opportunities for healthy lifestyle activities. This project would explore the renovation of an existing building to create a community wellness and cultural learning center in Northway. The space would provide a safe and consistent location for physical activity, youth mentorship, cultural teaching, and wellness programming coordinated with local partners. By creating a place for year-round health, cultural, and community activities, the project would strengthen prevention efforts and improve overall wellness in the community.	Northway Village Council proposes to explore the renovation of an existing community building to create a community wellness and cultural learning center that can support year-round health, prevention, and cultural activities in the community. The project would focus on developing a safe and welcoming indoor space where residents can participate in physical activity, youth mentorship, cultural learning, and community wellness programming. The space could include areas for movement and exercise, gathering space for cultural teaching and workshops, and room for community wellness events and prevention activities. Programming would be coordinated in partnership with existing community programs. The Northway Clinic Community Health Representative could help host wellness activities such as walking programs, group exercise for Elders, and community health education events. The tribe’s Social Services Director could coordinate youth mentorship, family activities, and prevention programming supported through existing grants and services. The center would also create opportunities for Elders to share traditional knowledge and skills with younger generations through workshops, cultural gatherings, and intergenerational activities. By bringing together physical wellness, cultural learning, and community support in one location, the project would strengthen prevention efforts and create a consistent place for positive activities throughout the year. Northway Village Council would also work with regional partners such as Tanana Chiefs Conference and local organizations to support programming and ensure the center can contribute to long-term health and wellness in the community.	\$50,000-\$250,000	Single Community	Southeast Fairbanks Census Area	Advance to Implementation Application

Northwest Nurses & Allied Health LLC	Bringing Nurses and Allied Health Professionals to Rural Alaskan Communities.	AK	Alaska suffers from a drought of healthcare providers. This issue is exaggerated in rural and frontier communities. Northwest Nurses intends to be a conduit to incentivize and bring healthcare providers to rural Alaskan markets. We are a company founded by healthcare professionals who know the challenges of operating in Alaska.	The first step in our approach is to build the bench. Currently, we have over 30 nurses and allied health professionals ready to step into their first contract. If awarded funding our approach would be to incentivize greater recruitment through not only competitive pay and benefits packages, but a commitment to truly showcase the career opportunity that experience in rural Alaska has to offer. Second, we apply a two tier approach to serving Alaskan communities. 1) A direct to facility approach for hospitals and clinics in rural Alaska. They need help staffing their outfit, we bring it to them. 2) For remote and frontier communities we would identify the need for mobile clinics on a case by case basis. One identified, we would arrange for the necessary equipment and personel to be transported to location for a set time period. This could be days to weeks dependant upon need and may include mobile housing units.	\$1M-\$5M	Other	Statewide	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Yakutat (City and Borough)	Deferred or Not Advanced

Norton Sound Health Corporation	1G Maternal and Neonatal Equipment Upgrades	AK	NSRH delivers between 60 and 110 babies each year with a consistent record of high-quality care. The maternal and neonatal equipment at Norton Sound Regional Hospital is nearing the end of its functional life cycle, putting that quality at risk. The current system also lacks modern telemedicine interfaces to tertiary obstetric and neonatal facilities. This technological gap creates a "referral burden" where patients are sent to Anchorage simply because the local facility lacks the specific stabilization hardware required for high-risk deliveries. Current data indicate that 50% of infant deaths in Alaska occur in the neonatal period (0–27 days), with over half of those being very or extremely preterm infants who require immediate, high-fidelity stabilization. Without updated equipment, NSHC remains vulnerable to equipment downtime and cannot use modern telehealth links that could enable local clinicians to consult with NICU specialists in real time. This project presents an opportunity to design a State-of-the-Art Perinatal Suite. By planning a comprehensive upgrade, NSHC can transition to a model that integrates wireless, remote fetal monitoring—which has been shown to shorten labor duration and improve patient outcomes—with advanced neonatal stabilization. This allows us to standardize care to AAP and ACOG national standards, ensuring that every child born in the region has access to lifesaving technology that matches the level of care found in urban tertiary centers.	NSHC will employ a multidisciplinary planning approach to ensure that new maternal and neonatal technologies are not only procured but fully integrated into the clinical workflow and physical infrastructure of the Norton Sound Regional Hospital. 1. Clinical Gap Analysis & Standardization The project will begin with a rigorous audit of existing Labor and Delivery (L&D) assets against the latest American Academy of Pediatrics (AAP) and ACOG national standards. We will identify specific equipment—such as T-piece resuscitators, high-fidelity fetal monitors, and advanced neonatal warmers—required to manage infants born at 32 weeks or later locally. This phase ensures that the new fleet of equipment standardizes care across all shifts and providers. 2. Technical Integration & Telehealth Mapping A key component of the approach is the selection of "smart" platforms that support real-time data sharing. We will design a Tele-NICU link that allows for synchronous consultation between NSHC clinicians in Nome and neonatologists at tertiary centers in Anchorage. This involves mapping the IT infrastructure and cybersecurity protocols necessary to transmit high-resolution fetal heart strips and neonatal vitals during critical stabilization events. 3. Infrastructure & Utility Validation Our facilities and biomedical engineering teams will evaluate the L&D unit’s current medical gas and electrical capacity. Modern neonatal ventilators and stabilization units often have higher oxygen and power demands than legacy equipment. The planning process will include any necessary "behind-the-wall" utility upgrades to ensure the facility can support a 100% duty cycle for life-sustaining equipment. 4. Implementation & Simulation Training Roadmap To ensure the transition does not disrupt active patient care, NSHC will develop a phased Go-Live schedule. This includes a comprehensive competency-based training program utilizing high-fidelity simulation. By practicing stabilization protocols with the new equipment before deployment, we ensure nursing and medical staff can respond with precision during high-stress obstetric emergencies. 5. Procurement & Sustainability Strategy The final stage of the approach involves developing a long-term procurement and maintenance contract. This ensures that the selected equipment is durable enough for Arctic transit and that a local stockpile of specialized consumables (e.g., neonatal sensors, circuits) is maintained to avoid supply chain disruptions.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	1L Tribal Healer Workforce Development	AK	The Problem We are facing a "knowledge gap" crisis. Traditional healing is a resource-intensive practice that requires years of one-on-one mentorship, yet NSHC currently lacks the dedicated funding to support apprentices during this long learning curve. With waitlists exceeding half a year, patients in crisis—especially those struggling with behavioral health issues or addiction—are being denied access to the very traditional practices that offer the most profound healing. Without a structured apprenticeship program, we risk losing the specialized knowledge of our Elders and failing to meet the clear community demand expressed in our 2025 patient data. The Opportunity This project presents an opportunity to formalize the Tribal Healer Apprenticeship Pipeline. By funding new apprentices, NSHC will: Reduce Waitlists: Increasing the number of providers to meet the 1,100+ visit demand. Integrate Care: Positioning Tribal Healers alongside Primary Care and Behavioral Health teams for a truly holistic "Whole Person" approach. Ensure Cultural Continuity: Protecting and passing on Alaska Native traditional medicine to the next generation of healers.	NSHC will implement a structured, mentorship-based apprenticeship program overseen by a Program Coordinator to ensure both clinical accountability and cultural integrity: Apprentice Recruitment & Mentor Matching: We will identify candidates from the region who show a calling for traditional medicine and pair them with experienced healers for intensive, hands-on mentorship. Key Training Milestones: The curriculum will include traditional plant medicine, bodywork, and spiritual counseling, balanced with documentation training. This documentation is vital for clinical safety and preparing for future Medicaid reimbursement pathways. Collaborative Reviews: Periodic progress reviews will be held with traditional healers and NSHC leadership. These reviews ensure that the "quality of care" meets both the high standards of traditional practice and the safety requirements of the modern clinical environment. Integrated Primary Care: Apprentices will participate in "Integrated Care Team" meetings, learning how to coordinate with doctors and therapists to support patients through recovery and chronic disease management.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	10 New Computers/Servers for NSHC	AK	The Problem Our current technology infrastructure has reached its "end of life." Servers are at capacity, and workstations are unable to run the latest medical software updates efficiently. This creates a high risk for system outages, which in a remote healthcare setting can be catastrophic. Furthermore, as NSHC expands its Telemedicine and data-driven wellness programs, our existing storage and switching capacity cannot handle the increased data load, leading to "digital congestion" that threatens the security and speed of patient data management. The Opportunity This project presents an opportunity for a Regional IT Modernization. By deploying medical-grade computers, printers, and high-capacity servers, NSHC will: Strengthen Cybersecurity: Implementing hardware that supports modern encryption and security protocols to protect patient privacy. Enable Clinical Growth: Providing the "headroom" needed for advanced imaging, high-definition video consults, and expanded data analytics. Standardize the Fleet: Creating a uniform equipment environment that simplifies maintenance and troubleshooting for our IT specialists.	NSHC will follow a structured, IT-specialist-led deployment strategy to ensure zero disruption to clinical services: Procurement & Compatibility Audit: Following a deep-dive consultation with IT specialists, we will select servers, switches, and workstations that are fully compatible with our current EHR and imaging software while offering a 5-to-7-year growth horizon. Tiered Deployment: We will roll out the new hardware in phases, starting with high-impact clinical areas and the "Core Server Room," followed by a village-by-village workstation refresh. Storage & Redundancy Upgrade: We will implement high-capacity storage devices and modern network switches to ensure data redundancy, protecting against data loss during power fluctuations common in rural Alaska. Post-Deployment Review: After each phase, we will gather staff feedback on system speed and reliability, adjusting our installation protocols to maximize efficiency for the next phase.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	2A Behavioral Health Integration and Care	AK	The Problem The region faces a lethal combination of high trauma, high SUD rates, and a fragmented delivery system. A four-week wait time for behavioral health is not just a delay—it is a critical safety risk in a region with suicide rates nearly seven times the national average. When mental health services are physically or procedurally separated from primary care, patients often drop out of the referral loop, leading to increased emergency room utilization and worsening chronic conditions. The Opportunity This project allows NSHC to design a "Total Health Integration" strategy. We have the opportunity to: Eliminate the "Referral Gap": Moving from a "referral-out" model to an "on-site" model where behavioral health is a standard part of every primary care visit. Specialized Staffing: Hiring a dedicated APP and Clinician to focus exclusively on bridging the gap between psychiatry and family medicine. Holistic Interventions: Creating evidence-based protocols that treat the "whole person," addressing the intersection of SMI (Serious Mental Illness), SUD, and physical comorbidities. Reduce Stigma: By normalizing mental health as a standard component of a clinic visit, we lower the cultural barriers that prevent residents from seeking care.	NSHC will utilize a Collaborative Care Model (CoCM) approach to design the integration: Embedded Staffing: The new Advanced Practice Provider (with psychiatric focus) and Licensed Clinician will be stationed within the primary care wing, attending daily huddles with medical staff. Universal Screening: The team will design a system-wide protocol for universal behavioral health screenings during all intake exams, using the PRAPARE and PHQ-9/GAD-7 tools. Warm Hand-Off Workflows: We will develop "immediate consultation" protocols, allowing a medical provider to bring a clinician into the exam room the moment a mental health need is identified. Psychiatric Consultation Bridge: The APP will serve as the bridge to specialized psychiatry, managing medications and complex cases that typically contribute to the four-week waitlist. Tele-Health Synergy: For our 15 village clinics, the team will design "Virtual Integration" pathways, ensuring remote residents have the same immediate access to the integrated team via high-definition video.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	2B Population Health Based Care Model	AK	The Problem Our region faces staggering rates of chronic disease, yet our current care delivery remains largely "facility-based." Patients in remote villages often wait until symptoms are severe before seeking care, leading to poor outcomes and high costs. Currently, there is a lack of structured, regional follow-up; patients are often discharged from the hospital back to their villages without the local support needed to manage their recovery or medications, resulting in a high rate of avoidable readmissions. The Opportunity This project allows NSHC to design a "Clinic Without Walls." We have the opportunity to: Proactive Outreach: Moving from "waiting for patients" to reaching out via text and phone to manage hypertension, diabetes, and prenatal care before crises occur. Addressing SDOH: Utilizing CHRs as the frontline "navigators" who connect patients with food security, housing, and heating assistance—factors that drive 80% of health outcomes. Modern Communication: Implementing a HIPAA-secure text and digital outreach platform that mirrors how our younger and working-age populations actually communicate. Workforce Empowerment: Creating five new community-based roles (CHRs) that provide local career paths for residents within their own villages.	NSHC will utilize a multidisciplinary "Squad-Based" approach to bridge the geographic and clinical gaps between our 15 remote villages and the regional hub. The core of this approach is the hiring of one Advanced Practice Provider (APP) and five Community Health Representatives (CHRs). Proactive Outreach & Data Stratification: The APP will act as the clinical lead, utilizing our Electronic Health Record (EHR) to risk-stratify the population. Instead of waiting for patients to present with symptoms, the team will proactively identify residents with high-risk chronic conditions—such as uncontrolled hypertension or complex diabetes—who have not had a clinical touchpoint in the last 90 days. Omni-Channel Communication: Recognizing the digital divide and cultural preferences, the team will implement a tiered communication strategy. This includes HIPAA-secure text messaging for younger/working-age populations, structured phone follow-ups for medication management, and traditional written communication for our Elder population. Embedded CHR Navigators: The five CHRs will serve as the "boots on the ground," conducting home visits and facilitating care coordination. They will focus on addressing the Social Determinants of Health (SDOH) by connecting patients with essential local resources like food security programs, heating assistance, and transportation for clinical appointments. Holistic Coordination: The team will facilitate a "warm hand-off" between patients and primary care providers, ensuring that every outreach effort is documented and actionable. This approach transforms care from a series of isolated clinical visits into a continuous, holistic wellness journey.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	2C Central Scheduling Model	AK	The Problem Currently, scheduling at NSHC is decentralized, meaning a patient might have to call three different departments to coordinate a primary care visit, a dental exam, and a behavioral health consultation. This fragmentation leads to high "no-show" rates, as patients struggle to track multiple uncoordinated appointments. Manually managed schedules often result in "dead zones" where providers are idle while patients are on a weeks-long waitlist. Furthermore, the lack of real-time analytics makes it impossible to deploy staff flexibly across the region based on shifting community needs. The Opportunity This project allows NSHC to design a "Unified Access Portal." We have the opportunity to: Automate the Administrative Load: Using AI to optimize calendar density and reduce human error in booking. Reduce Patient Wait Times: Identifying and filling cancellations in real-time to move waitlisted patients into slots faster. Enhance the Patient Experience: Providing automated, multi-channel reminders (text, phone, email) to reduce no-shows and improve adherence to care plans. Data-Driven Workforce Management: Using real-time analytics to identify where provider demand is highest and adjusting schedules to meet that need.	NSHC will lead a design and implementation process that merges advanced technology with a specialized centralized team: AI-Integrated Platform Design: We will select and configure an AI-powered scheduling engine that integrates directly with our existing Electronic Health Records (EHR). This system will use predictive algorithms to identify patterns in no-shows and suggest optimal booking intervals for different types of visits (e.g., complex chronic care vs. quick screenings). Centralized Scheduling Hub: We will design the operational structure for a dedicated Central Scheduling Team. This team will serve as the "Air Traffic Control" for the regional health system, handling all intake, specialty referrals, and village-to-Nome transport coordination. Real-Time Resource Analytics: The approach includes the development of a dashboard that provides administrators with a "heat map" of facility utilization. This allows us to maximize the use of expensive clinical space and ensures that high-demand specialists are fully booked during their limited rotations to remote villages. Multi-Channel Automated Reminders: To accommodate regional connectivity challenges, the system will be configured to send automated reminders via text, automated voice calls, and email, ensuring that patients in even the most remote locations stay connected to their care plan. Flexible Workforce Deployment: The system will feature "Float Pool" scheduling capabilities, allowing NSHC to rapidly deploy per-diem or traveling staff to specific villages during health outbreaks or staffing shortages.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	2D Development of a Regional Behavioral Urgent Response Team	AK	The Problem The Norton Sound region is currently facing a dual crisis of rising mental health emergencies and substance abuse outbreaks. Current response models are fragmented; local village responders often lack the specialized behavioral health training needed for acute stabilization, and regional clinicians in Nome are frequently too far away to provide immediate on-site support. This leads to a reliance on law enforcement and emergency medevacs, which are high-cost, high-trauma, and often escalate the patient’s distress. The lack of a rapid-response clinical team creates a "referral gap" where patients in crisis wait too long for intervention, leading to worse outcomes and increased strain on the regional healthcare workforce. The Opportunity This planning project allows NSHC to design a "Mobile Crisis Anchor." We have the opportunity to: De-escalate in Place: Providing the tools and staff to stabilize patients in their own villages, reducing the need for out-of-region transfers. Clinical-First Response: Moving away from law-enforcement-led interventions to a trauma-informed, clinical-led model. Telehealth Integration: Utilizing high-definition digital tools to "virtually deploy" specialists into a village the moment a crisis occurs. Workforce Protection: Offloading the burden of crisis management from local Health Aides to a dedicated regional team.	NSHC will lead a multidisciplinary design process to establish the BURT framework: Cross-Disciplinary Team Composition: The design will specify a team consisting of a Psychiatric Advanced Practice Provider (APP), a Licensed Clinician, and Peer Support Specialists with "lived experience." This ensures the response is clinically rigorous yet culturally grounded. Rapid Deployment Workflows: We will develop "Activation Protocols" for both virtual and physical deployment. This includes a 24/7 Crisis Dispatch model that integrates with current village emergency lines to ensure the BURT team is notified immediately. Tele-Crisis Technology Suite: The team will be equipped with ruggedized, high-definition telehealth kits (connected via Starlink) to provide "eyes-on" clinical assessment within minutes of an alert, even if weather prevents immediate travel to the village. Culturally Competent Crisis Training: We will develop a specialized curriculum for the BURT team focused on Arctic-specific trauma-informed care, incorporating Indigenous values of community healing and de-escalation. Digital Case Management & Follow-Up: The approach includes the design of a "Post-Crisis Bridge" in our EHR. This ensures that every BURT intervention triggers an automatic 24-hour, 72-hour, and 7-day follow-up with the patient’s primary care team and local CHRs.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	3J Implementation of Developed Project: Heart Disease Screening Technology	AK	The Problem The Norton Sound region experiences high rates of cardiovascular disease, yet our current diagnostic infrastructure is stretched beyond its limit. Prolonged waitlists for echocardiography and cardiac rhythm monitoring mean that patients with symptoms such as palpitations, chest pain, or shortness of breath are often left in a "holding pattern" for weeks. During this time, underlying conditions like atrial fibrillation or structural heart disease can worsen, leading to preventable hospitalizations or sudden cardiac events. The lack of available monitors and a single, over-utilized echo machine creates a critical bottleneck that hinders timely intervention and strains our clinical staff. The Opportunity This project presents an opportunity to build a "Rapid Cardiac Diagnostic Center." We have the opportunity to: Eliminate the Echo Backlog: Adding a second, modern unit to double our daily imaging throughput. Decentralized Monitoring: Using iRhythm Zio monitors—wearable, water-resistant patches—that allow patients to go home to their villages while their heart data is continuously recorded and analyzed. Specialist Integration: Leveraging the Alaska Heart Institute to provide faster expert interpretation and more frequent on-site clinics. Preventive Screening: Shifting from "crisis management" to early detection for high-risk diabetic and hypertensive patients.	NSHC will implement a high-tech, collaborative approach to cardiac care: Advanced Equipment Procurement: We will purchase a state-of-the-art Echocardiography unit with high-definition cardiac imaging capabilities and a large pool of iRhythm Zio ECG Monitors. These wearable monitors are specifically chosen for their high patient compliance and their ability to capture up to 14 days of continuous data. Expanded Partnership with Alaska Heart Institute (AHI): We will formalize an expanded service agreement with AHI to increase the frequency of cardiology "Field Visits" to Nome. This partnership will also include a "Tele-Cardiology" component where NSHC technicians can upload echo images for real-time specialist review. Streamlined Diagnostic Workflow: We will design an "Express Cardiac Path" where patients identified as high-risk in primary care can be immediately fitted with a Zio monitor and scheduled for an echocardiogram within 7 days, rather than the current month-long wait. Technical Training & Certification: NSHC ultrasound technicians and nursing staff will receive advanced training on the new echocardiography software and the iRhythm data management platform to ensure clinical results are high-quality and timely. Wearable Distribution Logistics: We will establish a village-based distribution model for Zio monitors. A patient in a remote village can have the monitor applied at their local clinic, wear it for the prescribed period, and then mail it directly to the processing center or return it to the clinic, ensuring data is captured without the patient ever leaving their community.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	3P Doppler Ultrasound Upgrade	AK	The Problem Our existing Doppler units are nearing the end of their service life and lack the sensitivity required for modern clinical best practices. Outdated scanners provide lower-quality audio and visual data, which can lead to "diagnostic uncertainty"—especially in high-stakes obstetric cases or when screening for vascular blockages. In the Arctic, where a medevac can cost upwards of \$20,000, we cannot afford to have ambiguous diagnostic tools. Currently, the lack of standardized, high-fidelity units across all campuses creates a "technology gap" between the regional hospital and the village clinics. The Opportunity This project presents an opportunity for Diagnostic Equity and Precision. We have the opportunity to: 1. Standardize the Region: Ensuring a pregnant mother in a remote village receives the same diagnostic accuracy as one in Nome. 2. Accelerate Medevac Decisions: Providing clinicians with crystal-clear Doppler data to confidently decide when a patient needs emergency transport. 3. Enhance Obstetric Safety: Using high-sensitivity fetal Dopplers to monitor heart rates with greater precision during prenatal visits and labor. 4. Improve Vascular Outcomes: Enabling bedside screening for DVTs and peripheral artery issues, preventing strokes and pulmonary embolisms.	NSHC will execute a comprehensive region-wide rollout of modernized Doppler technology: *Procurement of High-Fidelity Doppler Units: We will acquire a fleet of state-of-the-art handheld and bedside Doppler scanners. These units will feature advanced digital noise suppression and high-sensitivity probes capable of detecting even faint fetal heart tones or low-velocity vascular flow. *Region-Wide Deployment Schedule: We will replace legacy units across the Norton Sound Regional Hospital, the Quyaana Care Center, and all 15 village clinics. This ensures 100% "Diagnostic Parity" across the NSHC footprint. *Comprehensive Staff Training: We will implement a specialized training program for all providers and Community Health Aides (CHAs). This includes hands-on workshops in "Bedside Doppler Excellence," focusing on correct probe placement and sound interpretation for both obstetric and vascular applications. *Integration with Tele-Health: The new units will be compatible with our existing Tele-Health infrastructure, allowing village-based providers to share high-quality Doppler audio or visual data with specialists in Nome or Anchorage in real-time for second opinions. *Standardized Maintenance Protocol: We will establish a regional maintenance cycle, where NSHC’s Biomedical Engineering team performs regular calibrations and software updates on the standardized fleet, ensuring the devices remain in peak condition regardless of location. *Digital Data Logging: Where applicable, the units will integrate with our Electronic Health Record (EHR), allowing Doppler findings to be directly uploaded to a patient’s chart for long-term clinical tracking.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	3R Colonoscopy provider training program	AK	The Problem Alaska Native people suffer from colorectal cancer incidence rates of 80.9 per 100,000—the highest globally. While NSHC’s intensive efforts pushed our screening rate to 77% in 2025, many other rural Alaska regions still struggle with lower screening uptake and a lack of local procedural expertise. Colonoscopy is technically demanding; the "provider gap" in the bush is a major barrier to reducing cancer mortality. Currently, there is no centralized, high-fidelity simulation hub in the Bering Strait to facilitate the rapid training of new providers or to support peer-training for neighboring tribal health regions. The Opportunity This project presents an opportunity for Statewide Clinical Mentorship. We have the opportunity to: 1. Export NSHC’s "Success Blueprint": Sharing the methods and materials that achieved 77% screening with other bush communities. 2. Establish a Rural Training Center: Creating a destination in Nome where other rural providers can train on high-fidelity haptic simulators without traveling to the Lower 48. 3. Bridge Global Health Disparities: Leading the effort to lower colorectal mortality across all of rural Alaska through standardized, simulated mastery. 4. Sustain Local Access: Ensuring the seamless replacement of retiring providers while simultaneously elevating the skills of the regional workforce.	NSHC will implement a "Center of Excellence" model that serves our region and the broader rural Alaska network: *Procurement of Advanced Haptic Simulation Hub: We will acquire a state-of-the-art colonoscopy simulator capable of replicating the unique anatomical challenges often seen in our patient population. This hub will be the centerpiece of our regional training program. *Development of a "Rural Outreach" Curriculum: We will document the clinical and administrative workflows that led to our 77% screening success. This material will be packaged into a "Training Toolkit" available to other bush community providers. *Intra-Region Provider Rotations: We will establish a rotation program where providers from other rural Alaska health corporations can come to Nome for intensive "Sim-Lab" sessions, refining their haptic skills and biopsy techniques alongside NSHC experts. *Pathology Library Sharing: Our simulation software will include a digital library of aggressive lesions common in the Alaska Native population, which we will use to train all visiting rural providers in early-stage recognition. *Virtual Mentorship & Debriefing: Using the simulator’s cloud-based recording features, we will provide remote "proctoring" for other bush providers, allowing our experts to review their simulated cases and provide feedback from Nome. *Annual "Rural Alaska Endoscopy Summit": NSHC will host a training event in Nome, utilizing the simulation lab to synchronize best practices and safety protocols for endoscopy teams across the state’s most remote regions.	\$50,000-\$250,000	Hospital	Statewide	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	4B Direct Patient Monitoring for High-Risk Patients	AK	The Problem Traditional care models in the Norton Sound region are reactive, and the barriers to proactive care are both technical and emotional. High-risk patients often fall into a "communication black hole" if they lack a phone. However, technology alone is not the answer; if remote monitoring feels like "surveillance," it can trigger historical trauma and lead to low engagement. Geographic isolation already creates a sense of abandonment; without a culturally sensitive way to monitor health, patients remain at high risk for unmanaged complications and expensive, stressful emergency medevacs. The Opportunity This project presents an opportunity to build a "Culturally Anchored Safety Net." We have the opportunity to: *Trauma-Informed Connection: Using the bi-directional feature for supportive "Wellness Checks" rather than just data collection, reducing the anxiety associated with chronic disease management. *Cultural Literacy: Providing training and device interfaces that utilize local terminology and visual cues, ensuring the technology feels like a community tool rather than an outside imposition. *Independent Connectivity: Bypassing local infrastructure gaps with cellular-enabled "Smart Hubs" that ensure the most vulnerable have the most reliable connection. *Equity in Healing: Ensuring that the patients with the fewest resources receive the most consistent, respectful, and culturally aligned clinical support.	NSHC will implement a technology-enabled monitoring system rooted in cultural safety and trauma-informed care: *Procurement of Culturally Accessible "Smart-Hubs": We will deploy RPM devices that sync to a central, cellular-enabled base station. These hubs will be selected for their simplicity (one-touch use) and large-font, high-contrast displays to accommodate elders and those with sensory sensitivities. *Trauma-Informed Bi-Directional Messaging: The communication feature will be used for more than clinical alerts. The Program Coordinator will use it for supportive outreach, such as "Good morning" check-ins or encouragement of medication adherence, framed in a way that builds trust and reduces the "clinical" feel of the intervention. *CHA-Led Regional Training: We will travel to all 16 villages to conduct training in partnership with Community Health Aides (CHAs). By having local, trusted providers introduce the technology, we ensure the rollout is culturally oriented and addresses any community concerns regarding privacy or data use. *Integrated Data & AI Triage: Biometric data flows into a secure, HIPAA-compliant hub. AI triage identifies anomalies, allowing the clinical team to intervene early. These interventions will follow a Trauma-Informed Protocol, in which providers lead with empathy and active listening during the resulting telemedicine consult. *Behavioral Health "Safety-Netting": For high-risk behavioral health patients, the bi-directional messaging serves as a "virtual home visit." This consistent contact reduces the trauma of isolation and provides a secure, private channel for patients to express needs before they reach a crisis point. *Language & Visual Customization: Where possible, device prompts and training materials will be translated into regional dialects (Inupiaq, Central Yup'ik, or St. Lawrence Island Yupik) and other community languages, ensuring the technology speaks the language of the community.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Advance to Implementation Application

Norton Sound Health Corporation	1A Emergency Medical Transport Modernization	AK	The primary opportunity for this project lies in modernizing infrastructure to keep pace with historic growth in patient care volumes and clinical demand. As detailed in the January 2026 CEO Report, NSHC is currently experiencing "record-high volumes" at the Nome Primary Care Clinic and across its preventive service lines. However, the emergency transport fleet—the literal backbone of this system—is aging out. The current fleet includes hub ambulances in Nome and Unalakleet that are over 10 years old, creating a precarious vulnerability in a region where mechanical failure in sub-zero temperatures can be fatal. Furthermore, the existing ambulance garage in Nome is insufficient for the current scale of operations. With over 1,280 total ambulance and medevac runs conducted in FY2025, the facility lacks the climate-controlled capacity and maintenance space required to protect these high-value assets from Arctic degradation. This project presents a critical opportunity to replace the aging fleet and expand facility capacity, ensuring that NSHC's physical infrastructure is as resilient and high-performing as the clinical teams it supports.	NSHC's approach is a dual-track modernization of both mobile assets and fixed infrastructure to support the region's intense clinical demand. First, we will replace aging ambulances in Nome and Unalakleet with new, Arctic-grade vehicles. This is a critical necessity given that in FY2025, the Norton Sound Emergency Department managed 5,462 encounters, and the Unalakleet Clinic managed 3,541 encounters. These vehicles are the primary link for the thousands of patients seen at these hubs, ensuring that emergency ground transport is available and reliable regardless of extreme weather. Second, we will expand and modernize the ambulance garage and facility building in Nome. The current facility is at capacity and cannot efficiently house the fleet or provide the controlled environment needed for rapid response and preventative maintenance. By increasing the square footage and improving climate control, we protect these high-value assets and ensure that the paramedics and EMTs serving over 9,000 annual encounters across the ER and Unalakleet clinic have a staging area that matches the record-high patient volumes NSHC is currently seeing. This integrated approach ensures that our transport capabilities can scale alongside our growing clinical services.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1B Long-Term Care Facility Expansion	AK	As we expand our long-term care (LTC) facility, renovations are needed within the existing building where it will connect to the new addition. Improving this transition area is essential to ensure the two structures function as one cohesive, integrated care environment. Aligning hallways, resident rooms, and shared spaces will support smooth movement for residents and staff, reduce bottlenecks, and enhance overall safety. Upgrading the connection point also allows us to modernize older systems—such as ventilation, lighting, and accessibility features—so they match the standards of the new construction. This consistency supports better infection control, improved workflow efficiency, and a unified resident experience. These renovations ensure the expanded campus operates as a seamless nursing home rather than two separate facilities. By creating a smooth, well-designed transition between buildings, we strengthen care coordination, enhance daily living for residents, and support staff in delivering high-quality, person-centered long-term care.	The project will complete the Quyanna Care Center expansion and renovation by adding two additional resident rooms, new staff office space, and a modernized nursing station designed to support higher-acuity care. These upgrades will increase capacity, improve staff workflow, and enhance the quality of services provided to Elders who wish to remain close to family and community. The improved nursing station will support more complex clinical needs, strengthen monitoring capabilities, and ensure rapid response to changes in resident condition. To ensure orderly progress, the project will follow a phased construction timeline that maintains resident safety and minimizes disruption to daily operations. Work will be sequenced to protect occupied areas, preserve access to essential services, and prevent interruptions in long-term care routines. Each phase will include clear milestones, contingency planning for weather or supply delays, and coordination with departments responsible for infection control, maintenance, and life-safety compliance. A dedicated project manager will be assigned to lead the expansion, overseeing planning, scheduling, permitting, and on-site construction activities. This role includes maintaining communication with contractors, ensuring alignment with regulatory requirements, managing timelines and budgets, and monitoring the quality of all completed work. The project manager will also coordinate internal logistics to help staff prepare for temporary adjustments in traffic flow, noise, or space limitations during construction. Regular check-ins with key stakeholders—including organizational leadership, clinical staff, facilities teams, resident advocates, and Tribal or community representatives—will ensure the project remains aligned with operational needs and community expectations. These meetings will allow for early identification of potential issues, strengthen transparency, and ensure the renovation meets current healthcare facility and life-safety standards. Once complete, the expanded and renovated facility will offer a more functional, culturally supportive, and clinically capable long-term care environment. The project will enhance resident comfort, support staff effectiveness, and strengthen the long-term sustainability of Elder care services for the region.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1C Design/Plan for Conversion of duplex in Nome to a 4-bed assisted living facility	AK	The Bering Strait region faces a critical gap in its healthcare continuum: the absence of a dedicated Assisted Living Facility (ALF). Currently, 10 community members are forced to leave the region annually for assisted living placement because no middle-tier care option exists locally. This creates a heartbreaking dilemma where elders who do not require the high-acuity medical care of a skilled nursing facility are still "medically exiled" to Anchorage or beyond, leading to a profound disruption of family connections and cultural ties. Furthermore, this gap creates a "bed-blocking" inefficiency within NSHC’s existing infrastructure. As NSHC experiences record-high patient care volumes and historic growth in clinical demand (as noted in the Jan 2026 CEO Report), the lack of an ALF forces elders to remain in high-cost Long-Term Care (LTC) or acute care beds simply because there is no appropriate "step-down" housing available. This project addresses the urgent opportunity to convert existing underutilized space into a licensed ALF, resolving this physical bottleneck and ensuring that NSHC’s resources are utilized at the most appropriate and sustainable level of care.	NSHC’s approach focuses on the rapid, high-impact conversion of existing underutilized medical space into a licensed 4-bed Assisted Living Facility. This project is specifically right-sized to pilot a sustainable, local alternative for the 10 community members forced to leave the region annually due to the lack of middle-tier care. Key elements include: Structural Conversion: Modification of existing clinical rooms into 4 private, ADA-compliant residential suites. The design prioritizes a "small-house" model, which is proven to provide better health outcomes and higher quality of life for elders than large, institutional settings. Technological Integration: Utilizing our 2025 Advancing Health IT Award status, we will outfit these 4 suites with non-intrusive remote monitoring and emergency call systems, ensuring 24/7 safety without compromising resident autonomy. Workforce Utilization: The facility will be staffed by local caregivers from our robust pipeline—supported by 400+ scholarships awarded—ensuring that residents receive care in a culturally and linguistically familiar environment.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1D Design/Plan for NSRH expansion with Behavioral Health Focus	AK	The opportunity lies in moving away from a "medical-only" model for behavioral health crises. Currently, NSHC’s infrastructure lacks a dedicated BH wing, forcing high-acuity patients into the ED—which saw 5,462 encounters in FY2025—or into Acute Care beds that are designed for medical, not psychiatric, needs. This creates a high-risk environment for both patients and staff. The Data Gap: Beyond suicide rates, the prevalence of Serious Mental Illness (SMI) among AI/AN adults is 11% higher than the U.S. general population, yet these individuals are 17% less likely to receive treatment due to geographic barriers (SAMHSA, 2025). The Bottleneck: This expansion addresses the physical bottleneck by creating seven 24/7 local stabilization beds. This allows NSHC to "right-size" its facilities to accommodate the growing demand for mental health services without disrupting the record-high patient volumes currently managed across our primary and acute care lines.	Allocate planning and design funds to assess the feasibility of expanding the current 18-bed hospital to a 25-bed facility, including dedicated space for behavioral health patients. This effort will evaluate clinical needs, workflow requirements, safety standards, and infrastructure considerations to ensure the expanded unit meets growing demand for acute and behavioral health services. A detailed project timeline will be developed outlining key milestones for architectural planning, engineering assessments, regulatory review, and cost estimation. NSHC will assign a dedicated project manager to oversee all phases of the planning and design process, coordinate internal and external stakeholders, and ensure timely progress. Regular stakeholder meetings—including hospital leadership, clinical teams, facility staff, and community partners—will be scheduled to maintain transparency, support informed decision-making, and address challenges proactively throughout the project. NSHC will construct a specialized hospital wing designed for integrated BH stabilization. The approach centers on "Trauma-Informed Design," creating a secure yet healing environment that includes private stabilization rooms and a secure outdoor courtyard. Leveraging our 2025 Advancing Health IT Award, we will install high-definition tele-behavioral health links, allowing for 24/7 consultation with remote specialists. This approach ensures that we aren't just adding beds, but are creating a technology-forward hub that keeps patients in a local, culturally familiar setting while they receive world-class psychiatric stabilization.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1E Design for Patient Lodging and Assisted Living Options to NSRH	AK	The opportunity lies in filling a profound void in the regional continuum of care. Currently, the 16 remote communities of the Bering Strait face significant barriers to accessing care in Nome. With only 36 lodging rooms for a population where 6,500+ residents must travel by air for services, many patients stay in overcrowded or unsuitable conditions, increasing stress and complicating recovery. This planning project addresses the urgent need for dedicated patient lodging that provides a safe, reliable environment for the 100,000+ annual NSHC encounters, supporting better treatment adherence and allowing families to remain involved in the healing process. Simultaneously, the region currently has zero assisted living facilities, resulting in at least 10 residents each year being institutionalized or relocated outside the community. These forced relocations weaken cultural ties and disrupt the family connections essential to elder wellness. By developing the feasibility and design for a 12-bed ALF and 24-bed (or larger) Patient Hostel, NSHC will seize the opportunity to "right-size" its residential infrastructure. This project moves NSHC from a reactive model to a person-centered, culturally appropriate system that ensures more residents receive the right level of support within their own community, surrounded by their language and traditions.	**Project Overview** Norton Sound Health Corporation (NSHC) will use planning funds to design a new patient lodging facility that will be physically connected to the main hospital. This facility will include a dedicated assisted living section to address critical regional needs, creating a seamless continuum of care for Norton Sound residents. The project aims to bridge the gap between acute clinical care and long-term residential support through a technically sound and culturally sensitive design. **Phased Design Framework** NSHC will adopt a structured, four-phase approach to transition from concept to a "shovel-ready" final design: **Discovery & Technical Assessment:** A multidisciplinary team of architects and engineers will conduct structural, environmental, and regulatory assessments. This will ensure that the design meets stringent healthcare standards, residential safety requirements, and ADA accessibility guidelines while optimizing the physical connection to the hospital. **Schematic Design & Operational Flow:** We will hold design sessions with clinical providers and facility staff to map patient flow. This will ensure that the transition between the hospital and lodging is safe, private, and operationally efficient for both staff and residents. **Community-Integrated Design:** To ensure cultural appropriateness, NSHC will engage Elders, caregivers, and residents from remote villages. These sessions will help ensure that the facility reflects regional preferences, incorporating communal spaces and aesthetics that honor the heritage of the people we serve. **Final Blueprint & Regulatory Review:** The final phase will produce detailed architectural drawings, a comprehensive cost estimation, and a regulatory roadmap for assisted living licensure and healthcare compliance. **Project Governance and Accountability** NSHC will appoint a dedicated Project Lead to oversee all planning activities. This lead will be responsible for: - Coordinating architecture and engineering consultants and ensuring that milestones are met on schedule. - Managing communication between internal clinical, facilities, and executive departments. - Aligning the final design with NSHC's long-term organizational goals and capital budget. **Conclusion** This approach creates a practical blueprint for a facility that expands lodging capacity, introduces essential assisted living services, and strengthens the region's healthcare infrastructure.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1F Design/Plan for NSRH Ambulance Garage, Facilities, and Nutrition Storage Hub	AK	The Problem NSHC’s emergency vehicles and critical mechanical systems currently face significant operational risks. With a consistent volume of roughly 110 ambulance runs monthly, our fleet is heavily utilized but remains exposed to harsh Arctic elements. Aging utility systems are also housed within the main hospital footprint, complicating maintenance and limiting future expansion. Additionally, current food storage is over capacity and aging, resulting in occasional failures and food losses in a region where supply chains are already fragile. The Opportunity This project presents an opportunity to design a centralized Utility and Logistics Hub. By planning a dedicated, heated ambulance garage alongside a consolidated power plant and expanded nutrition storage, NSHC can solve three critical vulnerabilities. This approach frees up valuable space within the main hospital for clinical expansion while creating a weather-protected environment for emergency response and food security infrastructure that matches our current and projected service volumes.	NSHC will utilize RHTP planning funds to engage a multidisciplinary team of engineering, architectural, and construction experts to develop a comprehensive facility plan for a new outbuilding located behind the main hospital. The approach focuses on three integrated functional areas: emergency response readiness, infrastructure resilience, and nutritional logistics. 1. Technical & Engineering Assessment The planning effort will begin with a rigorous evaluation of the site layout and utility connection requirements. A primary focus will be the design of a centralized utilities hub to house the hospital’s main boilers, electrical systems, and critical mechanical infrastructure. Engineers will develop a transition plan to relocate these systems from the current hospital footprint into the new "power plant" without disrupting active patient care. This phase will also assess the high-load electrical and HVAC requirements for industrial-scale refrigeration. 2. Operational Readiness Design Architects will collaborate with EMS and Plant Operations teams to design a purpose-built, heated, and weather-protected garage. This facility will be engineered to securely house two ground ambulances and air ambulance vehicles. The design will prioritize "hot-start" capabilities to eliminate delays caused by frozen equipment or vehicle warm-up times in Nome’s extreme winter conditions, directly improving response readiness for the approximately 110 ambulance runs managed monthly. 3. Nutritional Logistics & Storage Mapping The planning team will design expanded walk-in refrigerator and freezer units specifically to address current space shortages and aging infrastructure. The approach involves mapping a storage workflow that accommodates the region’s unique shipping constraints, allowing for bulk procurement and the stable storage of traditional subsistence foods. 4. Regulatory & Safety Compliance NSHC will ensure the comprehensive facility plan meets all operational, safety, and emergency-response standards. This includes a thorough review of State of Alaska Fire Marshal codes for utility plants and EMS facility requirements. 5. Final Project Roadmap The final stage of this approach will produce a shovel-ready package including detailed architectural drawings, equipment requirements, and a Class C cost estimate. This will provide a clear path for subsequent construction phases while identifying how the new outbuilding creates space for future hospital expansion.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1H Patient Transport Access/Expansion	AK	The Problem The current lack of accessible transport options creates an "equity gap" in our healthcare delivery. While 15% of our general population reports transportation barriers, the impact is felt most acutely by those with mobility impairments. In our 15 remote villages, the absence of handicapped-accessible vehicles means that Elders often have to be transported in the back of trucks or on snowmachines, which is unsafe and undignified. This lack of appropriate infrastructure often forces patients with disabilities to relocate out of the region to access more "accessible" urban environments, leading to cultural isolation and diminished health outcomes. The Opportunity This project presents an opportunity to design a Region-Wide Accessible Transit Network. By planning for the procurement of handicapped-accessible, high-clearance vehicles for both the Nome hub and the village clinics, NSHC can ensure that "care at home" is a reality for everyone, regardless of physical mobility. This planning effort will focus on a fleet that meets ADA (Americans with Disabilities Act) standards while remaining rugged enough for Arctic terrain, ensuring that our Elders can age in place with dignity and reliable access to their medical providers.	NSHC will utilize a data-driven logistics approach to ensure these new assets are deployed where the 2025 PRAPARE data shows the most significant "transportation-to-care" gaps. The project will focus on the planning and procurement of a specialized eight-vehicle fleet: Fleet Specification (6 ADA-Compliant Vans): We will develop technical requirements for six high-clearance, 4x4 transit vans. These will be equipped with heavy-duty Arctic insulation, "hot-start" engine heaters, and hydraulic wheelchair lifts. These vans will serve as the primary transport link between the Nome airport, hospital campus, and regional housing, ensuring the 15% of patients reporting barriers can transition safely between travel hubs. Specialized Village Access (2 Side-by-Sides): For village clinics with more restrictive terrain or narrow boardwalk systems, we will specify two enclosed, heated side-by-side utility vehicles (UTVs). These will be outfitted with specialized patient-loading systems to allow for the dignified and safe transport of Elders and mobility-impaired patients from their homes directly to the clinic door. Geospatial Need Mapping: We will map the specific locations of patients who identified transportation barriers to determine the most impactful placement for each vehicle type across the 15-village network. Technical Training & Safety: A core component of the approach is the creation of a "Regional Driver Safety Manual." This will include training on the operation of ADA lifts in sub-zero temperatures and specialized patient-handling protocols for those with disabilities or complex medical needs.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	11 Increased Patient Transport Frequency for Little Diomedes Island	AK	The Problem Little Diomedes’s transport crisis is a "perfect storm" of limited capacity and zero redundancy. Since the sea ice can no longer reliably support a seasonal fixed-wing runway, the community is tethered to a single rotary-wing link. Our data from 2024–2025 proves that the existing schedule is insufficient; with healthcare staff taking up 25% of available seating on many flights, patients are frequently left behind. When combined with the high rate of weather and mechanical cancellations, residents can be stranded for weeks. This lack of predictable transit is a primary driver of the health inequities identified in our 2025 PRAPARE screenings. The Opportunity This project presents an opportunity to design a Dedicated Diomedes Medical Bridge. The planning effort will focus on: Contracted Surge Capacity: Formalizing a plan for NSHC-priority helicopter charters that bypass the "full capacity" limitations of the Essential Air Service flights. Provider/Patient Separation: Ensuring that traveling healthcare personnel have dedicated transport that does not displace patients. Mechanical/Weather Redundancy: Exploring multi-modal backups, including specialized vessel transport during the open-water season to provide a fail-safe when aircraft are grounded.	NSHC will implement a structured, three-phased coordination plan to eliminate the transport bottleneck between Nome and Little Diomedes. This approach moves away from the current ad-hoc system toward a reliable "Medical Bridge" specifically designed to bypass the 100% capacity issues identified in our 2024–2025 flight reviews. Phase 1: Demand & Capacity Assessment (Months 1–3) The initial phase will involve a rigorous audit of current travel patterns, patient demand, and helicopter seat availability. We will map the 15% transportation barrier identified in our 2025 PRAPARE data specifically to Diomedes residents to identify those with the highest clinical risk due to delayed care. Phase 2: Roster Optimization & Scheduling (Months 4–8) NSHC will organize patient rosters based on medical priorities, appointment availability, and weather windows. By grouping multiple appointments into each supplementary charter, we maximize efficiency and ensure that no flight departs with empty seats while patients are stranded. This phase creates a predictable, well-coordinated transport schedule that aligns patient travel with Nome-based clinic visits. Phase 3: Refinement & Continuous Improvement (Months 9–12) The final phase focuses on scaling the process based on utilization trends, patient feedback, and provider input. We will implement Quarterly Reviews to evaluate key indicators, including the number of patients transported, reductions in rescheduled visits, and the cost-effectiveness of each charter. Dedicated Oversight: The Transportation Coordinator A core component of this approach is the creation of a Dedicated Transportation Coordinator role. This individual will oversee all logistics, including: Real-time communication with the helicopter operator and Nome healthcare providers. Managing patient scheduling to ensure each supplementary flight is used to its full potential. Mitigating the impact of mechanical or weather-related cancellations by maintaining a "ready-to-travel" standby list. This role is essential for maintaining consistent access, reducing the "seat competition" between staff and patients, and ensuring the most remote community in the United States receives timely, reliable medical transport.	\$50,000-\$250,000	Hospital	Single Community	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1J Surgical Recovery Equipment	AK	The Problem The SRU is currently operating with non-functional hydration equipment. This creates a gap in the "Gold Standard" of post-surgical care. After procedures like colonoscopies, patients require immediate access to water and ice for hydration and to soothe throat irritation from sedation/intubation. When this equipment is broken, it negatively affects the patient’s recovery experience and comfort. Our 2025 PRAPARE data showed that 28% of our patients already face stressors related to their care journey; adding the discomfort of an inadequately equipped recovery room further complicates their path to wellness. The Opportunity This project presents an opportunity to modernize the Surgical Recovery Hydration Station. By replacing the obsolete unit with a medical-grade, high-efficiency ice and water dispenser, NSHC can: Improve Patient Satisfaction: Directly addressing a common pain point for the 200+ annual endoscopy patients. Ensure Clinical Compliance: Meeting the hydration requirements set by post-operative care protocols. Optimize Staff Time: Keeping nurses at the bedside by providing necessary recovery supplies within the unit itself.	NSHC will follow a structured procurement and installation plan to ensure the new unit is integrated seamlessly into the SRU: Technical Specification & Procurement: We will select a modern, antimicrobial ice/water unit designed for clinical environments. This unit must meet high-volume demands while adhering to strict hospital sanitation standards. Accountability & Installation: A Facilities Coordinator will be assigned to oversee the project, managing the removal of the non-functional unit and the plumbing/electrical installation of the new model. Timeline Development: We will establish a clear 6-month roadmap from bid to "first use" to minimize disruption in the surgical suite. Post-Installation Review: Following the first 100 procedures post-installation, we will conduct a review gathering staff and patient feedback to ensure the unit is meeting the expected performance and comfort benchmarks.	Under \$50,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1K Dental Infrastructure Modernization	AK	The Problem The existing dental compressor is aged and prone to mechanical failure. Because this single unit serves all 10 dental bays, a breakdown results in a total cessation of services, including emergency extractions and preventative cleanings. For the nearly 4,000 patients served annually, these interruptions are more than an inconvenience; they are a safety and compliance risk. Outdated air-delivery systems can struggle to maintain the moisture-free, medical-grade air quality required for modern dental procedures, potentially compromising the integrity of clinical work and equipment longevity. The Opportunity This project presents an opportunity to modernize the "engine room" of the Nome Dental Clinic. By replacing the outdated compressor with a high-capacity, oil-free, and energy-efficient unit, NSHC can: Eliminate Service Interruptions: Guarantee that all 10 bays remain operational. Ensure Clinical Safety: Meeting the highest standards for medical-grade compressed air. Optimize Facility Efficiency: Reducing noise pollution and energy consumption within the dental wing.	NSHC will execute a focused replacement plan centered on clinical continuity: Procurement & Specification: We will procure a medical-grade, multi-motor compressor system designed for a 10-bay high-volume clinic. This "redundant" design ensures that even if one motor requires service, the other can maintain enough pressure to keep the clinic running. Accountability: A dedicated Facilities Project Lead will be assigned to manage the vendor and coordinate with the Dental Department Lead. Coordinated Installation: To minimize disruption for the 3,785 annual patients, the installation will be scheduled during off-hours or a pre-planned administrative block. Post-Installation Review: We will conduct a performance review 30 days post-install to gather staff feedback on air pressure consistency and noise reduction, ensuring the unit meets all clinical needs.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1M Design/Plan Village Community Wellness Centers	AK	The Problem Health equity is impossible when a patient lacks a private, dignified space to meet with a provider. In homes without running water or privacy, a Telemedicine appointment can feel invasive or logistically impossible. Currently, the lack of a "third space"—a place that is neither the clinical exam room nor the overburdened home—means residents often skip preventive care and mental health resources. There is a desperate need for a reliable hub that offers both the "soft" resources of wellness (fitness, nutrition, self-help) and the "hard" resources of sanitation. The Opportunity This planning project allows us to design the "Village Sanctuary Model." We have the opportunity to: Dignify the Care Experience: Providing a safe, warm space where a person can shower and do laundry before or after a private video consult with a specialist. Modernize Telemedicine Access: Moving beyond the "clinic-only" model to a community-based Tele-Suite that feels less like a medical exam and more like a supportive self-care environment. Holistic Resource Centralization: Creating a one-stop shop for fitness equipment, nutrition resources, and self-help materials, making health a proactive, daily pursuit.	NSHC will lead a design process that prioritizes the "Human Experience" alongside technical clinical requirements: Design for Warmth and Safety: The Project Lead will work with architects to ensure the hub is not just functional, but inviting. This includes comfortable seating, natural lighting where possible, and a layout that ensures privacy for Telemedicine and showers while maintaining a communal "wellness" feel. The Wellness Hub Service Menu: We will map out how to integrate fitness equipment and nutrition education into spaces that also house laundry and sanitation facilities. Tele-Suite Technical Standards: Designing soundproof, high-speed Telemedicine kiosks that are easy to use for Elders and offer a private link to Nome-based specialists. Stakeholder Partnership: Coordinating with local entities to ensure the hub is a "safe space" for all community members, including those in recovery or seeking behavioral health support.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1P Renovation and Handicapped Access Improvements to the Main Entrance of NSHC Facilities	AK	The Problem The main entrance of the Norton Sound Regional Hospital faces unique Arctic challenges. Manual or aging automated doors can fail during high-wind events, and standard ramps often become dangerously slick despite constant maintenance. For patients with mobility aids, the physical effort required to enter the building during a storm can be significant. Additionally, a lack of consistent tactile wayfinding makes navigation difficult for patients with visual or cognitive impairments, creating an "accessibility gap" at the region's most critical health hub. The Opportunity This project presents an opportunity to design a State-of-the-Art Accessible Main Entrance for the Nome hospital. We will: Guarantee Reliability: Designing heavy-duty, "Arctic-rated" automated entry systems that function flawlessly in extreme weather. Ensure Slip/Fall Resistance: Engineering heated thresholds and specifying advanced, high-traction materials to eliminate ice buildup at the entry point. Prioritize Universal Design: Integrating intuitive wayfinding and "wave-to-open" sensors to support independent access for all 10,000 regional residents.	NSHC will lead a design process that marries ADA compliance with Arctic engineering: Specialized Accessibility Audit: We will evaluate the current hospital entrance using the ADA Standards for Accessible Design, specifically looking for "friction points" in the path of travel from the parking lot to the lobby. Engineering for Durability: The Project Lead will work with architects to specify corrosion-resistant aluminum and stainless-steel hardware and industrial-grade motors capable of handling high-traffic and wind-load requirements. Safety-First Surfaces: We will design an entryway that includes heated ramp systems and "Grip-Grate" or knurled aluminum surfaces to provide maximum slip resistance for wheeled devices and pedestrians. Intuitive Wayfinding: The design will incorporate high-contrast signage and tactile floor markers to guide patients with visual or cognitive impairments safely into the clinical wings.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1Q Renovation of the NSHC Day Shelter Facilities	AK	The Population in Crisis The need for this renovation is evidenced by the specific scale of housing instability in our region: 364 Unhoused Individuals: Our 2025 data identifies 364 residents currently experiencing homelessness, all of whom face extreme risks of frostbite, SMI, and SUD. Critical Mortality Rates: The suicide rate in the Nome Census Area (\$93.9\$ per \$100,000\$) underscores the lethal intersection of homelessness and untreated trauma. Barriers to Reintegration: Without a physical "bridge" to resources, these 364 individuals remain trapped in a cycle of instability due to a lack of private space for case management and digital access for housing applications. The Opportunity: The Supportive Bridge Model This planning project allows NSHC to design a "Bridge to Stability" that specifically moves these 364 residents toward health and housing. We will design: Direct Resource Links: Digital kiosks where guests can independently manage housing and benefit applications. Continuity of Care: Dedicated private suites for Peer Support Specialists and Case Managers to facilitate the "hand-off" to long-term social supports. Trauma-Informed Safety: A layout featuring "Quiet Wellness Zones" to support guests experiencing SMI or acute distress, ensuring the shelter is a place of healing rather than a source of further trauma.	For Question 3: Project Concept Approach, we focus on how the renovation will functionally operate as that "Supportive Bridge" for the 364 individuals experiencing homelessness. The design moves away from a traditional "open hall" shelter toward a zoned, clinical, and resource-rich environment. Project Concept Approach (Question 3) NSHC will employ a multidisciplinary planning approach that integrates Trauma-Informed Care (TIC), Behavioral Health Clinical Standards, and Social Determinant of Health (SDOH) Navigation: Zoned Trauma-Informed Layout: The design will move away from high-stress, open-plan spaces. Architects will create a "Zoned Environment" including: Active Zones: High-traffic areas for meals and social connection. Quiet Wellness Zones: Low-sensory areas with acoustic dampening for individuals experiencing SMI symptoms or acute psychological distress. De-escalation Nooks: Strategically placed "safe alcoves" that allow guests to self-regulate without leaving the safety of the facility. Integrated "Supportive Bridge" Suites: We will design private, soundproof consultation rooms equipped with high-fidelity Telemedicine hardware. These rooms are dual-purpose: Clinical: Allowing guests to meet privately with SUD counselors or Psychiatrists. Resource Navigation: Providing a dignified space for guests to meet with Case Managers to work through the 2025-identified barriers to housing and employment. Digital Resource Hubs: We will plan for the installation of ruggedized, user-friendly digital kiosks. These kiosks will serve as the primary interface for the "bridge" out of homelessness, offering a one-stop-shop for housing applications, PFD/Social Security management, and resume building, supported by on-site Peer Mentors. Culturally Responsive Healing Architecture: Following consultation with NSHC Tribal Healers, the design will incorporate "Healing through Heritage" elements—using natural materials, Indigenous artwork, and communal "Talking Circle" configurations—to foster a sense of belonging and reduce the "institutional trauma" often associated with clinical facilities. Safety & Passive Observation: To ensure the safety of both guests and staff, the design will prioritize passive security. This involves wide sightlines and shatter-resistant materials that allow for unobtrusive	Under \$50,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

supervision, reducing the need for a carceral security presence which can be a trigger for those with high rates of PTSD.

Norton Sound Health Corporation	1R Wales System Upgrades - Water Storage Tank Replacement	AK	The Problem The existing water storage tanks in Wales are functionally failing. Decades of salt-air exposure and extreme freeze-thaw cycles have caused significant structural corrosion and leaks. These vulnerabilities allow pathogens to enter the water supply, posing a severe public health risk. Furthermore, the lack of real-time data means that leaks or temperature drops are often only discovered after a system failure, leading to costly emergency responses and periods where the community is without safe water. The Opportunity This planning project allows NSHC to design a Modernized Arctic Water Storage System. We have the opportunity to: Eliminate Health Risks: Utilizing antimicrobial materials to prevent biofilm and bacterial growth. Implement Remote Oversight: Installing IoT sensors that allow NSHC facilities and local operators to monitor system health 24/7. Modernize the Workforce: Training local Wales residents on the maintenance of high-tech water systems, creating skilled local roles.	NSHC will lead a design process centered on technical reliability and local empowerment: Engineering & Environmental Audit: We will assess the current site to ensure the new tank foundations can withstand shifting permafrost and coastal erosion. Smart-System Specification: The design will include antimicrobial tank linings and an IoT sensor suite (connected via Starlink/Satellite) to provide real-time alerts on water quality and tank levels. Local Operator Curriculum: We will develop a training manual specifically for Wales operators, focusing on the maintenance of IoT hardware and emergency troubleshooting. Strategic Procurement: Given the logistical challenges of Wales, the planning phase will include a Barge Logistics Plan to ensure materials are delivered during the narrow summer shipping window.	\$50,000-\$250,000	Hospital	Single Community	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1S Outdoor Exercise Equipment and Walking Paths	AK	The Problem In our 15 villages, the environment is often a barrier rather than an asset for health. Residents face uneven, unlit terrain that poses a high risk of falls, especially for Elders. The total absence of public exercise equipment means that physical activity is often limited to high-intensity subsistence tasks, leaving a gap for those who need low-impact or rehabilitative movement. This lack of infrastructure contributes to a "seasonal sedentary cycle," where activity levels drop dangerously during the winter months, exacerbating chronic physical conditions and impacting mental well-being across the lifespan. The Opportunity This planning project allows NSHC to design a "Village Wellness Circuit" tailored for the Arctic. We have the opportunity to: Democratize Fitness: Providing free, 24/7 access to high-quality exercise equipment that is ADA-compliant and age-inclusive. Safety Through Design: Implementing solar-powered LED path lighting to ensure walking trails are safe and inviting during the long months of Arctic darkness. Digital Health Integration: Installing weather-resilient kiosks that provide health education and biometric tracking, turning a simple walk into a proactive medical check-in that empowers residents to manage their own wellness. Community Connectivity: Designing paths that link essential village hubs—such as the clinic, school, and post office—encouraging "active transport" as part of daily life.	NSHC will lead a multidisciplinary design process focused on Arctic resilience, inclusivity, and clinical integration: Community-Specific Site Mapping: We will work with local leadership in each of the 15 villages to identify optimal routes that maximize use and connectivity. This includes geotechnical assessments to ensure paths are built on stable ground, avoiding areas prone to permafrost degradation or coastal erosion. Universal and Adaptive Design: Equipment selection will prioritize "Universal Design" principles. We will specify adaptive resistance machines and cardiovascular stations that are accessible to both able-bodied individuals and those using mobility aids, ensuring the equipment remains functional in temperatures as low as -40°F. Smart Infrastructure & Lighting: The design includes high-intensity solar-powered LED lighting with motion sensors. This maximizes safety during the dark winter months while minimizing energy consumption. Integrated Wellness Kiosks: We will design digital hubs that offer biometric monitoring (blood pressure, heart rate, O2) and sync with NSHC wellness initiatives. These kiosks will be ruggedized to withstand extreme wind, snow, and salt-air exposure. Culturally Responsive Aesthetics: The design will incorporate local art and signage in Indigenous languages, fostering a sense of community ownership and pride.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	1U Collaboration with NPS and BSSD on upgrades to playground equipment for school and community use	AK	The Problem Regional playgrounds are currently "play deserts" for children with sensory processing disorders or physical disabilities. Many existing structures are over 20 years old, featuring high-impact surfaces that are dangerous in icy conditions and layouts that do not support modern STEM-based or imaginative play. This lack of inclusive infrastructure leads to social exclusion for children with special needs and misses a critical window for fostering early-childhood physical and cognitive health among our massive youth patient population. The Opportunity This project presents an opportunity to design "Next-Generation Developmental Play-Hubs." We have the opportunity to: 1. Guarantee Inclusion: Designing sensory-rich zones and ADA-accessible equipment that allows children of all abilities to play together. 2. Integrate STEM Learning: Creating interactive "outdoor classrooms" where play-stations teach physics, biology, and math. 3. Enhance Safety: Implementing real-time safety monitoring technology and non-slip, impact-absorbing Arctic surfaces. 4. Community Socialization: Creating hubs where caregivers can gather, promoting social connectedness—a key factor in reducing regional family stress and improving mental health.	NSHC will lead a collaborative design process focused on "The Whole Child": • District-Wide Partnership: We will form a design committee with the Nome Public Schools and Bering Strait School Districts to ensure play zones align with educational and developmental goals. • Inclusive & Sensory Mapping: The design will include "Quiet Zones" for children with autism and "Active Zones" with adaptive swings and carousels for children with mobility devices. • STEM Integration: We will design stations that incorporate traditional Indigenous knowledge—such as celestial navigation or local biology—into STEM play structures. • Arctic-Resilient Engineering: The Project Lead will specify materials like high-density polyethylene (HDPE) and powder-coated steel that resist cracking in -40°F temperatures. • Smart-Safety Monitoring: The design will include integrated sensor technology to monitor equipment integrity and high-definition, solar-powered lighting for safety during the long winter.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced
Norton Sound Health Corporation	2E Remote Clinic Morgue Electrical Backup	AK	Frequent power outages disrupt mortuary care in NSHC's village clinics, creating distress for families and staff and risking loss of dignity for decedents. In the past year, eight electrical outages directly affected morgue operations, leading to service delays, temperature instability, and increased emotional strain on families awaiting arrangements. Ensuring reliable backup power is essential to maintain safe storage conditions, protect the integrity of remains, and support consistent, respectful mortuary care under all circumstances.	Procure and install automatic-activation generators or transfer switches for all village morgue facilities to ensure uninterrupted operation during power outages. Establish a phased installation schedule that prioritizes communities with the highest outage frequency. Assign a facilities coordinator to oversee procurement, contractor scheduling, installation, and quality assurance. Following installation, conduct staff orientation and perform post-installation reviews to gather feedback, verify system performance, and address any operational challenges.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	2F Morgue Equipment Upgrades	AK	The Problem The current cadaver lift at the NSHC morgue is outdated, prone to mechanical failure, and poses a direct hazard to staff and the dignity of the deceased. In the past year alone, two workplace injuries occurred as a result of equipment malfunctions. These incidents not only endanger our employees but also threaten to disrupt funeral preparations for families who may have traveled long distances from remote villages. A failure during a funeral process is a profound violation of the standard of care and respect NSHC promises to its residents. The Opportunity This project presents an opportunity to modernize our mortuary infrastructure to meet current safety and ergonomics standards. We have the opportunity to: Eliminate Workplace Injuries: Replacing a manual/failing lift with a modern, powered unit that adheres to OSHA safety guidelines. Uphold Cultural Dignity: Ensuring the seamless and respectful handling of bodies during the critical window of funeral preparations. Modernize Facilities: Integrating high-capacity, reliable equipment that can accommodate the physical requirements of a diverse patient population. Enhance Operational Efficiency: Reducing the time and staff required for mortuary handling, allowing facilities teams to focus on broader campus maintenance.	NSHC will follow a rigorous facilities management approach to the selection and implementation of this equipment: Specifications & Selection: A facilities project lead will be assigned to identify a high-capacity, modern cadaver lift that features intuitive controls, safety locks, and smooth hydraulic or electric movement. The unit must be compatible with existing mortuary storage and Arctic environment climate controls. Installation Planning: We will develop a detailed installation timeline that coordinates with the clinical and mortuary schedules to minimize downtime. This includes the removal of the outdated unit and the structural reinforcement (if necessary) of the installation site to support the modern lift’s weight and power requirements. Workforce Safety Training: Once installed, we will launch a mandatory training program for all facilities and clinical staff involved in mortuary services. This training will focus on ergonomic operation, emergency shut-off protocols, and regular safety checks. Digital Integration: The equipment’s maintenance schedule will be integrated into NSHC’s centralized facility management software to ensure automated reminders for inspections and lubrication. Post-Installation Review: Within 60 days of installation, we will conduct a review gathering staff feedback to address any operational challenges and ensure the new equipment has successfully mitigated the safety risks associated with the previous unit.	Under \$50,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	2G Portable Back-Up generator for village clinics	AK	The Problem Frequent and unpredictable power outages in our remote villages create a dangerous instability in healthcare delivery. In the past year alone, nine significant outages across three clinics directly impacted the care of over 200 patients. When a clinic loses power, electronic health records (EHR) become inaccessible, lighting for emergency procedures fails, and temperature-sensitive medications are put at risk of spoilage. Currently, without standardized backup power, our Village Health Aides must operate in high-stress, low-visibility environments, often during the long months of Arctic darkness, which significantly compromises patient safety and provider well-being. The Opportunity This project presents an opportunity to "Harden" our regional health infrastructure. We have the opportunity to: Ensure Clinical Continuity: Maintaining 100% uptime for all medical and communication systems regardless of the local grid status. Protect Cold-Chain Integrity: Safeguarding thousands of dollars in vaccines and medications from temperature excursions. Enhance Disaster Resilience: Transforming village clinics into reliable "Emergency Shelters" for the community during prolonged regional power failures. Reduce Equipment Damage: Preventing the costly electrical surges and "brown-out" damage that occur when power is inconsistently restored to sensitive medical devices.	NSHC will implement a comprehensive engineering and facilities approach to ensure clinical power resilience: Site-Specific Engineering Audits: A facilities coordinator will lead a technical assessment of each clinic to determine precise load requirements. This ensures that generators are sized to support not just lighting, but high-draw medical equipment, HVAC systems, and IT infrastructure. Procurement of Arctic-Grade Units: We will specify industrial-strength, diesel-powered generators equipped with "Cold-Weather Packages" (including block heaters and insulated enclosures) designed to start reliably in temperatures as low as -50°F. Phased Installation & Logistics: Given the reliance on the seasonal barge system, we will develop a tiered installation timeline. Units will be staged in Nome and deployed to villages during the summer shipping window, with NSHC facilities teams coordinating the electrical integration at each site. Automatic Transfer Switch (ATS) Integration: Each system will include an ATS to ensure a seamless, sub-second transition to backup power the moment a grid failure is detected, protecting sensitive digital systems from crashing. Remote Monitoring Technology: We will install IoT-based monitoring systems that allow the Nome-based facilities team to track fuel levels, battery health, and engine status in real-time for every village generator. Local Maintenance Training: We will provide village-based staff with "First-Responder" maintenance training, ensuring they can perform basic checks and manual starts if necessary, supported by annual professional servicing.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	2H Improve snow removal for Norton Sound Health Corporation facilities, improve emergency operation	AK	The Problem Current reliance on third-party contractors for snow removal has proven insufficient for the scale and urgency of NSHC’s operations. Last winter, the region experienced 18 reported incidents of delayed snow removal at NSHC facilities, leading to six major access disruptions and two staff injuries related to slips and falls on uncleared paths. Contractors often prioritize municipal or residential contracts, leaving clinical emergency bays blocked during critical windows. The rising costs and inconsistent service levels of external vendors create an unpredictable operational environment that endangers patient safety and strains the facility's budget. The Opportunity This project presents an opportunity to build Internal Emergency Capacity. We have the opportunity to: Guarantee 24/7 Access: Establishing a dedicated team that initiates clearance the moment snow begins to fall, ensuring ambulance bays and ER entrances are never compromised. Enhance Workforce Safety: Reducing the risk of staff and patient injuries by maintaining a higher standard of "Black-Top" clearance and sanding. Cost Stabilization: Transitioning from high-cost, variable contractor fees to a stable, predictable in-house operational budget. Specialized Equipment: Procuring heavy-duty, Arctic-spec loaders and blowers specifically suited for the unique drifting patterns of coastal Nome and the surrounding villages.	NSHC will execute a phased transition to a fully self-reliant snow management model: Equipment Procurement: We will purchase a fleet of modern, high-capacity snow removal units, including a heavy-duty front-end loader with specialized snow-pusher attachments, a high-velocity blower for clearing large drifts, and a dedicated sanding/salting truck. Equipment will be specified with "Extreme Cold" packages to ensure hydraulic and engine reliability in sub-zero temperatures. Specialized Staffing: We will hire three full-time employees dedicated to the Snow Removal and Facilities Grounds team. These roles will be trained in Arctic-specific clearing techniques that prevent "snow-packing" and optimize drainage during the spring thaw. Operational Command & Oversight: An Operations Manager will be assigned to lead the team, implementing a "Weather-Watch" protocol. This ensures that the team is deployed proactively based on meteorological alerts, rather than reacting after snow has already accumulated. Phased Onboarding & Training: The project includes a structured onboarding timeline where new staff are trained on the specific site plans of each NSHC facility, identifying "Priority 1" areas such as ambulance egress, oxygen tank access, and emergency exits. Strategy Adjustment & Feedback: We will schedule quarterly reviews to gather feedback from clinical staff and emergency responders. This data will be used to adjust clearing routes and schedules, ensuring that the highest-utilization areas receive the most frequent attention.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	2i NSRH Kitchen Upgrades	AK	The Problem The current Norton Sound Regional Hospital kitchen facilities have reached the end of their functional lifespan. Outdated layouts and aging equipment hinder the preparation of safe, nutritious meals, leading to longer service times and a limited menu variety that can impact patient satisfaction and recovery. More critically, the frequent failure of refrigeration and freezer units has resulted in the significant wastage of food resources, which is particularly costly in Nome due to high freight expenses. Additionally, the inefficient kitchen layout contributes to staff fatigue and increases the risk of cross-contamination, posing a safety risk to both patients and the workforce. The Opportunity This planning project allows NSHC to design a "Modern Nutritional Hub." We have the opportunity to: Guarantee Food Security: Installing reliable, monitored refrigeration to prevent resource loss. Enhance Patient Recovery: Redesigning workflows to support a wider variety of fresh, nutritious, and culturally appropriate meals. Improve Infection Control: Implementing a layout that physically separates prep, cooking, and sanitation zones to eliminate cross-contamination risks. Boost Staff Well-being: Creating an ergonomic workspace that reduces the physical toll on our essential foodservice workforce.	NSHC will utilize a professional design and engineering approach to modernize the kitchen infrastructure: Ergonomic & Workflow Redesign: We will work with specialized kitchen consultants to create an "Efficient Flow" layout. This redesign will minimize unnecessary staff movement, optimize the "prep-to-plate" timeline, and ensure a logical flow that prevents the intersection of raw ingredients and finished meals. Energy-Efficient Appliance Specification: We will select industrial, energy-efficient appliances designed for high-volume hospital use. This includes high-recovery ovens, induction cooktops, and smart refrigeration systems that reduce the facility's carbon footprint and operational costs. Digital Inventory & Temperature Management: The approach includes the implementation of an automated, 24/7 digital monitoring system for all cold storage. This system will alert facilities staff to temperature fluctuations before food spoilage occurs, safeguarding our regional food investment. Innovative Waste Reduction: We will design a kitchen management system that utilizes digital inventory tracking to reduce over-purchasing and food waste, aligning with NSHC's goals for environmental sustainability. Safety-First Surface Upgrades: The design will specify non-porous, easy-to-clean surfaces and anti-microbial flooring to maintain the highest standards of sanitation and infection control. Stakeholder Engagement: We will conduct workshops with current kitchen staff and clinical dietitians to ensure the new design meets the specific nutritional needs of our patient population, including the ability to process and serve traditional local foods.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3A After-School Youth health/wellness program	AK	The Problem The Bering Strait region faces a significant "wellness gap" during the school year. While "Summer-cise" successfully engages youth in the warmer months, the transition to the long Arctic winter brings a lack of structured after-school activities. This void contributes to higher rates of youth inactivity and mental health challenges. Simultaneously, NSHC faces a persistent workforce challenge: the lack of reliable after-school care options in Nome and the surrounding villages. This deficiency results in frequent staff absenteeism, reduced clinical hours, and increased turnover as parents struggle to balance professional duties with family well-being. Without a dedicated youth wellness program, the region misses a critical opportunity to foster early healthy habits while supporting the healthcare workers who keep the community safe. The Opportunity This project presents an opportunity to create a "Year-Round Wellness Continuum." We have the opportunity to: Extend a Proven Success: Scaling the "Summer-cise" curriculum into a four-season model. Bolster Workforce Retention: Providing NSHC staff with a reliable, health-focused after-school solution. Holistic Youth Development: Combining physical literacy with academic support and nutritional education. Strengthen Community Partnerships: Utilizing existing infrastructure like the Nome Recreation Center and Bering Strait School District gyms to maximize impact.	NSHC will implement a collaborative, multi-site wellness model designed to meet the unique needs of Arctic youth: Collaborative Framework: We will partner with the City of Nome (Recreation Center) and the Bering Strait Regional School District to utilize existing gymnasiums and classrooms. This maximizes current infrastructure while ensuring programs are located in familiar, accessible community hubs. Curriculum Design: Building on "Summer-cise" principles, the program will offer a daily schedule that includes: Structured Physical Activity: High-energy indoor sports, traditional Native games, and fitness challenges to combat winter inactivity. Academic & Wellness Support: Dedicated time for homework assistance, combined with age-appropriate wellness workshops on nutrition, dental hygiene, and mental health resilience. Nutritional Support: Providing healthy snacks that meet federal nutritional standards, addressing food insecurity for participants. Staffing & Mentorship: We will hire a Program Coordinator and a team of Wellness Mentors. We will also create "Junior Counselor" roles for high school students, fostering leadership skills and creating a pipeline for future healthcare and wellness professionals. Digital Integration & Data Tracking: We will implement a digital check-in and health-tracking system to monitor participation rates and physical activity milestones. This data will be used to refine the curriculum and demonstrate the program's impact on youth wellness. Workforce Priority Access: While open to the community, NSHC will establish a "Priority Enrollment" tier for healthcare employees to directly address the workforce retention crisis. Safety & Cultural Competence: All staff will undergo intensive training in trauma-informed care and cultural safety, ensuring the program is a welcoming environment for all Indigenous youth in the region.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3B Recruitment and Retention Incentives	AK	The Problem NSHC faces a workforce crisis characterized by high vacancy rates and an over-reliance on expensive temporary "locum tenens" staff. The cost of living in Nome and the surrounding villages—especially housing and food—is significantly higher than the national average, making traditional salary structures uncompetitive. High turnover rates lead to "institutional memory loss," where new staff must constantly be retrained on regional protocols and cultural nuances. This instability leads to provider burnout, reduced patient satisfaction, and a fragmented care delivery model that struggles to meet the needs of a high-risk population. The Opportunity This planning project allows NSHC to design a "Total Rewards" Framework. We have the opportunity to: Level the Playing Field: Offsetting the high cost of Arctic living through strategic stipends and bonuses. Invest in "Grown-Our-Own": Including professional development incentives that encourage local residents to advance into higher-level clinical roles. Prioritize Well-being: Implementing wellness benefits that address the unique mental health challenges of working in isolated, high-latitude environments. Enhance Quality of Care: Building a permanent team that understands the specific medical and cultural history of our regional families.	NSHC will utilize a data-driven HR strategy to design a competitive and sustainable incentive model: Market & Cost-of-Living Analysis: We will conduct a comprehensive study comparing NSHC’s total compensation against other Tribal health organizations and urban Alaska centers. This includes a "Cost-of-Arctic-Living" index to ensure housing and utility stipends are accurately scaled. Tiered Incentive Structuring: We will design a multi-tiered package that addresses specific "High-Need" roles (e.g., Nursing, Mid-level providers, and Behavioral Health) while ensuring non-clinical support staff—who are the backbone of our operations—are also incentivized. Housing & Relocation Innovation: The approach includes designing a "Soft Landing" program, featuring housing stipends and assistance in navigating the limited local housing market, which is often the primary barrier to successful recruitment. Professional Development Pathways: We will build "Career Ladder" incentives, providing tuition reimbursement and paid "study time" for staff seeking advanced certifications. This specifically targets regional residents to move from entry-level to professional roles. Resiliency & Wellness Benefits: Recognizing the intensity of rural medicine, the package will include "Arctic Resiliency" benefits, such as enhanced mental health support, fitness memberships, and "Travel Stipends" to help staff maintain connections with family outside the region. Retention Milestones: Instead of just sign-on bonuses, we will implement "Loyalty Bonuses" at the 5, and 10-year marks, rewarding those who provide the long-term continuity our patients need.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3C HR File Upgrades/Modernization	AK	The Problem NSHC’s current HR infrastructure is heavily dependent on legacy paper records and manual data entry, which are susceptible to error and security vulnerabilities. As we expand to manage 58+ RHTP initiatives, we lack a standardized, digital framework to support high-volume recruitment and compliance tracking. However, rushing into a software purchase without a dedicated planning phase poses a significant risk of "system mismatch"—where a chosen platform may not integrate with our existing clinical systems or survive the bandwidth constraints of our remote village clinics. The Opportunity This project presents an opportunity to conduct a Comprehensive HR Technology Audit and Design. We have the opportunity to: Market Analysis: Review and demo modern HRIS/Document Management platforms (e.g., Workday, UKG, or specialized medical HR software) to find the best fit for a Tribal organization. Gap Analysis: Identify exactly where our current manual workflows fail and design digital "replacements" that automate compliance. Security Architecture: Design a cloud-based structure that meets stringent HIPAA and SOC2 requirements for sensitive workforce data. Implementation Readiness: Ensure NSHC is "shovel-ready" for a digital migration with a fully costed implementation plan.	NSHC will execute a multi-phased design process to move from a paper-heavy legacy to a digital-ready future. This extended timeline allows for Rigorous Vendor Validation and Infrastructure Alignment: Stakeholder Requirements Gathering: We will document the specific administrative hurdles faced by HR, department heads, and village clinic managers, ensuring the design solves the "Time-to-Hire" bottleneck. Cloud-Platform Comparative Analysis: We will evaluate 3–5 specialized healthcare HR platforms (e.g., UKG, Workday, or specialized Tribal health modules) to find a solution that balances high-security AI document processing with an intuitive user interface. Arctic Connectivity Proof-of-Concept: We will perform "Latency Drills" to see how cloud-based AI tools perform under real-world Bering Strait internet conditions. This ensures that a village clinic manager can upload a credentialing document as easily as someone in the Nome hub. AI & Automated Workflow Design: We will design the "Logic Gates" for automated compliance. This includes mapping how the AI will "read" a medical license, verify it against state databases, and trigger an automated alert to the provider 90 days before expiration. Archive Digitization Blueprint: We will design the protocol for the mass-scanning of our physical files. This includes determining the "Metadata" required so that all legacy records become instantly searchable and audit-ready. Compliance & Security Architecture: The design will prioritize a "Zero-Trust" security model, ensuring that sensitive workforce data is encrypted at rest and in transit, meeting all HIPAA, SOC2, and federal audit standards.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3D Ski Path grooming equipment to make a seasonal ski path on the NSHC Housing campus	AK	The Problem As the new NSHC housing complex opens in stages between 2026 and 2028, hundreds of staff will be moving into a centralized area that lacks immediate, safe, and reliably maintained outdoor exercise space. Without a technical study of the new building orientations, the newly created wind-tunnel effects could make grooming impossible if the trail is not strategically placed. Furthermore, purchasing heavy grooming equipment without a site-specific plan risks "equipment-mismatch" for the unique terrain of the new campus. The Opportunity This project presents an opportunity for a Dynamic Wellness Design Study. We have the opportunity to: Live Site Observation: Use the 2026 winter season to monitor actual snow accumulation and wind patterns around the first completed buildings to optimize the final trail map. Strategic Procurement Planning: Identify the specific "prime mover" and grooming attachments needed for a 2027/2028 implementation. Governance & Safety Design: Develop formal maintenance SOPs and MOUs with local partners (e.g., Nome Winter Sports Association) before full occupancy. Recruitment Advantage: Finalize a "Ski-In/Ski-Out" amenity plan to boost the recruitment of medical professionals for the 2027/2028 hiring cycles.	NSHC will utilize an 18-month planning window to ensure the trail system is technically sound and ready for implementation by the 2027/2028 season: Staged Site Analysis (2026 Winter): We will conduct on-site "Snow Mapping" during the initial 2026 opening phase. By observing how snow drifts against the new building footprints, we can identify the most stable corridors for a groomed track that requires minimal fuel and effort to maintain. Grooming Fleet Vetting: We will research and demo Arctic-grade grooming technology, specifically looking for high-torque, tracked UTVs or snowmobiles and "Renovator" drags capable of breaking wind-packed Arctic crust. Collaboration & Partnership Design: We will draft formal Memorandums of Understanding (MOUs) with the City of Nome and the Nome Winter Sports Association to coordinate equipment sharing, volunteer grooming, and regional trail connectivity. Operational SOP Development: We will create a comprehensive manual for trail maintenance, including "Trigger Points" (grooming schedules based on snowfall), safety protocols for dark-month operations, and equipment storage requirements. Resident Interest & Safety Planning: We will survey the initial 2026 residents to refine trail loops (beginner vs. intermediate) and design a solar-powered LED lighting plan to ensure the track is navigable during the 20+ hours of daily winter darkness. Implementation Roadmap: The planning phase will culminate in a finalized procurement list and budget for the 2027/2028 Implementation project, ensuring NSHC is "ready to buy" the moment the housing complex reaches full occupancy.	\$50,000-\$250,000	Hospital	Single Community	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3E Playground equipment for NSHC campus	AK	The Problem With the new housing complex reaching final occupancy in 2027/2028, a high density of children from both staff and patient families will reside on campus. Currently, there is no dedicated, safe outdoor play infrastructure designed for this diverse population. Patient families, often far from their home villages, face "confinement stress" without outdoor outlets. Furthermore, standard playground equipment often fails in the Arctic due to permafrost heaving and extreme cold, creating safety hazards rather than wellness opportunities. The Opportunity This project presents an opportunity for Integrated Arctic Family Wellness Design. We have the opportunity to: Shared-Use Synergy: Design a space that fosters connection between resident staff families and visiting patient families, building a stronger regional community. Therapeutic Play: Incorporate sensory and inclusive play features that support children who may be on campus for medical reasons. Technical Specification: Select "Cold-Weather Rated" materials that remain safe and durable at -40°F. Strategic Placement: Use the 2026 construction footprints to place the playground in a wind-sheltered "micro-climate" easily accessible from both the staff and patient housing wings.	NSHC will utilize an 18-month planning window to design a playground that is safe, inclusive, and ready for a 2027/2028 implementation: Dual-Access Site Analysis: We will utilize the 2026 "Staged Opening" phase to identify a central, wind-sheltered location that is equally accessible to both the employee and patient housing buildings. This ensures that families in medical transit have the same "doorstep" access to wellness as permanent residents. Inclusive & Therapeutic Design Research: We will work with specialized manufacturers to identify "All-Abilities" equipment. The design will focus on inclusive features that accommodate children with different mobility or sensory needs, recognizing that a portion of the users will be children of patients or pediatric patients themselves. Arctic Engineering & Foundations: We will research permafrost-stable foundation designs (e.g., helical piers) to prevent equipment from shifting during seasonal freeze-thaw cycles, ensuring the playground remains level and safe year-round. Safety & Visibility Blueprint: We will design a comprehensive safety plan, including cold-weather resilient, fall-attenuating surfacing and solar-powered LED lighting. This ensures the playground is a safe "Safe Zone" during the long periods of winter darkness. Governance & Maintenance Framework: We will develop a collaborative oversight model involving NSHC Facilities and a resident/patient-advocacy committee to ensure the equipment is maintained to the highest clinical safety standards. Phased Implementation Roadmap: The project will culminate in a finalized procurement list and installation budget, synchronized with the final 2027/2028 housing completion.	\$50,000-\$250,000	Hospital	Single Community	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3F Upgrades to the City of Nome pool and collaboration as a wellness and health care space	AK	The Problem The Nome pool relies on aging mechanical systems that are prone to failure. These outages disproportionately impact young children who travel across 23,000 square miles for short-term, intensive swim-safety programs. If the pool is down during their stay, a critical window for life-saving instruction is lost. Furthermore, our Elders face a "mobility gap"; when the pool is closed, they lose their primary tool for managing arthritis and cardiovascular health without the risk of falls on icy terrain. Currently, there is no formal agreement that synchronizes these specialized needs. The Opportunity This project presents an opportunity for Cross-Generational Life-Safety Integration. We have the opportunity to: *Drowning Prevention for Children: Secure the "Survival Pipeline" for village youth, ensuring the facility is operational for essential swim-safety instruction. *Elder Mobility and Healing: Design a clinical schedule that provides dedicated "Quiet Hours" and warm-water therapy for seniors and PT/OT patients. *Infrastructure Resilience: Replace failing equipment to ensure 99% uptime, protecting the community's most vulnerable users. *Clinical Synergy: Create a space where NSHC therapists can provide water-based rehabilitation without displacing school-based lessons.	NSHC will utilize a 12-month planning window to establish a sustainable operational and technical framework for this multi-agency facility: *Regional Partnership Coalition: We will convene a planning committee including NSHC, the City of Nome, NPS, BSSD, and NACTEC. This group will develop a Multi-Agency Joint-Use Agreement (JUA) that prioritizes both school-based swim safety, NSHC Medical and Elder-focused therapies, and open times for exercise and fun. *Technical Engineering Audit: We will partner with the City to conduct a mechanical audit. The resulting procurement plan will prioritize high-durability filtration and high-efficiency heating systems to maintain the consistent, warmer water temperatures required for Elder therapy and infant swim classes. *Coordinated Scheduling Model: We will design a "Regional Master Schedule" that accounts for intensive "Swim Weeks" for village youth while reserving dedicated blocks for Elder Wellness and NSHC clinical referrals. *Vulnerable Population Safety Protocols: The planning phase will include the design of specialized safety protocols, such as enhanced lifeguard training for pediatric and geriatric emergencies, and the selection of modern hydraulic lift systems for patients with limited mobility. *Shared Maintenance & Funding Strategy: We will establish a collaborative maintenance fund, exploring how NSHC medical billing, school district contributions, and municipal funds can be "braided" to ensure the pool's long-term financial health. *Accessibility Audit: We will perform a comprehensive review of ADA compliance, focusing on ensuring that the locker rooms and pool entry points are fully accessible to Elders and children with physical or sensory disabilities.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3g: Planning and Project Design: Critical Upgrades to Nome Recreation and Wellness facility.	AK	Problem The NRC is facing a systemic failure of its core utilities. The boilers are approaching obsolescence, creating a risk of a total facility freeze-up during peak event season. Currently, the locker rooms, kitchen, and lavatory areas are out of operation, reducing the facility's utility for the Nome Health and Career Fair and for the hundreds of athletes who travel to Nome for the Lonnie O'Connor Basketball Tournament. Because the NRC is the only local venue capable of hosting the Iditarod and Iron Dog banquets, these failures threaten the region's economic stability and cultural identity. Without an engineered plan, we risk a catastrophic closure during a major regional gathering. Opportunity This project presents an opportunity for Infrastructure Sovereignty and Event Resilience. We have the opportunity to: 1. Secure the "Big Event" Pipeline: Designing a fail-safe heating system that ensures the facility can host 1,000+ people during the Iditarod or Midnight Sun Music Festival. 2. Restore High-Capacity Hygiene: Planning the rehabilitation of locker rooms to support the influx of village youth and athletes during regional tournaments. 3. Optimize Clinical Spaces: Designing modern spaces and meeting rooms to support the Nome Health and Career Fair, health coaching, and NSHC-led screenings. 4. Engineer Shelter Readiness: Ensuring the facility is fully prepared to serve as a regional "Mass Care" shelter during disasters. 5. Preserve community exercise and wellness spaces.	NSHC will utilize a 12-month planning window to develop an actionable blueprint for the NRC’s modernization: *High-Capacity Mechanical & Structural Audit: We will hire Arctic engineers to assess the boiler plant and HVAC. The audit will focus on "Peak Load" capacity—ensuring the systems can handle the extreme demands of heating the building at maximum capacity during events like the Elders and Youth Conference. *Multi-Use Space Optimization: We will create architectural plans that allow for rapid transitions between uses—from a basketball court to a banquet hall for the Iron Dog or a concert venue for the Midnight Sun Music Festival. *Design of Health Spaces: We will develop A&E plans to modernize the facility's lab and meeting rooms, specifically designed to host the Nome Health and Career Fair, wellness classes, and year-round clinical events and screenings. *Emergency & Festival Infrastructure: We will design integrated power and data protocols to support the high-tech needs of modern festivals and the backup power required for an Emergency Evacuation Shelter. *Joint-Use & Maintenance Agreement (JUA): NSHC and the City will draft a formal agreement defining shared costs and the prioritization of the space for both daily Kindergym/Elder activities and the major regional tournaments. *Phased Construction Sequencing: We will develop a construction schedule that works around the "Big Three" (Iditarod, Iron Dog, and Basketball Tournament), ensuring the facility remains open during the region's most critical economic windows.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3H Purchase of laser surgical ophthalmology equipment and quarterly ophthalmology visits	AK	The Problem Access to surgical eye care currently relies on a "displacement model" that causes social and economic instability. Patients must leave the region for Anchorage, which disrupts childcare, subsistence, and cultural support. Furthermore, without a YAG laser in Nome, patients who develop common post-surgical clouding are forced to fly back to Anchorage for a two-minute procedure. This unnecessary travel increases exposure to urban stressors and substance use triggers. Currently, NSHC lacks the formal facility design and specialist partnership framework to host these surgical services locally. The Opportunity This project presents a Planning Opportunity for Comprehensive Vision Care. We have the opportunity to: 1. Design an End-to-End Cataract Care Model: Planning for both initial surgery and subsequent YAG laser capsulotomies in Nome. 2. Engineer Specialized Facilities: Designing a surgical bay that meets the strict environmental standards for sensitive laser equipment. 3. Establish Sustainable Partnerships: Formalizing quarterly specialist rotations with Anchorage-based ophthalmology groups. 4. Protect Patient Livelihoods: Designing a "Surgical Intensive" schedule that minimizes time away from work and family.	NSHC will utilize this planning phase to create a "shovel-ready" surgical ophthalmology program: *Technical Feasibility & Equipment Spec: We will identify the specific technical requirements for a comprehensive ophthalmology package, including an excimer laser (LASIK), a high-precision YAG laser, and phacoemulsification systems. *Facility Engineering and Design: We will engage with architects and medical engineers to design a dedicated "Eye Surgical Bay" within the hospital, focusing on redundant climate control and power stability required for lasers. *Specialist Partnership Development: We will draft and negotiate formal Memorandums of Agreement (MOAs) with specialized ophthalmologists to ensure reliable, quarterly surgical rotations. *Care Pathway Mapping: We will design the integrated pre- and post-op protocols that allow our local optometry team to manage patients before and after the specialist arrives, reducing the need for any out-of-region travel. *Tele-Ophthalmology Integration Planning: We will design the digital imaging infrastructure needed for visiting specialists to perform "virtual screenings" from Anchorage to prioritize the quarterly surgical queue. *Economic Impact Analysis: We will develop a scheduling model that aligns surgical "blocks" with seasonal subsistence cycles to minimize the economic impact on patients.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3I Implementation of Developed Project: Home Sleep Testing Expansion	AK	The Problem Sleep apnea is highly prevalent in our region, yet it remains critically underdiagnosed due to a lack of local testing infrastructure. Currently, NSHC has a limited number of HST units, leading to long waitlists and a "diagnostic bottleneck." Many patients, faced with the prospect of traveling to Nome for an in-lab study or waiting months for a home unit, simply opt out of testing. This result is a high volume of untreated cases that eventually manifest as costly emergency interventions for heart failure, stroke, or severe fatigue-related accidents. The Opportunity This project presents an opportunity to implement a "Community-Based Diagnostic Grid." We have the opportunity to: Eliminate the Backlog: Doubling our testing capacity to ensure that every referred patient can begin their study within 14 days. Reduce Patient Travel: Shifting the diagnostic model so that the equipment travels to the village, rather than the patient traveling to the hub. Preventive Intervention: Identifying sleep-disordered breathing early to mitigate the risk of high-cost cardiovascular comorbidities. Maximize Clinical Resources: Utilizing established neurology partnerships to provide remote interpretation of the increased data volume.	NSHC will utilize a coordinated regional logistics and clinical workflow to expand sleep diagnostics: Equipment Procurement & Specification: We will purchase six Type III Home Sleep Testing devices. These units are specifically chosen for their durability, ease of use for patients, and seamless integration with our digital neurology platforms. Regional Distribution Network: We will establish a "Rotation Schedule" where units are strategically deployed to village clinics based on referral volume. This ensures that equipment is never sitting idle and that high-demand communities have immediate access. Standardized Patient Education: We will develop culturally appropriate, simplified instruction kits (including visual guides and video tutorials) to ensure patients can successfully self-administer the test, reducing the rate of "invalid" studies that require a re-test. Staff Training & Competency: Village-based Health Aides and Nome-based respiratory staff will be trained in device sanitization, data uploading, and patient troubleshooting. Integrated Data Management: The project will leverage our existing Electronic Health Record (EHR) and neurology partnerships. Once a test is completed in a village, the data is uploaded to a secure cloud where board-certified neurologists can interpret the results remotely, facilitating a rapid turnaround from "test" to "treatment plan." Logistics Oversight: A dedicated coordinator will track the "Chain of Custody" for each machine as it moves between Nome and the villages via local air carriers, ensuring units are tracked and maintained according to manufacturer standards.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3K Implementation of Developed Project: MRI Modernization and Improvement	AK	The Problem Our current MRI scanner is a legacy system that lacks the gradient strength and software packages required for complex specialty imaging. Consequently, patients requiring advanced neurological, cardiac, or fine-tissue musculoskeletal scans must be medevaced or flown commercially to Anchorage. This creates a dangerous "diagnostic delay" and forces patients into the high-volume waitlists at ANMC. Additionally, the aging hardware faces increasing downtime, further extending regional wait times and compromising the reliability of our emergency diagnostic services. The Opportunity This project presents an opportunity for Regional Diagnostic Independence. We have the opportunity to: *Expand Clinical Scope: Enabling complex sequences (e.g., MRCP, Diffusion-Weighted Imaging, and advanced Angiography) to be performed locally. *Reduce ANMC Dependency: Bypassing the 4–6 week wait times often found at urban referral centers by providing immediate local access. *Eliminate Travel Barriers: Saving patients and the healthcare system the massive costs associated with air travel, lodging, and patient escorts for out-of-region imaging. *Accelerate Emergency Care: Providing high-definition imaging for stroke and trauma patients in-house, allowing for life-saving interventions to begin hours earlier.	NSHC will execute a phased modernization of the MRI suite to ensure minimal disruption to patient care: *Advanced System Selection: We will procure a state-of-the-art MRI unit equipped with advanced software packages specifically designed for high-complexity clinical needs, such as neuro-functional imaging and detailed cardiac mapping. *Infrastructure Retrofitting: Our facilities team will coordinate the necessary shielding and power upgrades. We will prioritize "Low-Helium" magnet technology to reduce our reliance on difficult-to-ship cryogen refills in our remote Arctic location. *Specialized Staff Training: NSHC radiologic technologists will undergo advanced certification training on the new complex protocols. We will also establish "Tele-Radiology" links with specialists to allow for real-time oversight of complex scans. *Logistical Synchronization: We will coordinate the magnet delivery—using specialized air-freight or barge logistics—to align with a "Quick-Turn" installation window to minimize service interruptions. *Service Continuity Plan: During the transition, NSHC will utilize a temporary mobile MRI solution or prioritize emergency air-transfers to ensure critical diagnostic needs are met without delay. *Digital Integration: The system will be fully integrated into our PACS, allowing for seamless image sharing with ANMC and other specialists for collaborative care, ensuring that while the scan is done in Nome, it can be read by the world's best specialists instantly.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3L Implementation of Developed Project: CT Scanner Cardiac Screening Upgrade	AK	The Problem Heart disease is often a "silent killer" in the Arctic. Many residents are unaware of their cardiovascular risk until they experience a myocardial infarction (heart attack), necessitating an emergency medevac that can cost upwards of \$25,000. Our current CT scanner lacks the specialized EKG-gating hardware and "Calcium Scoring" software required to visualize the coronary arteries without motion blur. This diagnostic gap means we miss opportunities for early prevention, forcing our healthcare system to remain reactive rather than proactive. The Opportunity This project presents an opportunity for Advanced Preventive Cardiology. We have the opportunity to: *Early Detection: Identifying "silent" coronary artery disease in asymptomatic patients during routine wellness exams. *Risk Stratification: Providing clinicians with a definitive "Calcium Score" to guide the aggressive management of cholesterol and blood pressure. *Cost Avoidance: Preventing expensive emergency medevacs and long-term disability through early, low-cost pharmaceutical and lifestyle interventions. *Local Access: Removing the travel barrier to cardiac screening, ensuring that high-risk residents can be screened and managed within their home region.	NSHC will execute a comprehensive technical and clinical upgrade to our existing CT suite: *Hardware Integration: We will procure and install an EKG-Gating System for the CT scanner. This hardware synchronizes the CT X-ray pulses with the patient's heartbeat, allowing the scanner to take "still" images of the coronary arteries between heartbeats. *Software Implementation: We will install specialized CAC Scoring Software that automatically identifies and quantifies the volume and density of calcium in the coronary arteries, generating a standardized "Agatston Score" for the radiologist. *Clinical Protocol Development: Our cardiology and radiology teams will collaborate to develop a "Cardiac Screening Pathway." This includes clear criteria for which patients should receive a CAC scan (e.g., those with a family history or borderline risk factors) and standardized follow-up care based on the results. *Specialized Staff Training: NSHC CT technologists will receive intensive training on EKG lead placement and cardiac-specific scanning techniques to ensure high-quality, motion-free images. *Diagnostic Integration: CAC scores will be integrated into our EHR and shared with the patient's Primary Care Provider (PCP) and Community Health Aides (CHAs) to ensure a "whole-team" approach to the patient's heart health. *Community Awareness Campaign: NSHC will launch a regional education initiative to explain the importance of "Heart Scoring" to village residents, encouraging high-risk individuals to seek screening during their next trip to Nome.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3M Rural Xray Training and Utilization	AK	The Problem NSHC has deployed X-ray hardware across the region, but under-utilization remains a challenge. Currently, some patients are still sent to Nome because village staff may lack the "hands-on" confidence to perform complex views. Furthermore, practicing X-ray techniques on live patients is ethically and legally restricted due to radiation exposure. Without a high-fidelity training mannequin that features human-like skeletal structures and tissue density, providers cannot "practice to perfection" in their home clinics, leading to avoidable travel costs and diagnostic delays. The Opportunity This project presents an opportunity for Regional Diagnostic Self-Sufficiency. We have the opportunity to: 1. Maximize Capital Investment: Ensuring the X-ray units in all 15 villages are utilized for 100% of appropriate clinical cases. 2. Practice Without Exposure: Using "X-ray Phantoms" to allow CHAs to practice difficult positioning (like lateral views or pediatric angles) without radiation risk to humans. 3. Standardize Imaging Quality: Developing a regional "Best Practices" curriculum that ensures images taken in a village clinic meet the same standards as the regional hospital. 4. Model Regional Success: Using our training framework to help other tribal health organizations across Alaska optimize their own remote imaging programs.	NSHC will implement a multi-modal training strategy to transform our village providers into expert "Limited-Scope" X-ray operators: *Procurement of X-Ray Training Phantoms: We will acquire high-fidelity training mannequins designed specifically for radiologic training. These phantoms contain human-like bones and soft-tissue equivalents, allowing staff to take actual X-rays of the mannequin to verify their positioning and exposure techniques. *Hands-On "Skills Blitz" Sessions: We will provide travel resources to bring village staff to the Norton Sound Regional Hospital for intensive rotations with certified Radiologic Technologists. *Remote "Over-the-Shoulder" Mentorship: We will leverage our telemedicine infrastructure to provide real-time, remote coaching. While a CHA is positioning the training mannequin in a village, a Technologist in Nome can provide live feedback via video. *Mastery-Based Positioning Lab: The training phantoms will be rotated through the 15 village clinics, allowing staff to complete a "Positioning Checklist" (Chest, Hand, Foot, Ankle) to maintain their proficiency and certification. *Quality Assurance (QA) Feedback Loop: Every image taken in a village will be reviewed by our Radiology team, with structured feedback provided back to the village provider. *Standardized Utilization Protocols: We will develop clear clinical guidelines that empower APPs to order and utilize local X-rays immediately, reducing "consultation lag."	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3N Pharmacist-Directed IV Pump Implementation	AK	The Problem Many of the most effective modern medications for chronic autoimmune and inflammatory conditions are available only via infusion. Because our 15 village clinics lack the high-precision IV pumps required to administer these "biologics," patients are forced into a disruptive "travel for treatment" model. This leads to poor medication adherence and worsened health outcomes. Furthermore, the lack of equipment standardization between the villages and the regional hospital creates a "technology hurdle" that increases the risk of medical errors during patient transfers. The Opportunity This project presents an opportunity for Chronic Disease Equity. We have the opportunity to: 1. Deliver Biologic Therapies Locally: Providing life-improving infusions for RA, Crohn’s, and MS directly in the village. 2. Standardize Regional Safety: Matching the village pump systems to the Hospital and Medevac fleets to eliminate transition-of-care risks. 3. Empower Remote Pharmacists: Utilizing the BD Alaris "Guardrails" software to allow Nome pharmacists to safely direct complex chronic infusions from a distance. 4. Improve Quality of Life: Eliminating thousands of hours of unnecessary patient travel, allowing residents to stay with their families while managing their chronic conditions.	NSHC will implement a unified regional infusion network focused on chronic disease management: *Procurement of Standardized BD Alaris Fleet: We will purchase units that are identical to the hospital’s upgraded pumps, ensuring a single, region-wide training and safety standard. *Chronic Infusion Formulary Expansion: The NSHC Pharmacy will develop specific protocols for common chronic biologics (e.g., Infliximab for RA/Crohn's, Ocrelizumab for MS) to be administered safely in a village setting using the pump's "Smart" drug library. *Unified "Guardrails" Sync: We will ensure every pump in the region—whether in a village clinic, on a medevac flight, or in the hospital—runs the exact same safety software, preventing dosing errors as patients move between levels of care. *Specialized Clinical Training: Village staff will be trained not just on pump mechanics, but on the specific monitoring requirements for chronic biologic infusions, including managing potential infusion-related reactions. *Tele-Pharmacy "Direct-Link": We will utilize the digital interface of the Alaris pumps to allow Nome pharmacists to perform a "Second Sign-Off" on complex chronic medications before the infusion begins in the village. *Long-Term Patient Tracking: Infusion data will be integrated into the regional EHR, allowing specialists to track the effectiveness of these life-altering medications over months and years without the patient needing to leave their community for every check-up.	Under \$50,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3O Bladder Scanner Expansion	AK	The Problem NSRH currently relies on a single bladder scanner shared across several geographically separated hospital units. This "single-point-of-failure" creates significant clinical risks: 1. Diagnostic Delays: During peak hours, clinicians in the ER may have to wait for the scanner to be released from the Acute Care wing, delaying the diagnosis of acute urinary retention. 2. Infection Risk: Delays in scanning often lead to "precautionary" catheterizations, which increases the risk of CAUTIs and patient discomfort. 3. Staff Inefficiency: Nursing staff spend valuable time tracking down equipment rather than focusing on direct patient monitoring. The Opportunity This project presents an opportunity for Point-of-Care Diagnostic Efficiency. We have the opportunity to: 1. Eliminate Equipment Bottlenecks: Providing immediate access to bladder scanning in both the Emergency and Acute Care units. 2. Enhance Obstetric Safety: Improving the monitoring of bladder volume in post-partum patients to prevent complications. 3. Reduce Clinical Risk: Minimizing invasive procedures through the use of reliable, non-invasive ultrasound technology. 4. Standardize Technology: Adding a second unit that matches the current fleet to ensure staff familiarity and ease of maintenance.	NSHC will implement a strategic expansion of its diagnostic imaging fleet: *Procurement of Advanced Bladder Scanner: We will acquire a high-fidelity, portable bladder scanner that utilizes automated 3D ultrasound technology to provide fast, accurate volume measurements. *Strategic Deployment: The new unit will be permanently stationed in a high-traffic clinical area (such as the Emergency Department or Labor & Delivery), while the existing unit remains in Acute Care. This ensures that a scanner is always within "seconds" of a patient in need. *Staff Competency Training: We will conduct hands-on training for all nursing and provider staff. This training focuses on correct probe orientation and interpreting results for diverse patient populations, including pediatric, obstetric, and geriatric patients. *Infection Control Protocol: We will implement standardized cleaning and maintenance protocols for the new device, ensuring it remains a sterile and reliable tool for point-of-care use. *EHR Integration: The new scanner will be configured to upload results directly to the patient’s Electronic Health Record (EHR). This allows the care team to track bladder volume trends over time without manual data entry, reducing the risk of transcription errors. *Biomedical Calibration: The unit will be added to the hospital’s Preventative Maintenance (PM) schedule, ensuring that NSHC Biomedical Engineering performs regular accuracy checks and software updates.	Under \$50,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3Q Emergency Workforce Training Technology	AK	The Problem Current emergency training is fragmented. Hospital Providers often travel to maintain ACLS/PALS certifications, leading to staffing gaps in Nome. Meanwhile, Community Health Aides (CHAs) and village responders struggle to maintain ETT/EMT skills because "low-fidelity" plastic manikins do not simulate the complex physical responses of a real patient. This "skill decay" is a major risk in remote villages where emergencies are high-stakes but low-frequency. Without a unified, high-fidelity simulation platform, we cannot guarantee a standardized response across our 15-village network. The Opportunity This project presents an opportunity for Total Regional Readiness. We have the opportunity to: 1. Standardize Advanced Care: Using simulation to provide ACLS and PALS training in-region, keeping doctors and nurses at the bedside. 2. Empower CHAs and Volunteers: Providing Health Aides and community responders with high-fidelity manikins that "respond" to their treatments during ETT/EMT drills. 3. Youth Workforce Pipeline: Engaging high school students in dual-credit emergency medicine courses using the latest simulation technology. 4. Integrated Drills: Running "Simulated Transfers" where a village EMT and a hospital Provider use identical technology to practice the hand-off of a critical patient.	NSHC will implement a "Full-Spectrum" simulation program across the region: *Procurement of High-Fidelity Simulator Fleet: We will purchase a range of advanced manikins: "Sim-Man" for ACLS and adult EMT training, "Sim-Junior" for PALS, and specialized trauma models for ETT certification. *CHA and Village Integration: We will deploy mobile "Sim-Kits" to village clinics. These allow Community Health Aides (CHAs) to practice high-acuity scenarios locally, with manikins that provide digital feedback on compression depth, airway management, and drug administration. *Provider Certification Hub: We will establish a permanent simulation lab in Nome for hospital staff to complete their ACLS/PALS renewals, utilizing software that records and debriefs their performance against international gold standards. *Community and Youth Outreach: We will partner with regional schools to offer ETT and EMT courses for high school students, using "gamified" computer simulations to teach anatomy and emergency protocols before moving to hands-on manikin practice. *Synchronized Regional Drills: Every quarter, NSHC will host a "Regional Code Day" where providers in Nome and responders in the villages participate in a synchronized simulation, practicing the entire arc of care from the initial EMT response to the hospital ACLS intervention. *Digital Performance Analytics: The system will track "skill trends" across the region, identifying if specific villages or departments need more focus on pediatric care or cardiac response, allowing for data-driven clinical education.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3S Safety and Communication Systems Modernization	AK	The Problem Our existing life-safety systems—including fire alarms, nurse call, and code alerts—are non-integrated and building-specific. Currently, an emergency in one facility may not be visible to responders in another because these systems do not "talk" to each other across the campus network. This fragmentation is exacerbated by our rapid growth; new construction often requires standalone fire panels and alert units, adding complexity rather than cohesion. Without a unified plan, we face a "response lag" during fire or medical crises, jeopardizing staff and patient safety, particularly for those with limited mobility. The Opportunity This project presents an opportunity for Campus-Wide Safety Synchronization. We have the opportunity to: 1. Eliminate System Silos: Designing a unified fiber/IP link that connects Fire, Code Blue, and Nurse Call into one life-safety loop. 2. Ensure Future Scalability: Engineering a "Plug-and-Play" architecture that allows new buildings to be added to the fire and safety network instantly. 3. Unified Alerting: Implementing systems that allow fire alarms to trigger automated, clear voice instructions via the intercom system for safer evacuations. 4. Regulatory Harmonization: Standardizing safety protocols so that NFPA, CMS, and Joint Commission compliance is maintained across every square inch of the NSHC footprint.	NSHC will utilize a 12-month planning window to design a sophisticated, campus-wide safety communication architecture built for growth: *Cross-Campus Infrastructure Mapping: We will conduct a technical assessment to establish a dedicated, redundant "Life-Safety VLAN" that ensures Fire, Nurse Call, and Code Blue signals have a clear, prioritized path across the entire campus. *Integrated Fire & Alert Design: We will design a system where a Fire Alarm or Code Blue triggered in any building is broadcast to centralized security hubs, mobile devices campus-wide, and digital signage, providing the exact location of the incident. *Scalable Staff Duress (RTLS) Engineering: We will develop specifications for a "Real-Time Location System" (RTLS), ensuring that a staff member's panic badge remains active and trackable as they move from the hospital to the QCC or support offices. *Inter-Building Intercom & Fire Voice Integration: We will engineer an IP-based intercom system capable of "Global Paging." This allows for automated fire evacuation instructions or emergency announcements to be broadcast across all NSHC buildings simultaneously. *Standardized Expansion Protocols: We will create a "Safety & Fire Construction Standard." This document will ensure that any new NSHC building is automatically compatible with our campus-wide fire and alert systems from day one. *Implementation & Training Roadmap: The design phase will include a multi-building training curriculum, ensuring staff are familiar with the unified fire and clinical alert tones regardless of which facility they are working in.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3T Telephone services upgrade for Norton Sound Regional Hospital	AK	The Problem NSRH is operating on a "fragile" communication foundation. Our current VoIP system is no longer supported, making us vulnerable to software crashes. Simultaneously, the physical structure of the hospital creates "RF shadows" that prevent cell phones from working in critical areas. This lack of integration means our emergency safety equipment and medical technology cannot "talk" to one another. Most importantly, without a functional repeater system, we lack a backup communication path if our internal network fails, creating a single point of failure that endangers patient care during critical incidents. The Opportunity This project presents an opportunity for Mission-Critical Communication Redundancy. We have the opportunity to: 1. Establish Dual-Path Reliability: Creating a redundant environment where VoIP and Cellular systems back each other up. 2. Eliminate Dead Zones: Installing a Distributed Antenna System (DAS) to provide 100% cellular coverage for staff and patients. 3. Modernize VoIP Infrastructure: Deploying a scalable, enterprise-grade phone system that integrates with our Electronic Health Record (EHR). 4. Enhance Safety Integration: Linking voice systems directly to hospital intercoms and nurse-call platforms for automated, high-speed emergency alerts.	NSHC will execute a comprehensive overhaul of our digital voice and cellular infrastructure to ensure maximum uptime: *Enterprise VoIP Replacement: We will procure and install a modern, cloud-hybrid VoIP platform. This system will feature advanced call-routing and encrypted messaging, providing the primary path for clinical communication. *Distributed Antenna System (DAS) Installation: We will deploy a network of cellular repeaters and internal antennas. This system serves as the secondary redundant path, ensuring that SIM-enabled devices (cell phones and tablets) function flawlessly in every room, providing a fallback if the VoIP network is interrupted. *Systems Integration: Our IT team will integrate both the VoIP and the cellular-enabled devices with the hospital’s Nurse Call and Overhead Paging systems. This allows for "smart alerts" to be sent via multiple paths, ensuring redundancy in emergency notifications. *Carrier-Neutral Design: The DAS will be designed to boost signals for all major providers (GCI, AT&T, Verizon), ensuring that every staff member, regardless of their service provider, has a reliable connection. *Cybersecurity & Encryption: The new system will include robust encryption to protect patient privacy and comply with HIPAA, while remaining accessible through multi-factor authentication. *Phased Rollout & Stress Testing: To ensure zero downtime, we will utilize a "Parallel Run" strategy where the new VoIP and DAS systems are stress-tested against various failure scenarios before the legacy system is decommissioned. This includes simulating a network failure to verify that the cellular backup path functions as intended.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3U Communication Satellite Mesh Network/Enable WiFi Calling/Emergency Response in Little Diomedes	AK	The Problem Little Diomedes is a "communications desert." Traditional copper and microwave links are frequently destroyed by ice and wind, and commercial providers often find the cost of repair to be prohibitive. When the phones go down, the village loses its ability to coordinate emergency medevacs, consult with doctors, or contact families. Satellite internet exists but is often limited to a single building, leaving the rest of the village—and first responders in the field—digitally isolated. The Opportunity This project presents an opportunity for Infrastructure Sovereignty and Resilience. We have the opportunity to: 1. Eliminate Single Points of Failure: Designing a "self-healing" mesh where if one node fails, the signal automatically re-routes through others. 2. Universal WiFi Calling: Replacing the need for a traditional landline by providing community-wide Wi-Fi that supports standard smartphone calling features. 3. Telemedicine Anywhere: Enabling a health aide to transmit vitals or conduct a video consult from a patient's home rather than only from the clinic. 4. Arctic-Hardened Design: Engineering nodes that are energy-efficient and capable of being powered by small-scale renewable sources, reducing the reliance on the island's limited fuel supply.	NSHC will utilize an 18-month planning and design phase to engineer a communication system that can survive Diomedes's unique challenges: *Topographical and RF Mapping: We will conduct a technical survey of the island's steep terrain to identify optimal "Line-of-Sight" locations for mesh nodes. This ensures maximum signal penetration into homes and along the village's main paths. *Satellite Backhaul Integration: We will design the interface between high-speed LEO satellite terminals (such as Starlink or OneWeb) and the local mesh network to ensure low-latency data flow for voice and video applications. *Self-Healing Mesh Architecture: The design will prioritize "Decentralized Intelligence." Each node will be programmed to automatically find the most efficient path to the satellite gateway, ensuring the network stays up even if several nodes are damaged by ice. *Energy-Efficient Node Engineering: We will develop specifications for nodes that require minimal power, incorporating Renewable Energy Integration (solar/wind) and high-capacity battery storage to ensure operation during winter darkness or fuel shortages. *Telemedicine and Emergency Protocol Design: We will work with NSHC's IT and Emergency departments to create "Priority Traffic" protocols. This ensures that a medical emergency call or a telemedicine video stream is always given the highest bandwidth priority on the network. *Remote Management Tools: We will design a "Digital Twin" monitoring system that allows NSHC IT staff in Nome to diagnose and troubleshoot the Diomedes network remotely, reducing the need for expensive technician travel to the island.	\$250K-\$1M	Hospital	Single Community	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3W Fire Alarm Replacement/Upgrade for NSRH, QCC, and Other Facilities	AK	The Problem Our existing fire alarm infrastructure consists of aging, standalone systems that lack communication with one another. These legacy units are increasingly prone to false positives and hardware malfunctions, and because they are not segmented, identifying the precise location of a "smoke event" in a large facility like NSRH can take precious minutes. Furthermore, the lack of remote monitoring means that facility managers cannot diagnose system health without being physically present at the specific panel, leading to reactive rather than proactive maintenance. The Opportunity This project presents an opportunity for Integrated Life-Safety Intelligence. We have the opportunity to: 1. Networked Monitoring: Centralizing oversight so that a single command center can monitor the status of every building on the NSHC campus simultaneously. 2. Precision Triage: Utilizing segmented, addressable detectors that pinpoint the exact room and type of event, allowing for targeted emergency response. 3. Real-Time Alerts: Integrating mobile app notifications for Facilities and Security teams, ensuring that critical data reaches the right people instantly, even if they are away from their desks. 4. Regulatory Compliance: Bringing all facilities up to the latest NFPA (National Fire Protection Association) standards, ensuring ongoing CMS and Joint Commission accreditation.	NSHC will execute a campus-wide fire safety modernization using a phased, non-disruptive installation strategy: Procurement of IoT-Enabled Infrastructure: We will purchase a modular, networked fire alarm control platform. This includes smart, addressable smoke/heat detectors, audio-visual notification appliances, and pull stations that are all linked to a central "Life Safety Hub." System Integration and Networking: Our IT and Facilities teams will work with specialized contractors to create a dedicated, secure fiber or wireless "safety loop" between NSRH, QCC, and support buildings. This allows for campus-wide visibility and cross-building alert protocols. Segmented Alert Programming: We will program the system to support "Zoned Responses." This ensures that an incident in one wing can be managed with specific protocols (e.g., "defend in place" for the QCC elders) without causing unnecessary panic in unrelated areas of the hospital. Mobile & Remote Oversight Implementation: We will activate IoT features, including remote diagnostics and mobile application dashboards. This allows Facilities staff to receive "Pre-Alarm" warnings on their mobile devices, identifying dirty sensors or minor faults before they trigger a full-building evacuation. Clinical and Safety Staff Training: We will conduct comprehensive drills and training sessions for all staff. This focuses on the new "Smart Notification" sounds and the mobile communication tree used during an event. Automated Data Logging: The system will be configured to automatically log all tests, drills, and events, simplifying the reporting process for fire marshal inspections and accreditation audits.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	3X Installation and Implementation of a Laundry Ozone Generator System for NSRH	AK	The Problem NSHC’s current traditional laundry processes are energy-intensive, requiring massive amounts of hot water and heavy chemical loads to meet medical-grade disinfection standards. These chemicals are not only expensive to ship to Nome but also accelerate the wear and tear on linens, leading to high replacement costs. Furthermore, traditional thermal disinfection is less effective against certain resilient pathogens, and the high heat required places a significant strain on the facility’s utility infrastructure. The Opportunity This project presents an opportunity to modernize our Infection Control and Utility Infrastructure. We have the opportunity to: *Superior Disinfection: Utilizing ozone to eliminate 99.9% of bacteria and viruses, providing a higher safety margin for patients and staff. *Arctic Resource Conservation: Reducing hot water demand by up to 90%, leading to significant savings in heating fuel and electricity. *Chemical Independence: Minimizing the need for chlorine bleach and detergents, which reduces our reliance on fragile barge-dependent supply chains. *Extended Asset Life: Ozone is gentler on fabrics than bleach, potentially extending the lifespan of hospital linens by 20–30%, resulting in long-term procurement savings.	NSHC will implement a state-of-the-art ozone disinfection system integrated into our existing laundry facility: *System Procurement & Installation: We will purchase a high-capacity ozone generator designed for commercial healthcare use. The system will be integrated with our existing washers, utilizing an injection manifold to deliver ozone gas directly into the wash water. *Automation and Digital Monitoring: The system will feature automated dosing and real-time digital monitoring to ensure that ozone levels remain at optimal concentrations for disinfection throughout every cycle. Sensors will provide data logs for compliance and safety reporting. *Cold-Water Optimization: We will reconfigure our wash protocols to leverage ozone’s ability to disinfect in cold water. This shift will drastically reduce the load on our boiler systems and lower the facility’s carbon footprint. *Staff Training and Safety Protocols: Our laundry and facilities teams will receive comprehensive training on the operation and maintenance of the ozone generator. We will implement ambient ozone monitors in the laundry suite to ensure a safe working environment for our staff. *Linen Lifecycle Tracking: As part of the implementation, we will establish a baseline for linen replacement rates and chemical costs to track the "Return on Investment" (ROI) and environmental impact over the first 12 months of operation. *Integration with Infection Control: We will coordinate with the NSHC Infection Control department to validate the disinfection efficacy through periodic swabbing and testing of linens, ensuring the system meets or exceeds all CDC and Joint Commission standards.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	4A Youth Wellness Program Expansion (“Summer-cise”)	AK	The Problem While the Nome-based "Summer-cise" program is highly successful, the logistics of a regional rollout are complex. Rural youth in our frontier villages face a "wellness vacuum" during summer break, with limited access to organized sports, nutritional education, or behavioral health support. Without a structured plan, expanding a hub-based program to 15 distinct villages risks "program dilution," where local needs—such as varying gym access or traditional subsistence schedules—are not met. The Opportunity This project presents an opportunity to design the "Summer-cise Village Blueprint." We have the opportunity to: *Scale a Proven Model: Adapting 20 years of curriculum for a multi-site, rural delivery model. *Preventive Intervention: Integrating substance use prevention and coping skills into a high-energy, fun environment. *Local Leadership Development: Designing a "Train-the-Trainer" model to empower village residents to lead the sessions. *Equity in Access: Ensuring that a child’s location in a remote village does not preclude them from the region's premier youth wellness program.	NSHC will utilize a 12-month planning window to design a scalable, culturally resonant regional expansion: *Curriculum Adaptation: We will review the existing "Summer-cise" curriculum and adapt it into a "Camp-in-a-Box" format. This includes modular lessons on physical activity, nutrition (utilizing local subsistence foods), and behavioral health (focusing on resilience and substance use prevention). *Infrastructure & Partnership Audit: We will conduct site visits to village schools and tribal offices to identify available gym spaces, kitchens for healthy snack preparation, and outdoor play areas. This ensures the program design is tailored to the actual facilities in each village. *Village Leader Recruitment Design: We will design the "Wellness Lead" position—a role for local village residents who will be trained by NSHC professionals. This phase includes creating the training modules that will ensure local leaders are equipped to deliver the health-based curriculum safely and effectively. *Logistics & Supply Chain Planning: We will map the logistical requirements for transporting program kits (sports equipment, educational materials, and healthy snacks) to 15 remote sites via the regional barge and air networks. *Evaluation Framework Design: We will develop a set of "Impact Metrics" to track youth engagement, physical activity levels, and wellness knowledge. This data will be used to secure multi-year implementation funding. *Cultural Alignment: We will collaborate with village Elders and Tribal councils to ensure the program respects and incorporates local traditions, languages, and subsistence calendars, making the wellness programming a natural extension of village life.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	4C Salt Water Distillation Planning Project	AK	The Problem Communities like Little Diomed and Wales face extreme water insecurity in late winter. Currently, the only solution is the emergency procurement of bottled water via air-freight—a model that is economically unsustainable and logistically fragile. Furthermore, these communities have historically struggled with "Best Practice" scores due to the technical complexity of their systems and high operator turnover. While NSHC’s CUAP has stabilized existing infrastructure, the region still lacks a designed, Arctic-ready solution for salt-water conversion when fresh water sources fail. The Opportunity This project presents an opportunity for Utility Mastery and Redundancy. We have the opportunity to: 1. Leverage CUAP Infrastructure: Integrating emergency distillation into the existing regional support and training network. 2. Apply Proven Success: Scaling the CUAP "Best Practice" model to include high-tech emergency water production. 3. Identify Arctic-Ready Tech: Vetting distillation units specifically designed for high-sediment, freezing maritime environments. 4. Eliminate Supply Chain Risk: Creating a blueprint that replaces \$100k+ in annual "water flight" costs with local production.	NSHC will utilize the CUAP’s regional technical assistance framework to design a robust emergency water system: *Technical Feasibility Study: We will evaluate purification technologies (MVC vs. RO) to determine which is most resilient against the specific "slush-ice" and high-sediment conditions of the Bering Strait. *CUAP Integration Planning: We will design the operational model to fit within the existing CUAP Regional Co-op, ensuring that maintenance, chemicals, and parts for the new units are managed through NSHC’s centralized supply chain. *Site-Specific Engineering: We will conduct engineering site visits to design intake systems that can operate through sea ice and identify heated housing locations near existing community tanks in Diomed and Wales. *Workforce Training Assessment: Leveraging the CUAP Training Calendar, we will identify the specific certification upgrades needed for village operators to manage desalination technology, building on our success in increasing operator retention. Energy & Regulatory Review: We will work with local utilities to model the electrical load and engage with the Alaska DEC to ensure the planned process meets all potable water standards. 2027 Implementation Blueprint: The final deliverable will be a "shovel-ready" plan, including finalized equipment quotes and a financial model for an implementation grant in 2027.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	4D Clinical-Grade Water Access Project: Point-of-Care Distillation for High-Acuity Patients	AK	The Problem Clinical and home-medical needs in five remote villages are currently met through a fragile dependency on sterile water flown from the Lower 48. This dependency creates a severe public health risk: 1. Infection Pathways: Using untreated "honey bucket" era water in medical devices or for wound care introduces pathogens directly into vulnerable patients, leading to amoebiasis, pneumonia, and meningitis. 2. Supply Chain Fragility: Weather delays in the transcontinental flight path frequently result in local "water gaps," forcing patients to choose between non-compliance with treatment or using unsafe water. 3. Exorbitant Costs: Shipping liquid weight 4,000 miles is a massive drain on tribal health resources that could be redirected to direct patient care. The Opportunity This project presents an opportunity for Regional Medical Self-Sufficiency and Pathogen Mitigation. We have the opportunity to: 1. Eliminate Life-Threatening Risks: Providing a local, verified source of pure water to prevent pneumonia and meningitis. 2. End Transcontinental Dependency: Replacing a 4,000-mile supply chain with on-site clinic production. 3. Ensure Clinical Readiness: Providing 100% availability of purified water for wound irrigation and medication preparation regardless of flight schedules. 4. Massive Cost-Avoidance: Eliminating the exorbitant air-freight fees associated with shipping sterile water from the Lower 48.	NSHC will implement a standardized clinical water production and distribution system: *Procurement of Clinical-Grade Hardware: We will purchase medical-grade distillation units and multi-stage Reverse Osmosis (RO) systems rated for high-volume clinical use and capable of removing biological pathogens. *Establishment of Clinic Hydration Hubs: Each of the target clinics will be outfitted with a dedicated production station, including the purification hardware and sterile, large-capacity storage reservoirs. *Clinic-to-Patient Distribution Model: We will implement a "Refill Program" where patients with home-based medical devices (CPAP, BiPAP, Oxygen) can pick up clinical-grade water from the clinic in sanitized containers. *Clinic Protocol Integration: We will update SOPs to include daily distillation schedules, ensuring a constant "rolling reserve" for both clinic procedures and patient distribution. *Health Aide Training: Village Health Aides will be trained on the operation and maintenance of the units and the protocols for safe water handling to prevent secondary contamination. *Environmental Health Oversight: The NSHC Office of Environmental Health will conduct periodic testing of the hub water to ensure it consistently meets purity standards for medical use and is free of pathogens like Naegleria fowleri or Legionella.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	Outdoor Exercise Equipment, Walking Path, Meeting, and Eating Space	AK	The Problem The NSHC Nome campus currently suffers from "Indoor Compression." Clinical and administrative staff spend nearly 100% of their time in windowless or high-traffic indoor areas, which impedes creative problem-solving and social bonding. Existing outdoor areas are in disrepair, lack ADA accessibility, and offer no protection from the wind or rain, making them unusable for professional workshops or healthy dining. This lack of a "third space" outside the clinical setting exacerbates workplace stress and reduces the effectiveness of organizational innovation. The Opportunity This planning project allows NSHC to design a "Campus Wellness Commons." We have the opportunity to: Decompress the Workforce: Creating a weather-protected "outdoor office" that supports mental clarity and stress reduction. Foster Collaboration: Designing modular seating and WiFi-enabled meeting zones that allow for workshops and communal dining outside the cramped breakrooms. Promote Physicality: Integrating fitness stations and walking paths that make exercise a convenient part of the workday. Ensure Inclusion: Replacing dilapidated, inaccessible infrastructure with modern, universal design that accommodates every member of our team and community.	NSHC will lead a design process focused on "Functional Resilience and Biophilic Design": Modular Collaborative Design: We will design weather-protected "hubs" featuring modular seating and tables that can be reconfigured for a private 1-on-1 meeting or a 20-person workshop. Connectivity & Technology Integration: The space will include ruggedized WiFi extenders and solar-powered charging stations, ensuring that the transition from the indoor office to the "outdoor commons" is seamless for workforce productivity. Biophilic Wellness Infrastructure: The design will include a loop of accessible walking paths interspersed with adaptive exercise stations, allowing staff to engage in "micro-workouts" during lunch or breaks. Arctic Shielding: To maximize the usable season in Nome, the design will prioritize wind-shielding glass panels and overhead radiant heating options (solar or electric) to protect users from the coastal elements. Universal Accessibility Audit: We will ensure all paths and seating areas meet or exceed ADA standards, providing equitable access for staff and visitors with mobility challenges.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Norton Sound Health Corporation	RA Administration and Operational Readiness	AK	The Opportunity NSHC is currently experiencing a period of high-impact growth, successfully managing a diverse range of innovative regional health initiatives. To sustain this momentum and ensure we are "doing the very best" for our residents, we must proactively scale our administrative support. Currently, our administrative staff handles a massive volume of complex grant reporting and specialized Arctic procurement. As we onboard new RHTP projects, there is an opportunity to move from a generalized support model to a "Grants and Logistics Center of Excellence." By adding a dedicated Grant Accountant and a Procurement Specialist, we can eliminate the risk of "logistical lag"—where projects are delayed by shipping windows or procurement red tape—and ensure that every regional investment is executed with world-class efficiency and financial transparency.	NSHC will implement a "Three-Pillar" administrative support model designed for high-performance grant management: Pillar 1: Financial Integrity (Grant Accountant): This role will focus exclusively on the RHTP portfolio, implementing advanced fund-accounting and real-time expenditure tracking. This ensures that every dollar is maximized for community benefit and that all federal "Uniform Guidance" standards are surpassed. Pillar 2: Logistical Precision (Procurement Specialist): This specialist will manage the end-to-end supply chain for regional projects. They will be responsible for navigating federal "Buy America" requirements, coordinating with Arctic barge operators for seasonal deliveries, and managing vendor relationships to ensure high-quality, cold-weather-rated materials are procured at the best value. Pillar 3: Administrative Synergy (Administrative Assistant): This role will act as the "Project Concierge," maintaining the centralized project management system and ensuring that clinical leads are supported with documentation, scheduling, and reporting. Integrated Compliance Dashboard: The team will develop a unified dashboard that tracks financial "burn rates" alongside procurement milestones. This allows leadership to see exactly where materials are in the supply chain relative to the project budget. Proactive Vendor Management: The Procurement Specialist will establish a "Pre-Qualified Arctic Vendor List," streamlining the bidding process for future projects and ensuring that NSHC always works with partners who understand the unique challenges of the Bering Strait.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Nome Census Area	Deferred or Not Advanced

Nuna Incorporated	Self-Management with Consumer-Facing Tools: A Personalized Community-Supported Digital ‘Coach’	CA	As highlighted in Alaska’s Project Narrative, 3 out of 4 Alaskans have or are at risk of chronic disease and 32-35% of adults in Alaska are obese. At the same time, over 80% of Alaska’s communities are remote, and many must travel by air or water to see a clinician. Primary and specialty medical care are concentrated in a few hubs. Alaskans face very unique challenges in living their healthiest lives. These complex logistics create high barriers to care access and support for the Alaskans living in rural and remote settings. Nuna sees an opportunity to reach Alaskans and their communities in a broad, personalized, relevant, and economically sustainable way that translates to better health outcomes. Technology has at last arrived at a point where it can facilitate and deliver highly personalized health support at-scale in a way that has been previously unfeasible. Alaska’s has an extraordinary vision for supporting rural Alaskans via telehealth, consumer-facing technology, and community grasps the transformative potential of this opportunity.	Nuna proposes using smartphone consumer-facing technology and AI to help Alaskans with, or at risk for, chronic disease-and their loved ones - live healthier lives. Most health outcomes are shaped not in the exam room, but in the time between visits. For Alaskans living with chronic diseases like hypertension, prediabetes, diabetes, obesity, and dyslipidemia, effective self-management means more than a daily checklist, an AI chat, occasional telehealth, or traditional remote patient monitoring. Long term management requires continuous, personalized support that heavily-person-supported care models cannot sustain at scale. Our approach gives each eligible Alaskan a personalized digital companion, coach, and advocate on their phone. This digital coach is an app which can text, call, and interact with Alaskans and their loved ones. It feels like a trusted friend that helps people adopt and sustain healthy lifestyle practices, support each other, connect to community resources, and connect to clinical teams when necessary. By handling day-to-day coaching, tracking, and education, Nuna helps people manage more on their own and surfaces only the most relevant summaries and alerts to clinicians—relieving some burden on overextended providers while keeping them connected to what matters most. We envision this technology as a personal health coach that also connects people to their communities as they work towards lasting health and self-management. Our approach will: -Incorporate Community: Include trusted caregivers and loved ones so they can reinforce healthy habits. -Integrate Clinically: Share concise, relevant information with care teams, so they can see trends, identify risk earlier, and intervene when needed without adding substantial documentation or monitoring workload. -Educate: Equip Alaskans with understandable, actionable information they can integrate into daily life. -Provide Relevant Devices: Pair the app with tools such as blood pressure cuffs and scales to support hypertension and diabetes management. -Maintain clear clinical boundaries: Support, but not replace, clinical judgement; the technology will summarize and share relevant information with licensed clinicians. Above all, we propose that this project should feel emotionally grounded, trusted, and relevant. Nuna is HIPAA-compliant, with robust privacy and security controls, and our app’s clinical content is overseen by our Medical Director to align with evidence-based care.	Over \$5M	Statewide	Anchorage (Municipality); Bethel Census Area; Copper River Census Area; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Matanuska-Susitna Borough; North Slope Borough; Sitka (City and Borough); Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Nunakins	Nunakins Childcare	AK	Kotzebue serves as the regional hub for the Northwest Arctic Borough, providing critical healthcare services to residents of Kotzebue and surrounding villages that are accessible only by air or seasonal travel. The region faces persistent challenges common to rural Alaska, including workforce shortages, high cost of living, geographic isolation, limited infrastructure, and elevated rates of stress-related health conditions among families with young children. A critical and often underrecognized barrier to healthcare access and workforce stability in the Northwest Arctic Borough is the lack of reliable, affordable childcare. Families with young children—particularly healthcare workers—face limited options, long waitlists, and inconsistent availability. As a result, parents are unable to maintain employment, pursue training, or accept positions in the healthcare sector. This challenge directly impacts healthcare delivery capacity, continuity of care, and long-term system sustainability. Investment in childcare infrastructure is therefore not ancillary to health—it is foundational to rural health transformation. Nunakins will seek to establish spaces available to Maniilaq healthcare providers to increase the recruitment and retention capacity of Maniilaq Healthcare Center.	Nunakins seeks to not only have a positive impact on the health and wellbeing of children and reduce negative health outcomes, but also help to build capacity for our community to recruit and retain health care providers. High-quality childcare directly improves child health and well-being by addressing social determinants of health during the most critical developmental period (birth to age five). Consistent childcare provides: • Stable, safe environments that reduce toxic stress and adverse childhood experiences • Early developmental monitoring, enabling timely referrals for speech, behavioral, or developmental support. We work closely with the Early Learning and Family Program (ILP/EI) • Predictable routines that promote emotional regulation, social skills, and resilience • Hygiene supports that reduce preventable illness and improve overall health In rural Alaska, where access to pediatric specialists is limited and medical travel is costly, early identification and prevention are especially impactful. Childcare functions as a frontline prevention strategy that reduces future strain on healthcare systems. Culturally grounded childcare programs also reinforce protective factors tied to community connection, language, and identity—recognized contributors to mental health and long-term well-being for Alaska Native children and families. The program will operate in coordination with local healthcare providers, family support services, and community partners to ensure alignment with workforce needs and child development best practices. This initiative represents a strategic, upstream investment that strengthens the health system while supporting the next generation.	\$50,000-\$250,000	Single Community	Northwest Arctic Borough	Advance to Implementation Application

Nunakins	Nunakins Family Support Center Diaper Bank	AK	Access to clean diapers is a foundational health need for infants and toddlers. Diaper insecurity is associated with increased rates of diaper rash, urinary tract infections, caregiver stress, and delayed access to childcare and healthcare services. In rural Northwest Alaska—where families face high costs, limited retail access, and transportation barriers—a regional diaper bank functions as a preventive health intervention that reduces avoidable medical visits, supports caregiver mental health, and promotes health equity for infants and young children. Diaper insecurity is closely linked to caregiver stress, anxiety, and symptoms of depression—particularly for parents of infants. In the Northwest Arctic Borough, where families already manage high living costs, housing instability, and limited childcare options, the added burden of diaper need contributes to toxic stress that negatively impacts both caregiver mental health and parent-child bonding. Families experiencing diaper need are often forced to make tradeoffs between purchasing diapers and meeting other basic needs such as food, heating fuel, or medication. In Kotzebue and village communities, where diaper prices are routinely 50–100% higher than road-system averages due to freight costs, these tradeoffs are especially acute. A single case of diapers can cost substantially more once air freight is included, and availability is inconsistent in village stores.	Access to clean diapers is a foundational health need for infants and toddlers, yet diaper insecurity remains a significant and often overlooked driver of poor health outcomes in rural Alaska. In Kotzebue and throughout the villages of the Northwest Arctic Borough, families face a convergence of challenges—high freight costs, limited retail availability, geographic isolation, and constrained household income—that magnify the health consequences of diaper need. A regional diaper bank operating from Kotzebue and extending service to outlying villages represents a cost-effective, preventive health intervention aligned with Rural Health Transformation goals of improving access, reducing avoidable healthcare utilization, and advancing health equity. When families lack sufficient diapers, caregivers are forced to ration diaper use well beyond medically recommended intervals. This practice is associated with increased rates of diaper dermatitis, skin breakdown, fungal and bacterial infections, and urinary tract infections in infants and toddlers. In rural Northwest Alaska—where primary care clinics already operate under capacity constraints and specialty care often requires medical travel—these preventable conditions contribute to avoidable clinic visits, antibiotic use, and, in some cases, emergency care. Our approach will include reaching out to health care providers and tribal leaders in each of the villages in the Northwest Arctic Borough and obtain information on the most effective way to launch regionally. The diaper bank currently operates in Kotzebue in conjunction with the local food bank, thereby consistently reaching families in need.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Northwest Arctic Borough	Deferred or Not Advanced

Nurses Diversified Systems Incorporated dba "ND Systems Inc."	2026 ND Systems Fellowship for New and Early Career Mental Health Providers RHTP Letter of Interest	AK	There is a well documented gulf between the mental health needs of our Alaskan Communities and available mental health providers. The demand far exceeds the availability of quality services and providers. There is well documented understanding that the level of burn out in mental health as well as other health related professions has led to a loss of providers and difficulty for new and early career providers entering the professions. Those that graduate with Masters in Social Work or Education with emphasis in counseling must work under supervision for on average of 3000 hours prior to being able to sit for their licensing exams. Finding supportive placement in rural communities with a living wage is difficult. Focusing on historical work of Dr. Patricia Benner's from Novice to Expert journeys it takes 2-3 years to achieve the level of competency. In many of our Alaskan organizations, new and early career providers arrive to serve and find that they, as new graduates, are actually expected to function as the experts in the organizations, resulting in poor outcomes for the organizations, the providers, and the communities. Over the past 15 years Dr. Margaret Flinter and her team have designed Fellowship programs to attract and retain new and early career Advanced Practice Clinicians (Nurse Practitioners and Physician Assistants) into Federally Qualified Health Centers providing primary care. Recent reports retention rates are 89%.	Strengthening Alaska's workforce with investment in a fully accredited fellowship model that will attract and retain new and early career providers to serve Alaskans mental health needs now and into the future. ND Systems, with funding, is well positioned to continue the journey to full implementation of the model modified for mental health developed by Dr. Flinter and the Community Health Centers team. 1. Partnering with Moses Weitzman HC - Community Health Consortium in Year One activities will also include 24 hours of targeted regulatory and accreditation consulting related to the Joint Commission standards and readiness planning for ND Systems. This will provide a path to seek National Accreditation for Alaska's first Fellowship Program. 2. Enhancing existing program initiatives, Fellows are honing purposefully focused mental health knowledge and skills to specifically address trauma focused and resiliency-based care. A model of care that uniquely addresses Alaska's high rate of suicidal ideation and intergenerational and community trauma. 3. Addressing the fragility of the healthcare payment systems for care and developing a sustainable fiscal plan to endow the Fellowship program beyond the 5 years of RHTP funding to ensure the on going functionality for the next generations of mental health providers to be fully grounded in service to Alaskans. This vision for supporting and sustaining new and early-career providers in mental health with a defined focus of trauma and resiliency-based practice model, is in line with the stated objectives of the funding stream known as “The Rural Health Transformation Program”. This is a unique model that ND Systems has internally funded for over 9 years and has proven viable and effective for attracting and retaining mental health providers.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough	Deferred or Not Advanced

Nurses Diversified Systems Incorporated dba "ND Systems Inc."	Anchored in Alaska: Modern IT Systems for Behavioral Health Access and Workforce Development	AK	Alaska’s behavioral health system depends heavily on telehealth, remote supervision, digital documentation, and virtual collaboration, yet most rural-serving organizations lack reliable technical infrastructure. Outdated communications systems, inconsistent connectivity, high VOIP costs, cybersecurity vulnerabilities, and fragmented data environments limit the ability of clinicians to serve rural and frontier communities. These gaps restrict access, impair crisis response, and create administrative burden that accelerates burnout. ND Systems’ current technology environment cannot fully support its statewide Fellowship/Residency Program, rural telehealth operations, trauma informed care tools, and data driven quality improvement. Rural clinicians often operate in low bandwidth or unpredictable field conditions without standardized mobile equipment, secure communication pathways, or reliable access to clinical systems. At the organizational level, disparate systems prevent ND Systems from aggregating actionable insights on workforce performance, telehealth utilization, care gaps, and trauma-informed outcomes. This creates a significant opportunity: modernizing ND Systems’ IT infrastructure to improve reliability, strengthen cybersecurity, expand telehealth capacity, support the rural workforce, and enable high quality, data driven behavioral health care across Alaska.	ND Systems proposes a comprehensive modernization of its technology ecosystem to strengthen behavioral health access, reliability, and workforce development across Alaska. The project has five integrated components: 1. Alaska Anchored Infrastructure ND Systems will co-locate critical systems in an Alaska based data center to ensure high availability, low latency for rural regions, improved cybersecurity, and full data sovereignty within Alaska. This will support telehealth platforms, EHR access, communication tools, analytics applications, and tele-supervision environments. 2. HIPAA Aligned SIP Communications Environment ND Systems will host its own PBX/SIP trunking to reduce VOIP costs, strengthen call routing for crisis response, and improve communications resilience across remote sites. This is not a move toward becoming a telecommunications provider but a cost saving, reliability enhancing modernization for clinical operations. 3. Mobile Rural Care Technology Kit To support clinicians who travel to remote, frontier, and offroad communities, ND Systems will deploy rugged, preconfigured, telehealth ready field kits. Kits include portable connectivity (satellite/hotspot), encrypted communication tools, telehealth peripherals, and access to tele-supervision systems, enabling high quality care in challenging environments. 4. Trauma Informed Remote Monitoring & Biofeedback Tools Adoption of wearable stress response sensors, remote biofeedback devices, and clinician dashboards will expand access to trauma and resiliency based interventions for clients who lack regular in person services. Clinicians gain real time insight into symptom patterns and treatment trajectories. 5. Cloud Assisted AI Documentation Tools To reduce administrative burden—especially for early career clinicians—ND Systems will implement AI assisted documentation that supports trauma informed charting, improves accuracy, reduces burnout, and speeds supervisory review. 6.Federated Behavioral Health Data Hub ND Systems will build a hub to unify aggregate data from telehealth systems, EHR metadata, remote monitoring tools, workforce metrics, and training outcomes. The hub provides population level insight to improve rural access, identify service gaps, strengthen supervision models, and support sustainability planning. Together these activities create a resilient, secure, data driven digital foundation for Alaska’s behavioral health workforce and the communities they serve.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough	Deferred or Not Advanced

Nurses for Nurses	Modern Health Fest	AK	Alaska’s rural and frontier health system depends on dedicated professionals who often work in demanding, high-responsibility roles with limited support. Long hours, professional isolation, limited advancement pathways, and few opportunities for connection contribute to burnout and turnover. When health care careers are not sustainable, communities lose continuity of care, institutional knowledge, and trusted relationships that are essential in small and remote settings. The core problem this project seeks to address is the lack of sustainable career pathways for health professionals serving rural Alaska. Many providers enter the workforce committed to long-term service, but without access to leadership development, mentorship, innovation exposure, and well-being resources, remaining in these roles can become difficult over time. Modern Health Fest, held in Anchorage annually, is designed to strengthen career sustainability by equipping providers with practical tools for resilience, professional growth, entrepreneurship, and expanded scope of practice. It creates space for connection, collaboration, and skill-building tailored to the realities of remote practice. By investing in the longevity, advancement, and well-being of Alaska’s health workforce, this project helps ensure that providers can build enduring careers in the communities that rely on them.	Our approach focuses on strengthening long-term career sustainability by equipping Alaska’s health professionals with the skills, support, and partnerships needed to thrive in rural and frontier practice. Modern Health Fest, hosted in Anchorage, serves as a centralized, in-state convening designed to provide practical tools and forward-looking solutions that providers can bring back to their communities. The event brings together nurses and other health professionals from across Alaska for targeted education, collaboration, and exposure to innovation. The proposed approach includes three core strategies: 1. Professional Development and Expanded Career Pathways We offer education on leadership development, entrepreneurship, certification programs, graduate pathways, and emerging models of care. By helping providers see clear advancement opportunities and diversified roles within health care, we support careers that can evolve and remain fulfilling over time. 2. Resilience and Workforce Retention Dedicated sessions focus on burnout prevention, mental wellness, sustainable workload practices, and boundary setting. By strengthening provider well-being and peer connection, we address one of the primary drivers of turnover in rural communities and help professionals build enduring careers. 3. Strategic Partnerships and Health Care Innovation Modern Health Fest intentionally partners with organizations across Alaska and beyond to introduce innovative health technologies, telehealth solutions, workforce programs, and care delivery tools. Through the exhibitor and resource space, rural providers gain direct access to new technologies and statewide resources that may not otherwise reach their communities. Attendees leave with practical partnerships and implementable solutions they can integrate locally, expanding service capacity and modernizing care delivery in remote settings. By combining professional growth, resilience support, and access to innovation, our approach strengthens workforce stability and ensures that rural communities benefit from sustainable, forward-thinking health care careers.	\$250K-\$1M	Statewide	Anchorage (Municipality)	Deferred or Not Advanced

Nurses for Nurses	Provider Pathways: Training & Startup Support Initiative	AK	Rural, remote, and frontier communities in Alaska face persistent health care access challenges, including provider shortages, limited service options, and difficulty attracting and retaining long-term clinicians. Many communities rely heavily on a small number of providers or external systems, which can create gaps in care, long wait times, and limited specialized services. At the same time, many licensed health care professionals have the skills and experience to expand services but lack access to structured training, business development support, and startup guidance needed to open independent clinics, concierge practices, or assisted living facilities. Regulatory complexity, financial barriers, and limited mentorship often prevent viable ideas from becoming sustainable community-based services. This project addresses the opportunity to empower health professionals to become locally rooted care providers and entrepreneurs. By combining training, education, and startup support, the initiative helps transform clinical expertise into sustainable health care businesses that expand access, strengthen local economies, and improve long-term system stability in underserved areas.	Our proposed approach is to create a structured Provider Pathways: Training & Startup Support Initiative that combines education, mentorship, and post-training grant support to help licensed health care professionals successfully launch sustainable practices in rural, remote, and frontier communities. The program will begin with comprehensive education and training focused on healthcare entrepreneurship, regulatory compliance, financial planning, operations management, leadership, and sustainable business models such as independent clinics, concierge practices, and assisted living facilities (ALFs). The curriculum will be practical and action-oriented, designed specifically for providers who want to expand services within their own communities. Following the training phase, participants will receive mentorship and technical assistance to refine their business plans, navigate licensing and regulatory requirements, identify community needs, and prepare for launch. Ongoing guidance will help reduce barriers, increase confidence, and improve the likelihood of long-term success. After completion of the training and mentorship requirements, eligible participants will have access to grant funding support to assist with startup costs such as equipment, initial staffing, compliance expenses, or facility setup. This phased model ensures that funding is paired with preparation, accountability, and readiness, increasing sustainability and responsible investment. By combining education, hands-on mentorship, and targeted startup grants, this approach builds locally owned health care solutions that expand access, strengthen workforce retention, and improve long-term care capacity in underserved Alaska communities.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Nurses for Nurses	Traumatic Event Debriefing Education Program	AK	Rural, remote, and frontier health care providers are regularly exposed to traumatic events, high-acuity situations, and emotionally intense patient outcomes with limited access to structured support. In many communities, formal systems for processing these experiences are minimal or inconsistent. As a result, providers often carry cumulative stress without opportunities for healthy debriefing or team-based reflection. This lack of structured support contributes to burnout, compassion fatigue, moral distress, and staff turnover. When health professionals do not have effective tools to process trauma, it can impact team communication, workplace morale, and long-term workforce stability. In small communities, losing even one provider can significantly reduce access to care and disrupt continuity for patients and families. The opportunity this project addresses is to strengthen internal resilience and team-based support within health care settings by equipping providers with practical traumatic event debriefing skills. By building structured, accessible debriefing practices into rural and frontier health systems, we can improve workforce well-being, enhance team cohesion, and support sustainable, high-quality care for the communities that depend on them.	Our proposed approach is to develop and deliver a statewide traumatic event debriefing training program that is accessible to any health care professional or community member in Alaska who is interested in learning these skills. The goal is to build a broad network of trained individuals who can provide structured, peer-based debriefing support within their own workplaces and communities. The program will offer evidence-informed education on trauma awareness, psychological safety, facilitation techniques, active listening, and structured debriefing models. Participants will learn how to lead or support post-event discussions, recognize signs of acute stress, and connect individuals to additional resources when needed. Training will focus on practical, adaptable tools that can be implemented in hospitals, clinics, emergency services, and community-based settings without requiring additional infrastructure. By creating accessible, scalable training available statewide, this project aims to build local capacity rather than relying on outside specialists. The intent is to develop a “train-the-trainer” model where participants can confidently support their own teams and help expand debriefing practices within their organizations. This approach strengthens workforce resilience, improves team communication, and normalizes structured emotional support after traumatic events. Over time, it will create a sustainable network of trained professionals across Alaska who can provide essential debriefing services where they live and work, improving well-being and supporting high-quality care in rural, remote, and frontier communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

NutriScape, LLC	Alaska NutriScape: Consumer & Professional Nutrition Content Websites	AK	Healthcare providers and Alaskan families are searching for solutions to serious and costly health problems driven by nutritional and lifestyle factors. Yet they find only fragmented answers with frustratingly vague, generic information designed not to educate, but to serve ads. Patients with questions don't know where to start. Healthcare providers do not have time to find effective nutrition resources. The result is a default to expensive disease care while prevention is neglected. This friction in finding ready resources to point patients to is at the core of why powerful nutrition interventions are neglected even when providers know what is at stake. And motivated patients have no trusted starting point for independent learning. NutriScape.NET is an ad-free site that was founded to make nutrition accessible to consumers and professionals. This project will create Alaska-specific platforms so comprehensive and frictionless that directing patients to them can become automatic. When a provider can send a patient to one trusted resource offering dietitian directories, food assistance programs, AI nutrition coaching, an Alaska menu and shopping app, telehealth nutrition services, food references, and on-demand courses tailored to Alaska, nutrition can be integrated into every patient conversation. That shift is transformational. It gives prevention-first a real chance to begin replacing a costly disease care system with one that keeps Alaskans healthier from the start.	The nutrition resources that Alaska's providers and families need often already exist — scattered across WIC, tribal organizations, the Alaska Department of Health, CDC, NIH, and hundreds of individual websites. The problem is not a lack of information. It is that no one has organized it into a single, trusted, Alaska-specific destination. This project will do exactly that. NutriScape.net is an ad-free, enterprise-scale WordPress multisite network established in 2014 to organize evidence-based nutrition information for consumers and professionals. This project will build two new Alaska-specific subdomains on that existing infrastructure. Alaska.NutriScape.NET will serve consumers with a dietitian directory, food assistance program connections, telehealth nutrition services, and Alaska-specific references addressing gardening, subsistence foods, seasonal availability, high food costs, and healthy eating with limited grocery access. AK.NutriScape.NET will serve healthcare providers and Community Health Aides with clinical references and clear use cases that help clinicians grasp a prevention-first mindset, build skills for motivating patients, and save time by directing patients to the consumer resources at Alaska.NutriScape.NET. Both sites will function as the connective tissue between rural Alaskans and every nutrition and preventive health resource available online and every live program in the state. The goal is a platform so useful that providers share it reflexively and patients return to it independently. Funding this project also establishes the digital ecosystem for hosting the nutrition education courses, telehealth dementia-focused nutrition services, and Alaska-specific AI nutrition coach and shopping applications proposed under separate but complementary LOIs. Without this platform, those projects lack a home. The project director is the creator, developer, and principal of NutriScape, LLC, having built and maintained the platform since 2014. As a Registered Dietitian Nutritionist practicing in Alaska since 1992, she brings both the clinical expertise and technical capacity to deliver this project. The platform will be optimized for mobile devices and lower-bandwidth connections common in rural communities.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

NutriScape, LLC	Nourishing Alaska: On-Demand Nutrition Courses for Alaska's Healthcare Workforce & Families	AK	Alaska's healthcare system spends heavily treating chronic diseases that nutrition education could help prevent. Heart disease, diabetes, obesity, and cognitive decline are among the state's costliest conditions, and poor nutrition is a modifiable driver of all of them. Yet the system focuses almost entirely on treatment after disease is established — medications, procedures, emergency transport — rather than prevention through nutrition. This imbalance is financially unsustainable, particularly for rural providers on thin margins under fee-for-service models. The opportunity is twofold. First, consumer nutrition education gives Alaskans knowledge and motivation to make food and lifestyle choices that reduce chronic disease risk before costly interventions become necessary. Second, Alaska's frontline rural providers — nurse practitioners and community health aides — receive minimal nutrition training, leaving them unequipped to counsel patients on the most impactful preventive strategy available. As Alaska transitions toward value-based payment models that reward outcomes over volume, providers must be equipped with effective prevention skills to succeed financially. Nutrition competence is foundational to that shift. This project builds both sides simultaneously: informed consumers who take ownership of their health, and a rural workforce trained to deliver compelling, motivational nutrition guidance as a core clinical skill — not a pamphlet handed out at checkout.	Our approach rests on a core insight: nutrition education fails at both the provider and consumer level because the messaging is divorced from motivational psychology and the science of behavior change. Conventional courses deliver bland facts and population statistics, timidly suggesting small generic changes rather than presenting the nuanced connections between nutrition and the physiology that drives disease. The result is a workforce that defaults to pharmaceutical intervention not out of preference, but because their training never demonstrated nutrition's power to change outcomes. Consumer resources are no better — heavy on what to eat, silent on why it matters, leaving people unaware of nutrition's power to transform quality of life. We will populate alaska.nutriscape.net and ak.nutriscape.net initially with curated courses from established sources, then develop original Alaska-tailored content across 11 topics for three audiences — consumers, community health aides, and healthcare providers — with language, depth, and motivational framing calibrated to each. Courses will expose learners to discoveries about the power of food and other pillars of health — sleep, movement, stress management, gut health — to improve the fundamental drivers of disease. Each topic will present compelling and often surprising ways nutrition shapes conditions people struggle with daily — cognitive decline, depression, ADHD, eating disorders, weight management, and childhood development. When people understand that what they eat can change how their brain functions, their child's attention, behavior, and intelligence, and whether a chronic condition progresses, motivation to act follows naturally. Addressing these conditions now prevents the costly diseases they lead to later. The provider track targets a fundamental shift in mindset — from treating disease to avoiding it through nutrition and lifestyle. Alaska's transition toward value-based payment demands exactly this transformation: providers who actively prevent chronic disease rather than manage it pharmacologically after the fact. These courses will give healthcare providers and community health aides the evidence, conviction, and motivational tools to make nutrition counseling a central part of every patient encounter, building permanent workforce skills and a preventive mindset where they live and work.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

NutriScape, LLC	Nourishing Rural AK: AI-Powered Healthy Menu, Shopping, & Recipe App and The AI Nutrition Advisor	AK	Nutrition is a primary modifiable risk factor for most chronic conditions, yet there is a lack of accessible self-service resources helping rural Alaskans understand how nutrition impacts their health. Online resources treat it as a bland "nice to know" topic — generic facts disconnected from the person's reality. This project deploys an AI chatbot using motivational interviewing principles to help each person understand why changes in nutrition, physical activity, and other pillars of health matter given their own conditions and goals — connecting the what to their own why. It empowers rural Alaskans to take independent action while promoting referrals to telehealth dietitian nutritionists for medical nutrition therapy that is available but underutilized. Beyond education, rural Alaskans need practical tools to act on knowledge — but generic shopping, menu, and recipe apps are not geared for health. They promote unhealthy choices through marketing and ignore healthful, bush-friendly options. With half of adults living with prediabetes or diabetes, the need is urgent — yet nothing defaults to diabetes-friendly choices or accounts for rural Alaska realities of limited selection, extreme costs, or seasonal availability. This project addresses two gaps: always-available health education connecting diet, activity, and lifestyle to quality of life, and a food planning tool linked to rural shopping with products curated for healthfulness, defaulting to diabetes-friendly options.	NutriScape will deploy two complementary AI-powered chatbot tools on the alaska.nutriscape.net platform, accessible statewide via any web browser. The Nutrition Coach uses motivational interviewing and coaching techniques to deliver personalized nutrition and lifestyle education encompassing the pillars of health. It is available on demand — whenever a person is ready to engage — eliminating scheduling barriers that cause people to lose momentum. By meeting users at the moment of motivation with motivational psychology and proven coaching techniques, the tool helps individuals understand how nutrition, physical activity, sleep, stress, and other lifestyle factors drive their health concerns. This prevention-focused approach empowers people to make informed changes before conditions progress. The chatbot draws from curated, evidence-based sources and refers users to telehealth dietitian nutritionists for medical nutrition therapy when needed. Care will be taken to avoid medical diagnosing while providing highly relevant curated nutrition education focused on the individual's health priorities. The Bush Kitchen Planner focuses on rural shopping, bush-friendly cooking, and meal planning with a baseline default toward food choices appropriate for metabolic issues and cardiovascular risk. It accounts for restricted product selection, high costs, and seasonal availability common in bush Alaska, generating meal plans, shopping lists, and substitution suggestions grounded in what rural Alaskans can actually access and afford. These are tools for personal action — and personal action is critical to health care system sustainability. When individuals prevent and manage chronic conditions through informed daily choices, downstream demand on an already strained rural health system is reduced. Community health aides and physicians will be encouraged to refer patients to these tools to reinforce guidance provided during clinical encounters. Both tools will be developed by Stephanie Figon, MS, RDN, LD, an Alaska-based registered dietitian with expertise in weight management, diabetes counseling, and AI-assisted development. A contracted developer advisor will provide code review, security auditing, and architecture oversight. The tools use retrieval-augmented generation to constrain responses to vetted, accurate nutrition content rather than generic AI output.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

NutriScape, LLC	Trace Lithium in Rural Alaska Water Systems and Mental Health Outcomes: A Study Planning Project	AK	What if a simple mineral deficiency is contributing to Alaska's devastating suicide and dementia rates? What if the answer lies in our drinking water? Most people do not realize that trace amounts of lithium are essential. Lithium exerts neuroprotective effects and improves mood. Population studies across multiple countries show that where drinking water contains more naturally occurring trace lithium, communities have lower rates of suicide, dementia, and violent behavior. A 2020 review of 15 studies confirmed this. A 2025 Nature study strongly suggests lithium deficiency may contribute to Alzheimer's pathology. A Danish population study showed 17% lower dementia rates in higher-lithium areas. Alaska's drinking water has never been systematically tested for lithium. Mental health providers need this critical community-level lithium data. Suicide in Alaska is more than double the national average and 23% of youth have seriously considered it. Without data, providers cannot evaluate whether this low-cost mineral intervention could help the patients they serve. This planning project will lay the groundwork for the first comprehensive statewide study of this critical mineral in Alaska's water, generating accessible data that could address a fundamental driver of suicide and dementia.	This planning grant will establish whether lithium data exists for Alaska's drinking water, support outreach to research partners to discuss possible study designs, and build the collaborative foundation needed for a full ecological study. It will be up to the lead investigator to ultimately propose the study and apply for grant funding to conduct the first comprehensive analysis of trace lithium in Alaska's water and its relationship to mental health outcomes. Phase 1 — Data Assessment: Research existing lithium and water chemistry data from DEC Drinking Water Watch databases, USGS water quality records, and university sources. Identify which rural and groundwater-dependent systems have been tested, which have not, and where critical gaps exist. Assess available mental health outcome data by community, including suicide rates, crisis contact volumes, and dementia prevalence. Phase 2 — Partnership Development: Establish collaborations with the Alaska DEC Drinking Water Program, UAA Division of Population Health Sciences, UAF One Health program and/or Center for Alaska Native Health Research, and the Statewide Suicide Prevention Council. Present the project concept and literature review to potential partners and identify a university-affiliated Principal Investigator to lead the full study. Phase 3 — Reporting and Handoff: Submit the planning grant final report and present findings to RHTP. It is anticipated that the Principal Investigator will apply for RHTP implementation funding in the next funding cycle to design and conduct the full study.	Under \$50,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Obtelecare Alaska PC	Strong Mothers, Strong Alaska: Expanding Maternal Care Across Rural Alaska	SC	According to the Society for Maternal Fetal Medicine (SMFM), shortages of subspecialty obstetrical care have contributed to the expansion of maternity care deserts, where high risk pregnant patients lack timely access to the advanced expertise required for complex pregnancies. MFM specialists are disproportionately concentrated in metropolitan areas, while many rural hospitals and clinics operate without local access to subspecialty maternal care. As a result, patients in rural regions often face long travel distances, delayed consultations, fragmented care, and increased risk of adverse maternal and neonatal outcomes. SMFM has identified a direct relationship between geographic access to MFM care and improved outcomes, noting that reduced access is inversely associated with preterm birth, perinatal mortality, and severe maternal complications. Obtelecare addresses the limited availability of MFM specialists by delivering a fully virtual teleMFM model that extends maternal care to rural hospitals and outpatient clinics without requiring an onsite specialist. By leveraging telehealth technology, Obtelecare enables MFM specialists to provide real time consultation, clinical decision support, and care coordination regardless of patient location.	By operating without a physical presence, Obtelecare removes common barriers to specialist recruitment and deployment, allowing rural health systems to access high risk maternity expertise quickly and sustainably. With our team of 6 board certified MFM providers, we can deploy Teladoc equipment to established locations of practice and build access to care models seamlessly. Our providers are licensed in the state and are credentialed to align with existing medical staff requirements and bylaws. For the programs that are new to telehealth, we will work with the MSO to provide a scope of practice for telehealth. Traditionally, Obtelecare can launch programs in 60-90 days based on credentialing timelines. Our goal is to provide 24/7 inpatient access to approximately 15 additional inpatient programs throughout Alaska, along with outpatient support for high-risk maternity patients in remote communities. Our program will be offered to every hospital and labor & delivery unit throughout the state of Alaska along with dedicated prenatal outpatient support in the communities that need it most. We will work with the Alaska Native Foundation and tribal communities to offer access through telehealth and virtual care for patients, without having to travel or leave their communities. Through building a consistent approach to virtual teleMFM we have a unique opportunity to work together with the Alaska Community Foundation to track outcomes and measure a significant impact to improving access to evidence based maternal care. This approach aligns with national recommendations from the Society for Maternal Fetal Medicine to expand telehealth as a key strategy for improving maternal outcomes in underserved communities	\$1M-\$5M	Maternal health	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

OCHIN Inc.	Alaska Health Information Technology Workforce Pathway Initiative	OR	Healthcare delivery in Alaska depends on digital health systems that connect patients, clinics, hospitals, and specialists across vast geographic distances. Telehealth platforms, electronic health records, health information exchange systems, cybersecurity infrastructure, and healthcare data analytics tools are essential to modern care delivery. Despite this reliance on digital infrastructure, Alaska faces a shortage of trained professionals capable of supporting these systems. Existing healthcare workforce programs largely focus on clinical roles such as nursing, medical assisting, and behavioral health services, leaving technical roles that support healthcare technology systems underdeveloped. This initiative addresses that gap by establishing a statewide Health Information Technology workforce development program designed for Alaska’s rural healthcare environment. The program will create a coordinated training pipeline connecting educational institutions, healthcare organizations, and workforce partners to prepare Alaska residents for careers supporting healthcare technology systems. Implementation will follow a phased approach: program design and partner engagement in Year 1; pilot training programs for students, adult learners, and rural providers in Years 1–2; and statewide expansion and workforce placement in Years 3–5. This strategy supports early success while building the partnerships needed for long-term impact.	The Alaska Health Information Technology Workforce Pathway Initiative will establish a three-track workforce development program designed to strengthen Alaska’s healthcare technology workforce. High School Health IT Career Pathway. This pathway introduces high school students in grades 11–12 to careers in health information technology through Career and Technical Education programs. Students will participate in a structured curriculum covering healthcare systems, electronic health records, healthcare data analytics, cybersecurity fundamentals, privacy and compliance standards, and professional career readiness. Students will earn micro-credentials and participate in applied projects, job shadowing opportunities, and mentorship experiences with healthcare organizations. Educators will participate in a train-the-trainer program enabling local delivery of the curriculum. Adult Workforce Training. The second pathway provides competency-based training for adults entering the healthcare technology workforce or transitioning careers. Participants will develop skills required for entry-level roles including: electronic health record support specialist health information technician healthcare data support analyst healthcare IT help desk specialist Training will include online coursework, applied learning exercises, and potential practicum opportunities with healthcare organizations. Rural Provider Technology Upskilling. The third pathway strengthens digital health capabilities for healthcare providers working in rural communities through role-based training tailored to the responsibilities of clinical, administrative, and technical staff. Training topics include: • telehealth systems • EHR workflow optimization • healthcare data reporting and analytics • cybersecurity awareness • digital care coordination tools Role-based learning modules will ensure that physicians, nurses, care coordinators, administrative staff, and IT support personnel receive training aligned with their day-to-day responsibilities and workflows. These trainings help providers use digital systems more efficiently, strengthen team-based care, and expand technology-enabled healthcare delivery across rural and frontier communities.	\$1M-\$5M	Statewide	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Kodiak Island Borough; Nome Census Area; Sitka (City and Borough)	Deferred or Not Advanced

Odyssey Family Practice	Odyssey Family Practice Facility Acquisition and Rural Access Expansion	AK	Odyssey Family Practice serves a federally designated Health Professional Shortage Area, where rural residents face geographic isolation, limited healthcare alternatives, and increasing demand for services. In recent years, the region has experienced significant provider turnover, creating instability and placing additional strain on the remaining practices. Existing facility space at Odyssey is fully utilized, limiting the clinic's ability to recruit additional providers, expand occupational health services, or integrate physical therapy, wound care, and additional diagnostic capacity. Simultaneously, regional workforce growth, including the anticipated LNG pipeline development, is increasing demand for comprehensive OccHealth services. Odyssey is the only full-service OccHealth provider on the Kenai Peninsula, but current space constraints restrict our ability to scale in response to employer and worker needs. The community's aging population further increases demand for chronic disease management, wound care, mobile health services, and accessible rehabilitation. Continued operation in a leased facility with high annual lease costs and multiple prior sale considerations limits long-term capital planning and diverts substantial operational resources away from reinvestment in patient-facing infrastructure and service expansion. This project addresses infrastructure instability and growing demand, supporting both population health and workforce resilience.	Odyssey Family Practice will implement a two-phase strategy to stabilize existing infrastructure and expand clinical capacity to meet rural and workforce demands. Phase 1: Secure and Upgrade Existing Facility Odyssey will acquire its current facility to eliminate infrastructure uncertainty and complete prioritized capital improvements necessary for safe clinical care, including roof replacement to address active water intrusion that has required temporary room closures and interrupted patient flow. Ownership ensures uninterrupted access to care while providing the structural control needed to complete critical repairs and support planned service expansion. Phase 2: Expand Capacity Through Construction of a Second Clinical Building A new 7000-square-foot facility will increase exam space, provider capacity, and dedicated occupational health space. Expanded space will allow the recruitment of another full-time provider, and will help redistribute patient load to reduce wait times and improve access. Dedicated occupational health suites will increase capacity for regulatory physicals, injury evaluation and recover, and employer-based medical services, strengthening support for regional employers and working families. Integration of on-site physical therapy will create a full recovery pathway for injured workers, improving return to work timelines and reducing external referrals. The expanded campus will also include the addition of diagnostic ultrasound and enhanced wound care services, localizing commonly referred services and reducing travel burden. Mobile health services will extend care delivery to homebound and assisted living residents, increase reach into areas of the community that struggle to access care. This phased approach creates an integrated rural healthcare campus capable of sustaining workforce growth, supporting an aging population, and strengthening long-term healthcare access in the region. Upon award, Odyssey is prepared to immediately initiate acquisition, with construction planning and contractor engagement to follow within the first six months. Recruitment of an additional provider will occur concurrently to ensure the expanded capacity is operational upon completion. This sequenced implementation ensures minimal disruption to existing services while accelerating increased access for rural residents and the regional workforce.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Old Harbor Alliance	Sitkalidak Healthy Harvest: Youth Learning Hub	AK	Youth in rural Alaska communities face high barriers to building healthy eating habits: limited access to affordable nutritious foods, high costs and inconsistent availability of fresh groceries, and few dedicated spaces for hands-on nutrition education and positive after-school/seasonal programming. In Old Harbor, these barriers are compounded by geographic isolation and the high cost of transporting food. At the same time, Old Harbor has a powerful opportunity: community-driven local food systems and cultural knowledge that can strengthen prevention and wellness when paired with the right facilities. The Sitkalidak Processing Plant and Sitkalidak Sunrise Farm supports local harvesting and food distribution efforts, but it is not yet optimized as an educational space where youth and families can safely learn cooking, preservation, and nutrition skills. This project addresses the opportunity to convert an existing local food system asset into a year-round youth and family learning hub—strengthening food sovereignty, preventing diet-related chronic disease over time, and reinforcing protective cultural connections through education and intergenerational activities that promote health and wellness.	Old Harbor Alliance will implement a combined capital + programming approach: 1) Processing plant improvements (capital/infrastructure): RHTP funds will support facility and equipment upgrades that enable safe youth and family instruction and expand preservation capacity. Improvements will include reconfigured food prep areas, improved insulation and interior walls, paint concrete floors, additional stainless work surfaces, improved refrigeration/freezer capacity, and preservation tools such as vacuum sealing, dehydration, smoking, and canning support equipment, along with safety, sanitation, and storage enhancements. These upgrades will allow the plant to function as both a processing facility and an educational site. 2) Installation of large-insulated yurts (capital/infrastructure): Large yurts with wood stoves will be installed as flexible classroom space for year-round educational and cultural activities tied to healthy habits. Yurts will host cooking demonstrations, nutrition education, cultural teaching sessions, agriculture camp and youth workshops that require warm, dry gathering space not available in many rural settings. 3) Youth and family programming (training/technical assistance + prevention): Programming will focus on youth ages approximately 5–18, with family participation encouraged. Core activities include: Youth-friendly cooking classes using local foods (bison, seafood, berries, local greens, garden produce and fruit) Food preservation training (freezing, drying, smoking, canning, safe packaging) Food safety and hygiene instruction; optional teen certification pathways where feasible Cultural education linked to traditional foods and intergenerational knowledge sharing Youth leadership opportunities (teen assistants, peer mentors, youth “cook teams”) 4) Partnerships and coordination: The Alliance will coordinate with the Alutiiq Tribe of Old Harbor, Old Harbor Native Corporation, and other local stakeholders (school, clinic/health partners as applicable) to align schedules, recruit participants, and connect programming to broader community wellness efforts.	\$50,000-\$250,000	Single Community	Kodiak Island Borough	Deferred or Not Advanced

Older Persons Action Group, Inc.	2026 Older Persons Action Group Directory for Older Alaskans	AK	Since 1982, the Older Persons Action Group, Inc. (OPAG) has compiled and published the “Directory for Older Alaskans”. Editions are updated every 3 to 5 years with the 2023 edition being the last edition and the next (2026) edition is in the build stage. Budget records for the 2023 edition indicate that \$68,340 was spent to deliver 8,000 copies of the 160-page directory on 80# stock with a spiral binding. AARP contributed \$5,000; ARPA contributed \$45,580; the State of Alaska (SOA) contributed \$15,000; and the Senior Voice sold \$2,760 of advertising. ARPA funds were associated with COVID relief programs, and the historical documentation does not identify what program from the SOA contributed to the print run. The cost-of-goods to publish the 2023 edition was \$8.54/copy before distribution. Customers were only charged for shipping & handling. OPAG is seeking financial assistance to replace the ARPA funds and the State of Alaska funding that are no longer available through the same channels that were available in 2022.	The obvious question that many consumers have asked, is why bother with a printed directory when on-line directories are available. There are several answers. First, I continue to receive requests for printed copies. Second, many parts of Alaska do not have reliable internet service. And third, the on-line directories focus on the resources in a specific geographical area rather than providing statewide suggestions on services. One objective for the 2026 Directory for Older Alaskans is to develop bridging between the print and on-line mediums. OPAG is actively developing a collaborabitive with United Way Alaska 211, Connect Matanuska, LINKS, UAA, ARA, and AARP for developing the bridging. However, OPAG has the expertise to develop the printed version, and our focus is on the resources needed to deliver a quality product to the consumer.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Omada	Alaska Rural Health: Omada Virtual Chronic Disease Prevention & Management	TX	Rural and remote Alaskan communities face serious barriers to getting quality care for chronic conditions, even as these issues become more common across the state. In Alaska, 33% of adults report high blood pressure, 30% high cholesterol, 27% arthritis, 17% asthma, 10% cancer, 9% diabetes, and 6% heart disease, and cancer and heart disease together account for more than a third of all deaths. Many residents also face risk factors that raise their chances of developing chronic disease over time—for example, 82% of Alaska adults are overweight or obese, 33% of high school students are overweight or obese, and 18% of adults report no physical activity. Without intervention, one in three people will develop diabetes, 14% will develop congestive heart failure, and 11% will experience heart disease within 10 years. Omada’s evidence based virtual care model is well suited to once again break down geographic barriers and bring chronic disease prevention and management support directly to Alaska, no matter where a member lives. Although Omada’s involvement with the Fresh Start program has temporarily lapsed due to funding constraints, we’re committed to renewing this work and getting back to supporting Alaskans across the state—from larger communities to remote and off road villages.	Project Concept Approach Omada Health proposes to address Alaska's chronic disease crisis through our proven virtual-first care model, eliminating geographic barriers and delivering evidence-based prevention and management programs statewide—from Anchorage to the most remote villages. Core Programs Cardiometabolic Care: CDC-recognized Diabetes Prevention Program targeting the 82% of Alaskans who are overweight or obese, Diabetes Self-Management (DSMES) for the 9% with diabetes, and Self-Monitoring Blood Pressure (SMBP) program for the 33% with hypertension. All programs follow gold-standard clinical guidelines and are supported by 29+ peer-reviewed publications. Musculoskeletal Care: URAC-accredited virtual physical therapy addressing the 27% of Alaskans with arthritis and other MSK conditions, eliminating need for costly travel to access PT services. Alaska-Specific Solutions 100% Virtual Delivery: All services delivered via smartphone, tablet, or computer—no travel required regardless of weather, distance, or road access. Members engage on their own schedule, accommodating subsistence activities and unpredictable conditions. Connected Devices: Cellular-enabled smart scales, blood pressure monitors, and glucose meters shipped directly to members at no cost. Devices work without Wi-Fi, critical for areas with limited internet connectivity. 1:1 Human Care Teams: Each member receives a dedicated health coach (cardiometabolic) or licensed Physical Therapist (MSK) who understands Alaska's unique challenges. Care teams provide personalized support through in-app messaging and video visits. Health Equity Focus: Program designed for populations facing greatest barriers, including those with lower digital literacy, Medicare/Medicaid beneficiaries, and remote communities. WCAG 2.1 AA accessible with 8th-grade level curriculum. Expected Impact Improved health measures (blood sugar, blood pressure, weight), reduced healthcare utilization, and lower long-term costs. Our activity-based billing ensures Alaska only pays for engaged members, maximizing value. By resuming our proven partnership, we'll once again bring specialized chronic disease care to every Alaskan, regardless of location.	\$250K-\$1M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Omega Garden Inc.	Farmdominium Food For Life Systems`	AK	Food Insecurity	Deploy systems in communites.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

On Demand Pharmaceuti cals Inc	Securing Alaska's Access to Essential Medications to Improve Rural Health Outcomes	MD	Alaska’s rural, remote, and frontier communities face persistent vulnerability to medication shortages that undermine efforts to deliver care as close to home as possible. More than 80% of communities are off the road system and rely on air, barge, or seasonal transport for essential medical supplies. Weather delays, low patient volumes, high operating costs, and workforce shortages amplify the impact of national drug shortages on critical access hospitals, Tribal health facilities, and small community clinics. When medications are unavailable, providers must delay care, substitute therapies, or transfer patients hundreds of miles, increasing cost, risk, and strain on already fragile rural systems. We are proposing an opportunity to partner with Alaska’s Tribal health organizations, rural hospitals, and state leaders to strengthen local medication resilience in a way that complements existing procurement and supports community-led regional planning. By establishing reliable in-state capacity to supply priority, shortage-prone medicines through a 503B sterile compounding production model designed to serve rural spokes from a central hub, this project seeks to reduce disruption, improve preparedness, and enhance the sustainability of rural health providers across Alaska.	ODP proposes establishing and operating a Shortage Response Pharmacy on Demand (SR-PoD), a 503B outsourcing facility in a major Alaska population center designed to serve rural, remote, and frontier communities through a hub-and-spoke model. The hub would supply a defined set of high-priority, shortage-prone medications to participating rural hospitals, Tribal health facilities, and community clinics based on locally determined needs and service agreements. The intent is not to replace existing procurement systems, but to add reliable in-state capacity that strengthens medication access when commercial supply chains are delayed, disrupted, or financially unsustainable. The SR-PoD uses a technology-enabled platform supporting safe, small-batch sterile medication preparation with integrated electronic quality oversight. Central to the long-term approach are Pre-Assembled Raw Materials Sequenced Packages (PARS-Paks), shelf-stable, pre-measured inputs that simplify production and support agile responses to shortages. Initial operations will establish sterile compounding capacity, with PARS-Pak-enabled agile production introduced in later phases. This SR-PoD model builds on a 2024 proof-of-concept pilot in rural Mississippi, where nearly 12,000 doses of sterile injectable medications were produced and delivered under a 503A compounding framework, demonstrating operational feasibility and informing the transition to a scalable 503B model. The SR-PoD hub would serve as a coordinated supply partner for rural providers, delivering priority medications through planned distribution without requiring each site to maintain costly infrastructure. This model supports RHTP objectives by: - Expanding access to essential medications closer to home and reducing avoidable transfers and care delays. - Strengthening rural provider sustainability by stabilizing access to frequently scarce or high-cost drugs. - Leveraging technology and shared data systems to promote quality, transparency, and accountability. - Creating a scalable platform that can expand formulary scope and spoke participation based on regional priorities. This project will follow a phased implementation approach. Early efforts will focus on partnership engagement, site selection, regulatory alignment, and establishment of the 503B facility. Later phases will operationalize services for rural partners, expand the formulary, and introduce agile production capabilities with ongoing stakeholder guidance.	Over \$5M	Pharmacy	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Onmed LLC	Connected Care	NY	Many communities across Alaska face persistent barriers to timely healthcare due to geographic isolation, provider shortages, transportation challenges, and limited local service capacity. In many rural and frontier areas, residents must travel long distances, often by air or seasonal routes, to access basic primary or urgent care. These barriers contribute to delayed treatment, avoidable emergency department use for non-emergent conditions, and poorer outcomes for people with chronic diseases. These challenges are reflected in high HPSA scores, low IMU values, broadband limitations, and elevated chronic disease burden across much of the state, all of which widen gaps in timely, lower-acuity care and strain hospitals, clinics, and a limited healthcare workforce. This project addresses that need by establishing a statewide network of telehealth-enabled CareStations in trusted community settings across Alaska. The model is designed to extend existing provider networks, improve access to primary and preventive care, support chronic disease management, and reduce avoidable emergency department use. Because CareStations are deployable, technology-enabled access points that do not require new construction or on-site clinician staffing, the network can be activated quickly, with deployment possible within 45 days.	The proposed project will deploy a statewide network of telehealth-enabled CareStations to expand access to timely primary and urgent care across Alaska’s rural, frontier, and underserved communities. CareStations are private, ADA-compliant, clinic-grade access points that connect patients in real time with licensed clinicians through secure telehealth technology. Each CareStation includes integrated diagnostic peripherals to capture vital signs, temperature, blood pressure, pulse oximetry, heart and lung sounds, and high-resolution exam imagery, enabling more comprehensive clinical evaluations. These capabilities support common acute care, preventive care, chronic disease management, and follow-up coordination with local and regional providers. The deployment concept is based on a data-driven assessment of Alaska’s healthcare access landscape, including provider shortages, medical underservice, broadband constraints, and chronic disease burden. That analysis supports a statewide network of approximately 38 CareStations across high-need communities and regional hubs. This model is designed for rapid implementation. CareStations can be deployed and operational in 45 days or less, allowing communities to respond quickly to documented care gaps, especially where residents face long travel times, limited provider availability, and delayed access to non-emergent care. CareStations will be placed in trusted community settings such as tribal health facilities, community health centers, hospitals, public health sites, workforce hubs, housing organizations, libraries, and other community-serving locations. The model is intended to strengthen existing provider networks by creating additional access points that support referrals, continuity of care, and more efficient use of healthcare workforce resources.	Over \$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Onward and Upward Inc	One Health Sciences Transformative Curriculum: An Evaluation, Innovation, and Expansion Project	AK	Rural Alaska needs more than downstream crisis response; it needs an upstream system that helps young people build lifelong health before problems escalate. Alaska’s RHTP identifies major needs among children and youth: 28% of Alaska children live below the federal poverty level, 13% are uninsured or underinsured, less than half of youth ages 12–17 receive needed substance use treatment, and 23% of Alaska youth have seriously considered suicide while 19% have attempted it. In the Mat-Su, the Community Health Needs Assessment highlights youth mental health and substance use as recurring and escalating concerns, with youth suicide consideration at 23.8% in traditional high schools and 41.3% in alternative high schools. There is a clear opportunity to deliver prevention-focused, school- and community-based health education that strengthens resilience, belonging, physical activity, nutrition, and family and community connection – meeting them right where they are. Founded in 2007 by social psychologist Dr. Randall Dowd, whose own childhood adversity informed a lifelong commitment to helping vulnerable youth access the protective factors he once lacked, Onward & Upward addresses a critical gap: rigorous, evidence-based health education that treats health as a science and connects mental, physical, social, cultural, and environmental wellbeing. This project will move youth health from fragmented, reactive services toward sustained prevention and lifelong healthy habits.	Onward & Upward proposes an innovative ready-to-launch, four-part Rural Health Transformation project centered on One Health Sciences education. First, we will engage the UAA Institute for Circumpolar Health Studies to conduct an external evaluation using an existing study design, generating credible evidence on implementation, outcomes, impacts, and scalability. Second, with the UAF Center for One Health Research, we will refine the curriculum into a more organized, evidence-informed, scalable model for broader Mat-Su and eventual statewide adoption. Third, we will expand delivery across committed school, Tribal, health, and community partners, including Mat-Su Borough School District sites and rural/remote partners, so more youth (especially those facing higher risk and fewer protective supports) can access prevention-focused programming. Fourth, we will integrate iPad Mini technology for the implementation of Photovoice, qualitative data collection, student reflection, and community dissemination; thereby strengthening both evaluation and technology-enabled engagement. The program is innovative, evidence-based, and student-centered. It combines health literacy, physical activity, nutrition education, mental health resilience, belonging, connection to place, and family engagement through experiential learning in Alaska’s natural and community classrooms. It directly advances Healthy Beginnings by building healthy habits for youth; Healthy Communities by expanding prevention-focused wellness and health education; Strengthens Workforce by creating health science and career exposure while training staff and partners; and Spark Technology Innovation through digital data collection, student voice, and community dissemination. It also reflects the Alaska Youth Behavioral Health Roadmap priorities: expand access, build collaboration among schools and community partners, emphasize prevention and early intervention, reduce stigma, and create healthy youth spaces and positive connections. This is not a short-term enrichment add-on. It is a transformative, sustainable program model that braids evidence-based curriculum, school partnerships, Tribal collaboration, program evaluation, and technology to build healthy habits for youth while expanding local capacity to support them. Because most partner sites are already piloted and/or committed, RHTP support would accelerate implementation immediately and position the model for broader regional and statewide expansion.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough; Nome Census Area; Petersburg Borough	Advance to Implementation Application

Ophthalmic Associates	Teleophthalmology AI supported Hub and Spoke model for Rural Alaska	AK	Rural Alaskans experience delayed diagnosis and treatment of eye disease due to limited local ophthalmology capacity and travel barriers. These delays can lead to preventable vision loss, higher downstream costs, and increased burden on families and the health system. The opportunity is to use a scalable, technology-enabled hub-and-spoke approach that equips frontline clinicians (PCPs, PAs/NPs, MAs/RNs, and optometrists) with an AI-assisted workflow to identify urgent eye conditions earlier, route referrals appropriately, and coordinate specialty care efficiently. This aligns with Alaska’s rural health transformation priorities to expand access through telehealth and digital tools and to strengthen coordination and sustainability of care delivery.	We will implement MyEyesAI as a teleophthalmology AI assistant integrated into a standardized “spoke-to-hub” workflow. Phase 1 focuses on onboarding initial spoke sites (pilot communities/clinics), defining clinical protocols, and training staff on image capture (when available), structured intake, red-flag identification, and referral packaging. MyEyesAI will guide frontline staff through consistent data collection and produce structured summaries and triage recommendations for ophthalmologist review at OA. OA ophthalmologists will provide asynchronous review (and synchronous teleconsult when needed) to: (1) advise local management when safe, (2) prioritize urgent transfers/referrals, (3) schedule appropriate in-person visits, and (4) route subspecialty needs to identified partners (pediatric ophthalmology: Bob Arnold, MD; Robin Grendahl, MD; retina: Chad Bouchard, DO; Matt Guess, MD; Scott Limstrom, MD) when indicated. Phase 2 expands to additional spokes, improves turnaround times, and adds quality metrics (e.g., time-to-triage decision, referral completeness, reduction in avoidable travel, adherence to follow-up). Phase 3 focuses on sustainability: payer alignment, workflow optimization, and regional scaling through a repeatable onboarding and training package. This approach directly supports the RHTP emphasis on technology and innovation, remote coordination, workforce enablement, and sustainable care models.	\$1M-\$5M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Optical Aleutians	construction of new exam room	AK	Optical Aleutians relocated in July 2025 to a high-visibility, lower-level facility to better serve the Unalaska community. While this new location provides the necessary square footage for expansion, it currently lacks the specialized infrastructure required to operate a full-service optometry clinic. Specifically, the space lacks a dedicated exam room, integrated plumbing for sanitation, and safe, finished flooring. Currently, eye exams must be conducted in a borrowed upstairs dental office. This creates significant barriers: it limits our scheduling based on third-party availability and creates a major accessibility hurdle for elders and handicapped patients who cannot navigate the stairs. Furthermore, the absence of running water in the suite prevents us from meeting modern clinical hygiene and infection control standards. There is a critical opportunity to transform this "raw" space into a professional, healthcare-compliant exam lane. By installing medical-grade flooring to remediate trip hazards, extending plumbing for sanitation, and constructing a sound-dampened exam room, we can provide a permanent, barrier-free health asset for the residents of Unalaska, Nikolski, and Akutan.	Our approach establishes a permanent, clinical-grade eye care center through a three-phase facility transformation: 1. Safety and Accessibility Remediation: We will repair the existing raw cement floor, which contains pits and uneven spots that present significant trip hazards for elderly and mobility-impaired patients. We will install medical-grade, slip-resistant flooring to create a level, safe, and sterile environment that meets clinical hygiene standards. 2. Sanitation and Infrastructure Integration: The space currently lacks running water, a barrier to standard infection control protocols. We have coordinated with the building owners to extend plumbing from a neighboring suite. This will allow for essential hand-washing stations and sterilization areas within the exam room, bringing the facility into compliance with healthcare regulations. 3. Construction of a Dedicated Lower-Level Exam Room: We will construct a 12x10 sound-dampened exam room on the lower level. Currently, patients must be escorted to an upstairs dental office, which is a major barrier for elders and handicapped patients due to the lack of an elevator. Moving the exam lane to the lower level provides barrier-free access, ensures patient privacy (HIPAA compliance), and grants the scheduling autonomy needed to increase the frequency of our exam runs to meet community demand. This project transforms a temporary, shared-space model into a dedicated clinical environment to provide consistent, professional care to the residents of Unalaska, Nikolski, and Akutan.	Under \$50,000	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area	Advance to Implementation Application

Opus Behavioral Health, Inc.	Mat-Su Valley Intelligence Dashboard - Planning & Design	CO	Mat-Su providers identified real-time bed availability as their most urgent need—hours wasted daily calling while patients wait in EDs. Simultaneously, Alaska's shift toward CCBHCs and value-based care (planning grant December 2024) requires tracking 17 federally-mandated quality measures and provider benchmarking—infrastructure that doesn't exist. Conversations with Dr. Victoria Kildall (ABHA CEO), John Solomon (former ABHA CEO), Karl Soderstrom (True North CEO), and Mat-Su providers revealed these needs. While ABHA may submit their own LOI, we propose an integrated solution: Mat-Su bed registry + statewide CCBHC infrastructure. Planning designs four capabilities validated by other states: - Real-Time Bed Registry (Mat-Su urgent need): Eliminates calling (Georgia GCAL: 2 min → 7 sec) - CCBHC Quality Dashboard (State need): Tracks 17 measures for value-based care, certification (Missouri/Oklahoma) - Provider Benchmarking (State need): Confidential peer comparison (Virginia CSB, NC Child BH) - State Capacity Planning (DOH need): System visibility, resource allocation - Mat-Su pilot (True North, Day Break, Set Free, Nugen's Ranch) solves bed crisis while validating CCBHC infrastructure for Fairbanks, Juneau, Southeast expansion. Opus brings Alaska foundation: True North/Wil-a-Mootk with AKAIMS, HIE, and bedboard integrations. 3-month planning designs pilot, governance, expansion roadmap. Dashboard: https://opus-rhttp.lovable.app	This 3-month planning addresses (1) Mat-Su bed availability crisis (urgent local need) and (2) Alaska CCBHC/value-based care infrastructure (statewide strategic need), leveraging proven frameworks from Georgia, Virginia, North Carolina, Missouri, Oklahoma: Month 1: Stakeholder Engagement & Requirements Working with DOH, ABHA (Dr. Kildall), John Solomon, Mat-Su providers (True North, Day Break, Set Free, Nugen's Ranch): - Mat-Su bed registry requirements: document calling workflows, quantify time waste - Statewide CCBHC requirements: map 17 quality measures to data collection needs - Provider benchmarking framework: define confidential peer comparison methodology - Expansion planning: sessions with Fairbanks, Juneau, Southeast ensuring statewide scalability - EHR-agnostic middleware: integration specs for Qualifacts, Netsmart, Epic, Cerner Month 2: Architecture & Governance - Mat-Su bed registry architecture (Georgia GCAL model: 2 min → 7 sec) - CCBHC quality dashboard design (Missouri/Oklahoma frameworks, 17 measures) - Provider benchmarking methodology (Virginia CSB/NC Child BH models, anonymized percentiles) - State capacity planning dashboard (DOH resource allocation) - Data governance framework (access controls, privacy, HIPAA, competitive safeguards) - Expansion architecture (regional replication blueprints) - Sustainability modeling (pilot costs to statewide scaling) Month 3: Implementation Roadmap - Mat-Su pilot plan: bed registry + CCBHC tracking - Statewide expansion: Fairbanks/Juneau (Year 2-3), Southeast/rural (Year 3-4) - Partner roles, change management, performance metrics Dashboard: https://opus-rhttp.lovable.app/	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Orca Labs, LLC	Keeping Alaska Elders Home Through Coordinated Family-and-Provider Care Teams	AK	Alaska has approximately 107,000 residents 65 or older — growing over 3% annually while the working-age population declines. The 85+ cohort is projected to increase 500% by 2050. Alaska has the smallest senior population of any state, meaning care infrastructure was never built to scale. The gap is sharpest in rural communities. 82% of Alaska's communities lack road access. Specialists are hundreds of miles away. Seniors are disproportionately Alaska Native — with higher chronic disease rates and fewer professional resources. The Alzheimer's Association reports 8,400 Alaskans with Alzheimer's alone; total dementia cases reach an estimated 11,000. The impact radiates outward. More than 25,000 Alaskans provide unpaid dementia care — \$887 million in uncompensated labor annually. These caregivers are themselves at elevated risk for depression, chronic illness, and financial hardship. When they burn out, elders end up in emergency departments for preventable crises — each visit costing \$25,000–\$50,000+ when rural medevac is involved. The core problem is not willingness — it is the absence of coordination infrastructure. Family caregivers are dispersed with no shared system. Community health aides arrive without access to care plans or medication records. The person closest to the elder becomes the default coordinator regardless of capacity. The result: preventable hospitalizations, caregiver collapse, and premature institutionalization.	Orca Labs (Anchorage, AK) serves as fiscal agent, project manager, and outcomes evaluator. Alula (Vestality LLC, Virginia — veteran-owned, service-disabled veteran majority ownership) is the technology partner. Together, they will deploy a 12-month pilot serving 50–75 rural and frontier Alaska families caring for elders with dementia, Parkinson's, or other complex care needs. Orca Labs leads: partnership development with Tribal Health Organizations and Alzheimer's Resource of Alaska; family recruitment; fiscal management and RHTP compliance; outcomes measurement; and statewide expansion planning. Founder Christine Shulman brings proven Alaska transformation experience, including relocating the Tanaina Child Development Center program to Alaska Regional Hospital and securing a \$1.2M financing arrangement through Rasmuson Foundation. Alula is a live caregiving coordination platform — in production today — that solves a problem every caregiving family faces: the person who happens to live closest to mom or dad becomes the de facto care coordinator, regardless of whether they have the skills, time, or information to manage what is effectively a complex team operation. Alula replaces that accidental structure with a digital chief of staff — one that knows the players, their strengths, has the data needed to make decisions, and guides each person to do their best work. The result is that dispersed, overwhelmed family members and rotating professional caregivers function like a coordinated team instead of isolated individuals guessing at what to do next. Alula's founding team brings both the technical capability and lived experience to build this. Founder Jason Eversole previously built large-scale real-time visibility networks across fragmented supply chains at FourKites — and saw the same coordination problem in his own family's caregiving. His cofounders include a Rhodes Scholar geriatrician with expertise in dementia, an emergency medicine physician and educator, and a near-decade caregiver to parents with both Parkinson's and dementia. What this pilot funds is deploying and validating the platform in Alaska's unique environment — working with THOs, community health aides, and families to identify what adaptations are needed and implement them during the pilot period.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Orca Labs, LLC	Built to Last: Technology Deployment and Impact Measurement for RHTP Grantees	AK	Alaska's Rural Health Transformation Program represents a generational investment in the state's health infrastructure. Yet the evidence is sobering: only 13% of major government IT projects succeed as planned, more than 80% run over budget or behind schedule, and 84% experience serious implementation problems. The technology funded by RHTP is only as valuable as the organizations deploying it and rural Alaska's health organizations are among the least resourced to absorb complex technology without dedicated support. The opportunity Orca Labs addresses is not a gap in technology it is a gap in execution. Telehealth platforms, remote monitoring tools, EHR integrations, and digital care coordination systems are only transformative when they are embedded into daily workflows, adopted by frontline staff, and measured against outcomes that matter. Without that layer of support, even well-funded technology quietly fails: unused licenses, workarounds, and tools that never outlast the grant that paid for them. Orca Labs partners with RHTP-funded projects to close this gap providing the technology deployment expertise, measurement infrastructure, and sustainability planning that rural health organizations need but cannot afford to hire full-time. The result is technology that actually reaches rural Alaskans, outcomes that can be demonstrated to CMS, and local capacity that endures long after the award period ends.	Orca Labs will serve as an embedded technology deployment and measurement partner for a cohort of RHTP-funded projects — working inside grantee organizations rather than advising from a distance. The approach is built around three integrated services, each targeting a documented root cause of government technology failure. First, Technology Deployment Support. Most rural health technology fails not because the tool is wrong, but because it gets layered on top of existing workflows instead of integrated into them. Orca Labs works alongside grantee teams to map how care actually flows, then designs deployment around those realities — co-developing workflow integrations, building staff training tailored to rural settings, and staying engaged through go-live to catch friction before it becomes failure. The goal is not a successful launch. It is sustained, confident daily use. Second, Impact Measurement Infrastructure. Without a measurement system, no one knows whether the technology is working until it is too late to fix it. Orca Labs builds simple, actionable scorecards and reporting tools using systems organizations already have — no new platforms required. We establish baselines at launch, translate RHTP metrics into weekly management rhythms, and produce quarterly reports that give grantees and funders clear, credible evidence of impact. Third, Sustainability and Local Ownership. Every engagement is designed around one question from day one: when Orca Labs support ends, can this community sustain what we built together? All workflows, tools, and measurement systems are documented in plain language and owned by local staff. We train internal champions, not just end users. The cumulative output — a statewide RHTP Technology and Measurement Toolkit — will be made freely available to the Alaska Community Foundation and Department of Health for use with future grantee cohorts. This is not a new technology. It is the operational and measurement layer that makes every other RHTP technology investment more likely to succeed.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Orca Labs, LLC	Decode Alaska: Little Readers, Big Futures	AK	Eight in ten Alaska 3rd graders cannot read proficiently. Alaska ranks 49th in 4th-grade reading nationally. Alaska Native high school youth report an average GPA of 1.7 — not because they lack ambition, but because the system has lacked the tools to reach them where they are. These numbers represent children remote villages, in communities without broadband, in classrooms where a single teacher serves multiple grades and has little access to specialized literacy support. The opportunity is this: proven, self-directed reading technology now exists that requires no internet connection, no specialist, and no classroom infrastructure. Curious Learning's evidence-based apps have reached children in some of the world's most remote and under-resourced communities — and they work. At the same time, Mindplay Academy offers accessible, online professional development that can equip Alaska educators with structured literacy and dyslexia tools regardless of where they teach. What has been missing is someone to connect these solutions to Alaska's youngest rural learners at scale — with the project management rigor, community coordination, and measurement infrastructure to make it stick. That is what Decode Alaska: Little Readers, Big Futures does. This is not a pilot built in Anchorage and handed to rural communities. It is designed from the ground up for children where they are today — it starts now, with tools that are ready and a project team ready to implement.	Decode Alaska: Little Readers, Big Futures operates on two coordinated tracks, designed to reach children where they are and equip the adults around them to help. Priority 1 — Curious Learning: Devices and Apps for Rural Communities The first and highest-priority track deploys Curious Learning's evidence-based, self-directed reading apps and preloaded Android devices to children ages 4–8 in rural Alaska communities outside Anchorage, Fairbanks, and Juneau. Curious Learning's apps require no internet connection — a non-negotiable requirement for frontier Alaska — and are designed for independent, self-paced use by young children. Devices will be distributed through schools, tribal organizations, and community contacts, with lightweight onboarding for families. The intent is simple: put a working, durable literacy tool into a child's hands and let it travel — to younger siblings, to cousins, to the next family who needs it. Children in cities will have access to the free reading app as long as they have an Android device. Priority 2 — Mindplay Academy: Educator Training Statewide The second track gives Alaska teachers statewide access to Mindplay Academy's research-based professional development courses — Comprehensive Reading for Educators, Teacher Companion, and Understanding Dyslexia — delivered entirely online so geography is no barrier. This is a self guided training. CTW Reads will provide implementation coaching to help educators translate course learning into daily classroom practice, with targeted support for students with dyslexia and dyscalculia. Orca Labs leads both tracks as fiscal agent and project manager, coordinating partners, tracking KPIs, and ensuring the model is documented for statewide scale.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Organized Village of Kake	Cultural Healing House	AK	Substance use disorders continue to affect Alaska Native communities in Southeast Alaska at disproportionately high rates, yet culturally grounded treatment options remain extremely limited. Existing behavioral health services are concentrated in regional hubs such as Juneau, Sitka, and Ketchikan, requiring many rural residents to leave their families, employment, and cultural environments to receive care. For Alaska Native communities, healing has historically been rooted in relationships with family, community, land, language, and cultural responsibility. When individuals must leave these foundations in order to seek treatment, recovery efforts can be disrupted and difficult to sustain. Community leaders in Kake, working through the Organized Village of Kake and its Cultural Advisory Council, have identified the need for a recovery model grounded in Indigenous lifeways and community connection. Through community meetings, cultural consultation with Elders, and local planning efforts, a clear vision emerged. The region needs a recovery program that fosters healing through reconnection to culture, land, and a sense of belonging to community. The Cultural Healing House responds to this vision by creating the first culturally centered residential addiction recovery program in rural Southeast Alaska.	RHTP funding will support the startup, planning, licensing, and capacity-building work required to launch the Cultural Healing House, a culturally grounded residential recovery program serving rural Southeast Alaska. Once operational, ongoing services will be sustained through Medicaid billing under Alaska's 1115 Behavioral Health Waiver. The Cultural Healing House is grounded in an Indigenous understanding that healing occurs through restored relationships to family, community, land, language, and cultural responsibility. Substance use disorder in many Alaska Native communities is closely connected to colonization and cultural displacement. Recovery is therefore approached as a process of restoring the cultural and relational foundations that support wellness, rather than merely as treatment for individuals. Cultural guidance will be provided by Elders, knowledge holders, and community leaders connected to the Organized Village of Kake, who are compensated and whose participation is structured to respect their well-being. Day-to-day facilitation will be carried by trained Peer Facilitators from the community. Startup activities include establishing the 501(c)(3) under OVK governance, obtaining behavioral health licensure and Medicaid enrollment, renovating the Portage Bay facility, conducting community engagement across Southeast Alaska, developing cultural curriculum with Elders, and launching the first residential cohort. The program model draws on the teaching of S'áxt' (Devil's Club), a respected Tlingit medicine plant known for its protective and restorative qualities. Healing unfolds in three phases: Phase I — Recovery Begins: Participants complete a 90-day residential program integrating trauma-informed behavioral health support with traditional practices — harvesting Alaska Native foods, language learning, Native arts mentorship, and land-based activities. Licensed clinicians provide oversight alongside Peer Facilitators. Phase II — Adding to the Medicine: Participants transition to partner transitional housing and vocational programs, building employment-readiness while remaining connected to cultural supports. Phase III — Sharing the Medicine: Graduates return to community life with continued support and opportunities for service, many becoming Peer Facilitators who strengthen the recovery network. Governance will begin under a 501(c)(3) affiliated with the Organized Village of Kake, long-term goal TBD. -	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

Organized Village of Kake	Aging in Place – Embracing our Elders with Culture and Community	AK	Development of the Feasibility Study was closely linked to the community, starting with local interviews by Gail Cheney with Collective Change, who provided the consultant team her living ties to the community. Interviews were followed by a community open house hosted by OVK and MRV to provide a listening session to better understand the reality of the concerns facing aging seniors in Kake. Based on meetings and interviews, a summary understanding of Kake goals and aspirations was developed. Not surprisingly, the number one issue raised by residents was the critical need to find a way for aging seniors to remain in Kake and not spend the last few weeks or months of their lives in a remote institutional or hospital setting, separated from family and community. The problem to be addressed by this ACF funding is to further develop the hybrid housing model which has been proposed for Kake, refining the physical, cultural, emotional and social needs of Elders, while adding rigorous analysis of operating models, staffing, and potential operational partners. It is critical that the model proposed function well for seniors, be correctly sized, and be financially sustainable through local and partner support. At a broader level, the urgency in Kake to accommodate their elders and allow aging in place is a critical concern across many Native village settings in Alaska. We believe that the model we are developing will have applicability across the State in other remote settings.	Over the past 3 years, OVK has been working to exploring a culturally-based care model for local Elders that emphasizes local housing, holistic health approaches, traditional healing, and intergenerational support. As noted above, a range of alternatives were studied through the now completed Conceptual Design phase. The preferred hybrid model includes many of the benefits of full assisted living by providing 24-hour care, coupled with improved accessibility, support services, and socialization opportunities. The Conceptual design completed by MRV proposes either renovation of an existing building or constructing a building which incorporates both a resident wing and management living space. The design includes 4 resident bedrooms with a private bath, accommodation for a live-in manager(s), and shared dining/living/kitchen space. One of the senior bedrooms is larger, allowing the potential to function as a hospice room or respite care room on a short-term basis. As was noted above, incorporating traditional healing practices will be an essential component of day-to-day programming. Providing culturally appropriate care is not just about medical treatment but about recognizing the home and community environments as integral to well-being. Once a funding announcement is received, OVK would move forward with establishing contracts with MRV Architects and the Juneau Economic Development Council (JEDC). MRV’s role in this project will include developing the next level of design will add existing building survey for potential renovation, site analysis, site selection, plan refinement, and further building design through a Schematic 50% design level. And obtaining construction cost estimates. JEDC will then develop an improved operations and business model, based on JEDC’s understanding of reimbursement programs and regulatory requirements, as well as feedback from the OVK Council on the appropriate level of care services. Community workforce development will be a necessary and related project development step, helping to provide educational pathways and opportunities for those living in Kake to staff the facility. JEDC will identify possible operating partners (e.g., SEARHC, Consumer Direct Care Network, SAIL, Island Care/Wellness Within, Tlingit and Haida, Catholic Community Services, , State of Alaska, etc.). JEDC will also provide step-by-step implementation strategies on how to create realistic operational scenarios.	\$250K-\$1M	Single Community	Petersburg Borough	Deferred or Not Advanced

Orion Technology Consulting, LLC	RHTP Program Management Office: An Innovative Model for Billion-Dollar Community Health Investments	AK	Alaska is deploying \$272 million per year through the RHTP - over \$1.36 billion across five years. This funding flows to dozens of organizations simultaneously executing hundreds of projects spanning telehealth, IT modernization, equipment procurement, workforce training, facility alterations, and care delivery innovation. Alaska has no centralized capacity to track this portfolio. Queryon proposes a Program Management Office (PMO) to provide it. PMOs are established best practice in energy, defense, and private healthcare - keeping billion-dollar programs on track. But this discipline is rarely applied as a shared service across independent community organizations under a single federal health program, where THOs, hospitals, nonprofits, and vendors manage projects independently with shared compliance requirements and no portfolio-level visibility. The risk without one is documented. GAO found 16.8% of all federal award funds - \$1.17 trillion over five years - linked to severe, persistent audit findings. PMI research shows government organizations lose \$148 million per \$1 billion due to poor program management. Without portfolio-level tracking, projects fall behind undetected - and CMS can redistribute unspent RHTP funds starting March 2028. The opportunity: pilot a PMO purpose-built for community-driven health transformation that becomes replicable for any state managing large-scale federal health investments.	Queryon proposes to pilot an RHTP Program Management Office (PMO) - applying proven program management methodology as a shared service for community-driven federal health transformation. Large programs in energy, defense, and private healthcare use PMOs routinely. Alaska's Pikka project (\$3.1B) uses this discipline. Mayo Clinic uses it. The Army Corps of Engineers uses it. But when federal health dollars flow to dozens of community organizations - each managing projects independently - this lens is rarely applied. This pilot brings that rigor to RHTP. Queryon is positioned to deliver it. We provide project reporting for the Pikka project on Alaska's North Slope while serving 100+ Alaska nonprofit, tribal, and healthcare organizations over 20 years. Our CEO hosts The Major Project Podcast focused on \$1B+ capital programs and moderates industry panels on project controls best practices. No other Alaska firm bridges major program discipline and community healthcare context. The PMO provides: Portfolio dashboard. Centralized Power BI platform giving DOH, ACF, and CMS real-time visibility - status, spending velocity, milestones, compliance, and risk flags. Fiscal accountability. Grant tracking from allocation to expenditure. Multi-source management for braided funding. Technology partner Kahua - FedRAMP-authorized, trusted by 16 federal agencies, used by Mayo Clinic - provides the compliance backbone. Spending velocity monitoring. CMS redistributes unspent funds starting March 2028. The PMO identifies at-risk projects early enough to intervene. Organization support. Reporting templates, compliance checklists, and analyst support reducing burden on healthcare organizations. CMS reporting. Aggregated statewide data in CMS-required formats protecting future-year allocations. Staff and Budget. PMO staffed with project controls professionals - scheduling, cost, risk, compliance, analytics - scaled to the funded portfolio. PMI research establishes 0.5-1% of program spend is associated with highest probability of success at this scale. Applied to \$272M, this yields \$1.4-2.7M per year - a modest investment to protect Alaska's largest-ever health program. Pilot Deliverable. A replicable methodology guide documenting how portfolio program management applies to community-driven federal health - a model for other states.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Orion Technology Consulting, LLC	Rural Health Technology Innovation Hubs: Building Local Capacity for Alaska's Health Transformation	AK	Alaska is about to deploy \$272 million per year in RHTP funding driving hundreds of technology-dependent initiatives across rural communities - telehealth, EHR modernization, population health analytics, care coordination, and CMS outcomes reporting. There is a fundamental gap between this investment and the capacity to execute it. Rural Alaska has minimal health technology workforce. When a clinic in Bethel needs an analytics platform, or a hospital in Nome needs project reporting integrated with existing systems, there are few if any people in those communities with the technical skills to do this work. Existing IT departments at regional health organizations are already at capacity maintaining current systems (EHR support, network administration, compliance, etc) and cannot absorb dozens of new RHTP projects simultaneously. The default is to fly consultants from Anchorage, Seattle, or the Lower 48 for short engagements. They implement, they leave, and the community is left with technology it did not implement and cannot sustain. This gap is not unique to Alaska. The Rural Policy Research Institute identified technology implementation capacity as a critical barrier to rural health innovation nationwide. But Alaska's geography, connectivity challenges, and the sheer scale of RHTP investment make the problem acute. Every dollar invested in technology without corresponding investment in the people who will operate and evolve that technology is a dollar at risk.	Queryon proposes Rural Health Technology Innovation Hubs: physical offices in Alaska's regional hub communities staffed by locally hired and trained technology professionals who serve as dedicated implementation capacity for RHTP-funded initiatives in their region. WHAT EACH HUB DOES: Hires local. Each hub employs 2-3 community residents as Health Technology Associates - permanent, salaried positions recruited from the community's existing workforce. Queryon provides technology skill building via a personalized 12-24 week training program based on projects selected and skills needed for implementation - example areas of skill development such as data analytics, AI fundamentals, health data standards, and business analysis. Trains continuously. Beyond initial training, Associates participate in ongoing development through Queryon's remote learning network, peer mentorship across hubs, support from Queryon’s existing consulting team, and quarterly in-person cohort gatherings. Serves regional health organizations. Hub staff embed alongside healthcare teams at THOs, hospitals, FQHCs, and community health organizations to implement RHTP-funded technology projects - building reporting capacity, configuring systems, supporting CMS compliance data capture, and training health workers on new tools. Connects to advanced capability. When projects exceed the hub team's current skills - complex AI modeling, enterprise data architecture - Queryon's senior analysts work with the hub team, transferring knowledge while delivering results. This hub-and-spoke model mirrors the state's own healthcare delivery architecture. TARGET COMMUNITIES (Year 1 Pilot): Nome (Norton Sound Health Corp.), Bethel (YKHC), Kotzebue (Maniilaq Association), and Sitka (SEARHC) — four regional hubs collectively serving 85+ communities across the Bering Strait, Yukon-Kuskokwim Delta, Northwest Arctic, and Southeast Alaska. If pilot is successful, a targeted expansion to 8 hubs in Year 2 and 12 hubs by Year 3-4. Queryon operates a distributed workforce model, scaling capacity per-project across Alaska - the same approach proposed for the hubs. Our team has 20 years of experience delivering technology solutions to Alaska nonprofit, tribal, and healthcare organizations including serving as CIO for Anchorage Neighborhood Health Center, technology infrastructure for Peninsula Community Health Services, and selection as vendor for ANTHC Data System Capacity Development.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kodiak Island Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough)	Deferred or Not Advanced

OrthoAlaska , LLC	Alaska Primary Care Value-Based Payment & Community Outreach	AK	Rural communities experience inconsistent access, delayed diagnoses, and higher rates of preventable complications. Traditional reimbursement structures do not support proactive chronic care or outreach. APVPCO addresses these gaps through a coordinated value-based payment strategy and community engagement.	Primary Care alternative payment model (APM) development, quality metric creation, EHR interoperability, community health workers (CHW) outreach, mobile screening units, and orthopedic bundled payment modeling. Infrastructure includes actuarial modeling, regulatory review, data dashboards, and mobile diagnostic tools.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Advance to Implementation Application
OrthoAlaska , LLC	Rural Primary Care Workforce Development Program	AK	Alaska faces a severe, long-term primary care shortage, with roughly 15 of 17 primary health care areas showing a 20–40% deficit in generalist physicians. To keep pace with aging and population growth, Alaska requires hundreds more primary care physicians by 2030, driven by high turnover and reliance on out-of-state recruitment. The shortage is driven by a 29% increase in demand from an aging population, 57% from overall population growth, and high provider turnover. The shortage causes high turnover, high overhead costs for practices, and long wait times for patients. Independent primary care practices across Alaska face worsening workforce shortages, with rising operational costs and competition from larger systems. Several providers within Primary Care Associates are approaching retirement with no incoming replacements. The shortage of primary-care-adjacent specialists compounds delays for rural patients. Many out-of-state clinicians lack awareness that Alaska offers viable, long-term practice opportunities. Without targeted recruitment incentives and infrastructure, rural communities will face widening gaps.	This program stabilizes and grows Alaska’s rural primary care workforce by combining competitive incentive packages with expanded recruitment infrastructure. Providers (MD/DO/PA/NP) will receive signing bonuses and annual retention payments tied to five-year service agreements. A dedicated professional recruiter will manage national outreach, partnerships with Lower-48 residency programs, candidate screening, and placement coordination. Participating facilities must meet HRSA HPSA/MUA criteria and demonstrate sustainability beyond the five-year period. Standardized agreements outline retention expectations, reporting obligations, and eligibility criteria.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Advance to Implementation Application
OrthoAlaska , LLC	Rural Workforce Empowerment & Stabilization Initiative	AK	Rural communities across Alaska face critical staffing shortages that jeopardize access to primary care, diagnostics, triage, and chronic disease management. RWESI establishes a comprehensive "grow-your-own" workforce development system to stabilize staffing and create resilient, multi-skilled rural teams.	RWESI provides four structured workforce pathways: Administrative Excellence, Clinical Support, Diagnostic Imaging, and Nursing Mentorship. It integrates telementoring (ECHO/RTTC), training partners (AAC, UAA, AHEC), retention stipends, SHARP referrals, and simulation-based development. A full-time coordinator oversees implementation and evaluation.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Advance to Implementation Application

OrthoAlaska , LLC	Consolidation and Expansion of Primary Care Services at 4115 Lake Otis Parkway	AK	Current service fragmentation across multiple aging sites leads to fragmented and inadequate access, delays in diagnosis, inefficient care coordination, and reduced capacity to support chronic disease management. Rural patients experience long wait times, limited urgent care availability, and inadequate access to preventive services. Existing facilities do not support integrated care, modern equipment, or team-based workflows.	The project renovates and modernizes the facility at 4115 Lake Otis Parkway—an owned building with completed architectural designs and municipal permits—to house primary care, urgent care, laboratory services, and preventive technology under one roof. Renovations include structural updates, workflow-optimized layouts, ADA accessibility, updated HVAC and electrical systems, and integrated clinical technology. Upon completion, services currently operating at separate sites will be relocated into the consolidated facility. Staff will be trained on integrated team-based care and workflows. VO2 Max metabolic testing capabilities will expand early detection of cardiopulmonary disease. Improved signage will allow for easier location identification for those unfamiliar with the area. Renovation completion: August 2026 Consolidation and staff onboarding: September - October 2026 Facility launch: November 2026	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska- Susitna Borough	Deferred or Not Advanced

OrthoAlaska , LLC	Family Medicine Rural Residency Rotation	AK	Alaska faces a critical shortage of family medicine physicians practicing in rural and frontier communities. Many hospitals rely on temporary locum coverage, creating gaps in continuity, increasing costs, and reducing community trust. A major contributor is the lack of rural exposure during residency training — without immersive rural experiences, most physicians do not consider rural practice viable. At the same time, rural facilities lack the administrative capacity to host residents, coordinate logistics, or offer competitive preceptor compensation. This project solves these gaps by establishing a structured, well-supported rural residency rotation that builds a sustainable pipeline of future rural physicians.	The program will launch a coordinated Family Medicine Rural Residency Rotation model across multiple rural communities. Key components include: 1) Dedicated Residency Coordinator – A full-time coordinator will manage rural site onboarding, ACGME compliance, clinical scheduling, travel coordination, housing logistics, and resident support. 2) Preceptor Payments – Participating rural clinicians will receive competitive stipends (\$1,200–\$2,500 per rotation) to offset productivity losses and ensure high-quality teaching and mentoring. 3) Resident Support – Funding will cover rural housing, travel reimbursement, and rural practice stipends to remove financial barriers and encourage participation. 4) Training & Innovation Infrastructure – Residents will train in advanced primary care models, including chronic disease management, behavioral health integration, population health, and telehealth-supported care. 5) Rural Site Partnerships – Primary partners include the University of Washington Family Medicine Residency Programs, as well as additional partner residencies to be determined. Rural hospital partners will be engaged as training sites. 6) Program Evaluation – The program includes data tracking of retention outcomes, patient visit impact, and community health indicators.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced
OrthoAlaska , LLC	Real-Time DME Eligibility & “Same-or-Similar” Verification for Rural Alaskans	AK	Without IVR or automated vendor tools, clinics cannot verify coverage, leading to delays, increased denials, and risks to patient safety. A dedicated specialist is required to support compliant, accurate, same-day dispensing.	The project funds a full-time DME Verification Specialist to: - Perform real-time Medicare eligibility checks (NMP, HETS, clearinghouse) - Conduct “same or similar” checks - Issue ABNs when needed - Coordinate payer documentation/prior auth - Support rural spoke clinics via remote workflows - Document compliance requirements	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

OrthoAlaska, LLC	Rural Integrated Health Connectivity and Efficiency Platform	AK	The Practice manages approximately 210,000 patient visits annually across multiple specialties and locations throughout Alaska. Documentation requirements, fragmented workflows, and revenue cycle inefficiencies consume staff time and reduce clinical capacity. Administrative tasks such as eligibility verification, prior authorization, and claims management require manual effort, diverting clinicians and staff from patient care. This project will modernize clinical and operational infrastructure through AI-enabled documentation, interoperable electronic health record (EHR) enhancements, and back-office automation. These tools will integrate with Alaska’s statewide health information exchange, healthEconnect, improving care coordination and data sharing. The project could establish scalable infrastructure that could be replicated across Alaskan Accountable Care Organizations (ACOs) and Clinically Integrated Networks (CINs), supporting collaboration statewide. By reducing administrative burden and improving efficiency, the practice will increase provider capacity and expand access to care for rural Alaskans.	The Practice proposes a phased digital transformation initiative designed to strengthen care delivery, improve operational efficiency, enhance patient experience and communication, and expand access to primary care services for rural and remote Alaskans. Over a 12–18 month implementation period, we will deploy technology-enabled improvements that modernize clinical documentation, electronic health record workflows, and back-office operations. We will also introduce integrated Remote Patient and Therapeutic Monitoring (RPM and RTM) to improve patient outcomes. The project will begin with implementation of Ambient AI clinical documentation technology to reduce the time providers spend on manual charting and administrative tasks. By automating clinical note generation and documentation workflows, providers will spend more time with patients and increase care capacity without increasing staffing levels. This step directly supports workforce sustainability and allows clinicians to practice at the top of their license. Following the documentation deployment, we will implement enhanced EHR and back-office capabilities within a siloed division as an initial pilot environment. This phase will focus on implementing RTM and RPM workflows and improving clinical data capture, scheduling, operational workflows, and claims processing efficiency. This will provide an ideal environment for early implementation because it allows us to test and refine workflows before scaling across the broader organization. Once validated, back-office automation will expand across clinical divisions to improve eligibility verification, coding accuracy, claims submission, and payment reconciliation. This expansion will reduce administrative burden, improve billing efficiency, and strengthen the financial sustainability of primary care services. In the final phase, enhanced EHR capabilities will be implemented across remaining clinical divisions to support improved interoperability and care coordination. The system will support integration with Alaska’s statewide health information exchange, healthEconnect, enabling seamless data sharing and coordination with providers across Alaska’s health system. This phased approach allows implementation of proven technology solutions in a structured, scalable way while minimizing disruption to patient care and ensuring measurable improvements in provider capacity, operational efficiency, and rural care access.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Osi Vision LLC	Healthcare Enhancements for Rural Outcomes (HERO) - Service Area (i.e., HERO-Bristol Bay)	TX	Alaska faces multiple challenges and opportunities in effectively serving its rural population. Our project focuses on several of the opportunities related to rural healthcare. The rural population has a high prevalence of chronic conditions with an increased risk of episodic events where the geography and isolation from healthcare resources can add intensity to such events. Maternal health mortality and consistent elderly care are also important concerns. Many rural areas of Alaska face limited access to healthcare providers, and the limitation on resources can also create issues relating to coordination of care. Patient and caregiver education can be challenging in rural areas. Infrastructure inadequacies, whether there is a lack of infrastructure, limited infrastructure, or infrastructure inaccessibility for serving healthcare needs, must be addressed to enable efficient workflows consistently resulting in effective and secure communications in a timely manner. The rural population can benefit from commitment and use of innovation, technology, and artificial intelligence as enablers and facilitators of healthcare services and general well-being. Local workforce growth is needed to support rural areas, and the community needs are not one size fits all. Communities are unique, and solutions need to understand that uniqueness. Rural areas present a variety of challenges around sustainability of quality healthcare services for addressing unpredictable situations and timing.	The demand for healthcare is constant in the rural population of Alaska, and the specific needs of each rural community and culture are unique. The supply of healthcare provider resources is physically limited in many geographies, but resources can be expanded virtually through technology, coordination, and facilitation. However, extended accessibility will only be productive if the community knows and trusts the healthcare resources available to them. A strong facilitator component is critical for the success of each collaborative partnership, especially with respect to project management. Our project focuses on the facilitator team and the project management requirements for planning, implementing, and sustaining effective rural healthcare services that consistently result in improved outcomes. The project manager must understand and be experienced in the nuances of healthcare and be held accountable for planning, coordinating, implementing, monitoring, reporting, and accomplishing the goals and objectives of the project. Osi is uniquely qualified to serve as an effective project manager for a variety of reasons. OsiLIFE is serving rural patient populations through remote monitoring in other states, and we understand the importance of incorporating the project healthcare activities into the providers' workflow to minimize their burden and optimize patient care management. We maintain a patient-centric, case management approach in compassionately serving patient populations, and we are familiar with devices and technology as effective tools. Osi Vision is experienced in working with government customers and brings expertise in cybersecurity standards, protocols, and tools, as well as innovation, technology, and AI. Core to all Osi operations is securely capturing, analyzing, and reporting on data. We will work with the Alaska DOH at both the state and local level to partner with healthcare provider resources. We will also work with the DOH, CHAs, THOs, and their networks to identify and partner with appropriate local partners, which will include healthcare and non-healthcare resources. Logistics and problem solving can be industry agnostic, so it can be beneficial to have perspectives outside of healthcare so that solutions may look at new ways to solve old challenges. Our approach will include enhancing healthcare education, knowledge, and engagement within the communities being served with a specific focus on developing new local career opportunities.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Nome Census Area; Northwest Arctic Borough	Deferred or Not Advanced

Out Patient at Home Physical Therapy LLC	Expansion of Outpatient at home rehabilitation services	AK	Project Overview Many Alaskan communities—especially rural and remote regions—face significant barriers to healthcare access, including: • Geographic isolation and limited transportation • Scarcity of specialty providers such as PT, OT, and SLP • Long wait times for rehabilitative services • Weather dependent travel constraints • Higher rates of chronic disease, injury, and developmental needs A mobile clinic model can bridge these gaps by bringing care directly to patients in their communities or homes, supported by telemedicine for follow up and continuity. Goals of the Expansion 1. Increase access to high quality physical therapy services. 2. Expand service locations to include more cities, villages, and remote hubs. 3. Integrate telemedicine for evaluation, follow up, home exercise program monitoring, and specialty consultations. 4. Add occupational therapy and speech language pathology to offer full rehabilitative care. 5. Improve outcomes for patients with orthopedic, neurological, pediatric, and chronic conditions. 6. Reduce healthcare disparities among rural and underserved populations.	If funding was available to get skilled PT, OT and ST’s into the state via telemedicine or small mobile clinics, access for all communities can improve for specialty care that is currently not being met in the current environment. It is a requirement for governmental insurance to have a referral, even though Alaska is a direct access state. Marketing to physician groups to know that we are available to establish a clinician who then has cycling work available. If you do not have the financial backing to get established in an area, because it takes in each location approximately 6 months to integrate into the community, once established referrals will come. It just is a matter of keeping the PT full. You also need ancillary staff to field calls and go out into the community within services. The most difficulty is incentivizing the healthcare professionals to work.	\$1M-\$5M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Pacific Community of Alaska	Anchorage–Rural NHPI Community Health Worker Network Expansion	AK	Native Hawaiian and Pacific Islander (NHPI) communities served by Pacific Community of Alaska (PCA) experience persistent barriers to primary and behavioral health care, care coordination, and prevention, driven by migration patterns, limited culturally aligned services, and systemic inequities. NHPI families often navigate language, cultural, and insurance barriers while managing chronic conditions, behavioral health needs, and social drivers of health such as housing, employment, and transportation. Local health centers and clinics may have limited capacity to provide sustained, culturally grounded outreach and navigation tailored to NHPI clients’ beliefs, practices, and community structures. Alaska’s geographic isolation increases the need for care coordination while making services harder to deliver. As a result, NHPI families and other underserved communities often experience delayed care, fragmented follow-up, and preventable emergency department visits that contribute to poorer health outcomes. This project seeks to close that gap by extending the Anchorage CHW hub model to Matanuska-Susitna, Juneau, Utqiagvik, Whittier/Girdwood where PCA has relationships or reach, co-designing NHPI-focused CHW-led services with residents, faith leaders, and local partners. By investing in NHPI-centered CHW capacity and regional coordination, we aim to improve access, trust, and continuity of care for NHPI community members while strengthening the broader local health workforce.	We propose a phased expansion of the Anchorage CHW Workforce Hub, led by PCA, to Matanuska-Susitna, Juneau, Utqiagvik, Whittier/Girdwood communities, centering NHPI voices through structured listening sessions, community circles, and faith-based engagement. In partnership with local health centers, clinics, and NHPI community organizations, we will identify priority needs for NHPI residents, clarify gaps in access and navigation, and define CHW roles such as outreach, care coordination, health education, behavioral health navigation, and connection to culturally relevant social and spiritual supports. Using these inputs, we will co-design site-specific implementation plans that reflect each community’s culture, geography, and capacity, including tailored training on NHPI cultural practices, languages, and community norms. The Anchorage CHW hub at Pacific Community of Alaska will serve as a regional backbone, providing training, supervision, mentorship, and quality improvement support to rural CHWs, while leveraging existing infrastructure (including Pear Suite) for data, documentation, and care coordination in ways that are meaningful to NHPI communities. Early activities (months 1–6) will focus on engagement and needs assessment in each community, followed by piloting CHW-led services in at least two sites and detailed implementation planning and sustainability strategy for all four communities within the RHTP funding period. RHTP funds will support CHW planning and engagement time, convenings and listening sessions with NHPI community members, culturally tailored training and supervision, IT/telehealth tools, and limited consultant support for managed care alignment, evaluation, and long-term financial planning.	\$1M-\$5M	Statewide	Anchorage (Municipality); Chugach Census Area; Juneau (City and Borough); Matanuska-Susitna Borough; North Slope Borough	Advance to Implementation Application

Pacific Community of Alaska	Native Hawaiian and Pacific Islander Community Health Worker Workforce Hub in Anchorage, Alaska	AK	Anchorage and surrounding communities face major gaps in primary and behavioral health care, particularly for Native Hawaiian and Pacific Islander (NHPI) communities and other underserved populations. Expanding culturally responsive care coordination can improve access to preventive services, support chronic disease management, and reduce unnecessary emergency visits, strengthening health outcomes for NHPI families, Alaska Native/American Indian and other minority communities throughout Alaska. Community Health Workers (CHWs) play a critical role in bridging health systems and communities by providing outreach, culturally grounded response and health education, care coordination, and social needs screening. For NHPI communities in particular, CHWs who share cultural and linguistic backgrounds build trust, improve health literacy, and help families navigate complex systems of care. Pacific Community of Alaska (PCA) currently employs 4 CHWs who have demonstrated measurable impact on client engagement, care continuity, and community trust. Expanding the team by 2 additional CHWs will allow us to deepen outreach to NHPI and other high-need communities in Anchorage, strengthen partnerships with safety-net providers, and expand culturally responsive care navigation. This project supports RHTP’s Strengthen Workforce initiative by recruiting, training, and retaining CHWs while building sustainable infrastructure for a community-based CHW hub to guide future statewide expansion.	Our approach will strengthen the Anchorage CHW Workforce Hub by expanding a culturally grounded workforce, enhancing infrastructure, and deepening partnerships to better serve NHPI communities and other underserved residents across Anchorage. Workforce Development (Strengthen Workforce Initiative): We will recruit and hire 2 additional CHWs, prioritizing multilingual candidates and individuals with lived experience in NHPI communities. Building on our current team of 4 CHWs, new staff will complete comprehensive training in motivational interviewing, trauma-informed care, care coordination, managed care navigation, and health-related social needs (HRSN) screening with structured onboarding, supervision, and ongoing professional development to ensure quality service delivery and workforce retention. Infrastructure and Technology (Spark Technology and Innovation Initiative): Funding will support essential tools that enable effective CHW work, including laptops and mobile devices for field documentation, secure communication platforms, and data systems to track services and outcomes. Pacific Community of Alaska already partners with Pear Suite, a population health platform recognized by the Alaska Department of Health, which supports real-time care coordination, HRSN tracking, and reporting. Service Delivery and Care Coordination (Health Care Access and Healthy Communities Initiatives): The expanded CHW team will conduct community outreach in neighborhoods with large NHPI populations, provide culturally responsive health education, screen for social needs, connect families to essential supports, assist with chronic disease management and behavioral health navigation, insurance enrollment, and care navigation for NHPI communities Partnership Integration: PCA maintains partnerships with Providence Alaska Medical Center , Envoy Integrated Health, Anchorage Neighborhood Health Center, and the Alaska Department of Health. These collaborations enable CHWs to coordinate care across clinical providers and health plans. Technical Assistance and Implementation: The project will receive targeted support from CHW policy and program experts, including Community Health Synergy, focusing on evaluation, quality improvement, and sustainability planning. The project is ready for immediate launch, with recruitment in Months 1–2, training in Months 2–3, and full service delivery and continuous improvement throughout Months 3–12.	\$250K-\$1M	Statewide	Anchorage (Municipality); Chugach Census Area; Juneau (City and Borough); Matanuska-Susitna Borough; North Slope Borough	Advance to Implementation Application

Pacific Dataport, Inc	Aurora Health Network: Expanding Secure Health Data Exchange for Rural Alaska	AK	Healthcare providers across Alaska face significant barriers exchanging patient information across different electronic health record systems and broadband networks. Rural hospitals, clinics, and tribal health organizations frequently operate independent systems that lack standardized interoperability capabilities, limiting their ability to coordinate care, share records, and support telehealth services. Existing health information transport networks were largely built using older wide-area networking technologies and are often tied to a single telecommunications provider. Participation in these networks may require healthcare organizations to purchase bundled connectivity services, which can restrict participation for providers operating on different broadband infrastructures. The Aurora Health Network represents an opportunity to modernize Alaska’s health information exchange infrastructure by deploying a secure interoperability platform built on Cisco SD-WAN technology. The network will create a secure transport layer that allows healthcare providers to exchange clinical information across different electronic health record platforms while maintaining their existing broadband providers. This project directly supports the Alaska Department of Health’s RHTP Spark Technology Innovation initiative by expanding access to interoperable electronic health record participation and strengthening secure health data exchange across Alaska’s healthcare system.	The Aurora Health Network will establish a secure interoperability framework connecting hospitals, rural health clinics, and healthcare providers to medical records and service providers across Alaska using Cisco SD-WAN technology and encrypted connectivity. Pacific Dataport will collaborate with participating healthcare providers and their internal IT teams to deploy SD-WAN edge devices at hospitals, clinics, and other participating facilities. These devices will create encrypted network overlays that allow healthcare systems using different electronic health record platforms to exchange clinical data securely across multiple broadband providers. The network architecture will follow a zero-trust cybersecurity model, ensuring that all network traffic is authenticated, encrypted, and segmented according to healthcare data protection requirements. Cisco’s SD-WAN platform supports advanced security capabilities including end-to-end encryption, network segmentation for protected health information, centralized policy management, and continuous monitoring of network traffic. A key innovation of the Aurora Health Network is its broadband-provider-neutral design. Unlike legacy health information networks that require healthcare organizations to subscribe to bundled telecommunications services, Aurora will function as a standalone secure transport platform capable of operating over any available broadband infrastructure. This structure reduces barriers to participation and expands opportunities for rural healthcare providers to securely exchange clinical information regardless of their connectivity provider. Through this approach, the Aurora Health Network will create the technical foundation needed for interoperable electronic health records, expanded telehealth services, and improved care coordination across Alaska’s healthcare system.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Pacific Northwest University of Health Sciences	Alaska Rural Service Scholars Program	WA	Alaska faces persistent challenges in ensuring equitable access to medical care across vast geography, extreme weather, and many rural and frontier communities. While the state has increased physician numbers overall, distribution remains uneven, and many rural areas rely on aging physicians nearing retirement. Communities often experience delayed diagnosis, high emergency utilization, avoidable medical travel, and disruptions in continuity due to turnover. Recruitment is costly, retention is difficult, and clinicians without preparation for rural practice or cultural humility often leave early, weakening trust and care coordination—especially in partnerships with tribal health organizations. Alaska’s Rural Health Transformation Program (RHTP) provides a rare opportunity to invest in long-term workforce stability rather than temporary staffing solutions. RHTP prioritizes workforce strengthening, primary and preventive care access close to home, and sustainable rural health infrastructure. A scholarship-for-service physician pipeline directly aligns with this intent. By supporting students committed to rural practice and preparing them through targeted training and placement, Alaska can build a durable workforce tailored to its rural needs. The opportunity is to turn time-limited RHTP resources into lasting physician capacity in communities where access is most fragile.	PNWU proposes a Scholarship-for-Service Physician Pipeline that expands and stabilizes Alaska’s rural physician workforce by aligning scholarship support with required service in underserved communities. Alaska would invest \$10M in scholarships, and PNWU would award up to \$50,000 per year (up to \$200,000 total) to students who commit to practicing in Alaska’s rural/underserved communities for one year per scholarship year received. This proven workforce lever reduces debt, influences specialty and location decisions, and creates predictable service capacity. The program includes six integrated components: 1. Targeted recruitment and selection. Criteria prioritize applicants with rural backgrounds, Alaska ties, interest in primary care or rural generalism, and demonstrated commitment to underserved populations. This increases the likelihood of long-term fit and retention. 2. Rural-focused training pathway. Scholars receive enhanced preparation in broad-scope primary care, emergency stabilization, behavioral health integration, telehealth-enabled team care, and culturally responsive practice with tribal and diverse communities. 3. Alaska clinical partnerships. PNWU coordinates with health systems, tribal organizations, and rural clinics to provide rotations that build early connections, increasing community familiarity and likelihood of return. 4. Service-obligation matching and workforce navigation. Support throughout medical school, residency, and job placement ensures scholars land in communities that match needs and readiness. 5. Retention supports. Mentorship, peer cohorts, CME, and connection to regional networks strengthen satisfaction and reduce turnover—an essential factor in Alaska’s frontier settings. 6. Measurement and improvement. Leading and outcome indicators (applications, awardees, rotations, match alignment, service years, retention, and community impact) ensure accountability and support continuous refinement. This model converts scholarship dollars into long-term, rural-placed physician capacity while advancing RHTP’s goals of access, quality, and sustainable workforce development.	\$250K-\$1M	Statewide	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Pacific Rim Counseling, Inc.	Recovery Gardens	AK	As a provider of substance use and mental health services in Fairbanks, a common community challenge we have observed is the limited availability of recovery-oriented community spaces and activities. More specifically, there is a particular need in our community for recovery-oriented spaces and social opportunities that are independent from specific recovery programs or orientations. Our community would benefit from a space where all people who share the goal of recovery can connect, without being limited by the need to agree on how recovery is achieved or committing to one specific recovery program.	Our agency would like to develop a community style teaching garden. Through this model, we would provide hands-on and supported opportunities to learn about basic gardening skills such as seed starting; plant selection; transplanting; garden planning; spacing and planting for in-ground, raised bed, and container gardens; garden maintenance; and harvesting. In order to achieve this, we would like to provide an agency-maintained teaching-oriented garden, as well as raised garden plots that can be self-managed (with available agency guidance) by participants and alumni. We would also like to be able to provide education on various forms of vegetable and fruit processing, and food preparation techniques and recipes. Our primary focus will be to develop an effective and sustainable approach within our agency first; however, long-term we are hoping to develop a method and program that we can share with other community agencies in the future, and work towards creating a greater community network of sober spaces and community partnerships.	\$50,000- \$250,000	Behavioral health/su bstance use disorder treatment	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced

Palco, Inc.	Family-Directed Maternal Health Community Support Infrastructure Pilot	AR	Alaska faces some of the nation's most severe maternal health challenges. Pregnancy-associated mortality in rural Alaska rose 184% between 2012 and 2021; Alaska Native and American Indian women experience rates of 307 per 100,000 live births, more than five times the rate for white women. Rural Alaskans must travel hundreds of miles to access prenatal care, often temporarily relocating to urban centers away from family and cultural support. After delivery, they return to communities with no postpartum services, no doulas, no lactation consultants, and no navigation support. The result: fragmented care, missed appointments, and preventable adverse outcomes. A severe shortage of community-based maternal health workers compounds these challenges. Even willing providers lack the infrastructure to formalize services or accept payment, while families face food insecurity, housing instability, and unreliable transportation driving poor outcomes far outside any clinic. Alaska's rural and Tribal communities need coordinated, community-rooted infrastructure that wraps around families across the full pregnancy and postpartum continuum, and are flexible, culturally responsive, and administratively sound. That is what Palco's Family-Directed Maternal Health Community Support pilot delivers.	Palco proposes seven integrated components delivering self-directed maternal health support across rural, remote, and frontier Alaska: 1. Enrollment & SDOH/BH Screening: Comprehensive intake using SDOH tools configured for Alaska's rural and Tribal context, identifying barriers across transportation, nutrition, housing, behavioral health, and Medicaid eligibility confirmed; MCO referral tracking initiated. Tools co-adapted with Tribal partners to reflect Alaska Native languages and community norms, not applied off-the-shelf. 2. Self-Directed Care Plan: Navigators develop individualized plans coordinating non-clinical services and goods alongside healthcare within a monthly cap of \$1,000. Families choose qualified local providers; Palco manages compliance and reporting through 12-month postpartum. Plans updated at regular intervals and aligned with Z-code data. Families drive their own care — increasing engagement and long-term outcomes. 3. Closed-Loop Referrals: Palco tracks referrals, conducts follow-ups, and provides appointment reminders. National and local partnerships with Uber, grocery vendors, and community-based organizations create an immediate resource network. Palco closes the loop on every referral so families are never handed a list and left to navigate alone. 4. Workforce & Provider Registry: Statewide registry of doulas, midwives, CHWs, and lactation consultants. Palco manages onboarding, credentialing, payroll, and earned wage access. Local hiring prioritizes Alaska Native candidates. Palco's model does not compete with ANTHC or existing Tribal workforce programs. 5. Data & Z-Code Mapping: Real-time Z-code data tracks social drivers, refines care plans, identifies service gaps, and builds population-level reporting for state and Tribal health policy. All infrastructure is mobile-accessible and offline-capable for frontier environments. 6. Hub-and-Spoke Operations: Regional Tribal health anchors serve as coordination hubs; satellite navigator networks extend reach into frontier and off-road-system communities. Designed to integrate with and amplify existing ANTHC, Southcentral Foundation, and YKHC programs, not duplicate them. 7. Sustainability by Design: From Year 1, Palco maintains a cost-and-outcomes dossier, engages Medicaid and MCO partners on reimbursement pathways, and embeds sustainability into program architecture, so infrastructure persists beyond the grant period.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Fairbanks North Star Borough; Kenai Peninsula Borough; Kodiak Island Borough; Kusilvak Census Area; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Palco, Inc.	NextGen Self-Direction by Palco	AR	Alaska faces significant gaps in access to long-term services and supports, especially for older adults living in rural, remote, and frontier communities. Many seniors experience preventable risks such as falls, food insecurity, poor oral health, and social isolation that can accelerate decline and increase avoidable medical use. Yet many are unable to access Medicaid services due to eligibility limits, geographic barriers, waitlists, or a lack of available providers. Self-direction offers a practical solution by empowering individuals to choose the services and supports that best fit their needs and, when desired, appoint a trusted family member or friend to help manage their care. This model expands capacity rather than duplicating services. It allows participants to hire caregivers directly from their own village or town, strengthening the local workforce. Participants may also purchase needed goods and services locally, supporting small businesses and improving safety and independence at home. The opportunity addressed by this project is to establish NextGen Self-Direction by Palco as a flexible, cost-effective option that fills critical gaps for seniors who are ineligible for Medicaid or unable to access traditional services. By aligning with Alaska’s RHT goals, this model extends support beyond Medicaid limits, bridges persistent provider shortages, and creates a sustainable approach tailored to Alaska’s geography, culture, and community priorities.	NextGen Self Direction by Palco offers a practical, scalable approach expanding supports for Alaskans who face provider shortages, long travel distances, and limited access to traditional services. The model empowers individuals to recruit, hire, train, schedule, and supervise their own support staff, reducing reliance on agencies that often cannot sustain a workforce in rural or remote regions. Allowing participants to hire trusted family or community members promotes cultural continuity and strengthens local caregiving networks. Participants can set worker wages within their authorized budgets, enabling competitive pay without increasing administrative costs for the state. This flexibility helps attract and retain workers in areas where standard agency rates may be insufficient. Direct support workers benefit from predictable, participant-directed schedules, improving job satisfaction and reducing turnover. The model is cost-effective. Administrative expenses are typically lower than traditional agency-based models, and participants tend to use services more efficiently when they manage their own support plans. This approach helps stretch limited resources further, particularly in remote regions where travel, overtime, and staffing premiums significantly increase service costs. Most importantly, NextGen Self-Direction improves equity and access. Individuals who previously lacked services due to workforce shortages or geographic isolation can receive reliable, consistent support. Families can remain together, elders can age in place, and local residents can participate directly in caregiving roles that reflect community values. Participants also have access to state-approved Goods & Services that enhance safety, promote independence, and help delay or avoid institutional care. Palco’s infrastructure including streamlined enrollment, compliant payroll and tax management, background checks, budgeting tools, and Navigator support ensures program integrity and simplifies participation for both individuals and the state. These tools allow participants to tailor supports to their unique needs while reducing administrative burden. In geographically and culturally diverse state like Alaska, NextGen Self-Direction is not just an optional service model. It is a strategic, sustainable solution that strengthens the HCBS system, expands capacity in underserved regions, and helps Alaskans remain safely and independently in their homes.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Palliative Care Alaska Network	Palliative and End-of-Life Education for Alaska’s Rural Communities	AK	Rural Alaskan communities often face unique barriers to palliative and end-of-life care, including geographic isolation, limited specialty resources, workforce shortages, and cultural considerations that must be thoughtfully integrated into care. To address these challenges, we propose developing a hybrid education initiative that combines accessible video-based learning with in-person training and community engagement across rural regions.	The project would include the creation of a series of high-quality educational videos designed for multiple audiences, including frontline providers, community health aides, clinicians, caregivers, and community members. Topics would include symptom management, goals-of-care conversations, advance care planning, culturally respectful end-of-life care (transition of life), grief support, and coordination of care in resource-limited settings. The videos would be designed for asynchronous access so that providers and communities in remote locations can engage with the material regardless of schedule or connectivity limitations. In addition to digital learning resources, the project would support both travel to rural communities and travel from rural communities to provide in-person education and collaborative training sessions. These visits would include case-based discussions, practical skill-building, and opportunities to engage with local providers and community members. Importantly, these sessions would also allow us to listen and learn from communities to ensure the educational materials reflect local priorities, cultural values, and existing strengths.	Under \$50,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Palmer Pain and Headache, LLC	PPH North-South Access: Expanding Provider Networks in Fairbanks and Palmer	AK	Based on CDC and NIH data, 20.9% of U.S. adults experience chronic pain. The prevalence is disproportionately higher among specific populations and demographics served by our practice. The sheer volume of the "unmet need" becomes clear as a combined population [Mat-Su Borough (117,613) and Fairbanks (95,500)] totals 213,113 Alaskans. Applying federal health benchmarks to this specific demographic illustrates a clinical gap where an estimated 44,540 residents are currently living with chronic pain (defined as pain lasting three months or longer). In the Mat-Su Borough, ~ 24,500 should individuals require pain management services, with nearly 9,500 suffering from high-impact pain that severely restricts their ability to work or complete daily life activities. In Fairbanks , ~ 19,959 residents have chronic pain, including 7,640 individuals with high-impact, debilitating conditions. A combined total of 17,049 Alaskans are currently suffering from high-impact chronic pain. With our limited staff, our practice is one of a few specialized lifeline for a population of over 44,000 potential patients. This underscores our current staffing levels are under-resourced and mathematically incapable of providing timely, quality care for profound medical needs of Alaskans with high-impact pain. Untreated chronic pain can lead to higher risk for substance use disorders, rising rates of anxiety and depression, and economic community impacts due to lost productivity and disability.	Our project is planned to scaling the human capital needed to reach these ~44,500 individuals. Palmer Pain & Headache must expand in order to reach the Alaskans suffering from chronic and high impact pain. Hiring additional providers is not merely a business expansion; it is a critical public health intervention. Increasing our provider count will allow us to transition these thousands of Alaskans from waiting lists to active recovery and healing, reducing the burden on local emergency rooms and improving the quality of life across the state in the boroughs that are served by the clinics.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Pandere Shoes	Rural Mobility and Foot Health Program	AK	Mobility loss among older adults is widely studied, but footwear is rarely tested as a direct intervention. Conditions such as swelling, diabetes, post-surgical recovery, and the use of braces frequently make standard shoes difficult or impossible to wear. Despite how common these problems are, few programs address footwear as a practical mobility solution, and coverage is limited outside of narrow diabetes programs. This gap leaves many elders relying on oversized shoes or slippers that provide little support and can increase fall risk. Yet appropriate footwear may play a critical role in whether someone can walk safely, leave the home, attend medical appointments, and remain active in their community. This project will pilot the use of properly fitted adaptive footwear as a mobility intervention for rural elders. By evaluating whether improved footwear access supports mobility and daily function, the project aims to test a simple, scalable approach to supporting independence for aging populations in rural Alaska.	This project will pilot a Rural Mobility and Foot Health Program serving rural elders who struggle to find footwear due to conditions such as swelling, diabetes, braces, or post-surgical recovery—conditions that can make it harder to walk comfortably and safely. Community clinicians, aides, or partner organizations will help identify participants and gather basic foot measurements and health history using a simple screening process. This information will be reviewed to match participants with available footwear options appropriate for swelling and changing foot volume. Participants will receive properly fitted adaptive footwear delivered directly to their homes. Because footwear can be shipped, the program can reach rural and remote communities without requiring new clinics or specialized infrastructure. The pilot will track participant feedback and basic mobility indicators to evaluate whether access to appropriate footwear improves comfort, walking stability, and the ability to safely leave the home. Findings from the project will help determine whether footwear can serve as a practical mobility intervention for rural elders across Alaska.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Matanuska-Susitna Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Wrangell (City and Borough)	Deferred or Not Advanced

Partners for Progress in Delta, Inc.	Medical Training Facility - Completion	AK	Medical training has been a constant need in our community and others. Four years ago our organization started an expansion project to specifically address this need. Half of the current new expansion is slated for a medical training wing. This will allow people from all over Alaska to have access to specialized training in the medical field at a reduced cost.	Partners for Progress in Delta, Inc has been training people for the workforce for over 20 years. We had outgrown our capacity to add training programs and we addressed that issue by adding an expansion to our current facility. Half the facility is slated for medical training with a hospital grade classroom, locker room with showers, up to date technology and an anatomage table that we currently own.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Partners for Progress in Delta, Inc.	Workforce Development - Expanding Training	AK	Affordable access to training in the Interior is non-existent. For over 20 years our facility has brought affordable training to rural communities (and to the entire state) which has put thousands of workers into the workforce. Over the years we have seen a drastic increase in the need for trained medical professionals. Several years ago we put a plan in motion to address this need. Due to this plan of expanding our facility we have been able to bring more courses to our area.	In 2025 we completed a 2500sqft expansion to our current facility. This is allowing us to greatly expand our course offerings. Specifically in medical training with our new medical wing almost at completion. We are currently holding ETT, EMT and Wilderness First Responder courses in the new facility. We hope to get this additional funding to bring even more courses to the Interior.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Path of the Heart, Inc.	Homer Healing House Community Resilience Pilot: A Rural Behavioral Health and Workforce Wellness Hub	AK	Many rural Alaska communities lack accessible spaces where individuals can gather to learn practical skills that support emotional well-being, healthier lifestyles, and long-term resilience. Prevention-focused wellness programming that addresses stress, social isolation, and behavioral health risk factors is often limited in rural and frontier communities, particularly outside of traditional clinical environments. As a result, community members and healthcare professionals often have limited access to tools that support emotional regulation, social connection, and healthier coping strategies. The Homer Healing House Rural Wellness Hub will address this gap by creating a community-centered learning and retreat environment in Homer where healthcare professionals, educators, and community members can participate in prevention-focused wellness programs that strengthen resilience and support healthier lifestyles. Alaskans seeking to improve their health through innovative smoking-cessation programming that integrates mindfulness practices, emotion regulation skills, and peer support will be served. By helping participants better understand cravings, stress responses, and behavior change strategies, the program aims to reduce tobacco use and the significant chronic disease comorbidities associated with smoking. Together, these programs will create a welcoming rural space that supports learning, connection, and the development of practical skills to improve health and wellbeing.	The Homer Healing House Rural Wellness Hub will implement a community-centered approach that combines prevention-focused wellness programming, workforce resilience training, and community gathering space within a renovated rural property in Homer, Alaska. The project will transform Homer Healing House into a functional learning and retreat environment where healthcare professionals, educators, and community members can access practical skills that support emotional well-being, healthier lifestyles, and behavioral health resilience. The approach includes three integrated program areas. First, the project will establish community wellness programming through the Alaska Healing Arts Café. This initiative will offer hands-on creative workshops that encourage reflection, social connection, and emotional expression through artistic practices such as journaling, painting, driftwood carving, and other creative mediums. These programs help reduce loneliness and strengthen social protective factors that support mental health. Second, the project will provide resilience and emotional regulation training for healthcare workers, educators, and community members. Workshops and retreats will introduce practical techniques, including Emotional First Aid, mindfulness-based stress reduction, meditation, Tai Chi, Qigong, and other evidence-informed approaches to help individuals manage stress, strengthen emotional regulation, and support trauma-informed environments in healthcare and community settings. Third, the project will pilot an innovative mindfulness-based smoking cessation initiative designed to help participants understand cravings, stress responses, and behavior change through mindfulness practices and peer support. By addressing emotional triggers and stress-related smoking patterns, the program aims to reduce tobacco use and associated chronic disease risks. These programs will be delivered through workshops, retreats, and community gatherings hosted at Homer Healing House and supported by partnerships with regional healthcare organizations, educators, and community groups. The project will begin as a regional pilot serving the Kenai Peninsula and surrounding communities, with the long-term goal of demonstrating a replicable rural wellness hub model that can support prevention-focused health programming across Alaska.	\$250K-\$1M	Private practitioner	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Pathroot Health, Inc.	Alaska ROOT: Rural Outreach & Ongoing Transformation	SC	Rural Alaska communities face persistent challenges related to geographic isolation, limited behavioral health infrastructure, and gaps in continuity of care for individuals and families affected by substance use. While prevention education and harm-reduction efforts increase awareness of overdose and fentanyl poisoning risks and expand access to tools such as naloxone, many communities still lack consistent ways to help individuals remain connected to recovery guidance after initial engagement. Alaska ROOT addresses this challenge by bridging the gap between trusted community outreach and sustained recovery engagement for individuals and families affected by substance use. Through statewide prevention education and outreach led by AK Fentanyl Response Project, communities can identify individuals and families who may benefit from additional recovery guidance. Pathroot provides structured recovery education, peer groups, and family guidance that help participants remain connected to recovery resources between formal treatment interactions. Coordinated by iEXIST, LLC, Alaska ROOT links community outreach, referrals, and recovery engagement into a more coordinated system. This approach helps rural communities strengthen behavioral health access while generating practical insights that can inform broader rural recovery strategies across Alaska.	Alaska ROOT strengthens recovery engagement in rural Alaska by connecting trusted community outreach with structured recovery resources and coordinated implementation. The initiative brings together three complementary partners: AK Fentanyl Response Project, Pathroot, and iEXIST, LLC. AK Fentanyl Response Project will conduct statewide prevention education, overdose and fentanyl poisoning awareness, and naloxone distribution across Alaska communities. Through community events, school presentations, and partnerships with Tribal organizations, local leaders, first responders, and service providers, these efforts expand awareness of overdose risks and strengthen local response capacity. This trusted outreach also helps communities identify individuals and families who may benefit from additional recovery engagement. To strengthen continuity beyond initial outreach, Alaska ROOT will introduce Pathroot’s recovery guidance tools in pilot communities in Anchorage and the Bethel Census Area. Anchorage serves as a key hub for rural and Alaska Native residents traveling for medical and specialty care, making it an important location for strengthening recovery continuity. Pathroot provides recovery education, peer groups, check-ins, and family guidance that help participants stay connected to recovery resources between treatment visits. Because these tools can be accessed remotely, individuals in rural communities can remain engaged even when local services are limited. iEXIST, LLC will coordinate project implementation and partner integration, ensuring outreach activities, referrals, and recovery engagement function as a connected system. Implementation will be guided by local relationships and carried out in collaboration with Tribal organizations and community partners to align with culturally responsive care practices. During the first RHTP implementation period, Alaska ROOT will launch this coordinated model through a focused pilot while maintaining statewide outreach engagement. Lessons from participating communities will help identify practical strategies Alaska can use to strengthen continuity of recovery engagement across rural regions.	\$250K-\$1M	Statewide	Anchorage (Municipality); Bethel Census Area	Deferred or Not Advanced

Patient Focused Telehealth, LLC	Alaska Rural Health Initiative: Improving Village-Based Infection Care and Wound Care with APTT3X	TX	Rural Health Challenge in Alaska Rural Alaska faces significant challenges related to infection management and wound care due to several factors: • Long distances between communities and hospitals • Weather-related transportation delays • High rates of diabetes and chronic wound complications • Occupational and subsistence-related injuries • Limited clinical resources in remote village clinics Healthcare providers in rural Alaska frequently must manage injuries and infections in environments where advanced medical support may be hours or days away. When early infection control is limited, these conditions can escalate and require hospital admission or costly medical evacuation (medevac). In Alaska, a single medevac flight from a remote community to a regional hospital may cost \$25,000–\$100,000 or more, depending on distance and medical needs. These events create financial strain on healthcare systems and significant disruption for patients and families who must leave their communities for treatment. Strengthening early wound management capability at the village level represents a meaningful opportunity to improve patient outcomes and reduce escalation of infections.	Integration with Alaska’s Community-Based Healthcare System Alaska’s healthcare system relies heavily on community-centered care models, particularly through the nationally recognized Community Health Aide/Practitioner (CHA/P) Program, which supports healthcare delivery in more than 170 rural communities. Community Health Aides and rural clinic providers often serve as the first and most critical point of medical care for patients experiencing injuries or infections. Providing these providers with effective tools for early infection control can strengthen the existing rural healthcare infrastructure and support better patient outcomes. Role of Telehealth in Rural Care Telehealth services are widely used across Alaska’s healthcare system to connect village clinics with regional medical providers and specialists. While Patient Focused Tele-Health, LLC does not provide telehealth services within this initiative, telehealth consultation could provide valuable clinical support for rural providers managing complex wound cases. In settings where telehealth access is available, it can complement the use of frontline wound care tools by enabling remote consultation and clinical guidance when needed. Communities Served This initiative is intended to support rural and remote communities across Alaska, including: • Alaska Native Tribal Health organizations • Community Health Aide/Practitioner (CHA/P) clinics • Rural health clinics • Village health programs • Regional tribal healthcare systems These communities represent populations that often face the greatest barriers to timely wound care and infection management. Potential Impact Strengthening infection control capability at the earliest point of care may help: • Improve early management of wounds and infections in remote communities • Reduce progression of infections requiring hospital treatment • Support rural providers managing injuries in resource-limited environments • Improve healing outcomes for patients with acute and chronic wounds • Reduce healthcare costs associated with advanced infection treatment and medical evacuation By equipping rural providers with practical infection management tools, this approach supports a more resilient healthcare system capable of delivering effective care closer to where patients live.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

PATIENTONE INC	Bridging Healthy Beginnings: Strengthening Alaska’s OB/GYN Care Continuum, RPM & Case Management	MT	Problem / Opportunity Statement Alaska faces the most acute healthcare access crisis in the United States. Over 200 communities have no road access, the state has one of the lowest physician-to-patient ratios in the nation, and rural Alaskans are hospitalized for preventable chronic conditions at rates far exceeding the national average. For patients managing hypertension, diabetes, COPD, and musculoskeletal disorders, the gap between clinic visits is not an inconvenience — it is a clinical risk. At the same time, a significant and largely untapped opportunity exists. Federal RPM and RTM reimbursement infrastructure is mature, billable, and designed precisely for this challenge — yet adoption in Alaska's rural, remote, and frontier communities remains critically low due to connectivity barriers, workforce shortages, and lack of implementation support. PatientOne exists to close that gap — delivering continuous, connected, reimbursable care to the communities that need it most.	Proposed Approach: PatientOne RPM/RTM/CCM Platform for Alaska Rural Health Transformation Alaska's rural, remote, and frontier communities face a healthcare access crisis that conventional care models cannot solve. Geography, workforce shortages, and infrastructure gaps leave thousands of Alaskans without continuous clinical oversight — particularly those managing chronic conditions where early intervention is the difference between a care management call and a medevac flight. Device-Agnostic Monitoring: PatientOne integrates with devices patients already own — Dexcom and any CGM, blood pressure cuffs, digital scales, pulse oximeters, and thermometers — eliminating procurement barriers and accelerating enrollment from day one. For patients where device interaction is a barrier, PatientOne offers continuous, contact-free passive monitoring sensors ideal for Alaska Native elder populations. Seamless EHR Integration: Using FHIR-based protocols via PatientOne's native API, Redox, or Big Sky Connect, the platform integrates bidirectionally with any EHR — removing the most common implementation barrier cited by rural providers, including Tribal Health Organizations and IHS facilities. Clinician-Built Protocols: Co-founded by a practicing clinician, PatientOne's platform delivers built-in early intervention protocols for hypertension, diabetes, heart failure, and COPD — fully customizable by each provider organization to reflect their patient population's unique needs and cultural context. Case Management Staffing: PatientOne pairs technology with dedicated RPM Case Managers — one per 150 enrolled patients — who conduct required monthly patient interactions, coordinate SDOH services, manage medication adherence, and serve as the consistent human touchpoint that drives outcomes. Where possible, we recruit locally, including training Community Health Aide/Practitioner (CHAP) program participants as village-level monitoring extenders. Sustainable Reimbursement: From the first enrolled patient, PatientOne generates billable RPM, RTM, and CCM revenue under established CMS CPT codes — ensuring the program outlasts the grant cycle. PatientOne is proven at Community Medical Center, Billings Clinic, and the International Heart Institute. We are ready to bring that infrastructure to Alaska.	\$50,000-\$250,000	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

PeaceHealth Ketchikan Medical Center	Enhancing Rural Access to Comprehensive Primary Care Through Telehealth Innovation in SE Alaska	AK	Rural and island communities in southeast Alaska face continual barriers to timely and continuous primary care. Geographic isolation requiring boat and/or air travel up to 3.5 hours, weather related disruptions, limited provider availability and long wait times make it difficult for residents to access routine, urgent, behavioral health and chronic disease follow-up care. These challenges contribute to avoidable Emergency Department (ED) use, delayed diagnoses, fragmented care, and deepening inequities for underserved populations. In 2024, 2,765 ED visits out of 8,386 were avoidable—more than a quarter of ED visits could have been cared for in primary care. The Galileo partnership will establish a comprehensive 24/7 telehealth primary care “digital medical home” that wraps around existing local clinics. Galileo’s ability to operate effectively in low bandwidth environments through text and phone-based care, combined with its culturally responsive approach and multispecialty clinicians, offers a scalable solution for rural Alaska. This model can expand same day access, stabilize chronic disease management, integrate behavioral health support, reduce unnecessary transfers and emergency visits, and strengthen continuity and coordination of care across Ketchikan and neighboring remote communities. The initiative improves patient outcomes while easing the workload on scarce local clinical staff and enhancing the long-term sustainability of rural health care delivery.	To address the challenges of primary care access, this pilot project implements a comprehensive Tele-Primary Care Expansion in partnership with Galileo, a proven virtual care provider with deep experience serving Medicaid and underserved populations. The initiative establishes a 24/7/365 virtual medical home that wraps around existing local clinics, dramatically expanding health care access while reducing reliance on travel for routine and urgent needs. Galileo’s advanced primary care model integrates urgent care, behavioral health, pediatrics, chronic disease management and multispecialty support, enabling residents to receive high quality, culturally responsive care from their home communities. The project strengthens healthy communities by ensuring residents can access timely care even in low bandwidth environments. Galileo’s platform supports phone based and text based care, making it well suited for remote islands where video connectivity is limited. This inclusive design reduces disparities for individuals with limited digital resources. A core focus is strengthening the local workforce. Virtual clinicians will coordinate closely with local providers, offering documentation, follow up and care transition support that reduces burden on overstretched staff. By stabilizing chronic conditions and managing behavioral health needs upstream, the model helps local teams focus on in person care that requires their expertise. The approach advances pay for value goals by expanding same day access, reducing unnecessary Emergency Department (ED) utilization and improving continuity—key drivers of quality and cost performance. These efficiencies contribute directly to fiscal sustainability for the region’s healthcare system, where limited staffing and high travel related costs strain budgets. Finally, the project sparks technology and innovation by bringing a modern, mobile first virtual care model to some of Alaska’s most isolated communities. This scalable approach creates a durable, equitable and community aligned pathway for delivering comprehensive primary care across southeast Alaska.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Advance to Implementation Application

PeaceHealth Ketchikan Medical Center	Improving Maternal, Fetal and Neonatal Safety with Advanced Monitoring and Teladoc Integration	AK	Rural families in our region face limited access to timely maternal, fetal and neonatal care due to geographic isolation, staffing constraints and the absence of on-site specialists. These challenges increase risks of delayed recognition of pregnancy complications, unnecessary transfers and inconsistent patient monitoring. This project presents an opportunity to implement critical perinatal surveillance, improve early detection of maternal and fetal risk and introduce neonatal Teladoc support—strengthening safety, reducing barriers to specialty care and improving outcomes for rural and remote maternal health patients. There are no nearby hospitals offering a higher level of neonatal or specialty care in the greater Ketchikan region. PeaceHealth Ketchikan Medical Center is the only realistic option for timely maternal care, especially during emergencies or weather disruptions. The hospital and its clinic on Prince of Wales Island provide critical access to care for patients who would otherwise face dangerous delays and significant barriers to care, especially for pregnant patients and newborns. The closest medical centers with Level III and Level IV neonatal services are located in Anchorage (775 miles away) and Seattle (668 air miles away) requiring at least 90 minutes of flight time under ideal conditions. The OBIX Perinatal monitoring system and Teledoc virtual systems will provide necessary tools to significantly improve rural and remote maternal care.	Our approach combines technological innovation with improved clinical workflows to strengthen maternal, fetal and neonatal care across our rural and frontier communities in southeast Alaska. Implement Advanced Perinatal Monitoring We will deploy the OBIX Perinatal Data System with centralized fetal monitoring, automated maternal risk alerts and E-tools for fetal heart rate and uterine activity assessment. This creates real-time visibility for clinicians, supports early identification of complications and standardizes high-reliability perinatal care across locations. Create Streamlined Documentation Full integration with our enterprise EHR reduces documentation burdens, decreases risk of transcription errors and enables a cohesive, team-based approach to maternal and fetal care. These efficiencies help support provider retention by making workloads more manageable. Expand Neonatal Specialty Access with Teladoc Consults Neonatal Teladoc capabilities provide immediate access to certified neonatologists for newborn assessments, stabilization guidance and care decision support. This reduces unnecessary transfers, supports local birth services and ensures infants receive timely specialty care without leaving their community. Leverage Technology to Strengthen Access and Care Remote monitoring, telehealth connectivity and AI-assisted assessment tools extends the reach of clinical maternal health expertise across isolated communities like Prince of Wales and other areas accessible only by boat or small aircraft. These tools support ongoing care needs for chronic disease management and behavioral health follow-up by improving coordination and continuity of care. Support Workforce Recruitment, Retention and High-Reliability Practice Standardized monitoring, clinical alerts and remote specialist support reduce the cognitive load on local teams and enable clinicians to practice at the top of their license. Improved workflows, reduced transfers and real-time expert consultation help rural providers feel supported, improving job satisfaction and retention. Strengthen Rural Health Sustainability By improving early detection of complications, decreasing avoidable transport costs and maintaining local obstetric and newborn services, the project supports long-term sustainability of healthcare delivery in rural and frontier regions. Enhanced care pathways for maternal health contribute to a stronger, more resilient local health system.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Advance to Implementation Application

PeaceHealth Ketchikan Medical Center	Remote Monitoring for High-Risk Patients Across In-Facility, Post-Acute and Community Care	AK	Southeast Alaska’s rural, remote and frontier communities face unique realities: long travel distances, severe weather, workforce constraints and limited ability to keep eyes on a patient between encounters. As a result, patient clinical decline is often detected too late. That pattern contributes to avoidable transfers, Emergency Department visits and hospitalizations that are disruptive for patients and challenging for rural teams already stretched. These challenges provide a critical opportunity to use cloud-based analytics and exception-based workflows to help clinicians monitor larger geographies with a hub-and-spoke model, focusing attention to rising risks rather than relying on episodic check-ins. In facilities, patients can deteriorate between routine checks and care teams may lack consistent ways to identify early risk signals. In the post-acute period, days and weeks after discharge are a high-risk window where gaps in follow-up, limited access to timely reassessment and delayed recognition of worsening trends can drive preventable readmissions. At home, high-risk chronic patients are often without a mechanism to detect early warning signs before problems become crises, especially when specialty care and in-person monitoring are limited. A remote monitoring approach can support early risk detection, timely outreach and escalation pathways that are clinically appropriate and operationally realistic.	We will implement an Alaska-rooted, hub-and-spoke Remote Monitoring Pilot Program designed to support rural, remote and frontier communities across three care settings through a phased rollout with clear operational ownership and delivery capacity. The program will be structured so Alaska-based teams can operate it reliably using cloud-based predictive analytics and scalable exception management that prioritizes attention to patients whose health is deteriorating. This process enables centralized monitoring across large rural geographies with escalation to local care teams as appropriate. Phase I (launch immediately): In-facility monitoring across hospital and Skilled Nursing Facility/Long Term Care setting. We will deploy short-term continuous monitoring for appropriate inpatient and facility-based cohorts to support earlier detection of patient deterioration and more timely clinical response. Initial rollout will start with a defined footprint and cohort and then scale up to full utilization over 6 to 12 months based on staffing capacity and operational readiness. Phase II (staggered start 6–12 months after Phase I): Post acute discharge monitoring and advanced care at home. We will extend monitoring for a defined period after discharge, supported by structured outreach and clear escalation pathways. This reduces avoidable readmissions by enabling timely intervention during a high-risk window when rural follow up is often delayed by distance, weather and workforce constraints. Phase III (staggered start 6 to 12 months after Phase II): Community monitoring for defined high-risk, complex and chronic patient cohorts. We will support longitudinal monitoring for patients with unstable trajectories or frequent exacerbations, enabling earlier identification of worsening trends and more efficient care close to home through exception-based workflows and clear escalation pathways. Full implementation across all settings is planned over three years. Year 1 will focus on launching Phase I for in-facility monitoring, operational quality, establishing hub-and-spoke operating model, and preparing clinical workflows, staffing patterns, and necessary reporting to initiate Phase II on a staggered schedule. This approach aligns with the Rural Health Transformation Program’s intent to strengthen the rural health system over time through sustainable solutions, locally informed care delivery and responsible stewardship of public funds.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Advance to Implementation Application

PeaceHealth Ketchikan Medical Center	Rural Surgical Transformation: Expanding Access and Modernizing Care	AK	Rural and island communities in SE Alaska face persistent barriers to accessing timely, high quality surgical care. Geographic isolation, reliance on boat and air travel, frequent weather disruptions and limited on site specialty services create delays that place patients at greater risk for complications and poorer outcomes. Many residents must travel long distances to urban centers for procedures that could be safely performed locally if modern surgical capabilities were available. This contributes to care inequities, higher costs and significant strain on patients and families. Our surgical infrastructure—lighting, booms, integration systems and specialty tools—is aging and no longer aligns with today’s standards and minimally invasive procedures. Lack of advanced technology limits the region’s ability to recruit and retain skilled surgeons, further restricting local access to essential and emergent care. The opportunity is to integrate the operating room through advanced imaging, robotic assisted surgery, updated urology equipment and remote consultation technology. These upgrades support rural health transformation goals by expanding local access, improving clinical quality, strengthening the workforce and reducing preventable patient travel. With modern tools and capabilities, PeaceHealth Ketchikan Medical Center can provide safer, more effective surgical care and deliver more procedures locally ensuring equitable access for rural, remote and frontier communities.	Improving Ketchikan’s surgical environment to overcome long standing access barriers and transform delivery of specialty care for our remote, rural communities is a top priority. This strategy advances Alaska’s Rural Health Transformation initiatives by improving access, strengthening the workforce, ensuring sustainability and accelerating innovation. 1. Modernize Surgical Infrastructure Replacing aging surgical booms, lighting and overhead equipment with modern Amico systems will improve safety, illumination and infection control. These upgrades ensure a reliable, advanced operating environment for high quality surgical care and aligns with the Health Care Access and Healthy Communities priorities. 2. Implement Advanced OR and Safety Technology The Olympus 4K Ultra High Definition Operating Room Integration System unifies imaging, data, documentation and workflow functions into a single platform. Automated safety features reduce risks of human error, while real time remote consultation capabilities allow specialists outside the region to support local surgical teams. This advances the Spark Technology & Innovation initiative by enabling virtual expertise and improving care quality in a rural setting. 3. Expand Minimally Invasive and Complex Surgical Capabilities The Velys orthopedic robotic assisted system, a da Vinci robotic surgical platform and urology lasers will dramatically expand the types of surgeries locally available, reducing the need for patients to travel long distances for surgery. These investments support Healthy Communities and Pay for Value & Fiscal Sustainability by improving outcomes and reducing costly medical travel. 4. Enhance Patient Safety with Surgical Capable Beds Four new radiographic compatible, surgical capable beds will improve higher acuity patient care and ensure safe positioning, transport, and imaging during procedures. This strengthens patient safety and supports the Healthy Beginnings initiative for maternal and surgical care. 5. Strengthen Workforce Capacity and Recruitment Modern technology and robotic capabilities make Ketchikan a more competitive site for recruiting and retaining skilled surgeons, anesthesiologists, and OR staff—directly supporting the Strengthen Workforce initiative. Our approach creates a surgical program that expands access to high quality care, enhances safety, reduces preventable patient travel and ensures long term sustainability for rural and frontier residents in southeast Alaska.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Advance to Implementation Application

PeaceHealth Ketchikan Medical Center	Advancing Rural Alaska Care Through Infusion Expansion and Technology Upgrades	AK	Rural and island communities in southeast Alaska face persistent barriers to timely and reliable specialty care. Patients who need infusion therapy for oncology, autoimmune conditions, hydration, or chronic disease management often encounter long wait times or must travel by ferry or plane to receive essential, recurring treatments—travel times can total up to 5.5 hours to Anchorage. Weather disruptions, transportation costs and the physical strain of travel frequently delay care, increase the risk of complications and place significant financial and emotional burdens on patients and families. Ketchikan Medical Center’s current infusion capacity and clinical technology are not sufficient to meet rapidly growing patient needs. Restricted space, aging monitoring systems, limited digital infrastructure and gaps in emergency communication tools create vulnerabilities in a rural hospital environment where specialty resources are scarce and rapid response capability is critical. These challenges limit the hospital’s ability to safely manage complex patients locally and adds significant strain to an already stretched rural workforce. The opportunity to double infusion capacity and modernize key clinical technologies to deliver more services close to home, enhance patient safety, reduce preventable travel, and strengthen long-term sustainability of care is critical to expanding access to essential infusion services for rural and remote residents.	Our proposed approach addresses the shortage of local infusion capacity and need for advanced clinical technology through a coordinated, phased strategy designed to expand essential services and strengthen long-term rural health system resilience. PeaceHealth Ketchikan Medical Center’s proposed infusion center expansion project is ready to launch, expenses total approximately \$6,800,000. 1. Expand Infusion Center Capacity We will double the number of infusion chairs from four to eight, reconfigure clinical workspace and improve scheduling efficiency to meet growing demand for oncology, immunotherapy, hydration and chronic disease infusions. This expansion enables more patients—particularly those traveling from Prince of Wales and other island communities—to receive recurring, time-sensitive care close to home. Increased capacity minimizes treatment interruptions due to weather or transportation barriers and improves comfort, safety and continuity of care. 2. Modernize Clinical Monitoring and Technology Infrastructure The project upgrades essential patient monitoring systems, digital workflow tools and communication infrastructure to meet contemporary safety and reliability standards. Advanced monitoring technology supports earlier detection of patient deterioration, improves clinical documentation and strengthens care coordination. Enhanced digital infrastructure increases emergency readiness and reduces avoidable transfers, critical improvements in a rural hospital with limited specialty care backup. 3. Support Rural Care Delivery Through Integration and Workforce Training New systems will be fully integrated into existing clinical workflows with comprehensive training for nurses, physicians and support staff. This approach ensures smooth adoption and maximizes the effectiveness of new tools. Improved communication pathways between Ketchikan and neighboring rural communities further strengthens coordination, referral processes and continuity of care. 4. Build Long-Term Sustainability and System Resilience By expanding local service availability and reducing reliance on out-of-community travel for essential treatments, the project enhances the stability and sustainability of rural health care delivery. Increased efficiency, reduced emergency transfers and improved chronic disease management support better long-term outcomes and ensure that high quality specialty care remains accessible to geographically isolated Alaskans beyond the grant period.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

PeaceHealth Ketchikan Medical Center	Advancing Technology to Improve Rural Access and Care	AK	Rural and remote communities in the greater Ketchikan region rely on PeaceHealth Ketchikan Medical Center, a small nonprofit hospital with a limited clinical workforce. Due to the small critical access hospital, staffing constraints contribute to delayed response times, gaps in patient monitoring and the need to transfer patients out of the community for care that could be delivered locally with the right technology. This project presents a critical opportunity to strengthen patient safety, expand access and improve care efficiency by implementing advanced clinical tools. An advanced patient monitoring system (\$350K) will enhance real time awareness and reduce response delays. MRI upgrades (\$360K) will expand local diagnostic capability, reducing costly and disruptive off island referrals. Outpatient Teledoc systems (\$30K for two Teledoc systems) in Ketchikan and Craig will increase same day access to primary and specialty care without requiring travel. These improvements will also strengthen our partnership with Ketchikan Indian Community (KIC) by increasing confidence that high quality, technologically supported care can be delivered locally—reducing the need for patients to leave the community and supporting KIC’s goal of keeping care close to home. These technological advancements address workforce limitations while building a more resilient, sustainable rural health system that improves patient outcomes and attracts community partnerships.	To address consistent patient access, quality and workforce challenges in the greater Ketchikan region, this project implements a coordinated modernization of patient monitoring, diagnostic imaging and virtual care infrastructure. Together, these upgrades strengthen clinical responsiveness, expand same day access and reduce reliance on costly out of community patient transfers for rural, remote and frontier residents in southeast Alaska. The approach begins with a comprehensive overhaul of patient monitoring capabilities throughout PeaceHealth Ketchikan Medical Center. The project replaces aging, fragmented systems with 18 Philips MX100 transport monitors and transitions the hospital to the advanced PIC 4 central monitoring platform. Standardized, interoperable equipment ensures every clinical department has dependable, real-time visibility into patient status. MX100 devices enable seamless transitions between bedside and transport monitoring, reducing data loss and improving safety during patient movement. PIC 4 unifies data from bedside, wearable and specialty monitors into a single, accessible platform, strengthening early detection, response times and care coordination. To expand access beyond the hospital walls, the project deploys outpatient Teledoc units in clinics in Ketchikan and Craig. These systems provide virtual primary and specialty care, remote triage and follow up support for residents who face long travel times, limited provider availability and weather-related disruptions. By integrating virtual care into local workflows, the approach reduces delays, supports chronic disease management and ensures patients remain connected to care teams even when in person visits are not feasible. The project also upgrades the hospital’s diagnostic capacity through advanced MRI technologies, including Deep Resolve for accelerated imaging, SEMAC for metal artifact reduction, and FREEZEit for motion robust sequences. These enhancements improve image quality, reduce scan times and allow more complex studies to be performed locally—supporting earlier diagnosis and reducing the need for travel to distant facilities. Collectively, these investments create a more responsive, accessible and sustainable regional health system capable of meeting the needs of Southeast Alaska’s most remote communities.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

PeaceHealth Ketchikan Medical Center	Improving Quality Care and Connection for Long-term Care Patients in Southeast Alaska	AK	New Horizons, located within the PeaceHealth Ketchikan Medical Center (PKMC), faces an urgent need to replace 27 aging long term care beds that no longer meet the comfort, positioning or safety needs of acute rehabilitation, LTC and elder patients living with chronic disease, mobility limitations and cognitive impairments. Outdated beds increase fall and pressure injury risk, safety risks that can contribute to avoidable hospital transfers and place strain on staff—threatening care quality and sustainability in a region with limited healthcare resources. At the same time, residents need more meaningful and culturally relevant engagement than traditional activities can provide, especially individuals who are bed bound or living with dementia. Limited access to enrichment services in rural Alaska further widens this gap. The Obie Interactive Engagement System presents a key opportunity to address this challenge by delivering adaptable, multisensory programming that reduces isolation, supports emotional well-being and encourages gentle movement. Its portability ensures equitable engagement for residents of all mobility levels, including those who cannot join group activities. Together, replacing outdated beds and integrating the Obie Interactive Engagement System addresses critical safety, comfort and engagement needs for medically fragile patients who rely on New Horizons as their regional long term care and acute rehabilitation provider.	New Horizons will address the critical need for updated long term care infrastructure and enriched resident engagement by replacing 27 aging hospital beds with specialized long term care beds and integrating the Obie Interactive Engagement System into daily programming. As the region’s primary long term care provider, New Horizons serves approximately 25 residents whose needs range from elder care to extensive rehabilitation as they recover from complex medical events. These residents and patients rely on New Horizons for high-quality, person-centered support. Existing beds have reached the end of their functional lifespan; replacing them with specialized modern, long term care models will enhance comfort, therapeutic positioning and overall care consistency for those living with chronic disease, cognitive impairment or mobility limitations. The project is structured for rapid completion within four to 6 months of award, ensuring timely improvement in the daily experience of rural residents who depend on remaining close to family and community support. To further strengthen resident well-being, New Horizons will implement the Obie Interactive Engagement System as a core enhancement of its activities program. The system will be incorporated into both group and individual sessions, expanding access to meaningful, multisensory engagement. During group programs, Obie will facilitate cooperative games, memory activities, culturally relevant content and movement-based exercises that foster social connection and reduce isolation. For residents who are bedbound or have limited mobility, Obie’s portability allows staff to provide personalized, room-based engagement tailored to individual abilities, preferences and cultural backgrounds. Activity staff will receive training to use Obie’s diverse therapeutic tools—including motion activated games, cognitive exercises and sensory stimulating activities—ensuring flexible, adaptable programming that meets the holistic needs of Alaska’s elders. Operationally, integrating updated LTC beds and the Obie system strengthens sustainability by improving staff efficiency, reducing setup time and supporting a home like, person centered environment aligned with New Horizons’ mission and statewide elder care priorities.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

PeaceHealth Ketchikan Medical Center	Improving Regional HazMat Preparedness and Decontamination Capability in Rural Southeast Alaska	AK	PKMC must be prepared to independently manage hazardous material exposures due to geographic isolation, severe weather, and limited transport options that often delay transfers to higher level care. Current decontamination resources are insufficient to safely manage chemical, biological or environmental contamination, increasing the risk of staff exposure, contamination of clinical areas and disruption of essential services. The hospital plays a central role in regional emergency response and relies on multiple communication channels—including dedicated two way radios—to maintain real time coordination across clinical units, security, the emergency department and incident command. This system ensures uninterrupted information flow during power outages, storm or system failures, a critical need in a rural environment where external communication can be disrupted. These challenges create a timely opportunity to strengthen emergency readiness. Expanding decontamination capacity while integrating equipment into established communication systems will allow the hospital to manage hazardous events more safely, maintain uninterrupted care and enhance sustainable rural health infrastructure across its remote service area.	Ketchikan Medical Center (PKMC) will implement a comprehensive, ready to launch approach that expands decontamination capacity, strengthens staff readiness and integrates operations into the hospital’s established emergency communication systems. • Purchase nine 3M Versaflo PAPRs, fifteen HazMat suits, a portable decontamination shower and four 300-gallon chemical resistant containment tanks, enabling staff to conduct safe, rapid decontamination without risking exposure or contamination of clinical areas. • Ensure radios support integration with the hospital’s internal emergency response and the 24/7 Level IV trauma center operations. • Configure radios with designated channels for Emergency Department, labor and delivery, security, engineering and Incident Command. • Implement channel priority levels and establish emergency broadcast and lockdown capabilities. • Install charging stations at strategic points to ensure high readiness. • Train all applicable clinical and non clinical staff, including department leaders, charge nurses, security and ED personnel. • Conduct scenario based drills aligned with emergency procedures, such as mass casualty events, hazardous weather disruptions, and internal emergencies. • Validate competency and update standard operating procedures (SOPs) for radio use.	Under \$50,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

PeaceHealth Ketchikan Medical Center	Rural Workforce Resilience & Readiness Pilot Program	AK	Rural critical access hospitals face consistent workforce and safety challenges, including high risk, low frequency clinical events, limited opportunities to maintain competency, fragmented communication systems, and process changes that outpace educator capacity. Small, geographically isolated teams must manage neonatal emergencies, trauma, airway crises, sepsis, and behavioral health events with limited specialty access and constrained training resources—creating gaps in consistency, increasing onboarding demands and straining hospitals working to sustain essential services. This project addresses these challenges by pairing Elemeno’s just in time clinical support platform with high fidelity simulation mannequins. Elemeno provides immediate, evidence-based guidance, micro learning and procedure refreshers at the point of care, helping clinicians stay prepared for low volume, high acuity events. Its hub and spoke model extends standardized maternal, child health, emergency and EMS workflows across regional partners. High-fidelity simulation enables realistic practice of rare but critical scenarios, improving time to intervention, teamwork and readiness. Together, these tools modernize training, reduce reliance on resource intensive education and strengthen rural workforce resilience—offering a scalable, sustainable model to standardize care and improve outcomes across southeast Alaska’s remote communities.	To address gaps in clinical competency, care consistency and workforce sustainability across rural Alaska, PeaceHealth Ketchikan will implement Elemeno Health’s microlearning and communications platform, paired with clinical simulation mannequins. Together, these tools create a continuous learning environment that reinforces skills with hands on practice. Elemeno includes a national library of 40,000+ peer developed job aids, enabling rapid access to clinical guidance. High fidelity simulation mannequins allow rural hospitals with low patient volumes to routinely practice high risk scenarios, reinforcing skills and team coordination so staff remain prepared to deliver safe, expert care when emergencies occur. 1. Rural Workforce & High-Risk Events PeaceHealth Ketchikan will deploy Elemeno learning across L&D, ER, ICU, OR, Med/Surg, and Ambulatory services in Ketchikan and Prince of Wales. Staff will have 24/7 access—on any device—to concise multimedia job aids that translate policies into actionable guidance. Use cases include high risk protocols, behavioral health workflows, rare trauma events, equipment refreshers, onboarding standardization, and skills reinforcement. To strengthen competencies in low volume settings, the project includes purchasing modern simulation mannequins (obstetric, pediatric, trauma, airway). These allow staff to practice high acuity scenarios and reinforce learning through Elemeno micro training, supporting retention and readiness. 2. Regional Hub and Spoke Coordination Ketchikan Medical Center (KMC) will serve as the regional knowledge hub with tailored Elemeno learning sites for community partners. Spoke sites will support referral pathways, “who to call/when” workflows, community resource directories, substance use disorder guidance, youth services navigation, and cross agency care coordination. Anticipated partners include the Ketchikan Wellness Coalition, Ketchikan Indian Community, Residential Youth Care, and treatment providers. 3. Leveraging Elemeno’s Shared Resources Elemeno’s national shared resource network enables rapid implementation, adoption of proven rural and academic workflows, and reduces administrative burden. Over time, KMC will contribute to Alaska specific best practices to support statewide learning. Together, Elemeno and enhanced simulation capacity will provide a scalable system for real time clinical support, hands on skill development and strengthened workforce readiness.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

Pear Suite, Inc.	Launching an Alaska Community Health Worker Provider Network and Managed Services Hub	HI	Community-based organizations and CHWs play a critical role in helping residents navigate healthcare and social services. However, many CHW programs operate outside of traditional healthcare delivery systems and lack the operational infrastructure needed to partner with healthcare providers, tribal health organizations, and health plans. Barriers include limited access to clinical compliance support, billing infrastructure, contracting pathways, and standardized documentation systems. These gaps make it difficult for community-based organizations to sustainably participate in care coordination initiatives or value-based care models, even when their services significantly improve health outcomes in rural communities. Without an entity designed to support CHWs and community-based organizations with the operational infrastructure needed to collaborate with healthcare systems, we won't be able to enable community providers to participate in Medicare and Medicaid reimbursement pathways. Although Alaska does not yet have a Medicaid reimbursement pathway for CHW services, many stakeholders anticipate this evolving. Health plans have also expressed strong interest in contracting with coordinated CHW networks rather than managing individual contracts with multiple organizations or independent CHWs. This project addresses the opportunity to establish the operational backbone needed to support coordinated community-based care statewide.	This project will implement a Community Health Worker Provider Network that enables community-based organizations to participate more effectively in Alaska's healthcare ecosystem through shared operational infrastructure, clinical alignment, and coordinated care workflows. The provider network will operate through Pear Suite Provider Group PC, a friendly PC-MSO entity already established in Alaska to support CHWs and community organizations with the administrative and operational capabilities needed to partner with healthcare providers and health systems. Through this network, participating community-based organizations will gain access to shared infrastructure that supports clinical compliance, documentation standards, billing readiness, and contracting pathways. The model allows CHW programs to maintain their community-based operations while participating in coordinated care initiatives through standardized workflows and shared reporting tools. The network will also integrate referral coordination with statewide resource systems such as FindHelp and Alaska 211, helping CHWs connect residents with services related to housing, transportation, food access, behavioral health, and other social determinants of health. Interoperability planning with the state's Health Information Exchange will help align community-based coordination with broader healthcare data systems. In rural communities with limited provider capacity, CHWs will also be able to connect residents with board-certified primary care providers through telehealth partner Rocket Doctor, expanding access to clinical services when local providers are unavailable. Pear Suite has implemented similar provider network models in other states, where community organizations are able to participate in Medicare and Medicaid reimbursement pathways through shared infrastructure. While Alaska does not yet have a formal Medicaid reimbursement pathway for CHWs, establishing the provider network infrastructure now ensures that community-based organizations will be ready to participate as reimbursement models emerge. Health plans have also expressed interest in contracting with coordinated CHW networks rather than managing contracts with multiple individual providers. The proposed hub provides the governance structure and operational backbone needed to support these partnerships while strengthening coordinated care across Alaska's rural and frontier communities.	\$250K-\$1M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Pear Suite, Inc.	Scaling Alaska’s Community Health Worker Workforce Through Training and Credentialing Infrastructure	HI	Alaska’s rural and frontier healthcare systems increasingly rely on CHWs to support care coordination, address social determinants of health, and help residents navigate healthcare and social service systems. However, the growth of this workforce is limited by the lack of consistent training pathways, accessible credentialing support, and shared infrastructure to support workforce development across geographically dispersed communities. Today, CHW training across Alaska is often delivered through locally developed programs that vary in scope, supervision practices, and documentation standards. While these programs are rooted in strong community expertise, the lack of coordinated training infrastructure makes it difficult to scale workforce development statewide or align training with emerging healthcare system needs. Geographic isolation and limited training capacity further restrict access to workforce development opportunities for rural and frontier communities. As Alaska continues to explore CHW credentialing and expanded care coordination models, there is a growing need for accessible, culturally responsive training pathways that prepare CHWs to work alongside healthcare providers while remaining rooted in their local communities. Without shared infrastructure to support training, credentialing assistance, and workforce development, Alaska risks underutilizing a workforce that could significantly expand access to care across rural and frontier regions.	This project will establish a coordinated Community Health Worker training curriculum and learning management system (LMS), as well as a credentialing assistance “help desk” designed to expand workforce development opportunities across Alaska. The initiative will start with co-developing CHW training curriculum alongside Alaska-based organizations, healthcare providers, and community leaders to ensure the content reflects the cultural, linguistic, and regional realities of Alaska’s communities. The program will combine Pear Suite’s LMS and experience deploying training programs across the country, with curriculum contributions from local subject matter experts, community organizations, and healthcare partners. This infrastructure will allow training to be delivered through hybrid and remote learning pathways, making workforce development accessible to individuals and organizations across rural and frontier regions. In addition to virtual learning, the initiative will support partnerships with community organizations, healthcare systems, and local agencies to provide field-based training opportunities that complement classroom instruction and allow CHWs to gain practical experience working with care teams. Pear Suite will also provide credentialing assistance through a help desk model to support CHWs and community organizations as Alaska develops its statewide credentialing framework. Drawing on experience training over 10,000 CHWs nationwide and working with leading CHW training experts, including the authors of Foundations for Community Health Workers, the project will help Alaska build a scalable and sustainable workforce development system capable of preparing CHWs to support care coordination and improve access to healthcare across the state.	\$250K-\$1M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Pear Suite, Inc.	Integrating Community-Based Care Into Alaska’s Health Information Infrastructure	HI	Across Alaska, healthcare providers, community-based organizations, CHWs, and care navigation programs play essential roles in helping residents access medical care and social services. However, these partners often operate in separate systems with limited shared visibility into referrals, outreach activities, or service completion. Healthcare providers frequently do not know whether patients successfully connect to community services, while CBOs and CHWs often lack access to the information needed to coordinate care effectively. Although Alaska has invested in statewide clinical data infrastructure through its Health Information Exchange (HIE), most existing systems are designed primarily for hospitals and clinical providers. Community-based care providers delivering essential services, such as housing navigation, transportation support, food access, and care navigation, often operate outside of these systems. This project addresses the opportunity to better integrate community-based care coordination into Alaska’s broader health information ecosystem. By connecting healthcare providers, CBOs, and CHWs through shared referral workflows and data exchange aligned with the HIE, the initiative will strengthen collaboration across healthcare and social service systems. This improved connectivity will help rural and frontier residents access coordinated support more efficiently while enabling providers and community partners to better track service delivery and outcomes.	This project will establish a community-integrated care coordination framework that strengthens collaboration between healthcare providers, community-based organizations, CHWs, and Alaska’s statewide health information infrastructure, which could include referral platforms like Find Help. Working in partnership with healthEconnect Alaska, local service providers, and care navigation partners, the project will convene key stakeholders to define shared workflows for referrals, outreach activities, service documentation, and reporting of social needs outcomes. These convenings will help identify how community-based service providers and CHWs can participate more effectively in coordinated care while aligning with Alaska’s existing Health Information Exchange infrastructure. The initiative will support the development of standardized coordination workflows that allow healthcare providers to refer individuals to community services while enabling CBOs and CHWs to document outreach, service delivery, and referral completion. These workflows will create greater visibility into whether individuals successfully connect to services and where additional follow-up may be needed. The project will also explore interoperability pathways that enable community-based service data to align with Alaska’s broader health information ecosystem. Technical partners will provide expertise in designing integration models that allow organizations with varying levels of technical capacity to participate without replacing their existing systems. In addition to infrastructure alignment, the project will include training and technical assistance to support adoption among participating organizations. Community providers, care navigation programs, and healthcare partners will receive support in implementing shared referral workflows, documenting service delivery, and participating in coordinated care models. Through stakeholder engagement, infrastructure alignment, and workforce training, the project will establish a scalable coordination framework that strengthens connectivity between healthcare providers and community-based services. This approach will help rural and frontier communities across Alaska improve access to coordinated care and social services while building a foundation for long-term cross-sector collaboration.	\$50,000-\$250,000	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Peninsula Allergy & Asthma Center LLC	Advancing Rural Allergy and Asthma Care Through Digital Innovation	AK	Communities in rural Alaska face persistent barriers to timely, coordinated healthcare due to geographic isolation, transportation limitations, extreme weather, and unreliable telecommunications infrastructure. These structural challenges directly affect specialty access and chronic disease management, particularly for patients requiring frequent follow-up, medication coordination, and ongoing monitoring. While telehealth can mitigate distance barriers, its effectiveness is limited by inconsistent broadband capacity and outdated communication systems. Within our clinic, an aging phone and internet platform results in dropped calls, limited bandwidth for virtual visits, difficulty transmitting medical records, and fragmented communication between patients and care teams. These infrastructure limitations contribute to delayed care, missed appointments, follow-up gaps, and inefficient coordination across providers. Staff manage a high call volume manually while also spending significant time obtaining and reconciling medical records from multiple care settings. This administrative burden reduces clinical capacity, strains workforce sustainability, and limits our ability to proactively manage chronic disease. Without automated patient engagement tools and interoperable data exchange, opportunities for early intervention, preventive care, and value-based coordination are constrained—ultimately increasing the risk of avoidable emergency department visits and hospitalizations.	Our clinic will implement a phased infrastructure modernization strategy to strengthen rural specialty access, care coordination, and workforce efficiency in alignment with Alaska’s Rural Health Transformation Project (RHTP). First, we will replace our outdated phone platform with a cloud-based, integrated system designed to reduce dropped calls, improve call routing, and streamline scheduling and triage workflows. Enhanced call management tools will allow staff to prioritize urgent clinical needs, reduce hold times, and improve real-time communication between patients and care teams. Second, we will modernize our internal internet network infrastructure. These improvements will stabilize connectivity, support high-quality telehealth visits, and enable faster, secure transmission of medical records. Reliable internet access will expand virtual specialty access for patients in remote areas and reduce disruptions that currently limit telehealth effectiveness. Third, we will implement eClinicalWorks (eCW) Healow Genie to automate and enhance patient engagement. Healow Genie will generate appointment reminders, proactive outreach alerts, and risk stratification reports identifying patients at risk for missed visits or poor medication adherence. The platform will manage routine patient interactions—including appointment scheduling, prescription refill requests, bill payment, referral coordination, and test result access—through AI-supported automation integrated with our phone system. This 24/7 functionality will reduce administrative burden while enabling earlier intervention and improved chronic disease management. Finally, we will integrate with HealthEconnect Alaska, the state-designated Health Information Exchange, to enable secure, interoperable data sharing across care settings. Participation in the HIE will improve referral coordination, reduce duplication of services, and strengthen continuity of care. Collectively, these investments will expand rural specialty access (Health Care Access), support preventive chronic disease management (Healthy Beginnings and Healthy Communities), enhance workforce sustainability through operational efficiencies (Strengthen Workforce), advance interoperable, data-driven care (Spark Technology & Innovation), and promote value-based sustainability by improving coordination and reducing avoidable emergency department utilization (Pay for Value).	Under \$50,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Peninsula Allergy & Asthma Center LLC	Expanding Rural Allergy Clinic Capacity to Improve Access to Advanced Specialty Testing	AK	Inaccurate penicillin allergy labeling affects about 10% of the population, yet more than 95% of these labels are incorrect (Blumenthal et al., 2024). Unverified labels drive use of broad-spectrum antibiotics, increasing costs, toxicity, antimicrobial resistance, longer hospital stays, and risk of MRSA, VRE, and C. difficile infections. Despite these harms, most patients never receive formal evaluation, and rural communities face added barriers, as drug allergy testing and supervised challenges are rarely available outside academic centers. Similarly, inappropriate food allergy diagnosis leads to unnecessary dietary restrictions and avoidable healthcare costs. Without access to oral food challenges (OFCs)—the diagnostic gold standard—patients rely on sensitization testing alone, resulting in overdiagnosis (Greiwe et al., 2020). Barriers to OFCs, including time, space, and staffing constraints, disproportionately affect rural areas and unnecessary food avoidance increases nutritional risk and financial strain, especially for families experiencing food insecurity. Works Cited Blumenthal, K. G., Smith, L. R., Mann, J. T. S., et al. (2024). Reaction risk to direct penicillin challenges: A systematic review and meta-analysis. JAMA Int. Medicine, 184(11), 1374–1383. Greiwe, J., Oppenheimer, J., Bird, J. A., et al. (2020). AAAAI work group report: Trends in oral food challenge practices among allergists in the United States. JACI: In Practice, 8(10), 3348–3355.	To address limited rural access to definitive drug and food allergy evaluation, our clinic will expand clinical space, monitored procedure capacity, and staffing to support comprehensive drug and food allergy evaluation and challenges. This expansion will establish our clinic as a regional specialty hub delivering evidence-based allergy diagnostics locally for rural communities within the Kenai Peninsula Borough. The project includes renovation of space to create dedicated challenge rooms equipped for continuous monitoring and emergency response. Increased procedural capacity will enable timely penicillin allergy evaluation, including risk stratification, direct oral challenge when appropriate, and skin testing when indicated. Removing inaccurate β-lactam allergy labels will allow safe use of first-line antibiotics, reducing antimicrobial resistance, hospital utilization, and unnecessary medication costs. Expanded oral food challenge (OFC) capacity will provide definitive diagnosis of suspected food allergies, particularly in pediatric patients. By increasing monitored challenge appointments and staffing support, we will reduce reliance on sensitization testing alone, prevent unnecessary dietary restrictions, and improve nutritional and psychosocial outcomes. Standardized protocols aligned with national guidelines will ensure safe, high-quality care. To maximize reach, in-person challenge services will be integrated with telehealth screening and follow-up. Patients will complete virtual pre-evaluations to determine eligibility, reducing unnecessary travel. Post-challenge follow-up and education will also be delivered via telehealth when appropriate. The clinic will strengthen referral partnerships with regional primary care providers and hospitals through streamlined pathways for drug delabeling and food allergy evaluation. Provider education will support appropriate referrals and reinforce the benefits of accurate allergy diagnosis.	Under \$50,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Peninsula Allergy & Asthma Center LLC	From Crisis to Prevention: Reducing Emergency Utilization Through Proactive Asthma Specialist Care	AK	Asthma care in rural Alaska is constrained by limited access to in-office pulmonary function testing and the high cost and logistical burden of hospital-based diagnostics, as well as delayed medication access. Many rural clinics lack on-site testing, requiring reliance on symptoms and physical exam findings or referral for costly hospital-based body box testing that involves facility fees and long wait times. These barriers delay diagnosis and severity assessment, increasing the risk of misdiagnosis and inappropriate treatment and contribute to preventable exacerbations, greater systemic corticosteroid use, and higher emergency department visits and hospitalizations (Global Initiative for Asthma, 2025). Medication access challenges further compound the problem. Rural pharmacies often maintain inconsistent stock of controller inhalers and do not carry high-cost biologic therapies. Patients requiring advanced treatment must depend on out-of-state specialty pharmacies, facing prior authorization delays, complex coordination, and extended shipping times vulnerable to weather disruptions. Together, these systemic gaps delay treatment initiation and continuity, undermine disease control, and drive avoidable acute care utilization among patients with severe asthma. Works Cited Global Initiative for Asthma. (2025, November 15). Global strategy for asthma management and prevention: 2025 update [PDF]. https://ginasthma.org/wp-content/uploads/2025/11/GINA-2025-Update-25_11_08-WMS.pdf	Our approach transforms asthma care in the Kenai Peninsula Borough by expanding local capacity, standardizing evidence-based management, and delivering comprehensive care close to home. This project addresses critical gaps in diagnostic access, medication availability, patient education, and advanced therapy access—shifting care from reactive, emergency-driven treatment to proactive chronic disease management. 1. Expand Local Diagnostic Capacity We will obtain a PulmOne MiniBox, a compact pulmonary function testing system that measures lung volumes without requiring a traditional hospital-based body plethysmography “body box.” Conventional body box testing requires costly, space-intensive hospital infrastructure and the enclosed chamber can also be poorly tolerated by children and elderly patients. The MiniBox uses flow-interruption technology to deliver accurate lung volume measurements in an outpatient setting, expanding timely access to advanced pulmonary diagnostics. 2. Standardize Evidence-Based Management All patients will receive individualized asthma action plans and structured education on inhaler technique, trigger avoidance, and self-management. These protocols will be embedded into routine workflows to ensure consistent, guideline-aligned care. 3. Establish In-Clinic Medication Dispensing We will obtain dispensing licensure and develop an in-clinic dispensing program to maintain on-site inventory of essential controller inhalers and coordinate biologic therapy distribution. This will reduce delays caused by inconsistent rural pharmacy stock and out-of-state specialty shipping, improve adherence, and support timely initiation of advanced therapies. 4. Strengthen Workforce Capacity Staff will be trained in pulmonary diagnostics, asthma education, and medication coordination to ensure continuity and high-quality care. 5. Improve Access and Engagement Same-day diagnostics, education, and dispensing will reduce travel burden. Telehealth follow-up and reminder systems will promote continuity, particularly during winter travel disruptions. 6. Monitor Outcomes and Sustainability We will track action plans, medication access, biologic initiation, emergency visits, hospitalizations, and oral steroid use to guide quality improvement and ensure long-term sustainability. This integrated model improves access, enhances quality, reduces emergency utilization, and advances health equity for rural Alaskan communities.	\$50,000-\$250,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Penn Foster Career School	Alaska’s Rural Health Workforce Pipeline: Expanding Accredited, Career Pathways	UT	Alaska faces persistent workforce shortages across primary care, behavioral health, allied health, and support roles. Rural and frontier communities are disproportionately affected due to geographic isolation, recruitment challenges, and limited local training capacity. Strengthening workforce pipelines is essential to achieving RHTP goals related to access, value-based care, and long-term fiscal sustainability.	Penn Foster Group will partner with Alaska-based entities to deliver accredited, competency-based training programs aligned with high-demand health occupations. Proposed offerings include medical assistant, medical billing and coding, pharmacy technician, behavioral health technician, health information technology, and other allied health pathways identified by state and regional partners. Key components: • Online and hybrid training models adaptable to low-bandwidth environments • Employer-aligned curricula mapped to Alaska licensure and certification requirements • Career pathway frameworks supporting entry-level to advanced role progression • Data tracking to measure completion, credential attainment, and employment outcomes • Technical assistance for employers implementing earn-and-learn or apprenticeship models	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Penn Foster College	Strengthening Alaska’s Rural Health Workforce Pipeline: Expanding Accredited, College Pathways	AZ	Alaska faces persistent workforce shortages across primary care, behavioral health, allied health, and support roles. Rural and frontier communities are disproportionately affected due to geographic isolation, recruitment challenges, and limited local training capacity. Strengthening workforce pipelines is essential to achieving RHTP goals related to access, value-based care, and long-term fiscal sustainability.	Penn Foster Group will partner with Alaska-based entities to deliver accredited, competency-based training programs aligned with high-demand health occupations. Proposed offerings include medical assistant, medical billing and coding, pharmacy technician, behavioral health technician, health information technology, and other allied health pathways identified by state and regional partners. Key components: • Online and hybrid training models adaptable to low-bandwidth environments • Employer-aligned curricula mapped to Alaska licensure and certification requirements • Career pathway frameworks supporting entry-level to advanced role progression • Data tracking to measure completion, credential attainment, and employment outcomes • Technical assistance for employers implementing earn-and-learn or apprenticeship models	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

PeopleAK	Community Intelligence & Workforce Platform: Building the Foundation for Rural Alaska Health	AK	Currently, no statewide, community-validated source of health information exists to guide strategic investment, and programs collectively invest hundreds of millions annually in rural health and workforce systems with persistently poor outcomes because investment is reactive, siloed, and often disconnected from community-defined priorities. Community leaders across rural Alaska describe “vendor overload”: an accumulation of disconnected vendor relationships, each with its own intake process, data requests, and reporting requirements layered onto communities whose administrative capacity is already exhausted. The communities most in need of coordinated support bear the greatest burden of fragmentation. The RHTP creates an unprecedented opportunity to build coordination infrastructure that has never existed: a community-validated intelligence platform connecting community voice, program and asset inventories, and grantor-facing analytics in one authoritative system. Phase 1 is a 12-month pilot with one partner community that proves the engagement model, data governance approach, and platform functionality under real rural Alaska conditions, producing a Community-Endorsed Initiative Roadmap and community-owned Capacity Profile that directly govern investment sequencing. Year 2 expands via a small ramp-up cohort using pilot-tested onboarding and consent criteria, ensuring subsequent RHTP investments are guided by what communities have chosen—not what vendors have proposed.	Phase 1 is a 12-month pilot delivered with one partner community to test, validate, and refine a repeatable model for community-led priority setting and a purpose-built intelligent platform that makes resulting data actionable for administering grantors and communities alike. The pilot includes four sequential, overlapping components. Community Listening Sessions (Months 1–3) are facilitated by PeopleAK navigators alongside locally identified community liaisons. Sessions are held in community spaces at community-determined times, accessible via video for remote participants, conducted in plain language, and compensated for community members in advisory roles. Plain-language session summaries are returned to the partner community within 30 days. Concurrent Structured Needs Assessments (Months 2–5), led by a software and platform developer with experience in rural Alaska in coordination with PeopleAK, cover eleven rural health domains aligned to RHTP priorities from workforce stability and Medicaid sustainability to behavioral health capacity and capital infrastructure. The partner community receives a Community Capacity Profile owned by the community and shared with grantors through the platform only with community consent. Community Prioritization Workshops (Months 4–7) translate findings into a Community-Endorsed Initiative Roadmap. This governance-signed action plan becomes the governing document for subsequent program investments. No initiative is scoped for a community without a signed roadmap in place. Replication & Collaboration Mapping (Months 7–10) documents what worked, what must change, and what is required to scale, producing a pilot replication toolkit and identifying opportunities for regional or hub-based collaboration as additional communities join through a small ramp-up cohort. The platform (Months 3–11) is built and tested through the pilot, providing grantors with real-time dashboards, initiative tracking, compliance reporting tools, and investment gap analysis. Community modules include a Profile Portal, a searchable asset directory, and a connection hub. The platform is mobile-first, low-bandwidth compatible, plain language, and bilingual. The Community Health Index, a composite scored profile across 10 evidence-based community health elements weighted by population health contribution, maps community-identified gaps directly to RHTP initiatives to ensure data drives program sequencing.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Perfecting Peds LLC	Comprehensive Medication Management for Alaska's Rural High Risk Pediatrics	DE	Medication-related problems are a silent driver of avoidable pediatric utilization in rural and frontier settings. Children with neurologic disorders, behavioral health comorbidities, asthma, rare genetic conditions, and medical complexity frequently take multiple high-risk medications prescribed by different specialists. In remote communities, prescribers often lack integrated visibility into the full medication regimen. The opportunity is to create a scalable, technology-enabled pediatric medication optimization layer that sits across existing providers, strengthens local care delivery, and reduces preventable emergency department visits and hospitalizations tied to medication issues. This is particularly relevant in Alaska, where transportation to tertiary centers is costly and disruptive, and a single avoidable inpatient event carries significant financial and social impact.	The project will deploy Remote Pediatric Comprehensive Medication Management serving Medicaid beneficiaries ages 0 to 24 in rural and frontier communities. The approach includes: Identification and Stratification High-risk pediatric members are identified through claims analysis, referral, and clinical risk indicators. Children with high utilization, polypharmacy, neurologic or behavioral complexity, and technology dependence are prioritized. Pharmacist-Led Medication Optimization Board-certified pediatric pharmacists perform full medication reconciliation, indication review, therapeutic duplication screening, pharmacokinetic dosing assessment, safety monitoring verification, and deprescribing evaluation. Recommendations are evidence-based and aligned with pediatric clinical pathways. Family-Centered Engagement Each family receives a structured Medication Action Plan that clarifies what the child is taking, why, how to monitor response, and what to do if symptoms change. Education is culturally appropriate and delivered virtually to eliminate travel burden. Provider Integration Medication recommendations are documented and communicated to local primary care and specialty clinicians. The program augments provider capacity rather than operating independently. Ongoing Monitoring Children remain on panel for longitudinal oversight, titration monitoring, side-effect assessment, and rapid response to clinical change. The model is built to integrate within Medicaid payment structures and support long-term adoption following demonstration of cost and quality impact.	\$1M-\$5M	Pharmacy	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Petersburg Medical Center	Alaska Independent CAH Network (AKICN) Shared Medical Office Planning Project	AK	In proposing this project, the AKICN member hospitals are responding to shared problems we face. Our hospitals serve exclusively rural and remote populations with extremely limited or zero peer providers to refer to locally, and each operates in a HRSA-designated Rural Health Professional Shortage Area. As unaffiliated, community-owned hospitals, each contends with outstanding infrastructure and capital needs with no clear funding source; operating from facilities a decade or more past their useful life. PMC and CCMC serve populations with no road access to other providers, while SPH serves communities both on and off the road system. Alaska’s BRFSS data shows a significant intersection between elevated chronic disease burden and other health outcome disparities in rural/remote communities with limited access to routine and specialized services and screenings. When our hospitals struggle to recruit positions or maintain service lines, the cost to rural Alaskans is immediate. The absence of local services forces patients to travel to other regions for care – incurring significant costs for airfare, transport, and lodging on top of procedure costs – or make difficult decisions to delay or forego care. We are also responding to opportunities. Community-owned hospitals cycle critical resources into each of our local economies, through employment and investments in training and professional development as well as our provision of comprehensive healthcare.	Through this immediately actionable project, AKICN will establish an AKICN Shared Medical Office capable of reducing cost inefficiencies and expanding access to clinical care, including by recruiting family medicine and emergency physicians. While our independent status intensifies challenges from rising costs and workforce shortages, it also allows greater responsiveness to emerging health needs and priorities in the communities we serve. The purpose of Critical Access Hospitals is improving rural and remote Americans’ access to healthcare by keeping essential services alive in our communities. With the places we serve hit particularly hard by inflation and cost volatility over the past five years, we are confident in the potential for this planning project to materially strengthen our rural workforce foundation and ultimately contribute to achieving the State’s third RHTP goal. Building the infrastructure needed for the proposed Shared Medical Office to launch a Rural Residency Rotation in the subsequent project year supports bringing early-career physicians to our remote service areas to experience the high quality of life and unparalleled sense of purpose practicing in rural Alaska offers. The Shared Medical Office will enable a range of projects to reduce all AKICN hospitals’ overall costs, enabling a framework for meaningful and consistent identification of resource sharing opportunities. Through the proposed planning project, the AKICN member hospitals will establish the infrastructure, staffing, and budget needs of a Rural Health Network Shared Medical Office. This includes developing data sharing agreements, staffing plans, and a multi-year budget; recruiting qualified applicants for AKICN Medical Director and Residency Coordinator roles to be hired by the final quarter of this project period, in order to launch the Shared Medical Office and Rural Residency Rotation program in a subsequent implementation project. A dedicated Network Director will coordinate project activities, convening AKICN hospital leadership to effectively leverage the potential of this partnership. While PMC will provide grant accounting and reporting, all governance and decision-making are shared. The problems we face are significant, but our opportunity lies in joining forces to confront them head-on to achieve the AKICN members’ vision that community-owned rural hospitals are the sustainable source of comprehensive modern healthcare Alaskan families depend on every day.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Kenai Peninsula Borough; Petersburg Borough	Advance to Implementation Application

Petersburg Medical Center	Petersburg Medical Center Behavioral Health Department Launch Project	AK	Alaska has profound, well-documented unmet behavioral health (BH) needs. DPH estimates that nearly one fifth of Alaskan adults have a depressive disorder; the CDC reports that suicide is the leading cause of death for Alaskan youth and young adults (third nationally). An Alaska Native Epidemiology Center study found that 18% of White people and 28% of Alaska Native people statewide had experienced ACEs in four or more categories, an inflection point for health effects stemming from childhood trauma. Alcohol-related disorders are the leading cause of emergency department visits for Alaskan adults under age 65 – even in 2020 (Vital Records), with a state rate of alcohol-induced death three times the national rate. The Alaska Epidemiologic Profile reported nine of the state’s ten leading causes of death can be associated with substance misuse as a potential contributing cause (DBH) and recent estimates show the annual cost of harms and adverse outcomes related to alcohol misuse was \$2.4 billion. Petersburg Borough is a HRSA-designated Health Professional Shortage Area. In recent years, State BRFSS data has shown our region has an alcohol-related death rate higher than the state average and the highest prevalence of self-reported binge drinking. There is no local inpatient or intensive outpatient SUD treatment and currently no more than four practicing BH professionals of any kind. The need to expand preventative, screening, clinical, and specialty BH care access is undeniable.	In this immediately actionable project, PMC will leverage a decade’s investment in incremental BH expansion to establish a fully operational Behavioral Health Department. In the first RHTP budget period, the proposed project will (1) establish dedicated full-time leadership, (2) recruit an additional clinician whose professional experience complements existing gaps in the continuum of care, (3) expand access to PMC’s current telepsychiatry provider for provider consultation and periodic in-person services, (4) connect primary care providers with relevant BH training onsite, (5) plan a BH internship for new BH providers pursuing licensure to launch in 2027, and (6) work closely with hospital leadership to identify and prioritize new telehealth, hybrid, and onsite service line additions to be added within the following three years. The project is designed to build full spectrum BH access within the only local medical provider for those living in remote communities in and around Petersburg Borough. PMC’s healthcare services are provided through our Joy Janssen Primary Care Clinic, 12 inpatient hospital beds, and 24-hour Emergency Department; a State-licensed Medicare-certified Home Health agency and Long Term Care Unit with a five-star rating from Medicare’s Nursing Home Compare; school-based and outpatient behavioral health; visiting specialties; full-service lab, imaging center with same-day diagnostic testing; on-site licensed drug and pharmacy compounding rooms; and a robust Community Wellness program providing nature-based outdoor childcare and summer camps, community- and school-based suicide and substance use prevention activities, and falls prevention programming for older and disabled residents. PMC also provides our community with overnight observation stays and infusion services, such as chemotherapy, blood transfusions, and monoclonal antibodies, and is soon to open the Borough’s first local MRI services. Each of these service lines is a potential referral point for behavioral health services, once expanded access has been established. Given our region’s seasonally fluctuating population and Southeast residents’ preference for traveling by boat to nearby providers over a flight outside, PMC serves unduplicated individuals far in excess of U.S. Census and Alaska Department of Labor estimates for our Borough’s total population. Service expansion within our hospital system has the potential for outsized impact in our region and the state as a whole.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Petersburg Borough	Advance to Implementation Application

Petersburg Medical Center	Petersburg Medical Center Home & Community-Based Services Expansion Planning Project	AK	Southeast Alaska has one of the nation’s highest populations of older adults and has been among the fastest growing for more than a decade. In 2025 the Department of Labor estimated a quarter of Petersburg Borough’s population was over age 65, with the relative population of 65+ year-old residents projected to remain at or above 25% through at least 2035. The Alaska Commission on Aging reports Alaskan seniors living below the poverty line increased in the last decade. Rapid increases in the availability of specialized Home Health, HCBS, and Long Term Care are needed statewide, but most of all in remote communities like ours, where these services have been closing, consolidating, or struggling to gain a foothold under burdensome and contradictory federal regulations for well over a decade. For our communities, it is essential to meet the needs of this population; to empower older adults to live as long as possible in their own homes, reduce the strain family caregiver faces, and prevent unnecessary or accelerated transfers into higher-cost, institutionalized care far away. It is deeply unjust when rural Alaskans are denied access to the HCBS that can enable continued independent living and end of life care in the communities they chose to spend life in. PMC’s Home Health team is determined to act on the unprecedented opportunity offered by Alaska’s Rural Health Transformation Program and reduce the stark divides between rural and urban access to these essential services.	In this immediately actionable project, PMC will conduct internal, community, and regional planning in preparation for a three-year expansion of vital Home and Community-Based Services (HCBS) by developing necessary infrastructure, equipment, supplies, and CMS service line additions. Capital investment in a wheelchair converted van and purchase of safety supplies/wellbeing activities for those with Alzheimers Disease and Related Dementias (ADRD), combined with coordinated planning by the project team, prepare us to launch the HCBS our region currently lacks, including Transportation, In-Home Services, Respite and more; and enable expansion of PMC’s limited Adult Day Services program. HCBS can prevent people’s institutionalization and sustain local caregivers by establishing supports they have a right to – but currently zero access. The project is led by a team of highly qualified PMC providers, including the Home Health Manager, who will oversee integration of nursing-centered service lines and inpatient respite; Home Health Patient Navigator, to coordinate service line requests to CMS and travel by boat among 12 nearby communities, conducting in-person and remote outreach to identify telehealth and remote monitoring opportunities and priorities; and Quality Improvement Coordinator, who will work with local partners to conduct mobility assessment in the city of Petersburg and support development of referral/billing protocols and risk/liability parameters. Additional staff time supports timely completion of the AI enhancements to the EMR, project data collection and monitoring, and communication about new service lines and opportunities for public comment. Finally, the project invests in a unique position designed to bridge the planned comprehensive HCBS expansion with patients’ lived reality. The Coverage Integrity Navigator will serve patients in Clinic, Emergency, Long Term Care, Home Health, and community settings. Consider a rural resident in their 70s who walked into PMC’s Clinic never having applied for Medicare. It is not enough to point this person to online forms, or even to write off their bill. What they need is someone to sit down with them and listen. To hear the full range of their challenges and walk beside them in accessing coverage, enrolling with a provider, and connecting with food, housing, or transportation supports if needed. The bridge is as needed as the service to prevent needless suffering and emergencies.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Petersburg Borough; Wrangell (City and Borough)	Advance to Implementation Application

Petersburg Medical Center	Petersburg Medical Center Telehealth Integration Program	AK	It’s hard to overstate the impact of telehealth access in communities like ours. Rural Alaskans often go without needed healthcare when it requires lengthy, costly, logistically complicated travel; or delay that travel until a health condition has become more acute and expensive to treat. Access to specialist care in the places we live is vital. Straightforwardly, telehealth saves lives in rural and remote Alaska. Remote access to providers improves outcomes whether experiencing stroke, complications of chronic disease, or behavioral health conditions. It reduces the potential dangers of polypharmacy for patients with complex medication management needs and increases patients’ sense of privacy and willingness to seek care for stigmatized physical or behavioral health conditions in tightknit places. The potential for impact when expanding use of telehealth in rural healthcare is nearly unparalleled. However, the benefits of telehealth can be undermined by multiple factors. The importance of relationship and data exchange between local and remote providers; the cost of launching services that may take 12-18 months to stabilize and self-sustain; the gaps in small hospitals’ existing billing, coding and EMR systems that make long term sustainability impossible if not resolved; the need for building "soft” infrastructure, like referral pathways and community education, without which service uptake will flounder, and more. These are challenges our project strives to address.	In this immediately actionable project, PMC will establish two positions needed to integrate telehealth usage, technological infrastructure, and consistent referral, coding, billing, and patient care practices across all departments. Within the first RHTP budget period, the project will integrate telehealth service line development into our EMR, establish remote service days for primary care and integrative health, and build out new telehealth specialties focused on urology and endocrinology (prioritized due to high prevalence of diabetes morbidity/mortality). PMC’s healthcare services are provided through our Joy Janssen Primary Care Clinic, 12 inpatient hospital beds, and 24-hour Emergency Department; a State-licensed Medicare-certified Home Health agency and Long Term Care Unit with a five-star rating from Medicare’s Nursing Home Compare; school-based and outpatient behavioral health; visiting specialties with out-of-town providers; a full-service lab and imaging center; on-site licensed drug and pharmacy compounding rooms; and a robust Community Wellness program providing suicide and substance use prevention activities, falls prevention programming for older and disabled residents, and nature-based outdoor childcare and summer camps. PMC provides our community with overnight observation stays and infusion services, such as chemotherapy, blood transfusions, and monoclonal antibodies, and is soon to open the Borough’s first local MRI services. Given our region’s seasonally fluctuating population and Southeast residents’ preference for traveling by boat to nearby providers over a flight outside, PMC serves unduplicated individuals far in excess of U.S. Census and Alaska Department of Labor estimates for our Borough’s total population. The project will be implemented by a Telehealth Program Coordinator who will manualize protocols, roles, and referral pathways, deliver provider training and tech uptake, and identify clinically-driven priorities for new service lines. A Telehealth Access Facilitator will schedule with providers and patients, deliver appointment support, and coordinate follow-up care. Other critical roles include remote Nurse Practitioner and Physician care delivery, timely completion of EMR integration, project data collection, and community outreach about new services. The planning team is confident that this planned infrastructure supports rapid parallel planning and service additions, achievable within the 2026 RHTP project period.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Petersburg Borough	Advance to Implementation Application

Petersburg Medical Center	Petersburg Medical Center Maternal Health & Early Childhood Planning Project	AK	It is not possible to describe this problem more clearly than Alaska’s Department of Health did in illustrating it for CMS: “Families living off the road system face provider shortages, long travel distances, and unreliable transportation, often requiring pregnant women to leave their communities and temporarily relocate prior to delivery to access facilities equipped for labor, delivery, and high-risk monitoring, which creates emotional, financial, and logistical strain. After birth, mothers and infants often face isolation and limited support for needs such as lactation, nutrition and pediatric needs.” Like many rural and remote Alaskan communities, those in our Borough face the high costs and increased isolation and stress of having to leave home to give birth. In many of the state’s communities, however, a Tribal Health System provider with hub OBGYN interoperability serves all residents. For those living in and around Petersburg Borough, this context is reversed. The community-owned Critical Access Hospital provides primary, emergency, and other healthcare for all residents, including beneficiaries of the regional Tribal health consortium (SEARHC). While we cherish our role, this context uniquely exacerbates the challenges of reengaging postpartum individuals and their newborns in services. The best way to bridge this is to offer these families value, through services that have an immediate impact on family wellbeing as well as the longterm health of their child.	In this immediately actionable project, PMC’s Primary Care Clinic will launch lactation services and engage the Community Wellness Program in assessing the viability and priorities for a future expansion of clinic-linked, community-based services designed to improve maternal and infant health. There is currently no breast pump rental offered in Petersburg Borough, WIC no longer serves the Southeast region from Juneau, and PMC saw an average of 31 infant patients per year in recent years, so rapid service launch is vital. The plan of action (including budget and staffing needs) generated during this project period will inform further potential service expansion beginning mid-2027. Launch of lactation services will be led by Kellii Wood, RN, CLC, BSN; a Petersburg mother and healthy lactation advocate who has also been a dedicated part of PMC’s Grow-Our-Own pipeline partnership with UAA School of Nursing. Her insight into the challenges new parents encounter in our Borough and commitment to expanding access to the services they need are key to project success. Ms. Wood will oversee the development of charting practices, patient protocols/policies, and program inventory; work with an IT specialist to ensure timely integration into PMC’s Cerner electronic medical record; and partner with the Clinic leadership and PMC Public Relations to deliver patient and provider education. Concurrent with the development and launch of lactation consulting services, Clinic and Community Wellness leadership will assess sustainable opportunities to address prenatal, postpartum, and early childhood health gaps in our service area through community-based services such as home visiting or other structured outreach (diaper pantry, quarterly baby shower, etc.). The State’s RHTP approach embraces Healthy Beginnings and Health Care Access working hand in hand to deliver lifelong health and wellbeing. As sole provider of most healthcare in our service area, and given our region’s seasonally fluctuating population and Southeast residents’ preference for traveling by boat to nearby providers over a flight outside, PMC serves unduplicated individuals far in excess of U.S. Census and Alaska Department of Labor estimates for our Borough’s total population. RHTF investment in the proposed project has the potential for outsized impact in our service area and region as a whole.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Petersburg Borough	Advance to Planning

Petersburg Medical Center	Petersburg Medical Center Critical Medical Equipment & Training Request	AK	PMC’s proposed omnibus capital equipment and training investment directly addresses some of our state’s most significant health disparities for rural Alaskans. Alaska’s BRFSS data demonstrates a significant intersection between elevated chronic disease burden and other health outcome disparities in our rural and remote communities with limited access to routine and specialized services alike. Cancer is Alaska’s leading cause of death, yet fewer Alaskans served by Medicare receive mammogram screenings than the national average. Our Department of Health reports colorectal cancer as the state’s second highest type of cancer death, but nearly a third of Alaskans 50-75 years old do not meet colorectal cancer screening guidelines. Heart disease causes nearly one in five deaths in Alaska and roughly a third of adults in the state have high blood pressure. In each of these high mortality areas, rural families like those we serve face unique challenges accessing the prevention, screening, and monitoring needed to address their risk. Residents of the Southeast region of the state, where PMC is located, have the state’s highest death rate from diabetes. Our Borough also has one of the state’s highest proportions of senior residents, at one in four individuals. In this project, PMC has an unprecedented opportunity to solve gaps across each of these health disparities, transforming access to modern prevention, diagnostic, and treatment technology, within a single funding period.	In this immediately actionable project, PMC will coordinate medical equipment purchases – and related training and EMR integration – across the hospital’s ER, Primary Care Clinic, Imaging, and Laboratory. A detailed line item budget of high-priority needs is ready for the State’s review. Direct project costs include oversight in each department, IT, purchasing, and data collection, with administrative costs usually assessed in an indirect rate covered by PMC. All personnel involved in execution of project objectives have been engaged in planning, budget development, and review. In addition to capital equipment investments, the project establishes three new positions, each sustainable through billing by the end of the project period with no further RHTF request. These include a Nurse Educator to integrate new technology and equipment into workflow; an experienced onsite MRI Technician to implement PMC’s new MRI service line; and an MRI Tech Aide/Registrar anticipated to be a local CNA or Medical Assistant hire trained onsite through this project. The project directly addresses gaps described above by investing in our Borough’s sole provider of nearly all health services. PMC’s services are provided through our Joy Janssen Primary Care Clinic, 12 inpatient hospital beds, and 24-hour Emergency Department; State-licensed Medicare-certified Home Health agency and Long Term Care Unit with a five-star rating from Medicare’s Nursing Home Compare; school-based and outpatient behavioral health; a visiting specialties program coordinating local care with out-of-town providers; full-service lab, imaging center with same-day diagnostic testing, and licensed drug and pharmacy compounding rooms; and a robust Community Wellness program providing suicide and substance use prevention, falls prevention for older and disabled residents, and nature-based outdoor childcare and summer camps. PMC provides overnight observation stays and infusion services, such as chemotherapy, blood transfusions, and monoclonal antibodies, and is opening the area’s first local MRI services. PMC serves unduplicated individuals far in excess of U.S. Census and Alaska Department of Labor estimates for our Borough’s total population. Given our region’s seasonally fluctuating population and Southeast residents’ preference for traveling by boat to nearby providers over a flight outside, RHTF investment in the proposed project will have an outsized impact in our service area and greater region.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Petersburg Borough	Deferred or Not Advanced

Petersburg Medical Center	Petersburg Medical Center Replacement Health Campus Design Project	AK	Rural Alaskans are routinely expected to settle for less access to comprehensive healthcare in the places we actually live, fewer preventative screenings and service types, and lower quality, aging buildings that cost more to maintain and cannot support the tech demands of modern healthcare. The absence of local services often forces rural Alaskans to travel to other regions for healthcare – incurring significant airfare, transport, and lodging expenses on top of procedure costs – or make the impossible decision to delay or forego care based on the financial, caregiving, or other access barriers created by the need to travel. Most rural Alaskans, like those PMC serves, also live in HRSA-designated Health Professional Shortage Areas. Health professionals want to work in modern, well-equipped, functional facilities built to comply with current patient safety regulations and support innovation. Recruitment challenges are made much worse when our facilities are all but held together by duct tape. Alaska’s Critical Access Hospitals sustain access to healthcare by keeping essential services in rural communities. With those very communities hit hardest by inflation and cost volatility, community-owned CAHs like PMC face uphill battles trying to fully fund urgently needed infrastructure and capital improvements. Yet as a provider uniquely governed by and responsive to the people we serve, there is simply no alternative: we will keep working toward a solution on every front possible.	With all local healthcare for Petersburg Borough currently located in a facility past its functional life, the danger of losing full access to local care in this area is imminent. In this immediately actionable project, PMC will engage an architect to rapidly bring designs for both a new hospital and Long Term Care center to 100% completion. Funding will cover the direct costs of developing a community-informed plan for this state-of-the-art, emerging tech-centered health campus, reflecting current and future needs of our service area. The health campus site is shovel-ready (Phase 1) with the first of three health campus buildings completed in 2025. The proposed design project will happen in parallel with PMC’s continued development of the full funding stack required to begin construction, materially improving our ability to qualify for a diversified range of construction funding sources. PMC’s healthcare services are provided through our Joy Janssen Primary Care Clinic, 12 inpatient hospital beds, and 24-hour Emergency Department; State-licensed Medicare-certified Home Health agency and Long Term Care Unit with a five-star rating from Medicare’s Nursing Home Compare; school-based and outpatient behavioral health; visiting specialties program; full-service lab, imaging center with same-day diagnostic testing; on-site licensed drug and pharmacy compounding rooms; and a robust Community Wellness program providing youth suicide and substance use prevention activities, falls prevention programming for older and disabled residents, and nature-based outdoor childcare and summer camps. PMC provides overnight observation stays and infusion services, such as chemotherapy, blood transfusions, and monoclonal antibodies, and is soon to open the Borough’s first local MRI services. Given our region’s seasonally fluctuating population and Southeast residents’ preference for traveling by boat to nearby providers over a flight outside, PMC serves unduplicated individuals in excess of U.S. Census and Alaska Department of Labor estimates for our Borough’s total population. When complete, the PMC Health Campus will comprise a Wellness Center (Phase 2, completed in 2025 on schedule and under budget), expanded Long Term Care with integrated Home Health Services and Youth Programs for an innovative full spectrum model of care (Phase 3), and Hospital with Emergency Department and Primary Care Clinic (Phase 4).	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Petersburg Borough	Deferred or Not Advanced

PGA Solutions	Expanding Access to Creative and Therapeutic Learning in Rural Alaska	AK	Rural Alaska communities face limited access to early childhood education, affecting long-term health, development, and well-being. Our project addresses this gap by providing high-quality preschool programs at our Homer learning center, integrating family engagement, nutrition, and health education. We will train staff, purchase new learning tools for children, and improve facility infrastructure to enhance program quality, support healthy development, and align with RHTP goals of expanding access, quality, and sustainability while advancing CMS priorities for preventive care and community-based health initiatives.	Rural Alaska communities face significant gaps in early childhood education and supportive services, which directly impact long-term health, developmental outcomes, and community well-being. Many families in remote and frontier regions lack access to high-quality preschool programs that integrate health, nutrition, and family support. Girassol Learning Center, based in Homer, Alaska, seeks to address this opportunity by expanding its early childhood education programs to serve more children and families with comprehensive, community-centered support. Our project focuses on strengthening program quality and sustainability through multiple strategies. We will provide specialized training for staff, enhancing their ability to deliver developmentally appropriate curriculum, integrate health and wellness concepts, and respond to the unique needs of rural children. New learning tools and educational materials will be purchased to create interactive, engaging, and culturally responsive classroom environments. We will also improve the facility infrastructure to support a safe, accessible, and stimulating learning environment, including enhancements that promote hygiene, mobility, and flexible learning spaces. These efforts align directly with Alaska RHTP goals, addressing access, quality, and sustainability of health-related services in rural and frontier communities. By embedding health education, family engagement, and preventive care practices into our preschool programming, we are strengthening early childhood outcomes, supporting healthy beginnings, and creating a replicable model for community-based interventions. This approach also supports CMS priorities by integrating preventive care, promoting healthy development, and building local capacity to sustain long-term improvements in health and wellness. Ultimately, our project positions Girassol Learning Center as a hub for early childhood education and wellness, addressing critical gaps in rural Alaska while fostering community resilience, workforce development, and lasting positive impacts on children and families.	\$50,000-\$250,000	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

PGA Solutions	Rural Clinic Technology Integration and Systems Efficiency Initiative	AK	Rural and frontier healthcare providers across Alaska face operational and technology barriers that limit their ability to deliver efficient, coordinated care. Many small clinics operate with limited administrative staff and little access to systems analysts or technical experts who can support implementation and optimization of health information technologies. As a result, clinics often rely on fragmented systems for scheduling, documentation, communication, and patient records, creating inefficiencies that increase administrative burden and reduce time for patient care. These challenges are acute in rural communities where recruiting specialized technical staff is difficult and providers must manage both clinical and operational responsibilities. Without support to evaluate workflows, integrate digital systems, and train staff, rural clinics struggle to fully use electronic health records, telehealth platforms, and other tools designed to improve care coordination. This project will strengthen rural healthcare delivery by providing systems analysis, workflow optimization, technology integration, and staff training for clinics serving remote and frontier communities. These improvements will increase provider capacity, strengthen care coordination, and support sustainable healthcare services in rural communities.	This project will strengthen rural healthcare delivery in Alaska by improving clinic operations, expanding the effective use of digital health technologies, and building workforce capacity in clinics serving remote and frontier communities. The project aligns with the CMS Rural Health Transformation Program’s goals to improve sustainable access to care, strengthen the rural workforce, and advance technology-enabled healthcare delivery across Alaska’s rural health system. The project will begin with operational and workflow assessments at participating clinics to evaluate administrative processes, health information system use, and care coordination practices. These assessments will identify inefficiencies, technology gaps, and opportunities to improve clinical workflows, data sharing, and communication across providers and care settings. Findings will inform tailored improvement plans that reflect each clinic’s staffing capacity, existing infrastructure, and role within Alaska’s regional hub-and-spoke healthcare delivery system. Based on these assessments, the project team will provide targeted technical assistance to optimize digital health tools, including electronic health record systems, telehealth platforms, scheduling systems, and secure provider communication tools. Implementation activities will focus on improving interoperability, strengthening data management practices, and enabling more efficient coordination between rural clinics, regional health hubs, and specialty care providers. The project will also support workforce development by providing training and hands-on technical support for clinic staff. Training will focus on practical use of digital health systems, workflow optimization strategies, and operational practices that allow providers and support staff to work more efficiently in resource-constrained rural environments. By strengthening staff capacity to manage technology-enabled care delivery, the project will help rural clinics sustain improvements beyond the grant period. Through these activities, the project will improve operational efficiency, strengthen care coordination, and expand access to technology-enabled care services in rural communities. By supporting technology adoption, workforce capacity, and coordinated healthcare delivery models, the project will contribute to long-term system transformation and improved health outcomes for rural Alaskans.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

PharmaSmart International LLC	RHTP: Pharmasmart Screening + SDOH + EHR Prevention (Hypertension/Diabetes)	MI	Rural, remote, and frontier communities in Alaska face persistent barriers to timely preventive care—long travel distances, limited workforce capacity, weather-related disruption, and fewer routine touchpoints with primary care. As a result, hypertension and diabetes risk often go undetected or unmanaged until complications occur, increasing avoidable emergency visits, hospitalizations, and long-term costs. This project addresses the opportunity to shift screening and prevention upstream by expanding access to clinically validated BP and metabolic risk screening in convenient community settings, capturing SDOH barriers that affect follow-through, and ensuring results are integrated into the EHR so local care teams can act on findings, coordinate referrals, and support sustained risk reduction over time.	We will implement an EHR-connected, community-based screening and prevention model that brings clinically validated hypertension and diabetes risk screening to rural and frontier settings, while ensuring results translate into follow-up care. Core approach Deploy Pharmasmart screening stations in accessible local sites (community pharmacies where available, village clinics/tribal facilities, regional hubs, local community centers, and mobile outreach events). Standardize screening workflows to capture clinically validated BP, pulse, weight, and BMI (with repeat BP measurement when indicated) plus brief diabetes risk screening and prevention education. Capture SDOH factors at the point of screening (e.g., transportation, food access, housing stability, connectivity, medication affordability) with the ability to be further customized, to identify barriers and route people to appropriate local resources. Integrate results into participating EHRs (or secure reporting pathways where needed) so care teams can review findings, trigger referrals, and document follow-up without manual re-entry. Establish closed-loop follow-up with local clinical partners (telehealth or in-person as appropriate) for elevated BP and diabetes risk, including referral to prevention and management supports. Provide data to enable the tracking outcomes and performance metrics (screening volume, abnormal results, successful follow-ups/referrals, and improvements over time) to guide iteration and support scale. This approach is designed to be practical in low-resource environments, scalable across multiple communities, and focused on converting screening into measurable improvements in prevention and chronic disease control.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Pharos Capital Group	Pharos Capital - Healthcare Impact Investing for Underserved Communities	TX	We will defer to our other pending applications for more detailed descriptions that are individualized to each unique project. Our intent to apply here at the parent level is in effort to provide flexibility and support to our organizations as they navigate the RHT process.	We will defer to our other pending applications for more detailed descriptions that are individualized to each unique project. Our intent to apply here at the parent level is in effort to provide flexibility and support to our organizations as they navigate the RHT process.	\$1M-\$5M	Private practitioner	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Philips North America LLC	PHILIPS partnering with the State of Alaska on improving pregnancy health literacy and outcomes.	DC	Over the past three years in working in other States, we have found that the majority of pregnant women do not use the State-offered website for maternal health but instead, use their phone for research and education. Our app resides on their phone and can be their direct and trusted source for maternal health guidance. Many pregnant women are not aware of preventative steps they should be taking once they become pregnant. Our goal is to ensure the app helps pregnant women become better prepared during their pregnancy, have better awareness of what resources are available, and where to actually go to get those resources. The success we have shown in Michigan, Arkansas, and New York are the best examples of reaching our goal.	We currently have 15% of pregnant women in the State that are users on our app. The app is free and the add downloads to any phone using iOS or Android. Once we enter into a contract with a state department, such as Department of Health, we then prompt the user within the app to confirm their State of residence. The user then receives updated content that expands with additional resources available specifically in their State, in addition to the content already provided to the user. Due to the significant limited number of locations for prenatal care, the app can guide users to the nearest locations based on incorporating state location sites within the app.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Physician Research Institute	Early Alzheimer’s Dementia Detection and Care Pathway Mapping in Rural Alaska	MD	In 2020, ~8,400 Alaskans age 65+ were living with Alzheimer’s (AD), a number projected to double by 2030 and quadruple by 2050. Mortality rates from Alzheimer’s disease have significantly increased over time, with more deprived counties showing a 34% higher mortality rate compared to less deprived areas. Many older adults are at elevated risk of developing mild cognitive impairment (MCI), and already ~12–18% of people age 60+ have MCI. However, outside urban hubs, limited specialty access and advanced diagnostics can delay recognition until functional decline is evident. Because ~45% of dementia cases may be preventable or delayed by addressing modifiable risk factors, Alaska has a major opportunity to shift upstream. MINT-AD uses demographics, routine health history, baseline cognition, and social determinants to stratify individuals into low/medium/high risk of cognitive decline with a 90% accuracy. Opportunity: Costs are substantial; Medicaid spending for Alaskans 65+ with AD/other dementias is ~\$119M, while unpaid caregiving is valued at ~\$887M annually. PRISM moves the front door of dementia prevention into primary care and trusted community settings so higher-risk, cognitively normal adults can be identified and enrolled in structured, evidence-informed lifestyle supports. Even delaying progression by ~2 years for a modest cohort (e.g., ~1,000 Alaskans) could save millions in direct medical and long-term care costs while preserving caregiver and workforce capacity.	This 12-month demonstration and launch is designed to stand on its own by establishing the operational infrastructure needed for long-term impact. If Year 1 targets are met, Alaska can scale PRISM in Years 2–3 using the same implementation playbook. Phase 0 (Months 0–4): PRISM stand-up. We will finalize MOUs/LOIs with two core sites plus one to two additional partner sites; map site workflows; define a minimal dataset; conduct train-the-trainer sessions; complete go-live checklists; and activate consent, data governance, and secure data handling processes. Phase 1 (Months 4–12): Launch + screening ramp. We will embed screening into routine primary care and community touchpoints; deploy outreach and recruitment materials; and operationalize MINT-AD risk tiering to stratify participants into low/medium/high risk with defined referral rules and follow-up pathways. Phase 2 (Months 6–12, in parallel): Intervention start. Once cohorts enroll, participants begin a POINTER-informed multidomain lifestyle pathway designed for ongoing follow-up beyond Year 1 as the program scales. Check-ins occur monthly or every 6–8 weeks, caregiver education/support is activated, and progress tracking uses low-burden engagement (phone/SMS prompts and optional wearable-enabled capture where feasible). Phase 3 (Month 12): Transition planning. We will complete implementation documentation (workflow maps, training materials, governance templates, reporting dashboards) and finalize a sustainability and replication plan for additional rural sites, contingent on Year 2–3 funding.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Pillars of Care Assisted Living, LLC	Fire Sprinklers	AK	Our assisted living home currently lacks automatic fire sprinklers, creating a serious life safety gap for our vulnerable residents—many with mobility limitations or cognitive impairments or developmental disabilities—in a remote rural Alaskan community. This project presents a high-impact opportunity to install life-saving sprinklers, dramatically improving resident safety, ensuring continuity of care, and protecting our essential role in Alaska's limited rural long-term care network.	Our proposed approach is to install a comprehensive automatic fire sprinkler system throughout the entire assisted living home, designed and installed in full compliance with NFPA 13 standards for healthcare occupancies and applicable Alaska building/fire codes. Key steps include conducting a professional fire-protection engineering assessment and hydraulic design to ensure optimal coverage, water supply adequacy, and minimal disruption during installation. The installation will be phased or conducted in sections to maintain resident safety and minimize care interruptions. This process will also involve post-installation acceptance testing, inspection, staff training on system operation and response protocols, and securing permits, inspections, and final certification from the local authorities having jurisdiction.	\$50,000-\$250,000	Home-and community-based services provider	Single Community	Kodiak Island Borough	Deferred or Not Advanced
Pinnacle Integrated Medicine, Inc.	Alaska Provider Network (APN) Rural Health Transformation Coordination Project	AK	1. Strengthen Maternal & Childhood Development (Healthy Beginnings) by Funding Training (Strengthen Workforce) in Lactation Support and Maternal Depression & Childhood Development SCREENINGS. 2. Improve PCP access by investing in rural CNA/CHA/LPNs & IMAGING (Health Care Access). 3. Use RPM/CCM to Increase access to specialized services (Health Care Access), Deploying consumer-facing digital tools (Spark Technology and Innovation) that Evaluates and Pilots emerging health technologies (Spark Technology and Innovation). 4. DEPLOY MOBILE MEDICAL CLINICS (Health Care Access). 5. Strengthen TRIBALLY LED CARE (Health Care Access). 6. CONDUCT PROVIDER GAP ANALYSES (Health Care Access). 7. Integrate analytics across multi-payer health and data systems by Empowering providers' use of EARLY STAGE INTERVENTION AI tools for care delivery (Spark Technology and Innovation). 8. Deliver TA for SUCCESSFUL VBC PARTICIPATION (Pay for Value) to Establish innovative care models to support regional care coordination (Pay for Value). 9. Support VBC and APM INFRASTRUCTURE (Pay for Value) by building infrastructure to support provider participation in VBC (Healthy	1. Screenings: MNA & ACP will provide TA for Lactation Support and Maternal Depression & Childhood Development Screenings. 2. CNA/CHA/LPN & Imaging: MS & MNA will train case managers, supporting home health & hospice (HHH) solutions aided by telemedicine and mobile X-rays. X-Ray, CT imaging, Cyclotron and Nuclear Pharmacy through KMG in Homer and VI in the Valley to keep care local. 3. RPM/CCM: Expanding ECG aligns with CMS's Health Technology and ASTP/ONC criteria for patient-facing apps, one of CMS's top priorities. 4. Deploy mobile medical clinics: Kabo, MVHS and SALA will deploy mobile clinics to patients with no access to care, including discharged homeless. 5. Tribally led care: The Knik Tribe, who will fund buildout, will deploy a multi-specialty clinic for its 10K+ members. 6. Conduct provider gap analyses: APN & HUB have access to statewide data with provider analyses, geo-mapping and analytics core to our service offering. 7. Early-Stage Intervention AI: APN will deploy its Predictive Analytics AI models and ECG devices with real-time EMR Alerts for early acute risk patient intervention. 8. TA for successful VBC participation: APN will help develop State VBC solutions. HUB will support by designing benefits that align incentives. 9. APM Infrastructure: APN will implement HITECH-Cert EHRs as needed to ensure interoperability and build APIs in new and existing EHRs for claim and RPM integration. 10. Establish APMs: MNA & HUB will design and implement DPC benefits, educate employees, and navigate the unique aspects of Alaska's DPC legislation to ensure compliance while maximizing access.	Over \$5M	Other	Statewide	Aleutians East Borough; Anchorage (Municipality); Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area	Advance to Implementation Application

- Communities).
10. ESTABLISH APMs for preventative and chronic disease management (Pay for Value).
11. Integrate and store patient health data in the HIE (Spark Technology and Innovation).
12. Create TELEHEALTH-ENABLED SPECIALTY CARE access programs (Spark Technology and Innovation).
11. HIE: APN will leverage its integration expertise and provide API integrations from provider’s EMRs to the State HIE.
12. Telehealth-enabled specialty care: Troy’s operational telemedicine will expand, working with rural clinics. ACP will guide a cloud-based HIPAA-compliant VoIP UCaaS platform. Data archiving, integrated video, messaging, file sharing, recording, AI-enabled support and higher data fidelity will provide collaboration with patients, enabling mobile and unmanned care models such as dental clinics and health kiosks. MNA will deploy Endocrinology In-Person/Telemedicine clinics with training for dietitians and educators, in partnership with the State of Alaska’s Healthy Start Program, the use of CGM Monitoring, and new VBC/DPC models. Offering enhanced training, structured mentorship, tele-consultation support, and professional development.

Pioneer Peak Farm	HomeCookin Caregiver Nutrition Support Pilot	AK	Family caregivers in Alaska provide essential daily care for individuals living with dementia, developmental disabilities, chronic illness, and age-related conditions. In rural and communities these caregivers often function as an extension of the health care workforce. Despite their critical role, caregivers frequently experience high levels of stress, time constraints, and limited access to convenient, nutritious food options. These pressures can lead to caregiver burnout, declining health for both caregivers and those they care for, and increased reliance on emergency services or institutional care. In Alaska’s remote communities, where workforce shortages and geographic barriers already strain the health system, strengthening caregiver capacity is an important opportunity to support community-based care and improve long-term health outcomes. This project addresses the opportunity to support caregiver wellbeing through a preventive, community-based nutrition support program that provides nutritionally balanced prepared meals to caregiver households. By reducing daily meal preparation burdens and improving access to healthy food, the program aims to help caregivers maintain their health and resilience while continuing to provide essential care at home. The pilot will explore how caregiver-focused nutrition support can serve as a scalable strategy to strengthen community health systems and support sustainable care in Alaska’s rural and frontier communities.	The HomeCookin Caregiver Support Pilot will test a community-based model designed to support family caregivers through improved access to nutritious prepared meals and practical nutrition support. The program will provide weekly distributions of nutritionally balanced prepared meals for caregiver households supporting individuals with dementia, developmental disabilities, chronic illness, or age-related conditions, and other households with special circumstances. Meals will be designed to support overall wellness. By reducing the time and effort required for meal planning, grocery shopping, and food preparation, the program helps relieve daily pressures on caregivers, allowing them to focus more fully on providing care while maintaining their own health and wellbeing. The pilot will initially serve caregiver households in the Matanuska-Susitna Valley, with program design intentionally developed to inform future expansion to additional rural and frontier communities. Meals will be prepared through the existing HomeCookin program infrastructure and distributed through flexible pickup locations and regional delivery partnerships to maximize accessibility. A key component of the project will be workforce development. Culinary arts and nutrition students will participate in menu development, food preparation, and nutritional analysis under program supervision. This provides hands-on training opportunities while helping build a pipeline of professionals interested in community health, food systems, and preventive care initiatives. The pilot will also collect program data and participant feedback to evaluate caregiver participation, satisfaction, and perceived impact on caregiver wellbeing and household food access. These findings will help determine the feasibility and effectiveness of caregiver-focused nutrition support as a scalable strategy to strengthen community-based care. By integrating nutrition access, caregiver support, and workforce development, this pilot will test an innovative approach to improving health system sustainability and supporting families providing essential care across Alaska’s rural and frontier communities.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Pioneer Peak Farm	HomeCookin Postpartum Nutrition Support Pilot	AK	Family caregivers in Alaska’s rural communities often experience significant challenges during the postpartum period. New mothers must recover from childbirth while caring for a newborn, often with limited support systems or having additional children to take of in the home. The postpartum period is a critical window for maternal health. Adequate nutrition, rest, and support can significantly influence recovery, mental health, breastfeeding success, and long-term wellbeing for both mother and infant. However, many families face time constraints, financial pressure, and geographic barriers that make consistent access to healthy meals difficult during this time. This project addresses the opportunity to support maternal recovery and early family health by providing nutritionally balanced prepared meals to postpartum mothers. By reducing the burden of meal preparation and improving access to healthy food, the program aims to support maternal recovery, reduce stress during the postpartum period, and contribute to healthier outcomes for mothers and infants in rural Alaska.	The HomeCookin Postpartum Nutrition Support Pilot will test a community-based approach to supporting maternal recovery by providing nutritionally balanced prepared meals to postpartum households during the critical early weeks following childbirth. Participating mothers will receive weekly distributions of prepared meals designed to support postpartum recovery, energy needs, and overall maternal wellbeing. Meals will focus on nutrient-dense ingredients that support healing, sustained energy, and breastfeeding where applicable. By reducing the time and effort required for meal planning, grocery shopping, and cooking, the program helps families focus on recovery, infant care, and household stability during the postpartum period. The pilot will initially serve families in the Matanuska-Susitna Valley and Eagle River, where existing infrastructure can support meal preparation and distribution. A workforce development component will engage culinary and nutrition students in menu design, food preparation, and nutritional analysis. This provides hands-on training while helping build workforce capacity in community health, nutrition, and preventive care initiatives. Program feedback and participation data will be collected throughout the pilot to evaluate feasibility, participant satisfaction, and potential health and wellbeing benefits for postpartum families.	\$50,000-\$250,000		Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced
Pioneer Peak Orthopedics	Capturing Patient Outcomes	AK	We would like to track outcomes for patients across a series of different treatments and surgeries to see how successful their recovery process is and what leads to a more successful outcome for patients. We have identified 40 areas of service that we would like to track to see what affects patient outcomes during and after treatment. With a diverse population and a population that spans thousands of miles, we are looking to capture the best treatment options for patients who don't always have access to immediate medical care.	We would like to bring a research assistant on board to help develop, manage and quantify patient responses. Our plan is to identify questions pertaining to each treatment we offer and follow the patient for up to 1 year after treatment. Factors we will be looking at will be recovery times, rates of infection, environmental factors, social supports.	Under \$50,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Pioneer Peak Orthopedics	Outreach to remote Practicioners	AK	We would like to travel to to Barrow, Bethel and Nome twice a year to meet with and train Practitioners. We see and service any patient who is transferred from Northern Alaska as Wasilla AK and Fairbanks AK are the closest major hospital systems. Often times, there are simple and effective treatments that can be made to stabilize an Orthopedic injury. We would like to train: Shoulder, hip knee arthroscopy and management following surgery Telehealth optimization for postoperative follow-up Fracture and rotator repair of shoulder Gain an understanding of perioperative management for those from remote areas (as in how long they need to stay, when they need to return and what imaging can be done).	Identify practitioners that treat orthopedic injuries in each community. Set up clinics to meet and educate providers. We would train on a particular topic per visit. We would also help to establish clinic needs in order to effectively treat, stabilize and provide follow-up care for orthopedics injuries. The goal is to establish relationships that make it easier for remote Alaskan's to receive care so there is a direct line of communication between their community Provider and the Specialist.	Under \$50,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Matanuska-Susitna Borough	Deferred or Not Advanced
Planned Parenthood Great Northwest Hawaii Alaska Indiana Kentucky	Expanding Telehealth Access and Patient Navigation for Rural Alaskans	WA	Rural and remote communities in Alaska face significant barriers to accessing timely health care. Geographic isolation, limited local provider capacity, travel complexities, and weather-related disruptions often make it difficult for patients to obtain essential preventive and reproductive health services. These barriers have led to reduced utilization of preventive and basic sexual and reproductive health care, such as STI testing and treatment, birth spacing and pre-pregnancy health optimization, cervical cancer screening, and other preventive health services. In addition, there is often limited coordination to support patients who need to travel for in-person evaluation or treatment when telehealth alone is not sufficient. At the same time, there is a strong opportunity to expand access through improved telehealth infrastructure, better care coordination, and partnerships with trusted community organizations. We have seen significant development of at home testing and hybrid healthcare providing more opportunity than ever to reach patients that have been historically marginalized from traditional healthcare services. This project aims to address established gaps by capitalizing on evolving technology paired with formal wrap around and navigation services rooted in deep trust and connections to community.	Our approach focuses on expanding telehealth access, strengthening patient navigation, and building partnerships with community-based organizations to improve access to care for rural and remote Alaskans. First, we will invest in telehealth infrastructure, including hardware, software, EMR integration, and dedicated telehealth clinicians. This will allow patients in rural communities to access services such as STI screening and treatment, birth control counseling and prescribing, pregnancy testing and counseling, cervical cancer screening coordination, and preventive reproductive health services without needing to travel long distances. Second, we will develop a rural patient navigation and case management program. Nurses and care coordinators will support patients who require in-person evaluation or treatment at our Anchorage or Fairbanks health centers by helping coordinate appointments, travel logistics, and follow-up care. This will ensure continuity of care and reduce delays for patients who need higher levels of care. Finally, we will strengthen relationships with local healers, community health organizations, and other trusted partners to ensure care models are culturally responsive and community-informed. These partnerships will help keep as much care as possible within local communities while ensuring patients can access additional services when needed.	\$1M-\$5M	Clinic	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough)	Deferred or Not Advanced

Plus Eightys Remain In Alaska (PERA)	Treasure Our Oldest Alaskans, Keep Them Healthy, And Keep them Here (TKK)	AK	In the past Alaska was a young person’s game. People hunted the land, made their money, and then left for warmer climates or closer connection with family. But that has changed: In 2010 there were 1,240 people in the FNSB out of 97,581 (12.7%) 80 or older; by 2025 that had risen to 2,332 people 80+ out of 97,803 (24%). (2010 and 2025 Alaska Population Overview, Alaska Department of Labor and Workforce Development). The trend for coming years is for the elder population to continue to grow. Problem As this group expands in population so does the need to address their physical and mental health needs. At older ages, health is shaped not only by physical and social environments but also by the stressors related to ageing. Exposure to adversity, significant loss in intrinsic capacity, a decline in functional ability, and a reduced sense of purpose after retirement lend themselves to psychological distress. Social isolation and loneliness, too, which affect about a quarter of older people, are key risk factors for mental health conditions in later life. (Data from WHO Commission on Social Connection. Geneva: World Health Organization; 2025.) Opportunity In our interactions we find many seniors retain a keen curiosity. On-going curiosity presents an opportunity to craft experiences that keep the mind seeking and engaged, making days filled with discovery and meaning and leading to improved and sustained mental health for our oldest urban and rural residents .	People who do the same thing day after day tend to atrophy, with severe consequences to mental and physical health like depression, anxiety, and anger. (Research summary at https://news.columbia.edu/news/why-being-bored-can-be-hazardous-your-health) Our approach is to maintain and enhance the mental health of senior community residents (+80s) through sustained and intensive travel experiences. Travel can be a profound practice in mindfulness, offering moments of mental clarity that are hard to achieve in the state of drift and idleness often found in older people. We purposefully want our seniors to waking up in a different place, where the sights, sounds, and even the air feels unfamiliar. This shift from the norm will be incredibly refreshing for the mind. It disrupts the automatic pilot mode that many senior seniors are on, leading them to become more aware and present. Moreover, a change of scenery can provide the mental distance needed to relax and recharge, giving the mind a break from the constant barrage of thoughts and worries that come with aging. In this way, travel serves as a mental reset. It offers a chance to break free from the constraints of routine, allowing seniors to return home with a refreshed perspective, renewed energy and a positive mental outlook. The experiences gained while traveling often stay with them, providing a lasting sense of rejuvenation long after the trip has ended. The results of quantitative studies showed that travel improves the physical and mental health of the elderly. Scores for cognitive function, daily activities, and vitality are higher among elderly travelers compared to non-travelers. Additionally, the quality of life and well-being scores of elderly travelers were significantly higher compared to those who did not travel and travel experiences for the elderly are often associated with better life satisfaction, a sense of peace, and purpose in life. (The Role of Travel in Enhancing Domains of Health for Seniors: A Review. At: https://pmc.ncbi.nlm.nih.gov/articles/PMC12309315/) Transformative Potential for Health Care: TKK does not structurally transform rural health care delivery. Instead, it proposes to implement a novel practice with evidence-based benefits within the health care system. TKK’s project workproduct – the template for this practice - is intended for use beyond the Plus Eighties Remain in Alaska (PERA) organization and to be integrated into other projects.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Nome Census Area; Northwest Arctic Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

PNC IT	PNC AI – Alaska Statewide Rural Healthcare Intelligence Platform	AK	Healthcare providers across Alaska face growing workforce shortages and increasing demand for care. Workforce projections estimate the state will need more than 9,400 new healthcare workers annually to meet future demand, while rural communities already experience limited provider availability and geographic barriers to care. Administrative documentation, patient intake, and care coordination consume significant provider time. National studies estimate physicians spend nearly two hours on administrative work for every hour of direct patient care, contributing to clinician burnout and limiting the number of patients providers can serve. At the same time, rural healthcare systems remain far behind in adopting technologies that could improve efficiency. A 2025 survey of 972 rural healthcare leaders found only 8% of rural community and critical access hospitals use AI-driven analytics, compared with 65% of hospitals nationwide. This project addresses that gap by establishing the PNC AI Rural Healthcare Intelligence Platform, designed to become Alaska’s first statewide HIPAA-compliant artificial intelligence infrastructure for healthcare providers. The platform will provide secure tenant-isolated environments with strong data governance and compliance controls, allowing rural clinics, tribal health organizations, and healthcare systems across Alaska to adopt AI tools safely while improving efficiency, expanding provider capacity, and strengthening healthcare access statewide.	PNC IT will develop and deploy the PNC AI Rural Healthcare Intelligence Platform, a secure artificial intelligence infrastructure designed specifically for healthcare environments. The platform will provide a centralized AI environment that integrates with existing healthcare technology systems while maintaining strict privacy, security, and compliance protections. Initial deployment will occur with pilot partners including Upstream Family Medicine, Aurora Maternal Fetal Medicine, and the Ninilchik Traditional Council, allowing workflows to be tested and refined within real-world rural healthcare environments. Lessons learned during the pilot phase will inform broader expansion to additional healthcare providers across Alaska. Key components of the project include: HIPAA-Compliant AI Infrastructure PNC IT will deploy secure cloud-based infrastructure designed to host healthcare-compliant AI models capable of supporting clinical workflows while protecting patient data and maintaining strict HIPAA compliance. AI Clinical Workflow Tools The platform will support AI-assisted documentation, patient intake automation, telehealth workflow support, and administrative process automation. These tools will reduce provider documentation time, streamline operations, and allow clinicians to focus more time on patient care while maintaining human oversight. Integration with Healthcare Systems PNC IT will integrate the AI platform with commonly used healthcare systems including electronic medical records and telehealth platforms used by participating healthcare organizations. Security and Compliance Framework The platform will include strong security controls such as HIPAA-compliant data handling, secure authentication, role-based access control, and audit logging to ensure responsible and secure AI use. Training and Workforce Enablement Healthcare staff will receive training on safe and effective AI use in clinical environments. Training will emphasize data privacy, human oversight, and appropriate clinical application. Through this approach, rural healthcare providers across Alaska will be able to safely adopt emerging AI technologies without needing to independently build complex infrastructure, expanding care capacity while strengthening long-term healthcare system sustainability. The platform is designed to scale across Alaska, allowing additional rural clinics, tribal health organizations, and healthcare systems to join over time.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Denali Borough; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; North Slope Borough; Northwest Arctic Borough; Sitka (City and Borough); Wrangell (City and Borough)	Deferred or Not Advanced

Polaris Transitional and Extended Care	Alaska Long Term Care Value Based Incentive Program	AK	Rural and frontier health care providers operate in an increasingly fragile environment. At the same time, these facilities serve patients with complex medical needs who rely on local care options following hospitalization or when long-term services are required. When rural providers struggle financially or experience quality challenges, communities risk losing critical access to care close to home. Currently, there are limited mechanisms within existing reimbursement structures to directly incentivize and support measurable quality improvement in rural post-acute settings. Providers are expected to improve outcomes such as reducing avoidable hospital readmissions, strengthening care transitions, and improving patient experience, yet they often lack the financial flexibility needed to invest in staff development, quality infrastructure, and care coordination efforts that drive these improvements. This project presents an opportunity to align financial incentives with measurable quality outcomes. By introducing a targeted quality-based incentive program, rural providers will be rewarded for achieving defined performance benchmarks that improve patient outcomes and strengthen care delivery. This approach supports providers in making meaningful quality improvements while helping stabilize essential health services in rural and frontier communities.	The proposed project will implement a Quality-Based Incentive Program designed to improve care outcomes while strengthening the long-term sustainability of rural and frontier health care providers. The program will establish a structured framework that rewards measurable quality improvements without altering the existing Medicaid reimbursement methodology. The first phase of the project will focus on a small trial of this program at two local facilities in Anchorage. Polaris Transitional and Extended Care and Centennial Post Acute. During this phase, participating providers and clinical leaders will collaborate on identified quality metrics that reflect meaningful improvements in patient outcomes and care delivery. Priority measures will focus on areas such as reducing avoidable hospital readmissions through the improvement in identified quality metrics. These measures will be selected based on their relevance to rural providers, the ability to measure performance consistently, and their potential to improve patient experience and clinical outcomes. Incentive payments will be distributed based on the achievement of defined performance benchmarks or demonstrated improvement from baseline. This structure ensures that providers at different starting points can participate meaningfully while maintaining a strong focus on measurable quality outcomes. Finally, the project will include ongoing monitoring and evaluation to assess program effectiveness and identify opportunities for refinement. Data collected throughout the program will inform adjustments to the incentive structure and quality measures over time. The intent is to demonstrate a scalable and sustainable model that the state can continue to support beyond the initial grant period. Through this structured approach, the program will align financial incentives with improved care delivery while supporting the stability of rural health care providers and preserving access to essential services in remote communities.	\$1M-\$5M	Other	Statewide	Anchorage (Municipality)	Deferred or Not Advanced

Preeclampsia Foundation	Alaska Safe Mothers Blood Pressure Program	FL	Preeclampsia is a deadly condition of pregnancy; rates are rising. Preeclampsia rose 19% from 2014-2018 (Source:https://www.bcbs.com/media/pdf/HOA-Trends-Pregnancy-Childbirth_2020.pdf) and gestational hypertension and preeclampsia now affect 1 in 7 hospital births in the U.S (https://archive.cdc.gov/www_cdc_gov/media/releases/2022/p0428-pregnancy-hypertension.html?utm_source=chatgpt.com). It is also an expensive burden, costing 3x more to treat a patient with preeclampsia than one without, and impacting the U.S. healthcare system by over \$2B annually (Source: https://pubmed.ncbi.nlm.nih.gov/28708975/). In Alaska, hypertension in pregnancy affects 14.5% of births compared to 10.4% nationally (https://health.alaska.gov/media/wrbjik3l/2024-alaska-vital-statistics-annual-report.pdf. p29). Well-established clinical risk factors for preeclampsia such as obesity, diabetes, and chronic hypertension disproportionately affect non-Hispanic Black, American Indian or Alaskan Native, and Hispanic populations (https://www.ajog.org/article/S0002-9378(20)30769-9/fulltext). Many rural counties are “maternity care deserts,” without obstetric services, leaving pregnant patients reliant on remote services without specialized staff. Rural women with preeclampsia experience higher rates of severe maternal morbidity, emergency C-sections, and infant complications, and are less likely to receive postpartum follow-up for blood pressure monitoring (https://pmc.ncbi.nlm.nih.gov/articles/PMC5135522/).	Our approach is a strong community-led solution designed for rural and frontier Alaskans: “Alaska Safe Mothers Blood Pressure Program.” The Preeclampsia Foundation’s Cuff Kit Program is a proven solution marrying a pregnancy-validated blood pressure device with patient education materials that are evidence-based to get women's attention and promote understanding of preeclampsia. More than 70,000 kits have been distributed across the United States and Canada since 2020. The Journey Pregnancy is an AI-driven remote patient monitoring smartphone app and companion provider dashboard developed by Eimage Solutions Technology. Continual monitoring is the key to successfully identifying hypertension and preeclampsia before it becomes acute, and this technology is robust and unique in its ability to do so. The app is the first of its kind to inform patients in real time of their risk for preeclampsia through a proprietary "Preeclampsia Score," a wellness score developed with National Science Foundation support intended to educate patients about preeclampsia and initiate conversations with their care team, serving as more accessible tool to anticipate preeclampsia risk than blood tests and biomarker tools. The app also provides: personal virtual doula Aria, kick and contraction counters, health tips, connectivity to wearable devices, article repositories, and more. As a collaborative team, we will follow processes already in place through similar successful projects funded by the National Science Foundation, HHS, Black Ambition, and the State of Arizona. Our process includes: •Patient recruitment in collaboration with Golden Heart Community Midwifery and other clinical partners. •Patients will enter their blood pressure, heart rate, mood, pregnancy symptoms, and other health information in The Journey Pregnancy App; AI-driven insights will provide support to monitor risks for preeclampsia. •Care teams can follow the patients' vitals in real time on the provider dashboard, if they choose. •Patients will be guided to do digital check-ins on the app with The Journey Pregnancy’s personal virtual doula, Aria •Clear instructions for patients are provided regarding what to do if their readings are abnormal.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Premera Blue Cross	Statewide Access to Virtual Advanced Primary Care for Rural Alaskans	WA	Alaskan residents, especially those living off the road system, face persistent barriers to accessing timely, high-quality primary care – particularly in communities where workforce shortages, geographic isolation, and limited specialty access create significant barriers to timely care. As of 2025, various think tanks estimate Alaska’s shortage of primary care physicians to be between 170 and 350 (Robert Graham Center; HRSA). In addition, national survey data indicates that over 40% of Alaska adults report barriers to receiving timely primary care, including long wait times, travel distance, and provider availability (Commonwealth Fund). Premera Blue Cross Blue Shield of Alaska is uniquely positioned to address this challenge. Serving Alaska since 1952, Premera covers nearly 150,000 Alaskans, contracts with more than 80% of provider groups statewide, and has invested extensively in rural workforce development, behavioral health infrastructure, and community provider capacity. Aligned with Alaska Rural Health Transformation Program priorities, this project proposes a scalable statewide solution which expands access to advanced, integrated primary care by leveraging Premera’s Kinwell clinical infrastructure and virtual first care model designed to reach rural and off-road communities across Alaska.	To address Alaska’s persistent primary care access challenges, Premera proposes expanding access to advanced primary care by deploying Kinwell Advanced Primary Care through a scalable, virtual first care delivery model. This approach is designed to overcome provider shortages, geographic isolation, and access disparities—particularly for rural, remote, and off road communities. Kinwell delivers advanced primary care that integrates comprehensive medical services, behavioral health, care coordination, and population health management into a single clinical model. Through this project, Premera will extend Kinwell’s established clinical infrastructure to Alaska, enabling residents statewide to access high quality primary care through telehealth. Kinwell currently operates a statewide virtual clinician model in Washington, with a dedicated team experienced in delivering virtual care for patients who face geographic and transportation barriers to improve access, continuity, and outcomes—experience that will be directly applied in Alaska. The project will focus on three implementation activities. First, Premera will complete licensure, credentialing, and operational readiness activities required for Kinwell providers to deliver care in Alaska. This includes establishing telehealth infrastructure, integrating care coordination, regulatory compliance, and enabling participation in Medicaid and Medicare programs. Second, Kinwell’s virtual clinics will begin providing statewide primary care services, offering same-day and next-day appointments. Kinwell operates independently of any specialty or tertiary care organizations, allowing it to focus on whole-person primary care and guide patients to high-value follow-up care when needed. A distinguishing feature of the Kinwell model is its use of integrated digital clinical tools including PicassoMD, for real time specialist “curbside consults” and fully virtual Shared Medical Appointments to support effective management of chronic conditions. Third, Premera will leverage its population health analytics infrastructure to identify high-risk patients, proactively manage chronic disease, and coordinate care across providers. This approach is designed to complement and extend existing Alaska provider capacity by functioning as a scalable virtual hub that expands access, strengthens care coordination, and supports long-term system sustainability.	\$1M-\$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Presbyterian Hospitality House	Complex Care Program	AK	Presbyterian Hospitality House (PHH) is prepared to fill the gap in Alaska’s continuum of care for complex care residential homes. With co-occurring behavioral health, medical, and other problems, this population is at extreme risk of out-of-state placement, inappropriate and/or frequent change of placements, and hospitalization. Medical conditions that require specialized care and staffing ratios prevent these individuals from accessing residential treatment programs, while co-occurring behavioral health problems prevent their use of assisted living or skilled nursing facilities. Working in conjunction with the State of Alaska, Presbyterian Hospitality House (PHH) is prepared to serve these youth in a family-style, home environment where youth receive round-the-clock care and support from a multi-disciplinary team capable of addressing the medical, behavioral, and other conditions that affect these youth.	For 38 years, PHH has provided high quality residential treatment in a family-style, homelike setting – augmenting this foundation will guide the approach to delivering high quality, complex care residential services. This service is provided in medium-to-large single-family homes with the capacity for five recipients, and private living quarters for live-in staff; traditionally a married couple who act as on-site administrators. Support staff come to the home throughout the week to aid in the care and treatment of the youth placed in the home. Complex care residential would take place in this same home environment; augmented with increased staffing for safe ratios, specialization of the home for monitoring, intervention, or treatment, and added care coordination to ensure continuity between members of the multi-disciplinary team. The initial phase of this project would be setting up one complex care residential home in the Matsu Valley due to proximity to strong agency relationships and medical resources in Anchorage. Subsequent phases would be setting homes up in other rural centers such as Fairbanks, Kenai, and Juneau. Allying with the State of Alaska in developing and following new Complex Care Residential Home licensing regulations and payment methodologies ensures that the service will be permanently sustainable.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Presbyterian Hospitality House	AI & Resiliency Conference	AK	Alaska faces a significant behavioral health crisis driven by isolation, workforce shortages, and high exposure to trauma. Many rural residents live far from behavioral health centers, leaving clinicians to cover large regions with limited access to consultation, peer support, or training. Rural communities experience higher unmet mental health needs, reduced access to specialty care, and increased provider burnout. These challenges are intensified by high rates of adverse childhood experiences, depression, anxiety, and suicide, especially in Indigenous communities. Clinicians often manage crises, trauma treatment, substance use, and family systems while carrying heavy documentation burdens, contributing to workforce instability and inconsistent care. Trauma-informed practice improves engagement and outcomes, yet rural providers receive far less trauma-specific training, creating gaps in standards and confidence. At the same time, ethical, HIPAA-safe AI tools can reduce administrative burden and improve efficiency—an important opportunity in rural Alaska, where even small gains in provider capacity increase access. The AI & Resiliency Conference responds to these challenges by offering unified trauma-informed training, culturally grounded frameworks, system-level implementation planning, and ethical AI workforce tools to expand rural mental health services without increasing burnout.	The AI & Resiliency Conference is a three-day, single-track statewide convening of approximately 200 behavioral health professionals, tribal partners, educators, child welfare staff, and agency leaders in Anchorage. Rather than dividing participants into specialty tracks, the conference uses a shared plenary model, so all attendees receive the same trauma-informed framework, cultural context, implementation guidance, and AI workflow training. This structure promotes statewide consistency in practice and reduces fragmentation across regions. The conference features a renowned national trauma keynote speaker alongside an Alaskan clinician trainer, Alaska-based rural practitioners, tribal speakers addressing historical trauma and community resilience, and Alaska Native cultural performers who provide grounding and context for healing. Programming emphasizes applied learning and implementation. Participants engage in live demonstrations, facilitated discussions, panels on rural service delivery challenges, and guided action-planning sessions. Agencies and regional groups develop written implementation plans, identifying priority changes, workflow adjustments, leadership responsibilities, and timelines. A central innovation of the conference is training in ethical, HIPAA-safe AI workflows. AI is presented as a workforce support tool, not a replacement for clinicians. Participants learn how to use non-identifying AI applications to aid in the development of Group, Individual, and Family Psychotherapies. AI’s ability to create documentation templates, organize treatment plans, prepare supervision summaries, develop psychoeducation materials, and support administrative functions such as onboarding and quality assurance will be highlighted. Health services research shows that reducing documentation burden can reclaim 20–30 percent of clinician time. In rural Alaska, this reclaimed capacity translates directly into added appointments, outreach, and crisis response availability.	\$50,000-\$250,000	Statewide	Anchorage (Municipality); Bethel Census Area; Chugach Census Area; Denali Borough; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Matanuska-Susitna Borough; North Slope Borough; Northwest Arctic Borough; Skagway (Municipality); Southeast Fairbanks Census Area; Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Presbyterian Hospitality House	Emergency Stabilization & Assessment Centers	AK	There is a lack of short-term community care Emergency Stabilization & Assessment Center for youth experiencing homelessness, mental health, emotional or behavioral crisis. The PHH ESAC will offer 24/7 supervision, providing immediate stabilization, symptom reduction, and rapid connection to community-based support services. According to the State of Alaska Response for the RHTP 75% of Alaskan youth experience mental health conditions. This program is intended for youth to stay a maximum of 30 days for youth ranging from 12-18 years old.	Presbyterian Hospitality House will operate a two 5 bed Emergency Stabilization & Assessment Centers that will be open 24/7 in Fairbanks and the Mat Su area. The ESAC’s will be focus on rapid stabilization and trauma informed care to deescalate crisis, decrease unnecessary psychiatric hospitalization, decrease homelessness and connect the youth to community services. Professional staff will provide immediate assessment and intervention, 24-hour monitoring, counseling, and peer support with individual care decisions prioritizing a strength-based environment. At the point of referral or intake, staff will work with various resources when limited collateral information is given. Collaboration with families and referrals to the proper resources. The ESAC will meet the basic needs of the youth in a safe and secure residential setting. Youth will have access to food, clothing, and hygiene items in addition to showers and laundry. Youth will establish contact with their family/guardian. Transportation will be available. The program will employ Clinical staff to provide the needed assessments and therapy, Case managers to coordinate services and aftercare, Teaching staff will provide therapeutic interventions and full-time night monitors to ensure safety. Administrative staff will support the needs of the program. Staff will use an electronic health record system. We already have the needed staff for outcomes data reporting.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Fairbanks North Star Borough; Matanuska-Susitna Borough	Deferred or Not Advanced
Presbyterian Hospitality House	PHH Youth & Family Wellness Center	AK	Presbyterian Hospitality House (PHH) is pleased to send this Letter of Intent describing our plans to establish the PHH Youth and Family Wellness Center in the Mat-Su area. This opportunity will address the need to improve behavioral health and mental health in youth and families. PHH would like to offer the opportunity to increase the availability of early intervention and prevention programs and expand comprehensive, integrated management across behavioral health programs.	PHH’s approach will be a collaborative, team-based, and highly individualized care planning process for youth and families in a safe, supportive, and enriching environment. The Wellness Center will include a full gym for physical activity, a commercial kitchen for nutrition education, a computer lab for academic support, a garden area and baseball field, clinical office space to include telehealth space, and dedicated group rooms for in person therapeutic services. Expanding the knowledge of youth and families regarding resources in the communities as well. PHH will hire and maintain a professional workforce for administrative oversight, program directing, clinical therapy and other needed positions as deemed appropriate for a Wellness Center.	\$1M-\$5M	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Presbyterian Hospitality House	TTH Rural Hub Expansion	AK	Currently, there are over 3,000 Alaskan youth that are removed from their homes annually due to trauma, addiction, or behavioral health crises. For youth in rural Alaska, this often means a traumatizing displacement, sometimes being medevaced thousands of miles to larger hospitals and can even mean being sent out of state for treatment. The gap in distance that occurs as a result, severs ties to the family, culture and community which are all things that are essential in long term healing. Furthermore, there is a lack of regionalized “step-down” placement options that prevent youth from transitioning safely back to their home villages, leading to high recidivism and over reliance on emergency departments, detention centers, and high-cost acute care. Presbyterian Hospitality House has identified this funding opportunity as a transformative opportunity to expand and regionalize the effective and replicable Therapeutic Treatment Home (TTH) model. By establishing regional hubs with dedicated program and clinical teams, in Juneau, Kodiak, Valdez, Kotzebue, Nome, and Utqiagvik we will create a sustainable regional system of much needed care for Alaskan youth and families. This initiative shifts the paradigm from displacement for care, to care within the youth’s community and culture, ensuring Alaska’s most vulnerable youth can heal without losing their sense of place.	Presbyterian Hospitality House plans to implement a phased “hub-and-spoke” expansion to deliver Therapeutic Treatment Home (TTH) services into six regional hubs. Leveraging 66 years of experience serving over 160 Alaska communities, our approach prioritizes high quality behavioral health services, local workforce development, and strengthening cultural and family ties. In year one, we focus on expansion into Juneau, Kodiak, and Valdez. Year two will see expansion into Kotzebue, Nome and Utqiagvik. Each regional hub will be anchored by a team designed to support the needs of each respective region. These regional staffing teams will be composed of a Rural TTH Specialist, Rural TTH Program Manager, Rural Clinical Supervisor, Behavioral Health Clinician and Behavioral Health Clinical Associates (mentors). The staffing team will support up to five TTH homes in each regional hub. The TTH homes will be local, licensed foster homes that have received the training and have the expertise to be designated as TTH homes in accordance with “Alaska Behavioral Health Provider Service Standards”. Until fully staffed, oversight will be managed through PHH’s existing sites in Wasilla, Fairbanks, and Kenai. We will use a robust supervision-travel model combined with remote supervision, where a Rural Clinical Supervisor and Therapeutic Treatment Home Manager conduct frequent on-site rotations to each hub. By year 5, we will transition into physical regional offices. RHTP funds will facilitate this transition by covering office leasing, furniture, supplies, high speed satellite and telehealth technologies. To prioritize a sense of community, support, and collaboration, we will host monthly TTH Hub meetings, where meals will be provided to our TTH families, youth, and staff. These meetings will offer an opportunity for training, team building, moral support, collaboration, and prevent isolation-based burnout that is common in rural areas. Our sustainability approach is built on a bridge to the Medicaid strategy. RHTP funds will act as start-up funds for infrastructure and recruitment. Then as hub teams solidify, we will have the necessary components to offer services that lead to sustainable Medicaid billing.	\$1M-\$5M	Statewide	Anchorage (Municipality); Chugach Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Primary ENT, L.L.C. (dba ENT Urgent Care)	Pediatric and Family Home Ear, Nose, and Throat camera with AI and specialty virtual care	MN	Rural and remote communities across Alaska face major barriers to timely ear, nose, and throat (ENT) care. Common conditions such as ear infections, hearing problems, chronic nasal congestion, allergies, and sleep-related breathing disorders often require specialty evaluation. However, families in many regions must travel long distances or wait months for appointments, creating delays in diagnosis and treatment. These delays can lead to preventable complications, missed school for children, lost work time for parents, and increased healthcare costs. Community health organizations and primary care clinics carry much of this burden but often lack easy access to ENT specialty support. This project proposes a community-centered model that brings specialty ENT evaluation closer to home. Families—initially focusing on households with children—would receive access to a connected ear, nose, and throat imaging device linked to a secure digital platform. Using the device, families can capture images of the ear, nose, and throat and complete a guided symptom assessment. These findings are reviewed through an AI-supported triage system with the ability to escalate cases to virtual ENT specialists when needed. When in-person care is required, the program supports coordination with local clinics and regional referral centers.	Our proposed approach is to shift the starting point of ENT, Allergy and Sleep specialty care from distant clinics to the patient’s home using connected medical technology and specialist-guided digital tools. The project will pilot a home-based ENT care model using a connected ear, nose, and throat camera that allows families to capture high-quality images and videos of the ear canal, nasal passages, throat, and of breathing. These images/videos upon patient permission will be sent to our virtual platform where they are reviewed using AI-supported symptom assessment tools developed and supervised by board-certified ENT specialists. By combining connected imaging with structured symptom questionnaires and AI-assisted triage, families can receive rapid guidance on whether a condition can be managed at home, requires virtual specialist evaluation, or should be referred for in-person care. Our exclusive connected hardware partner, FOND Circle, has sold over 2 million remote devices already. The pilot will initially focus on rural Alaska families with children, as pediatric ENT conditions such as ear infections, hearing problems, nasal obstruction, and sleep-related breathing disorders are common and often difficult to access specialty care for in remote communities. Participating families will be provided with the connected ENT camera and access to a secure digital platform that enables 24/7 symptom assessment, image submission, and escalation to virtual specialty care when appropriate. When in-person evaluation or procedures are necessary, the program will coordinate referrals with local community health clinics, tribal health systems, and regional specialty providers. This approach supports existing healthcare infrastructure rather than replacing it, helping community clinicians access specialty input when needed while reducing unnecessary travel for patients. Over time, the pilot will evaluate outcomes such as reduced travel burden, earlier diagnosis of ENT conditions, improved care coordination, and patient satisfaction. Data from the pilot can inform expansion to additional rural communities and integration with existing telehealth programs. By combining connected diagnostic tools, specialist-guided AI triage, and coordinated referral pathways, this project aims to bring high-quality ENT care closer to home for rural Alaska families and create a scalable model for improving specialty care access in remote regions.	\$250K-\$1M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Prince of Wales Equal Housing	Rural Adult Foster Care Pilot and Medicaid Access Navigation Program	AK	Rural communities on Prince of Wales Island face significant barriers to accessing health and long-term support services. Families often provide unpaid care to vulnerable adults with disabilities, chronic health conditions, or functional limitations while navigating the complex Medicaid eligibility and waiver enrollment process. In Alaska, this process can take months or even years, and there is currently no funded system to support families during this waiting period. Without structured assistance, applications are delayed, documentation is incomplete, and individuals go without coordinated care. This gap increases caregiver burnout, preventable health decline, crisis intervention, Adult Protective Services involvement, and unnecessary institutional placement outside the community. Rural provider shortages and geographic isolation further compound these challenges. This project addresses the opportunity to create a structured Rural Adult Foster Care Access & Stabilization Pilot that supports families during the Medicaid application process. By providing care coordination, application assistance, and modest caregiver stabilization support, the project will reduce service gaps, improve timely access to health coverage, and prevent avoidable crises while building sustainable rural health infrastructure.	Prince of Wales Equal Housing will implement a Rural Adult Foster Care Access & Stabilization Pilot to bridge the gap between caregiving need and Medicaid service enrollment in rural Southeast Alaska. The approach includes three integrated components: 1. Structured Care Coordination The project will establish a dedicated Grant Administrator/Program Director to develop compliant policies, fiscal oversight systems, and outcome reporting aligned with Alaska and federal requirements. Participating households will receive individualized care coordination to assist with Medicaid applications, waiver documentation, physician certifications, Social Security enrollment, and referrals to primary and behavioral health providers. Applications will be tracked to ensure accuracy, completeness, and timely submission, reducing avoidable processing delays. 2. Caregiver Stabilization Support Families providing care to vulnerable adults during the Medicaid eligibility process will receive modest monthly stipends to offset caregiving-related costs. Care Coordinators will provide monthly monitoring, documentation assistance, appointment tracking, and risk screening to prevent health deterioration. This structured support reduces caregiver burnout, prevents unnecessary institutional placement, and allows individuals to remain safely in their home communities while awaiting formal services. 3. Data Collection, Oversight, and Sustainability Planning The pilot will implement measurable performance indicators, including Medicaid application completion rates, time to eligibility, crisis event reduction, and caregiver retention. Financial controls and reporting systems will ensure transparency and accountability. Data collected during the pilot will inform sustainability planning, policy recommendations, and potential future integration into Alaska’s long-term care framework. By combining administrative infrastructure, direct navigation assistance, caregiver stabilization, and measurable oversight, this approach strengthens rural health access, improves continuity of care, reduces preventable crises, and builds scalable infrastructure for frontier communities experiencing provider shortages and geographic isolation.	\$50,000- \$250,000	Multi- Community or Participating in Regional Hub-and- Spoke	Haines Borough; Petersburg Borough; Prince of Wales- Hyder Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

Prince of Wales Health Network	Prince of Wales Health Network Mobile Integrated Health (MIH) Program	AK	Prince of Wales Island is a geographically isolated, roadless region with limited access to acute and specialty healthcare services. Residents face significant barriers including transportation challenges, high rates of chronic disease, and frequent reliance on emergency medical services for non-emergent needs. We would like to explore the possibility of putting infrastructure in place to help residents with preventive and non-urgent healthcare related needs. The population of POW is aging with 20% of the population being 65 years or older, which is putting a strain on our medical services.	Funding through the Alaska Rural Healthcare Transformation Grant will support program planning, workforce training, clinical equipment, telehealth capabilities, and initial implementation. The program will be designed to be sustainable and scalable, with a focus on innovative ways to meet the needs of community members, improving patient outcomes, and strengthening the rural healthcare continuum on Prince of Wales Island. The Prince of Wales Health Network is committed to transforming rural healthcare delivery through innovative, patient-centered models that reflect the unique needs of island communities. We believe this MIH program aligns strongly with the goals of the Alaska Rural Healthcare Transformation Grant and represents a meaningful opportunity to improve health equity and system resilience in Southeast Alaska.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Prince of Wales-Hyder Census Area	Advance to Implementation Application

Programs for Infants and Children	Alaska Infant Learning Program specialized electronic record: Shared platform	AK	Currently, Alaska’s 15 Infant Learning Programs each serve different regions and use their own systems to document services. Implementing a unified documentation system would streamline workflows, reduce administrative burdens, and allow skilled providers to spend more time delivering services to infants and toddlers. Many ILP programs also lack sufficient knowledge and resources to bill third-party payers for eligible services. A comprehensive electronic record would include: • Documentation of all ILP-specific actions, evaluations, IFSPs, and transitions. • Integrated billing functionality, including posting payments and reconciling accounts. • Automated protocols to transfer data directly into the State of Alaska ILP Database. Working together to design and implement an electronic record is what has been identified as a top priority for many ILP programs.	The project will implement a statewide, unified electronic documentation and billing system for all 15 Infant Learning Programs. The approach includes: Needs Assessment & System Design: Conduct a thorough review of current documentation practices, billing capabilities, and workflow challenges across all programs. Utilize current ILP workforce to design a user-friendly, standardized system that meets ILP-specific requirements. Technology Development & Integration: Develop or customize an electronic record system that includes comprehensive ILP documentation, integrated billing, and automated data transfer to the State ILP Database. Ensure interoperability with existing state systems and third-party payers. Training & Support: Provide extensive training to ILP staff on the new system, including documentation standards, billing processes, and data management. Offer ongoing technical support to ensure smooth adoption. Pilot & Phased Implementation: Pilot the system in selected regions to refine workflows, then roll out statewide in phases, incorporating feedback and lessons learned. Evaluation & Continuous Improvement: Monitor usage, service delivery efficiency, and billing accuracy. Use performance data to make ongoing system improvements and support sustainability.	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Programs for Infants and Children	PIC: Efficiency and IT Innovation in Early Intervention	AK	Programs for Infants and Children, Inc. (PIC) has utilized an Electronic Health Record (EHR) system since 2008. While functional, the current platform was not designed to meet the unique geographic, regulatory, and service delivery needs of Alaska’s Infant Learning Program (ILP). This project will modernize and customize the EHR to better align with Alaska’s early intervention system, improving efficiency, compliance, and service quality.	1. AI-Enhanced Documentation Integration of AI tools within the existing EHR to generate draft progress notes and evaluation summaries based on provider-entered data. Providers will review and finalize notes, significantly reducing documentation time while maintaining clinical integrity and compliance. 2. Streamlined Evaluation Reporting Development of structured skill-marking tools within the record (e.g., marking observed skills during routines-based or developmental assessments) that automatically generate a base evaluation report. This reduces repetitive writing and improves consistency across providers. 3. Electronic Signature Capture Implementation of tablet- and phone-based signature capture for IFSPs, consent forms, and required documentation, increasing efficiency and improving access for families in remote communities. 4. Client-Level Workflow Automation Creation of automated workflows and alerts at the child level to track required timelines (evaluation, IFSP development, reviews, transitions), reducing missed compliance deadlines and strengthening quality assurance. 5. Full API Integration with the Alaska State Database Development of a complete API connection to the Alaska ILP state database to eliminate dual data entry and ensure real-time, accurate data reporting. 6. Secure Inter-Program Data Transfer Enable secure transfer of child records between Alaska ILP programs operating on the same platform when families relocate, reducing service disruption and paperwork burden. 7. Integrated Language Translation Embed translation functionality across forms and family-facing documents so materials are available in families’ primary languages, improving access and equity. 8. Hardware enhancements Utilize hardware to interface between providers, families, and electronic records.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Lake and Peninsula Borough	Advance to Implementation Application

Programs for Infants and Children	Infant Learning Program Expanded Eligibility for Programs for Infants and Children	AK	Alaska’s Infant Learning Program (ILP), the state’s system under Part C of the Individuals with Disabilities Education Act (IDEA), currently has the most restrictive eligibility criteria in the nation. As a result, many infants and toddlers with developmental delays do not qualify for early intervention services during the most critical period of brain development and growth. Without access to these supports, children in both urban and rural communities miss opportunities to receive therapies and early childhood services that help build the foundational skills needed for success in school and later in life.	The project would use a phased systems-development approach to gradually expand eligibility for Alaska’s Infant Learning Program (ILP) while ensuring the workforce and service infrastructure can support the increased number of children served. The approach balances policy change with workforce development so that access expands without overwhelming providers or reducing service quality. First, Programs for Infants and Children (PIC) would establish a multi-year expansion framework that identifies workforce capacity, service gaps, and regional needs in both urban and rural communities. This planning phase would include data analysis, provider capacity assessments, and collaboration with ILP programs, universities, and training partners. Second, eligibility would be expanded incrementally using a tiered approach. As workforce capacity grows, eligibility criteria would gradually move toward serving children with developmental delays of 25 percent or greater. This phased approach allows programs to responsibly increase access while maintaining service quality and provider sustainability. Finally, the project would include ongoing evaluation and system improvement. Data would be used to monitor workforce growth, service access, and child outcomes to ensure the expansion improves access to early intervention services across Alaska while maintaining high-quality services for families. PIC would work closely with Raviant, a consultant who has been working on expanding ILP services for the past 2+ years. PIC’s individual project combined with their expertise in organizational change would all but insure a successful launch of ILP eligibility expansion.	\$1M-\$5M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Lake and Peninsula Borough	Deferred or Not Advanced

Programs for Infants and Children	Programs for Infants and Children Recruitment and Retention of Highly Qualified Staff	AK	Alaska does not currently have sufficient pre-service training programs within the University of Alaska system to prepare professionals for the specialized services required by the Infant Learning Program under IDEA Part C. As a result, there is a significant shortage of qualified providers, including Occupational Therapists, Physical Therapists, Speech-Language Pathologists, Social Workers/Behavioral Health providers, and Developmental Therapists (Early Childhood or Special Educators). Recruitment and retention of these professionals is a persistent challenge. Vacant positions often take many months—and sometimes more than a year to fill, leaving programs understaffed and reducing access to services for infants and toddlers with developmental delays. Because the workforce pool in Alaska is limited, strategies that support recruitment and incentivize retention of existing staff are critical to maintaining and expanding services.	To address Alaska’s shortage of specialized early intervention providers, this project will implement a comprehensive workforce strategy focused on competitive compensation, recruitment, workforce development, and retention of professionals needed to deliver services required under Individuals with Disabilities Education Act Part C. A key component of this approach is ensuring Infant Learning Programs can offer salaries and benefits that are competitive with other healthcare, education, and behavioral health employers in the community or region. Salary disparities often draw providers away from early intervention to hospitals, schools, or private practice. Supporting competitive compensation will help PIC recruit and retain qualified professionals, particularly in rural and high-cost areas. Recruitment strategies will include signing bonuses, relocation assistance, and student loan repayment or tuition assistance for hard-to-fill positions such as Occupational Therapy, Physical Therapy, Speech-Language Pathology, Developmental Therapy, and Behavioral Health. The project will also create paid internships or residency opportunities to attract new graduates to early intervention. Often if a student completes an internship with us they express a desire to work for us when they graduate. To strengthen the workforce pipeline, the project will partner with the University of Alaska System to expand practicum placements, increase exposure to early childhood disability services, and support distance supervision and tele-mentoring for students and providers in rural communities. We would also like to develop a mentoring program to help providers meet the Highly Qualified definition required by the State of Alaska ILP program. We believe helping to grow our own providers is more beneficial than only attracting workers from the lower 48. Retention strategies will include service-based retention bonuses, rural service incentives, continuing education support, and mentorship opportunities to reduce professional isolation and burnout. Together, these strategies will stabilize the workforce and improve timely access to early intervention services for infants and toddlers with developmental delays across Alaska.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Lake and Peninsula Borough	Deferred or Not Advanced

Programs for Infants and Children	Strengthening Rural Access to Early Intervention Services	AK	Families with infants and toddlers in rural areas of the state often don’t have equal access to ILP services due to distances from hub ILP program. Staffing changes in schools, health clinics, as well as Infant Learning Program staff creates challenges to building lasting relationships that build trust in rural communities. Because of this challenge, families may not know or understand what Early Intervention services are and that services are available to them at no cost.	Families with infants and toddlers in rural Alaska face persistent and systemic barriers to accessing services through the Alaska Infant Learning Program (ILP). Geographic distance from hub-based ILP programs limits timely, consistent service delivery, often requiring extensive travel, weather-dependent access, and high logistical costs. These barriers delay identification and intervention during the most critical period of brain development. In addition to geography, frequent staffing changes within schools, health clinics, and ILP programs disrupt continuity of care and undermine relationship-building efforts. In rural communities, trust and long-term relationships are foundational to family engagement. When providers change frequently, families may disengage or decline services, resulting in missed opportunities to support developmental progress early—when intervention is most effective and cost-efficient. This project will strengthen rural access to early intervention by stabilizing service delivery models, investing in community-based partnerships, and building sustainable local capacity. Strategies may include tele-intervention expansion, cross-system staffing collaboration, community health worker partnerships, and targeted workforce recruitment and retention supports. The goal is to ensure infants and toddlers with developmental delays—regardless of geography—receive equitable, timely, and culturally responsive services that improve outcomes and reduce the need for more intensive services at school age. By addressing structural access barriers and prioritizing relationship-based service delivery, this initiative will promote developmental equity for Alaska’s youngest children and reinforce the state’s commitment to early intervention as a cost-effective, prevention-focused investment.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Lake and Peninsula Borough	Deferred or Not Advanced

Project GRAD Kenai Peninsula	THRIVE KP	AK	Youth in rural Kenai Peninsula communities encounter barriers to regular physical activity, mental health support, and organized afterschool programs that encourage healthy growth. More than 21% of Kenai Peninsula Borough residents are under age 18. Communities like Nanwalek, Port Graham, Tyonek, Ninilchik, and Seldovia face additional difficulties due to geographic isolation, transportation issues, and limited youth development and behavioral health services. Economic and health indicators highlight the need for prevention-focused youth programs. Census data show that over 10% of borough residents live in poverty, and about 15% of residents under age 65 are without health insurance. The Alaska Kids Count Data Book reports that around 14% of Alaska children live in poverty, and nearly one-third reside in households with unstable employment. Youth health data further emphasize prevention needs. Alaska Youth Risk Behavior Survey results show that about 37% of Alaska high school students report ongoing feelings of sadness or hopelessness, and only about 23% meet recommended daily physical activity levels. Schools often serve as the main gathering place for youth and families in rural communities but frequently lack resources to provide structured wellness programs outside the school day. THRIVE KP addresses these gaps through school based afterschool programming and in school counseling that promote physical health, positive relationships, and healthy lifestyle habits.	THRIVE KP will implement a school-based youth health and wellness initiative designed to increase physical activity, strengthen supportive relationships, and promote mental health awareness among Alaska Native youth. The program will begin in three pilot communities—Nanwalek, Port Graham, and Tyonek—with plans to expand to Ninilchik and Seldovia. These communities face limited access to youth wellness programming and behavioral health supports, while schools remain the most reliable gathering place for youth and families. Afterschool programming will occur twice per week for approximately two hours per session and will be delivered primarily by locally recruited Afterschool Health Coaches. These community members will receive training and ongoing mentorship from an itinerant school counselor and a community health and wellness coordinator who rotate among participating communities to support program delivery. Programming will focus on four key areas that support youth wellbeing and prevention. Physical activity programming will increase youth participation in regular exercise through structured activities aligned with the Presidential Youth Fitness Program. Statewide data show that fewer than one in four Alaska youth meet recommended daily physical activity levels. The itinerant school counselor will lead social-emotional learning and relationship development activities (both during and after school hours) that strengthen communication skills, emotional awareness, and peer support while helping youth build positive connections with mentors and community members. The community health and wellness coordinator will provide nutrition and healthy lifestyle education integrated into program activities to encourage lifelong wellness habits. Family and community engagement activities will encourage parents and caregivers to participate in wellness events and reinforce healthy behaviors at home. The program will also create youth leadership opportunities through peer mentorship, team activities, and community wellness projects, encouraging students to take an active role in promoting healthy lifestyles in their schools and villages. By expanding access to physical activity, strengthening supportive relationships, and promoting healthy lifestyle habits, THRIVE KP advances the goals of the Rural Health Transformation Program’s Healthy Communities initiative and supports healthier rural communities across the Kenai Peninsula.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Providence Health & Services-Washington	Advanced Prenatal Access: Implementing a Hybrid OB Access Model in Seward & Anchorage	WA	Pregnant patients in the Seward service area face significant barriers to timely and safe obstetric care due to geography, distance, and unpredictable Alaskan weather. The nearest hospital with full obstetric and surgical delivery capability is approximately 90–125 miles away, and travel can become unsafe or impossible because of winter storms, avalanche conditions, and seasonal road or marine disruptions. Because Providence Seward Medical Center does not have OB surgical delivery capability, routine prenatal care may be delayed, urgent maternal-fetal evaluations may be deferred, and unplanned local deliveries can occur when transfer is not possible. These conditions increase the risk of preventable maternal and neonatal complications and disrupt continuity of care for mothers and newborns. This project addresses a critical rural access and safety gap by strengthening local prenatal access and maternal-fetal monitoring without building a full OB department.	With targeted RHTP investment, Providence Seward Medical Center proposes implementing a Hybrid OB Access Model with Providence Alaska Medical Center that expands local prenatal services while integrating continuous specialty obstetric support through the continuum of care. The model includes structured in person prenatal care such as vital sign and symptom assessment, fetal heart tone monitoring, limited point-of-care ultrasound, nonstress testing, routine prenatal laboratory collection, and comprehensive patient education. Limited OB triage capacity will supplement outpatient clinic hours to reduce unnecessary travel to Anchorage. Telehealth partnerships with an OB and/or maternal-fetal medicine provider will support virtual prenatal visits, real-time review of local assessments, collaborative care planning, early identification of complications, and provider-to-provider consultation. Periodic onsite OB specialist visits further extend specialty expertise into the rural setting without requiring permanent surgical OB capacity.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough	Advance to Implementation Application

Providence Health & Services-Washington	Coordinating to Drive Redesign and Sustainability of Alaska's Graduate Medical Education Programs	WA	Alaska faces a critical shortage of physicians, driven by longstanding structural underfunding of Graduate Medical Education (GME), limited residency capacity, and challenging primary care payment models. Alaska currently trains far fewer residents than any other state—only 4.91 GME trainees per 100,000 residents, compared to a national average of 35.42—resulting in a workforce pipeline that cannot meet statewide needs. Despite having one of the nation’s highest retention rates—75% of Alaska Family Medicine Residency (AKFMR) graduates remain in Alaska, and half practice in rural areas. Strengthening AKFMR presents a significant opportunity. Because where physicians train strongly predicts where they practice, expanding and sustaining GME in-state is one of Alaska’s most effective strategies for building a long-term workforce. Over 25% of the state’s practicing family physicians trained at AKFMR, serving both Anchorage and rural communities. RHTP funding also presents the opportunity for collaboration and partnership among health care providers statewide, with guidance from the State of Alaska. We view the State of Alaska as having the opportunity to come alongside partners to design the future of GME, incentivize growth, and sustain the program.	One approach to strategically growing Alaska’s physician workforce is by developing a Rural Track Program (RTP) that expands Alaska Family Medicine Residency (AKFMR) capacity and leverages existing rural clinical partnerships. Under RTP requirements, more than half of a resident’s training must occur in a designated rural community, typically during the second or third year of residency. AKFMR already has strong clinical relationships in these communities, positioning the program to launch rural track program without needing to build new partnerships from scratch. Another idea includes the creation of new Anchorage-based family medicine clinic training, in which residents complete a substantial amount of training at community-based local continuity clinics, for example Southcentral Foundation (SCF), or Anchorage Neighborhood Health Center (ANHC). These sites already provide high-quality primary care training and would distribute educational load across multiple clinical partners, creating operational benefits while reducing teaching capacity strain on AKFMR’s main clinic. Providence would appreciate exploring training partnership opportunities through both local and statewide design planning. Through the above-mentioned ideas, partnering with other entities also submitting GME- focused LOIS, and shifting a portion of training to community sites and rural locations, AKFMR can increase its total training capacity without overwhelming existing infrastructure. This approach simultaneously strengthens rural clinical pipelines, aligns with state and federal priorities for rural workforce expansion, and positions Alaska to grow toward a sustainable GME program.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Providence Health & Services-Washington	Dual-Eligible Value-Based Care (VBC) Model Design and Readiness Initiative	WA	Alaska’s dual-eligible population represents a critical opportunity to advance integrated care and fiscal sustainability, yet current payment and delivery structures remain fragmented across Medicare and Medicaid. This fragmentation results in misaligned incentives, limited accountability for outcomes, and avoidable cost growth particularly for individuals with complex medical and social needs. The State of Alaska has identified Pay for Value: Fiscal Sustainability as a core RHTP initiative, including the need to develop foundational capabilities for integrated care for dually eligible Alaskans. However, a statewide VBC model tailored to Alaska’s dual population has not yet been fully designed or operationalized. This project addresses that gap by positioning Providence as a strategic partner to support the State in designing a scalable, data-driven, and Alaska-specific VBC approach. Providence has an impressive track record of design of alternative payment models combined with execution and results, across our system footprint. We are seeking to partner with the state to bring statewide alternative payment model and clinical pathway solutions to this vulnerable population.	Providence proposes to serve as the State’s partner in designing a statewide value-based care model for dual-eligible Alaskans, beginning with a focused planning and readiness phase. Phase 1: Analytics, Opportunity Identification, and Co-Design -Conduct a robust review and analysis of available Medicare and Medicaid claims and encounter data to identify: High-cost and high-need subpopulations; Drivers of avoidable utilization; Opportunities for improved care coordination and alignment. -Assess existing delivery, contracting, and care management capabilities across Alaska. -Co-design a VBC framework with State partners that aligns incentives between the state Medicaid plan, providers, and communities. -Define programmatic goals, performance measures, and payment mechanisms aligned with Alaska’s Pay for Value: Fiscal Sustainability initiative. This phase will result in a clearly articulated statewide VBC model, implementation roadmap, and readiness assessment to support future phased deployment. The approach is intentionally collaborative and designed to complement—not replace—existing regional and Tribal delivery systems.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Providence Health & Services-Washington	Implementing Remote Patient Monitoring Reimbursement to Drive Sustainability & Positive Outcomes	WA	Remote Patient Monitoring services include the collection and analysis of patient physiological data using digital devices to remotely monitor and manage a patient’s health conditions. This is a powerful tool in the prevention and treatment of chronic conditions, and efficient chronic disease management can lead to a decrease in years of potential lives lost (YPLL). For example, according to the 2021 Primary Care Needs Assessment, diseases of the heart lead to a mean YPLL of 7.8 years. By focusing on incentivizing chronic disease management, this program can decrease YPLL through appropriate management of hypertension and other diseases of the heart. Additionally, the state of Alaska currently does not reimburse for this service for Medicaid patients. Providence has been providing these services for our Medicare population where analyses and peer reviewed publications have shown better control of chronic diseases and reduced total cost of care.	Remote Patient Monitoring is a powerful tool in the prevention treatment of chronic conditions like heart failure, diabetes, chronic obstructive pulmonary disease, and hypertension, reducing readmissions and the overuse of the emergency department. These services are covered by Medicaid when they are ordered by a qualified healthcare provider, defined as a physician, advanced practice registered nurse, or physician assistant. This project would introduce Remote Patent Monitoring (RPM) reimbursement for four specific disease states: Congestive Heart Failure, Hypertension, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. Providence Medical Group already has an established infrastructure and full integration with our EHR and has contracted with Cadence as a vendor solution for this service since early 2024 for the Medicare population. The population of focus would include empaneled patients with Medicaid as the primary partner with a diagnosis of one of the four disease states mentioned above.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Chugach Census Area; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area	Advance to Implementation Application

Providence Health & Services-Washington	Improve Continuity of Care in Rural Alaska via Community Connect	WA	Providence currently offers Community Connect to healthcare provider organizations throughout Alaska. We specifically work with organizations who might otherwise not be able to afford the tools to fully integrate their electronic medical record system with other hospitals and providers. This includes pushing health data to the state’s shared HIE, HealthEConnect. We pass the incremental costs associated with adding additional caregiver practices to tools Providence invests in so that patients throughout Alaska benefit from their local providers having access to clinical content and continuity of care they might otherwise only see in urban areas. We currently support the following clinics and hospitals as users of the Providence EHR via our Community Connect program: Alaska Women’s Care, Alaska Pediatric, Seward Community Health, Central Peninsula Hospital, Northstarr Cardiothoracic, Iliuliuk Family and Health Services, Alaska Neurology Center, Anchorage Neighborhood Health Center, Alaska Neurological, and South Peninsula Hospital. As part of this proposal, we’d open the door to groups like Cordova Community Medical Center, Bartlett Regional Hospital, and Alaska Heart and Vascular Institute where they serve vital communities, are eager to move to a shared and integrated platform, but the expense to deploy makes it unattainable.	We propose using RHTP funds to aid rural healthcare organizations in the deployment and services related to moving from aging EMR systems to available shared systems. Community Connect improves collaboration across healthcare organizations first by creating a single shared patient record for participating providers within the shared EHR, but also by providing the tools necessary for data sharing with other Epic facilities via CareEverywhere and more broadly via integration with the State’s HIE and other services such as TEFCA.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Juneau (City and Borough)	Advance to Implementation Application

Providence Health & Services-Washington	Seward Community Care Hub: Advancing Health Through Coordinated Social Support Services	WA	Adverse social determinants of health—housing instability, food insecurity, and unsafe living conditions—are significant barriers to health outcomes, especially in remote and rural Alaska. In Seward, the emergency department often serves as the frontline of care for residents that are impacted by several of the above adverse determinants of health. Unfortunately, many of Seward’s social services are not coordinated to best serve the community efficiently and effectively. This project would serve as the missing infrastructure to transform a fragmented social services landscape into a centralized hub model.	Providence Seward Medical Center (PSMC) proposes to lead the development of a coordinated social services hub in Seward designed to address critical social determinants of health, including housing instability, food insecurity, and unsafe living conditions. The hub will integrate essential services such as emergency and transitional housing support, community meal and food access programs, and domestic violence prevention and response services. This model will function as a central coordination point, aligning healthcare, social services, and community-based resources to better serve vulnerable populations. This project will require strong collaboration across local and municipal government, faith-based organizations, non-profits and tribal partners, law enforcement and emergency services, state and federal funding entities, and private philanthropy. In the first year, PSMC will focus on foundational development and partnership alignment, with the following outputs: Conduct a community needs assessment and service gap analysis; Establish a multi-agency governance and leadership structure; Formalize partnership agreements (MOAs/MOUs) across key stakeholders; Identify and secure physical location(s) for hub services; Develop a phased implementation plan (transitional housing, food services, domestic violence support); Initiate pilot programs for highest-priority needs (e.g., food access or navigation services); Secure initial staffing model and workforce plan; Begin funding alignment and grant acquisition strategy.	\$1M-\$5M	Hospital	Single Community	Kenai Peninsula Borough	Advance to Implementation Application
Providence Health & Services-Washington	Strengthening Rural Alaska Imaging Access Through Remote Technology	WA	MRIs and CTs are critical pieces of imaging equipment for hospitals and clinics that provide key information to healthcare providers for effective patient treatment. There exists a nationwide shortage of radiology technologists, especially those with training in MRI and CT. All locations in Alaska (both Providence and non-Providence facilities) are struggling to hire MRI and CT techs. Valdez had to stop performing MRIs in September 2024 because of staffing, and other locations struggle to provide access to care because of this same issue. As a result, patients often lose access to essential imaging services, hindering timely diagnosis and care. The Virtual Cockpit (VC) platform addresses this gap by enabling experienced technologists in Anchorage to remotely operate scanners in rural areas—providing immediate, reliable imaging access while reducing workforce strain and ensuring continuity of care.	The purpose of this project is to launch a program called “Syngo Virtual Cockpit” (VC), where we will be able to operate MRI and CT scanners from a distant location, removing the barrier of staffing from why a patient cannot get access to the care they need. The MRI and CT techs will 'remote in' from a distant 'steering client', while onsite personnel, trained in positioning, MRI safety, IV placement and patient experience, will assist the patient. Providence is well equipped for this project as we have 14 MRI/CT scanners across Alaska including Anchorage, Seward, Valdez and Kodiak. We share a common Electronic Medical Record and have a shared IT team that supports our network and applications. We also have the relationships across the different communities and hold expertise in project management, which will contribute towards the success of this project implementation.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough; Kodiak Island Borough	Advance to Implementation Application

Providence Health & Services-Washington	Transitions of Care Value-Based Payment Pilot for Rural and Frontier Alaska	WA	Hospitals and SNFs serving rural Alaska face persistent challenges related to extended lengths of stay, delayed access to physical and occupational therapy, and limited financial incentives to transition patients efficiently to lower-acuity settings. Traditional fee-for-service reimbursement models often do not support timely therapy initiation or coordinated discharge planning, particularly for patients returning to remote communities. This misalignment contributes to avoidable utilization and acute hospital stays that may exceed what is required clinically. Higher utilizations and longer hospital stays result in higher costs to the Alaskan healthcare system and poorer patient outcomes. There is a clear opportunity to test a value-based payment approach that aligns financial incentives with timely, high-quality transitions of care and improved post-acute outcomes.	This project proposes a Transitions of Care Value-Based Care (VBC) pilot that introduces an extension payment model to support post-acute care delivery and accelerate safe transitions from hospitals to SNFs, home, or rural post-acute partners (for example, inpatient rehab facilities and/or critical access hospital swing beds serving as rehab). Key components include: -A value-based extension payment to address gaps in PT/OT access within SNFs -Data-sharing and analytics support to identify transition-ready patients earlier -Incentives tied to reduced length of stay, successful discharge to home or community-based care, and reduced readmissions -Structured collaboration between hospitals, SNFs, and rural post-acute providers The model is explicitly designed to test alternative payment methodologies for hospitals, aligning with RHTP’s Pay for Value initiative by shifting focus from volume-driven utilization to outcomes, efficiency, and fiscal sustainability.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Advance to Implementation Application

Providence Health & Services-Washington	Alaska Statewide Health Interoperability Assessment Framework	WA	Alaska’s health care system faces longstanding challenges related to geography, workforce shortages, and fragmented delivery systems. These challenges are compounded by inconsistent interoperability practices, variable health IT maturity, and a lack of shared statewide standards for data exchange, governance, and technical architecture. Providence was a key contributor to CMS’s most recent interoperability standards, which require the use of HL7 FHIR (Fast Healthcare Interoperability Resources) APIs to improve data exchange, reduce administrative burden, and streamline prior authorization. As Alaska advances RHTP initiatives, particularly efforts to support value-based care and fiscal sustainability, Alaska-based providers must be able to exchange clinical, administrative, and quality data reliably across organizations and regions. Without a coordinated, statewide approach to interoperability that embraces new technologically advanced standards, providers risk duplicative investments, limited scalability, and exclusion from value-based payment models that depend on timely, accurate data sharing. This project addresses the opportunity to create a shared interoperability foundation that aligns technical standards with Alaska’s RHTP goals and reduces barriers for providers, public health works, payers, and the vendors that support them statewide. Establishing this foundation is a necessary first step, upon which Alaska can layer more complex solutions.	This project proposes a conceptual, statewide initiative to assess current interoperability capabilities across Alaska’s health care ecosystem and to establish a common set of interoperability standards, architectural principles, and requirements to guide future investments. Key components of the concept include: -A statewide interoperability assessment examining existing health IT systems, exchange methods, data standards, and governance practices across providers, payers, and partners. -Development of recommended statewide interoperability standards, including data exchange frameworks, minimum technical requirements, and alignment with national standards, ASTP/ONC interoperability requirements, and Health Tech Ecosystem initiatives where appropriate. -Definition of a reference architecture that can be used by providers, vendors, and partners to support scalable, interoperable solutions across Alaska, with targeted use cases such as quality measurement, patient risk profiling, care management, census/notification, and other priority workflows. -Identification of optional pilot opportunities to test and validate selected standards or approaches in representative settings (e.g., rural clinics, regional hubs, or cross-organizational care coordination scenarios), without committing to full implementation at this stage. The project is intentionally focused on planning, alignment, and standards development — including a shared statewide interoperability approach — rather than procurement or system replacement.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Providence Health & Services-Washington	Developing the Alaska Healthcare Workforce via School Based Career Education and Awareness	WA	Research has clearly shown that individuals pursue careers based upon role models and interest that is established early in one’s lives (e.g., middle / high school age). Given the significant need for healthcare workers in Alaska, it is essential that we create knowledge and interest in these careers that wouldn’t happen otherwise. Through school-based career education and awareness, the School Ambassador Program assigns current healthcare workers to high / middle schools to build and maintain career education. This is accomplished through building awareness and knowledge with students, staff, and faculty, and by providing shadowing and mentoring, alongside other activities, in and out of the classroom.	This funding would support School Ambassador Program expansion throughout Anchorage and in rural Alaska. Current healthcare employees (nurses, technicians and other staff) would be assigned to one high school or middle school and subsequently partner with local school personnel to offer presentations, shadowing and other experienced-based learning opportunities. Ambassadors are expected to commit to the role for one academic year and spend about 3-hours/month on the program. Data is collected from pre- and post-career exploration surveys to assess interest in working in healthcare. Data has shown that interactions with an Ambassador, and/or other mentors, may help solidify the future plans of students who already feel like they will pursue a career in healthcare and interactions with an Ambassador, or others, may help influence students to pursue a career in healthcare who may have previously been unsure. Overall, our School Ambassador Program is a promising model for the healthcare industry to achieve engagement with K-12 partners, with the central goal of providing students more exposure, knowledge, awareness and understanding of healthcare careers.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough; Kodiak Island Borough	Deferred or Not Advanced

Providence Health & Services-Washington	Hub to Home Alaska: Regional Care & Chronic Disease Pilot	WA	Alaska’s health care system faces persistent challenges related to fragmentation, rising costs, and misaligned fee-for-service incentives—challenges that are especially acute for rural patients with complex and chronic conditions. Anchorage based providers function as regional anchors for specialty and tertiary care, yet coordination across organizations, payers, and care settings remains inconsistent. At the same time, chronic disease management activities essential to improving outcomes—such as care coordination, patient education, and longitudinal monitoring—are often under supported financially. The Rural Health Transformation Plan identifies Pay for Value: Fiscal Sustainability as a critical priority, highlighting the opportunity to align payment with outcomes and support regional care models that improve coordination and reduce avoidable utilization.	This project will pilot an integrated regional care coordination and chronic disease management model that aligns care delivery, data, and payment across providers and payers. Key elements include: -An Anchorage based hub and spoke specialist care coordination network -Standardized referral, transition, and follow-up workflows across participating organizations -One to two evidence based chronic disease management programs tailored to rural settings -Telehealth enabled touchpoints and proactive longitudinal care management -Data informed performance tracking and shared accountability -Alternative payment methods (e.g., PMPM care management, bundled or hybrid value-based arrangements) that reduce reliance on fee-for-service reimbursement The pilot will generate operational, clinical, and financial learnings to support broader statewide replication.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Providence Health & Services-Washington	Preparing for a Sudden Cardiac Arrest Events: Launching Project ADAM in Rural Alaska Schools	WA	Response to Sudden Cardiac Arrest is often delayed in community settings and survival rates decrease with each minute of delayed defibrillation. Immediate CPR, coupled with immediate and correct use of an Automated External Defibrillator (AED), can double or triple a person’s chance of survival. Project ADAM was launched to get systems into place in communities across the country to offer the best chance of survival to people who suffer Sudden Cardiac Arrest. This project would equip local rural community members to efficiently respond to cardiac arrest through awareness, training, standardized protocol implementation, and AED deployment.	The ADAM Project would establish the Alaska Children's Hospital as the statewide hub to guide rural school nurses and staff in attaining a Project ADAM Heart Safe School designation. This is attained when a school meets criteria as assessed by the Project ADAM team. Local team members must complete drills to respond to sudden cardiac arrest events with CPR, AED use, and cardiac emergency response. Project ADAM focuses on the response team creation, preparation, and implementation of drill test logistics, practice and skills. A core team of clinicians coordinates the program and will administer the Heart Safe School designation when the site meets criteria with redesignation every two years. The program would be maintained through partnerships with Alaska Children’s Heart Center, school districts, tribal health organizations, and integration into existing school health programs.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Providence Health & Services-Washington	PROOF (Payment, Reform for Outcome, Oversight and Financial Sustainability)	WA	Recently, the State of Alaska has expressed interest in exploring opportunities to transition Medicaid into a value-based reimbursement model. As the state’s leader in VBC (Value Based Care) Medicare models, we have the opportunity to lead the change with the adoption of this positive one-sided risk program. In doing so, we will have a stronger focus on providing high quality care for low income and vulnerable community members across Alaska, including rural Alaskans. A one-sided risk will spur efficiency improvements, provide long-term financial sustainability and improve access for vulnerable Alaskans.	The Primary Care PROOF project is designed as a reintroduction of a prior demonstration project, transitioning Medicaid reimbursement from fee-for-service to a value-based approach. The proposal for this project is a capitated and one-sided positive PMPM, in addition to standard FFS (Fee-for-Service) reimbursement. The goal is to evaluate TCOC (Total Costs of patient Care) savings attributed to reducing unnecessary or overutilized care, aligning with the state’s goal of transitioning FFS Medicaid to a value-based reimbursement model. At conclusion, it can be determined through a comparable means analysis if the cohort and variable groups showed statistical significance for cost savings with the goal of expanding this demonstration project to a full 2-sided risk reimbursement model for the State of Alaska.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Providence Health & Services-Washington	Purchasing Equipment to Enhance Hospital Infrastructure in Anchorage	WA	It is difficult, if not impossible, to integrate technology and reimagine health care delivery with aging equipment. We need to be able to invest in both spaces to care for the growing needs of our communities. Many factors such as vendors, shipping, logistics, delivery can all lead to extreme costs of replacement or new equipment availability. In addition, the financial circumstances that exist in the current uncertain healthcare industry limit the long-term investment of dollars towards equipment, especially to areas that may not see high patient use of critical but specialized equipment. Due to the many factors in the high cost for equipment purchases, this LOI represents a high dollar figure investment of RHTP funds. We view this LOI as an exhibit on what hospitals in Alaska need to deliver the best care possible in their communities. Whether this LOI is selected for further funding or not, we hope the State of Alaska finds this information helpful in advocating for RHTP fund use to meet the capital and equipment needs for hospitals and facilities in Anchorage. We will meet the need for equipment in Anchorage through purchasing equipment that has been identified by local leaders as instrumental to hospital and programmatic operations for the safety of patients and the caregivers who deliver the care.	Equipment needs in Anchorage are wide ranging, demonstrated by examples highlighted below. To best serve our patients based in Anchorage, travelling to Anchorage for care, or receiving virtual services from Anchorage, a variety of equipment is needed across Providence Alaska Medical Center (PAMC), Providence Imaging Center (PIC), and Providence Saint Elias Specialty Hospital. At PAMC, a catheterization lab needs updated equipment totaling \$2.5M. The cath lab diagnoses and treats heart and vascular conditions using minimally invasive, image-guided procedures, ensuring Alaskans can receive life altering care at a trusted facility. Items such as blood bank freezers (\$40,000) and radio communications (\$1.9M) are also needed. The overall equipment needs at PAMC total \$11.7M. At PIC, new mammography machines are needed, totaling \$990,000, crucial to ensuring patients across the state have access to early diagnosis and treatment. Overall, a total of \$6.5M is needed for equipment expenses at PIC. At Providence Saint Elias Specialty Hospital, which focuses on long-term rehabilitation, examples of need include ceiling lifts in patient rooms, totaling \$120,000, ensuring patient and provider safety. The total need at St. Elias is \$650,000. Behavioral Health is also in need of equipment purchases, including vehicles to transport residential patients, and a fridge and freezer, all totaling \$115,500. Overall, equipment needs in Anchorage, across all sites, total \$19M.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough; Kodiak Island Borough	Deferred or Not Advanced

Providence Health & Services-Washington	Purchasing Equipment to Enhance Rural Hospital Infrastructure in Kodiak	WA	It is difficult, if not impossible, to integrate technology and reimagine health care delivery with aging equipment. We need to be able to invest in both spaces to care for the growing needs of our communities. One of the biggest needs in CAHs is keeping facilities and equipment up-to-date, which is difficult in rural areas due. Many factors such as vendors, shipping, logistics, delivery can all lead to extreme costs of replacement or new equipment availability in rural areas. In addition, the financial circumstances that exist in the current uncertain healthcare industry limit the long-term investment of dollars towards equipment, especially to areas that may not see high patient use of critical but specialized equipment. Due to the many factors in the high cost for equipment purchases for rural areas, this LOI represents a high dollar figure investment of RHTP funds. We view this LOI as an exhibit on what rural hospitals need to deliver the best care possible in their communities. Whether this LOI is selected for further funding or not, we hope the State of Alaska finds this information helpful in advocating for RHTP fund use to meet the capital and equipment needs for rural hospitals. We will meet the need for equipment in critical access communities through purchasing equipment that has been identified by local leaders as instrumental to hospital and programmatic operations for the safety of patients and the caregivers who deliver the care.	Equipment needs are wide ranging, demonstrated by examples highlighted below. In Kodiak, needs include an advanced X-ray (RAX) fluoroscopy, which would provide diagnostic insights and treatments, estimated at \$1.3M. Other examples of needs include: An OB Hugs System (\$283,000) and OB badge readers (\$130,000) ensuring safety for our youngest patients, and delayed egress doors for Chiniak Bay Elder House (\$101,351), ensuring our facility is safe and updated for our elder patients. The overall equipment needs in Kodiak total \$17.4M. More information on needed equipment is available upon request.	Over \$5M	Hospital	Single Community	Kodiak Island Borough	Deferred or Not Advanced

Providence Health & Services-Washington	Purchasing Equipment to Enhance Rural Hospital Infrastructure in Valdez	WA	It is difficult, if not impossible, to integrate technology and reimagine health care delivery with aging equipment. We need to be able to invest in both spaces to care for the growing needs of our communities. One of the biggest needs in CAHs is keeping facilities and equipment up-to-date, which is difficult in rural areas due. Many factors such as vendors, shipping, logistics, delivery can all lead to extreme costs of replacement or new equipment availability in rural areas. In addition, the financial circumstances that exist in the current uncertain healthcare industry limit the long-term investment of dollars towards equipment, especially to areas that may not see high patient use of critical but specialized equipment. Due to the many factors in the high cost for equipment purchases for rural areas, this LOI represents a high dollar figure investment of RHTP funds. We view this LOI as an exhibit on what rural hospitals need to deliver the best care possible in their communities. Whether this LOI is selected for further funding or not, we hope the State of Alaska finds this information helpful in advocating for RHTP fund use to meet the capital and equipment needs for rural hospitals. We will meet the need for equipment in critical access communities through purchasing equipment that has been identified by local leaders as instrumental to hospital and programmatic operations for the safety of patients and the caregivers who deliver the care.	Equipment needs are wide ranging, demonstrated by examples highlighted below. In Valdez, needs include equipment such as Sonosite portable system (\$19,000), a compact, point of care ultrasound system, contributing to ease of use for caregivers and allowing patients to stay close to home for their imaging needs. Other needs include a dental chair and accompanying equipment (\$100,000), allowing us to partner with a dentist to provide dental care, especially to patients with no dental resources. The overall equipment needs in Valdez total \$506,000. A full list of equipment needs is available upon request.	\$250K-\$1M	Hospital	Single Community	Chugach Census Area	Deferred or Not Advanced

Providence Health & Services-Washington	Transforming Rural Care: Technology Modernization & Enabling Technology Access for Virtual Services	WA	Severe workforce shortages in rural Alaska mean that many of our Critical Access Hospitals (CAHs) are chronically understaffed, resulting in increased length of stay (LOS), care coordination gaps, deferred care, and increasing the need for patient travel from Kodiak, Seward, and Valdez to Anchorage for specialty care. Aging technology equipment in rural communities creates challenges in virtual specialty care provision and adversely impacts patient and provider satisfaction and clinical safety. Overarchingly, these challenges threaten rural residents’ overall health and wellbeing and prevent patients from staying in their home communities for specialty care. This transformative project seeks to modernize rural technology equipment and enable technology access for virtual services. Subsequently, virtual services could be delivered via an urban-rural hub and spoke model.	This hub and spoke model comprises two principal approaches: Rural Technology Modernization and Enabling Technology Access for Virtual Services. Rural technology modernization will upgrade clinical communications platforms, nurse call systems, and high-acuity patient monitoring to ensure technologies are stable and secure across CAHs, with Providence Alaska Medical Center (PAMC) as a hub. This modernization, coupled with enabling technology access for virtual services, will allow real-time collaboration between onsite teams and urban specialty teams, to promote the highest quality care close to home. As an example of what might be included in virtual telehealth services, virtual case management would allow telehealth-based case managers to perform pre-discharge virtual visits and coordinate post-hospital services. Following technology modernization, the “Bridge Program” would transition patients in the hospital awaiting long term care placement out of the hospital to a Skilled Nursing Facility (SNF) 4-6 weeks sooner while continuing to work on long term care placement. Coupled, rural technology modernization and technology access to enable virtual services targets persistent barriers such as workforce shortages, discharge delays, aging equipment, safety, and deferred care, while aligning with Alaska DoH priorities of implementing innovative care and technology across the state.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Kenai Peninsula Borough; Kodiak Island Borough	Deferred or Not Advanced

Provision Ministries	Empower Through Access: Transportation and Supportive Housing for Mat-Su Residents	AK	One of the most persistent barriers to health care access in rural Alaska is the lack of reliable transportation. Rural challenges are not defined solely by distance. Many Alaskans face poor road maintenance, difficult terrain, and a shortage of transportation providers willing or able to reach their location with sufficient staffing and appropriate vehicles. These barriers often result in missed medical appointments, delayed treatment, and worsening health conditions. In the Matanuska-Susitna Borough, many working-age adults rely on transportation assistance to attend substance use treatment programs, behavioral health appointments, maternity and postpartum care, physical therapy, dialysis treatments, and other critical medical services. Some individuals also experience cognitive or behavioral limitations that make it difficult to safely navigate transportation systems or engage with the community independently. Community organizations and health providers consistently report that transportation barriers and housing instability are among the most common reasons individuals miss appointments, fall out of treatment, or struggle to maintain stability. Provision Ministries was created as a grassroots effort to address these gaps by improving transportation access and exploring supportive housing options for residents who face barriers to stable housing and consistent care.	Provision Ministries proposes to develop coordinated community-based transportation services that connect individuals with health care providers, clinics, treatment centers, and other essential services throughout the Matanuska-Susitna Borough. The project will begin by acquiring up to five transportation vans to provide safe and reliable transportation for residents traveling to behavioral health services, substance use treatment programs, maternity and postpartum care, dialysis treatments, physical therapy, and other medical appointments. Transportation services will prioritize affordability and reliability in areas where existing options have struggled to keep pace with population growth and limited service availability. Grant funds would support the acquisition and operation of vehicles, including the high cost of insurance required for medical transportation services and supplemental driver wages, while prioritizing volunteer drivers whenever possible. In addition to transportation services, Provision Ministries plans to develop small micro-unit supportive housing within a building previously operated as an assisted living home in the Mat-Su Borough. The property owner has indicated willingness to make the building available through purchase or lease. The project would complete necessary roof repairs and renovate the building to provide small supportive housing units designed to work alongside existing housing voucher programs. Together, these efforts aim to improve access to care while supporting long-term stability for individuals who face barriers to transportation and housing.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Ptarmigan Pediatrics LLC	: Pediatric Diagnostic Excellence & Early Intervention Initiative	AK	This proposal aims to bridge the specialist care gap in rural Alaska by integrating advanced screening technology directly into the primary care setting. By eliminating the logistical and financial hurdles of travel, we can ensure early intervention and improved outcomes for high-risk pediatric and respiratory patients. Key Initiatives Vision Screening (Pre/Non-Verbal): Utilizes automated screeners to detect amblyopia, strabismus, and refractive errors in infants and children with developmental delays. This non-invasive method prevents permanent vision loss where traditional charts fail. Universal Hearing Evaluation: Employs Otoacoustic Emission (OAE) screeners as a safety net for newborns (including home births) and children with speech delays. We will implement a universal protocol for ages 4–6 to ensure school readiness. Non-Invasive Jaundice Monitoring: Using Transcutaneous Bilirubinometers (TcB), clinicians can measure jaundice through the skin. This replaces painful heel-sticks, reduces outpatient lab costs, and ensures safe monitoring during the first two weeks of life. Objective Asthma Management: Integrating Pulmonary Function Testing (PFT/Spirometry) allows for "gold-standard" asthma care. Real-time, objective data enables immediate medication adjustments, reducing emergency room visits.	This initiative addresses the "lost follow-up" crisis in rural Alaska caused by travel costs and logistics. By bringing specialist-level diagnostic tools into the primary care setting, we can provide immediate, life-altering interventions without requiring patients to travel. Our patient population is 16,500 which is approximately 55% of the pediatric population in our catchment area. All patients in age and disease appropriate groups with benefit from testing. A \$60, 000 investment with provide screening tools, supplies, maintenance of equipment and training for staff. Core Screening Initiatives Vision (3 Automated Screeners): Targets infants and non-verbal children. By using light-based detection rather than traditional charts, clinicians can identify amblyopia and strabismus early, preventing permanent vision loss. Hearing (3 OAE Screeners): Acts as a safety net for newborns (including midwife births) and children with speech delays. Universal screening at ages 4, 5, and 6 ensures students enter school without undiagnosed hearing impairment. Jaundice (2 TcB Bilirubinometers): Provides non-invasive, instant monitoring of newborn jaundice through the skin. This eliminates painful heel-sticks and saves families thousands in outpatient lab fees during the critical first two weeks. Respiratory (2 PFT/Spirometry Machines): Establishes the "gold standard" for asthma care. By using objective lung function data rather than subjective reports, clinicians can adjust medications in real-time, significantly reducing ER visits. Expected Impact This equipment transition shifts the burden of care from the patient to the clinic, ensuring that geography is no longer a barrier to essential pediatric and respiratory health outcomes.	\$50,000-\$250,000	Clinic	Single Community	Matanuska-Susitna Borough	Advance to Implementation Application

Ptarmigan Pediatrics LLC	Digital Transformation of Rural Care at Ptarmigan Pediatrics	AK	This grant proposes a dual-layered technology infusion: 1. A Custom Integrated Portal: A user-friendly interface that sits between our EMDs and Phreesia, allowing for seamless scheduling, document sharing, and messaging without the clunky limitations of a standard EMR portal. 2. Ambient Clinical Intelligence (DAX): AI-powered voice technology that securely captures patient encounters in real-time, allowing providers to remain fully engaged with the child and family while the AI generates high-quality, clinical notes. This transformation will protect the 55% of the region's children we serve by ensuring their providers are present, focused, and administratively efficient.	1. The Integrated Portal (The "Digital Front Door") Unlike standard EMR portals, this system will offer a "one-tap" experience for Alaskan parents. • Benefits: Reduces "phone tag" for 16,500 patients, allows for digital intake via Phreesia before the family leaves their home, and provides a secure platform for sharing Speech and Behavioral Health results instantly. • Infrastructure: Includes dedicated server space and enhanced IT support to ensure 100% uptime in rural connectivity environments. 2. Nuance Dragon Ambient eXperience (DAX) DAX is a sophisticated AI that "listens" to the visit (with parental consent) and converts the conversation into a structured note. • Benefits: Increases "eye contact time" between the pediatrician and the child. For pediatric behavioral health, this is transformative, as it captures the nuances of the interaction that are often lost when a provider is typing. • Productivity: By reducing charting time by up to 50%, providers can see 1-2 more patients per day or spend that time on complex care coordination.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Ptarmigan Pediatrics LLC	Medical Support Staff Retention Initiative	AK	The health of 16,500 children is not maintained by physicians alone; it is maintained by the "village" of support staff who answer the phones, score the assessments, coordinate the referrals, and welcome the families. At Ptarmigan Pediatrics, we recognize that our support staff are the guardians of our clinic's efficiency and our patients' comfort. The Support Staff Retention Initiative is a direct investment in the stability of rural Alaskan families. By removing the financial "gross-up" burden from our clinic's operating budget, we can focus our resources on clinical excellence while ensuring our staff feels the full weight of our appreciation. We are asking the RHTP to help us keep this village intact, ensuring that the faces our children see today are the same faces they will trust throughout their childhood.	This grant requests a 10% annual retention fund, fully "Grossed Up" to cover all tax liabilities. This ensures that our 39 staff members receive the full value of their bonus, insulating them from the high cost of living in Alaska. By providing these bonuses strategically (1–4 times per year), we create a consistent "pulse" of appreciation and financial security, making Ptarmigan Pediatrics the employer of choice in a competitive market where primary care often struggles to match specialty-clinic wages. Our staffing model accounts for current needs and the necessary growth to meet the demands of our 16,500-child catchment area. Staffing & Salary Projections • Current Full-Time Employees (FTE): 33 • Current Part-Time Employees: 2 • Planned New Hires (FTE): 4 • Total Anticipated Workforce: 39 • Total Anticipated Base Salary: \$1,945,000 The "Zero-Burden" Bonus Model To ensure the 10% bonus feels like a true reward, the grant includes the "Gross-Up" (approximately 30% for taxes/FICA) and the 4% 401(k) match.	\$250K-\$1M	Private practitioner	Single Community	Matanuska-Susitna Borough	Advance to Implementation Application

Ptarmigan Pediatrics LLC	Strategic Initiative for Pediatric Workforce Sustainability in Rural Alaska	AK	Ptarmigan Pediatrics is seeking grant funding to onboard a newly graduating pediatric resident to address a looming primary care shortage in our catchment area. Currently serving 16,500 patients—representing 55% of the local pediatric population—our clinic is the cornerstone of child healthcare in the region. With a significant portion of the local physician workforce nearing retirement within the next 5–10 years, this recruitment is a proactive measure to prevent a "care cliff." We are requesting a total investment to cover initial salary support, a significant retention-based sign-on bonus, and essential technological infrastructure (including AI-driven clinical tools) to ensure the new provider reaches self-sustainability within 9 months while maintaining high patient throughput.	The health of our community’s children is dependent on the foresight of our recruitment efforts today. By supporting this grant request, the Rural Health Transformation Project will enable Ptarmigan Pediatrics to secure a dedicated new physician, stabilize the local medical workforce against upcoming retirements, and leverage cutting-edge AI technology to ensure sustainable, efficient care. Ptarmigan Pediatrics is requesting a one-time investment of \$333,606 to bridge the 9-month "ramp-up" period for a new pediatric resident. This total includes \$164,500 for 70% of the \$235,000 base salary and \$44,063 for benefits and taxes. To ensure long-term retention in rural Alaska, we include a \$105,635 grossed-up sign-on bonus and \$5,000 for relocation. Finally, \$14,408 is allocated for essential infrastructure, including EMR licensing and Nuance DAX AI tools to maximize clinical efficiency. By month 9, the provider will be self-sustaining through patient revenue.	\$250K-\$1M	Clinic	Single Community	Matanuska-Susitna Borough	Advance to Implementation Application

Ptarmigan Pediatrics LLC	Pediatric Specialty Access Planning Initiative - Expanded Telemedicine Capabilities (PSAPI)	AK	In rural Alaska, "telemedicine" is often limited to basic sick visits. Complex pediatric conditions—such as Fetal Alcohol Spectrum Disorder (FASD), speech delays, and neuropsychological needs—require multidisciplinary teams and objective data (vitals, growth charts). Currently, families must travel to urban hubs for these evaluations, often resulting in deferred care or incomplete diagnoses. While basic telemedicine (video chat) is widely available, complex pediatric evaluations—such as Fetal Alcohol Spectrum Disorder (FASD) or Speech Therapy—often require a "hybrid" approach where a local provider collects physical data (vitals, growth, neuro-physical observations) while a remote specialist conducts the assessment. Our goal is to evaluate the feasibility of expanding telemedicine capabilities to include these complex medical condtions. The PSAPI planning year requires a total of \$20,000. The majority, \$12,600, funds the NP Coordinator for 12 months of research and four intensive field visits. \$6,200 is allocated for travel, lodging, and per diem to assess remote site readiness firsthand. The final \$1,200 covers administrative costs, including legal reviews of MOUs and platform trials. This focused investment ensures that the high-cost hardware and implementation phases in Years 2 and 3 are built on a sustainable, clinically sound, and community-verified foundation.	The Pediatric Specialty Access Planning Initiative (PSAPI) is a strategic one-year project designed to solve the "specialty gap" in rural Alaska by creating a robust telemedicine bridge between urban specialists and remote clinics. A central component of the plan is the formalization of "Sister Site" agreements. These partnerships ensure that remote clinics are equipped and staffed to provide essential hands-on data, such as vitals and growth charts, while the specialist manages the clinical diagnosis from the Wasilla hub. By conducting onsite audits of clinical workflows and hardware requirements, the project moves beyond simple video calls to high-fidelity assessments for nutrition, lactation, and behavioral health. The ultimate goal is to transition from this planning phase into a sustainable, insurance-reimbursed model that eliminates the need for families to endure expensive and exhausting travel for routine specialty care. By June 2027, the project will produce a clear roadmap for equipment procurement and site readiness, ensuring that geography is no longer a barrier to "gold-standard" pediatric medicine The first year (July 2026 – June 2027) will be dedicated to building the "Human Infrastructure" required for Year 2 implementation. 1. Expert Project Coordination (Nurse Practitioner) We will utilize a Nurse Practitioner (NP) with extensive experience in community relations and distant clinic operations to lead the planning. • Coordination: Identifying "Sister Sites" (remote clinics/schools) and establishing Memorandums of Understanding (MOUs). • Research: Identifying HIPAA-compliant platforms that can handle the high-definition video required for neuropsychological observation. • Workflow Design: Determining how height, weight, and vitals will be integrated from a remote site into the patient's medical record. 2. Sister-Site Feasibility Tours The NP Coordinator will conduct 3–4 site visits to remote medical facilities. These 2-day trips are essential to audit: • Connectivity Gaps: Testing broadband for "lag-free" speech therapy or counseling. • Clinical Space: Evaluating if local rooms provide the privacy needed for lactation or neuropsychological testing. • Relationship Building: Meeting local staff to ensure the "Train-the-Trainer" model is sustainable in Year 2.	Under \$50,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Planning

Ptarmigan Pediatrics LLC	: Ptarmigan Pediatrics Community Summer Health & Wellness Fair	AK	Ptarmigan Pediatrics identifies a critical opportunity to address the geographic and systemic barriers that prevent rural families from accessing essential health and safety resources. In many rural regions, healthcare is fragmented; families often travel significant distances to multiple locations for basic needs like vaccinations, developmental screenings, and safety education. This fragmentation leads to lower health literacy and deferred preventative care, ultimately increasing long-term health risks for children. By hosting a comprehensive Summer Health Fair, we aim to collapse these barriers, transforming our clinical site into a centralized community hub. The event provides a "one-stop shop" where over 35 local entities—ranging from emergency services to educational non-profits—can engage with residents in a high-visibility, trusted environment. This project represents a strategic shift from reactive office visits to proactive community engagement. By consolidating vital services into a single, accessible day, we can significantly boost preventative care rates and foster direct connections between families and the support networks they need. Funding this initiative as a three-year renewable partnership allows us to move beyond a one-time event, establishing a predictable cornerstone of rural health that builds multi-generational trust and improves the overall well-being of our region’s youth.	In rural Alaska, health outcomes are heavily influenced by environmental and social factors. This fair directly addresses key SDOH categories: • Access to Healthcare & Health Literacy: By bringing 35+ providers to a central, visible location, we eliminate "navigation barriers." Residents can meet specialists and non-profit leaders face-to-face, reducing the intimidation factor often associated with institutional healthcare. • Social and Community Context: Isolation is a significant health risk in rural areas. This event builds "social capital" by gathering residents in a safe, celebratory environment, strengthening the community fabric. • Neighborhood and Built Environment: Hosting the event in the center of the "medical community" helps residents mentally map out where resources are located, ensuring they know where to turn during a crisis. A grant of \$10,000 per year would cover advertising, special event items, DJ and music, health/safety giveaways, sanitation and provision of food for attendees.	Under \$50,000	Private practitioner	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Ptarmigan Pediatrics LLC	Alaska Remote Community Speech & Language Support Program	AK	This proposal outlines a one-year outreach initiative to send 2–4 certified Speech-Language Pathologists (SLPs) to remote communities in Western Alaska three times during the year. The purpose of the program is to train parents, caregivers, educators, and community members in practical, culturally responsive strategies to improve speech and language development for children from preschool through middle school. By building community capacity and leaving behind sustainable materials and tools, this program will strengthen communication outcomes in regions where consistent speech-language services are limited. Project Overview • Serving Rural Alaskans: Directly serves families in Western Alaska by removing the need for expensive travel to urban hubs and providing services in familiar community settings. • Concept Approach: Three multi-day outreach trips (Fall, Winter, Spring) featuring workshops, classroom demonstrations, and the distribution of permanent support toolkits. • Sustainability: Knowledge and physical materials (manuals, games, and visuals) remain in the community, supplemented by remote teleconsultation between visits.	Primary Goal: To increase community capacity to support speech and language development for children ages 3–13. Objectives: 1. Conduct three multi-day outreach visits during one calendar year. 2. Train parents and community members in evidence-based language strategies. 3. Provide take-home materials and classroom toolkits to sustain efforts. 4. Offer follow-up consultation between visits as needed. Program Structure Service Model The program will include three outreach trips (Fall, Winter, Spring). Each trip will include: • 3–5 days on-site per visit • Parent and caregiver workshops • Classroom strategy demonstrations • Small group consultation sessions • Distribution of speech and language support materials Staffing Each visit will include 2–4 licensed Speech-Language Pathologists with experience in early childhood and school-based practice. The total funding request for this one-year initiative is \$69,060. A significant portion of this budget (\$36,000) represents the Clinical Opportunity Cost, ensuring the home clinic remains sustainable while its specialists are deployed to the field. Approximately 26% of the remaining funds are dedicated to the logistical realities of Alaskan travel, while \$9,000 is invested directly into permanent materials that stay within the community to ensure a lasting legacy of support.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Ptarmigan Pediatrics LLC	Bringing clinical diagnostics home - Fiberoptic Endoscopic Evaluation of Swallowing	AK	Currently, when one of our 16,500 pediatric patients requires a swallow study, they must be referred to an urban hospital (Anchorage, Fairbanks, or Seattle) for a modified barium swallow study (MBSS) . For 50 patients annually, the estimated societal and system costs are up to \$190,000 per year for hospital fees, travel, lodging/meals, and lost wages for parent/guardian. Some of the benefits of FEES: • Real-Life Testing: Unlike MBSS, which uses barium-coated "fake" food in an intimidating X-ray suite, FEES allows the SLP to use the child’s actual breastmilk, formula, or favorite home-cooked foods in a familiar clinic setting. • No Radiation Exposure: FEES uses a light-based camera, making it safe for repeated follow-up studies to monitor a child’s progress without cumulative radiation concerns. • Immediate Biofeedback: The SLP can show the parent the video immediately after the scope, helping them visualize why their child is coughing or choking. This drastically increases "buy-in" for therapy and safety maneuvers.	The Pediatric FEES Implementation Project is a four-year strategic plan to transition Ptarmigan Pediatrics from diagnostic dependence to self-sufficiency • Phase 1 (Planning & Mastery): Intensive clinical training for two Speech-Language Pathologists (SLPs). • Phase 2 (Capitalization): Procurement of a state-of-the-art pediatric FEES tower and specialized procedure chair. • Phase 3 (Operationalization): High-volume clinical testing (50+ patients/year). • Phase 4 (Sustainability): Full integration into clinic operations, funded by specialized billing and reimbursement : The entire 3-year grant request for the FEES program (\$115,000) is less than the cost of just one year of travel-based MBSS studies for our population.	Under \$50,000	Clinic	Statewide	Matanuska-Susitna Borough	Deferred or Not Advanced
Ptarmigan Pediatrics LLC	Ptarmigan Pediatrics Community Health Education Series	AK	In rural Alaska, "health" is often hindered by a lack of access to specialists. This program brings those specialists directly to the people. • Access to Experts: Residents gain face-to-face time with content specialists they might otherwise never meet due to travel or insurance barriers. • Resource Navigation: A primary goal is teaching parents how to access existing local resources, effectively strengthening the entire rural health ecosystem. The Ptarmigan Pediatrics Community Health Education Series is an investment in the most valuable resource in rural Alaska: informed parents and caregivers. By funding this project, the RHTP will foster a more resilient, educated, and self-reliant community.	This program transitions our clinic from a site of reactive medical treatment to a center for proactive community education. • Year 1 Planning Phase (July 2026 – Sept 2026): This critical three-month window will be dedicated to curriculum development, securing partnerships with content specialists (e.g., OB/GYNs, nutritionists, and safety experts), and establishing a recruitment pipeline for attendees. • Operational Phase (Oct 2026 – Sept 2027): Monthly 2–3 hour classes open to the public. While initially free, specialized courses involving certifications (like CPR) may include a nominal fee to cover materials.	Under \$50,000	Clinic	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Ptarmigan Pediatrics LLC	Standardizing Pediatric Preventative Diagnostics in Rural Alaska	AK	In rural Alaska, "lost-to-follow-up" is a significant clinical risk. Traditional lab models require sending samples to central hubs, often resulting in multi-day delays. Furthermore, adolescent sexual health is often underserved due to the stigma of "opt-in" testing. This project creates an opportunity to set a new standard of care where diagnostic excellence is built into the routine well-visit, regardless of a family's proximity to an urban center. This initiative represents a paradigm shift in how we approach pediatric health in rural Alaska. By integrating advanced point-of-care diagnostics and a universal, stigma-free screening model for adolescents, Ptarmigan Pediatrics is moving beyond traditional reactive medicine toward a high-efficiency, preventative standard of care. This project not only addresses the immediate geographic barriers our 16,500 patients face but also establishes a fiscally responsible, self-sustaining clinical framework that will serve the community for years to come. We are committed to ensuring that every child in our catchment area—regardless of their proximity to an urban center—has access to the rapid, high-quality diagnostic data required for a healthy future.	We will install a localized diagnostic suite within the clinic: • Metabolic/Lipid: Two Piccolo Xpress machines for immediate CMP and Lipid panels. • Hematology: A Cytochip system for CBCs. • Diabetes Screening: DCA Vantage for hgbA1c. • Universal STD Screening: Implementation of the Aptima system to offer universal multiswab testing for all patients aged 15–18 during well visits. By making this "universal" rather than "requested," we remove the barrier of patient/provider discomfort and increase detection rates. • Access: By utilizing point-of-care machines like the Piccolo and DCA Vantage, we provide "same-visit" results to families who travel long distances, eliminating the need for follow-up travel or phone calls. • Quality: Immediate data allows for "real-time" clinical interventions—such as nutritional counseling for an elevated hgbA1c or immediate treatment for a positive STD screen—greatly improving health outcomes. • Sustainability: The project utilizes established CPT codes for laboratory reimbursements. Once the initial hardware and first-year supplies are funded, the revenue generated from high-volume screening will cover all future reagent costs and staff time.	\$250K-\$1M	Clinic	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Ptarmigan Pediatrics LLC	The Clinical Continuity & Rural Stability Initiative	AK	In rural Alaska, the greatest threat to pediatric health is provider turnover. When a clinician leaves, families often face long travel times, fragmented care, and delays in medical and behavioral health diagnoses. This grant seeks to bridge the gap between financial reality and the need for long-term patient stability. By providing 100% upfront funding for incentives, payroll taxes (gross-ups), and 401(k) matches, this grant ensures that Ptarmigan Pediatrics can guarantee a stable medical home for 55% of the catchment area’s children without straining the clinic's operating budget.	This project requests \$1,677,960 in upfront funding to establish a three-year retention program for 25 essential clinical staff members, including pediatricians, nurse practitioners, and behavioral health specialists. By fully funding these incentives—including all "gross-up" tax obligations and 401(k) matching—this grant removes the financial burden from the clinic's operating budget, ensuring clinical continuity in rural Alaska. To ensure the intended incentive reaches the provider’s pocket (\$25k, \$15k, etc.), the grant absorbs the \$191,100 in annual tax liability. Providers receive the full net incentive amount upfront to maximize the immediate retention impact. The clinic does not retain any portion of the grant for operations; instead, the associated "gross-up" tax funds and employer matches are held in a Restricted Tax Reserve Account. These funds are disbursed annually to satisfy tax and fee obligations in the specific year they are reported to the IRS, ensuring the clinic remains compliant without straining future cash flow. To promote long-term financial health, we have included a 4% match on these supplemental wages. Requesting the full \$1,677,960 in Year 1 allows Ptarmigan Pediatrics to maintain a strong balance sheet while providing staff with the psychological security of knowing their three-year incentive is already secured. Each incentive is treated as a 3-year loan that is forgiven in equal monthly installments (\$1/36th\$) provided the provider remains employed. If a provider leaves before the 36-month term, the unforgiven portion of the grant must be repaid by the provider. These recouped funds are held by Ptarmigan Pediatrics in a "Future Provider Fund" used specifically for the recruitment and onboarding of a replacement. This creates a self-sustaining cycle that protects the patient population's access to care regardless of individual staff changes.	\$1M-\$5M	Clinic	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Ptarmigan Pediatrics LLC	The Ptarmigan Feeding & Eating Wellness Initiative	AK	The nonprofit arm will operate within Ptarmigan Pediatrics to provide a "one-stop" clinical home. Our approach integrates various specialties to treat the "whole child": • Registered Dietitian (RD): Clinical nutrition management and growth monitoring. • Occupational Therapist (OT): Addressing sensory processing and oral-motor mechanics. • Future Expansion: Integration of SLPs (swallowing), Lactation Consultants (infant feeding), and Mental Health providers (ARNP/Psychology) for eating disorder management. To ensure the clinic does not rely solely on grants: • Hybrid Revenue: Providers will maintain a percentage of general pediatric cases within their scope of practice to ensure full schedules and consistent billing revenue. • Insurance Integration: We will bill private and state (Medicaid) insurance to create a sliding-fee scale for the uninsured.	Our model utilizes a Hybrid Clinical Model. To maintain financial solvency, providers carry a dual caseload: specialized feeding/eating disorder cases and general pediatric cases within their scope of practice. Key Personnel & Staffing Plan • Project Director / Registered Dietitian (RD): Leads clinical nutrition, growth monitoring, and grant compliance. • Lead Occupational Therapist (OT): Specialized in oral-motor mechanics and sensory processing. (Salary: \$120,000). • Post-Doctoral Psychology Fellow: Provides specialized counseling and eating disorder intervention. (Salary: \$90,000). • Practice Support Specialist: A full-time navigator (\$20/hr) managing scheduling, authorizations, and bookkeeping. The initial grant is requested to "seed" the two most critical roles: <table><thead><tr><th>Position Role</th><th>Justification</th></tr></thead><tbody><tr><td>Project Director / RD Clinical Oversight & Nutrition</td><td>Will manage grant compliance, coordinate the multidisciplinary team, and provide medical nutrition therapy.</td></tr><tr><td>Lead OT (Feeding) Sensory & Motor Specialist</td><td>Will implement high-level feeding protocols (e.g., SOS Approach) and train junior staff.</td></tr></tbody></table> Foundations often ask: "Why are you seeing general patients if the grant is for eating disorders?" Here is how we answer that in the proposal: "To ensure the clinical and financial health of the nonprofit, providers will maintain a 'Hybrid Caseload.' While the primary focus remains on feeding and eating disorders, providers will see general pediatric patients within their scope of practice. This strategy serves three purposes: 1. Clinical Competency: Ensures providers maintain broad pediatric skills. 2. Financial Stability: Fills schedule gaps to maximize insurance revenue, reducing long-term dependency on grants. 3. Community Access: Addresses the general shortage of OT, Speech, and Dietitian services in the region."	Position Role	Justification	Project Director / RD Clinical Oversight & Nutrition	Will manage grant compliance, coordinate the multidisciplinary team, and provide medical nutrition therapy.	Lead OT (Feeding) Sensory & Motor Specialist	Will implement high-level feeding protocols (e.g., SOS Approach) and train junior staff.	\$250K-\$1M	Clinic	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced
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Public Consulting Group LLC	Alaska Rural Health Fellowship: Growing & Sustaining the Rural Workforce	MA	Rural, remote, and frontier communities across Alaska face persistent health workforce challenges that limit access to care, strain existing providers, and threaten long-term system sustainability. Chronic vacancies, high turnover, and reliance on short-term or external staffing solutions make it difficult for communities to maintain consistent, community-responsive health and public health services. At the same time, there is a significant opportunity to strengthen Alaska’s rural health ecosystem by investing in workforce pathways that prepare professionals for rural practice, embed them within communities, and support long-term retention. PCG currently manages a statewide fellowship program in New York State that demonstrates how paid, structured fellowships—paired with hands-on placement, targeted projects, and sustained support—can expand workforce capacity while improving service delivery. This project adapts that proven fellowship model to Alaska’s unique rural and frontier context. By placing paid fellows with Alaska-based partners and engaging them in targeted fellowship plans that directly support community members, the project addresses immediate workforce needs while building durable pipelines that reduce dependence on temporary staffing and strengthen local health systems over time.	Our proposed fellowship model applies the proven structure of PCG’s New York State fellowship project, recruitment, paid placement, training, and ongoing support, while tailoring the program to Alaska’s rural, remote, and frontier landscape through strong partnerships with Alaska-based organizations. Fellows will be hired into paid fellowship roles and placed with local host organizations through targeted fellowship plans that align community needs, organizational priorities, and fellow skillsets. These placements are intentionally designed so fellows support both systems-level workforce initiatives and direct, community-facing projects related to health care access, public health, and service coordination. The fellowship follows a two-phased approach. In Phase One, fellows increase immediate workforce capacity by supporting priority initiatives such as workforce planning, operational improvements, service coordination, and projects that bring health and public health resources closer to rural and frontier communities. In Phase Two, fellows focus on longer-term capacity building by strengthening systems, documenting processes, supporting staff development, and advancing strategies that reduce reliance on short-term or external staffing solutions. PCG will provide a strong program backbone informed by best practices from prior fellowship programs including structured onboarding, professional development, peer learning, and ongoing technical assistance. PCG staff are prepared to be on-site in Alaska to support partner engagement, fellow success, and program implementation, ensuring placements remain responsive to local conditions. While the core “bones” of the fellowship are established, the Alaska program will be built collaboratively with Alaska-based partners to ensure cultural relevance, operational feasibility, and meaningful community impact.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Public Policy Lab	Elevating Rural Older Adults' Health Care Experiences in Alaska	NY	Alaska's population is aging rapidly, yet policymakers and service providers lack accessible qualitative insight into how older Alaskans, particularly Alaska Native elders and residents of rural and frontier communities, experience aging, navigate health care systems, and manage chronic conditions in daily life. Quantitative data can show where systems fall short. It cannot explain how those failures are lived, why they recur despite intervention, or what residents do when formal support is unavailable. For a state as geographically and culturally distinct as Alaska, that explanatory gap has direct consequences for policy design and service delivery. This project addresses the gap by documenting older adults' experiences through in-depth qualitative interviews and integrating their perspectives into The People Say, a national research platform focused on aging and health systems. By elevating rural Alaskans' firsthand accounts of navigating care, managing health needs, and accessing community services, the project provides decision-makers with the grounded insight needed to identify where systems are failing, why, and what changes would meaningfully improve access, quality, and the sustainability of care.	The project builds on The People Say's established research infrastructure, a national qualitative platform with a proven methodology deployed across 15 states. The approach pairs rigorous in-depth research with a structured dissemination platform designed to make lived experience accessible and actionable for policymakers, health system leaders, and community organizations. First, PPL will work with Alaska-based partners, including state agencies such as the Alaska Department of Health's Commission on Aging and community organizations, to identify rural and frontier communities where older adults face significant barriers to health care. Partners will help guide recruitment and ensure the project reflects local priorities and conditions that outside researchers could not anticipate. Second, trained researchers will conduct in-depth, semi-structured interviews with older adults living in rural Alaska. Interviews explore how residents access care, manage chronic conditions, coordinate services, and interact with Medicare, Medicaid, and community-based programs. The aim is to capture how policies and health systems function in practice from the perspective of people who use them daily. Third, interview data will be analyzed through an iterative qualitative process to identify patterns around access, system navigation, care coordination, and community resilience. Cross-location synthesis enables researchers to distinguish Alaska-specific challenges from those that cut across rural and frontier contexts nationwide. Findings will be shared with Alaska partners to support local interpretation and ground truth. Finally, interviews and analysis will be integrated into The People Say platform as curated video clips, transcripts, and tagged qualitative data aligned to a structured research taxonomy. This format allows policymakers, health administrators, and advocates to explore Alaska's rural health realities directly and compare them with evidence from other states, enabling both local application and national learning.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

PwC US Consulting LLP	AI-Powered Expenditure Tracking and Real-Time Anomaly Detection Platform	FL	Beginning March 2028, CMS will evaluate Alaska's RHTP fund utilization and may redistribute unobligated or mismanaged funds to other states. Alaska's \$272 million annual allocation — \$1.36 billion over five years — is at risk if expenditure patterns cannot be tracked, validated, and reported at scale. This is not hypothetical: CMS has redistributed funds in other federal programs when states could not document effective stewardship. Alaska's RHTP will fund dozens of subrecipients, creating significant financial monitoring requirements across a dispersed and administratively diverse portfolio. The challenge is structural: subrecipients use different financial systems, report on different cycles, and operate under varying levels of admin capacity. Financial anomalies detected months after expenditure leave DOH with limited corrective options. This project addresses that structural challenge with technology. Palantir Foundry provides an integrated, automated expenditure tracking and anomaly detection platform — the same infrastructure powering financial oversight at HHS, CDC, and VA. PwC configures the risk models, integrates with ACF's GrantInterface, and designs the governance layer. The result is continuous, automated financial visibility across all subrecipients — enabling DOH to act early, before anomalies become audit findings. This platform is the data infrastructure that independent evaluation and grants administration functions depend on to operate effectively.	PwC and Palantir propose deploying Palantir Foundry as the automated expenditure tracking and anomaly detection infrastructure for Alaska's RHTP. This is a technology platform engagement — focused on data integration, automated monitoring, and real-time financial visibility — designed to complement and enable human-led oversight functions. Component 1 — Expenditure Tracking Platform (Palantir Foundry): Deploy a centralized platform integrating subrecipient financial data — budgets, expenditure reports, invoices, drawdown requests — with project milestones, deliverable completion, and performance metrics. Integrate directly with ACF's GrantInterface through API connections and structured data feeds, enabling automated ingestion of award data and budget allocations. This eliminates dual data entry for subrecipients and ensures DOH has a continuously updated view of fund utilization across the full portfolio. Component 2 — AI Anomaly Detection (Palantir AIP + PwC Risk Models): Deploy machine learning models identifying expenditure anomalies including: unusual spending velocity; costs inconsistent with project scope; duplicate expenditures across subrecipients; performance-expenditure mismatches; and vendor payment irregularities. PwC designs the risk model logic; Palantir AIP provides the AI/ML engine. All anomaly alerts flow to DOH and ACF for structured human review — the platform surfaces signals, human reviewers determine response. False positive rate targeted below 15% with 90%+ detection sensitivity for material anomalies. Component 3 — Real-Time Dashboards & Automated CMS Reporting: Deploy dashboards providing DOH leadership, ACF, and the Advisory Council continuous visibility into fund utilization, risk indicators, milestone tracking, and portfolio-level performance. Automate quarterly and annual CMS reporting, reducing manual burden on DOH staff and ensuring consistent, audit-ready documentation across the grant period. Component 4 — Governance Integration: Design data governance and access control framework ensuring DOH, ACF, tribal health organizations, and subrecipients access only appropriate data. Tribal subrecipient data governed per ANTHC protocols and tribal data sovereignty requirements. Establish structured alert-to-review workflow connecting platform outputs to DOH and ACF decision-makers.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

PwC US Consulting LLP	Alaska HIE Transformation & Last-Mile Interoperability Strategy	FL	Alaska's RHTP investments in value-based care, telehealth, and chronic disease management share a common dependency: health data must flow across the full continuum of care. HealthEConnect Alaska provides statewide infrastructure, but five documented gaps limit HIE effectiveness for RHTP purposes. First, behavioral health data sharing remains limited to basic clinical summaries, not full bidirectional BH or SUD record exchange. Alaska's CCBHC demonstration launches Q3 2026, making HIE connectivity for ABHA member organizations a time-sensitive priority. Second, crisis services data exchange is insufficient. Alaska documents the closure of its only short-term adolescent psychiatric crisis center and a suicide rate more than twice the national average. Crisis units, mobile teams, and EmPATH facilities produce clinical data that rarely reaches follow-up providers — a gap RHTP Initiative 2 directly targets. Third, correctional health is disconnected. Individuals with BH and SUD conditions are disproportionately represented in Alaska's correctional population, yet no health data from Department of Corrections facilities reaches community providers at discharge. Fourth, many rural and frontier providers lack ONC-certified EHRs, preventing HIE participation entirely. Fifth, rural providers lack the analytics infrastructure required for Initiative 4 value-based arrangements — a prerequisite the initiative explicitly identifies as an eligible use of funds	PwC and Converge Health will execute an integrated, four-workstream engagement pairing Converge Health's interoperability expertise with PwC's rural EHR implementation experience, financial planning, gap analysis, and program management capability. • Workstream 1 — Statewide HIE Gap Assessment & Environmental Scan (Converge Health-led, Months 1–9): A comprehensive assessment mapping all provider types — acute, ambulatory, behavioral health, crisis, EMS, tribal, corrections, and community-based organizations — against HIE connectivity status, data types, interoperability standards, and governance structures. Deliverable: a prioritized interoperability roadmap aligned to all six RHTP initiatives, approved by DOH and healthEconnect Alaska. • Workstream 2 — EHR Adoption for Non-Connected Rural Providers (PwC-led, Months 4–24): Technology readiness assessments for providers outside the HIE. Evaluation of ONC-certified EHR options for low-bandwidth environments, business case development, financial planning, and implementation support — prioritizing providers serving Alaska Native and rural medically underserved populations. • Workstream 3 — Last-Mile Interoperability Implementation (Converge Health-led, Months 6–30): Phased implementation across five domains: (a) Behavioral Health — full data integration beyond clinical summaries aligned with 42 CFR Part 2; (b) Crisis Services — data exchange for stabilization units, mobile crisis teams, and EmPATH facilities; (c) Correctional Health — reentry data exchange connecting DOC facilities to community providers; (d) EMS — bidirectional AURORA-Elite ePCR and HIE integration; (e) Tribal Health — data governance co-design with ANTHC and tribal organizations preserving tribal data sovereignty. • Workstream 4 — VBC Analytics & Program Governance (PwC-led, Months 6–36): Population health analytics for risk stratification, care gap identification, and RHTP outcomes reporting. Program governance design for DOH, ACF, and healthEconnect. Medicaid administrative match analysis, post-RHTP operations planning, and rural provider VBC readiness support for Initiative 4 participation.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

PwC US Consulting LLP	Federated Population Health Data Platform with AI Analytics	FL	Alaska's health data sits in silos — Medicaid data in Conduent's MMIS, clinical data across Cerner, RPMS, and Epic, healthEconnect, behavioral health systems, and social services data — with no unified platform integrating them while respecting tribal data sovereignty. Without this integration, Alaska cannot deliver risk stratification, care coordination, and value-based care central to RHTP's goals. Alaska's own milestones make this urgent now: HIE expansion is (Q1 2026), interoperability (Q2 2026), EHR investments (Q3 2026), and risk stratification (Q4 2026). The infrastructure to support all six RHTP initiatives must be in place within this window. PwC and Palantir have done this before. Foundry powers federated health data integration for CDC, VA, HHS, and 35+ US health systems — including rural operators Lifepoint Health and HCA Healthcare. Critically, Foundry overlays and connects to existing systems — healthEconnect, Conduent's MMIS, Gainwell's provider enrollment, Cerner and RPMS at tribal sites — through 200+ pre-built connectors. This is the same approach proven at NHS England, where the Federated Data Platform integrates with dozens of existing systems without requiring costly migrations. Existing investments are preserved and enhanced, not displaced. PwC, as Palantir's strategic partner, provides healthcare domain expertise, CMS compliance, and Alaska stakeholder engagement to deploy this proven technology in Alaska's unique context.	PwC and Palantir propose deploying Palantir Foundry as the data federation and analytics platform, with PwC providing health care domain expertise, implementation management, and stakeholder engagement. Phase 1 — Data Foundation & Governance (Months 1-4): Build the data ontology mapping health system entities into Foundry's semantic object model. Co-design tribal data governance framework with ANTHC. Execute data-sharing agreements with healthEconnect, Medicaid systems, and providers. Begin initial data connections — healthEconnect integration via CRISP Shared Services/TEFCA is a days-to-weeks effort given Foundry's existing FHIR/HL7 connectors. Phase 2 — Integration & Initial Analytics (Months 3-12, overlapping with Phase 1): Deploy federated data connections to Medicaid administrative systems, tribal health organizations and providers. Leverage Foundry's native OMOP-to-FHIR conversion for EHR data normalization. Configure operational decision-support views — near-real-time, actionable information (resource allocation status, care coordination gaps, population health trends by borough) that enables corrective action, not just reporting. Deploy initial rules-based risk stratification models using integrated multi-source data. Phase 3 — AI-Enabled Use Cases (Months 8-24, parallel with Phase 2): Layer Palantir's AI Platform (AIP) for operational AI use cases mapped to RHTP initiatives: #1Healthy Beginnings → maternal health risk prediction; #2 Health Care Access → patient throughput optimization and AI-powered referral management to reduce days-to-appointment; #3 Healthy Communities→ chronic disease population segmentation and care gap identification; #4 Pay for Value → VBC performance monitoring and revenue cycle optimization; #5 Workforce → AI-driven staffing optimization and skill-mix matching; #6 Spark Tech → automated RHTP performance monitoring and CMS reporting. All use cases governed by clinical expert oversight and responsible AI framework. Phase 4 — Optimization & Sustainability (Ongoing from Month 12): Continuously iterate on decision-support logic, risk stratification parameters, and operational ML model configurations using Alaska-specific data patterns — refining pipelines, adjusting thresholds, and engineering prompts for AIP rather than retraining foundational models. Train DOH and healthEconnect staff through a Centre of Excellence model mirroring NHS FDP's training infrastructure. Transition to sustainable operations.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

PwC US Consulting LLP	Independent Evaluation and Program Integrity for Alaska RHTP	FL	CMS requires ongoing performance measurement and independent end-of-grant evaluation for RHTP. To maintain \$272 million in annual federal funding and avoid redistribution beginning March 2028, Alaska must demonstrate measurable progress across all six initiatives. PwC proposes to serve as an independent evaluation and monitoring partner that supports DOH in demonstrating impact while reinforcing transparent oversight and responsible stewardship of federal funds. Large-scale federal investments benefit from clear controls, structured monitoring practices, and defined escalation pathways that help identify compliance risks, documentation gaps, or unusual spending patterns early, before they develop into audit findings or funding disruptions. DOH needs an independent partner who can deliver credible, CMS-aligned findings while strengthening accountability and continuous improvement. PwC will develop a defensible CMS-aligned evaluation framework; deploy performance dashboards and reporting tools; validate submitted data; and implement a fraud, waste, and abuse function that applies risk-based monitoring and advanced analytics to identify anomalies in reporting or expenditures. Where potential concerns arise, PwC can support structured FWA review and fact-finding processes consistent with government oversight expectations, reinforcing confidence in program	PwC proposes to serve as Alaska’s independent third-party evaluator for RHTP through four integrated components that strengthen accountability, support continuous learning, and advance measurable improvements in rural health outcomes. Evaluation Approach: PwC will build a practical evaluation framework aligned with CMS requirements and Alaska’s RHTP metrics. We will define how progress is measured, what data is collected, and how outcomes are assessed across all initiatives. Because Alaska’s rural communities have small populations and may have limited data, we will use methods suited to these settings, combining quantitative analysis with interviews, project reviews, and community input. Our approach will respect tribal sovereignty while providing a clear picture of program performance. Performance Measurement and Monitoring: PwC will establish dashboards, standardized quarterly reporting, and data validation protocols to strengthen the reliability of reported results. Site monitoring tools will combine virtual engagement with targeted in-person reviews appropriate for Alaska’s geography. PwC will apply risk-based monitoring and analytics to identify anomalies and flag potential compliance concerns early. These activities are designed to reinforce existing State oversight by highlighting areas that may warrant additional documentation review, technical assistance, particularly in rural settings where administrative capacity may be limited. Program Integrity and Fraud Prevention: PwC can implement an FWA function that combines advanced analytics with confidential reporting mechanisms. A secure hotline or reporting portal allows stakeholders to raise concerns safely, supported by clear review and escalation protocols to address issues promptly and fairly. This approach emphasizes preventative awareness, early detection of irregular patterns, and structured review processes, rather than duplicating DOH’s existing processes. Learning and Final Evaluation: PwC will implement a structured feedback loop to provide actionable insights . Periodic reports will highlight effective practices and emerging challenges. At the conclusion of the grant period, PwC will conduct CMS’ required independent evaluation and provide recommendations to sustain transformation efforts statewide. Where monitoring identifies recurring documentation or control weaknesses, findings can inform targeted technical assistance to strengthen compliance capacity among subrecipients.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

PwC US Consulting LLP	Regional Health Care Delivery Planning	FL	Alaska's RHTP application envisions coordinated regional delivery plans aligning funded projects for maximum community impact. Alaska's regions vary dramatically in infrastructure, provider availability, tribal health system integration, population needs, and organizational capacity. DOH identified regional planning workshops for Spring/Summer 2026 as a near-term milestone, but no single organization has the combined national planning expertise and local Alaska knowledge to facilitate effective planning across all regions. Effective regional planning requires structured facilitation, rigorous gap analysis, multi-stakeholder governance design, and alignment of diverse proposals into coherent strategies while maintaining local ownership and cultural responsiveness.	PwC leads regional delivery planning in partnership with local partners (e.g., Hospital systems, Alaska Primary Care Association). Provider & Service Gap Analysis: Systematic assessment of provider availability, service capacity, and access barriers across Alaska's regions. Map provider-to-population ratios by care type (primary, behavioral, oral, specialty, emergency, HCBS). Identify priority gaps for RHTP investment using both quantitative data and community input. Community-Led Planning Workshops: Design and facilitate engagement sessions in each region. Ensure participation from tribal health organizations, hospitals, community health centers, borough governments, social service agencies, and community members. Incorporate culturally responsive facilitation — including Alaska Native community engagement protocols and interpretation services. Regional Delivery Plan Development: Synthesize gap analysis and community input into actionable plans for each region. Define priorities, project sequencing, partnership structures, accountability frameworks, and performance metrics. Ensure plans are realistic given regional capacity and RHTP funding constraints. Portfolio Coordination: Support DOH in ensuring regional plans align with statewide RHTP goals. Map individual LOIs and project proposals against regional plans to identify gaps, overlaps, and complementarities. Advise DOH on portfolio balancing across initiatives and regions. Local partners will provide Alaska community planning experience, established DOH relationships, and cultural fluency. PwC brings national health system planning, network adequacy analysis methodology, and multi-state RHTP implementation perspective.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

PwC US Consulting LLP	RHTP Grants Administration Support, Subrecipient Readiness TA, and Compliance Monitoring	FL	ACF serves as subrecipient administrator for RHTP. PwC has significant experience in end-to-end grant program strategy, design, standup, and execution. PwC will flex our toolkit to ACF’s RHTP operating model, enhancing ACF’s approach to specific grant management workstreams (e.g., process design, financial controls, application review, monitoring analytics, fraud controls, compliance monitoring, and readiness assessments). Our role would reinforce, supplement, and enhance existing structures by providing additional resources, visibility, analytics, and monitoring, and not replace existing functions. This project will focus on decreasing the barriers that applicants face in accessing and effectively using RHTP funding by helping ACF to create readily accessible and easy to understand grants management processes; enable consistent oversight across the RHTP program; meet operational and document-driven Federal and CMS funding requirements, including cost support and expenditure tracking, procurement and vendor documentation, performance reporting, subrecipient monitoring, and audit-ready record retention (including Single Audit readiness where applicable). In addition, the project will provide pre-award readiness support and Technical Assistance (TA) for applicants. Many smaller rural organizations need this support to participate meaningfully in the program.	PwC will support DOH and ACF's grants administration infrastructure. We will align processes to end-to-end federal funding expectations: readiness, award set-up, monitoring, reporting, and closeout, grounded in 2 CFR 200 principles and audit-ready documentation. Our support can adapt to ACF’s operating model, augmenting ACF’s day-to-day grants administration and/or providing DOH portfolio-level oversight and monitoring. Pre-Award Readiness TA: Assess applicant organizational readiness for federal grant management. Provide targeted TA to help organizations develop realistic project scopes, budgets, financial controls, register in SAM.gov/UEI, and understand CMS requirements. Prioritize outreach to small rural and tribal organizations with limited federal grant experience. Award Set-Up & Subaward Terms: Establish standard subaward templates and grant file checklists (e.g., budget, reporting, documentation expectations, and roles). Create a grants calendar and procedures for clear communication of requirements across subrecipients. SubAward Monitoring Framework: Design risk-based monitoring protocols scaled to subrecipient size and risk level, with a lighter-touch for established organizations and a deeper-dive for first-time grantees. Develop site monitoring tools adaptable to Alaska's geography. Focus monitoring on documentation completeness for cost support/allowability, procurement and vendor files, subaward compliance, payment validation/reconciliation, and performance reporting, in alignment with 2 CFR 200 and CMS requirements. Create corrective action and escalation pathways. These activities support early identification of compliance gaps and provide structured feedback to strengthen subrecipient controls over time. Financial Controls & Compliance: Design expenditure tracking systems meeting CMS and Single Audit Act requirements while minimizing administrative burden. Build compliance analytics dashboards with real-time visibility into spending trajectories, milestone progress, and risk indicators across subrecipients. Define drawdown and payment procedures, including required reviews/reconciliations to reduce risk of improper payments. Ongoing Subrecipient TA: Deliver continuous support for organizations on reporting, procurement, change requests, budget modifications, and federal compliance questions. Facilitate peer learning among subrecipients. Develop template tools (reporting forms, budget tracking sheets) adapted for Alaskan orgs.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

PwC US Consulting LLP	Smart Health Infrastructure Implementation Support: Data Integration & Administrative Burden Relief	FL	Alaska's RHTP is a once-in-a-generation chance to fix what's broken. SHN resolves the transaction-layer problem — connecting every provider and payer through a single real-time network. PwC builds what the technology alone can't: the Medicaid policy framework to authorize it, the data integration work to connect it to systems already in use, and the provider adoption infrastructure to make it last. The complexity here is real. Alaska's rural facilities run a fragmented mix of EHR platforms — MEDITECH, CPSI, RPMS, and others. Each connects to six or more payer systems through separate portals. SHN replaces that fragmentation with a single connection point. But moving from fax-based workflows to real-time transactions requires hands-on integration at every facility — mapping data fields, testing payer connections, validating claim formats, retraining billing staff. Alaska also needs a dedicated policy track. Authorizing SHN as an approved Medicaid transaction utility and enrolling managed care organizations before launch — none of that happens automatically.	Workstream 1 — Federal Authorization and Medicaid Setup (Months 1–9): We work with Alaska DOH and the Division of Public Assistance to authorize SHN as Alaska's Medicaid transaction utility. We prepare the CMS Advanced Planning Document and structure the project to qualify for up to 90 percent federal matching funds under existing health IT provisions — materially reducing Alaska's net RHTP cost. Managed care organization enrollment is secured before go-live. Workstream 2 — EHR and Data Integration (Months 3–18): We lead the technical integration between SHN and the EHR systems running across Alaska's rural facilities — field mapping, workflow redesign, payer connection validation, and claims format testing at every site, whether they run MEDITECH at a Critical Access Hospital or CPSI at a rural health clinic. We don't leave facilities to self-configure. Workstream 3 — Provider Onboarding and Adoption (Months 6–24): We design and run the adoption strategy across all six deployment regions. Training built for low-bandwidth settings and no dedicated IT staff. Facility-level savings reporting so every provider sees their actual cost reduction each quarter. Adoption coordinated through Alaska Primary Care Association, ASHNHA, and the Alaska Medical Association. Target: 30 percent provider enrollment by end of Year 1	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

QAWALANG IN TRIBE OF UNALASKA	Unalaska Health and Wellness	AK	Youth in rural Alaska communities face unique health challenges shaped by geographic isolation, limited access to preventive health education, and the intergenerational impacts of historical trauma. In Unalaska, opportunities for youth to engage in structured wellness programming that connects physical health, behavioral health awareness, and cultural identity remain limited. At the same time, many Qawalangin Tribal members live in Anchorage while maintaining strong ties to their Tribal community. Youth living off-island may have fewer opportunities to participate in culturally grounded programs connected to their Tribe. This project addresses the need for accessible, culturally responsive youth wellness programming that supports healthy habits, strengthens health literacy, and builds connections between youth, families, and healthcare systems. By integrating cultural teachings, prevention education, and practical health knowledge, the program will help youth better understand how to care for their physical and mental health while maintaining strong cultural and community connections. This effort also presents an opportunity to strengthen community capacity by providing behavioral health and prevention trainings for community members, helping ensure that youth and families have access to supportive, informed networks both in Unalaska and among Tribal members living in Anchorage.	The Qawalangin Tribe proposes a combined youth wellness model that integrates culturally grounded programming, health literacy education, and prevention-focused community training. The project will support youth and families by promoting healthy habits, increasing understanding of healthcare systems, and strengthening culturally responsive wellness practices. The program will focus on several core strategies. First, the Tribe will develop culturally responsive educational materials and workshops that help youth and families better understand how to access and navigate healthcare services, including primary care and behavioral health resources. These materials will incorporate culturally relevant teachings and community knowledge to ensure the information is meaningful and accessible. Second, the project will support youth wellness programming that promotes healthy lifestyles, including activities focused on physical activity, mental wellness, and nutrition awareness. Cultural teachings and community traditions will be incorporated into programming to reinforce the connection between cultural identity and overall well-being. These activities will be offered to youth and families in Unalaska while also creating opportunities for Tribal members living in Anchorage to participate through coordinated programming, gatherings, or virtual engagement. Third, the project will strengthen community capacity through training opportunities that equip community members with practical tools to support youth health and safety. Trainings may include First Aid, SBIRT (Screening, Brief Intervention, and Referral to Treatment), and ASIST Suicide Intervention Training. These trainings will help youth leaders, educators, and community members recognize early warning signs of behavioral health concerns and respond appropriately. Finally, the Tribe will collaborate with local partners, schools, and healthcare providers to ensure programming aligns with community needs and supports stronger connections between youth, families, and healthcare services. By integrating cultural knowledge, health education, and prevention strategies, the project will promote long-term healthy habits while strengthening community resilience among Tribal youth and families in both Unalaska and Anchorage.	\$50,000- \$250,000	Multi- Community or Participating in Regional Hub-and- Spoke	Aleutians West Census Area; Anchorage (Municipality)	Advance to Implementati on Application

R.E.A.C.H. 907 - Restoring, Empowering Alaska's Children and Homes	Expanding Youth Behavioral Health Services Access via Workforce Development in the Mat-Su Valley	AK	Youth behavioral health needs in the Mat-Su Valley continue to grow, while workforce shortages limit access to care. Families frequently experience long waitlists for services, and providers face high caseloads and burnout. The opportunity addressed by this project is to expand workforce capacity and strengthen the infrastructure needed to deliver these services sustainably in a rural environment. This is our vision and dream. This LOI takes us a step closer to this vision. Psychotherapy (individual and family): 6–8 clinicians serving 150–200 clients (currently at 2.5, with a 3rd joining in June, 2 LPC-S provide oversight) Outpatient/intensive outpatient wrap-around services: 32–40 behavioral health clinical associates (currently at 17 clinical associates providing TBHS, PSS, CRSS) Case management and intensive case management: 6 case managers for 150-200 clients (2.5 currently) School-based therapeutic behavioral health services: 40-60 youth supported by clinical associates (17 associates currently, as mentioned above) Therapeutic treatment home services / foster care: 25-30 youth supported in 10–15 homes over 1–3 years (just launched, 2 homes onboarding) Future phase: Complex residential care for youth with lifelong behavioral health challenges. We have 4 clients now needing wrap-around school-based TBHS services. Ready to hire more associates.	This project will implement workforce expansion designed to strengthen access to youth behavioral health services in the Mat-Su Valley. REACH 907 will expand its clinical and direct service workforce by hiring mental health clinicians, behavioral health clinical associates, and support staff who work together to develop further outpatient behavioral health services and residential therapeutic foster care support. These roles provide coordinated care for youth with complex behavioral health needs. Clinicians deliver therapy and treatment planning, behavioral health clinical associates support skill development and daily therapeutic activities, and case management and foster care staff support family engagement and coordination of services. The project also supports workforce supervision, recruitment, and onboarding processes needed to grow a rural behavioral health program responsibly. REACH 907's proposed approach is a continuum of care that closes gaps for families. As youth and families engage in behavioral health services, their level of care often fluctuates based on changes in home and environmental dynamics. A comprehensive continuum of care ensures service gaps are closed, allowing youth and families to receive the appropriate level of care as needs increase or decrease. Proposed Continuum of Care - Prevention & Early Intervention: Trauma-informed camps (current) Mentoring clubs (current) Outpatient therapy (current) Stabilization: Intensive outpatient services: IT, CM, ICM, TBHS, CRSS, PSS, etc (current) School-based therapeutic behavioral health services (current) Partial hospitalization (new, establishing) Residential:	\$250K-\$1M	Behavioral health/substance use disorder treatment	Single Community	Matanuska-Susitna Borough	Advance to Implementation Application

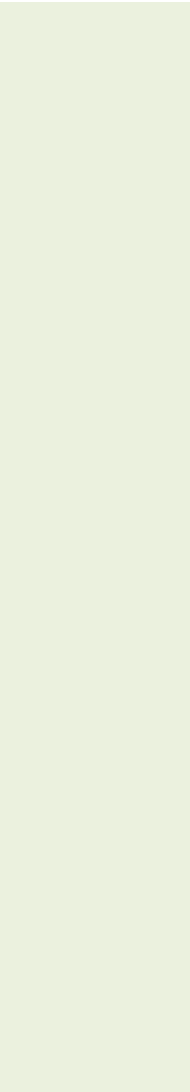
Therapeutic foster care (new, establishing)

Crisis stabilization (future phase)

Higher Acuity:

Residential long-term complex care (future phase, may be dependent upon the state’s own licensure)

Inpatient services (possible future phase)



R.E.A.C.H. 907 - Restoring, Empowering Alaska's Children and Homes	Modernizing Clinical Infrastructure for Youth Behavioral Health Services	AK	As demand for youth behavioral health services grows, clinical infrastructure must evolve to support expanding workforce capacity. REACH 907’s current documentation system and limited clinical workspace create inefficiencies that increase administrative burden and slow service delivery. The opportunity addressed by this project is to modernize clinical infrastructure so staff can deliver services more efficiently while maintaining compliance and quality of care. Improved systems will support growing service demand while strengthening coordination across outpatient and therapeutic foster care programs. By investing in technology and infrastructure improvements now, REACH 907 can support workforce expansion and increase access to behavioral health services for youth in the Mat-Su Valley and surrounding rural communities.	This project will provide a more efficient clinical technology infrastructure to support expanding behavioral health services for youth. Funding will support the transition from the current EHR system to a more robust and sophisticated EHR system, including system implementation, data migration, and staff training. This upgrade will improve clinical documentation workflows, strengthen reporting capabilities, and reduce administrative burden on clinical staff. The project will also support limited facility modifications that create HIPAA-compliant workspaces for additional clinical staff. These improvements allow REACH 907 to expand workforce capacity while maintaining privacy, compliance, and safe clinical environments. Together, these improvements strengthen operational efficiency and allow clinicians to dedicate more time to direct care while supporting the growth of youth behavioral health services	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

R.ehabilitati ve E.ducational A.daptive L.iving Solutions	Rebuilding Capacity: Alaska Rural Brain Injury Rehabilitation and Return-to-Work Network	AK	Adults with acquired brain injury in Alaska frequently experience long-term unemployment, social isolation, and increased reliance on public systems after discharge from medical rehabilitation. While clinical rehabilitation addresses physical and cognitive impairments, Alaska lacks programs that bridge the transition from rehabilitation to sustainable employment and community participation, leaving many individuals without a pathway to rebuild work capacity and independence. The need is urgent in Alaska, where traumatic brain injury rates are approximately twice the national average and nearly three times higher among Alaska Native populations. Geographic isolation, workforce shortages, and fragmented services further limit access to coordinated recovery pathways, particularly in rural and frontier communities. REAL Solutions proposes to address this gap by launching Alaska’s first Transitional Return-to-Work (tRTW) rehabilitation program for adults with brain injury. The program will begin with a pilot cohort in Anchorage, where existing infrastructure and partnerships allow immediate implementation. The pilot will establish protocols and training resources supporting expansion through a hub-and-spoke network with partners in Kenai, Mat-Su, Fairbanks, and other regions. By creating a coordinated pathway from rehabilitation to employment, the project expands provider capacity and improves access to brain injury recovery services across Alaska’s rural and frontier communities.	The project will launch Alaska’s first Transitional Return-to-Work (tRTW) rehabilitation program for adults with brain injury, addressing the gap between medical rehabilitation and sustainable employment. The program provides structured interdisciplinary services that rebuild cognitive capacity, physical endurance, self-management and vocational readiness required for successful return to work and community participation. The program will begin with a pilot cohort in Anchorage, where REAL Solutions has secured facility space, equipment, administrative infrastructure, and clinical partnerships allowing immediate implementation. Participants will engage in coordinated rehabilitation activities designed to restore work tolerance, executive function and independence. Services include functional work simulation, life skills development, adaptive wellness activities, environmental modification strategies, and coordination with vocational rehabilitation systems and employers. Unlike traditional outpatient rehabilitation, the tRTW model focuses on translating clinical recovery into real-world outcomes. Therapists work with participants to rebuild work endurance, address cognitive and environmental barriers, and support transition to sustainable employment. Short-term transitional housing may be available for individuals who require a structured environment while rebuilding independence and vocational capacity. The Anchorage pilot will serve as the initial hub for a statewide hub-and-spoke rehabilitation network. During the pilot phase, the program will refine treatment protocols, referral pathways, outcome measures, and training resources that support implementation in other communities. Following the pilot, the program will expand through partnerships in Kenai, Mat-Su, and Fairbanks, with the goal of supporting additional rural and frontier communities across Alaska. Regional partners will receive training, telehealth consultation, shared protocols, and coordinated program support. The hub will deploy rotating rehabilitation clinicians to rural communities to provide direct services, mentor local providers, and support program implementation where specialty staff are limited. By combining a launch-ready pilot with a structured replication strategy, the project establishes a scalable statewide model that expands access to brain injury rehabilitation while strengthening coordination among rehabilitation providers, vocational systems and community partners across AK	\$250K-\$1M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Radiology Services - UT, LLC	Closing Alaska's Invisible Healthcare Gap	TN	~60% of Alaska's 583 dentists operate CBCT scanners, generating ~50,400 scans per year. These produce 3D medical imaging capturing far more than teeth—yet virtually none are interpreted by a board-certified radiologist. An estimated 252,000 unread scans have accumulated over five years on dental computers across Alaska. Research shows 77% of CBCT scans contain incidental findings. Our clinical data identifies carotid artery calcifications—a leading stroke precursor—at 3.1%. These scans also capture head and neck cancers, airway pathologies, and other serious conditions dentists are not trained to diagnose. Three barriers created this gap: radiologists are in-demand, salaries exceed \$1 million, making interpretation cost-prohibitive; technical integration is too expensive for small offices; and individual practices generate too few scans to secure radiology contracts. No solution has existed at the right price and scale to bridge dental imaging to medical radiology—until now. The consequences are severe, especially in remote Alaska. Catching carotid stenosis presymptomatic means medication for hundreds of dollars. Missing it means a stroke—in communities hours from emergency care by air, that is often fatal or permanently disabling, costing hundreds of thousands. Early-stage head and neck cancer has survival above 80%. By Stage IV, survival drops below 40% and treatment exceeds \$200,000. The imaging already exists. The pathologies are already captured. They have not been read.	Radiology Services-UT will deploy its secure cloud-based teleradiology platform to connect Alaska's dental practices to board-certified, Alaska-licensed medical radiologists for CBCT interpretation. The program operates in two phases. Phase 1 — Backlog Clearance: We onboard Alaska's ~350 CBCT-equipped practices and read the estimated 252,000 unread scans accumulated over five years. Each scan is interpreted by a board-certified radiologist reviewing the full anatomical volume—not just the dental area of interest, but the complete head and neck region. Where pathology is identified, the report includes medical referral recommendations. Time-critical findings are flagged for expedited review and immediate notification. Phase 2 — Ongoing Interpretation: We continue interpreting all new scans at enrolled practices. At ~50,400 scans per year and \$80 per read, ongoing annual cost is \$4,032,000, establishing radiologist interpretation as the permanent standard of care. How it works: Our software is installed remotely—a process proven across hundreds of dental offices, including one in Alaska. It is compatible with all CBCT machines and dental software platforms. Once installed, it configures a secure cloud connection to the practice's existing system. No new hardware, no on-site visits required. DICOM files are transmitted via encrypted connection, interpreted by our radiologist, and a report is returned. The practice simply continues taking scans as normal. Budget: At \$80 per scan all-inclusive, the backlog costs \$20,160,000. First-year ongoing interpretation adds \$4,032,000. Total first-year cost is \$24,192,000—~8.9% of Alaska's \$272 million RHTP award. The \$80 covers integration, transmission, interpretation, reporting, and administration. This requires no construction, no equipment purchases, and no workforce relocation—leveraging existing infrastructure and existing imaging to deliver specialist care to every corner of Alaska immediately.	Over \$5M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Railbelt Mental Health & Addictions	Technology Upgrades	AK	Rural Alaskans face barriers to timely, high-quality behavioral health care due to geographic isolation and limited resources. This project will invest in modern behavioral health technology to improve client access, streamline administrative processes, and efficiently track outcomes. Integrating multiple platforms into a single system will enable providers to serve more clients, enhance the quality of care, and support sustainable services in rural and remote communities.	Our approach leverages modern behavioral health technology to improve access, quality, and efficiency in rural communities. A new EHR system with integrated state AKAIMS functionality will eliminate duplicate data entry, streamline administrative tasks, and consolidate multiple platforms into a single interface. Combined with hardware upgrades, technical assistance, and staff training, this system will enhance care coordination, allow providers to serve more clients, and support sustainable, high-quality behavioral health services locally.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Yukon-Koyukuk Census Area	Advance to Implementation Application
Railbelt Mental Health & Addictions	Building Capacity for Certified Community Behavioral Health Clinic (CCBHC) Status	AK	While Railbelt Mental Health & Addictions (RMHA) has operated an outpatient Behavioral Health clinic for many years, we still struggle with service gaps. Both residents of Nenana and the Deali Borough have recognized, through community needs assessments, that Behavioral Health care is an ongoing concern. Residents in the Railbelt Mental Health & Addictions service area can face significant barriers to accessing timely behavioral health care due to the region’s rural and frontier geography. Long travel distances, limited transportation, workforce shortages, and extended wait times often delay treatment for individuals experiencing mental health or substance use challenges. These barriers can lead to worsening conditions, increased reliance on emergency services, and limited continuity of care, particularly for vulnerable and low-income populations. This project addresses the opportunity to strengthen the region’s behavioral health system by preparing RMHA to pursue the Certified Community Behavioral Health Clinic (CCBHC) designation. The CCBHC model will improve access through same-day assessments, 24/7 crisis services, and expanded care coordination, while providing comprehensive, integrated care regardless of ability to pay. By increasing service capacity and improving coordination between providers, the project will help reduce emergency department use and ensure residents in these rural communities can receive timely, high-quality behavioral health care close to home.	At this stage, funding would support a structured approach to refining the project concept, including conducting needs assessments, gathering stakeholder input, and identifying key priorities. It will also allow us to determine the specific requirements and steps necessary to become a Certified Community Behavioral Health Clinic (CCBHC). Additionally, funding would support early coordination with community partners and other stakeholders to ensure alignment and collaboration, as well as strengthen administrative readiness by establishing necessary systems, protocols, and planning structures, positioning the project for a successful full application and eventual implementation.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Yukon-Koyukuk Census Area	Advance to Planning

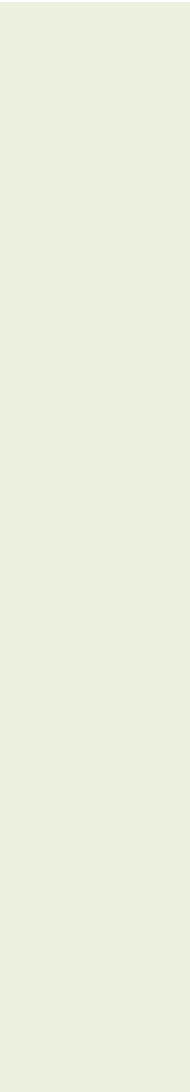
Raviant LLC	Alaska Early Intervention Transformation: Infrastructure, Assessment and Implementation Readiness	OR	Alaska's Infant Learning Program (ILP) serves children birth to three with developmental delays through 15 provider programs statewide. Alaska uses a 50% delay threshold for eligibility — one of the nation's most restrictive. Alaska's Part B special education program uses a 25% threshold leaving children with moderate delays ineligible for early intervention but eligible for special education at age three. Many children who receive ILP services achieve typical development and don't need special education preK-12, which presents a significant cost avoidance opportunity. Preliminary financial modeling indicates break-even within 5-8 years of expanded eligibility, after which the state realizes sustained cost avoidance. Responsible, phased, multi-year expansion requires: 1) a comprehensive, evidence-based picture of where the system stands today — workforce capacity, service delivery variation, data infrastructure, and family experience across all 15 programs; and 2) the governance, financial modeling, readiness criteria, and implementation planning infrastructure to steer sustainable expansion. This project addresses both. Using the ECTA/DaSy System Framework and Active Implementation Frameworks, Raviant — with key partners AILPA and the ILP state office — will build the transformation infrastructure that Alaska's ILP system needs to expand eligibility responsibly, beginning the first increment by 2028-2029. https://health.alaska.gov/media/5pqbncwa/alaska-ilp-part-c-report.pdf	This is one of two coordinated proposals Raviant is submitting under RHTP. The companion project addresses ILP workforce pipeline development. The Raviant team and subcontractors bring specialized expertise in Part C regulation and service delivery, early childhood systems consultation, technical assistance and implementation science. The project runs two parallel tracks, structured within the ECTA/DaSy System Framework and Active Implementation Frameworks. Both frameworks treat system-building as iterative rather than sequential — the Active Implementation Frameworks' Exploration stage develops governance, workforce, data, and financial drivers concurrently through improvement cycles. The ECTA/DaSy Self-Assessment is itself a governance-building process: conducting it collaboratively with providers, AILPA, and the state office generates shared understanding and aligned ownership that the transformation infrastructure depends on. The two tracks are mutually reinforcing — assessment findings inform infrastructure and planning decisions, while the developing KPI and readiness frameworks inform assessment. Track 1: System Assessment. A rigorous statewide current state assessment using the ECTA/DaSy Self-Assessment — evaluating Alaska's ILP system across governance, finance, workforce, data systems, and accountability components. Supplemented by provider surveys and interviews across ILP programs, family experience input gathered with AILPA, and structured benchmarking against peer and high-performing states. Conducted collaboratively to generate shared understanding alongside diagnostic findings. Track 2: Transformation Infrastructure. Running concurrently from project launch: governance structure and decision-making framework development; AILPA formation as a legal entity and future RHTP lead applicant; KPI framework and monitoring dashboard; financial model refinement and credentialing with caseload projections under multiple expansion scenarios. In the project's second half, assessment findings ground the workforce needs estimates, readiness criteria, and implementation plan — including supports at provider, program, and state levels. RHTP funds the planning, coordination, and infrastructure work. The growing operational cost of serving more children will be carried by Medicaid, federal Part C dollars, and state general funds. A core project deliverable is documenting the Medicaid billing and rate reform pathway that makes this financing model viable.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Raviant LLC	Building Alaska's Early Intervention Workforce: Pipeline Development and Professional Pathways	OR	Alaska's Infant Learning Program (ILP) serves children birth to three with developmental delays through 15 provider programs statewide. Alaska uses a 50% developmental delay threshold for eligibility — one of the nation's most restrictive — creating an inequitable gap with the state's own special education program, which uses a 25% threshold. A companion RHTP project is building the transformation infrastructure and assessment foundation for responsible, phased eligibility expansion. Realizing that opportunity has a direct workforce implication. Preliminary modeling — subject to validation through the companion assessment project — suggests that eligibility expansion could roughly double the number of qualified early intervention providers needed statewide. Alaska's current workforce pipeline is insufficient to meet that demand. Meeting the workforce demands of an expanded ILP system requires activating available pathways into early intervention practice. Alaska has multiple routes — master's level academic programs, transfer pathways for professionals in related fields such as occupational therapy, physical therapy, and speech-language pathology, and in-service training for those with bachelor's degrees — each of which can be strengthened, streamlined, or reactivated to grow the pool of qualified providers. This project addresses the supply side of Alaska's workforce challenge directly, laying the pipeline foundation that responsible eligibility expansion requires.	This LOI is one of two coordinated proposals Raviant is submitting under RHTP. The companion project addresses ILP transformation infrastructure, system assessment, and implementation readiness. Together they lay the foundation for Alaska's multi-year ILP eligibility expansion effort. The Raviant team and subcontractors bring specialized expertise in Part C regulation and service delivery, early childhood systems consultation, technical assistance and implementation science. AILPA contributes provider community perspective and direct knowledge of workforce conditions across Alaska's ILP programs — ensuring pipeline development reflects the system's actual needs and regional realities. Core workstreams include: UAA curriculum development and revised program design for the early childhood special education master's program, drawing on prior experience building the original program — producing a package ready for UAA's internal approval and accreditation process; mapping UAA's internal governance pathway, accreditation requirements, and enrollment thresholds; employer commitment development with ILP provider programs to signal hiring demand and support UAA's enrollment viability case; student funding mechanism mapping identifying scholarship, stipend, and service commitment pathways; transfer and articulation pathway development within the UA system; partnership exploration with PT, OT, SLP, and early childhood special education programs in the Pacific Northwest and broader American West — including articulation agreements, distance delivery, and structured practicum and clinical rotation placements in Alaska; and in-service training pathway development for bachelor's-level professionals in adjacent fields. Program design will incorporate federal service commitment requirements applicable to RHTP-funded workforce development, ensuring pipeline graduates are positioned to serve rural and remote communities where need is greatest. All workstreams are informed by workforce needs findings from the companion project, ensuring pipeline development is connected to the system's actual expansion timeline and regional workforce gaps.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

RDC LLC	Fire Protection Enhancement	AK	RDC LLC owns and operates medical office space that houses specialty healthcare clinics serving patients in Fairbanks and throughout Interior Alaska. One of the buildings currently lacks a modern fire suppression system, as it was constructed before sprinkler systems were commonly required in commercial medical facilities. This presents a safety concern for both patients and healthcare providers working within the building. Many patients visiting specialty clinics have mobility limitations and may rely on wheelchairs, crutches, or other assistive devices, making rapid evacuation during a fire or emergency more difficult. This project presents an opportunity to upgrade the building’s fire suppression infrastructure by installing a modern sprinkler system. Improving the building’s safety systems will help ensure that healthcare providers can continue operating in a safe, compliant environment while protecting patients who rely on this facility for specialty medical care, including those traveling from rural and frontier communities across Interior Alaska.	To address this safety concern, RDC LLC proposes to install a modern fire suppression system in the medical office building that currently lacks sprinkler protection. The project will involve designing and installing a building-wide sprinkler system that meets current fire safety standards and protects both patients and healthcare providers occupying the facility. The first step will include working with fire protection engineers and licensed contractors to assess the building and design a system appropriate for the structure. Once the design is finalized, the project will move into the installation phase, which will include integrating sprinkler lines, installing fire suppression equipment, and connecting the system to the building’s existing fire safety infrastructure. Careful coordination will occur with the healthcare clinics operating within the building to minimize disruptions to patient care during installation. Once completed, the upgraded fire suppression system will significantly improve building safety, particularly for patients with limited mobility who may require additional time or assistance during emergency situations. This improvement will allow the facility to continue safely supporting specialty healthcare services for patients traveling from Fairbanks and rural communities across Interior Alaska.	\$250K-\$1M		Statewide	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kusilvak Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced
REACH, Inc.	IT Modernization Plan Phase II – EHR with HIE Integration	AK	REACH is a 170-employee behavioral health provider serving rural Alaska communities with an annual revenue of roughly \$10.9 million. Like many community-based service organizations in Alaska, REACH, Inc. (“REACH”) has been forced to maintain operations and provide top-quality service while relying on aging and outdated technology that has often served as a barrier to success instead of as an asset. As part of REACH’s IT Modernization Project, REACH wants to prioritize the acquisition of an Electronic Health Records system with a Health Information Exchange integration.	REACH, Inc. is in the early exploratory phase of this project. At this stage, funding would support obtaining a Project Manager or Specialized Consultant to manage and oversee project development activities like data collection and research, conducting outreach to other organizations and providers for system referrals, implementation planning, IT consultations, etc.. REACH knows that it is looking for an EHR system that – (1) has a high-quality patient access portal, (2) has a high degree of customization, (3) is compatible with record keeping and documentation requirements for Federal Part C services, and (4) has billing capabilities. Integration with the Health Information Exchange is also a system requirement, as it is important that REACH is able to coordinate and confer with other providers and programs easily, especially when providing services in rural communities.	\$50,000-\$250,000	Home-and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

REACH, Inc.	REACH, Inc. – Supported Employment Program Expansion – Teen Internship Program	AK	REACH, Inc. currently operates a successful Supported Employment Program in Juneau, AK that connects individuals with developmental disabilities with career paths that suit their abilities, talents, and interests. REACH coaches work with local employers and provide on-the-job support and training to individuals at no cost to employers. REACH’s current program only serves adults (ages 18+) currently enrolled with and receiving services through REACH. However, work-eligible teens (ages 14+) who are currently receiving services through the Individuals with Disabilities Education Act (IDEA) Part B are approaching their Secondary Transition wherein they will soon begin partaking in transition assessments and services and outlining appropriate measurable postsecondary goals. Alaska’s Part B Annual Performance Report reported that significantly more of these individuals pursued employment after high school as opposed to pursuing higher education. This pilot project aims at utilizing REACH’s Supported Employment program model, in coordination with the individual, family, and school system, to allow teenagers receiving services under this program to participate in internships with local businesses and organizations, including REACH itself.	Utilizing REACH’s existing Supported Employment model, an Employment Specialist would participate in Secondary Transition planning along with the teenager receiving services, the teenager’s family and/or caregivers, and the school system in order to begin identifying the individual’s needs, abilities, interests, and skills. At the appropriate time (as determined by the Secondary Transition team) the Employment Specialist would assist the teen with: - Working to prepare a resume or employment application and develop interview skills; - Exploring interests through volunteer opportunities, job tours, or job shadowing; and finally – - Procuring an internship opportunity with a local business or organization that matches the teen’s talents and interests. Just as with REACH’s existing Supported Employment Program, the Employment Specialist would remain available to help the teen navigate: - Getting to know their employer; - Meeting their coworkers; - Understanding workplace culture; The Employment Specialist is also responsible for – - Partnering with local businesses and organizations; - Providing on-the-job training and support for the teen, their coworkers, their employer, and their circle of support; - Providing support through job coaching; - Advocating for the teen through any problems with their employer; and - Regularly checking-in on the teen to ensure continued success. This expansion of REACH’s Supported Employment program is intended to set teens with disabilities up for success through early intervention, job training, and exposure. This program is still in the very-early developmental phases, and REACH would like further planning to be completed prior to launch. Some questions to be addressed in the planning and program development phases include: - Are there any clearances necessary to successfully operate this program? - At what age can teenagers begin to work in the disability services field? - Is this a billable service and does age affect this? - Does REACH need to work with the Department of Vocational Rehabilitation (DVR)? - How will transportation needs be addressed? At this stage, funding would support obtaining a Project Manager to oversee initial project development including data collection, establishing necessary partnerships (with the school systems, local	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

businesses and organizations, potentially DVR?), strategic planning activities, and operations coordination.



REACH, Inc.	IT Modernization Plan Phase I – Cybersecurity, Organization Hardware, and Accounting Software	AK	REACH is a 170-employee behavioral health provider serving rural Alaska communities with an annual revenue of roughly \$10.9 million. Like many community-based service organizations in Alaska, REACH, Inc. (“REACH”) has been forced to maintain operations and provide top-quality service while relying on aging and outdated technology that has often served as a barrier to success instead of as an asset. Last year, REACH experienced a “security incident” that put client data at risk, and in response REACH immediately hired an Information Technology (IT) and Cybersecurity Consultant, seeking to ensure that client data was secured as quickly and efficiently as possible. While preliminary cybersecurity efforts to initially secure data have been made, REACH would like to grow from maintaining operations in spite of technical constraints to expanding services utilizing advanced technology as a tool to better serve individuals and communities in Southeast Alaska. Phase I of REACH’s IT Modernization Plan includes top-level cybersecurity updates that will ensure further security incidents don’t occur; long overdue hardware upgrades for staff that will improve administrative efficiency; and the replacement of REACH’s outdated and siloed financial system with a modern, cloud-based accounting system designed for nonprofits that is intended to improve fiscal stability, support evidence-based management, and free up resources for clinical services.	Cybersecurity In addition to REACH’s standard IT maintenance, in the 2027 Fiscal Year (beginning in July 2026) REACH will add a Chief Information Security Officer who will -- in addition to infrastructural projects like Managed iPad and Mobile Device management, network segmentation, installation of surveillance systems in brick-and-mortar locations, server room UPS refreshes, and refreshes to network peripherals – be providing on-going staff training on enterprise risk including policy, end-user training, and best practices. Sage Intaact for Nonprofits – Accounting Software Purchase & Implementation As part of REACH’s IT Modernization Plan REACH plans to replace their legacy accounting platform (described by REACH’s CFO as ‘outdated and siloed’) with Sage Intaact for Nonprofits, a modern, cloud-based system that is intended to improve fiscal stability, support evidence-based management, and free up resources for clinical services. This project includes the purchase of Software Licensing, an Implementation Consultant that will ensure the system is configured correctly and aligned with REACH’s healthcare workflows, and hands-on staff training that includes online courses, on-site workshops, and follow-up support to build proficiency and to help achieve a smooth transition between platforms without disrupting service delivery. Additionally, this project requires travel from consultants and key staff who will conduct on-site configuration and training at REACH’s remote facilities; an annual maintenance and support subscription that covers product updates, security patches, customer support, and user communities; data migration and integration; cybersecurity enhancements; and a temporary project manager (for a period of four months) who will coordinate between internal departments, consultants, and the software vendor, as well as oversee tasks, manage timelines, and monitor budgets. Staff Hardware Upgrades REACH’s IT Maintenance company has a maximum upgrade timeline of five years post-installation. Due to budget constraints, REACH has hardware dating back to 2013 that has yet to be upgraded. REACH’s past-due upgrades include 21 computers and 8 laptops. Additionally REACH needs two video conferencing systems for conference rooms.	\$250K-\$1M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

REACH, Inc.	REACH – Establishing an Internal Transportation Department – Transportation Phase I	AK	REACH, Inc. serves 60+ individuals with developmental disabilities who are ISW/IDD Waiver recipients, some of whom live on-site in REACH’s residential group homes. Both ISW and IDD Medicaid Waivers mandate that transportation services be provided to these individuals in accordance with all activities outlined in their Individualized Service Plan, which can include doctor’s visits, daily exercise, employment, various therapies, etc. Currently, REACH is experiencing a shortage of both staff and vehicles. This shortage is resulting in excess time spent coordinating transportation responsibilities day-to-day, disrupting the schedules of both the staff and the individuals. Individuals are forced to carpool to activities, requiring the individuals to spend more of their personal time in transit. Staff occasionally have to utilize their own personal vehicles to ensure individuals are successfully transported to their destination. Despite being chronically short-staffed, REACH has had to turn down job applicants who did not have a drivers license as they would be unable to provide this necessary and in-demand service.	REACH Inc. seeks funding to establish a dedicated, Medicaid-compliant transportation department that provides reliable, all-weather, handicap-accessible mobility for ISW/IDD Waiver recipients and individuals with disabilities throughout Juneau. This initiative fills a long-standing service gap in evening and weekend transportation, ensuring clients receive consistent, dignified, and specialized access to community participation, medical appointments, employment, and essential daily activities. To launch the proposed program, REACH will invest in a purpose-built accessible fleet and necessary technology consisting of multiple AWD Ford Transit 350 high-roof vans equipped with ADA-compliant lifts and Q’Straint securement systems. Vehicles will be shipped via Alaska Marine Lines and outfitted with in-vehicle tablets and RouteGenie dispatching software to support efficient routing, real-time tracking, and Medicaid-compliant manifesting. Meeting Alaska’s regulatory and safety requirements is essential for operational integrity. Funding will support mandatory PASS driver training, CPR/First Aid certifications, background checks, commercial transportation insurance tailored for vulnerable-population services, and Medicaid provider enrollment. Because Medicaid reimbursements are delayed at program start-up, REACH requests runway support for the first 180 days. This includes competitive wages for multiple drivers and a Program Director, along with early-stage fuel costs and specialized maintenance for lift-equipped AWD vehicles. This temporary buffer ensures uninterrupted service delivery during the critical launch phase while billing cycles stabilize. The projected investment for full implementation ranges from \$1.11 million to \$1.50 million. Once operational, the department will sustain itself through Medicaid reimbursement via standard waiver trips (T2003) and specialized paratransit trips (T2003-CG), consistent with Alaska DHSS FY26 Juneau regional rate schedules.	\$1M-\$5M	Home- and community-based services provider	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

REACH, Inc.	REACH, Inc. – Community Outreach, Training, and Education	AK	In many of the rural communities REACH serves, and even in Juneau, there are no comparable services available locally to adequately communicate the array of supports available for individuals with developmental disabilities, or to provide guidance regarding need-to-know information, common practices, or generally to raise awareness about developmental disabilities and how to support and care for disabled individuals in the community. Currently, REACH’s presence in these communities is limited, and even in Juneau opportunities for community education and trainings can be rare. Additionally, all communities in Alaska have one or more Health Professional Shortage Area (HPSA) designations for a variety of healthcare fields, especially in rural communities – this makes it difficult to find skilled presenters who can provide trainings and educational services even on a limited or one-time basis.	“Better community education leads to better community integration.” Naomi Studevan - REACH, Inc. Executive Director The purpose of this project is to, through the utilization of the FTE coordinator, grow community audiences for participation in education and training opportunities, document barriers to access, and acquire and coordinate skilled presenters to provide these opportunities. Additionally, due to the access barriers we are currently aware of, especially those facing communities more rural than Juneau, the coordinator will oversee the creation and development of virtual training and education opportunities, potentially one day through a secure online course platform. This will allow members of these rural communities to participate without being forced to travel to an out-of-town location. Potential topics for training and education include: ADLs, IADLs, and Levels of Support (Activities of Daily Living and Instrumental Activities of Daily Living); Care Coordination; Medicaid Services and Advocacy; Support Plan Development; First Aid and CPR; Mental Health (various); Supported Decision-Making; Assistive Technology; Disability Advocacy; and more. The State’s Rural Health Transformation Proposal references proven models such as the Community Health Aide/Practitioner (CHA/P) and Behavioral Health Aide/Practitioner (BHA/P) programs that train local residents to deliver frontline care – in communities outside of Juneau where REACH only has a semi-regular presence, the eventual development of community frontline care for individuals with disabilities serves as an admirable long-term goal for Community Outreach and Education.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

REACH, Inc.	REACH, Inc. – Community-Wide Transportation Startup – Transportation Phase II	AK	In addition to the transportation challenges REACH is facing as an organization (detailed in the proposal for REACH - IT Modernization Plan - Planning) Juneau’s disabled community is encountering service gaps in the community transit system – Capital Transit does not operate 24/7 and is often unavailable for extended evening and weekend hours, leaving individuals who lack mobility or the ability to drive with very few options for moving from place to place. Phase II of REACH’s Transportation as a Service Plan is a Community-Wide Transportation Start Up that seeks to fill this gap in transportation services for disabled individuals in Juneau.	Phase II of REACH’s Transportation as a Service Plan is still in early stages of development, but some logistics have been identified to ensure continuity of transit services and availability for individuals with disabilities. In order to cover the gaps in existing services, REACH’s Transportation Department will need to add 4-5 high-capacity vans that can hold 12-15 passengers, and 5-6 rabid response minivans. A mix of full-time and part-time staff will be necessary to ensure 24/7 coverage or extended evening/weekend hours. This project strengthens Juneau’s transportation equity infrastructure by expanding ADA mobility access and ensuring that no individual with disabilities is left without safe, reliable transportation—regardless of weather or time of day. At this stage of project development funding would support planning efforts such as – - Updates to Juneau’s Coordinated Human Services Transportation Plan to incorporate project logistics; - A federal transit specialist to consult on REACH’s planned funding streams, coordination efforts, and Medicaid billing practices; - A project manager to coordinate with and gather information from local transit agencies and other community organizations in order to ensure project design is efficient and encompassing of existing efforts; etc.	\$1M-\$5M	Home- and communit y-based services provider	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

REACH, Inc.	REACH, Inc. – Growing a Skilled Workforce – Professional Development	AK	As stated in the State’s Rural Health Transformation proposal, “all communities in Alaska have one or more Health Professional Shortage Area (HPSA) designations . . . and most rural areas experience high staff turnover and rely on temporary workers (1).” REACH, Inc. is not an exception to this element of healthcare operations in Alaska. REACH is consistently seeking skilled workers (in medical, mental health, and behavioral health), and has a recurring need for staff with experience in offering co-occurring support (developmental disability plus an additional disability). Seeking employees who have experience or have already received training for these roles is pulling from too small of a bucket, even in Juneau. REACH believes these skills need to be a standard part of employee development for disability service professionals. By implementing professional development as a core-responsibility of all REACH staff positions, REACH can select from and contribute to the growth of a larger employment pool in each community where it operates. REACH wants to set the standard for pursuing Disability Services as a professional career by hiring staff with the understanding that REACH will be supporting and contributing to their growth within the profession.	In pursuit of becoming a leading employer in Alaska’s community-based healthcare industry, REACH strives to help employees grow and develop further than simply mastering the core functions required of their position, and instead seeks to develop Subject Matter Experts that enrich their communities, the organization, and especially the individuals they serve. REACH hopes to support professional development opportunities for staff that include trainings on: grief, sexuality, aging, de-escalation, medication, mandated reporting, leadership, and cultural responsiveness. Employees seeking to expand their professional portfolio should be able to receive in-home care provider and caregiver training, become a certified nursing assistant, and pursue DSP certification. In an effort to provide the best care possible and meet the unique needs of rural communities, REACH would like staff to be able to access education on community coordinating and research sharing, as well as navigating Medicaid. REACH’s Infant Learning Program seeks to develop a highly trained and specialized staff who can identify developmental needs in children earlier, can provide more expertise and guidance to families and caregivers, and who can assess community needs and be conscious of cultural factors in the development of response plans and in job performance. ILP staff will have access to trainings and educational opportunities in infant and early childhood mental health, specialty feeding support certifications, sensory/motor disorders, and more, as well as leadership development training for the purpose of retaining highly qualified professionals in the field and maintaining a positive team culture and high quality program oversight. Essentially, REACH seeks to be a responsive employer that invests in its employees’ success. Disability services is a multi-faceted field and areas for growth are limitless. REACH seeks professional development funding to support core functionality, yes, but also to support its employees in the pursuit of knowledge and skill-development that they believe will contribute to their growth as a service provider, REACH’s organizational success and service capacity, and community care and well-being.	\$50,000-\$250,000	Home-and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

REACH, Inc.	REACH, Inc. ILP – Ensuring Successful Transition of Services through Increased Care Coordination	AK	The Individuals with Disabilities Education Act (IDEA) obligates states to have policies and procedures in place to support fair and equitable education for individuals with disabilities. IDEA Part C, which the Infant Learning Program operates under, supports infants and children with developmental delays or disabilities from birth to their third birthday, while IDEA part B includes protections for children ranging from ages three through 21. Under Part B, a child traditionally transitions to special education services offered through the school district, while some transition to community-based outpatient therapy, or the family or caregivers choose not to enroll the child in additional services under Part B at all. REACH, Inc. has found that it is in this transition from Part C to Part B that individuals and their families and caregivers who were receiving services under Part C either struggle to appropriately coordinate care and services under Part B, or fail to enroll in Part B supports altogether, leading to these children falling through the cracks instead of receiving the support they need to thrive. This is especially prevalent in rural communities where access to case management, programming, and supports is limited, and with high-risk individuals and children involved with foster care or Child Protective Services (CPS).	This project, through the use of a “Family Services Coordinator,” will continue to provide case management and coordination services for an additional 6 months after a child turns 3 to ensure a smooth transition for the individual and their families and caregivers from Part C services to Part B supports, as opposed to all ILP services ending on the child’s third birthday. This project will feature an emphasis on the rural communities REACH serves, as there is often little-to-no case management assistance available in these communities for families who need ongoing support. In the final three months of the child’s enrollment in the Infant Learning Program, the child’s primary ILP coordinator (and eventual Family Services Coordinator) will begin to work with the full ILP team on developing and executing the beginning stages of a Transition Plan. They will assist the family in meeting with the school district or new outpatient therapy program, developing an IEP or treatment plan, outlining the logistics of the transition, and ultimately ensure the individual and their family or caregivers feel support from parties on both sides of the transition and can communicate positively to ensure their child’s needs are being met. The Family Services Coordinator will have a minimum of two contacts a month with the family where they ensure that the family is connected to and appropriately utilizing medical, therapeutic and educational services, and ensuring that these services are fully meeting the family’s needs. If the family’s needs are not being met, the Family Services Coordinator will help connect the family with better resources. Additionally, Infant Learning Program and other Early Learning community-based services are typically provided in-home in the child’s natural environment. The transition from Part C to Part B services also involves a transition from in-home to clinic services, which the Family Services Coordinator will help the individual and their families and caregivers prepare for, including confirming that transportation is available and appointments are conveniently scheduled to incorporate a variety of factors, transportation included.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

REACH, Inc.	REACH, Inc. ILP – Expanding Eligibility for Alaska’s Infant Learning Program – Pilot Project	AK	Since IDEA Part C’s nationwide implementation in 1986, Alaska has utilized an eligibility criteria that includes a 50% developmental delay cutoff for ILP eligibility. Alaska is one of only three states that have restricted eligibility to this degree, as federal policy does not limit states at this threshold. The ILP (Part C) 50% eligibility is in conflict with Alaska’s less restrictive special education (Part B) program, which supports children and youth aged three through 21 with a 25% delay in one area of development, or a 20% delay in two or more areas of development, meaning that many children who experience a developmental delay don’t become eligible for support until age 7. Early intervention is crucial for supporting the long-term health and wellness of our state’s most vulnerable youth. Children with disabilities are at increased risk for adversity and adverse childhood experiences and life events. By providing intervention to infants and children with lower percentage delay, they will have increased opportunities for skill development and require less specialized education services, thus decreasing the total number of children needing intensive services at older ages. Additionally, a lower eligibility threshold will better align Early Intervention and Special Education, allowing for a seamless transition from ILP to special education services.	Lowering the eligibility threshold would increase the current REACH ILP by an average of around 40%. For this reason, it is recommended that the expansion from 50% to 25% developmental delay is done incrementally, to allow for the development of the necessary provider workforce and supporting infrastructure over time, monitoring anticipated and actual increases in children needing and receiving services. For REACH, this looks like gradual addition of at least 4 FTE direct service providers who will also travel to provide services in the rural Southeast communities, and the implementation of a new data management system for documentation, child records, and improved billing functionality and separate accounting processes for this expanded cohort of children. Currently approximately 20% of infants and children are eligible for ILP through clinical opinion, 20% through established conditions, and the remaining 60% enroll through developmental delay. Through expansion of services in conjunction with the lower percentage delays, providers will be able to quickly and easily refer families for services without the concern that a referral may be declined for lack of sufficient developmental delay, allowing enrollments to grow through increased provider referral rates. RHTP funding will be utilized for implementation to support operations as REACH 1) explores opportunities to expand the state’s Medicaid plan for developmental therapies; 2) enrolls more children in programming; and 3) explores additional paths for billing developmental therapies.	\$1M-\$5M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

REACH, Inc.	REACH, Inc. ILP – Expanding Outreach to Rural Communities	AK	In their most recent needs assessment, the Children and Youth with Special Healthcare Needs (CYSHCN) Advisory Committee identified “increas[ing] or promot[ing] equitable access to medical and pediatric specialty care and family supports” as their priority. The 2021-2022 National Survey of Children’s Health estimated that 18.9% of Alaskan children fall into this category – of this group more than 20% of families found services or specialist care difficult obtain, likely due to the large rural population, geographic challenges, and long-standing healthcare access needs that make the Rural Health Transformation Program necessary. In the State of Alaska’s RHTP Proposal, the state specifically notes AN/AI youth lacking access to culturally appropriate screenings. Communities with a REACH presence already have a higher percentage of children who meet the Alaska standards for school readiness than the state average. This project aims to continue supporting infant and toddler development while also providing long-term supports for caregivers and families in these rural communities, ensuring consistent care coordination through transitional phases.	1 FTE Rural Services Coordinator will travel at least monthly to communities outside of Juneau (above) to develop community partnerships with local clinics, schools, child care centers, and families. Through these partnerships, the Rural Services Coordinator will create opportunities to host no-cost developmental screenings for children ages 0-3, provide community education on early intervention services, and facilitate and address community concerns contributing to the development of needs-based operation strategies for rural communities. The Rural Services Coordinator will serve as the initial case manager for families in need of early intervention support – referring them to the Infant Learning Program, connecting them with additional resources, and working with them to develop an individualized family service plan. Additional hearing and vision screeners will be purchased as part of this project for use in these rural communities. The Rural Services Coordinator may host community outreach health fair events, work with other local organizations serving families and children to provide screenings, set-up office hours for families to come ask questions and receive information, and other activities based on community needs. The Rural Services Coordinator will work with broader ILP and REACH staff to discuss and address community needs in order to develop a larger community-oriented service plan to ensure that families in these communities have access to the support and services necessary to promote healthy infant development and ensure smooth care coordination.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Ready.net	Closing Alaska's Rural Telehealth Gap: Ready Pods for Libraries & Community Sites	DC	Alaska received the second-largest RHTP allocation in the nation because the need is acute. With vast distances between communities and rural healthcare access erosion, Alaskans in rural areas face critical barriers to telehealth, behavioral health, maternal care, chronic disease management, and workforce development. Alaska's RHTP application calls for investing in telehealth infrastructure, expanding consumer-facing digital health tools, and testing new delivery modalities. The opportunity is clear: Alaska needs physical telehealth access points in the communities where residents already gather, not more brick and mortar locations they can't reach. The gap: currently, no turnkey, fleet-managed, compliance-ready telehealth station exists in the Alaska market. Existing telehealth kiosk vendors target hospitals and pharmacies, not libraries and community sites. Basic acoustic booths deployed in other states lack clinical-grade video, fleet management, compliance reporting, or behavioral monitoring. Alaska has the funding, the need, and the framework to deploy a statewide network of community telehealth access points, but needs the right technology partner to deliver it as a turnkey solution. Ready Pods fill this gap; purpose-built for exactly the kind of rural health transformation Alaska envisions under Initiative 6 (Spark Technology & Innovation) and Initiative 2 (Health Care Access), with cross-cutting benefits for workforce development and healthy communities.	Ready proposes deploying Ready Pods, turnkey telehealth and workforce development stations, across Alaska's rural communities, managed through the BOSS/Pods fleet management platform with geospatial site selection powered by GAME and RAD. PHASE 1 - SITE SELECTION & PLANNING (Months 1–3): Ready uses GAME (Geospatial Asset Management Engine) and RAD (Ready Address Database) to analyze healthcare access gaps, broadband availability, and population data across Alaska's boroughs and census areas. We produce a rank-ordered deployment recommendation. We then work collaboratively with the Alaska Department of Health, Tribal Health Organizations, Alaska Community Foundation, Schools Health & Libraries Broadband Coalition (SHLB), and local library systems to finalize deployment sites, quantities, and phasing based on community priorities and consultation. PHASE 2 - PROCUREMENT & DEPLOYMENT (Months 3–9): Ready fabricates, upcycles, and ships Pods to selected sites. Ready conducts broadband assessments at each site if needed, configures telehealth and training app integrations (compatible with AFHCAN telemedicine infrastructure or commercial platforms), applies Alaska DOH branding, and commissions each unit. Site hosts receive operational training, playbooks, and ongoing helpdesk support. PHASE 3 - OPERATIONS & MONITORING (Ongoing): BOSS/Pods provides the State with a real-time admin dashboard showing fleet status, utilization metrics, session data, maintenance requests, and impact KPIs. Community members book sessions through the Ready Pods mobile app or walk-up QR booking. ARC (Automated Reporting & Compliance) generates formatted reports aligned with CMS RHTP requirements. Ready provides ongoing platform support, software updates via over-the-air delivery to the edge controller in each Pod, and helpdesk support for site hosts. Each Pod supports telehealth (primary care, behavioral health, maternal health, specialty consults), workforce development (vocational training, job interviews, certifications), and community health education (idle-screen resource displays). The BOSS platform tracks all utilization automatically, providing Alaska with the data needed to demonstrate RHTP outcomes to CMS. Ready is working with a current state partner to deliver ~100 Pods, with first deliveries Spring/Summer 2026, providing a direct operational proof case.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Recover Alaska	AURORA: Alaska’s Unified Response on Reducing Alcohol Harms Through Data and Community Action	AK	We propose the AURORA initiative to address a critical gap in Alaska’s public and behavioral health systems: the lack of a coordinated, data-informed statewide strategy for reducing alcohol-related harms. As noted in the federal proposal, Alaskans with behavioral health and substance use disorders in rural communities are a key target population, yet Alaska currently lacks a coordinated statewide strategy for addressing alcohol-related harms despite alcohol remaining the state’s most significant behavioral health challenge. While numerous organizations work on prevention and treatment, these efforts are often fragmented across systems, limiting Alaska’s ability to effectively address harms and contributing to disparities in health outcomes. AURORA will build Alaska’s first coordinated statewide strategy for reducing alcohol harms. The project will integrate data mapping, community engagement, and cross-sector collaboration to create shared understanding and coordinated action. Through statewide data integration and locally grounded engagement, AURORA will generate actionable insights supporting improved prevention, treatment access, and recovery systems across Alaska. This project aligns with the RHTP Healthy Communities and Health Care Access Initiatives, particularly potential work focused on strengthening statewide data collection, conducting community-level needs assessments, and improving cross-system coordination to guide resource allocation and health planning.	AURORA will unfold across three interconnected phases that operate simultaneously and inform one another. Phase 1: Statewide Data Gathering and Systems Mapping Recover Alaska will conduct a statewide settings-of-harm assessment that integrates data across multiple systems including emergency departments, hospitals, law enforcement, behavioral health services, and public health surveillance, highlighting alcohol-related gaps in services, coordination, and prevention infrastructure. Findings will be translated into Community Alcohol Impact Profiles that provide regional stakeholders with actionable information. Phase 2: Community Engagement and Local Systems Planning Recover Alaska will partner with three diverse rural communities to pilot a structured engagement process that connects local knowledge with statewide data. Through facilitated listening sessions, data-sharing conversations, and collaborative planning processes, communities will identify their priority alcohol-related challenges and develop locally grounded strategies. Community Champions will be trained to facilitate dialogue, interpret data, support ongoing engagement and serve as local connectors between community priorities and statewide systems. To ensure lessons emerging from these pilots are shared statewide, AURORA will produce a podcast documenting the project’s community-based work. Episodes will feature Community Champions, local leaders, and practitioners discussing how alcohol harms manifest in their communities and what solutions they are developing. This platform will enable continuous knowledge exchange across Alaska’s widely dispersed regions and help other communities learn from the pilot experiences in real time. Phase 3: Statewide Coordination and Strategy Development Insights from the statewide assessment and community pilots will inform the work of the AURORA Task Force, a cross-sector body composed of tribal health organizations, behavioral health leaders, treatment providers, educators, policymakers, and community representatives that will synthesize findings to develop Alaska’s first coordinated Statewide Alcohol Harm Prevention Strategy. At the same time, each pilot community will begin implementing community-led interventions addressing their locally identified priorities. These phases function as an iterative system rather than a linear process, allowing data, community insights, and statewide coordination to continuously inform one another.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Recover Alaska	Statewide & Regional Survey of Alaskan Perspectives on Alcohol and Alcohol-Related Harms	AK	Recover Alaska proposes a project aligning strongly with RHTP Healthy Communities, Health Care Access, and Healthy Beginnings Initiatives. As noted in the State of Alaska’s federal proposal, Alaskans with behavioral health and substance use disorders in rural communities are a key target population, yet Alaska lacks current statewide and regional data on public perceptions of alcohol harms, treatment access, and recovery. The first representative survey addressing these issues was commissioned by Recover Alaska in 2018 but has not since been updated. The absence of current data creates a major barrier to effective planning and accessibility to potential funding streams to increase accessibility. Without reliable information it is difficult to identify where treatment access gaps exist, how public perceptions of recovery may be changing, and which communities face the greatest barriers to care. This project will address that gap by conducting a new statewide survey of Alaskan adults that produces both statewide and regionally valid findings. The survey will measure alcohol consumption patterns, awareness of alcohol-related health risks, perceptions of treatment access, and attitudes toward recovery. The resulting dataset will provide critical evidence to inform behavioral health policy, guide investment decisions, and support improved access to treatment and recovery services across Alaska.	Recover Alaska will partner with an experienced national public opinion research firm to conduct a representative statewide survey of Alaska adults. The survey will complete approximately 1,450 interviews with Alaska residents age 18 and older. Sampling will be structured to produce statistically valid results across Alaska’s seven public health regions. The survey will use a mixed-mode methodology designed to reach residents across Alaska’s diverse urban, rural, and remote communities. Participants will have the option to complete the survey online, by telephone, or through a mailed questionnaire. Outreach will include mailed invitations, reminder mailings, text invitations, and telephone follow-up to ensure participation from all communities. Survey questions will build on the 2018 Recover Alaska survey while incorporating updated topics relevant to the RHTP Health Care and Healthy Communities Initiatives, such as alcohol consumption patterns, awareness of health risks associated with alcohol use, perceptions of recovery, experiences seeking treatment, and barriers to accessing care in rural areas. The project will include four phases: 1) Survey development and cognitive pretesting will refine questions and ensure clarity for respondents. 2) Data collection will follow using the mixed-mode methodology. 3) Survey responses will be weighted to produce a representative sample of Alaska’s adult population. 4) Data analysis will include regional comparisons and demographic analysis. The project will produce a comprehensive analytic report describing statewide trends and regional differences. Findings will be shared with policymakers, health systems, tribal organizations, and community partners to support evidence-based decision-making. By providing reliable statewide and regional data, the project will strengthen Alaska’s ability to address alcohol harms through targeted prevention, treatment, and recovery strategies, supporting evidence-based programming and data collection called informing RHTP Healthy Beginnings, Health Care Access, and Healthy Communities Initiatives.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Recover Alaska	State-Wide Recovery Community Organization	AK	Alaska currently lacks a statewide recovery infrastructure capable of supporting and connecting the grassroots recovery initiatives emerging across rural communities. This project presents an opportunity to establish Recover Alaska as the state’s first statewide Recovery Community Organization, to strengthen and connect community-led recovery efforts across Alaska. In this role, Recover Alaska would provide technical assistance, data, coordination, and shared tools to support the development and sustainability of local RCOs and grassroots recovery initiatives. RCOs are uniquely suited to Alaska’s rural context because they rely on the expertise of people with lived experience rather than clinicians, allowing communities with limited clinical workforce to build recovery support services locally. RCOs can also provide navigation and peer support services that help individuals access assessments, treatment, and recovery resources—services critical for connecting people to care. This project aligns with the RHTP initiative focused on strengthening community-based health systems and care coordination, particularly potential projects related to expanding community-based workforce capacity, improving service navigation, and strengthening regional collaboration. By supporting locally governed recovery organizations and building statewide coordination, this model will strengthen recovery infrastructure and expand access to peer-led recovery supports across Alaska.	The approach focuses on four complementary strategies: 1. Establish Recover Alaska as a statewide Recovery Community Organization Recover Alaska will obtain certification through Faces & Voices of Recovery and develop the governance, ethical standards, and peer leadership structures required of a statewide RCO. This will position RAK to serve as Alaska’s recovery systems backbone organization supporting local recovery initiatives statewide. 2. Conduct a statewide recovery infrastructure assessment. Recover Alaska will map existing recovery resources and grassroots initiatives across Alaska, including recovery groups, peer services, recovery housing, tribal recovery programs, and justice-related recovery supports. We will include a rural listening tour that coincides with RAK’s AURORA project – a statewide and regional data-gathering and organizing project – to identify regional priorities, leadership, and opportunities for local RCO development. These activities will produce Alaska’s first Recovery Landscape Report, statewide recovery resource map, and rural gaps analysis, improving coordination and visibility of services. 3. Develop the Alaska Recovery Ecosystem framework. Using the assessment findings, Recover Alaska will create a statewide recovery system blueprint defining the roles of RCOs, treatment providers, prevention organizations, tribal health systems, and peer workforce pathways. This framework will guide the development of locally governed RCOs and strengthen the continuum of care between treatment, recovery support services, and community-based prevention. 4. Provide technical assistance and network development for emerging RCOs Recover Alaska will support grassroots organizations and recovery leaders in forming local RCOs through technical assistance, connection to trainings, and shared infrastructure. Recover Alaska will develop a "How to Start an RCO in Alaska" toolkit. Support may also include nonprofit development guidance, peer workforce training, governance support, and sustainability planning according to each partner's needs. The first two strategies represent the first year of foundational work. Strategies three and four would follow in subsequent years. Future phases could expand the recovery ecosystem by launching the Alaska Recovery Network, advancing a statewide Recovery Policy Agenda, expanding peer workforce development, and building additional sustainable funding pathways for recovery organizations.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Relevant LLC	Stories & Wisdom Rural Behavioral Health Transformation	WA	Rural, remote, and frontier communities in Alaska face some of the most severe behavioral health challenges in the nation. Mental health conditions affect approximately 20% of adults and nearly 75% of youth. Alaska’s suicide rate is more than twice the national average, and drug overdose deaths continue to rise sharply, with the state ranking sixth in the United States. At the same time, dementia care and research remain heavily focused on pharmacological interventions that may slow disease progression but do little to address the psychosocial burdens of isolation, loneliness, and caregiver burnout that shape quality of life. These challenges are compounded by geographic isolation and workforce shortages that limit access to care. Many residents must travel hundreds of miles, sometimes over multiple days due to weather and transportation barriers, to reach specialty services, and 65% of rural counties have no practicing psychiatrist. Behavioral health programs have also been reduced or remain insufficient in many rural areas, contributing to delayed care and worsening outcomes. Across suicide prevention, substance-use recovery, and dementia care, a critical and under-addressed driver of poor outcomes is social isolation. There is a significant opportunity to deploy low-bandwidth, community-centered digital tools that strengthen social connection, extending behavioral health support and aligning with Alaska’s Health Care Access and Spark Technology and Innovation initiatives.	We propose a scalable, consumer-facing model, the Stories & Wisdom Rural Behavioral Health Transformation Initiative, that treats connection as care to address the hidden epidemic of social isolation driving poor health outcomes in rural communities. Our neuroscience-informed, gamified digital storytelling platform (STORIES®) and data analytics engine (WISDOM®) empower patients and caregivers to share lived experiences in structured, facilitator-led sessions that foster connection and belonging—core determinants of behavioral health. In the STORIES® experience, a small group of participants and a trained facilitator join from any browser-enabled device. The facilitator guides turn-taking, models simple, personal, and authentic (SPA) storytelling, and provides technical support. On their screen, participants see a Prompt Card and their hand of Response Cards and during their turn, they pair a Response Card with the Prompt Card to create a statement and answer, “Why is this true for you?” by sharing a personal story. As they share, other participants provide live feedback through four reactions: “Pausing to reflect,” “Learnt something new,” “I’m with you,” or “Inspired to act,” fostering dialogue. All stories are transcribed, and reaction data is captured for analysis on our WISDOM® platform. Using AI, WISDOM identifies themes, assesses sentiment, and generates insights that can inform state health improvement plans and targeted interventions. Our model integrates neuroscience research from Dr. Paul Zak (Claremont Graduate University), Dr. Barbara Oakley (Oakland University), and Dr. Uri Hasson (Princeton University) demonstrating that storytelling triggers oxytocin and dopamine, biological mechanisms that build trust and empathy. The proposed initiative also builds on over 22 national awards for digital innovation and real-world deployments across military, healthcare, and corporate environments, where 92% of participants reported feeling more connected and post-session well-being scores increased by over 30%. Our technology is low-bandwidth, browser-based, HIPAA-compliant, and accessible across all devices, making it ideal for rural environments with limited infrastructure. Our approach directly supports Alaska’s RHTP priorities by: (1) Expanding access to behavioral health services through culturally appropriate telehealth for youth and adults and (2) Empowering providers with AI-driven insights to identify emerging risks and tailor care.	\$1M-\$5M	Behavioral health/su bstance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Remote Hands	Rural Health Support Services: Local Workforce for Health Technology, Home Support & Care Navigation	AK	Rural Alaska faces a fundamental support gap that undermines health system investments and strains limited clinical resources. When a patient's blood pressure monitor stops transmitting data, when an elder needs help navigating benefits enrollment, when someone is discharged from the hospital but needs in-home support—the current options are either expensive fly-in services (\$2,000+ per visit) or overburdened clinical staff performing non-clinical tasks. This gap affects multiple RHTP priorities simultaneously: health technology goes unused, care coordination breaks down, hospital readmissions increase, and clinical workforce capacity is consumed by tasks that don't require clinical training. Meanwhile, capable local residents in these same communities lack employment opportunities. The opportunity is to build local workforce capacity that can meet diverse community health support needs—from technology troubleshooting to home-based assistance to care navigation—keeping service delivery local, reducing costs dramatically, and creating sustainable employment in rural communities.	Remote Hands Alaska proposes to expand its proven rural workforce model to address health-related support needs across three service categories: 1. Health Technology Support: Local technicians deploy, troubleshoot, and maintain remote patient monitoring devices, wearables, telehealth equipment, and assistive technology. Working with live video guidance from remote experts, they provide same-day support that would otherwise take weeks. 2. Home-Based Support Services: Chore services, respite care support, and in-home assistance for elders and individuals with disabilities—services currently difficult to access in rural communities. This extends existing Senior and Disability Services programs by providing the local workforce infrastructure to deliver them. 3. Care Navigation & Benefits Support: Hospital discharge coordination, benefits enrollment assistance, and connection to social services through platforms like GetHelp. Local navigators help community members access programs they qualify for but struggle to enroll in. The model works because it already exists. Remote Hands currently operates a network of 80+ certified local technicians across 56 rural Alaska communities under a \$1.2M AFN Tribal Broadband Connectivity Program contract. We propose to: • Develop health-specific training curriculum with our nonprofit partner T3 Alliance • Train 75-100 individuals annually through regional hub training events • Employ trained workers as on-call, part-time Remote Hands technicians • Provide centralized dispatch, quality assurance, and remote expert support • Build referral relationships with healthcare organizations, tribal health, and state programs	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Renal Care 360	AI-Enabled Early Detection & Chronic Care Management for Kidney Disease in Rural Alaska	TN	Project Concept Opportunity Chronic kidney disease affects approximately 1 in 7 Americans, yet up to 90% of cases remain undiagnosed until advanced stages. Late diagnosis leads to kidney failure requiring dialysis, with annual costs exceeding \$90,000 per patient and significant burdens on rural communities. Alaska’s rural populations face additional risks due to limited access to specialty care and long travel distances. There is a critical opportunity to improve early detection, patient engagement, and chronic disease management using scalable technology that supports local providers.	Project Concept Approach RC360° will deploy an integrated program consisting of: 1. Integration of a proprietary predictive analytics platform into partner health systems’ electronic medical records 2. Screening of patient populations to identify undiagnosed CKD and high-risk individuals 3. Risk stratification and clinical decision support dashboards for providers 4. Enrollment of eligible patients into AI-enabled chronic care management 5. Continuous patient engagement, education, and monitoring 6. Referral coordination and escalation to local care teams The AI care manager delivers personalized outreach, behavior coaching, medication adherence support, and clinically relevant data capture, enabling proactive intervention and reducing disease progression. This model is highly scalable and can operate across dispersed communities without requiring significant new infrastructure.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Renewable Energy Alaska Project	Weatherization and Energy Efficiency for Child and Elder Care	AK	This project aims to address the issue of homes that provide childcare or are occupied by elders are energy inefficient and/or have deferred maintenance needed to maintain safety, efficiency, affordability and healthy indoor air quality. Inefficient and poorly maintained buildings pose several risks to occupants and the community. Children and elders are significantly more vulnerable to respiratory illness that can be caused or exacerbated by poor indoor air quality. There is a substantial body of evidence that providing weatherization upgrades guided by established building science practices and principles dramatically improves indoor air quality, occupant comfort, and affordability. For elders, uncomfortable, unhealthy and unaffordable conditions at home can also expedite the move to a costly long-term care facility. While the primary benefit is healthier indoor conditions for vulnerable populations, other benefits include job creation, lowering costs for essential local businesses with small margins, and improved cost of living for aging populations on fixed incomes.	This project proposes the establishment of a statewide weatherization program targeted towards in-home childcare facilities and homes occupied by elders. If funded, REAP would set up an accessible, low-barrier application process for individuals and care providers to receive up to \$75,000 of energy upgrades, 15-25% of which can be spent on life, health, or safety remediation. REAP will contract directly with certified energy auditors and trusted and experienced general contractors who will manage the construction projects. Engaging directly with a limited number of general contractors eases the burden on program participants and offers a larger potential contract with the general contractors to encourage longer term investments in training, certifications, and staffing. With the potential for multi-year funding, REAP could invest further in identifying training opportunities and recruitment of weatherization providers. Additionally, REAP would welcome the opportunity to partner with providers who work with these populations supporting the care or housing of children or elders. This program could benefit from being coupled with other programs offering home accessibility upgrades, long term housing, in home care, childcare, or other services.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Resilient Youth & Community, Inc.	Behavioral Health Workforce Recruitment & Retention Initiative	AK	Rural communities in Alaska face significant shortages of behavioral health professionals, particularly clinicians and behavioral health workers who support youth experiencing complex mental health and behavioral challenges. Geographic isolation, high relocation costs, and limited professional networks make recruitment and long-term retention of behavioral health staff especially difficult in frontier communities. For providers such as Resilient Youth & Community (RYC), these workforce shortages directly limit the availability of services for youth and families. When behavioral health positions remain vacant, organizations must reduce service capacity, extend wait times, or limit admissions to treatment programs. Staffing instability also disrupts continuity of care for youth who require consistent therapeutic relationships and coordinated treatment services. Demand for youth behavioral health services continues to increase across Alaska, yet the ability of rural providers to expand services is constrained by workforce shortages. This project addresses the opportunity to strengthen rural behavioral health capacity by recruiting and retaining key behavioral health leadership, clinicians, and behavioral health workers who support youth treatment services.	Resilient Youth & Community (RYC) will address rural behavioral health workforce shortages by implementing a targeted recruitment and retention strategy designed to attract and retain the clinical staff and behavioral health workers necessary to expand youth behavioral health services in Southeast Alaska. The project will focus on recruiting key behavioral health leadership, licensed behavioral health clinicians, and behavioral health workers who support youth treatment services. RYC will utilize professional recruitment firms with experience placing health care leadership and clinical professionals in rural and frontier communities. These firms will conduct targeted searches and national outreach to identify qualified candidates with experience in behavioral health care and youth treatment services. To overcome barriers to rural recruitment, the project will provide structured recruitment incentives and relocation support for new hires. These incentives will help offset the financial and logistical challenges associated with relocating to a remote community and allow RYC to compete more effectively with urban health systems and telehealth providers for a limited behavioral health workforce. The initiative will also implement retention incentives tied to multi-year service commitments to support workforce stability once positions are filled. These incentives are designed to encourage long-term employment and reduce turnover, which is a persistent challenge for rural behavioral health providers. By investing in targeted recruitment and retention supports, this project will stabilize RYC’s behavioral health workforce, expand clinical staffing capacity, and increase the number of youth and families who can receive behavioral health services. Strengthening staffing capacity will reduce service wait times, improve continuity of care, and support the long-term sustainability of youth behavioral health services in rural Alaska.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Advance to Implementation Application

Resilient Youth & Community, Inc.	RYC Regional Hybrid Psychiatry & Telehealth Expansion: Sustainable Access for Rural Youth	AK	Southern Southeast Alaska faces persistent gaps in youth behavioral health access due to geographic isolation, limited local specialty psychiatric capacity, and severe workforce shortages in remote communities such as Prince of Wales Island. Youth and families often experience long wait times, fragmented care, and inconsistent continuity across levels of service, particularly during transitions from crisis stabilization, residential treatment, or hospitalization. A central barrier is the inability of rural communities to reliably recruit and retain sufficient psychiatric providers and clinical/case management staff. When specialty coverage and care coordination are unstable, youth rely on repeated crisis response, delayed medication management, or out-of-region referrals, undermining sustainable access to care close to home and contributing to preventable escalation. This challenge presents an RHTP-aligned opportunity to redesign specialty delivery by stabilizing rural psychiatric and care coordination capacity through a hybrid model anchored in Ketchikan and supported by an Anchorage Access & Continuity Hub. By leveraging Anchorage’s larger clinical workforce and extending psychiatric oversight and clinical/case management support through telehealth-enabled workflows, RYC can expand appointment availability, strengthen post-discharge continuity, reduce vacancy impacts, and advance RHTP goals to expand rural specialty access and build sustainable workforce capacity.	RYC’s proposed approach is to implement a regional hybrid psychiatry and clinical support model that expands specialty psychiatric access and strengthens continuity of care for youth ages 10–21 and their families across Southern Southeast Alaska, including Prince of Wales Island and other remote communities. The model is anchored by a Ketchikan Psychiatric Hub and reinforced by an Anchorage Access & Continuity Hub that leverages Anchorage’s larger workforce pool to stabilize rural capacity. Rather than relying solely on recruitment in frontier communities, RYC will extend psychiatric oversight and clinical/case management support through technology-enabled workflows that increase appointment availability and reduce disruption caused by vacancies. Access Expansion: RYC will provide psychiatric evaluation, medication management, and structured telepsychiatry through coordinated referral pathways and centralized scheduling. Because RYC serves youth statewide in residential treatment, this model strengthens psychiatric continuity before, during, and after care while expanding access to follow-up and stabilization closer to home when clinically appropriate. Earlier specialty access reduces travel burden, limits out-of-region referrals, and decreases crisis-driven entry into care. Continuity and Quality: The Anchorage hub strengthens intake coordination, discharge transitions, and post-stabilization follow-up using standardized protocols, shared workflows, and measurable tracking across sites. The model is designed to improve 7- and 14-day follow-up as leading indicators and support higher 30-day follow-up after hospitalization, reduce crisis recurrence, and improve stabilization and suicide risk reduction. Sustainability: The model is integrated into existing service lines and reimbursement pathways. Telepsychiatry delivers specialty capacity without proportional rural hiring, improving efficiency and reducing volatility from workforce shortages. By stabilizing psychiatric oversight and care coordination, the initiative reduces reliance on high-cost crisis utilization and keeps youth connected to services close to home. By combining a rural psychiatric anchor hub with Anchorage-based workforce depth, this project advances RHTP priorities to strengthen workforce capacity, expand sustainable specialty access, modernize technology-enabled care delivery, and build an outcomes-driven behavioral health system for rural youth.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Advance to Implementation Application

Resilient Youth & Community, Inc.	Ketchikan TMS Pilot: Expanding Sustainable Access to Rural Specialty Depression Care	AK	Rural Southeast Alaska faces a severe behavioral health access gap driven by high rates of depression, suicide risk, geographic isolation, and limited specialty psychiatric capacity. Alaska consistently experiences some of the highest suicide rates in the nation, and rural communities face disproportionate barriers to timely, effective treatment. For many adolescents and adults with Major Depressive Disorder, symptoms persist despite medication and therapy, increasing crisis risk and disruption to school, work, and family stability. A key structural gap in Southeast Alaska, including Ketchikan and surrounding island communities, is the absence of advanced outpatient interventions for treatment-resistant depression. When individuals do not respond to standard care, there are few local options beyond repeated medication trials or out-of-region referral to Anchorage or beyond. This results in delayed stabilization, avoidable crisis escalation, and travel burdens that many rural families cannot sustain. This project addresses an RHTP-aligned opportunity to increase access to high-quality specialized behavioral health services close to home by establishing the first local Transcranial Magnetic Stimulation (TMS) service line in the region. By filling a missing tier in the rural behavioral health continuum, the project strengthens quality, reduces reliance on crisis systems, and advances Alaska’s rural health transformation goals.	RYC’s proposed approach is to establish the first local Transcranial Magnetic Stimulation (TMS) service line in Southeast Alaska as a specialty outpatient intervention for adolescents (15+) and adults with Major Depressive Disorder, anxious depression symptoms, and OCD. This pilot will increase access to high-quality specialized depression treatment close to home in a region that currently lacks advanced outpatient options for treatment-resistant depression. RYC is uniquely positioned to implement TMS because it maintains an onsite psychiatric provider with prescribing authority, an established clinical facility in Ketchikan, and an integrated outpatient and residential continuum. Many rural communities cannot offer TMS due to lack of psychiatric oversight or infrastructure; RYC has both in place, reducing implementation risk and accelerating access for Southeast patients. TMS will be integrated into existing workflows with structured referral pathways, standardized eligibility and safety protocols, and measurement-based care. The service will function as an intermediate tier between traditional outpatient treatment and higher levels of care, strengthening the continuum and supporting earlier stabilization before crisis escalation. Regional referral pathways will enable access for Ketchikan residents and patients from surrounding Southeast communities when travel is feasible, reducing out-of-region referrals. Outcomes will be tracked through defined access, clinical, and system measures, including time from referral to treatment initiation, completion rates, symptom improvement on standardized depression scales, functional stability indicators, reduced crisis escalation, and reduced need for out-of-region specialty referrals. The pilot is intentionally data-driven to generate Southeast-specific demand, staffing feasibility, and reimbursement information to inform long-term sustainability. Following start-up, the program is expected to transition to a reimbursement-supported model through established billing pathways, reducing reliance on grant subsidy and strengthening fiscal viability. By building a missing tier of evidence-based depression care in a rural hub community, this project expands specialty access, strengthens quality through standardized protocols and outcomes tracking, and establishes durable behavioral health capacity closer to home for Southeast Alaska communities.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

Resilient Youth & Community, Inc.	RYC Training Center Modernization: Strengthening Rural Workforce and Sustainable Access	AK	Rural, remote, and frontier communities across Alaska face persistent behavioral health workforce shortages, high turnover, and vacancy-driven service disruption. These challenges weaken care close to home and contribute to inconsistent practice, delayed onboarding, and gaps in continuity—especially in hub-and-spoke systems where staff support multiple communities and levels of care. A key structural barrier is limited access to standardized, evidence-informed training for rural providers and community partners. Travel costs, limited trainer availability, and insufficient distance-learning capacity prevent consistent onboarding, annual recertification, and continuing education. As a result, workforce readiness varies across organizations, collaboration is harder across systems, and retention risk increases. This creates an RHTP-aligned opportunity to strengthen workforce stability and consistent standards of care by expanding scalable training infrastructure. By modernizing a dedicated training center and enabling high-quality distance delivery, RYC can address a core system gap: the lack of reliable, affordable training capacity that supports recruitment, retention, and consistent practice for youth-serving behavioral health teams in rural and frontier communities.	Resilient Youth & Community (RYC) will modernize and expand its established training center to function as a regional workforce hub supporting youth-serving behavioral health providers across Southeast Alaska. For more than 30 years, RYC has delivered standardized on-boarding and required core trainings—including Peer Support, Teaching Family Model, MANDT, CPR, and Youth Mental Health First Aid—across residential and community-based programs. This project builds on that foundation by upgrading physical capacity and distance-delivery infrastructure to ensure scalable, consistent workforce development. Investments will include durable commercial furnishings to expand in-person training capacity, upgraded computer and recording equipment to support high-quality virtual delivery, standardized training module formatting for hybrid use, and trainer development for distance facilitation. These improvements will enable centralized, standardized training from Ketchikan while supporting staff delivering services in surrounding rural communities within a hub-and-spoke model. Enhanced distance capability reduces travel burden and service disruption, allowing rural providers to complete on-boarding, annual recertification, and continuing education without leaving their communities. Standardized modules and centralized delivery will improve time-to-competency, increase training completion rates, and reduce vacancy-driven disruption by accelerating workforce readiness. The upgraded center will also host structured in-person and virtual trainings for community partners, strengthening shared standards of practice and cross-sector coordination across Southeast Alaska. By formalizing and expanding scalable workforce training infrastructure, this project advances RHTP’s Strengthen Workforce initiative by stabilizing rural workforce capacity, improving on-boarding efficiency, and supporting consistent, high-quality care close to home for youth and families in rural and frontier communities.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Deferred or Not Advanced

Resilient Youth & Community, Inc.	SeaLevel Youth Center Renovation: Healthy Communities, Sustainable Access, and Workforce Innovation	AK	Youth in rural Southeast Alaska experience disproportionately high behavioral health risk driven by geographic isolation, workforce shortages, limited specialty capacity, and fragmented prevention and early intervention systems. Currently, many youth only enter care at the point of crisis, driving avoidable reliance on emergency departments, schools, law enforcement, and higher levels of care. Early needs frequently go unidentified, referrals go incomplete, and families face practical barriers such as technology gaps, difficulty navigating Medicaid and intake requirements, and stigma associated with formal treatment. A major structural gap is the lack of a consistent, youth-centered “front door” where prevention, early intervention, service navigation, and transition supports are integrated in one place. This is also a recognized community opportunity: SeaLevel has been identified and supported as a youth prevention transformation solution by the City of Ketchikan, Ketchikan Gateway Borough, and Peace Health, and is reflected as a desired youth support model in Alaska’s Behavioral Health Roadmap for Alaska Youth. This project addresses an RHTP-aligned opportunity to strengthen Healthy Communities, Health Care Access, Strengthen Workforce, and Spark Technology & Innovation by shifting the system upstream, expanding care close to home, and reducing downstream crisis-system strain.	SeaLevel is designed to advance Alaska’s Rural Health Transformation Plan (RHTP) by shifting the system upstream, strengthening sustainable access, and expanding care close to home for rural Southeast Alaska youth. It functions as a consistent, community-centered “front door” where prevention, early intervention, service navigation, workforce development, and continuum-of-care transitions are integrated within one coordinated, outcomes-driven model. To address gaps in prevention and early identification, SeaLevel expands RYC’s established after-school infrastructure into a structured prevention platform focused on mentorship, protective-factor development, substance use prevention, and health and nutrition education. This prevention-first approach strengthens whole-person well-being and reduces the likelihood that emerging behavioral health needs escalate into crisis, supporting RHTP’s goal of shifting spending from acute intervention toward preventive care. To reduce access barriers, SeaLevel will operate a modernized, technology-enabled learning and access hub that provides reliable connectivity, telehealth-capable private space, and staff-supported completion of referrals, documentation, and service navigation. Real-time warm hand-offs to clinical and case management services convert referrals into completed connections, improving care coordination and producing measurable improvements in access and engagement for rural youth. To strengthen long-term workforce stability, SeaLevel includes a teaching kitchen and supervised workforce café that delivers Food Workers Card readiness, job coaching, education support, and independent living skill development. This “grow our own” pipeline builds youth economic stability while contributing to rural workforce recruitment, retention, and community resilience. Integrated with RYC’s residential stabilization, psychiatric, and community-based services, SeaLevel reinforces continuity of care across the full continuum. By reducing crisis-driven entry into care and increasing successful linkage to preventive and early intervention supports, SeaLevel advances measurable improvements in access, quality, and fiscal sustainability consistent with RHTP goals.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area	Deferred or Not Advanced

Resilient Youth & Community, Inc.	Southern Southeast Alaska Rural Health Transformation Planning Initiative	AK	Southern Southeast Alaska lacks a coordinated, regionally aligned strategy to guide Rural Health Transformation across Ketchikan, Prince of Wales Island communities, Metlakatla, Wrangell, Petersburg, and surrounding frontier areas. While committed health system and Tribal partners are working to address community needs, the region faces persistent barriers consistent with those identified in Alaska’s Rural Health Transformation Program: geographic isolation, workforce shortages, limited specialty access, infrastructure and telehealth gaps, fragmented referral pathways, and financial strain on low-volume rural providers. These challenges contribute to delayed access to care, inconsistent coordination across Tribal and non-Tribal systems, duplication of limited services, and over reliance on crisis-driven models rather than prevention-focused, sustainable approaches. Smaller frontier communities face unique capacity constraints that make externally designed or one-size-fits-all solutions unrealistic. The opportunity is to bring regional partners together in a structured, community-grounded planning process to identify shared priorities, clarify service and workforce gaps, and define a sequenced vision for transformation aligned with RHTP goals. Without coordinated planning, future investments risk remaining fragmented, duplicative, and financially unsustainable.	To address the lack of a coordinated regional strategy for Rural Health Transformation in Southern Southeast Alaska, this project will implement a structured, community-grounded planning process that produces a practical, implementation-ready five-year transformation plan aligned with Alaska’s Rural Health Transformation Program priorities. Resilient Youth & Community, PeaceHealth, and Ketchikan Indian Community will convene health system partners, Tribal providers, community organizations, and regional stakeholders across Ketchikan, Prince of Wales Island communities, Metlakatla, Wrangell, and Petersburg to identify shared priorities and realistic solutions tailored to frontier conditions. The approach includes three phases. 1. Baseline Assessment and Gap Analysis The project team, working with Agnew:: Beck, will synthesize existing regional assessments, service data, and prior planning efforts to identify access gaps, workforce shortages, infrastructure and telehealth limitations, referral fragmentation, and areas of service duplication. Findings will be aligned with RHTP focus areas including Health Care Access, Healthy Communities, Strengthen Workforce, and Spark Technology and Innovation. 2. Regional Convenings and Rural Site Engagement Two regional convenings in Ketchikan will frame the effort. The first will establish shared priorities and focus areas. The second will review and validate the draft roadmap. Between convenings, task forces will conduct rural community visits and listening sessions in Prince of Wales Island communities, Metlakatla, Wrangell, and Petersburg to ensure strategies reflect real workforce capacity, transportation constraints, and small-community feasibility. 3. Five-Year Transformation Plan Development The final deliverable will outline phased strategies, partnership roles, measurable outcomes aligned with RHTP goals, and sustainability considerations. It will identify priority actions to improve access to primary, behavioral, maternal, and specialty care, strengthen workforce recruitment and retention, expand telehealth and hybrid delivery models, reduce duplication, and improve coordination across Tribal and non-Tribal systems. This structured approach reduces fragmentation, strengthens collaboration, focuses on whole person care and community health, and positions Southern Southeast Alaska for coordinated implementation that improves access, quality, and long-term sustainability in rural and frontier communities.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

Resonant Strategies	Voices of Strength Peer Workforce Initiative	OK	Alaska’s rural and frontier Tribal communities face severe behavioral health challenges driven by isolation, workforce shortages, and limited access to culturally grounded care. With no Tribal-specific peer support curriculum, Alaska Native communities lack a culturally relevant pathway to train residents as peer support specialists—despite urgent need where licensed providers are scarce. This project fills that gap by creating a culturally rooted Behavioral Health Peer Support curriculum and a tailored training-of-trainers (ToT) model. Preparing residents who share cultural identity and lived experience supports Alaska’s RHTP goal to build a resilient rural health workforce through recruitment, training, and retention, and advances the priority to expand behavioral health access. A culturally specific curriculum improves access and quality by ensuring services reflect Native values, languages, and healing traditions. Developed with Alaska-based partners, Native reviewers, and culturally grounded designers, the curriculum will be community-owned, culturally resonant, and clinically sound. The ToT model creates long-term sustainability by enabling Tribal communities to continually train new specialists without relying on outside trainers. In sum, this project fills a critical statewide gap, expands culturally relevant behavioral health care, and builds a durable, locally led workforce infrastructure that strengthens Alaska’s rural and frontier health systems for the long term.	The proposed approach directly addresses the behavioral health workforce crisis facing Alaska’s rural, remote, and frontier Tribal communities by creating a Tribal focused Substance Use and Mental Health Peer Support Specialist curriculum. Because no culturally grounded, Tribal specific curriculum currently exists, Alaska Native communities lack a standardized pathway to train local residents—despite the urgent need for community based behavioral health support in regions where licensed providers are scarce or unavailable. This project fills that gap by developing a culturally rooted curriculum and a training of trainers model tailored specifically for Alaska Native peoples. By preparing local residents who share cultural identity, lived experience, and community ties, the approach strengthens early intervention, recovery support, and ongoing behavioral health care. This directly advances Alaska’s RHTP initiative to “build a resilient rural health care workforce through pipeline, recruitment, training, and retention strategies,” offering a sustainable solution where traditional recruitment efforts have repeatedly fallen short. The approach also expands behavioral health access by ensuring that training reflects Alaska Native values, languages, and healing traditions. RHTP explicitly supports investments that increase access to substance use disorder and mental health services, and a culturally specific curriculum enhances both the quality and cultural safety of care delivered in Tribal communities. A key strength of the approach is its collaborative design process. Alaska based partners, Native curriculum reviewers, and culturally grounded graphic designers ensure the curriculum is clinically sound, culturally resonant, and community owned. This aligns with RHTP’s emphasis on strengthening local and regional partnerships to improve rural health system stability and access. Finally, the training of trainers model ensures long term sustainability by enabling Tribal communities to continually train new peer support specialists without relying on outside trainers or temporary grant funded staff. This supports RHTP’s mission to create “long term system level change” and strengthens Alaska’s behavioral health system well beyond the life of the grant. Overall, this approach improves access, enhances quality, and ensures sustainability by building a culturally grounded, self-renewing behavioral health workforce within Alaska’s Tribal communities.	\$50,000-\$250,000	Statewide	Southeast Fairbanks Census Area	Deferred or Not Advanced

Resource Center for Parents and Children RCPC	Pathways to Healing for Children, Parents, and Families	AK	This project addresses the need for accessible behavioral health services for families in Interior Alaska and the North Slope. We will provide specialized behavioral health support for postpartum mothers, new parents, families involved with the Office of Children’s Services (OCS), and children who have experienced trauma, along with their caregivers. Services will be delivered through in-person appointments, telehealth for remote access, and travel to rural villages to ensure families in remote communities can receive care. Focusing on these populations is critical because early childhood experiences and caregiver well-being are foundational to long-term health and family stability. Postpartum parents and families navigating child welfare involvement often experience high levels of stress, isolation, and untreated trauma, increasing the risk of poor mental health challenges and family disruption. Providing timely, trauma-informed behavioral health services during these pivotal moments strengthens parent-child relationships, supports healthy child development, and helps reduce the likelihood of future abuse, neglect, and deeper system involvement. Housed at the Resource Center for Parents and Children (RCPC), this program will integrate evidence-based trauma therapy and postpartum/new parent behavioral health care while collaborating with RCPC’s existing programs and regional partners across the Interior and North Slope to expand access to coordinated, family-centered care.	The proposed program will deliver trauma-informed, evidence-based behavioral health services. Services will be provided through a combination of in-person counseling in Fairbanks, secure telehealth services for families in remote communities, and scheduled travel to rural villages across the Interior and North Slope. This flexible model will reduce geographic barriers and ensure that families living in rural and remote areas have access to high-quality behavioral health care. Licensed behavioral health clinicians will provide evidence-based trauma therapies and parent-focused interventions tailored to postpartum mothers, new parents, children who have experienced trauma, and families involved with the Office of Children’s Services (OCS). Services may include individual therapy, family therapy, caregiver support, and parent-child sessions focused on strengthening attachment, improving emotional regulation, and supporting healthy child development. The program builds on RCPC’s existing behavioral health capacity, not duplicating efforts, and its long-standing role as a trusted provider of family support and child abuse prevention services across the Interior. For the past five years, RCPC has supported a grant-funded clinician dedicated solely to serving children who have experienced trauma. As part of this next phase of growth, RCPC will expand its capacity to include Medicaid billing, which has not previously been explored. The current Licensed Clinical Social Worker (LCSW) will provide clinical supervision and oversight for the program, ensuring quality care and adherence to evidence-based practices. Additional clinicians brought on through this project will focus on meeting Medicaid billing requirements while expanding access to services for families. This initiative will also serve as a workforce development opportunity. RCPC will provide licensure supervision at no cost to clinicians working toward independent licensure, along with training in trauma-informed and evidence-based therapy modalities. By strengthening the behavioral health workforce while building sustainable reimbursement through insurance billing, this program will expand access to care and support long-term, community-based behavioral health services for families across RCPC’s service area.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; North Slope Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

ReviveHealth, Inc.	Technology, Innovation, and Services Partner for Alaskans' Access to Rural Healthcare	FL	Alaska's Rural Health Transformation Program accelerates progress toward reliable healthcare access across one of the nation's most geographically complex care environments. More than 80% of Alaska communities are off the road system, many residents must travel by air or seasonal routes to reach care, and internet connectivity can be costly, limited, or unreliable. At the same time, every community carries at least one Health Professional Shortage Area designation, and suicide rates remain more than double the national average. These conditions create significant barriers to timely access to primary and urgent care, behavioral health services, weight health, pharmacy, and specialty consultation for rural residents. The opportunity is to deploy scalable care models that can reach remote communities reliably, expand care capacity for local providers, and deliver services as close to home as possible despite geographic and infrastructure constraints.	Revive proposes deploying a virtual-first care model that supports frontier environments in expanding access to care for rural and remote Alaska communities. The approach combines universal access technology, integrated clinical services, and partnerships with local care teams to deliver care as close to home as possible. Universal Access Infrastructure: The platform uses Plain Old Telephone Service (POTS) to connect patients directly with board-certified physicians by telephone. Because the model does not require broadband, smartphones, or mobile apps, it can reliably reach residents in communities where internet connectivity is limited or unreliable, expanding access across the 82% of Alaska communities that lack road connections. Integrated Whole-Person Clinical Care: Through a single access point, residents can receive urgent and primary care, behavioral health support, weight health, pharmacy, and coordinated specialty referrals. Physicians and clinicians can diagnose conditions, prescribe medications, provide behavioral health triage, and coordinate follow-up care. Medications for many common acute and chronic conditions can be delivered directly to patients' homes, helping address adherence barriers in remote communities. Extending the Local Care Workforce: The platform complements Alaska's existing care ecosystem, including tribal health organizations, regional providers, and Community Health Aide/Practitioner (CHA/P) teams. By managing low- to medium-acuity episodes virtually, Revive's care extends the capacity of local physicians/clinicians so they can focus on complex in-person care while improving continuity of care close to home. Technology, Navigation, and Data Integration: The platform supports remote patient monitoring, wearable device integration, and community-based care navigation tools that connect residents with clinical and social services. AI-enabled tools assist clinicians with triage, documentation, and care coordination. Interoperable data systems enable integration with health information exchange (HIE) infrastructure and other vendor technologies, while advanced analytics support population health management, emergency department diversion, and claims redirection tracking. Together, this approach creates a scalable, technology-enabled access layer that strengthens Alaska's rural health system while supporting workforce capacity, improved care coordination, and sustainable health system transformation.	\$250K-\$1M	Clinic	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

RH Health Inc.	Home-Based Chronic Disease Screening and Care Navigation for Rural Alaska	CA	Over 21% of Alaska's population is Alaska Native or American Indian, and more than 30% of residents live in remote villages accessible only by plane or boat. These communities face chronic disease rates exceeding national averages, yet screening for diabetes, kidney disease, and colorectal cancer remains critically low The barriers are structural. When the nearest clinic requires a flight, provider shortages mean months-long waits, and weather can ground transportation for days, patients do not get screened. Conditions progress to late-stage disease requiring medevac transport and out-of-state specialty care. The cost is enormous. Uncontrolled diabetes leading to kidney failure costs over \$90,000 per patient annually. Colorectal cancer caught at Stage IV has survival below 15%, compared to over 90% when caught early through a home screening test. Alaska's RHTP has identified chronic disease prevention, consumer-facing technology, and innovative care as priorities. RH Health's NIH peer-reviewed platform addresses all three. We ship tests to patients' homes, use AI-powered engagement to drive completion, and coordinate follow-up via telehealth so abnormal results do not fall through the cracks. The opportunity is to prove a technology-enabled screening model can close chronic disease gaps in the most geographically challenging healthcare environment in the country.	RH Health will deploy a home-based chronic disease screening and care coordination platform in partnership with Alaska-based FQHCs or tribal health organizations. The model has three core components: home-based screening, AI-powered patient engagement, and telehealth care coordination. Patient Identification: Our platform, Sherwood, integrates with partner EHRs via HL7 FHIR to identify patients overdue for diabetes (HbA1c), kidney disease (ACR), and colorectal cancer (FIT) screening, focusing on uninsured, underinsured, or unscreened patients. Home-Based Screening: Patients receive FDA-approved diagnostic test kits shipped to their homes with simple instructions, collection materials, and a prepaid return mailer. They complete the test on their schedule and mail it back. Labcorp processes specimens and returns results electronically to our platform and the partner EHR. AI-Powered Patient Engagement: Our AI agent, Mariann, handles outreach via SMS: shipment notifications, reminders, check-ins for unreturned kits, and result communications. Patients can text back with questions and receive immediate responses. Complex issues escalate to clinical staff. Available in English and Spanish, with capacity to add Alaska Native languages through partner collaboration. Care Coordination: Every abnormal result triggers a structured workflow. The patient receives a call within 48 hours, a telehealth visit is scheduled with our physicians, and if specialist referral is needed, we coordinate and track it to resolution. This closes the loop that breaks down in most screening programs. EHR Integration: Results flow automatically into the partner EHR. Care teams receive alerts for abnormal findings. Quality metrics update automatically, extending the clinic's reach without adding burden to rural health staff. Implementation follows a phased approach: partnership and EHR integration in months 1-3, soft launch in month 4, active screening in months 5-12, and evaluation in months 13-15	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Fairbanks North Star Borough; Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; Northwest Arctic Borough	Deferred or Not Advanced

Rhiza Psychiatry	HealthBridge: Alaska's First Cross-Sector Platform for Real-Time Behavioral Health Care Coordination	AK	Alaska's highest-need patients — domestic violence survivors, people experiencing homelessness, individuals with co-occurring mental health and substance use disorders — do not have one need. They have five or six at once. But Alaska's service system is built to handle one at a time. Behavioral health providers cannot see housing availability. Housing programs cannot see legal aid capacity. No shared platform exists to coordinate across all these sectors simultaneously. The cost of this fragmentation is enormous. Alaska spends approximately \$1,200 per day per person in emergency shelter — yet most of those individuals also need psychiatric care, legal support, and case management that nobody is coordinating. Unmanaged co-occurring disorders drive 30 to 40% of Alaska's non-emergent emergency department visits. Suicide rates run 2.5 times the national average. These outcomes are not inevitable — they are what happens when a system treats complex needs one piece at a time. No existing Alaska platform coordinates care across behavioral health, housing, legal aid, and social services simultaneously. HealthBridge fills that gap — and Rhiza Psychiatry is uniquely positioned to build it because we already coordinate all four every single day.	HealthBridge is a secure, HIPAA-compliant cross-sector coordination platform purpose-built for Alaska's highest-need populations. It solves a problem no existing platform addresses: the inability to coordinate care across behavioral health, housing, legal aid, medical services, and social supports simultaneously in real time. The platform has three core tools working together. First, a Needs Assessment Engine that screens a patient once and instantly identifies needs across all sectors — psychiatric, housing, legal, medical, and social — generating a unified care plan in a single session instead of five separate intake processes. Second, a Live Cross-Sector Dashboard that shows real-time availability across all partner organizations simultaneously — psychiatric appointments, transitional housing slots, legal aid clinics, and social service openings — so a case manager can coordinate everything in one place without making dozens of calls. Third, a Warm Handoff and Tracking System that documents every referral, confirms every appointment, and alerts the care team when a patient misses a connection or falls through a gap — something no current Alaska system does reliably. The platform is built specifically for Alaska. It runs on low-bandwidth connections for rural and frontier communities, includes a toll-free telephonic option for communities without smartphones, supports Alaska Native languages, and integrates with tribal health organization data systems that national platforms ignore entirely. Rhiza Psychiatry's Adaego Recovery Center ensures substance use disorder services are fully integrated alongside psychiatric care, housing, and legal supports — because for our population these needs are never separate. The 5-year rollout begins with a pilot serving Anchorage's highest-need populations in Year 1 and expands to rural and frontier communities across Alaska by Year 3, reaching full statewide coordination capacity by Year 5 with 150+ partner organizations actively sharing real-time availability data.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Rhiza Psychiatry	Northern Haven: Integrated Behavioral Health & Transitional Living for Rural Alaska Women & Children	AK	Alaska faces converging crises with no integrated solution: the nation's highest rates of intimate partner violence, record-level homelessness disproportionately affecting Alaska Native women and families, 27 federally designated Mental Health Professional Shortage Areas covering 400,000+ residents, and rural communities where some villages have no mental health provider within 200 miles. Existing services are siloed — emergency shelters offer 30 to 90 day stays that are insufficient for trauma recovery, while outpatient clinics lack housing supports and housing programs lack clinical depth. The cost of doing nothing is staggering. Alaska spends approximately \$1,200 per day per person in emergency shelter. Transitional housing with wraparound services costs roughly \$150 to \$200 per day. For an 80-resident program like Northern Haven, that gap represents nearly \$29 million in annual system savings against a \$6 million annual investment — a nearly 5 to 1 return before counting a single dollar in healthcare savings or reduced recidivism. Children bear a disproportionate burden too. DOJ research shows 27.7% of U.S. children are exposed to physical violence between parents by age 18, with lifelong consequences. Without an integrated care model, these children cycle through emergency systems repeatedly. Northern Haven breaks that cycle by combining safe housing, clinical care, and real pathways to permanent stability under one roof — something no current Alaska program provides.	Rhiza Psychiatry will operate Northern Haven as an integrated transitional living village combining comprehensive psychiatric services with 12-24 month transitional housing for approximately 80 women and children (20 adults, up to 60 children) fleeing domestic violence in Alaska. The model is structured around four sequential phases. Phase 1 (Intake & Safety, Weeks 1-4): Comprehensive bio-psycho-social assessment within 72 hours; individualized safety planning; urgent legal, medical, and benefits coordination; primary case manager assignment; children's developmental screening. Phase 2 (Stability, Months 2-6): Evidence-based individual trauma therapy using TF-CBT, EMDR, and Seeking Safety; psychiatric medication management; household routine coaching; targeted child interventions including play therapy; housing readiness activities; weekly peer groups. Phase 3 (Empowerment, Months 7-18): Employment and education milestone pursuit; advanced financial capability services; tenancy readiness simulations; child academic support and IEP coordination; parenting education using evidence-based curricula; family therapy. Phase 4 (Transition & Aftercare, Months 19-24+): Coordinated move-out; landlord engagement and mediation; structured follow-up contacts tapering from weekly to monthly; rapid response for tenancy crises; alumni peer mentorship; formal exit evaluation. Rhiza Psychiatry provides the clinical anchor: psychiatric assessment, medication management, telepsychiatry for rural outreach, crisis intervention, and clinical supervision. Northern Haven provides housing, 24/7 residential support, case management, childcare, workforce development, and housing navigation. Cultural responsiveness is operationalized through a Cultural Advisory Circle of Alaska Native elders and practitioners who co-design programming, ceremonies, and staff training. Telehealth infrastructure extends services to rural referral sources and supports care continuity after program exit, aligning directly with RHTP's Spark Technology & Innovation and Health Care Access initiative priorities.	Over \$5M	Behavioral health/substance use disorder treatment	Statewide	Anchorage (Municipality); Bristol Bay Borough; Denali Borough; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Northwest Arctic Borough	Deferred or Not Advanced

RingMD USA, INC.	Alaska IDD and All-Waiver Telehealth Expansion Platform	SC	Alaska has already established that people with intellectual and developmental disabilities need specialized telehealth support because rural access barriers, provider shortages, and poorly matched crisis response can drive avoidable emergency services and weaker continuity of care. RingMD’s active SDS contract is proof that this need is real, current, and statewide. Alaska’s broader RHTP framework separately identifies complex-care models for populations such as IDD, autism spectrum disorder, traumatic brain injury, severe and persistent mental illness, dementia, and serious medical conditions. The opportunity is to move beyond a narrow single-population service and convert an existing Alaska telehealth operation into a scalable all-waiver and complex-care access platform. By doing so, Alaska can expand timely specialist support, improve rural crisis and follow-up pathways, reduce duplication across populations, and create shared infrastructure that supports more than one program objective at a time.	RingMD proposes to launch the Alaska IDD and All-Waiver Telehealth Expansion Platform as an immediate expansion of an operating Alaska service rather than as a new pilot. As one interoperable care-delivery layer in RingMD’s broader Alaska rural health infrastructure portfolio, this platform connects naturally with the Digital Front Door, the Integrated Crisis Continuum, and the Behavioral Health AI workforce layer. The current SDS/RingMD program already provides 24/7 telehealth support, crisis triage, hospital and EMS coordination, follow-up behavioral health support, technical assistance, and rural access facilitation for IDD/ISW participants. The project uses that live operating base as the foundation for a platform serving additional Alaska-selected waiver and complex-care populations. In year one, the launch does three things. First, it strengthens the current IDD/ISW model with follow-up, caregiver and DSP workflows, referral completion tracking, dashboards, and quality reporting. Second, it adds configurable intake, triage, escalation, and follow-up pathways for one or more additional waiver or complex-care populations selected by Alaska leadership. Third, it creates a shared operating model—one telehealth platform, one help desk, one training model, one analytics structure, and common care-coordination workflows—that can be reused as more populations are added. The service is designed for frontier use from day one: mobile, tablet, computer, and phone access; accessibility supports; low-bandwidth performance; and technical support for participants, guardians, designees, caregivers, and DSPs. Because RingMD already runs the Alaska base service and has deep Anchorage-based support through Potawatomi Ventures and six years of Alaska Native service via IHS, no pre-award pilot recruitment is required to begin. The expansion can launch immediately through the existing operating base while SDS selects the first additional populations and workflows for rollout.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

RingMD USA, INC.	Alaska Integrated Crisis Continuum Platform	SC	Rural Alaskans in crisis often move across separate systems—988, IDD telehealth, behavioral health providers, EMS, emergency departments, Tribal health organizations, and waiver or care-coordination teams—without a shared workflow for triage, handoff, follow-up, or performance tracking. This fragmentation is especially harmful in frontier Alaska, where geography, weather, workforce shortages, and limited connectivity can delay the right response and increase avoidable transports, emergency department use, repeat crises, and caregiver burden. RingMD’s current SDS IDD telehealth work confirms the need is real and current: many crisis events involve overlapping medical, behavioral health, and disability-related needs that do not fit neatly into a single program silo. The opportunity is to join those priorities into one statewide rural crisis-continuum coordination platform that begins with a live Alaska operating base and then expands. Instead of funding another isolated pilot, Alaska can fund a launch-ready coordination layer that helps the right actor act faster, supports warm handoffs and follow-up, reduces repeated intake and duplication, and creates measurable visibility into crisis pathways across rural communities where fragmentation is hardest to overcome.	RingMD proposes to launch the Alaska Integrated Crisis Continuum Platform as a ready-to-deploy shared service that begins immediately through RingMD’s existing SDS Alaska operating base and then scales to broader crisis-continuum use cases. As one interoperable coordination layer in RingMD’s broader Alaska rural health infrastructure portfolio, the platform links naturally with the Digital Front Door, the IDD/All-Waiver Telehealth platform, and the Behavioral Health AI workflow service. The current SDS/RingMD service already provides 24/7 telehealth support for individuals with IDD, including immediate crisis evaluation, triage, coordination with hospitals and EMS, follow-up behavioral health support and rural access facilitation. The proposed project uses that live service as the foundation for a statewide crisis coordination layer rather than starting from zero. In year one, RingMD would launch workflows for crisis intake normalization, warm handoffs, follow-up scheduling, role-based work queues, referral completion tracking, and dashboards that can be used by the SDS-centered operating model, then by additional pathways as they onboard. This means the project can go live immediately even before full 988, hospital, Tribal, or EMS integration is complete. RingMD already controls the launch-critical components: platform, low-bandwidth access, phone fallback, messaging, dashboards, APIs, training materials, help desk, documentation workflows, operational staffing and RingMD’s federally hardened security posture. The first-wave scope emphasizes what Alaska can deploy now: coordinated crisis and urgent-concern workflows anchored in IDD and complex-care telehealth, structured handoff to local or regional next steps, follow-up tracking, and reporting on turnaround time, pathway utilization, and repeat crises. The platform would be configured so additional entities—including behavioral health crisis operators, hospitals, EMS agencies, Tribal health partners, or other state-selected participants—can be onboarded after launch without redesigning the core system. The result is a real, immediate rural crisis-continuum infrastructure project, not an aspirational interoperability diagram. The approach builds on RingMD’s prior statewide crisis infrastructure deployments, notably in the State of Ohio where a shared digital crisis coordination layer significantly improved response efficiency, reduced duplication across providers, and generated measurable cost savings.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

RingMD USA, INC.	Alaska Rural Behavioral Health Automation Workflow and Documentation Enablement Service	SC	Rural behavioral health providers in Alaska face a persistent mismatch between demand and operating capacity. Even when clinicians are available, too much staff time is absorbed by intake, repeated history collection, structured screening, note drafting, reminders, follow-up task management, QA requests, and reporting instead of direct patient care. In frontier communities, that burden translates into slower first response, delayed assessments, weaker continuity, longer waits, more incomplete intakes, and higher staff burnout. Alaska’s own RHTP materials explicitly signal support for AI-powered workflow tools, provider training for technology adoption, stronger data infrastructure, and practical technology investments that improve rural access and sustainability. This creates a timely opportunity for Alaska to launch a governed statewide service that helps rural behavioral health providers use human-in-the-loop AI workflow and documentation tools safely and consistently without requiring each site to buy, govern, train, secure, and maintain its own AI stack. The project opportunity is not generic AI innovation. It is a rural access and workforce-capacity project that uses workflow technology to help small teams move patients through intake and care more quickly, improve documentation quality, and sustain services in places where every hour of clinician time matters.	RingMD proposes an Alaska Rural Behavioral Health AI Workflow and Documentation Enablement Service: a ready-to-deploy statewide shared service that can be launched immediately upon award and made available to eligible rural behavioral health providers through a structured onboarding process. As one interoperable layer in RingMD’s broader Alaska rural health infrastructure portfolio, the service complements the Digital Front Door, Integrated Crisis Continuum, and IDD/All-Waiver Telehealth platforms by strengthening workforce capacity and documentation quality behind the scenes. Instead of funding a narrow software pilot at one site, RHTP funds would establish a practical statewide implementation service that gives participating rural providers access to governed human-in-the-loop workflow tools, training, help desk support, configuration, analytics, and implementation guidance. First-wave functions would include structured intake support, documentation drafting for clinician review, screening and outcome-measure capture, reminder and follow-up workflows, QA prioritization, operational dashboards, and role-based reporting. The project is intentionally not framed as autonomous AI replacing clinicians. Final clinical judgment remains with licensed professionals, and all outputs are reviewable, auditable, and controlled through acceptable-use policies, role-based access, audit logs, and training. The service can launch without named pilot providers because the first-year deliverables are vendor-controlled and implementation-ready: statewide workflow templates, governance rules, training modules, reporting dashboards, technical support, and an onboarding pathway for eligible providers selected post-award using readiness criteria approved by the lead Alaska entity. That means the project can begin immediately while still allowing Alaska to bring in providers in phases. The concept also directly supports Alaska’s published Spark Technology and Innovation milestone to launch technical assistance and training programs for providers using AI-powered workflow tools. RingMD can credibly deliver this because it already operates in Alaska through the SDS IDD/ISW telehealth program, has six years of Alaska Native service experience through IHS and maintains a federally hardened security posture with annual third-party audit and a multi-year ATO.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

RingMD USA, INC.	Alaska Rural Digital Front Door and Scheduling Platform	SC	Rural Alaskans often face fragmented entry points into care and limited visibility into what happens after a referral is made. A patient, parent, elder, or caregiver may know help is needed but not know whether the right next step is primary care, behavioral health, specialty telehealth, maternal support, community services, or another pathway. Providers face the same problem in reverse: referrals are often misdirected, incomplete, or never closed, and there is limited statewide visibility into where the access process breaks down by region, service line, or population. Alaska’s own RHTP materials explicitly point to community-based care navigation and scheduling assistance applications as a desired technology investment, making this one of the clearest opportunities in the program. A statewide rural digital front door creates one trusted access layer that reduces wrong-door referrals, shortens the path to the right next step, and gives Alaska a durable, measurable, consumer-facing infrastructure for rural access improvement.	RingMD proposes to launch the Digital Front Door and Scheduling Platform as a shared service that can begin operating immediately after award without requiring pre-award pilot recruitment. As one interoperable layer in RingMD’s broader Alaska rural health infrastructure portfolio, the platform functions as the consumer-facing access layer that complements the Integrated Crisis Continuum, the IDD/All-Waiver Telehealth platform, and the Behavioral Health AI workflow services. RingMD controls the core components already needed to go live: the platform, consumer-facing workflows, referral and request logic, API framework, messaging, dashboards, accessibility features, low-bandwidth design, help desk, training materials, and implementation staff. Rather than waiting for deep provider-specific integrations before launch, the project starts with an Alaska-wide minimum viable service supporting searchable pathway discovery, request-for-help intake, scheduling assistance, referral routing, reminder prompts, and closed-loop status tracking for prioritized pathways. The initial deployment will focus on a small number of high-value statewide pathways selected with Alaska program leadership, such as behavioral health access, primary care/FQHC access, specialty telehealth referral, maternal navigation, and other Alaska-prioritized service lines. Users will be able to enter through web, mobile, or phone-assisted workflows, answer a small set of routing questions, submit a request, receive next-step guidance, and remain connected until the referral, callback, or appointment process is complete. RingMD will operate centralized navigation and scheduling-assistance workflows where direct provider integration is not yet available, which makes the service launchable from day one while still leaving room for later regional or provider-specific integration. RingMD has implemented comparable digital access and care-routing infrastructure supporting statewide behavioral health and crisis access networks in Ohio. These deployments demonstrate how a shared digital front door can streamline navigation, connect individuals to the right provider faster, and improve scheduling and referral coordination across distributed care networks.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Rise Above Recovery LLC	Expanding Rural Alaska Behavioral Health Access Through Telehealth Innovation	AK	Rural and remote Alaska communities face significant barriers to behavioral health care, including provider shortages, long travel distances, limited infrastructure, and seasonal isolation. These challenges contribute to unmet mental health needs, delayed treatment, and increased risk of crisis. Telehealth has emerged as a critical tool for bridging these gaps, yet many communities still lack consistent access to behavioral health providers, culturally responsive care, and sustainable service models. This project addresses the opportunity to expand behavioral health access through a telehealth-enabled model that strengthens workforce capacity, improves service coordination, and delivers high-quality care to underserved regions.	The project will expand behavioral health access in rural Alaska through a phased telehealth and community-based service model. Phase 1 focuses on infrastructure development, including telehealth platform enhancements, workforce recruitment, training, and establishing referral pathways with local clinics, tribal health organizations, and community partners. The project will implement standardized workflows, culturally responsive practices, and quality assurance processes to ensure consistent, high-quality care. Phase 2 focuses on service delivery expansion, offering assessments, therapy, care coordination, and crisis support through secure telehealth. Providers will receive ongoing supervision and training to ensure competency in rural behavioral health needs. The project will also integrate community engagement strategies, including collaboration with schools, tribal councils, and local service providers and local church community's members that currently provide services in multiple rural villages. Evaluation and data collection will track access, timeliness, client outcomes, and workforce stability. Findings will inform continuous improvement and long-term sustainability planning.	\$50,000-\$250,000	Behavioral health/su bstance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Rising Roots Recovery LLC	Expanding Opioid Treatment Access in Alaska Through Technology-Enabled Care	AK	Alaska faces significant barriers to accessing treatment for opioid use disorder (OUD). Despite the state’s large geographic footprint, opioid treatment programs remain limited and are concentrated primarily in a few urban areas. Many individuals living in rural and frontier communities must travel long distances or temporarily relocate to access medication-assisted treatment such as methadone. These geographic barriers contribute to delayed treatment, reduced retention in care, and increased risk of overdose and other health complications. At the same time, clinical providers face growing administrative and regulatory burdens that can limit the capacity of existing programs to expand services. There is a clear opportunity to strengthen Alaska’s opioid treatment infrastructure by expanding treatment capacity and integrating technology-enabled care models that improve efficiency while supporting access for patients traveling from rural and underserved communities.	Rising Roots Recovery LLC proposes to establish a technology-enabled opioid treatment program in Anchorage designed to expand access to evidence-based treatment for opioid use disorder across Alaska. The clinic will serve as a central treatment hub capable of supporting approximately 200 patients while helping address the growing demand for medication-assisted treatment services. The project focuses on strengthening clinical infrastructure and implementing modern technology that improves both patient access and provider efficiency. Planned investments include telehealth capabilities, virtual care tools, remote diagnostic technology, and AI-assisted clinical documentation systems. These tools will help reduce administrative burden on clinicians, improve care coordination, and allow providers to spend more time delivering direct patient care. Because many individuals seeking treatment travel from outside Anchorage, expanding capacity at this location will improve access for patients from surrounding regions including the Mat-Su Valley, Kenai Peninsula, and rural communities that rely on Anchorage as a regional healthcare hub. The project will also prioritize collaboration with rural hospitals, tribal health systems, and community health providers to support referrals and coordinated care. By combining expanded treatment capacity with technology-enabled care delivery, Rising Roots Recovery aims to strengthen Alaska’s behavioral health infrastructure and create a more accessible and sustainable pathway to recovery for individuals experiencing opioid use disorder.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Kenai Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area	Deferred or Not Advanced

RMX Monitoring, LLC	Expanding Rural Cardiac Monitoring for Alaska Communities	NJ	Alaska’s rural and frontier communities experience some of the most significant barriers to cardiovascular care in the United States. Many residents live in isolated areas where no cardiology services are available locally, and harsh weather, long distances, and limited transportation make specialty care difficult or impossible to access. As a result, early signs of cardiovascular disease often go undetected until they manifest as medical emergencies, contributing to elevated rates of stroke, heart failure, and avoidable hospitalizations. This project addresses these gaps by deploying remote cardiac monitoring technology capable of screening at-risk patients directly in their home communities. The wearable, cellular-enabled device requires no external gateway or clinic visit, allowing patients to complete a full 14-day diagnostic study regardless of geography or infrastructure limitations. Providers receive rapid, clinically actionable reports that support early detection of arrhythmias and timely preventive treatment—an approach shown in other rural settings to improve outcomes and reduce downstream costs. [a-z-animals.com] By eliminating traditional access barriers and extending specialty-level diagnostic capability into underserved areas, this initiative strengthens Alaska’s capacity to manage cardiovascular disease proactively, improves equity in access to care, and creates a scalable model for frontier health delivery.	Our approach brings specialty-level cardiac diagnostics directly into Alaska’s rural and frontier communities through a fully remote, end-to-end screening and care-coordination model. Building on our proven remote monitoring workflow—where wearable devices collect continuous ECG data over a 14-day period and deliver full diagnostic reports to the ordering provider in just a few days—this project eliminates geographic, weather-based, and transportation barriers that currently prevent early detection of cardiovascular disease. We will partner with rural primary care clinics, tribal health organizations, FQHCs, and community health aides to identify adults with elevated cardiovascular risk. Local providers will receive training on referral pathways, device placement, and interpreting our clinical reports. Patients receive a lightweight, single-component monitor with built-in cellular transmission, removing the need for gateway devices or broadband access. This technology has been validated in other rural environments for its ease of use and high patient compliance. Every heartbeat is transmitted to our U.S.-based monitoring center—staffed by nationally certified cardiac technicians—who verify arrhythmia findings in near real time. Our proprietary clinical platform synthesizes the full 14-day dataset into a comprehensive provider-ready report. Providers receive actionable diagnostic reports within 2–3 days of study completion, enabling timely intervention for arrhythmias such as AFib before they escalate into severe events. When urgent findings occur, alerts are routed to the clinic immediately. Patients diagnosed with cardiovascular disease are connected to preventive care pathways. Additional screenings are conducted for newly identified high-risk individuals, enabling early intervention across the program’s duration. Our organization’s existing monitoring, reporting, and patient-support infrastructure, refined over many years of national cardiac monitoring operations—allows deployment on day one without reliance on local specialty resources. By integrating remote diagnostics, community partnerships, and rapid cardiology-level interpretation, this project provides Alaska with a scalable, frontier-adapted model capable of reducing preventable cardiac events and strengthening long-term rural health capacity.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Rosarium Health	Alaska Aging in Place Value-Based Care Initiative	CO	Alaska’s healthcare system faces rising financial and demographic pressure. The population of older adults is growing quickly while the cost of hospital care and long-term institutional services continues to increase. At the same time, many residents who could remain safely at home are unable to do so because their homes lack basic accessibility features. Without early intervention, everyday hazards can escalate into falls, hospital visits, and costly institutional care. Alaska currently lacks coordinated infrastructure that allows healthcare providers, community organizations, and service professionals to address home safety risks at scale. As a result, opportunities for prevention are often missed. This initiative by Rosarium Health offers a path forward. By establishing a statewide aging-in-place model built on prevention and value-based care, Alaska can improve health outcomes while reducing avoidable healthcare spending. Home safety improvements can prevent falls, reduce hospital utilization, and delay institutional placement. The initiative also strengthens Alaska’s workforce and economy by creating new opportunities for clinicians, therapists, contractors, and small businesses to deliver accessibility services that support safe, independent living.	Our approach is to build a coordinated aging-in-place infrastructure that connects healthcare providers, community organizations, and local service professionals to address home safety risks before they become medical crises. Working with the Juneau Economic Development Council and regional partners, Rosarium Health will launch the program in Juneau and Anchorage and expand over three years. Community organizations such as Southeast Alaska Independent Living, AARP Alaska, Catholic Community Service, and SEARHC will help identify residents who may benefit and coordinate referrals with care managers, clinicians, and social service providers. Once referred, licensed clinicians will conduct comprehensive home safety assessments to evaluate mobility barriers, fall risks, and accessibility challenges. These assessments may occur in person or through secure telehealth-enabled home evaluations, allowing residents in rural and frontier communities to receive expert guidance without long travel distances. Clinicians will recommend practical improvements that help residents safely navigate their homes and maintain independence. Rosarium will then coordinate local contractors and service providers to complete the recommended accessibility improvements. These may include entry ramps, railings, curbless showers, grab bars, widened doorways, improved lighting, stair supports, and other modifications that reduce fall risk and improve daily living. By coordinating these services through a single platform, the program ensures projects are completed efficiently and consistently across communities. Workforce development is a core component of the model. Rosarium will recruit occupational therapists, rehabilitation specialists, and school-based clinicians across Alaska and support them in expanding their practice into community-based home safety services. Local contractors and small businesses will also gain training and access to supply chains that support accessibility improvements. The program will operate within a value-based framework. Initial services will align with existing reimbursement pathways while building the data and outcomes needed to transition toward value-based payment models tied to fall prevention, reduced hospital utilization, and improved independence. Through this coordinated system, the initiative builds scalable infrastructure that improves safety at home, strengthens Alaska’s workforce, and allows more residents to remain in the place they call home.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Roshal Health	Rural/Frontier Health Ultrasound Collaboration	TX	Ultrasound is a foundational diagnostic tool used in maternal health, emergency care, chronic disease management, and trauma evaluation. However, rural communities frequently lack access to these services due to geographic isolation, equipment costs, and the nationwide shortage of certified sonographers. As a result, many Alaskans must travel long distances—often by air—to receive basic imaging services, delaying diagnosis and increasing healthcare costs. The Rural/Frontier Health Ultrasound Collaboration addresses these barriers through a scalable tele-ultrasound model that combines advanced ultrasound technology, real-time remote clinical guidance, and workforce training. The program equips rural facilities with modern ultrasound systems and telehealth-enabled imaging platforms that allow local clinicians—including nurses, medical assistants, and radiology technicians—to perform exams while being guided in real time by certified remote sonographers. This triad team model immediately expands diagnostic capacity while building sustainable clinical capability within local healthcare teams.	Program Scope & Target The Rural/Frontier Health Ultrasound Collaboration can serve all 13 Critical Access Hospitals and 29 FQHC’s across Alaska. The program utilizes a triad team model that combines local staff, remote experts, and real-time technology: • Local Operator: A healthcare professional (e.g., MA, nurse, X-ray tech, or provider) at the facility who positions the ultrasound probe and follows remote guidance. • Remote Guide: A certified sonographer connected via secure tele-ultrasound technology who provides step-by-step, real-time instruction and oversight. • Real-Time Communication: Integrated audio/video streaming allows the remote sonographer to guide image acquisition and ensure diagnostic-quality results suitable for interpretation. This model transforms existing rural staff into capable on-site operators supported by remote expertise—creating immediate, sustainable capacity for ultrasound services. Proposed Solution 1. Roshal Health – \$67,800 per Facility • Provide the tele-ultrasound platform and hardware (laptop, webcam, tripod, speaker, streaming kit). • Supply certified remote sonographers to guide on-site staff in real time 24/7. • Conduct three weeks of virtual training and one in-person site visit. • Provide 10 Remote scans and radiology interpretation services Monthly for 2-years. • Train billing and coding teams on ultrasound CPT reimbursement optimization. 2. GE Precision Healthcare, LLC – \$66,000 per Facility • Provide advanced ultrasound systems (general and echo capabilities). • Include AI-assisted imaging guidance to support probe placement and visualization. • Partner with academic institutions and nursing programs to support training and practice. Total Investment per Site: \$133,800 Total Program Cost (13-42 sites): \$1,739,400 - \$5,619,600	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Rural Alaska Emergency Services	Interior Alaska Mobile Integrated Healthcare Consortium	AK	The issue in our region is and always will be funding. The recoverable funds from billing will never sustain a 24/7 EMS service with a call volume of less than 600 (911) service calls per year, and most communities average between 100–400 calls, with only about 50% of those being actual transports that can be billed for. We live in an area that creates a perfect storm for EMS system failure: very high Medicaid and Medicare utilization, long transport times, no local emergency department, and all the other factors that make rural America one of the hardest places to run a proficient EMS service. The opportunity is to transform this failing model into a sustainable, locally controlled Mobile Integrated Healthcare system. By deploying triage-capable ALS ambulances with telehealth, point-of-care diagnostics, and treat-in-place protocols, and by building a local EMT workforce pipeline, this project will convert no-pay non-transports into billable encounters, reduce avoidable ER visits and air transports, and stabilize EMS as critical health infrastructure for Interior Alaska.	We will implement a tri-entity, corridor-wide Mobile Integrated Healthcare (MIH) system that combines (1) a regional nonprofit financial backbone, (2) a public-utility EMS operator, and (3) a dedicated workforce pipeline supported by the Interior Region EMS Council (IREMS) and Partners for Progress. First, Rural Alaska Emergency Services (RAES) will serve as the regional managing nonprofit and fiscal agent. RAES will receive RHT funds, build and manage a \$30 million endowment, coordinate mutual aid across Tok–Delta Junction–Fort Greely–Copper Center–Glennallen–Wasilla, negotiate treat-in-place/MIH contracts with Medicare, Medicaid, Tribal, commercial, and hospital/ACO partners, and provide centralized billing, compliance, and data reporting. This creates a stable regional backbone that de-risks participation for small communities. Second, the City of Delta Junction will operate as a public-utility EMS provider, owning and operating triage-equipped ALS ambulances that also serve Fort Greely and provide mutual aid along the corridor. These units will add telehealth, point-of-care lab, ultrasound, expanded monitoring, and an enhanced formulary to standard ALS capabilities, enabling safe treat-in-place and alternative destination transport. Additional triage units for Tok, Copper Center/Glennallen, and Mat-Su connector communities will be phased in over five years, following a clear capital and staffing timeline. Third, Partners for Progress will build a “grow your own” workforce pipeline via high-school EMT programs, a dedicated training ambulance, simulation lab, and region-wide continuing education. IREMS will provide regional training support, curricula alignment, instructor development, and QA/QI linkages so that local EMT education, protocols, and skills maintenance match state and national best practices. This combined Partners for Progress–IREMS approach creates a steady stream of locally rooted EMTs and paramedics, reduces recruitment costs, and improves retention. Together, these components convert non-billable non-transports into reimbursable encounters, reduce avoidable ER and air ambulance use, and transition EMS funding from fragile local subsidies to a mix of endowment income and enhanced billing, achieving long-term sustainability.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Fairbanks North Star Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Rural Alaskan Alliance for Transformative Healthcare, Inc.	VITAL Alaska (Vitality, Independence, Technology, Aging, and Longevity)	AK	Alaska’s rural and frontier older adults face significant barriers to accessing consistent, evidence-based preventive health services. Geographic isolation, limited transportation infrastructure, extreme weather, and provider shortages mean that many older Alaskans have no access to structured wellness programming that can reduce fall risk, prevent chronic disease progression, and support functional independence. Falls are the leading cause of injury-related death among older adults nationally, and Alaska’s rural communities face disproportionate risk due to isolation and limited access to rehabilitation services. Physical inactivity accelerates chronic disease, frailty, and loss of independence, driving costly emergency department visits, hospitalizations, and premature transitions to institutional care. Traditional in-person wellness programs cannot reach the vast majority of rural Alaska communities. There is an urgent need for scalable, technology-enabled solutions that deliver high-quality, supervised exercise programming directly to older adults in their homes or community settings, regardless of location.	We propose VITAL Alaska (Vitality, Independence, Technology, Aging, and Longevity), a personalized virtual strength program designed specifically for older adults in rural and frontier communities. The program aligns with Alaska's RHTP priorities - Healthy Communities, Health Care Access, and Spark Technology and Innovation - delivering evidence-based wellness programming that reduces fall risk, improves functional independence, and builds social connection among older adults in rural, remote, and off-road communities. We are ready for immediate statewide deployment and our project is designed to complement, not duplicate, existing state, Tribal, and community-based health services. Key program components include: • Live, instructor-led small-group classes delivered via Zoom with real-time feedback and individualized exercise modifications • Regular one-on-one functional assessments to quantitatively and qualitatively track participant engagement and strength improvement over time • A virtual, technology-enabled delivery model that eliminates transportation barriers while preserving accountability and social connection • A science-backed, evidence-informed focus on strength, balance, and mobility to reduce fall risk and support healthy aging • Large-group livestream classes as a lower-barrier entry point for new or hesitant participants Implementation will follow a phased approach, initially in RAATH's home, the Kenai Peninsula Borough; this includes community outreach and enrollment, participant onboarding with technology support, live virtual program delivery, and ongoing assessment and reporting. We will hire an Alaska-based project manager and certified personal trainers/physical and/or occupational therapists to ensure local presence and cultural alignment. The program will coordinate with Tribal organizations, Area Agencies on Aging, and community health partners. We can provide participant devices, where necessary. While internet connectivity is an unallowable use of RHTP funds, Starlink could be utilized for areas not accessible to Internet or 5G coverage.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

RurAL CAP	Community Action Health Framework	AK	RurAL CAP's more than 60 years of place-based work in Alaska has given us deep insight into persistent gaps and under-leveraged strengths within rural health and social service systems. Rural Alaskans face layered barriers to health, safety, and wellbeing, including geographic isolation, workforce instability, limited mental and behavioral health access, overcrowding, high rates of DV/SA, and fragile food and transportation systems. These challenges are compounded by fragmented systems that lack shared integration pathways, aligned planning, and accessible health literacy supports, creating unnecessary barriers to care. At the same time, many rural communities have vital programs and committed partners. What is often missing is the integration needed to connect available resources into a cohesive, community-led system. As a result, services and programs are accessed late, siloed, or underutilized, contributing to preventable crises and higher long-term costs. RHTP presents an opportunity to shift from fragmented service delivery toward integrated, locally grounded models that improve access, coordination, and sustainability. Drawing on decades of experience alongside rural communities, RurAL CAP will pilot practical, scalable, and replicable approaches that reduce navigation burdens and silos, and strengthen health literacy and continuity of care across the lifespan from cradle-to-grave.	Serving as the backbone, RurAL CAP will collaborate with communities, healthcare, and adjacent partners to design and implement community-specific models of integrated services grounded in existing local resources, strengths, and priorities, resulting in a shared navigation system that supports local impact but also informs the larger Framework. CAHF will begin in communities where RurAL CAP already has an established presence, and it will emphasize coordination through community workgroups and co-ownership. This includes piloting cross-sector projects to create new pathways and develop resources that support long-term, collaborative service delivery from cradle-to-grave. This light-touch administrative structure supports consistency, accountability, and replication-readiness without over-standardization. CAHF includes 5 Workstreams. In Year 1, each participating community will begin at least 1 Workstream, based on local readiness, priorities, and existing capacity. Workstreams and project examples include: •Healthy Lifespan: Improve preventative health access and literacy across service communities through provider partnerships. EX: Rural health fairs, trainings, transportation supports, and health promotion programs in interested Head Start and AmeriCorps Seniors communities. •Integrated Care: Partner to embed coordinated behavioral, mental, and preventative care within stable housing. EX: Permanent Supportive Housing hub demonstration in Anchorage to directly connect people with the highest needs to integrated care. •Caregiver Supports: Strengthen caregiver capacity using culturally relevant, evidence-based community models. EX: Community connection groups and home visiting in Mountain Village delivered with local clinics or tribal organizations. •Food Security: Advance food security as preventive care through training and service coordination. EX: Garden projects at Mutual Self-Help Housing developments in Seward, aligning nutrition, health literacy, and support across industries. •Workforce: Advance community health and housing stability by embedding workforce development into community infrastructure investments. EX: Workforce-embedded housing construction in Kodiak to expand housing supply and reduce overcrowding that contributes to poor health outcomes. Year 1 will prioritize readiness and early implementation by formalizing any pending partnerships, launching ready-to-go projects, planning identified pilots, and forming baseline measures.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Copper River Census Area; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Matanuska-Susitna Borough; Nome Census Area; Prince of Wales-Hyder Census Area	Advance to Implementation Application

RurAL CAP	Community Action Training and Technical Assistance	AK	Rural communities across Alaska face persistent barriers to accessing high-quality, sustainable health care, including geographic isolation, workforce shortages, limited organizational capacity, and high costs of care delivery. While the State of Alaska’s Rural Health Transformation Program (RHTP) provides a historic opportunity to address these challenges through system-level change, many community-based organizations, providers, and regional partnerships lack the technical capacity, administrative infrastructure, and implementation support needed to effectively design, launch, and sustain RHTP-aligned initiatives. This project addresses the opportunity to close that capacity gap by providing targeted, culturally appropriate Training and Technical Assistance (TTA) that enables rural organizations to translate RHTP goals into actionable, compliant, and sustainable projects. By strengthening local readiness and execution, the project supports Alaska’s broader RHTP objectives to expand access to care, strengthen the health workforce, improve care coordination, and build fiscally sustainable health systems tailored to Alaska.	RurAL CAP will partner with the State of Alaska to deliver flexible, needs-driven, and culturally appropriate TTA to state-identified projects, organizations, and regional collaborations advancing RHTP priorities. The approach builds on RurAL CAP’s role as Alaska's sole Community Action Agency and our demonstrated success delivering relationship-based, implementation-focused TTA across rural Alaska. Through our Community Action Resource Center (CARC), RurAL CAP has supported tribal governments, nonprofits, and rural community organizations with culturally responsive, hands-on assistance grounded in trust, continuity, and practical problem-solving. This support has helped partners navigate simple to complex funding and compliance environments, from initial SAM.gov registrations to American Rescue Plan Act’s (ARPA) Coronavirus State and Local Fiscal Recovery Funds (SLFRF) reporting requirements. Drawing on lessons learned through CARC and other capacity-building efforts, RurAL CAP’s TTA emphasizes meeting partners where they are and tailoring assistance to locally identified needs. RurAL CAP’s TTA will help move initiatives from planning into implementation, while remaining adaptable to the specific needs and structures of RHTP-funded efforts. Our approach is intentionally adaptive, allowing support to be deployed where it is determined to be the best fit. Core TTA activities may include RHTP project design and refinement; implementation planning; partnership and governance support; workforce development strategies; reporting readiness; sustainability and fiscal planning. RurAL CAP will leverage its statewide community network and experience working across housing, early childhood, food security, workforce, and community development to support integrated, whole-person approaches to health. Assistance will be culturally responsive, grounded in local context, and designed to help rural partners move from concept to execution while meeting state and federal requirements. This approach directly supports the State’s goal of using RHTP as a time-limited investment to build durable systems, operational models, and partnerships that can continue beyond the grant period.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Rural Healthcare Initiative	Rural Healthcare Access Blueprint: A Statewide Plan to Guide Priorities, Decisions and Investments	NC	Alaska's rural communities face healthcare access challenges of extraordinary complexity, challenges that demand a coordinated, strategic response rather than investments made in isolation. The core challenge is one of balance. When there are not enough services, healthcare is not effective. When there are too many services, healthcare is not sustainable. Further, effective rural healthcare planning must employ systems thinking that recognizes the interconnected nature of healthcare delivery across diverse rural regions. Rather than analyzing each community in isolation, successful planning examines three critical success factors: geographic access to care, appropriate level of service availability, and long-term financial sustainability. Given the scale of the need and opportunity, we believe there is significant benefit to first establishing a comprehensive, statewide plan to guide prioritization and decision making in future years. Such a plan would involve a data-driven planning process that thoughtfully considers and accounts for the unique situation of each community, incorporates the perspectives of residents, integrates input from key stakeholders, and includes recommendations based on long-term sustainability. The ultimate deliverable would be a detailed Blueprint containing region-specific and community-specific recommendations that account for each area's unique demographic profile, health needs, existing resources, geographic constraints, and economic realities.	Our proven approach has been demonstrated through a recently completed 18-month Rural Healthcare Sustainability Project spanning 78 rural counties in North Carolina, which inventoried more than 50 service and provider types, surveyed more than 1,600 adults statewide, and conducted 12 listening sessions and over 100 stakeholder interviews. Please visit https://ruralhealthcareproject.com/ Five distinctive approaches anchor that work and will anchor Alaska's Blueprint. Systems Thinking: Rather than examining individual facilities or communities in isolation, all touchpoints of healthcare delivery are treated as interconnected. Rural residents naturally cross county lines and switch between providers to find needed care, creating utilization patterns that transcend political boundaries. Patient Perspective and Optimization Balance: Planning is approached from the patient perspective, balancing three critical factors: proximity (services available at appropriate distances), complexity (the fullest sustainable range from routine to specialized), and stability (reducing duplicative services to enable financially stable providers to invest in needed services). Comprehensive Scope: Analysis goes far beyond the economic viability of hospitals to examine healthcare effectiveness at the individual level, inventorying the full spectrum of services and provider types to understand where care is truly available. Integrated Study Design: Deep quantitative analysis is paired with extensive qualitative research, including statewide surveys, listening sessions, and stakeholder interviews, reaching beyond traditional healthcare boundaries to include social service, education, and faith community perspectives. Flexible, Future Focus: The Blueprint provides decision-makers with data-informed pictures of healthcare supply and demand rather than prescribing outcomes for specific facilities, acknowledging that ultimate decisions rest with providers, communities, and policymakers. This methodology directly supports Alaska's Health Care Access priority to conduct a comprehensive provider gap analysis and the technical assistance and training use of funds, providing the analytical foundation that eligible entities need to develop strong applications and successfully implement Health Care Access projects.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Russell DeGroote MD PC	Improving Rural Health Access with Remote Haptic Physical Examination Technology	AK	Rural and frontier communities in Alaska face major barriers to timely specialty care due to geographic isolation, lack of road access, limited local clinical resources, and dependence on weather-sensitive air transport. Many clinical decisions require physical examination findings such as joint stability, abdominal tenderness, cervical changes, or tissue characteristics, which cannot be adequately assessed through traditional telehealth. As a result, patients often travel long distances or require costly medevac transport for evaluations that could potentially be managed locally with specialist input. This leads to delayed diagnosis, increased healthcare costs, and disruption for patients and families. The opportunity addressed by this project is to enable real-time remote physical examination through haptic technology, allowing specialists to directly assess tactile findings from a distance and bring advanced diagnostic capability to rural communities without requiring patient travel.	To address the limitations of traditional telehealth in rural and frontier Alaska, this project will develop and validate the Alaska Remote Haptic Examination System (ARHES), a novel telemedicine platform that enables real-time remote physical examination through tactile (haptic) technology. ARHES consists of two integrated components: a sensor-enabled examination glove worn by a Community Health Aide or rural provider during patient examination, and a corresponding haptic feedback glove worn by a remote specialist. The sensor glove captures pressure, motion, and tactile characteristics during the examination and transmits this data securely in real time via existing broadband or satellite connectivity. The specialist glove reproduces these tactile signals, allowing the specialist to directly perceive clinical findings such as joint stability, tissue resistance, tenderness, or anatomical changes while simultaneously observing the patient through standard telehealth video. The project will be implemented in three phases. First, a multidisciplinary engineering and clinical team will design and develop clinical-grade prototype gloves and a secure software platform that integrates real-time haptic transmission with video telehealth and the applicant’s electronic health record system. Second, the system will undergo controlled clinical validation under IRB-approved protocols to assess reliability, usability, and diagnostic concordance compared to in-person examination. Third, pilot deployment will occur in Southeast Alaska rural clinic settings, where Community Health Aides and specialists will use ARHES to conduct supervised remote examinations. Standardized examination protocols and training programs will be developed to ensure consistent and reproducible use. Outcome metrics will include time to specialist assessment, reduction in unnecessary patient transfers, diagnostic accuracy, provider confidence, and patient satisfaction. Cost-effectiveness and operational feasibility will also be evaluated to support long-term sustainability and broader rural deployment. By enabling specialists to directly assess physical findings from a distance, ARHES brings advanced diagnostic capability to remote communities, reduces travel burden, and improves the timeliness and quality of care for rural Alaskans.	\$1M-\$5M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Kenai Peninsula Borough; Kasilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Russell DeGroote MD PC	Reducing Medevac Transport Through AI-Enabled Portable MRI in Rural Alaska	AK	Rural and frontier communities across Alaska face significant barriers to accessing advanced diagnostic imaging, particularly MRI. Most rural clinics lack the infrastructure, space, and resources required to support conventional MRI systems. As a result, patients with neurologic symptoms, traumatic injuries, infections, or musculoskeletal conditions frequently must travel to regional hospitals in cities such as Anchorage or Juneau for diagnostic evaluation. Because many communities are not connected by road, this often requires air travel or medevac transport, which can cost tens of thousands of dollars per patient and delay diagnosis and treatment. This project addresses the opportunity to expand access to diagnostic imaging in rural Alaska by deploying portable low-field MRI systems supported by artificial intelligence (AI) and tele-radiology connectivity. These systems can operate in small clinical settings with minimal infrastructure, allowing advanced imaging to be performed locally in rural communities. By enabling earlier diagnosis and improving clinical decision-making at the point of care, the project aims to reduce unnecessary patient transfers, improve access to timely care, and strengthen the sustainability of rural healthcare delivery.	This project proposes the creation of a distributed rural diagnostic imaging network that deploys portable low-field MRI technology combined with artificial intelligence (AI) diagnostic support and tele-radiology connectivity to expand access to advanced imaging in frontier communities across Alaska. The goal is to bring diagnostic capability closer to patients, reducing the need for costly travel and improving timely clinical decision-making. The project will deploy portable low-field MRI systems in selected rural clinics that currently lack access to advanced imaging. Unlike traditional MRI scanners, these systems require minimal infrastructure, operate on standard electrical power, and can function in small clinical spaces. This allows rural facilities to perform MRI imaging locally for conditions such as neurologic symptoms, traumatic injuries, spine pathology, infections, and musculoskeletal injuries. Artificial intelligence tools will be integrated to support image reconstruction and assist clinicians in identifying urgent or clinically significant findings. AI can improve image quality from low-field scanners and provide decision support by highlighting abnormalities that may require urgent attention, such as intracranial hemorrhage, spinal cord compression, or septic joints. This support is particularly valuable in rural settings where radiology specialists may not be immediately available. All imaging studies obtained in rural clinics will be transmitted securely to regional radiology networks for specialist interpretation. Tele-radiology connectivity will allow radiologists and specialists at regional centers—including facilities in communities such as Ketchikan, Juneau, or Anchorage—to review images and provide timely consultation. This integrated network will ensure that rural providers receive expert guidance while maintaining diagnostic services locally whenever possible. Implementation will occur in phases. Initial pilot sites will be selected based on geographic isolation, current imaging limitations, and patient need. During the pilot phase, the program will track key outcomes including reduction in patient transfers, time to diagnosis, provider satisfaction, and cost savings. By decentralizing advanced diagnostic imaging and connecting rural clinics to regional specialists, this project will strengthen the rural healthcare system, improve clinical decision-making, and reduce the need for unnecessary travel.	Over \$5M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Kenai Peninsula Borough; Kuskokwim Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Rx for Health, LLC	Pharm Chat: Expanding Pharmacist Consultations Through Mobile App	AK	Medication errors are a major contributor to medical harm, accounting for approximately 37% of adverse events and costing the U.S. health care system nearly \$21 billion annually. These risks are amplified in rural and remote communities across Alaska, where geographic isolation, limited transportation, severe weather, and ongoing health care workforce shortages frequently prevent residents from obtaining timely pharmacist counseling or having urgent medication questions addressed. Many communities are not connected to the state’s road system and must rely on air or boat travel to reach health care facilities, making routine access to pharmacy services difficult. As a result, residents may have only intermittent access to pharmacist support or receive medications without direct counseling, which can lead to delays in addressing medication-related concerns, confusion about proper use, medication non-adherence, and poorly managed chronic conditions. Collectively, these challenges contribute to preventable medication errors, increased health care utilization, non-compliance, and persistent disparities in access to medication management for rural Alaskans.	To address these barriers, this project proposes a HIPAA secure, text-based mobile app that connects rural Alaskans directly with a licensed pharmacist in real time, available 24 hours a day, seven days a week. A pharmacist-by-text platform will provide patients with direct access to medication expertise through a secure messaging system, allowing them to ask questions about their medications, receive guidance on proper use, discuss potential side effects, and obtain support to improve medication adherence and chronic disease management. By providing timely pharmacist guidance, this platform can help reduce preventable medication errors, ensuring safer medication use and improving patient outcomes. By making pharmacist expertise available without requiring travel to a clinic or hospital, the platform helps overcome geographic and transportation barriers that often prevent rural residents from receiving timely medication counseling. This model extends the reach of pharmacy services beyond traditional settings, enabling pharmacists to support patients across multiple rural communities. It offers a scalable and sustainable approach to delivering pharmacy care in regions where on-site services are limited or intermittent. By improving access to medication guidance, supporting safe and effective medication use, reducing medication errors, and reinforcing chronic disease management, this initiative aims to strengthen health care delivery and improve health outcomes for rural and remote populations across Alaska.	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Rx for Health, LLC	Voices of Alaska: Living wisdom — A Preventative Health Library for Rural Families.	AK	Rural and frontier communities in Alaska face significant barriers to accessing preventive health education due to geographic isolation, limited healthcare infrastructure, and workforce shortages. Many communities rely on Community Health Aides as the primary point of care. While these providers deliver essential clinical services, they also use culturally grounded educational tools that connect modern preventive health strategies with traditional knowledge. At the same time, Alaska Elders hold invaluable knowledge related to nutrition, traditional food systems, family wellbeing, and resilience. Much of this knowledge has historically been shared through storytelling and lived experience but is at risk of being lost without intentional preservation and transmission to younger generations. Voices of Health: Living Wisdom—A Preventive Health Library for Rural Families presents an opportunity to bridge this gap. The project will collaborate with Elders, healthcare professionals, and a filmmaker to create a multimedia library of culturally grounded preventive health modules. These resources will support CHA/Ps and rural health programs in educating families about nutrition, healthy beginnings, and disease prevention. By combining Elder wisdom with evidence-based health education in a storytelling format, the project will expand access to culturally relevant preventive health resources while strengthening connections between traditional knowledge and modern healthcare practices.	The project will develop a culturally grounded preventive health education library through collaboration with Alaska Native Elders, healthcare professionals, Community Health Aides/Practitioners, and a filmmaker. The initiative will document Elder knowledge related to traditional foods, nutrition, family wellbeing, and healthy lifestyles while integrating evidence-based preventive health guidance. Filmed storytelling modules will be created to capture Elder perspectives alongside practical health education. These short modules will be designed for use by CHA/Ps and rural health programs during clinic visits, community education sessions, home visits, and outreach programs. Topics will include family nutrition, healthy pregnancy and early childhood development, traditional food systems, chronic disease prevention, and the role of subsistence activities in physical health and wellbeing. Modules will be organized into a digital library that is easily accessible to rural clinics, tribal health organizations, and community programs. Educational guides and discussion prompts will accompany each module to support health aides in facilitating conversations with families. Through this approach, the project strengthens the capacity of the rural healthcare workforce while providing families with culturally relevant health education that supports prevention and healthier lifestyles.	\$250K-\$1M	Home- and community-based services provider	Statewide	Anchorage (Municipality); Bristol Bay Borough; Dillingham Census Area; Juneau (City and Borough); Nome Census Area; Southeast Fairbanks Census Area	Deferred or Not Advanced

Rx for Health, LLC	Workforce Pipeline Augmentation: Expanding Care Capacity Across the Last Frontier	AK	Recruiting a sufficient number of highly qualified health care providers to meet Alaska’s needs remains a persistent challenge. We propose a paradigm shift in the approach to recruitment. Currently, most recruiting efforts are conducted by organizations based outside of Alaska. While these firms may have broad networks, they often lack a real understanding of Alaska’s culture, the specific needs of the rural health organizations they represent, the unique challenges associated with relocating, and the characteristics that contribute to a successful long-term transition for providers moving to Alaska. External recruiters frequently underestimate the geographic diversity of Alaska’s work environments while failing to effectively communicate the distinctive professional and personal opportunities available here. Alaska offers an exceptional work-life balance, unparalleled access to outdoor recreation and adventure, and the meaningful opportunity to make a profound difference in the lives of persons in rural and underserved communities. When these realities are not accurately represented, recruitment efforts falter. The result is a smaller and unoptimized candidate pool, longer recruitment timelines, and ultimately higher turnover rates. Addressing these gaps via a locally informed, Alaska-centered recruitment strategy will strengthen the health care workforce and improve long-term retention across the state.	As an Alaska-owned company that has successfully recruited pharmacists and technicians nationwide for over a decade, we understand the unique challenges and opportunities involved in attracting and retaining healthcare professionals in the Last Frontier. Our experience has provided valuable insight into the factors that support successful recruitment, relocation, and long-term retention in Alaska’s diverse communities. We have also piloted innovative staffing models that allow pharmacy professionals to work shorter, rotating assignments. This approach helps meet the staffing needs of rural Alaska while offering providers greater flexibility and exposure to varied practice environments. Building on these lessons, we propose establishing an Alaska-based central clearinghouse for healthcare recruitment. This hub would enable Alaska Native and rural health organizations to coordinate and strengthen their individual recruiting initiatives while benefiting from shared resources and a unified strategy. We will collaborate with Landsick Media, an Alaskan production company, to develop regionally tailored promotional video content for each rural health organization. Videos will highlight each organization’s facilities, workplace culture, community environment, and unparalleled recreational and lifestyle opportunities across Alaska. By authentically showcasing these elements, we can better inform and attract high-quality healthcare professionals who will embrace the unique experience of working in rural Alaska. An Alaska-based recruiting hub will also promote greater flexibility and collaboration across the state’s healthcare system. For example, a nurse or other provider completing a rotation at one location could easily transition to another site on a future assignment. This model encourages the cross-pollination of talent across organizations while offering providers enriching professional experiences and diverse personal opportunities throughout Alaska. This initiative will strengthen healthcare staffing across rural Alaska through captivating promotional media, coordinated recruitment efforts, and more efficient alignment of workforce needs. By clearly communicating both the professional rewards and lifestyle opportunities available, we can better align providers’ personal and professional goals with the needs of Alaska’s communities and improve retention. The project will enhance the quality and continuity of healthcare delivery across rural Alaska.	\$50,000-\$250,000	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Ryan Air	Using Advanced Air Mobility systems to delivery perishable pharmaceuticals to remote destinations	AK	Insulin, blood transfers, and hormonal and biological medications are highly perishable and need temperature-stable storage in-flight to ensure their effectiveness for the person(s) relying on them. Many health centers have reported shipping four vials of insulin, hoping that one arrives on time and in good condition to the customer. Many legacy aircraft in the state cannot make their cabins or cargo holds climate-controlled, increasing the risk of spoilage or packaging costs. Lastly, existing aircraft have higher operating costs, which limits air carriers' ability to move these medicines economically and drives up the cost for our regional health corporations and the end user.	Ryan Air has agreed to partner with Beta Technologies (an aircraft developer and leader in the Advanced Air mobility space) to bring electric vertical take-off and landing aircraft to Alaska. These aircraft have been designed from inception for medical transport, thanks to a partnership with United Therapeutics. They are designed to fly with temperature-controlled cargo areas that keep items at their intended temperature in both -20 and 90-degree environments. These new aircraft, since they can take off like a helicopter and fly as an airplane, can land on very short runways. When some villages experience runway issues due to snow, storms, or other environmental factors that limit the operations of legacy aircraft, these aircraft can still land and deliver critical supplies. Lastly, because operations are cheaper, these aircraft offer more economical delivery options, keeping the last-mile cost down. Additionally, as these systems move to fully autonomous in the coming years, they can operate 24/7, negating the need for crew duty days and rest requirements for human-piloted aircraft.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Dillingham Census Area; Nome Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Sacred Seeds Foundation	Living Waters Wellness Centers	AK	LWWC responds to a persistent gap in how rural Alaskans receive preventive and chronic disease care. Today, many rural residents must string together screenings, labs, imaging, and specialist visits across multiple trips and locations, often far from home. This leads to delayed detection of high-risk conditions, avoidable emergency visits and hospitalizations, and significant disruption for families, employers, and communities. The burden is especially heavy for people connected to Western Alaska regions and for residents of the rapidly growing Mat-Su Borough. Alaska’s RHTP goals call for measurable reductions in chronic disease risk, expanded access to care close to home, and a shift from reactive acute care to prevention and coordinated management. Existing efforts in Alaska and the broader U.S. address important pieces of this challenge but do not yet offer a comprehensive one- or two-day check-up hub specifically designed for Alaska’s rural and frontier realities, with built-in pathways back to local and tribal providers. The opportunity is to adapt high-efficiency comprehensive check-up models into an Alaska-specific, hub-and-spoke design that can sit inside regional RHTP delivery plans. Year 1 will determine how a Mat-Su hub can best serve rural communities across Western Alaska and other regions identified in the feasibility study, creating a practical blueprint for an integrated prevention and chronic disease model that prioritizes rural and underserved Alaskans.	LWWC is a three-phase initiative. Funding in this round will support Phase 1: Rural Co-Design and Feasibility, a disciplined research and design year that prepares for early implementation pilots in Phase 2. In Year 1 we will: Conduct structured rural co-design sessions with communities in the Mat-Su Borough and at least two Western Alaska regions connected with CC, BBNC, and BSNC, with additional locations identified through the feasibility study. Sessions will include tribal health perspectives, frontier and road-limited communities, and a focus on chronic disease and aging, while remaining open to similarly aligned partnerships statewide. Complete a feasibility and systems-integration study that maps how a Mat-Su hub-and-spoke check-up center can support rural residents across these regions. This includes defining referral pathways with tribal health organizations, primary care clinics, and hospitals, and ensuring the model can sit inside community-led regional RHTP delivery plans rather than creating a parallel system. Undertake a workforce reality assessment, including interviews with rural clinicians, community health aides, behavioral health providers, and system leaders. This will define practical staffing models, scope of practice, and telehealth support structures and produce a written workforce strategy aligned with Alaska’s Strengthen Workforce and Spark Technology initiatives. Design the clinical, financial, and technological model, including one day diagnostic experience, a multi-year business plan, and a draft technology architecture that supports telehealth, remote monitoring, and data sharing with partners. A targeted technical assistance visit to Memorial Hospital in Istanbul, Turkey, will ground our understanding of the model, how it operates and how we can tailor it to RHTP goals. Four core team members (clinical, operational, financial, and patient-experience leads) will undergo the full check-up experience and participate in structured meetings with Memorial leadership. This visit will generate concrete Year-1 deliverables: - Draft Standard Operating Procedures for the LWWC experience - Prioritized equipment and diagnostic lists - Workforce role maps - Technology design adapted to Alaska’s rural and cultural context. Phase 2 will use these Year-1 products to launch early implementation pilots in Mat-Su and selected rural regions, and Phase 3 will focus on refinement and regional scaling in alignment with RHTP priorities.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area	Deferred or Not Advanced

Safety Net Connect	Alaska eConsult Initiative: Delivering Specialty Care Expertise Seamlessly to Every Community	CA	Rural and frontier communities in Alaska face persistent barriers to specialty care access, including severe provider shortages, long wait times, high travel costs, and geographic isolation. Many patients must travel hundreds of miles—often by air—for specialty visits, leading to delayed care, worsening conditions, and avoidable emergency department use. At the same time, primary care providers (PCPs) in rural settings operate with limited specialist support, contributing to professional isolation and referral bottlenecks. This project addresses the opportunity to redesign specialty access through a statewide, technology-enabled eConsult and care collaboration network. By connecting rural PCPs with specialists through secure, asynchronous consultation, patients can receive timely clinical guidance without unnecessary travel. The model strengthens local provider capacity, improves care coordination across medical and behavioral health services, and creates a more sustainable, workforce-efficient system of care tailored to Alaska’s rural landscape.	Safety Net Connect proposes to implement a statewide Rural Specialty Access Network using our enterprise eConsult and care collaboration platform to connect rural primary care providers (PCPs) with specialists across Alaska. The core of the approach is asynchronous eConsult. Rural PCPs will submit structured electronic consults to participating specialists, who will respond within defined service level timelines (e.g., 2–3 business days). Specialists will provide diagnostic guidance, treatment recommendations, and clear next steps. Many cases can be resolved without the need for an in-person visit; those requiring direct care will be prioritized appropriately, ensuring limited specialty capacity is used efficiently. This model reduces unnecessary travel, lowers system costs, and significantly shortens wait times. It also functions as a workforce multiplier by strengthening PCP capacity to manage complex conditions locally with specialist support. The platform will integrate with existing EHRs and support referral management, telehealth, and data reporting. For patients who require synchronous care, integrated telehealth workflows can facilitate virtual specialty visits when appropriate. Referral tracking ensures visibility into status and outcomes, improving care coordination and reducing delays. In addition, the system can support whole-person collaboration across medical, behavioral health, and social service providers when needed. Secure messaging, shared care plans, and real-time updates allow geographically dispersed providers to coordinate around high-risk patients. Implementation will follow a phased rollout: stakeholder engagement and governance design, specialty prioritization, onboarding of rural clinics and specialists, training, and go-live support. SNC provides project management, provider training, performance dashboards, and ongoing optimization. The approach is designed for long-term sustainability. The model can leverage existing Medicaid reimbursement pathways for interprofessional consultation, reducing reliance on ongoing grant funding. Built-in analytics will allow the State to track utilization, response times, resolution rates, avoided travel, and cost impact. By creating a connected virtual specialty network tailored to Alaska’s frontier environment, this project improves access, strengthens rural provider capacity, and builds a scalable, sustainable model of specialty care delivery.	\$250K-\$1M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Sage Consulting Incorporated	Alaska Medicaid Rural Clinics Service Expansion	AK	We would like to recommend revisions for rural health clinics covering Medicaid services. Rural Health Clinics eligible for reimbursement by Alaska Medicaid consist of federally qualified Rural Health Clinics and Centers (RHC/FQHC), Tribal health clinics, and private practitioner health clinics. All these providers have differing published guidelines for covered services and are reimbursable under different methodologies. None have published guidelines for Alaska Medicaid services that are current. They lack comprehensive explanation of services covered for their discipline, scope of practice guidance, and updated procedures for technological advances approved for coverage by CMS. We propose addressing each provider category by defining what they are allowed based on legal requisites to provide for covered services, what they have for covered services now, and the difference of what they lack compared to their current covered services appropriate for Medicaid reimbursement. There are many services that can be provided with the use of new technologies and paraprofessionals under the direction of qualified health providers. And CMS has published new codes for coverage for these types of services in 2025-2026 which are not covered services for Alaska Medicaid.	Based on new technologies, and community infrastructure, we would like to propose recommendations for widening available services while identifying any administrative hurdles to overcome in completing the workplan to accomplish any accepted recommendations for change. Here are some examples of changes that require no regulatory changes: 1. RHC/FQHC providers currently do not have HCPCS code G2025 (specific to RHC/FQHC telemedicine services, real-time and audio only for non-behavioral health services. 2. In 2025-2026 CPT/HCPCS new codes for technology include 11 codes for remote patient monitoring & digital health, 6 for virtual communication and telehealth (5 for non-physician services), and more that address primary care and behavioral health services not reimbursed by Medicaid. These services are generally not considered traditional "telehealth" and do not always require real-time audio-visual communication. We will also propose the introduction of paraprofessional providers with defined services and oversight requirements to bolster the use of existing community members to aid workforce development. And as we map existing covered and potentially available community services, and more defined parameters for covered services, we would intend on connecting all who are willing and able to connect to the Alaska Health Information Exchange (Health e-Connect). We feel that this approach to shoring up Medicaid coverage that has not been done yet is in the spirit of the Alaskan “North Star” objective for this great funding opportunity. The intent is to recommend modifications to existing programs that have existing infrastructure which will address preventative and essential services at a lower cost and improve access to patient care that serves both medical and health related social needs. There is a great need to accommodate new technologies and that will be an integral part of our review.	\$50,000-\$250,000	Statewide	Anchorage (Municipality); Copper River Census Area; Kenai Peninsula Borough; Matanuska-Susitna Borough; Sitka (City and Borough); Southeast Fairbanks Census Area	Deferred or Not Advanced

SAIC	Addressing Alaska’s Rural Healthcare Needs: the Alliance for Advancing Rural Healthcare	VA	The Alliance for Advancing Rural Healthcare (AARH) is a coalition that brings together eight leading players in the rural healthcare sector. The Alliance is led by SAIC, a leader in Mission Integration, with decades of experience serving state governments and federal health agencies (i.e., CMS, FDA, VA, NIH, CDC). SAIC is the submitting entity for this LOI as they lead the coalition, but the work in Alaska will be supported by all member organizations. Each of our coalition members provides a different area of expertise, including: - SAIC: Ecosystem Enablement, Cybersecurity, AI - TruBridge: Largest Nationwide Rural EHR, Ambient AI, RCM - Castlight: Care Navigation, Virtual Care, Remote Monitoring - Telemedicine.com: Telehealth, Remote Patient Monitoring - Arcadia: Interoperability, Analytics, Population Health - Covista: Workforce Training, Upskilling - Mission Mobile Medical: Satellite Mobile Clinic Network - Walgreens: Second Largest U.S. Pharmacy Chain, Primary Care Our project will address all of Alaska’s rural health transformation initiatives by providing a package of solutions spanning maternal and child health, expanding access, promoting healthy communities, improving pay for value, strengthening the health care workforce, and modernizing technology infrastructure.	Our Alliance is guided by three key mission-driven principles. - People First Focus: Bring care closer to rural residents, reducing barriers and expanding timely access where people live and work - Purpose-Built: Partner with states and providers to deliver solutions that reflect local community needs and priorities - Built to Last: Strengthen rural health systems so care is reliable, sustainable and available for the long term Our approach to addressing Alaska’s rural health needs will be driven by those principles, as our eight member companies work together to deliver measurable improvements in Alaska.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Saige, Inc.	AR / STAR Medevac Aircraft Satellite Connectivity Deployment - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes strengthening emergency response capacity, improving access to care in remote communities, and enhancing rural health system resilience. North Slope Borough’s Search and Rescue (SAR) and emergency medical aviation operations serve as critical lifelines across approximately 94,000 square miles of Arctic terrain. Medevac aircraft transport patients from remote villages to higher-acuity facilities under severe weather, long-distance, and time-sensitive conditions.	North Slope Borough will implement aircraft connectivity modernization across its SAR / STAR fleet through a structured deployment program. Implementation activities will include: 1. Equipment Procurement • Acquisition of aviation-certified satellite connectivity hardware • Procurement of required mounting, structural integration, and power systems • Redundancy and backup communication system alignment 2. FAA-Compliant Installation • Engagement of FAA-certified installation providers • Aircraft modification and integration during scheduled maintenance windows • System validation and flight testing 3. Clinical Integration • Activation of secure in-flight telemedicine capability • Integration with receiving facilities for real-time patient data transmission • Development of standardized in-flight consultation protocols • HIPAA-compliant data handling procedures 4. Crew Training & Operational Adoption • Training for flight crews on equipment use • Telemedicine escalation protocols • Communication coordination procedures • Ongoing operational support framework 5. Performance Monitoring & Reporting • Definition of connectivity uptime metrics • Monitoring of telemedicine utilization during transport • Measurement of response time improvements • Documentation of receiving facility readiness improvements	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Behavioral Health Access & Capacity Analytics Framework - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes improving access to care, strengthening rural system sustainability, and advancing long-term health outcomes in frontier communities. Behavioral health services in rural systems may face challenges related to provider availability, referral completion timelines, crisis recurrence patterns, and care coordination. Limited visibility into demand patterns and access bottlenecks can affect both clinical outcomes and fiscal sustainability. This grant provides an opportunity to: • Assess current behavioral health referral and access workflows • Analyze wait times, service capacity, and utilization variability • Identify gaps between behavioral health demand and available service resources • Evaluate recurrence patterns in crisis or emergency behavioral health events • Determine feasibility of a structured behavioral health access monitoring framework Saige proposes to conduct this structured planning effort in collaboration with North Slope Borough stakeholders and define an implementation-ready behavioral health analytics framework aligned with Health Care Access and Healthy Communities objectives. This initiative is structured as part of a broader rural modernization planning framework and may inform future implementation phases.	Saige will lead a structured planning project focused on behavioral health access analytics design, capacity modeling, and executive integration — not direct clinical service redesign. Planning activities will include: 1. Access & Referral Workflow Assessment • Documentation of behavioral health referral pathways • Analysis of referral completion timelines • Review of appointment availability and scheduling variability 2. Capacity & Utilization Analysis • Evaluation of provider capacity relative to demand • Analysis of service utilization trends and seasonal variability • Identification of service bottlenecks 3. Crisis & Recurrence Pattern Modeling • Multi-year review of crisis-related encounters • Identification of repeat behavioral health acute events • Risk stratification of high-recurrence cohorts 4. Fiscal & Sustainability Impact Modeling • Estimation of cost exposure associated with delayed or fragmented care • Scenario modeling of improved access coordination • Identification of KPIs tied to sustainability outcomes 5. Implementation Roadmap Development • Defined behavioral health access monitoring framework • Dashboard architecture blueprint • KPI framework for leadership oversight • Phased implementation roadmap with cost estimates	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Care Access Variability & Equity Analytics Framework – North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes improving access to care, strengthening rural system sustainability, and advancing long-term community health outcomes. Across North Slope Borough’s eight remote communities, access to care may vary due to weather conditions, travel logistics, workforce availability, and clinic capacity. These factors can influence appointment availability, referral completion, wait times, and continuity of care. Limited structured visibility into access variability across communities and service lines may reduce the ability to proactively allocate resources, prioritize service expansion, and strengthen long-term sustainability. This grant provides an opportunity to: • Analyze multi-year access patterns across communities and service lines • Identify variability in appointment availability, referral completion, and utilization • Evaluate geographic differences in care continuity and follow-up completion • Assess fiscal and operational impacts associated with access variability • Determine feasibility of a structured care access monitoring framework Saige proposes partnering with North Slope Borough Health Department leadership to conduct this structured planning effort and define an implementation-ready access analytics framework supporting improved access stability, resource planning, and equitable service delivery across rural communities.	Saige will lead a structured project focused on access analytics design, variability modeling, and executive integration — not service redistribution decisions. Planning activities will include: 1. Access & Utilization Pattern Analysis -Multi-year review of appointment availability and service utilization by community -Analysis of referral completion rates and wait-time variability -Identification of service categories with significant access differences 2. Continuity & Follow-Up Variability Assessment -Evaluation of follow-up adherence by service line -Analysis of repeat acute utilization relative to access variability -Identification of patterns indicating service gaps 3. Geographic & Service-Level Modeling -Stratification of utilization patterns by community -Assessment of travel-related service variability -Scenario modeling of alternative resource allocation approaches 4. Fiscal Impact & Sustainability Modeling -Estimation of cost exposure associated with access variability -Modeling of stabilization potential under improved monitoring -Definition of executive oversight thresholds 5. Implementation Roadmap Development -Defined access variability monitoring framework -Dashboard and reporting blueprint -KPI framework for leadership integration -Phased implementation roadmap with cost estimates	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	CHAP Digital Documentation & Field Enablement - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes workforce stabilization, rural access continuity, and operational sustainability across frontier communities. Within North Slope Borough Health Department (NSB DHR), CHAP provide essential frontline services across remote villages. CHAP providers are often the first — and sometimes only — point of contact for patients. Currently, CHAP clinical documentation relies heavily on handwritten notes and paper-based workflows. This creates: • Administrative inefficiencies • Delayed reporting and reconciliation • Limited real-time visibility into service delivery • Increased risk of documentation errors • Reduced integration with behavioral health and PHN services • Additional reporting burden when transferring data to State systems In a rural environment where workforce capacity is already constrained, paper-based workflows increase strain on frontline providers and limit system responsiveness. This Defined Approach project provides an opportunity to modernize CHAP documentation workflows through structured digital enablement while aligning with State and Tribal reporting requirements. This initiative is focused specifically on CHAP digital workflow stabilization and complements — but does not replace — broader DHR Clinical Documentation modernization efforts.	Saige will lead a structured Defined Approach phase focused on CHAP workflow digitization, field enablement design, interoperability planning, and implementation roadmap development — not full system replacement. Project activities will include: 1. CHAP Workflow & Documentation Assessment • Mapping of current handwritten documentation workflows • Identification of duplication points and reporting bottlenecks • Inventory of required clinical forms and reporting outputs • Assessment of device availability and connectivity constraints in each community 2. Digital Documentation Framework Design • Standardization of CHAP documentation templates into structured digital formats • Design of mobile-first clinical documentation workflows • Offline-capable documentation logic (critical for remote connectivity conditions) • Integration alignment with existing DHR systems 3. Field Technology Enablement Model • Definition of appropriate device strategy (tablets, secure laptops, hybrid models) • Security and access control design • Role-based permissions and privacy compliance • Workflow integration with clinic-based systems 4. Interoperability & Reporting Alignment • Design of structured export pathways to: AKAIMS (Behavioral Health, where relevant) State reporting requirements Future DHR data layer initiatives • Identification of structured data fields required for automated reporting • Elimination of manual re-entry wherever feasible 5. Workforce Stabilization & Efficiency Modeling • Quantification of administrative time currently spent on paper workflows • Modeling of documentation efficiency gains under digital workflows • Assessment of reduction in reconciliation burden • Evaluation of improved real-time visibility for leadership	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

6. Implementation Roadmap Development

- Defined CHAP Digital Enablement architecture blueprint
- Device and integration requirements
- Training and certification plan
- Phased rollout sequencing
- Cost ranges and resource estimates

Saige, Inc.	CHAP Workforce Mobility & Cost Optimization - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes workforce stabilization, cost sustainability, and improved access across rural and frontier communities. Within North Slope Borough Health Department (NSB DHR), Community Health Aides/Practitioners (CHAP) operate across geographically dispersed villages. Due to population distribution, workforce rotation schedules, seasonal conditions, and service demand variability, CHAP travel between communities is often required to maintain coverage and continuity. However, structured analysis of: • CHAP travel deployment frequency • Travel cost (airfare, lodging, per diem, lost productivity) • Service delivery efficiency during travel periods • Opportunity for telehealth substitution has not been systematically performed. In a region where transportation costs are high and workforce capacity is limited, mobility decisions materially impact: • Operational sustainability • Service continuity • Workforce strain • Fiscal stability This project provides an opportunity to analyze CHAP workforce mobility patterns and define an optimization framework that improves service alignment while reducing avoidable cost and strain	Saige will lead a structured study focused on CHAP travel analytics, cost modeling, substitution analysis, and optimization framework design — not workforce restructuring. Project activities will include: 1. CHAP Travel Deployment Analysis • Multi-year analysis of CHAP travel frequency by community • Identification of travel drivers (coverage gaps, demand spikes, rotation scheduling) • Seasonal variability analysis • Mapping of travel intensity by service type 2. Travel Cost Modeling • Comprehensive cost breakdown: Airfare Lodging Per diem Escort or support costs (if applicable) Opportunity cost of travel time • Cost-per-encounter analysis for travel-based service delivery • Variance analysis across communities 3. Service Delivery Efficiency Assessment • Comparison of service volume delivered during travel-based deployment vs in-community coverage • Assessment of appointment density and productivity during travel windows • Identification of potential inefficiencies caused by compressed visit schedules • Evaluation of care continuity impacts linked to mobility cycles 4. Telehealth Substitution Modeling • Identification of service categories suitable for telehealth substitution • Modeling of potential reduction in travel frequency under telehealth-supported scenarios • Connectivity and workflow feasibility assessment • Cost comparison of travel-based delivery vs telehealth-supported delivery 5. Workforce Stability & Risk Modeling	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

- Identification of mobility-related workforce strain indicators
- Risk modeling for burnout or turnover linked to travel intensity
- Scenario modeling of alternative coverage models (clustered scheduling, telehealth hybrid, adjusted rotation patterns)

6. Implementation Roadmap Development

- Defined CHAP Workforce Mobility Optimization framework
- Travel reduction threshold triggers
- Cost-stabilization targets
- Telehealth integration recommendations
- Phased operational adjustment roadmap

Saige, Inc.	Continuity of Care & Travel Risk Monitoring Framework	NY	In Arctic systems, care continuity is frequently disrupted by weather delays, travel dependency, specialist scheduling gaps, and workforce variability. The Continuity of Care & Travel Risk Monitoring Framework improves rural health access by identifying patients at risk of missed follow-up, delayed referrals, or fragmented care pathways. Access Impact • Flags care gaps before they escalate • Improves coordination between village clinics and regional facilities • Reduces preventable emergency transport Quality Impact • Improves follow-up completion tracking • Strengthens chronic condition management • Reduces repeat acute episodes Sustainability Impact • Lowers avoidable medevac and emergency costs • Improves reimbursement alignment tied to care continuity • Stabilizes utilization variability For North Slope Borough’s remote communities, strengthening continuity reduces the cascading consequences of missed or delayed care.	Project Concept Approach Saige will lead a structured planning project focused on continuity analytics design, risk modeling, and executive integration — not clinical workflow replacement. Planning activities will include: 1. Continuity & Follow-Up Analysis • Multi-year review of follow-up adherence rates • Identification of repeat acute utilization potentially linked to missed follow-up • Analysis of service-level continuity patterns 2. Access & Travel Impact Assessment • Evaluation of travel-related barriers affecting appointment completion • Assessment of seasonal or scheduling variability • Analysis of referral completion timelines 3. High-Risk Cohort Identification • Identification of patients at elevated risk for repeat utilization • Chronic condition and post-acute follow-up risk modeling • Stratification by service category 4. Fiscal & Operational Impact Modeling • Estimation of cost exposure associated with care disruption • Scenario modeling of improved follow-up monitoring • Identification of intervention trigger thresholds 5. Implementation Roadmap Development • Defined continuity monitoring framework • Dashboard architecture blueprint • KPI framework for leadership oversight • Phased implementation roadmap with cost estimates	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Digital Intake, Scheduling & Engagement Workflow - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes improved access to care, workforce stabilization, and operational sustainability across rural and frontier communities. In North Slope Borough (NSB), administrative burden related to intake processing, appointment coordination, manual reminders, and no-show follow-up contributes to workforce strain and delayed access to care. Missed appointments, fragmented intake documentation, and inconsistent routing workflows may reduce clinical efficiency and limit service continuity. This project provides an opportunity to: • Standardize digital intake and triage workflows across service lines • Automate appointment reminders and follow-up for missed visits • Improve referral routing and clinician notification processes • Reduce administrative overhead associated with manual scheduling coordination • Increase visit completion rates and strengthen reimbursement capture Saige proposes to partner with North Slope Borough to design and deploy a Digital Intake, Scheduling & Engagement Workflow that improves operational efficiency and care continuity while reducing administrative burden in a rural health environment.	Saige will lead a structured 6-month project focused on system configuration, workflow design, integration planning, and pilot readiness. Activities will include: 1. Workflow Standardization & System Design • Mapping current intake, scheduling, and reminder workflows • Defining standardized digital intake forms by service type • Designing automated triage and clinician routing rules • Establishing reminder cadence logic (SMS/email/voice where appropriate) 2. EHR & System Integration Planning • Integration design with existing scheduling and EHR systems • Privacy, consent, and role-based access configuration • Data capture and reporting alignment 3. No-Show & Re-engagement Automation Framework • Automated follow-up prompts for missed visits • Waitlist management logic • Visit adherence analytics dashboard 4. Workforce Impact & Efficiency Modeling • Administrative time savings estimation • Visit completion improvement modeling • Reimbursement capture impact modeling 5. Pilot Implementation Readiness • Defined deployment scope and technical configuration plan • Training framework for administrative and clinical staff • Implementation roadmap with cost and sequencing	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	EMR Documentation & Interoperability Modernization - North Slope Borough	NY	North Slope Borough’s Department of Health & Social Services (HSS) delivers behavioral health, public health nursing (PHN), and Community Health Aide (CHAP) services across remote and dispersed communities. Clinical documentation workflows currently operate across multiple systems: • Behavioral Health: AKAIMS • PHN: eClinicalWorks • CHAP: primarily paper-based documentation • Manual reconciliation and repetitive State reporting processes These fragmented documentation environments limit interoperability, create duplication, reduce clinical visibility across service lines, and increase administrative burden on frontline staff. HSS has identified the need for Electronic Medical Record documentation modernization and interoperability alignment that: • Digitizes CHAP documentation workflows • Reduces manual duplication across EMR systems • Improves internal cross-program visibility • Simplifies reporting to State systems • Strengthens continuity of care across behavioral and physical health	Saige will conduct a 6-month structured planning effort including: EMR Workflow Mapping • Detailed mapping of AKAIMS, eClinicalWorks, and CHAP documentation processes • Identification of duplication, manual reconciliation, and reporting inefficiencies CHAP EMR Digitization Design • Structured electronic documentation templates • Mobile-capable and offline-enabled workflows • Integration pathways into existing EMR systems Interoperability & Translation Layer Architecture • Design of structured data mappings between internal EMR systems • Automated reporting alignment to State requirements • Governance framework for cross-program visibility Implementation Blueprint • Vendor-neutral capability requirements • Phased deployment roadmap • Cost ranges and integration sequencing • Governance and adoption strategy	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Enterprise Data Governance Framework - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes sustainability, interoperability, fiscal accountability, and responsible modernization across rural communities. As reporting expectations evolve and technology modernization initiatives expand, structured data governance becomes essential to ensure that data is secure, appropriately stewarded, interoperable, and aligned with compliance requirements. While the current governance structures within North Slope Borough (NSB) require structured assessment, this Planning Grant provides an opportunity to: • Evaluate existing data ownership, stewardship, and access controls • Assess privacy, compliance, and reporting alignment frameworks • Identify governance gaps that may limit interoperability or reporting readiness • Define standardized data policies aligned with RHTP and Medicaid requirements • Develop a sustainable governance structure to support future modernization initiatives Saige proposes to partner with North Slope Borough to conduct this structured governance planning effort and develop an implementation-ready roadmap aligned with Spark Technology & Innovation objectives. This initiative is structured as a modular component within a broader Rural Health Modernization Planning Framework designed to support phased strategy-to-delivery transformation across rural Alaska communities.	Saige will lead a structured assessment and planning phase focused on governance design, policy development, compliance alignment, and sustainability modeling — not system deployment. Planning activities will include: 1. Governance Landscape Assessment • Review of existing data policies and procedures • Stakeholder interviews to understand stewardship practices • Evaluation of data access controls and approval workflows • Assessment of compliance alignment (HIPAA, Medicaid reporting, grant reporting) 2. Governance Framework Design • Definition of data ownership and stewardship roles • Development of governance charter • Standardized data classification framework • Access control and role-based permission model • Escalation and issue resolution protocols 3. Reporting & Compliance Alignment • Alignment of governance model with RHTP reporting expectations • Documentation standards for audit readiness • Data quality monitoring framework 4. Sustainability & Operating Model Integration • Governance oversight committee structure • Reporting cadence and accountability framework • Cost modeling for long-term governance operations 5. Implementation Roadmap Development • Defined phased governance rollout plan • Resource requirements • Training and change management outline • Draft Implementation Grant framework The outcome will be a documented, implementation-ready governance model tailored to NSB’s operational context.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Executive Health Command Center	NY	Alaska’s Rural Health Transformation Program emphasizes measurable outcomes, fiscal sustainability, workforce stability, and improved access across rural communities. Leadership teams in geographically dispersed environments must balance service utilization, workforce capacity, travel-dependent access, fiscal performance, and compliance obligations. Structured executive visibility across these domains can strengthen strategic decision-making and long-term sustainability. While the specific executive reporting environment within North Slope Borough (NSB) requires structured assessment, this Planning Grant provides an opportunity to: • Evaluate current leadership reporting processes and decision cycles • Assess availability and consistency of performance metrics across workforce, access, fiscal, and compliance domains • Identify gaps in executive visibility that may limit proactive planning • Define standardized performance indicators aligned with RHTP objectives • Determine feasibility of a unified Executive Health Command Center model This initiative is structured as a modular component within a broader Rural Health Modernization Planning Framework designed to support phased strategy-to-delivery transformation across rural Alaska communities.	Saige will lead a structured planning project focused on executive information needs assessment, performance framework design, governance integration, and sustainability modeling — not dashboard deployment. Planning activities will include: 1. Executive Information Needs Assessment • Identification of key leadership stakeholders • Documentation of current reporting workflows and decision cadence • Assessment of leadership performance visibility needs 2. Performance & Metric Framework Design • Definition of core performance domains (workforce, access, fiscal, compliance) • Standardization of key performance indicators • Alignment with RHTP reporting expectations • Data feasibility assessment 3. Command Center Architecture Blueprint • Design of executive dashboard structure • Definition of required data inputs • Role-based access and governance alignment • Integration feasibility mapping 4. Governance & Operating Model Integration • Reporting cadence design • Executive oversight framework • Accountability and escalation protocols 5. Implementation Roadmap Development • Phased deployment plan • Resource requirements and cost modeling • Training and change management outline • Draft Implementation Grant framework The outcome will be a documented, implementation-ready design for an Executive Health Command Center tailored to NSB’s operational context.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Rural Health Data Foundation	NY	Alaska’s Rural Health Transformation Program emphasizes long-term sustainability, interoperability, and modernization across rural, remote, and frontier communities. While the specific data infrastructure and reporting environment within North Slope Borough (NSB) requires structured assessment, increasing federal reporting expectations and value-aligned care initiatives highlight the importance of integrated, governed data architecture in rural systems. This Planning Grant provides an opportunity to: • Conduct a comprehensive inventory of clinical, EMS, workforce, and financial data systems • Evaluate current reporting workflows and compliance processes • Assess interoperability readiness and governance structures • Identify opportunities to strengthen fiscal transparency and reimbursement alignment • Determine whether an integrated Health Data Foundation would materially improve sustainability and reporting capacity Saige proposes to partner with North Slope Borough to conduct this structured planning effort and, based on findings, define an implementation-ready roadmap aligned with Spark Technology & Innovation objectives. This initiative is structured as a modular component within a broader Rural Health Modernization Planning Framework designed to support phased strategy-to-delivery transformation across rural Alaska communities.	Saige will lead a structured Planning Phase in collaboration with North Slope Borough stakeholders. This Planning Grant will focus on feasibility, architecture design, governance development, and sustainability modeling — not infrastructure deployment. Planning activities will include: 1. System Landscape & Reporting Assessment • Inventory of clinical, EMS, workforce, financial, and reporting systems • Documentation of data flows and reporting requirements • Evaluation of compliance workflows 2. Interoperability & Architecture Blueprint • Design of scalable data integration framework • Assessment of interoperability readiness • Development of phased implementation strategy • Identification of required technology components 3. Governance & Stewardship Framework • Definition of data ownership and stewardship roles • Access controls and privacy alignment • Governance charter supporting long-term sustainability 4. Fiscal & Sustainability Modeling • Evaluation of reporting efficiency opportunities • Identification of reimbursement alignment opportunities • Cost modeling and sustainability analysis • Risk assessment 5. Implementation Roadmap Development • Defined scope, timeline, and cost estimate • Phased deployment plan • Outcome measurement framework • Draft Implementation Grant framework The outcome of this Planning Phase will be a fully scoped, feasibility-tested blueprint ready for potential Implementation Grant submission.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Rural Health Technology Youth Workforce Pipeline - North Slope	NY	Alaska's Rural Health Transformation Program identifies workforce development and technology innovation as key pillars for sustainable rural health systems. On the North Slope, workforce shortages are compounded by geographic isolation, limited local training pathways, and heavy reliance on imported labor, creating instability in health service delivery. At the same time, North Slope Borough youth face limited structured engagement opportunities outside school hours, contributing to behavioral health challenges including substance use, social isolation, and disengagement. Research increasingly links digital skill-building and structured technology engagement to improved youth outcomes. This grant provides an opportunity to: • Assess feasibility of a guided AI-assisted technology learning platform tailored to rural Alaska youth • Evaluate how youth-built digital tools could address local health data and service delivery needs • Design a curriculum linking digital skills development to rural health system modernization • Model a pathway from youth digital engagement to health technology workforce placement • Determine alignment between youth behavioral health engagement and workforce pipeline goals Saige proposes partnering with North Slope Borough to design a Rural Health Technology Youth Workforce Pipeline that addresses youth engagement, workforce sustainability, and health technology capacity simultaneously.	Saige will partner with North Slope Borough leadership, school district representatives, youth program coordinators, behavioral health providers, and relevant Tribal entities to refine and structure a Rural Health Technology Youth Workforce Pipeline concept aligned to community priorities. This effort will focus on clarifying scope, defining roles, and determining whether a youth-centered technology workforce model can simultaneously strengthen youth engagement and local health system capacity. Activities will include: 1. Community & Youth Engagement Landscape Assessment • Map existing youth programming, participation gaps, and after-hours engagement challenges • Assess digital literacy levels, connectivity access, and device availability across communities • Document behavioral health indicators relevant to structured engagement programming • Identify culturally grounded priorities and guardrails for youth programming 2. Health System Needs & Alignment Review • Identify health system modernization needs suitable for youth-supported, non-clinical technology contributions (e.g., dashboards, reporting aids, workflow supports) • Clarify operational constraints and supervisory capacity within NSB health and IT functions • Determine realistic skill levels and contribution boundaries for youth participants 3. Program Model & Partnership Development • Define potential cohort structures, supervision models, and mentorship approaches • Identify required partner roles (education, health administration, Tribal partners) • Outline appropriate curriculum components aligned to community needs • Develop a governance framework for safe and structured participation 4. Administrative Readiness & Workplan Development • Define preliminary scope, staffing assumptions, and cost ranges • Identify sustainability pathways (education funding, workforce grants, program partnerships) • Produce a structured Defined Approach proposal framework for potential Year 2 submission	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Rural Scenario Stress Testing Simulator - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes long-term sustainability, improved access stability, and resilient rural health system operations. Rural and frontier health systems often face high-impact variability across workforce capacity, access disruption, emergency transport demand, reimbursement performance, and seasonal demand fluctuations. Without structured scenario modeling, leadership teams may be forced to respond reactively rather than plan proactively for predictable risk conditions. This grant provides an opportunity to: Assess current strategic planning and forecasting practices Identify the highest-impact operational and fiscal risk scenarios affecting sustainability Define a structured scenario stress-testing framework for leadership decision support Model how variations in workforce, demand, access disruption, and reimbursement affect service continuity and cost exposure Determine feasibility of an implementation-ready scenario simulation tool that supports proactive, data-informed planning Saige proposes to conduct this structured planning effort in collaboration with North Slope Borough stakeholders and define an implementation-ready scenario simulation framework aligned with Pay for Value and Health Care Access objectives. This initiative is structured as part of a broader rural modernization planning framework and may inform future implementation phases	Saige will lead a structured planning project focused on scenario definition, model architecture design, and executive integration — not operational policy replacement. Planning activities will include: 1. Scenario Identification & Prioritization Stakeholder workshops to identify highest-impact scenarios Selection of priority scenario categories (workforce loss, demand spikes, access disruption, emergency transport surges, reimbursement changes) Definition of scenario assumptions and severity tiers 2. Baseline System Modeling Establishment of baseline workforce, service utilization, and fiscal models Identification of key input variables and dependencies Mapping of data sources required for simulation 3. Stress Testing Framework Design Design of simulation logic and scenario levers Definition of outputs: cost exposure, service continuity indicators, staffing sufficiency, access delay impacts Development of threshold-based triggers for executive action 4. Fiscal & Sustainability Impact Modeling Estimation of fiscal volatility under each scenario Modeling of mitigation strategies (reserve approaches, capacity reallocation, targeted interventions) Alignment with governance and executive reporting cycles 5. Implementation Roadmap Development Defined simulator blueprint and functional requirements Dashboard / interface concept and user roles KPI and output framework for leadership use Phased implementation roadmap with cost estimates	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Service Delivery Utilization & Capacity Optimization - North Slope Borough	NY	Within North Slope Borough Health Department programs, service delivery is constrained by workforce travel schedules, limited on-site availability, and variable demand across villages. Behavioral health clinicians, CHAP providers, and PHN services operate across remote communities without consistent visibility into utilization patterns, demand spikes, travel load, or follow-up gaps. Without structured capacity alignment, the system may face: • Behavioral health and crisis bottlenecks • CHAP travel overextension • Inconsistent psychiatric/counseling visit cadence • Delayed referrals and follow-ups • Limited workforce forecasting ability This project will: • Assess service delivery patterns across behavioral health, CHAP, and PHN • Analyze utilization trends and demand variability • Identify workforce and travel optimization opportunities • Model demand-aligned visit cadence thresholds • Determine whether structured utilization optimization improves access stability and sustainability Saige will partner with North Slope Borough Health & Social Services to develop an implementation-ready Service Delivery Optimization Framework aligned with RHTP goals of workforce stabilization and continuity of care.	Saige will lead a structured planning project focused on internal service demand analysis, workforce alignment modeling, and operational optimization design — not program redesign. Project activities will include: 1. Service Delivery & Workflow Assessment • Inventory of behavioral health, CHAP, and PHN service delivery models • Mapping of visit cadence, travel scheduling, referral intake, and follow-up workflows • Identification of operational constraints (travel windows, clinician capacity, clinic availability) • Documentation of internal service coordination gaps 2. Demand & Utilization Pattern Analysis • Multi-year analysis of service volume by program and community • Assessment of psychiatrist utilization frequency and visit cadence • CHAP travel deployment frequency and load analysis • Identification of high-variance communities and episodic demand spikes • Analysis of no-show, follow-up completion, and service backlog trends 3. Capacity & Scheduling Optimization Modeling • Development of demand-aligned visit clustering logic • Threshold-based triggers for psychiatrist or behavioral health visit frequency • CHAP travel optimization modeling • Scenario modeling of alternative workforce deployment strategies • Service prioritization framework based on utilization intensity 4. Continuity & Workforce Impact Modeling • Identification of service continuity gaps caused by travel-based delivery • Modeling of potential reduction in service bottlenecks under optimized scheduling • Workforce strain indicators and capacity stabilization thresholds • Executive-level visibility dashboard blueprint 5. Implementation Roadmap Development • Defined Service Delivery Optimization Model framework • KPI framework for leadership oversight • Dashboard and reporting design blueprint • Phased implementation roadmap with cost estimates • Staffing and integration requirements	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Service Line Cost Transparency Model - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes fiscal sustainability, responsible stewardship of public funds, and improved alignment between service delivery and long-term system viability. In rural and frontier systems, small population volatility, travel dependency, and workforce constraints can significantly impact cost-to-serve by service type. Structured visibility into service-line cost performance is critical for sustainable decision-making, reimbursement alignment, and long-term planning. This grant provides an opportunity to: • Assess current cost allocation methodologies across clinical, EMS, and support services • Evaluate cost-to-serve by service category, including travel-related cost drivers • Identify service lines with high variance between cost and reimbursement • Develop scenario models to assess sustainability under different utilization patterns • Determine whether structured cost transparency tools would materially strengthen fiscal stability	Saige will lead a structured project focused on cost modeling, fiscal analysis, and sustainability design — not financial system replacement. Planning activities will include: 1. Cost Structure Assessment • Review of current cost allocation methodologies • Identification of direct, indirect, and travel-related cost drivers • Documentation of fixed vs. variable cost components 2. Service-Line Cost Analysis • Development of cost-to-serve models by service category • Margin variance assessment (cost vs. reimbursement) • Identification of high-cost volatility drivers 3. Travel & Rural Impact Modeling • Analysis of travel dependency impact on cost structures • Scenario modeling under seasonal or staffing shifts • Sensitivity testing for utilization fluctuations 4. Fiscal Sustainability Modeling • Identification of service-line sustainability thresholds • Scenario modeling of cost stabilization strategies • Risk modeling for small-population variance 5. Implementation Roadmap Development • Defined cost transparency framework • Dashboard and reporting requirements blueprint • Change management and executive adoption plan • Phased implementation roadmap with cost estimates	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Sexual Health Access & Confidential Supply Program - North Slope Borough	NY	Sexually transmitted infections remain a recognized public health concern in many rural regions, where access to preventive services may be constrained by geography, privacy concerns, and clinic availability. Current access to preventive supplies and sexual health information in North Slope Borough primarily occurs through clinic visits or public health outreach. In small communities, privacy concerns and logistical barriers may discourage individuals from requesting services or educational resources. There is an opportunity to explore a digitally enabled access model that strengthens prevention while integrating with existing public health services. Design elements include: • Confidential digital request channels for preventive supplies • Access to culturally appropriate sexual health educational resources • Optional home-based testing options where clinically appropriate • Flexible fulfillment models aligned with community preferences (clinic pickup, discreet shipping, or hub distribution) • Privacy-protecting monitoring tools to support public health planning while protecting individual confidentiality The initiative focuses on improving preventive access and reducing barriers to early engagement with sexual health services while supporting existing public health programs.	Saige will partner with North Slope Borough Public Health, Tribal health organizations, youth program leaders, and community stakeholders to design a confidential, technology-enabled access model that strengthens preventive sexual health services. The 6-month Planning Phase focuses on research, design, and implementation readiness rather than immediate deployment of new services. 1. Community Engagement & Access Barrier Assessment • Conduct stakeholder consultations with Tribal leaders, youth representatives, public health staff, and clinicians • Document current preventive supply distribution methods and outreach programs • Identify barriers related to confidentiality, stigma, clinic access, and supply logistics • Assess community preferences for confidential access channels and fulfillment models 2. Digital Access Model Design • Design secure digital channels that allow residents to request preventive supplies confidentially • Evaluate potential access interfaces such as secure web forms, SMS-based requests, or community-access kiosks • Define privacy-preserving workflows for request intake and fulfillment • Develop culturally appropriate educational materials integrated into digital access channels 3. Supply Chain & Distribution Coordination • Assess current procurement and distribution processes for preventive supplies • Design fulfillment models aligned with village preferences (clinic pickup, discreet shipping, or hub distribution) • Develop inventory monitoring and resupply planning approaches • Identify operational requirements for scaling supply distribution across communities 4. Privacy, Governance & Data Framework • Define confidentiality protections appropriate for small community settings • Establish minimal data collection and retention practices • Align program design with Tribal governance expectations and public health policy • Identify regulatory considerations related to supply distribution and optional testing services 5. Implementation Readiness & Sustainability Planning	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

- Develop operational cost estimates and staffing assumptions
- Identify public health funding pathways and prevention grants
- Define monitoring metrics for preventive engagement and program performance
- Produce an implementation-ready pilot roadmap for North Slope Borough communities

Saige, Inc.	Substance Use & Crisis Pattern Analytics Framework – North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes improving access to care, strengthening community health outcomes, and advancing long-term sustainability in rural health systems. Across North Slope Borough’s eight remote communities, behavioral health crises—including substance use–related incidents—can generate repeated emergency encounters, medevac transport, and service strain. Limited structured visibility into recurrence patterns, service coordination gaps, and follow-up completion may reduce the ability to intervene earlier and stabilize care. This grant provides an opportunity to: • Analyze multi-year crisis-related service utilization patterns across emergency response, behavioral health services, and follow-up care • Identify recurrence trends and clustering patterns in crisis encounters • Evaluate coordination gaps between crisis response systems and behavioral health services • Assess variability in crisis demand across communities and service lines • Determine feasibility of a structured crisis pattern analytics and monitoring framework Saige proposes partnering with North Slope Borough stakeholders to conduct this structured planning effort and define an implementation-ready crisis monitoring framework supporting earlier intervention, improved service coordination, and more stable behavioral health service delivery.	Saige will lead a structured planning project focused on system-level utilization analytics, recurrence modeling, and executive integration — not clinical program redesign. Planning activities will include: 1. Crisis Utilization Analysis Multi-year review of crisis-related encounters across service systems Identification of repeat encounter patterns Analysis of utilization variability across service lines 2. Recurrence & Cohort Modeling Identification of high-recurrence cohorts Analysis of time-to-recurrence intervals Risk stratification modeling to identify elevated-risk patterns 3. Service Coordination Review Evaluation of follow-up completion after crisis encounters Identification of handoff gaps between services Assessment of documentation and reporting variability 4. Fiscal & Operational Impact Modeling Estimation of cost exposure associated with repeat crisis events Scenario modeling of improved continuity and early intervention monitoring Identification of monitoring thresholds for executive oversight 5. Implementation Roadmap Development Defined crisis pattern analytics framework Dashboard and monitoring blueprint KPI framework for leadership integration Phased implementation roadmap with cost estimates	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Telehealth & Service Delivery Readiness Modernization - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes improving access to care, strengthening workforce stability, and modernizing rural service delivery infrastructure across frontier communities. Within North Slope Borough Health Department programs, telehealth infrastructure exists across communities, yet functionality, connectivity reliability, staff training, and workflow integration remain inconsistent. Behavioral health clinicians, CHAP providers, and traveling clinical staff rely on digital systems to maintain continuity of care across dispersed villages. Current challenges include: • Inconsistent telehealth equipment functionality across clinics • Variable bandwidth reliability and connectivity limitations • Limited digital literacy training for clinical staff • Service continuity gaps during clinician travel rotations • Underutilization of telehealth capacity due to workflow misalignment Rather than focusing on specialty expansion, this project centers on strengthening the telehealth foundation supporting service delivery, clinician mobility, and continuity of care. This initiative provides an opportunity to: • Conduct a telehealth readiness and connectivity assessment • Inventory clinical technology and identify functionality gaps • Assess digital literacy and training needs for staff • Evaluate telehealth’s role in reducing CHAP and clinician travel strain • Design a telehealth optimization framework aligned with workforce stabilization	Saige will lead a structured project focused on readiness assessment, operational optimization, and telehealth integration design — not network expansion or specialty program redesign. Project activities will include: 1. Telehealth Infrastructure & Connectivity Assessment • Connectivity audit across all North Slope communities (bandwidth, uptime, reliability) • Inventory of BTC units and telehealth-capable equipment • Functional assessment of hardware, software, and workflow usability • Identification of technical and infrastructure gaps 2. Clinical Workflow & Digital Literacy Assessment • Mapping of telehealth integration within behavioral health, CHAP, and PHN workflows • Digital literacy assessment of clinical and administrative staff • Evaluation of training gaps and support requirements • Identification of workflow barriers limiting telehealth adoption 3. CHAP & Workforce Travel Optimization Analysis • Analysis of CHAP travel patterns and frequency • Assessment of opportunities to substitute telehealth for selected travel-based services • Modeling of service continuity gaps during clinician rotation cycles • Evaluation of telehealth as a stabilizer during high-demand or travel-constrained periods 4. Telehealth Optimization Framework Design • Defined telehealth utilization model aligned with service demand patterns • Threshold-based guidance for when telehealth should be deployed • Integration blueprint with existing EHR systems • Operational governance model for telehealth oversight 5. Implementation Roadmap Development • Prioritized infrastructure upgrades (if required) • Staff training and certification framework • Phased telehealth adoption roadmap • Cost estimates and integration requirements • KPI framework for executive oversight	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Weather-Adjusted Service Demand Forecasting Framework - North Slope Borough	NY	Alaska’s Rural Health Transformation Program prioritizes strengthening rural health system resilience, improving access stability, and advancing long-term fiscal sustainability. Across North Slope Borough’s eight remote Iñupiat communities, health services operate within an Arctic environment where weather conditions, seasonal travel limitations, and flight availability can significantly affect clinical access, workforce mobility, and emergency transport. Storm conditions, limited flight windows, and seasonal workforce rotations can delay patient travel, restrict clinician movement between communities, and increase emergency service demand. These environmental factors create predictable patterns of operational strain, yet they are rarely integrated into structured service demand forecasting. This grant provides an opportunity to: • Analyze multi-year service utilization patterns relative to seasonal variability • Evaluate correlations between environmental conditions and service demand • Identify service lines sensitive to seasonal travel disruption or access constraints • Assess variability in scheduling, emergency transport demand, and travel-dependent care • Determine feasibility of a weather-adjusted service demand forecasting framework Saige proposes partnering with North Slope Borough Health Department leadership to design an implementation-ready forecasting framework supporting improved resource planning and access stability in rural communities.	Saige will lead a structured project focused on utilization analysis, environmental correlation modeling, and forecasting framework design — not operational system replacement. Planning activities will include: 1. Historical Utilization & Seasonality Analysis • Multi-year review of service utilization by category • Identification of seasonal demand patterns • Analysis of acute events relative to time-of-year variability 2. Environmental Correlation Modeling • Evaluation of service utilization variability relative to environmental indicators • Identification of service lines sensitive to travel disruption or seasonal access variability • Analysis of emergency transport patterns relative to environmental cycles 3. Workforce & Capacity Alignment Review • Assessment of staffing variability relative to seasonal demand • Identification of scheduling inefficiencies linked to predictable variability • Modeling of capacity-demand mismatch scenarios 4. Fiscal Exposure & Volatility Modeling • Estimation of cost exposure associated with demand spikes • Scenario modeling of proactive resource allocation • Identification of forecasting thresholds for executive oversight 5. Implementation Roadmap Development • Defined weather-adjusted forecasting framework • Dashboard architecture blueprint • KPI framework for leadership integration • Phased implementation roadmap with cost estimates	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Workforce Capacity & Risk Dashboard - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes strengthening and stabilizing the rural health care workforce. In frontier communities, workforce sustainability depends not only on recruitment but also on long-term development of local talent pipelines. Structured visibility into trainee progression, credential milestones, placement outcomes, and retention patterns can improve long-term workforce planning and reduce reliance on external contract staffing. This grant provides an opportunity to: • Assess existing workforce development and training pathways serving North Slope Borough (NSB) • Map progression from education and certification through placement and retention • Identify drop-off points or credential bottlenecks • Evaluate alignment between training investments and service demand • Determine feasibility of a structured workforce pipeline monitoring framework Saige proposes to conduct this structured planning effort in collaboration with North Slope Borough stakeholders and define an implementation-ready workforce pipeline framework aligned with Strengthen Workforce objectives. This initiative is structured as part of a broader rural modernization planning framework and may inform future implementation phases.	Saige will lead a structured planning project focused on pipeline mapping, progression analysis, and sustainability modeling — not direct training program deployment. Planning activities will include: 1. Workforce Pipeline Mapping • Identification of local education, certification, and training programs • Documentation of progression stages (education → credential → placement → retention) • Mapping of workforce categories (clinical, EMS, behavioral health, support roles) 2. Attrition & Bottleneck Analysis • Identification of credentialing or placement drop-off points • Evaluation of time-to-placement and time-to-certification patterns • Analysis of workforce shortages by role 3. Demand Alignment Modeling • Comparison of projected service demand to projected workforce pipeline output • Scenario modeling of workforce gaps over 3–5 years • Evaluation of targeted training investments 4. Incentive & Retention Modeling • Assessment of current incentive structures • Modeling of retention impact scenarios • Evaluation of rural-specific workforce stabilization strategies 5. Implementation Roadmap Development • Defined workforce pipeline monitoring framework • Dashboard and reporting blueprint • Governance integration plan • Phased implementation roadmap with cost estimates	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Workforce Credentialing & Compliance Readiness Tracker - North Slope Borough	NY	Alaska’s Rural Health Transformation Program emphasizes workforce stabilization and rural system sustainability. In geographically remote systems such as NSB, lapses in CPR certification, licensure renewals, and required clinical trainings may disrupt service continuity and increase reliance on costly contract staffing. Manual tracking processes increase administrative burden and reduce proactive workforce planning. This project provides an opportunity to: • Standardize credential tracking across roles • Automate renewal reminders and compliance alerts • Reduce last-minute staffing disruptions • Improve workforce planning visibility • Strengthen audit readiness and regulatory compliance Saige proposes to partner with North Slope Borough to design and implement a Workforce Credentialing & Compliance Readiness Tracker aligned with Strengthen Workforce and Spark Technology & Innovation objectives.	Saige will lead a structured 6-month project focused on system configuration, integration design, and operational readiness. Activities will include: 1. Credential & Compliance Inventory • Role-based mapping of required certifications and renewal cycles • Documentation of current tracking practices • Identification of high-risk compliance gaps 2. Automated Monitoring & Alert Framework • Renewal reminder logic by credential type • Compliance risk scoring model • Dashboard design for leadership visibility 3. HR & System Integration Planning • Integration blueprint with HR systems and training records • Role-based access controls • Reporting alignment with regulatory requirements 4. Workforce Stability Modeling • Estimation of service disruption risk reduction • Analysis of contract staffing avoidance • Administrative efficiency modeling 5. Implementation Roadmap • Defined scope and cost estimate • Phased deployment plan • Training and adoption framework	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Youth Behavioral Health Digital Intervention Platform - North Slope Borough	NY	Alaska’s RHT program prioritizes improving access to care, strengthening rural health system sustainability, and advancing long-term community health outcomes. Across North Slope Borough’s remote communities, youth behavioral health services face structural challenges including geographic isolation, limited provider availability, and gaps in after-hours support. These factors can delay early engagement with counseling services and increase reliance on crisis intervention. Statewide resources such as the Alaska Care Line provide important support but primarily rely on voice-based communication. Research across adolescent behavioral health programs shows that young people are more likely to seek help through text or chat-based channels, lowering barriers to early engagement. This Planning Grant provides an opportunity to: • Assess youth behavioral health access and engagement patterns across North Slope communities • Evaluate feasibility of a text- and chat-based engagement channel connecting youth to trained counselors • Identify integration pathways with school-based mental health programs and Tribal behavioral health providers • Develop privacy, safety, and crisis escalation protocols for minors in rural communities Saige proposes partnering with North Slope Borough stakeholders to evaluate this model and define an implementation-ready approach that strengthens early intervention and improves access to culturally competent behavioral health support.	Saige will partner with North Slope Borough behavioral health services, the school district, Tribal health entities, and youth program leaders to evaluate a digitally supported youth behavioral health access model that complements existing services rather than replacing them. This Concept Formation effort will clarify service scope, provider roles, privacy considerations, and sustainability pathways prior to detailed implementation planning. Activities will include: 1. Behavioral Health Access & Gap Assessment • Map existing services, referral pathways, and crisis response processes • Identify unmet youth engagement needs and communication barriers • Document provider capacity and licensing constraints 2. Service Model Clarification • Define potential service models (navigation support, triage, short-term counseling, hybrid) • Outline supervision and escalation protocols • Define integration with school-based and Tribal health programs 3. Privacy, Safety & Governance Framework • Define minor consent and confidentiality protocols • Clarify data handling, documentation, and compliance responsibilities • Align with Tribal governance expectations 4. Budget, Sustainability & Workplan Structuring • Develop cost ranges and staffing assumptions • Identify reimbursement and non-reimbursement sustainability pathways • Produce a Defined Approach submission framework	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

Saige, Inc.	Youth Vulnerability Protection & Interagency Coordination Technology Feasibility Study	NY	North Slope Borough youth regularly transition between villages and urban service centers for healthcare, education, and social services. During these transitions, responsibility for youth safety may span multiple organizations including schools, behavioral health providers, child welfare agencies, and law enforcement. Coordination across these systems can be difficult due to geographic isolation, jurisdictional complexity, and limited shared visibility into early indicators of youth vulnerability. While North Slope Borough agencies actively work to protect youth, there is currently no structured framework to analyze vulnerability patterns, evaluate coordination gaps, or determine whether privacy-respecting technology tools could strengthen early protective response. This grant provides an opportunity to: Assess patterns of youth vulnerability across North Slope communities Evaluate existing protective services, reporting mechanisms, and coordination workflows Identify gaps in interagency communication between schools, behavioral health services, child welfare, and law enforcement Research models for early identification and protective coordination used in other rural or Indigenous communities Explore whether technology-enabled coordination tools could improve protective response while respecting privacy, Indigenous governance, and community trust This feasibility effort focuses on coordination and prevention, not surveillance or enforcement.	Saige will lead a structured Feasibility and Planning Phase in collaboration with North Slope Borough Health & Social Services, the school district, law enforcement, Tribal organizations, and behavioral health providers. Given the sensitivity of youth protection initiatives, the planning phase prioritizes research, stakeholder engagement, and ethical governance development. 1. Youth Vulnerability & Risk Landscape Assessment Review available data on youth vulnerability indicators, behavioral health risk factors, and protective service utilization Analyze patterns associated with youth travel, service transitions, and school or behavioral health referrals Conduct stakeholder interviews with child welfare professionals, school counselors, law enforcement, Tribal leaders, and behavioral health providers Review protective coordination programs deployed in comparable rural and Indigenous communities 2. Protective Services Coordination Audit Inventory current youth protection services and mandatory reporting workflows Identify coordination gaps between borough agencies, state services, Tribal authorities, and community organizations Review existing hotlines, reporting tools, and crisis response pathways Document jurisdictional responsibilities across agencies 3. Technology & Early Identification Model Research Evaluate technology-enabled models used to support youth protection and coordinated response Assess privacy-preserving approaches such as anonymized indicator monitoring rather than individual tracking Review programs from national child protection organizations and rural service networks Identify approaches that balance effectiveness with community trust and cultural appropriateness 4. Ethical & Cultural Governance Framework Facilitate community engagement on acceptable boundaries for youth protection tools	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	North Slope Borough	Deferred or Not Advanced

- Establish ethical guidelines balancing safety, privacy, and autonomy
- Integrate Indigenous governance principles into data and decision-making protocols
- Conduct legal analysis of jurisdictional requirements and data sharing constraints
- 5. Feasibility Determination & Implementation Roadmap
 - Evaluate whether technology solutions can meaningfully improve coordination and youth protection outcomes
 - Develop conceptual models and policy frameworks if feasibility is confirmed
 - Identify staffing, governance, and operational requirements
 - Recommend whether to pursue a future grant or alternative policy approaches

SALA LLC	Mobile Healthcare for Rural & Vulnerable Alaskans, Elders, Post Hospital & Preventive Care	AK	Rural, remote, and frontier communities in Alaska face significant healthcare access gaps, particularly among vulnerable populations, homebound elders, individuals experiencing homelessness, and patients recently discharged from hospitals. Many Alaskans outside of Anchorage or larger hub communities lack proximity to primary care providers, specialty services, and preventive health programs. Long travel distances, extreme weather, transportation barriers, and limited local healthcare infrastructure contribute to delayed care, unmanaged chronic conditions, and avoidable emergency department utilization. Homebound elders often struggle to attend clinic appointments due to mobility limitations, resulting in medication mismanagement, untreated conditions, and increased risk of hospitalization. Similarly, patients discharged from hospitals frequently lack structured follow-up care in rural areas, leading to gaps in continuity and higher readmission rates. Vulnerable populations, including those experiencing housing instability, face additional barriers to consistent preventive and chronic care. This will enable access to Mobile Integrated Healthcare (MIH) style programs, many rural regions do not have mobile primary and preventive care services. This project addresses these disparities by expanding mobile healthcare delivery into underserved communities, creating a reliable system of in-home and community-based care where traditional clinic access is limited or unavailable.	The proposed approach is to expand a proven Mobile Integrated Healthcare (MIH) model into rural and frontier communities through Mobile Healthcare Services. This model brings preventive, transitional, and primary care directly to individuals who face barriers accessing traditional clinic-based services. A mobile clinical team, may including a Physician Assistant, or Physician, Paramedic and Mental Health Clinician will provide care in homes, shelters, community settings, and other locations where patients reside. Services will focus on hospital discharge follow-up, chronic disease management, preventive screenings, wound care, infectious disease testing and treatment, medication management, and coordination with existing healthcare providers. Delivering care in community settings removes barriers related to transportation, education, prescription pickups, mobility limitations, distance to clinics, and weather conditions that frequently prevent rural residents from receiving timely care. This approach builds upon SALA’s Mobile Integrated Healthcare program, which has already demonstrated measurable success in improving patient outcomes. An independent analysis conducted by Evergreen Economics found that patients served through the SALA’s MIH program were 85 percent less likely to be readmitted to a hospital or emergency department compared with similar Medicaid, Medicare patients. In addition, patients receiving MIH services remained out of the hospital more than four months longer on average than the comparison group due to the holistic care provided. The mobile care team will collaborate with hospitals, primary care providers, and community partners to ensure continuity of care following hospital discharge and to support individuals who are at risk of falling through gaps in the healthcare system. Special focus will be given to vulnerable populations including homebound elders, individuals experiencing homelessness, and residents of rural communities with limited access to preventive and primary care services. By expanding this proven model into rural Alaska, Mobile Healthcare Services strengthens access to care, improves care coordination, and provides a scalable approach to delivering healthcare services in communities where traditional clinic access is limited or unavailable.	\$1M-\$5M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough	Advance to Implementation Application

Sanderling Renal Services, Inc.	Providing Nephrology and Dialysis Services to Rural Communities	TN	Approximately 1500 individual are receiving dialysis in Alaska. People living in rural areas have very limited access to dialysis. Without dialysis these patient with severe kidney failure (End Stage Kidney Disease) will die in weeks or months. In addition to the individuals on dialysis the epidemiologic data implies there are more than 5,000 patients with advanced kidney disease who would benefit from the expertise of a board certified nephrologist. Another 5,000 individuals probably suffer from advanced heart disease, and many of those patients also have renal disease which, if treated, can relieve some of the issues caused by the heart failure. It is this population of patients with serious chronic illness, that Sanderling aims to serve, both with dialysis, and the expertise of board certified nephrologists and specialized nephrology Registered Nurses.	Sanderling will identify existing healthcare providers in each target community. This would most likely be the local hospital or an outpatient clinic. Members of the community will be invited to receive training to become a Certified Clinical Hemodialysis Technician. This group of individuals will be trained by Sanderling through a combination of televised classroom training, and on-site practical training by a Sanderling staff member. The workforce created through this training will become the on-site personnel to set up dialysis machines in the hospital and/or patients' homes. Sanderling, through this grant, will procure, install, and commission telemedicine equipment and portable dialysis machines in hospitals, clinics, and patients' homes. Quality assurance will be provided through Sanderling's proprietary Electronic Medical Record, and will be overseen a medical director assigned to this program.	\$1M-\$5M	Home- and communit y-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Sauna Valdez LLC	Community Wellness Center in Valdez - Sauna & Contrast Therapy	AK	Valdez, Alaska is a small, isolated community of 4,000 residents facing significant public health challenges. Substance abuse and suicide have ranked as the community's top two health concerns for over ten years. Like many rural Alaskan towns, Valdez lacks welcoming, sober social infrastructure — the only communal gathering spaces are churches and bars. Seasonal Affective Disorder compounds these challenges, with long, dark winters deepening isolation, depression, and anxiety for residents of all ages. There is currently no public sauna or yoga studio in Valdez, which would be near ideal community gathering spaces. This gap represents both a pressing problem and a clear opportunity.	Sauna and contrast therapy are among the most accessible, evidence-backed forms of preventive care available — and a community sauna is uniquely positioned to address physical, mental, and social health simultaneously. Providing a healthy, sober third space where residents can gather, recover, and build welcoming community resilience. Sauna Valdez is expanding into a permanent community wellness facility through a phased approach. Phase 1 — a new sauna structure with a commercial cold plunge — is already under construction, completing June 1, 2026. The cold plunge is our critical remaining need, as contrast therapy amplifies sauna's well-documented benefits: improved cardiovascular health, reduced dementia risk, stronger immunity, better sleep, and elevated mood during Alaska's dark winters. Rooted in both Nordic tradition and Alaska Native sweat lodge culture, sauna has always been a community and family practice. We are building on that foundation with family-friendly programming, affordable membership pricing, and streamlined operations that keep access equitable. Phase 2 adds a bathhouse and yoga studio, targeting Fall 2027 — creating a comprehensive wellness resource Valdez has never had and urgently needs.	\$50,000-\$250,000	Single Community	Chugach Census Area	Deferred or Not Advanced

Scene Health	Expanding Video DOT to Improve Medication Adherence in Rural Alaska	MD	The cost of managing chronic conditions, infectious diseases, and substance use disorders continues to rise across the United States, placing increasing strain on health systems and public health resources. These challenges are amplified in Alaska, where patients in rural, remote, and frontier communities face significant barriers to consistent care, including geographic isolation, limited transportation infrastructure, workforce shortages, and intermittent connectivity. For patients who require ongoing medication adherence monitoring, traditional in-person approaches can be difficult to sustain and costly for both patients and providers. The Alaska Department of Health has already implemented video Directly Observed Therapy (vDOT) using the Scene Health platform to support tuberculosis treatment. This project represents an opportunity to expand that proven model to additional conditions that require reliable medication adherence and patient support, including other infectious diseases and opioid use disorder. By expanding access to vDOT, Alaska can improve continuity of care for patients in rural, remote, frontier, and native communities while reducing travel burdens and enabling care teams to support more patients efficiently. Building on an existing program allows the state to rapidly scale a digital care model that improves treatment support while helping control the long-term cost of care.	Scene Health proposes to expand healthcare access and improve treatment adherence for Alaskan populations living in rural, remote, frontier, and Alaska Native communities through its clinically validated, CDC-endorsed vDOT platform. Scene’s vDOT enables patients to record secure, asynchronous videos of themselves taking prescribed medications using a mobile device. These videos are reviewed by a care team that provides daily adherence monitoring, patient support, and timely intervention when doses are missed or potential issues arise. This model enables consistent medication monitoring without requiring frequent in-person visits. The approach directly addresses barriers common in rural Alaska, including limited provider availability, long travel distances, workforce shortages, and intermittent connectivity. Because the platform is designed to function in low-bandwidth environments and supports asynchronous video submission, patients can participate even in communities with limited internet access. The platform is patient-centered and designed to support diverse populations. It offers multilingual capabilities, user-friendly onboarding, and ongoing technical support to ensure equitable access for patients across different communities and levels of digital familiarity. Providers receive real-time adherence data and alerts, improving care coordination and enabling earlier intervention when adherence risks are identified. To further improve accessibility for Alaska Native and other underserved populations, the platform can incorporate additional language support and culturally appropriate patient engagement tools. Expanding language capabilities will help ensure patients can receive instructions, reminders, and support in languages that are most familiar to them, improving understanding, trust, and sustained engagement with treatment programs. Published research has demonstrated that Scene’s vDOT programs improve medication adherence, enhance clinical outcomes, and reduce healthcare costs across chronic and infectious conditions including diabetes, hypertension, substance use disorder, asthma, tuberculosis, and hepatitis C. Expanding vDOT in Alaska will extend care beyond traditional clinical settings, strengthen workforce capacity, and create a more sustainable model for delivering care to geographically dispersed populations. Scene’s clinical validation can be viewed here: https://www.scene.health/clinical-validation	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Scholars in Medicine, LLC	Scholars in Medicine's Health Initiative Strengthening Alaska's Rural Healthcare Workforce	HI	Scholars in Medicine will deliver accredited medical education tailored to Alaska’s rural healthcare workforce, including approximately 1,152 physicians and 1,125 nurse practitioners, physician assistants, and nurses. The program will produce 20 accredited, on-demand webinars for clinicians practicing in geographically isolated settings where access to specialty consultation and continuing education is limited. The curriculum will focus on diseases most commonly associated with hospitalization in rural Alaska to ensure training is practical and relevant to daily clinical practice. Topics will include maternal and newborn care, infectious diseases, cardiovascular disease, behavioral health and substance use disorders, respiratory disease, and digestive and metabolic conditions such as appendicitis, gastrointestinal disease, and diabetes complications. Additional content will address injury and trauma, delayed-treatment infections, and pediatric respiratory illness. Each webinar will feature experienced physicians with expertise in specialty disease states, emphasize case-based learning relevant to resource-limited settings. Programs will be available on demand, allowing clinicians to access education without leaving their communities while strengthening knowledge, clinical confidence, and the quality of care delivered in rural Alaska. Networking and clinical discussion opportunities will be available with live question and answer sessions following each webinar.	Scholars in Medicine’s (SiM) Rural Health Initiative Team will implement a targeted awareness and engagement campaign to ensure Alaska’s rural healthcare workforce becomes familiar with the SiM platform and can rapidly access its full educational benefits. Outreach will include print and digital communications, as well as direct phone contact, to introduce the platform, highlight its value, and assist clinicians in developing user profiles that tailor learning to the specific needs of the patient populations they serve. Through this effort, SiM will establish an online rural health community that connects frontline clinicians with specialty experts through best-practice–driven discussions, disease-state guideline–based case reviews, and access to specialist insight. By supporting an informed and connected workforce, the initiative will encourage adoption of advanced treatments and current clinical guidelines, strengthen clinical decision-making, and ultimately improve care delivery and patient outcomes in Alaska’s rural and remote communities. SiM will also conduct regular user surveys and ongoing platform optimization to ensure information is easy to locate, actionable, and quickly digestible, enabling clinicians to efficiently access relevant guidance during patient visits.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Sealaska Heritage Institute	From Village to Vital Care: Community-Centered Rural Health Pathways for Southeast Alaska	AK	Despite expanded medical infrastructure (Sitka, Juneau, Wrangell, Haines, etc.), and a forecasted 1,100 new healthcare jobs statewide in 2026 alone (Alaska Dept. of Labor Trends Jan. 2026), Southeast Alaska continues to rely heavily on a nonresident medical workforce. Southeast Alaska’s Health Care and Social Assistance workforce is 17.1% nonresident (Alaska Department of Labor, Nonresidents Working in Alaska 2026). While Southeast enjoys relatively modern medical infrastructure, urban hubs, and consistent broadband connectivity, local workforce development remains insufficient. Additionally, the region leads the state's “silver tsunami” – with more than 1 in 4 Southeast Alaska residents being 60+. In Juneau, residents age 65+ grew by 21% between 2020 and 2024 (Juneau Economic Development Council 2024). There is projected to be significant additional need for healthcare and medical access within the region due to its aging population. SHI brings 44+ years of experience operating educational programs and creating opportunity for Southeast Alaska youth, with its successful postsecondary planning programs currently serving all graduating seniors in 37 high schools located within 15 Southeast Alaska’s school districts. In addition to providing support for traditional postsecondary medical pathways, SHI proposes creating new medical pathways for the region’s high school and college aged youth through work study, internships, and mentor-apprenticeships.	In 2024, SHI served 60,777+ individuals in 121 communities, and SHI currently provides postsecondary planning to all graduating seniors in 37 high schools located within 15 of 16 Southeast school districts. Building upon SHI’s successful CTE consortium of 37 high schools and the Our Strength postsecondary planning/workforce development curriculum, SHI will include health exploration units, as well as annually evaluate educational needs with communities for healthcare educational and workforce opportunities. SHI will add additional capacity through traveling career counselors to support the region and provide youth with medical opportunities including mentorships, work study, internships, dual enrollment, and postsecondary pathways or apprenticeships to medical certification, and institute 10 HOSA – Future Health Professional clubs within Southeast schools. College age youth would have access to expanded internships within the medical field coupled with a cohort and dedicated guidance to ensure successful completion of their internship. Internships, work study, and apprenticeships will provide youth opportunities to advance into unsubsidized jobs within the healthcare workforce. Additionally, SHI is an official Registered Apprenticeship Program sponsor with the US Department of Labor and can add apprenticeships within the medical industry upon demand for additional pathways to medical certification outside of traditional postsecondary approaches. Participants may pursue and receive college credit towards medical certification. The proposed project expands upon existing work taking place within Southeast Alaska in partnership with 15 school districts, and community partners including SEARHC, Bartlett, PeaceHealth, Healing Hands Foundation, Goldbelt Heritage Foundation, and the University of Alaska. SHI’s experience in recruiting and supporting youth participants will be critical to Southeast Alaska’s success within the Rural Health Transformation Program. Utilizing SHI’s Council of Traditional Scholars and Southeast Education Committee, SHI will ensure that its RHTP project is community and community-engaged and successful for Southeast Alaska. The Council of Traditional Scholars is an advisory panel of Southeast Alaska clan leaders and elders knowledgeable in traditional customs and SHI’s Southeast Education Committee is composed of Southeast Alaska teachers who provide input and direction in SHI educational programs.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Sealaska Heritage Institute	On the Land: Promoting Wild Food Harvest and Use in Southeast Alaska	AK	The Indigenous peoples of Southeast Alaska have long relied on wild foods as their primary source of nutrition. However, over the past century, the proportion of unhealthy processed foods has increased dramatically. Helen Drury noted this alarming trend in 1985, building off research dating back to 1933 that documented decreased dental health apparently resulting from increased consumption of non-Native foods (Price 1939). This ongoing trend is concerning because traditional diets are known to produce far lower rates of diseases associated with modern Western diets (Caprara 2018). The National Rifle Association has also documented declines in both hunting and public support of legal hunting, making the knowledge of how to hunt inaccessible to many. Medical anthropologists draw strong correlations between health and cultural consonance – an individual’s ability to live out a culturally meaningful life (Dressler 2012). Dr. Lisa Wexler has worked with Alaska communities on mental health promotion since 2000 and found suicide among Native people to be rare prior to the 1960s. But by the 1960s, Alaska’s Indigenous people had been forced into sedentary villages, altering lifeways and social structures; youth were “no longer an integral part of their family’s survival” (Woodward 2012). For Alaska Native people, Indigenous intellectual traditions, including cultural teachings and practices, are the heart of individual, family, and community wellness (Allen, Wexler, & Rasmus 2021).	Nutrient-dense wild foods and the physical exercise required to harvest in rugged environments nourish the minds and bodies of rural Alaskans. However, much subsistence knowledge is being lost today. To combat this trend and revitalize wild food use, SHI is actively piloting educational subsistence programs to restore traditional practices (e.g., mountain goat hunting, butchering, fish processing, and sharing wild foods). These programs are celebrated across Southeast Alaska for getting communities back out on the land; this project builds on those SHI programs and partnerships to ensure the momentum of wild food revitalization continues to grow. SHI’s On the Land app will gather real-time data on contemporary harvest activities, promote healthy lifestyles characterized by physical activity on the land, and encourage consumption of wild foods from the land; it will provide an accessible digital space for sharing harvest techniques and recipes, building community, and “virtually honoring” (e.g., badges, tiers, levels) the use of wild foods. SHI will also collect baseline and longitudinal harvest data through the app to assess and continue to develop the impact of the On the Land app. The Baby Raven Reads On the Land book series will encourage families to prioritize pediatric care, early literacy, and harvesting and consuming wild foods. Through vertically aligning its K-5 English language arts curricula and curricular resources (e.g., Raven Writes; Voices on the Land; TCLL) with On the Land goals, SHI will engage educators and provide school districts with culturally responsive English language arts curricula that will inspire young minds to seek nutritious foods and healthy futures. SHI and youth (grades 6-12) in its STEAM programs will probe factor in disease/preventative care and create a film to document the return and health impacts of wild food traditions in Southeast Alaska, focusing on mountain goat hunting and fueled by inquiry-driven topics developed by youth. The film will involve, educate, and inspire more young hunters and local mentors to get involved, and SHI will support them to hunt safely: hunter education classes, instruction on harvest regulations and identifying suitable harvest locations, wilderness first aid certification, and firearms safety training and equipment. Combined, SHI’s On the Land approach will provide residents of Southeast Alaska with the tools and inspiration they need to get healthy and back out on the land.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Seattle Children's Alaska Track Pediatric Residency	Pediatric Workforce Development in Alaska	WA	Our project aims to increase the pediatric physician workforce in Alaska. We continue to face challenges with recruitment and retention of pediatricians to Alaska. While our program has helped fill some gaps over the past 11 years, we continue to have workforce needs across the state, especially in our rural communities. Pediatricians can provide not only improved access to care for children, and especially children with complex medical needs, but also support family practice physicians and advanced practice providers (PA/NPs). In these ways, pediatricians in rural communities have have a large impact working in both direct primary care as well as as a specialist consultant for general practice physicians.	Through the support of RHTP funding, we aim to: 1. Expand services in the Mat-Su region through a new partnership with Ptarmigan Pediatrics, a well established private practice primary care pediatric clinic. We will place 6 Seattle Children's pediatric residents per year at Ptarmigan Pediatrics. Each pediatric residents will rotate 2 months per year providing direct patient care at nearly 1.0 FTE. 2. Provide faculty training and professional development at our new site. We have longstanding partnerships with the University of Washington and Seattle Children's Hospital. We will bring speakers and tenured faculty to help train and develop our new faculty members at a faculty development day. 3. Increase the number of pediatric subspecialty care by providing support for pediatric fellows to rotate in Alaska. This support includes salary and benefits, travel and housing and licensure fees during their 1 month rotation in Alaska. Fellows from needed specialties such as Pediatric Neurology, Rheumatology, Nephrology, Critical Care, Hospital Medicine, Development will spend time rotating in Alaska. This exposure will help with post-fellowship recruitment plans. 4. A recommended initial State PRA of \$163,000 per resident per year has been identified through statewide review and AK GME Council consensus. We have 4.0 resident FTE per year to support. What have the infrastructure and program staff including physician associate program directors and program coordinator based in Alaska. We just need funding.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Matanuska-Susitna Borough	Advance to Implementation Application

SeaView Community Services	Stabilizing Behavioral Health Access and Workforce Capacity in the Eastern Kenai Peninsula	AK	SeaView Community Services is the primary behavioral health provider serving Seward and surrounding communities in the Eastern Kenai Peninsula. The organization provides crisis services, outpatient treatment, residential care, and transitional housing for individuals experiencing mental health and substance use disorders. However, maintaining reliable access to these services is increasingly difficult due to workforce instability, housing shortages, and aging infrastructure common across rural Alaska. Recruiting providers to Seward is particularly challenging because limited rental housing forces many providers into temporary or high-cost rental arrangements. These conditions contribute directly to staff turnover and make long-term workforce retention difficult. Each vacancy disrupts service delivery, increases wait times, and places additional strain on remaining staff in a rural community with few alternative behavioral health providers. In addition to workforce challenges, several components of SeaView’s service infrastructure require modernization. Aging facility systems and outdated technology increase the risk of operational disruptions that could interrupt behavioral health services. These targeted investments will allow SeaView to reduce workforce vacancies, maintain consistent staffing, and ensure reliable behavioral health services for residents of the Eastern Kenai Peninsula.	SeaView will implement a coordinated set of workforce, housing, infrastructure, and technology investments designed to maintain reliable behavioral health services in the Eastern Kenai Peninsula. First, the project will strengthen workforce recruitment and retention. SeaView will implement retention incentives for staff who commit to remaining with the organization for 12–24 months and recruitment incentives for hard-to-fill behavioral health positions. A Workforce Retention and Development Manager will coordinate retention efforts, manage workforce housing placement, oversee professional development initiatives, and support staff training and career advancement. Second, the project will address one of the most significant barriers to rural workforce stability by acquiring dedicated workforce housing to recruit and retain behavioral health clinicians. Limited housing availability in Seward often forces clinicians into temporary or high-cost rental housing, contributing to turnover. Workforce housing will provide stable living arrangements for essential staff and reduce reliance on expensive leased housing currently used for recruitment. Third, SeaView will complete targeted facility improvements necessary to maintain access to care. The aging elevator serving the primary outpatient clinic will be replaced to ensure continued ADA-accessible access for elders, individuals with mobility limitations, and clients seeking behavioral health services. Fourth, SeaView will modernize technology systems to improve operational reliability and reduce administrative burden. This includes migrating aging server infrastructure to a secure cloud environment, implementing AI-supported documentation tools, and expanding telebehavioral health services to reach individuals who face transportation or geographic barriers. Finally, SeaView will expand professional development opportunities for staff, including continuing education, licensure support, and leadership development initiatives that strengthen long-term workforce capacity. These efforts will focus on building internal career pathways that support direct care staff in advancing into behavioral health clinician roles. The Workforce Retention and Development Manager will coordinate these initiatives, track participation and outcomes, and align training opportunities with workforce needs identified through recruitment and retention trends.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

See Stories	Culture & Care: Youth Filmmaking for Mental Health Awareness	AK	Culturally responsive healthcare and community wellbeing are pillars of health, especially in Rural Alaska, where factors like historical trauma inform staggering mental health statistics in local communities (Allen et al., 2025). Despite heartbreaking statistics depicting mental health metrics in rural Alaska, these communities tend to be left out of health data analysis and healthcare access due to small population sizes (Ndugga et al., 2025). Mental health care can be hard to access. There is a stigma against acknowledging and getting support for mental health related issues (Alaska Mental Health Trust Authority, 2023). In addition to mental health challenges in rural Alaska, there is an educational need for broader offerings that contribute to comprehensive health education in Alaskan school districts. Alaskan school districts are encouraged under Alaska Statute §14.30.360 to offer comprehensive health education that addresses topics such as substance abuse, personal safety, family health and disease prevention. Our proposed “Culture & Care” project will utilize See Stories’ strong relationships and culturally responsive approach in rural Southeast Alaska to tackle the above-mentioned problems: 1) the stigma around seeking support for mental health related problems, 2) the lack of education about how to seek support for mental health related problems 3) the lack of appropriate, standards aligned curriculum for health education throughout Alaska.	Our overall vision for this 5 year project is to engage local youth storytellers through digital media production to create culturally-grounded films about health and wellness, and to utilize these films for a region wide (and beyond) education and engagement campaign. To achieve this in year one, See Stories will use this planning grant to expand on our current relationships and build new partnerships with Community Health Aides throughout Southeast Alaska. We have a cadre of trained youth filmmakers as well as ongoing partnerships with the schools, Tribal Councils, Native Corporations, Alaska Youth Stewards, and other local partners in Angoon, Kake, Yakutat, Wrangell and Juneau. This upcoming year we would expand those relationships to include Community Health Aides. The Community Health Aide program is unique to Alaska, and is designed to help foster individual, community and family well-being. By building these new partnerships with Community Health Aides, See Stories will both plan and pilot our vision to engage youth filmmakers in sharing vital mental health films (or “PSAs”) for the communities where they live and beyond. In years 2 - 5 of this project we would scale up and roll out our work, disseminating mental health messaging through social media, radio, broadcast TV, at health clinics themselves, and community screenings and conversations, with the goal that at least half the people living in Southeast Alaska would engage with these mental health based films and messages so that community members 1) know how and where to receive mental health services, 2) destigmatize mental health related issues, and 3) support people to connect to culturally relevant activities that support positive mental health outcomes. In addition, we would integrate these student produced films into our “teacher tools” web-platform and virtual teacher professional development class for educators state-wide. To see a sample student produced film that documents and promotes positive mental health outcomes, watch Angel Jack’s "Healing Through Time" (https://seestories.org/videos/healing-through-time/). Angel explores the 1882 Angoon Bombardment and the U.S. Navy’s apology. Through community and virtual screenings, her film supports healing from historical trauma. It demonstrates how storytelling can address wellbeing and how broader social and cultural factors also contribute to community wellbeing.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Seldovia Village Tribe	Seldovia Village Tribe: Upgrades to Improve Health Access (UIHA)	AK	SVT seeks to enhance access to high-quality, coordinated healthcare in rural communities where workforce shortages, aging telecommunications infrastructure, and administrative burdens can impede timely service delivery. Communities in the Homer service region often face limited provider availability, long travel distances to specialty care, and operational challenges associated with small rural health systems. The UIHA initiative addresses these barriers by modernizing telehealth systems, improving clinical communications, introducing secure AI-assisted clinical documentation tools, strengthening workforce retention strategies, and streamlining patient intake workflows.	The UIHA initiative is designed as a multi-component rural health modernization strategy addressing both clinical infrastructure and workforce sustainability. Telehealth & Communication Infrastructure Modernization • Upgrade telecommunications infrastructure to a unified Mitel communication system • Transition from legacy PRI phone lines to scalable SIP trunking • Integrate Mitel systems with Zoom for high-definition telehealth visits • Improve provider communication reliability between Homer, Seldovia, and Anchor Point • Provide staff training to ensure adoption and effective utilization Tribal AI Sovereign Cloud Infrastructure • Deployment of a locally hosted Tribal LLM Sovereign Cloud supporting 100+ staff • High-concurrency AI assistance for clinical and administrative workflows • Clinical transcription and long-context summarization of telehealth encounters • Retrieval-Augmented Generation (RAG) knowledge base allowing staff to query HR policies and clinical protocols • HIPAA-compliant automation of prior authorizations and referral letters Digital Patient Intake Kiosks • Deployment of self-service patient check-in kiosks across Homer, Seldovia, and Anchor Point • Integration with eClinicalWorks for demographic updates, consent forms, and insurance verification • Point-of-service payment processing through secure payment integration • Reduced front desk workload and improved data accuracy Workforce Stabilization Strategy • Participation in salary benchmarking surveys to develop competitive compensation structures • Expanded employee wellness reimbursement to support retention • Professional certification and training opportunities for staff • Potential buyout of a locum provider to transition to permanent staffing	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Senior Citizens of Kodiak Inc	Improve home & community based care access with SCOK facility improvements and educational outreach	AK	Since a new census was taken in 2023, we have found a continued increase in the Kodiak Island senior population (60 and older). According to GetCare Data, an increase has also been found for those 80 and older, and those at poverty level. SCOK has consistently identified seniors within these categories who require home and community-based care by doing outreach in the community as well as collaborating with the agency's many partnering agencies, but collectively, we are still not reaching all those who require support to remain aging in place. We hope to improve access to home and community-based care by addressing the following opportunities: - Targeted facility improvements for SCOK's aging and outdated infrastructure - Improvements to SCOK's IT system and broadband connectivity issues - Development and Implementation of educational outreach programs for Kodiak Senior population By addressing these opportunities, we will be able to improve access to community-based services, promote aging in place and reduce institutionalization for our Kodiak senior population.	Our goal is to promote aging in place and reduce institutionalization by improving access to home and community-based care for seniors 60 and older in Kodiak, Alaska. To do so, we will use funding to address the following opportunities utilizing the approaches outlined below: • Targeted Facility improvement for SCOK's aging and outdated infrastructure: SCOK was established in 1973 and moved into our current building in 1985. Our Island Cove Adult Day Program, the only adult day program in the state of Alaska open 7 days a week, was started in 1991 in a community room across the street. In 1996, the Kodiak Senior Center was remodeled, and Island Cove was moved to the lower portion of the building, previously a workshop with power tools. It has been 20 years since a major renovation, and our facilities are aging and require modernization. Facility and furniture upgrades would improve access, safety, efficiency of our programs and increase the availability of safe, person-centered care close to home. • Improve IT system and broadband connectivity: SCOK experiences poor broadband connectivity, and limited data-sharing capacity, which hampers access and care coordination. Funding would be used to improve IT software, hardware and equipment upgrades at the Kodiak Senior Center, improving operability of our systems, and increasing efficiency of care coordination. • Develop and implement collaborative approach to educational and healthy living programs for Kodiak Senior population: SCOK has funding through the State of Alaska and a variety of other sources for our home and community-based services that promote aging in the place, thus reducing institutionalization. However, we do not have funding specifically to support educational programs and offerings at the Kodiak Senior Center, instead we rely heavily on volunteers as they are available. Funding would be used to develop programming that would support seniors in their effort to remain living healthy and independent in the home and community of their choice. A collaborative approach with our partners would assist us to offer programs would include but not be limited to education on fall prevention, specialized nutrition support, healthy living & wellness, as well as offer therapeutic and social engagement opportunities to improve well-being and delay intensive care needs.	\$50,000-\$250,000	Home- and community-based services provider	Single Community	Kodiak Island Borough	Advance to Implementation Application

SERRC - Alaska's Educational Resource Center	Building Southeast Alaska's Behavioral Health Workforce Pipeline	AK	Pursuing behavioral health credentials in Southeast Alaska often requires significant financial and logistical sacrifice. For residents of rural communities, tuition is only one barrier; the costs of travel, lodging, and lost wages during training can make participation impossible. As a result, many qualified local residents are unable to pursue behavioral health careers. Due to the lack of a strong local training pipeline, regional healthcare providers frequently recruit behavioral health staff from outside the region, contributing to workforce instability and turnover. According to the Alaska Department of Labor and Workforce Development Occupational Projections (2022–2032), Alaska has behavioral health vacancy rates of approximately 9–12% and expects industry growth of up to 12% by 2032. These vacancies, combined with growing demand, make it difficult for providers to maintain consistent services. This project addresses these challenges by creating a homegrown behavioral health workforce pathway for Southeast Alaska residents. The program will support training at two levels: entry-level Counselor Technicians (CT), enabling residents to quickly enter the behavioral health workforce, and Chemical Dependency Counselors I (CDC I), allowing current behavioral health staff to advance their credentials and expand substance use treatment services. By covering tuition, travel, lodging, and stipends, the project removes financial barriers and helps build a stable local workforce.	This project removes the financial and logistical barriers that prevent Southeast Alaska residents from pursuing behavioral health training. For many rural residents, the challenge is not only the cost of tuition but also the travel, lodging, and lost income required to attend training. This project addresses those barriers by providing comprehensive support so that qualified local residents can participate in credentialing programs. Funding will support the full cost of participation for trainees, including: Education Costs: Coverage of tuition, books, and certification fees for Counselor Technician (CT) and Chemical Dependency Counselor I (CDC I) training programs. Travel and Lodging: Transportation and lodging for participants traveling from rural communities to training locations in Juneau or Anchorage. Participant Stipends: Work stipends and childcare assistance to offset lost wages and allow participants to focus on completing their training. The program will support training at two levels to build a clear career pathway within the behavioral health workforce: -Entry-Level Training – Counselor Technician (CT): This track prepares new entrants to join the behavioral health workforce quickly in roles such as behavioral health assistants or support staff. The project will support approximately 10 trainees per cohort per year in the CT training track. -Credential Advancement – Chemical Dependency Counselor I (CDC I): This track supports current behavioral health workers who are seeking to expand their credentials and provide substance use treatment services. The project will support approximately 6 trainees per cohort per year pursuing CDC I certification. Training will be delivered through Waypoint Continuing Education, Inc., which offers state-recognized behavioral health certification programs. SERRC will coordinate recruitment, participant support, and partnerships with regional healthcare employers to connect trainees with job opportunities following certification.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

SERRC - Alaska's Educational Resource Center	Rural Health Career Pathways for Alaska Students	AK	Alaska faces persistent healthcare workforce shortages, particularly in rural communities where recruiting and retaining providers can be difficult. For example, Alaska is projected to have the highest vacancy rate in the country, with an estimated 22.7% of nursing positions unfilled. At the same time, many rural students have limited exposure to healthcare careers or opportunities to earn early certifications that could lead to employment in the medical field. Providing healthcare and behavioral health education in rural schools addresses both challenges. In the short term, students gain practical skills such as CPR, First Aid, and Mental Health First Aid that can help them respond to emergencies in their homes and communities. In the long term, early exposure to healthcare careers can encourage more students to pursue training and employment in the healthcare field, strengthening Alaska’s local workforce and reducing reliance on out-of-state providers. An additional opportunity relates to proposed legislation in the Alaska Legislature that would require schools to provide CPR instruction to students. This bill has passed the Senate. If enacted, rural districts will likely lack the certified instructors or resources to meet the requirement. SERRC could support schools by providing certified instructors and training programs to help districts implement CPR instruction.	This project will build on SERRC’s Southeast Alaska Area Health Education Center (AHEC) programming by establishing a Health Education Coordinator who will travel to rural communities across Southeast Alaska to deliver healthcare education and workforce training. SERRC already works closely with school districts throughout the region. Leveraging these relationships, the coordinator will schedule visits with rural schools to provide hands-on healthcare training, certification opportunities, and career exposure for students. Programming will be delivered on site in rural schools by SERRC staff who are certified instructors in CPR, First Aid, Basic Life Support, and Mental Health First Aid. Students will also receive information about healthcare career pathways including Certified Nursing Assistant (CNA), Emergency Medical Technician (EMT), and other health professions. Health career camps and additional career exploration opportunities may be coordinated with SERRC’s Alaska Transition Outcomes Project (ATOP). When traveling to communities, the coordinator will also offer continuing education opportunities for healthcare workers and community members. Trainings may include CPR recertification, Mental Health First Aid, trauma-informed care, behavioral health awareness, and cultural proficiency. Over the course of the project, the coordinator will travel to approximately six rural communities annually, reaching approximately 80 K-12 students and providing continuing education opportunities for approximately 20 adult professionals.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

SERRC - Alaska's Educational Resource Center	Youth Brain Injury Program Expansion	AK	The Epidemiology Bulletin Traumatic Brain Injury in Alaska (2023) highlights Alaska’s disproportionately high TBI rates, the urgent need for targeted prevention, and gaps in access to treatment and supportive services. A Centers for Disease Control and Prevention (CDC) report to Congress similarly identifies TBI in children and adolescents as a significant public health burden and emphasizes the need to close gaps in assessment, service access, and coordinated care. Despite this documented need, Alaska lacks the infrastructure that many states have established to support students with brain injury. There is no statewide framework for school-based concussion management, consistent communication gaps between schools and medical providers, limited awareness of brain injury impact, and access barriers to specialized support and training. Without timely identification and support, students are more likely to experience persistent symptoms such as cognitive difficulties and nervous system dysregulation. These challenges are associated with increased risk of academic failure, justice system involvement, mental health conditions, substance misuse, and suicide, all critical concerns across Alaska. This project addresses the well-documented statewide gap by establishing the Youth Brain Injury Program as Alaska’s centralized resource and expanding its successful model to ensure statewide access to prevention, early identification, and coordinated school-based support.	In 2023, the Alaska Department of Health approached SERRC, Alaska’s Educational Resource Center, with a request to develop a system of support for students affected by brain injury. The resulting Youth Brain Injury (YBI) Program has successfully established an innovative, scalable model tailored to Alaska’s unique geographic and service challenges. Initial limited Mental Health Trust funding and a small sole source contract with the Department of Health have built a strong foundation; however, new funding is needed to expand statewide consultation, screening, and school-based support for students with brain injury. In year one, the proposed expansion model closes rural service gaps by strengthening statewide coordination and building local capacity in three key domains: 1) Expansion of Division of Juvenile Justice Brain Injury Support: Scale staff training and universal brain injury screening to 100% of Alaska juvenile probation offices. Expansion will ensure access to educational accommodations and coordinated community support for justice-involved youth with brain injury. 2) School District Capacity Building: Pilot a school-based Brain Health Liaison (BHL) program in five rural or frontier communities, building local capacity with the support of certified brain injury specialists. Collaborate with five school or community partners to expand use of the “Defend Your Brain” curriculum and increase access across districts. Pilot software tools that support real-time educator training and return-to-school protocols for students with brain injury in three school districts. 3) Community Partnerships and Systems Development: Develop new partnerships to position the YBI Program as a centralized statewide resource coordinating brain injury prevention, identification, and recovery support across Alaska. Deliverables include establishing at least five new referral partnerships in medical, educational, or juvenile justice systems; developing and disseminating model concussion and TBI management policy guidance to five school districts or partner agencies; and deliver professional development sessions to 10 new audiences across education, health care, social services, public safety, and tribal partners.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Set Free Alaska Inc	Rural Health EHR & Systems Modernization TA Initiative	AK	SFA operates two primary EHR systems—AKAIMS and CareLogic—alongside eCW for medical billing and claims. These systems do not fully integrate with one another or with external platforms, resulting in duplicate data entry, reporting burdens, and limitations in delivering fully coordinated behavioral health and medical services. Internal operational workflows also remain inconsistent and lack standardized, organization-wide protocols. This fragmentation limits efficiency, reduces scalability, and constrains leadership’s ability to leverage data for strategic growth. By conducting a comprehensive evaluation of both technology platforms and internal operational systems, SFA can identify opportunities to modernize, streamline, and better align processes while enhancing interoperability and data-driven decision-making. Without intentional modernization, these system gaps will continue to increase administrative burden and restrict the organization’s capacity to expand sustainable rural healthcare services. This Readiness Grant will enable SFA to engage expert consultants to provide TA, identify the optimal modernization pathway, and deliver recommendations for EHR consolidation, replacement, or enhancement, alongside operational workflow redesign. By leveraging this external expertise, the organization will establish a sustainable and innovative infrastructure foundation that maximizes access, efficiency, accountability, and quality across rural healthcare settings.	This project will follow a phased and structured approach to evaluate technology and operational systems, leveraging a dual-consultant model to ensure specialized expertise and independent, actionable recommendations. Year One (April–September 2026) will focus on readiness, evaluation, and strategic planning, while Year Two (October 2026–September 2027) will concentrate on implementing selected modernization strategies. By intentionally separating evaluation from execution, the organization reduces risk, strengthens governance oversight, ensures data-informed decision-making, and enhances long-term sustainability. In April 2026, SFA’s executive leadership team, including the CEO, COO, CFO, Director of Compliance, and Director of Strategy and Innovation, will attend the National Council for Mental Wellbeing’s NatCon Conference to conduct a formal market scan, identify emerging vendor solutions, and inform consultant selection. Engagement at NatCon will provide exposure to national best practices in integrated behavioral health EHRs, interoperability standards, and technology-enabled operational improvement. Insights gathered during this conference will ensure that selected consultants possess relevant expertise, current market awareness, and the capacity to tailor recommendations to rural and frontier behavioral healthcare environments. Following the market scan, two consultants will be engaged to produce independent and complementary recommendations. The first consultant will focus exclusively on EHR systems evaluation, assessing AKAIMS, CareLogic, and eCW functionality, interoperability capacity, day-rate billing requirements, reporting capabilities, and total cost of ownership. The second consultant will evaluate agency-wide operational workflows—including intake, documentation, billing, reporting, and administrative processes—providing recommendations for standardization, automation, policy alignment, and efficiency gains. Year One will conclude with two independent consultant reports and Board-level review of proposed modernization pathways. Year Two will focus on executing selected strategies in alignment with Rural Health Transformation Program Goals and Initiatives.	\$50,000- \$250,000	Behavioral health/su- bstance use disorder treatment	Multi- Community or Participating in Regional Hub-and- Spoke	Kenai Peninsula Borough; Matanuska- Susitna Borough	Advance to Implementati on Application

Set Free Alaska Inc	Telehealth Enhancement & Rural Model Development	AK	Across rural Alaska, communities lack access to co-occurring, dual-diagnosis IOP behavioral health services due to persistent workforce shortages and low population density. Smaller communities cannot recruit or sustain the licensed clinicians necessary to operate the group frequency and billable hours required for a full IOP program. This gap results in delayed care, untreated behavioral health conditions, repeated crisis utilization, or the need to relocate for services. Over the past year, SFA has engaged with referring providers, community partners, and other local stakeholders across the Kenai Peninsula to understand service needs. These discussions revealed a lack of readily available OP services and long waitlists for comprehensive assessments and IOP treatment, underscoring the urgent need for expanded, accessible programming in the region. The opportunity is to redesign how intensive behavioral health services are delivered in rural Alaska. Rather than replicating full clinical infrastructures in every community, Alaska must evolve toward a scalable hub-and-spoke model that leverages telehealth, centralized clinical teams, and local peer and crisis support capacity. By shifting administrative and clinical group functions to a central hub while maintaining in-person peer support and crisis “light” services locally, rural communities can access co-occurring, dual diagnosis OP/IOP programs without needing to independently sustain a complete clinical workforce.	In Year 1, the model will be implemented across Homer, Kenai/Soldotna, and Wasilla to establish a fully operational regional network. In Homer, services will expand to include in-person peer support and crisis “light” engagement supported by upgraded telehealth capabilities that connect clients to centralized clinical services. In Soldotna, SFA will remodel its newly acquired outpatient facility, hire core staff including a program coordinator, peer support specialists, and administrative personnel, and launch OP/IOP services supported by enhanced telehealth infrastructure. This phase serves as a proof-of-concept period in which the model will be implemented, tested, and refined to ensure operational, clinical, and financial viability. Simultaneously, telehealth systems at the Wasilla Therapeutic Campus, including outpatient and residential programs, will be strengthened to support centralized clinical delivery across all sites. Clinical groups, assessments, and therapeutic services will be delivered through secure telehealth platforms linking rural hubs to Wasilla-based and remote licensed clinicians, including out-of-state providers. Embedded peer staff in each community will provide in-person group engagement, care coordination, and community-based crisis intervention designed to stabilize individuals and connect them to treatment before conditions escalate. In Year 2, the project will shift toward strengthening performance, optimizing workflows, and solidifying service integration in Homer and Kenai/Soldotna. Data-driven refinements will improve care coordination, staffing efficiency, and client engagement to ensure long-term operational stability. Year 2 also begins the exploration and planning for expansion into at least one additional rural hub, with Bethel, Kotzebue, and Utqiagvik identified as potential sites. SFA will assess feasibility, community readiness, and resource requirements before moving forward with development and implementation into at least one of these communities. This phased implementation creates a scalable rural behavioral health infrastructure that expands access, strengthens workforce capacity, and delivers high-quality care across geographically dispersed communities. By combining centralized clinical expertise with locally embedded peer support, SFA ensures services are both clinically rigorous and community-responsive. This approach enables sustainable growth and responsible expansion into additional rural regions.	\$250K-\$1M	Behavioral health/su bstance use disorder treatment	Multi- Community or Participating in Regional Hub-and- Spoke	Kenai Peninsula Borough; Matanuska- Susitna Borough	Advance to Implementati on Application

Seward Community Health Center	Seward Community Health Center Rural Clinic Infrastructure Planning & Design	AK	SCHC operates in clinic space that was never designed for a growing rural primary care practice. With only two rooms per provider and minimal space for behavioral health or specialty care, patients experience longer waits, fewer appointment options, and limited onsite services. Rural residents routinely travel long distances for specialty care because SCHC does not have space to host visiting clinicians consistently. SCHC owns a one-acre parcel immediately north of the Critical Access Hospital and has long envisioned it as the future site of a new clinic. At the same time, the City of Seward – owner of the hospital building – has expressed willingness to accept federal interest and is open to exploring a jointly beneficial expansion. A modern clinic designed around patient flow, integrated care, and flexible community-use space is essential for sustaining health access for Seward and Moose Pass.	This project focuses solely on planning and design. SCHC will work with Alaska-experienced architects and engineers to complete full schematic design, design development, and construction-ready drawings. Work will include patient-flow modeling, room standardization, infection-control planning, and integrated behavioral health design. Design will also include a multipurpose community room with a teaching kitchen to support hands-on health education, healthy cooking classes, family nutrition programs, and community wellness events. SCHC will evaluate both potential building paths: constructing a standalone clinic on SCHC-owned land or expanding the hospital building in partnership with the City of Seward. The feasibility review will compare capital costs, operating costs, patient access, workflow, and design flexibility. Co-location could offer substantial advantages for rural patients – lab work and imaging across the hall, reduced overhead, and shared utilities – while a standalone clinic may offer greater design freedom and long-term expansion potential. The project also includes telehealth- and HIE-ready specifications, community engagement, and development of a construction financing strategy using technical assistance (fund development planning only, no fundraising activities).	\$1M-\$5M	Federally qualified health center	Single Community	Kenai Peninsula Borough	Advance to Implementation Application

Seward Community Health Center	Clinical Equipment Modernization & Diagnostic Capacity Upgrade for Rural Primary Care	AK	Core clinical equipment at SCHC is 20–30 years old, most of it inherited when SCHC took over clinic operations in 2014. Much of it appears original to the 1996 facility, far beyond typical medical equipment lifecycles. These aging assets impair safe procedures, reliable sterilization, cardiopulmonary triage, and infection-control. Only two rooms have adequate air filtration; exam tables create accessibility and safety concerns; and the legacy EKG system is incompatible with our EHR (Epic), causing delays and higher documentation risk. SCHC budgets modestly for small annual equipment replacements but lacks an established reserve fund capable of modernizing an entire diagnostic and exam infrastructure. Without RHTP support, outdated equipment will continue to impede safe, equitable care for rural residents who deserve the same standard as urban Alaskans.	Through this project SCHC will procure and install: (1) five ADA-accessible exam tables and one procedure table; (2) a reliable, clinic-scale autoclave; (3) four portable HEPA filtration units to achieve safe respiratory evaluation capacity in all six exam rooms; (4) two oxygen concentrators for in-clinic stabilization; (5) three Abbott ID NOW units for rapid molecular testing; and (6) a GE MAC 7 EKG system integrated with Epic EHR. Additional small equipment will be purchased if funding allows. SCHC has vendor quotes or estimated pricing for more than half of these items and is purchase-ready. Vendor-supported staff training will be provided for the EKG system, the Abbott ID NOW platform, and the autoclave to ensure competency, safety, and longevity of use. Implementation plan (12 months): Months 0–2: ordering, site prep, IT integration planning, SOP drafts. Months 3–5: delivery, installation, validation, training, and go-lives for HEPA, autoclave, exam tables, oxygen, and ID NOW. Months 6–9: EKG/Epic integration, competency sign-offs, early PDSA cycles. Months 10–12: outcome review, workflow refinement, and sustainability transition.	\$50,000- \$250,000	Federally qualified health center	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

Seward Community Health Center	Rural Care Coordination & "No Wrong Door" Referral Network	AK	The 2024 PSMC CHNA identifies fragmented navigation, delayed follow-up, and transportation barriers as major contributors to poorer outcomes in Seward. Many residents struggle to complete referrals or access specialty services outside Seward, and pregnant patients often relocate late in pregnancy to Anchorage or Kenai because local labor-and-delivery and NICU services are unavailable. Preventive care and follow up measures show room for improvement across all age groups, with gaps in screening completion, depression follow-up, and care plan adherence. These challenges point to the need for a coordinated approach that reduces navigation burden, supports timely care-gap closure, and strengthens continuity across medical, behavioral, and social services. A shared “No Wrong Door” model - supported by Epic Compass Rose, Azara DRVS, and structured RN led care management - would help ensure residents receive timely referrals, warm handoffs, consistent follow up, and improved navigation support.	Years 1–2: Build (Incubator Phase): • Hire an RN Case Manager and Program/Grant Manager. • Configure Epic Compass Rose for referral tracking and integrated navigation. • Begin workflow design and baseline data governance. • Train up to two internal Epic Super Users to support long term EHR optimization, workflow alignment, and navigation enhancements. • Launch core “No Wrong Door” (NWD) referral partnerships to support warm handoffs and shared coordination pathways using Compass Rose and Azara DRVS. Years 3–4: Formalize & Scale: • Formalize partner roles and strengthen workflow reliability. • Expand the NWD referral network to include more medical, behavioral health, and community organizations. • Continue internal EHR optimization and best practice development supported by trained Super Users. • Begin payer-readiness activities for Medicaid and Medicare value based payment (VBP) pathways. Year 5: Optimize & Innovate: • Enhance SDOH linkages and targeted outreach workflows. • Advance technical improvements and refine care management infrastructure. • Prepare for emerging VBP models through exploratory planning and pilot testing. Monitoring & Continuous Improvement: • Monthly Compass Rose review • Monthly Azara DRVS review • Quarterly PDSA cycles • Iterative refinement based on outcomes and partner feedback	\$250K-\$1M	Federally qualified health center	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

Seward Physical Therapy LLC	Seward Physical Therapy: provide direct access to PT services and cultivate a healthier community.	AK	I want to help decrease the barrier of receiving physical therapy services due to needing a referral prior to starting physical therapy as well as provide the community with a consistent provider that is involved in the community and knows the unique needs and struggles of our rural town. I want to provide physical therapy services to people quickly so that acute injuries can heal properly and decrease long term impairments. By giving the community another option for direct access physical therapy, patients will also initiate therapy when they are most motivated to improve, therefore increasing the chances of early healing and improving overall health. Currently there is no formal injury prevention program for athletics in the schools or in collaboration with school sports. I want to create a relationship with the high school and middle school athletics to aid in acute injuries and overuse injuries. I want to create an injury-prevention program for athletes to complete prior and during their sport season that is sport specific to decrease common injuries. I want to help implement fall prevention strategies to community members with collaboration of the senior community to decrease falls and decrease the severity of falls. Lack of healthy lifestyle education is prevalent amongst community members. I want to help educate the community on importance of physical activity and how it can improve and prevent chronic health conditions.	I am starting a physical therapy clinic, Seward Physical Therapy LLC, that will address the previously listed issues. By having my own practice, I can focus on addressing community needs without other organizational limitations. I plan to highlight the ability to access physical therapy without need of a referral and promote that knowledge to community members via community outreach. The outpatient clinic will function and run like any other outpatient clinic, with scheduled non-patient times to focus on implementing programs to address the listed issues. During the program building time I will create: 1. Injury prevention home exercise program (HEP) for middle school and high school sports. Each HEP will be specific to the sport. 2. Create a workshop to educate community members on importance and benefits of consistent exercise and how to implement daily changes to create an exercise habit. 3. Collaborate with the senior center and Alaska Falls Prevention CoP to implement fall prevention material, and safe home suggestions and modifications.	Under \$50,000	Specialist	Single Community	Kenai Peninsula Borough	Deferred or Not Advanced

Seward Prevention Coalition	Early Head Start Expansion to Strengthen Rural Maternal Health and Workforce Stability in Seward	AK	Rural Alaska faces persistent barriers to health care access driven by geography, workforce shortages, and limited service infrastructure. These challenges are particularly significant for pregnant and postpartum women and families with young children who often experience difficulty accessing coordinated prenatal care, behavioral health services, and early developmental supports. The Alaska Rural Health Transformation Program identifies poor maternal and infant health outcomes and behavioral health needs as statewide priorities requiring upstream, community based solutions. In Seward, these challenges are compounded by a severe gap in Early Learning and Care capacity for children from birth to age three. Local estimates indicate Seward has approximately 60 to 80 infants and toddlers under three each year, while existing licensed programs can serve only 10 children under 30 months, leaving families without access to early learning and care. This project addresses the opportunity to expand Early Learning and Care through a partnership between the City of Seward, owner of the Providence Seward Mountain Haven facility, and Chugachmiut Early Head Start. By creating additional Early Head Start capacity at Seward Mountain Haven, the project strengthens early developmental environments and improves families’ ability to access preventive health services, developmental screenings, and coordinated supports that contribute to healthier maternal and child outcomes in rural communities.	This project expands Early Learning and Care capacity for children birth to three through a partnership between Seward Prevention Coalition, Chugachmiut Early Head Start, the City of Seward, and Providence Seward Medical Center. The City of Seward owns the Mountain Haven facility, creating an opportunity to adapt existing infrastructure to support Early Head Start programming serving Seward and surrounding rural communities. The proposed approach focuses on establishing an Early Head Start classroom within Seward Mountain Haven that provides Early Learning and Care services aligned with the federal Early Head Start model. The program will support infants, toddlers, and their families through developmental screenings, family partnership planning, early relational health supports, and coordinated referrals to health and behavioral health providers. Embedding Early Learning and Care within a facility connected to health services improves coordination between early childhood systems and rural health infrastructure. Minor facility modifications will prepare existing conference space at Mountain Haven to support infant and toddler learning environments. Improvements will include sleep spaces, changing areas, sanitation infrastructure, and developmentally appropriate classroom materials. These upgrades allow the community to leverage an existing building rather than constructing new infrastructure. The project also supports recruitment and preparation of early childhood staff and the coordination needed to launch Early Head Start services. Seward Prevention Coalition, through the HYPER program, will coordinate implementation including partnership alignment, facility preparation, program startup, and community outreach. The Early Head Start classroom will be staffed by four Early Head Start teachers consistent with federal infant and toddler ratios, with Seward Prevention Coalition providing a project coordinator responsible for implementation oversight, partner coordination, and startup support. This partnership benefits Chugachmiut and its tribal beneficiaries by supporting expansion of Early Head Start services within the region and increasing access to comprehensive early childhood services for families. By expanding Early Head Start capacity in Seward, the project strengthens early childhood development, improves family stability, and increases access to coordinated health and behavioral health supports aligned with RHTP priorities.	\$250K-\$1M	Single Community	Kenai Peninsula Borough	Advance to Implementation Application

Seward Prevention Coalition	Alaska Prevention Model Pilot: Seward Youth Wellness & Resilience System	AK	Seward is facing a youth mental health crisis with limited rural capacity and fragmented pathways to early support. Provider shortages and long wait times mean many youth and families do not receive help until concerns escalate into high-acuity, high-cost crises. Local data show urgent gaps: 70% of female teens report poor mental health and 50% report high stress across indicators. We also see steep progression risk from first-time to regular cannabis use (40% to 32%), increasing long-term health costs. These pressures raise risk for substance misuse, and chronic stress-related health conditions. In rural systems with provider shortages and long wait times, families often do not receive support until challenges escalate into high-acuity, high-cost crises. This creates a costly cycle: stress and mental health concerns go unaddressed, substance use risk increases, and families rely more heavily on emergency response or intensive services that are harder to access in rural Alaska and far more expensive than early support. The opportunity is that Seward has a well-established coalition and cross-sector partners ready to implement a coordinated, data-driven prevention and navigation system. By piloting an Alaska Prevention Model adapted from IPM we can strengthen protective factors, create clearer early help-seeking pathways for caregivers and youth, and reduce long-term costs by preventing escalation before it reaches the most expensive parts of the health system.	We will pilot a replicable Alaska Prevention Model adapted from the Icelandic Prevention Model (IPM) and powered by Planet Youth data to address urgent local priorities: youth mental health, stress, substance use, ACE reduction, and stronger “skill discovery” and belonging. This approach aligns with Alaska RHTP initiatives for Health Care Access, Healthy Communities, Healthy Beginnings, and Strengthen Workforce and is implementation-ready through four coordinated roles and a shared workplan. Work-stream 1: Prevention Operating System (IPM + Planet Youth). An IPM Coordinator will restructure coalition governance and partner commitments under IPM and lead the full prevention cycle: data review, dissemination, priority setting, and a measurable action plan. The Planet Youth partnership will support ongoing data infrastructure and training so partners use shared indicators and strategies. Work-stream 2: Youth & Family Front Door (prevention + navigation). A School Prevention Specialist & Resource Connector will provide prevention-focused supports (stress regulation, coping skills, belonging/skill discovery, protective factors) and create efficient pathways to appropriate services through warm handoffs and access to free transportation. This directly responds to local data showing high levels of distress and stress among teens. Work-stream 3: Parenting Seward (0–18 caregiver capacity). With CHSC, we will build Parenting Seward, a locally tailored 0–18 caregiver hub modeled after ParentingMontana.org. It will centralize trusted guidance, supports, and referrals, strengthening Early Childhood Development through adolescence by improving caregiver knowledge, help-seeking, and connection to resources. Work-stream 4: Workforce and thriving adulthood pathways. A Career Pathways Coordinator will build career-connected learning and “grow our own” pathways with AVTEC, employers, and health partners to strengthen long-term rural stability, including healthcare-adjacent options and local training pathways. Accountability: A Project Coordinator will oversee compliance, spend-out, and reporting, and support partner implementation tracking. Year-1 measurable targets (modest, realistic): serve 300+ students through Prevention Specialist; complete 30 warm handoffs/referrals with follow-up; launch Parenting Seward within year one and reach 500+ caregiver users/visits; train 30–60 coalition partners/community leaders, support 25–40 youth placements/pathway engagements.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Shiftfocus LLC	Keeping Alaska's Investment: A Rural Health Career Development Ecosystem	AK	The RHTP will bring new talent into rural health careers through grow-your-own programs, expanded residencies, and service commitments. To protect that investment long-term, Alaska needs a shared infrastructure that gives health professionals a visible, compelling career arc that keeps them in state. The highest-risk window is years three to five, when professionals have proven their capabilities and become attractive to out-of-state recruiters. Service commitments buy time, but when they end, professionals need to see where they go next within Alaska. The goes beyond retention at any single organization. Transformation happens when we shift from organizational retention to system-level retention. A worker who develops at a village clinic and moves to a regional hospital carries rural knowledge into a larger system. A behavioral health provider who grows at a regional facility and steps into a hub leadership role brings that continuity with them. Over time, this intentional circulation builds leaders at every level with experience across Alaska's full care continuum. This requires a shared career development ecosystem where every organization knows how to recruit and onboard for the roles it provides, develop people while they are there, and prepare them for what comes next. When organizations are connected this way, talent moving between them strengthens the whole system. This is how Alaska turns a workforce investment into a leadership pipeline.	This project proposes a Portable Career Development Ecosystem for Alaska's rural health workforce, creating shared infrastructure that connects organizations across communities so professionals can see, plan, and pursue a career within Alaska's health system. This is a concept formation project. The intended outcome is a validated, pilot-ready framework with stakeholder support, positioned for expanded implementation in subsequent RHTP funding cycles. The project has three components: First, career pathway mapping. Working with a workforce partner, we will document how key rural health roles are distributed across facility types, from village to regional to hub facilities. For each role, we will define what it means to learn the role, perform well in the role, and be ready for the next opportunity. This creates a shared vocabulary that works across organizations. When a professional moves from one facility to another, both organizations will have a common understanding of that person's readiness and development needs. Second, manager development. Managers are a critical part of any retention strategy. We will develop and test training that equips rural health managers to assess where people are in their career, have effective development conversations, onboard new staff using shared standards, and prepare high performers for their next step. This will be tested with a small rural cohort to validate the approach before broader deployment. Third, stakeholder validation and evaluation design. We will engage at least two rural health facility types to test career maps, gather input on real-world career progression patterns, and assess organizational appetite for a shared development framework. Working with these stakeholders, we will co-develop measures for tracking the framework's impact on retention and talent development, producing the evidence base needed to support expanded piloting in Year 2. This project is personal. As a born and raised Alaskan, I have watched skilled professionals get recruited out of state for decades. As the leader of a technical consulting firm in Alaska, I lived this problem. I built the culture, the systems, and the frameworks that kept our people here and developed them into leaders. I learned that managers are the key to retention, and giving them practical tools and shared frameworks is what empowers them to succeed. That experience is the foundation of this proposal.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Copper River Census Area; Fairbanks North Star Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Shiftfocus LLC	Protecting Alaska's Investment: Leadership Support for RHTP Projects	AK	Alaska's RHTP will fund dozens of complex transformation projects across all six initiatives. These projects will be led by healthcare professionals who may be navigating new territory: managing large-scale change, coordinating across organizations, and leading teams through uncertainty. The RHTP has planned operational TA for the mechanics: applications, financial management, reporting, and data collection. But the difference between a project that meets its reporting requirements and one that actually transforms health care delivery is the people leading it. Research shows that fewer than half of organizational change initiatives meet their objectives, and that leadership support is the single largest predictor of success. RHTP projects will face these same dynamics in Alaska's unique environment. When a multi-million dollar project stalls because a team can't align, the cost isn't just the lost dollars. It's the lost trust and the lives impacted because they have to keep waiting for healthcare transformation. The RHTP includes TA as an allowable use of funds. This project is for a specific type of TA: supporting the people delivering transformation through a program that turns insights across projects into value for the whole program. This project protects Alaska's RHTP investment by supporting the people who will determine whether these projects succeed.	This project creates a coaching TA program for RHTP grantees with three components: a vetted coaching pool, a structured engagement process, and an Alaska-based coordinating entity. The coaching pool is anchored by Terawatt, a coach-matching platform with 80+ coaches whose credentials have been validated through an established vetting process. The pool will grow, adding Alaska-based coaches and specialists using the same vetting standards. This provides a deep, diverse, and expanding pool available to support projects. To access coaching, grantees will work with the DOH program office and ACF to determine their needs. They will select a coach based on project needs, budget, and the coach's area of expertise. Coaches will complete an orientation on Alaska Native peoples' cultural context, rural and frontier health delivery realities, and the specifics of the grantee's project at the start of an engagement. A post-mortem is conducted at the close to capture outcomes and identify cross-project themes. The coordinating entity, Shiftfocus, administers the program in Alaska. Shiftfocus founder Brian Walch is a lifelong Alaskan who built the systems that grew a technical consulting firm from 20 to over 200 employees. He knows what it takes to keep skilled professionals in Alaska. Shiftfocus ensures that every coaching engagement is set up to succeed and that the program as a whole delivers value beyond any single engagement. It prepares coaches, provides project-specific support, and conducts structured close-outs that capture what's being learned. Across engagements, Shiftfocus identifies patterns and surfaces them to DOH, such as common barriers grantees are facing or emerging needs the program could address. That cross-project visibility is what turns individual coaching into a program-level asset, creating opportunities to convene grantees around shared challenges or to develop resources that benefit the broader RHTP community. Year 1 stands up this infrastructure and puts it to work, actively placing coaching into approximately 10 grantee projects. Those first engagements will test the model, generate early cross-project insights, and provide the evidence DOH needs to continue investing in the people leading rural health transformation.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Shiloh Community Housing Inc.	Community Resource Center (CRC) Health, Wellness & Workforce Hub	AK	Alaska’s vulnerable residents face a fragmented and difficult-to-navigate system of care. This challenge is especially acute for rural Alaskans who must travel to Anchorage, the state’s primary hub for specialized social services. Older Alaskans, families with children, and individuals are impacted by a system where essential services are scattered across multiple agencies and locations. Behavioral health services, housing support, benefits enrollment, and workforce programs are typically located in separate facilities with different scheduling systems, eligibility requirements, and intake processes. Individuals are forced to independently coordinate multiple services during a limited window of time in the city. Systemic barriers such as appointments delayed, canceled, or missed, the entire chain of care can collapse. Individuals frequently return to their communities without completing treatment plans, securing benefits, or stabilizing their housing situation, resulting in reliance on high-cost emergency and crisis services. A one-stop-shop for health and wellness services, workforce development programs, housing navigation, benefits assistance, and partner-led support, allows individuals and families to address multiple needs during a single visit. Shifting the system toward integrated, preventative, and community-based care, the CRC will improve outcomes for vulnerable populations while generating long-term efficiencies across Alaska’s healthcare and social services.	SCHI established the CRC as a comprehensive, trauma-informed hub that co-locates traditional and non-traditional service providers on a single campus. Renovations will upgrade and update and of the 2nd floor and enhance other areas of the center: • Health & Wellness Center: Space for physical health supports, behavioral health services, wellness education, and care coordination and navigation, with telehealth infrastructure for rural patients traveling through Anchorage. Providers will schedule same-day appointments, coordinate follow-up care before patients depart, and connect individuals to telehealth services once they return home. This directly advances RHTP’s Health Care Access and Healthy Community and long-term services and support. • Workforce Development & Job Center operated by the DOL integrates SCHI’s established workforce programming to provide work readiness training, digital skills, and employment credential pathways strengthening Alaska’s workforce initiatives. • Financial literacy operated by local banks and economic development consultants will deliver money management education. Income instability is among the most consistent upstream predictors of poor health outcomes; this programming addresses it at the root. • Childcare accessibility and affordability are significant barriers for many individuals and families seeking essential services. Parents and caregivers who are responsible for young children often face difficult choices when attempting to attend appointments. Without safe and reliable childcare, many are forced to postpone or completely forego these critical services. This barrier disproportionately impacts single parents, caregivers of multiple children, and rural visitors who travel long distances to access services within urban centers. On-site childcare within a service delivery setting significantly reduces barriers by allowing parents and caregivers to fully engage in the services designed to support their stability and well-being. • Commercial Partner Office Suites: Nine or more spaces for partner agencies (health providers, social service organizations, state and local programs), enabling warm handoffs, co-located case management, and integrated service delivery under one roof. Operationally, the CRC will function as a coordinated entry point and referral workflows. Community outreach will move clients, especially rural Alaskans, from immediate needs to stabilization to long-term health and economic wellbeing.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Shiloh Community Housing Inc.	Cultivating a Rural Health Workforce Pipeline: LIFE@Work for Adults	AK	Alaska's health care system faces compounding workforce pressures. A 2023 State report found that more than 500 primary care and behavioral health positions remained unfilled statewide, with rural and remote communities disproportionately impacted. Turnover in frontline health care support roles runs 30 to 40% annually at some facilities, driving up costs and eroding care continuity. Meanwhile, thousands of Anchorage adults are underemployed and lack access to short, structured training pathways that lead to family-sustaining wages. SCHI's LIFE@Work program is an operational, evidence-informed work-readiness model serving youth ages 16 to 25. This proposal expands the proven platform to serve adults ages 25 to 55 by introducing a new health care support track focused on care navigation competencies. The new track will complement existing curriculum offerings and further strengthen the program's workforce development pathway. Alaska RHTP Initiative #5 identifies workforce development and care navigation as priorities for system transformation. No existing Anchorage-based workforce program combines adult reskilling, care navigation training, and integrated wrap-around supports in one program. This planning grant will support the design work needed to close that gap.	LIFE@Work will use 12 months of RHTP planning funds exclusively to design and validate an adult health care support track. This planning phase will produce an implementation-ready program for the next RHTP cycle. Building on LIFE@Work's fully remote operations during COVID, SCHI has the capacity to deliver curriculum and training virtually to improve access for participants who face transportation, caregiving, or geographic barriers. The planning phase is structured across four evidence-based design activities. During months 1 through 4, SCHI will adapt the LIFE@Work curriculum for adult learners using adult learning principles, trauma-informed instruction, and health literacy frameworks, and best practices while defining core care navigation competencies such as patient communication, HIPAA and confidentiality, motivational interviewing, system and benefits navigation, referral coordination, documentation, and related workplace readiness skills; SCHI will also map potential credential and certification options (including Community Health Worker pathways) alongside minimum employer hiring requirements. During months 3 through 6, SCHI will design a structured internship and externship model with employer partners, including supervision standards, learning objectives, feedback loops, and progression criteria, and will engage at least three employer sites spanning clinic, hospital, and community-based settings to ensure alignment with real hiring needs. During months 4 through 8, SCHI will formalize partnerships by executing MOUs with participating health care employers; health care professionals will assist in defining clear roles and responsibilities, referral protocols, and accountability structures for each partner according to best practices for remote learners. During months 8 through 12, SCHI will complete implementation readiness work by finalizing a recruitment and retention plan, outcomes and data collection framework, participant support budget, staffing model, and launch a budget for the first implementation cohort, culminating in a comprehensive, implementation-ready plan for RHTP review. CRC co-location with DOL eliminates a common barrier in workforce programs: Participants benefit from coordinated services such as unemployment assistance, workforce training programs, labor market data, and career pathway planning. This integrated model supports participants from training through job placement.	\$250K-\$1M	Statewide	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Matanuska-Susitna Borough	Deferred or Not Advanced

Shiloh Community Housing Inc.	SCHI Capacity Forward: Technical Assistance for RHTP Program Development and Administration	AK	SCHI has the vision, the community relationships, and the organizational foundation to be a meaningful RHTP participant. What it needs is the capacity to do so at full strength. As RHTP funding comes online, the demands on small organizations are substantial. Competitive applications require fluency in CMS requirements and RHTP criteria; assistance with detailed implementation plans, evidence-informed curricula, HIPAA-compliant workflows is needed. Expanded federal funding carries administrative obligations, including reporting, fiscal controls, and monitoring systems. Existing staff cannot absorb these requirements. SCHI has developed program concepts addressing multiple RHTP initiatives, including health care access, workforce development, and community-based health support. Each requires substantial design work before it can be implemented with the fidelity that measurable outcomes demand. Technical assistance is sought. This proposal requests a targeted, time-limited investment in technical assistance that directly unlocks larger, longer-term rural health investments. A skilled contractor performs the specialized work that allows SCHI’s programs to launch with fidelity, operate with CMS compliance, and produce the measurable outcomes RHTP targets. This is not overhead. It is the enabling investment that assist in quality assurance of program offerings.	SCHI will engage a qualified technical assistance contractor using a qualifications-based selection process, requiring demonstrated experience with federal health program grant writing, rural health systems, CMS compliance standards, and Alaska-specific community contexts. Contractor support will be organized across four domains: Grant Writing and Application Development: The contractor will lead or substantially co-develop RHTP full proposals and future-cycle funding applications, including needs assessments, program narratives, logic models, outcome frameworks, and budget justifications aligned with RHTP evaluation criteria. Each application will be grounded in RHTP’s evidence standards, demonstrate clear rural impact, and satisfy CMS permissibility requirements, enabling SCHI to pursue RHTP cycles with competitive, well-substantiated proposals rather than reactively assembled ones. Program Design and Planning: The contractor will develop implementation-ready program designs across SCHI’s priority service areas, including health navigation, care coordination, workforce development pathways, and community-based health support. Each design will include a detailed workplan, milestone framework, risk management strategy, and adaptive management protocol aligned with RHTP’s workplan and monitoring criteria. Curriculum and Standards Development: The contractor will develop workforce training curricula for health care support and care navigation roles, including competency frameworks, adult learning adaptations, trauma-informed instruction approaches, and health literacy integration. The contractor will also draft standard operating procedures for service intake, referral coordination, HIPAA-compliant data handling, and care transitions between Anchorage-based and rural providers. Administrative and Compliance Infrastructure: The contractor will develop fiscal management procedures, reporting templates, data collection frameworks, and performance monitoring systems. This infrastructure supports CMS compliance and RHTP accountability requirements, ensuring that all funded programs are administratively sound from launch.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced

Silver Tern LLC	Educating and enabling Alaskans in the healthcare management and prevention	AK	Silver Tern proposes a hybrid model of rotational village-based care and telemedicine services to address the unique healthcare challenges of Alaska’s rural, remote, and frontier communities. This approach improves access to high-acuity specialty care, strengthens local healthcare capacity, and reduces unnecessary medical evacuations (medevacs), all while maintaining cultural competency and continuity of care.	ilver Tern is headquartered in Alaska and operates with a focus on rural, remote, and frontier communities across the state. While Silver Tern does not maintain permanent brick-and-mortar offices in each community it serves, our staff—including clinicians, traveling RNs, and Community Health Aide Practitioner (CHAP) partners—are actively based in Alaska and operate throughout the region. Clinical operations are coordinated through regional hubs in Bethel, Nome, Kotzebue, and Dillingham, which serve as logistical centers for rotational village visits and telemedicine support. These hubs allow for efficient coordination of care, equipment distribution, and provider travel while supporting local partnerships with tribal and regional health organizations, including the Alaska Native Tribal Health Consortium, Southcentral Foundation, Yukon-Kuskokwim Health Corporation, and Norton Sound Health Corporation. Silver Tern’s team provides care through a hybrid model that combines in-person village rotations and telehealth services. This approach ensures that all participating communities have access to high-acuity specialty-informed care, consistent follow-up, and proactive chronic disease management, even in villages without permanent office space. By integrating our clinicians into local healthcare networks, we maintain a strong Alaska presence and ensure continuity of care while building sustainable partnerships with local healthcare providers.	\$250K-\$1M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

SimX, Inc.	Alaska Rural Maternal Health Workforce Readiness Initiative	CA	Alaska faces urgent maternal health challenges, especially in rural and Tribal communities. Between 2012 and 2021, rural maternal mortality rose by 184%, with Alaska Native women experiencing disproportionately high rates. In many rural areas, clinicians, nurses, EMS providers, and Community Health Aide/Practitioners must manage obstetric complications, such as postpartum hemorrhage and neonatal emergencies, without consistent training or specialist support. Persistent workforce shortages, skill decay from low patient volumes, and lack of simulation-based training compromise clinicians’ ability to manage maternal emergencies and deliver timely, high-quality prenatal, delivery, and postpartum care close to home. The SimX Alaska maternal health workforce readiness solution will strengthen rural maternal and early childhood health capacity through immersive simulation training for nurses, EMS, midwives, hospital clinicians, and Community Health Aide/Practitioners. Focus areas include obstetric emergency stabilization, neonatal care, and postpartum maternal health. Launching with Alaska Prehospital Education Consortium (APEC), Guardian Flight Alaska, and Alaska Native Tribal Health Consortium (ANTHC), this 1-year initiative will serve as a demonstration model to improve clinical competencies, reduce preventable complications, and sustain access to maternal services in underserved regions. It is implementation-ready and aligned with Alaska RHTP’s Healthy Beginnings initiative.	The proposed solution will deliver immersive simulation-based maternal and neonatal emergency training to rural clinicians. Alaska Prehospital Education Consortium (APEC) will serve as the clinical training hub, coordinating remote immersive VR training sessions for rural hospitals and clinics, while SimX will provide platform deployment, technical support, and simulation facilitation. Training will include instructor-led sessions and self-guided modules, allowing clinicians to maintain readiness despite geographic isolation and workforce constraints. Published studies of the SimX platform demonstrate that VR is an effective, learner-endorsed method for strengthening clinical preparedness, able to provide a 12% improvement in skills acquisition and up to 75% reduction in training costs compared to traditional manikin-based simulation. The initiative will initially deploy to 8 participating sites within the network and partner clinics serving rural and semi-rural populations in communities including Kodiak, Seward, Valdez, Eagle River, and the Mat-Su region. These sites include rural hospitals and affiliated clinics as well as partner community health centers and Tribal clinics that support maternal and infant health services. ANTHC is expected to collaborate in engaging Tribal clinics and Community Health Aide/Practitioner providers. Guardian Flight Alaska will participate in selected simulation exercises to strengthen coordination between rural providers and medevac teams. Training will focus on high-risk obstetric and neonatal emergencies that require rapid stabilization before medevac transfer. Core simulation scenarios will include postpartum hemorrhage, preeclampsia, shoulder dystocia, maternal sepsis, cord prolapse, neonatal resuscitation, and premature infant stabilization. Simulation sessions will occur biannually, supplemented by continuous on-demand training access so providers can refresh skills when caring for pregnant patients or preparing for potential delivery complications. Project evaluation will measure clinician competency improvement within simulation scenarios, number of providers trained, and participant satisfaction. Findings will inform refinement and potential expansion of the model. During the 1-year period, the initiative will establish an operational maternal emergency training network that can be expanded to additional rural hospitals, Tribal clinics, and EMS agencies in future RHTP phases.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Copper River Census Area; Denali Borough; Dillingham Census Area; Kenai Peninsula Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

SimX, Inc.	Alaska Rural Simulation & Clinical Competency Network (ARSCN)	CA	Alaska’s rural health system faces a structural workforce readiness challenge driven by extreme geography, low patient volumes, high turnover, and limited access to specialty backup. More than 80% of communities are off the road system and nearly all regions face Health Professional Shortage Area designations. Rural hospitals and EMS agencies have to manage high-acuity emergencies (e.g., maternal complications, trauma, behavioral health crises, chronic disease exacerbations) with limited opportunities for ongoing skills reinforcement. Low-frequency, high-risk medical events require rapid, confident clinical decision-making; however, workforce turnover and limited training access contribute to preventable patient transfers, costly medical evacuations, and reductions in local services that threaten access to care close to home. This project addresses a critical opportunity: to transform how Alaska develops, reinforces, and retains its rural clinical workforce. The Alaska Rural Simulation and Clinical Competency Network (ARSCN) will establish a statewide, technology-enabled training infrastructure that provides continuous, high-fidelity remote simulation training to rural hospitals, Tribal health organizations, EMS agencies, and training programs. By shifting from episodic training to ongoing, data-driven competency reinforcement, ARSCN will strengthen medical readiness, improve workforce retention, and stabilize essential services across rural and Alaska Native communities.	The Alaska Rural Simulation and Clinical Competency Network (ARSCN) will establish a statewide, implementation-ready workforce training and competency reinforcement infrastructure, directly advancing RHTP Initiatives #5 (Strengthen Workforce) and #6 (Spark Technology and Innovation). The ARSCN will deploy immersive, evidence-based virtual reality (VR) simulation to rural hospitals, Tribal health organizations, EMS agencies, and training programs. SimX’s immersive, multiplayer platform, which provides both cloud-based and offline operation to ensure full functionality in low-bandwidth regions and allows geographically dispersed teams to train together in real time, will enable clinicians across isolated communities to practice high-risk, low-frequency scenarios in realistic, interactive simulation environments. Multiple partners will be engaged during initial rollout. The approach includes four integrated components: - Statewide Simulation Deployment: Participating sites will be equipped with VR hardware, scenario libraries, and instructor tools to support maternal emergencies, trauma, behavioral health crises, chronic disease management, and/or team-based acute care. Mobile deployment kits delivered by mail will extend access to frontier facilities. - Workforce Pipeline Integration: VR simulation training will be embedded into CHA/P, nursing, EMS, and allied health training programs to expand clinical capacity and reinforce competencies prior to and during rural service. - Remote Simulation Coordination Hub: The ARSCN will establish regional hubs capable of facilitating remote, instructor-led simulation training to multiple rural sites simultaneously. - Performance Analytics: Competency tracking dashboards and LMS integration will be implemented to measure skill progression and workforce readiness over time. Timeline: Y1: Launch initial network deployment and establish the first regional simulation hub. Y2-3: Expand statewide deployment. Y4-5: Establish a fully operational statewide network with integrated analytics and continuous workforce training programs. By creating a technology-enabled competency infrastructure, ARSCN will shift rural workforce development from episodic continuing education to continuous readiness reinforcement, strengthening maternal and emergency care reliability and improving workforce retention across rural Alaska.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Sitka Counseling and Prevention Services Inc.	Sitka Counseling Therapeutic Services Expansion & Renovation Project	AK	This grant seeks to address the lack of adequate, safe, and accessible infrastructure to support early childhood mental health services and workforce development. Our Preschool and Family Center programs currently operate in two adjacent buildings originally built as family housing for the former Sheldon Jackson College and acquired by the agency in 2011. These buildings were not designed for clinical mental health services. The current facilities create significant operational inefficiencies and limit service capacity. The physical separation of two departments reduces clinical capacity and limits coordinated service delivery, supervision, and team-based learning. Staff transport materials between buildings, diverting time away from client care. Offices, therapy rooms, and waiting areas are multipurpose and insufficient, restricting program coordination and the efficient sharing of staff, supervisors, and clinical resources. The absence of designated group therapy rooms prevents or disrupts concurrent therapeutic sessions, and the shortage of clinical offices constrains the agency’s ability to hire additional clinicians despite documented community need. The facilities, physical buildings where we direct services to adults and adolescents, pose urgent and persistent safety, privacy, and accessibility risks. Transition areas between buildings are exposed to harsh weather, increasing the risk of slips and falls.	This planning grant will support preliminary work essential to renovating Sitka Counseling’s Preschool and Family Center facilities, primarily, as well as smaller improvement projects in for the Residential SUD, Adult Outpatient/Reception, and Adult/Teen rehab buildings. Funding will cover architectural and design services to create detailed renovation plans that address therapeutic needs, operational efficiency, safety, and accessibility. It will also support site preparation, including grading, leveling, and other groundwork necessary to ensure the property is construction-ready. Additionally, the grant will allow the agency to research and select appropriate therapeutic materials, furniture, fixtures, and signage to support clinical functionality, safety, and accessibility. Planning will include design considerations for interior space reallocation, upgrading building exteriors to address water damage and improve energy efficiency, replacing windows, repairing gutters, and enhancing insulation. The renovation plans will also make the facilities ADA-compliant by widening doorways, expanding bathrooms, adding a lift, and ensuring sufficient turn radius for wheelchairs. Safety and code compliance upgrades, such as a fire sprinkler system, will be incorporated, along with technological improvements, including strategically placed Ethernet connections, computers, and secure Wi-Fi, to support telehealth, training, and administrative operations. Investing in this planning phase will reduce risk and increase cost-effectiveness for the full renovation by identifying potential challenges early, ensuring compliance with safety and accessibility standards, and allowing informed decisions about design, materials, and operational workflows. These infrastructure limitations directly hinder the agency’s ability to expand and improve service capacity, develop its workforce, ensure safety and accessibility, and implement a sustainable hub-and-spoke model to extend specialized early childhood mental health expertise across rural Alaska. Upgrading the facilities is essential to meeting the growing mental health needs of individuals and families in Sitka, with an intent to extend reach to support outlying areas.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Single Community	Sitka (City and Borough)	Advance to Implementation Application

Sitka Counseling and Prevention Services Inc.	Early Childhood Mental Health Rural Collaborative (ECMHRC) Pilot Program	AK	The central problem this grant seeks to address is the lack of an integrated network for early childhood mental health services in rural Alaska. Early childhood care in rural Alaska faces two critical challenges: a shortage of clinicians trained in developmentally appropriate, evidence-based services for young children, and limited collaboration between community mental health agencies, schools, and tribal government social services. This gap hinders care that is both age-appropriate and culturally grounded. By establishing the Early Childhood Mental Health Rural Collaborative, this project presents an opportunity to connect providers, build regional networks, and offer culturally grounded, evidence-based training across rural Alaska’s early childhood social institutions. The collaborative will foster sustainable partnerships, streamline communication across systems, and enhance access to high-quality, culturally responsive services for young children and their families. In smaller communities, psychoeducation opportunities and evidence-based parenting psychotherapy groups remain extremely limited but are frequently requested by referring organizations, such as local school districts and the Office of Children’s Services. Evidence-based dyadic family therapy for young children and caregivers is also greatly inaccessible.	To address the lack of an integrated early childhood mental health (ECMH) network in coastal rural Alaska, this project proposes the Early Childhood Mental Health Rural Collaborative, with Sitka serving as the coordinating hub, piloting participation from Sitka, Yakutat, Cordova, and Valdez. Sitka Counseling will hire a program administrator to coordinate training, partnerships, and administrative functions, ensuring consistent communication and task management while minimizing administrative burden on local agencies, schools, and tribal governments. The collaborative will expand access to specialized training, including those such as DC:0–5 diagnostic training, Filial Therapy, Child-Parent Psychotherapy, and supporting credentials such as Registered Play Therapist (RPT) and Early Childhood Mental Health (ECMH) Endorsement. The collaborative will establish a network for regional reflective supervision to share clinical cases influenced by regional issues. In so doing it would promote problem-solving at both the individual psychotherapy and broader social service levels. It would also redistribute resources, such as tuition waivers, for qualified social service workers pursuing child-focused training. The initial communities included in this pilot program proposal were invited due to their limited access to clinicians trained in early childhood mental health, lack of integration within larger hospital systems, and reliable transportation connections through commercial air service and the Alaska Marine Highway ferry system. Sharing similar economic and cultural contexts, these towns provide an ideal foundation for a replicable, regionally informed collaborative model. The agency currently maintains contact with at least one organization in each community which has expressed initial interest in continuing discussions toward participation in the collaborative.	\$50,000- \$250,000	Behavioral health/su bstance use disorder treatment	Multi- Community or Participating in Regional Hub-and- Spoke	Chugach Census Area; Sitka (City and Borough); Yakutat (City and Borough)

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Sitka Homeless Coalition	Comprehensive Care	AK	In rural Sitka, geographic isolation, limited provider capacity, transportation barriers, and weather-dependent travel make consistent access to health care difficult. For individuals experiencing homelessness or housing instability, these barriers are compounded by unstable living conditions, lack of reliable communication, and limited support navigating health systems. As a result, many delay preventive care, struggle to manage chronic conditions, and rely on crisis services when health needs escalate. Sitka Homeless Coalition recently opened Hítx’i Sáani, a 12-unit Permanent Supportive Housing community serving individuals with significant medical, behavioral health, and housing stability needs. The opportunity now is to strengthen that housing community and expand access to care through the development of SHC’s Services Building. The Services Building will serve as the operational hub for SHC staff, including case management, while also providing coordinated wraparound services and seasonal emergency winter shelter. By bringing care navigation, health system support, and partnerships with local providers into a single trusted location, the project will help residents and other high-need community members connect with primary care, behavioral health services, and preventive supports. This approach reduces barriers to care while supporting long-term health stability in a rural community.	Sitka Homeless Coalition will address barriers to health access by operating a centralized Services Building that integrates housing support, care coordination, and low-barrier access to health services. Located within the Hítx’i Sáani Permanent Supportive Housing community, the building will serve as the operational hub for SHC staff and the primary site for coordinated wraparound services. Case managers and support staff will work directly from the Services Building to assist residents of Hítx’i Sáani and other community members experiencing homelessness or housing instability. Staff will provide individualized care navigation, helping participants connect with primary care providers, behavioral health services, substance use treatment, and other community health resources. This hands-on support helps individuals overcome practical barriers such as transportation challenges, complex enrollment processes, and difficulty coordinating appointments. The project will also expand access to care by creating space where services can be delivered directly. The Services Building will support telehealth access for specialty care that is not locally available, assistance with Medicaid enrollment and insurance navigation, and coordination of transportation to medical appointments. SHC will partner with local providers and organizations to host visiting service days, outreach clinics, and health education activities within the building. During winter months, the building will also serve as the location for SHC’s seasonal Emergency Winter Shelter, ensuring that individuals experiencing unsheltered homelessness have safe overnight shelter and immediate connection to services and care navigation. This proximity allows staff to engage individuals early and connect them to health care, housing pathways, and stabilization services. By combining housing, shelter, and coordinated support in one accessible location, the project reduces barriers to care and increases consistent engagement with health services. The Services Building strengthens the supportive community created at Hítx’i Sáani while expanding access for other vulnerable residents in Sitka. This approach improves continuity of care, supports management of chronic health conditions, and promotes long-term stability for high-need individuals in a rural frontier setting.	\$50,000-\$250,000	Single Community	Sitka (City and Borough)	Deferred or Not Advanced

Skagway Development Corporation	Skagway Community Wellness Trail and Outdoor Recreation Initiative	AK	Skagway is a rural Southeast Alaska community with limited healthcare access and seasonal conditions that can reduce opportunities for regular physical activity and community connection. While the community has strong outdoor recreation traditions, infrastructure supporting safe and accessible daily recreation close to town is limited. This project explores the development of a Skagway Community Wellness Trail and Outdoor Recreation Initiative designed to strengthen year-round access to safe outdoor spaces that promote physical activity, mental wellbeing, and social connection. By improving trail access, accessibility, and recreation infrastructure, the project aims to support preventative health behaviors and improve quality of life for residents and workers in the community.	The proposed initiative focuses on improving community access to outdoor recreation infrastructure that supports preventative health and wellness. The project would include improvements to existing trail access points, development of accessible walking routes and recreation loops near town, and installation of small-scale infrastructure that supports safe and inclusive use of outdoor spaces. Potential project elements may include improved wayfinding signage, benches and resting areas, trailhead improvements, and accessibility enhancements that allow seniors, families, and individuals with mobility limitations to safely access community recreation areas. The initiative may also include community-based outdoor wellness programming and recreation events that encourage residents to engage in physical activity and build social connections. These activities could include walking groups, outdoor wellness programming, and community recreation events that promote healthy lifestyles. By combining infrastructure improvements with community programming, the project seeks to create sustainable opportunities for physical activity and wellness in a rural community.	\$50,000-\$250,000	Single Community	Skagway (Municipality)	Deferred or Not Advanced

Skeetawk	Skeetawk Management Technology	AK	Passes/Products: Skeetawk currently has a real-time pass verification process, with physical passes checked visually by an employee before a user loads the lift. This process only supports 2 types of pass products: 1) day passes (riding the lift on that specific day) or 2) season passes (riding the lift any day of the season). As Skeetawk is entering the second year of the Mat-Su Borough School District (MSBSD) partnership, the program to provide outdoor recreation and education for school credit continues to expand to every school in the district through hybrid learning courses. At this volume, the MSBSD requires a season-long controlled product for their students that is less expensive than a season pass. Skeetawk stands ready to offer this service to the students of the MSBSD, but requires technology-based verification and recording infrastructure to facilitate these products. Remote transaction software: With Skeetawk's current system, users of Skeetawk must be physically present at Skeetawk to purchase passes or rent equipment (if under 18 - guardian must be present). With this new technology parents in more remote locations, sending their children to Skeetawk through school or public transportation, will be able to remotely purchase and reserve the child's passes, rental equipment, and anything they need to have a profitable day of outdoor recreation.	By installing Radio Frequency Identifier (RFID) technology and management software at the ski area, Skeetawk will be able to provide more structured access, ensuring fair and controlled use of the ski area at a lower cost than a full season passt to the MSBSD users and all users of Skeetawk. For example, the MSBSD has requested a 2-visit-per-week pass option for students enrolled in their courses. They would like the youth to be able to visit the ski area 2 times per week at any point during the week, up to a certain number of hours for course credit during the season. Currently, Skeetawk cannot control participants of that request with visual pass verification. With RFID, Skeetawk can issue any pass type imaginable to users. Using the example above, Skeetawk will issue a 2-visit-per-week pass to each student enrolled in the Winter Recreation course across the MSBSD. Those students will visit the ski area, and utilize their passes as required for their course. The RFID gates will automatically control the parameters for which their pass type is set, and will also track the usage of that pass at Skeetawk. That tracking and reporting feature is invaluable to the MSBSD as they will utilize the reports to ensure student participation in the program and issue school credit for that participation. For the community, this technology will also allow users to remotely purchase and reserve Skeetawk products, including e-waivers. This is extremely valuable for families who live far from the ski area, but have the opportunity to send their children to recreate through school programs, Mat-Su Borough public transportation options, or other community groups. Currently, parents/guardians must be physically present at the ski area to reserve equipment for their youth. Additionally, this technology will allow parents/guardians to load money directly onto the child's pass for ski area purchases like food and beverage or equipment (gloves, hats, helmets, etc). This option will allow parents greater fiscal monitoring and responsibility as they send their youth to the ski area for recreation. This technology will also better support year-over-year ski area users, as customers will build a profile in the system. As they return to recreate each year, their information and demographics are pre-saved, ensuring a more efficient year-over-year pass renewal and equipment rental process.	\$250K-\$1M	Statewide	Anchorage (Municipality); Chugach Census Area; Denali Borough; Fairbanks North Star Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

SKINLIFE LLC	SkinLife Early Detection, Skin Health, and Wellness Initiative	AK	Alaskans face delayed access to timely skin assessment, early detection, preventive education, and coordinated follow-up. Specialist access is limited, travel is burdensome, or referral pathways are fragmented. As a result, patients may wait too long to have suspicious or medically significant skin concerns evaluated, increasing the likelihood of poor long term outcomes associated with late detection and delayed treatment. SkinLife’s initiative is designed to address this gap by expanding access to early screening, telehealth-supported triage, prevention education, workforce capacity, and coordinated care pathways that improve how patients are identified, supported, and connected to appropriate care. Further, Alaska is lacking in access to the most cutting edge laser technologies surrounding skin health and wellness. The SkinLife providers will build on their 55+ years of laser & light experience with newly advanced laser technology.	SkinLife’s project will create a coordinated early-detection, skin health, and wellness model that expands timely access to screening, triage, prevention education, and follow-up care across Alaska. The project combines in-person services with asynchronous telehealth to improve earlier identification of suspicious and medically significant skin conditions and provide ongoing treatment and support. The approach includes recruitment and training of physician assistants, nurse practitioners, registered nurses, and support staff to provide prescreening, patient education, navigation, follow-up, and referral support. SkinLife will strengthen care quality through advanced training in dermatologic conditions, laser and light theory, laser safety, treatment planning across diverse skin tones, psychodermatology-informed care, and anatomy-based diagnostic education. The project also includes a prevention and wellness component focused on youth, families, and communities. This includes education on sun safety, sunscreen use, protective clothing, early recognition of concerning skin changes, and lifestyle factors that influence skin and overall wellness, including stress, sleep, hydration, nutrition, and hormone-related skin concerns. SkinLife will expand its existing seasonal Sunscreen Station currently staffed during the summer fishing months on the Kenai river and community outreach efforts into a broader prevention platform that connects education with screening, referral, and follow-up. To support long-term impact, the project will invest in telehealth infrastructure, portable diagnostic equipment, and standardized clinical workflows that improve access, care coordination, and sustainability beyond the grant period.	Over \$5M	Clinic	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Sitka (City and Borough)	Deferred or Not Advanced

Skypoint	Alaska Frontier Communities' AI-Enabled Rural Health Data Unification & Care Coordination Platform	OR	Rural, remote, and frontier communities in Alaska face significant barriers to timely, coordinated health care due to geographic isolation, workforce shortages, and fragmented health data systems. Providers often rely on multiple disconnected systems for clinical, claims, and community information, limiting their ability to identify high-risk patients, coordinate care across organizations, and proactively manage chronic disease, behavioral health, and maternal health risks. At the same time, rural providers care for complex populations with limited staff and resources. Without unified data and actionable insights, care teams struggle to prioritize outreach, monitor patients remotely, and coordinate care across Tribal Health Orgs, rural clinics, and regional health systems. This project addresses the opportunity to create a unified data foundation that connects health information across providers, telehealth systems, remote monitoring technologies, and Alaska’s statewide health information exchange (HIE). Through integrated analytics, real-time dashboards, and AI-ready infrastructure, providers can identify care gaps earlier, coordinate care more effectively, and deliver services closer to home. Strengthening data sharing and enabling AI-ready population health management across Alaska’s Tribal and rural health systems will improve access to care, support overburdened providers, and create a sustainable model for delivering high-quality care in remote communities.	Our approach is to implement a unified, secure data platform that connects health information across rural providers, Tribal Health Organizations, telehealth systems, remote monitoring technologies, and Alaska’s statewide health information exchange (HIE). This platform will integrate clinical, claims, and community data to create a comprehensive, real-time view of patient needs and population health trends across participating organizations. By unifying fragmented data sources, the platform will enable advanced analytics, predictive modeling, and real-time dashboards that help providers identify high-risk patients, monitor care gaps, and prioritize outreach. These capabilities will support proactive management of chronic disease, behavioral health conditions, maternal health risks, and other complex needs that disproportionately affect rural populations. The platform will be designed to integrate with existing electronic health records and care management tools used by rural clinics, Tribal Health Organizations, and regional health systems. This ensures providers can access actionable insights within their existing workflows while improving coordination across organizations and care teams. To improve access to care, the platform will also support telehealth and remote patient monitoring programs, allowing providers to track patient status between visits and intervene earlier when risks are identified. This approach helps reduce avoidable hospitalizations and emergency department visits while allowing patients to receive more care within their home communities. Finally, the platform establishes a scalable, AI-ready data infrastructure that prepares Alaska’s health systems for current and future AI-enabled tools. These capabilities can support clinical decision support, population health management, and intelligent agents that assist providers and care coordinators with patient outreach, documentation, and care navigation. Together, this approach strengthens care coordination, expands access to care, and equips rural providers with the data and tools needed to deliver sustainable, high-quality care across Alaska’s geographically dispersed communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Skyscape Medpresso	Scaling Rural Care: A Technology & Workforce Partnership	MA	Due to the vast geography, extreme climate, and sparsely populated rural/remote communities in Alaska, many residents live far away from critical care resources, and rural healthcare providers often work in isolation with limited access to real time care coordination, ongoing medical education, specialty support, and evidence-based clinical resources. Equipping rural healthcare teams with integrated digital and "responsible AI" driven trusted mobile clinical education and decision-support platform (Skyscape's Medical Library) and it's HIPAA-secure real-time communication and collaboration application (Skyscape's Buzz) can address these gaps by empowering healthcare clinicians individually or working as a team in a healthcare enterprise. This project specifically addresses the opportunity to: Amplify Provider Reach: Connect isolated Community Health Aides with specialists in real-time using Buzz™ our HIPAA-secure communication and collaboration platform, empowering every Alaskan clinician Accelerate Workforce Readiness: Nursing SkillsHub™, a mobile training platform accelerates clinical readiness and nurses and students master nursing skills whether in the Classroom, Lab, Clinic or Home. Also AI driven trusted clinical library in the pocket (mobile app) - Clinical and Nursing Constellation - for point of care peer reviewed guidance (no internet needed) This project represents an opportunity to invest in Alaska's digital health future!	Skyscape proposes deployment of an integrated responsible and trusted AI driven digital health enablement platform that combines secure clinical communication, mobile clinical decision support, and workforce training tools. This approach equips frontline healthcare providers—including Community Health Aides, nurses, and rural clinicians—with the resources needed to deliver timely, evidence-based care even in isolated environments with limited connectivity. The initiative will deploy the Buzz Secure Medical Messenger to enable HIPAA-compliant real-time communication and care coordination between rural providers and regional specialists, care teams, and referral centers. Buzz will allow clinicians to securely consult with specialists, share patient information, coordinate referrals, and collaborate on clinical decisions, reducing professional isolation and accelerating access to expert guidance. By transforming individual providers into connected members of a broader care network, this platform strengthens care coordination and expands the effective reach of Alaska’s healthcare system. Integrated AI tools will also allow clinicians to prepare care plans or other documentation easily from within the platform. In parallel, the project will equip participating clinicians and trainees with Skyscape’s mobile clinical knowledge platform, including the Skyscape Medical Library and Nursing SkillsHub. These tools provide trusted, peer-reviewed clinical references and structured skills training directly on mobile devices, enabling clinicians to access critical medical guidance and training materials at the point of care—even in low-bandwidth or offline environments. SkillsHub will support workforce readiness by enabling nursing students and practicing nurses to master core clinical competencies through structured learning modules, quizzes, and guided skill validation across classroom, lab, and clinical settings. Also an AI component within the medical knowledge provides a conversational paradigm to trusted information. Implementation will occur through a phased deployment model that includes stakeholder engagement with rural health organizations, onboarding and training of healthcare teams, and ongoing technical and clinical support. The project will prioritize usability in remote environments by leveraging mobile-first design, offline access to clinical content, and secure messaging optimized for limited bandwidth conditions.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Slana Community Corporation	Expanded Slana EMS Training (05)	AK	Slana EMS operates in a remote, frontier region where emergency responders face long distances, harsh conditions, and limited backup. Current training opportunities are constrained by geography and staff availability, creating gaps in advanced skills, certifications, and readiness. Expanding EMS training presents an opportunity to strengthen local expertise, improve emergency response capabilities, and better prepare personnel for the unique challenges of serving rural Alaskans.	The project will provide EMS personnel with expanded training in advanced emergency care, including updated certifications, hands-on skill development, and scenario-based exercises tailored to rural and frontier conditions. Training will be delivered through a combination of in-person sessions, regional instructors, and remote learning where appropriate. Scheduling will accommodate staff availability and seasonal accessibility, ensuring all responders can participate. This approach strengthens local capacity, equips personnel with up-to-date skills, and enhances the community’s overall emergency response readiness.	Under \$50,000	Single Community	Copper River Census Area	Advance to Implementation Application
Slana Community Corporation	Slana Area Rural Health Care Based on a Rural Alaska Native Health Care Type Model (06)	AK	The project aims to establish a functioning community clinic space in the SCC building and provide basic in-person services with telehealth access to regional providers. Residents will experience improved access to routine and preventative care without needing to travel long distances. Early operations will also provide insight into service demand and operational needs to guide future development of the clinic model.	The project will establish an as-needed community clinic space within the SCC building to provide basic health services and support telehealth access.	\$250K-\$1M	Other	Copper River Census Area; Southeast Fairbanks Census Area	Advance to Implementation Application
Slana Community Corporation	Slana Community Corporation Equipment Building & EMS Vehicle Storage Building Upgrades (02)	AK	Current facility is old & deficient in order to support emergency response, training, safety, and readiness.	Upgrade facility to modernize and make facility more accessible to responders and the public.	\$50,000-\$250,000	Other	Copper River Census Area; Southeast Fairbanks Census Area	Deferred or Not Advanced
Slana Community Corporation	Slana Community Corporation/Slana EMS Positive Revenue Stream Implementation (07)	AK	Rural emergency responders across Alaska often rely on fragmented information sources for weather, transportation conditions, hazard alerts, and operational coordination. This creates delays in situational awareness and response planning. Slana EMS leadership has identified an opportunity to develop a scalable digital platform that consolidates critical regional response information into a single tool for responders.	The project will support early development of a regional emergency response application designed to integrate weather data, road and aviation information, hazard alerts, standing orders, hazmat, technical orders, geospatial information, and emergency resource coordination tools. Initial work will focus on defining system requirements, establishing administrative capacity within Slana EMS, and coordinating with potential responder partners. The platform will be designed for scalability to support broader use by responders across Alaska. We currently have a prototype that is close to readiness for beta testing.	\$50,000-\$250,000	Other	Copper River Census Area; Southeast Fairbanks Census Area	Deferred or Not Advanced
Slana Community Corporation	Slana EMS Ambulance & Ambulance Equipment Upgrade (04)	AK	Current ambulance/equipment is outdated and unreliable.	New ambulance outfitted with current up to date equipment.	\$250K-\$1M	Other	Copper River Census Area; Southeast Fairbanks Census Area	Deferred or Not Advanced

Slana Community Corporation	Slana EMS Emergency Radio Communications Upgrade (03)	AK	Effective as of January 2021, all new radios added to ALMR must be TDMA capable/enabled. Slana EMS relies on outdated radios that are not TDMA-compliant. Limited coverage, aging equipment, and incompatible technology hinder timely communication, slow emergency response, and reduce coordination with regional responders. In a remote frontier community, these gaps create safety risks for both patients and EMS personnel.	Upgrading to TDMA-capable radios will provide reliable, interoperable communication across the community and with neighboring responders, firefighters, medical personnel, law enforcement, and incident command.	\$50,000-\$250,000	Other	Copper River Census Area; Southeast Fairbanks Census Area	Deferred or Not Advanced
Slana Community Corporation	Slana EMS Personnel Access (01)	AK	Timely emergency responses due to remoteness, lack of equipment, extreme weather and destructive geological activity and unforeseen events, which require reliable equipment. The lack of reliable equipment has already this year prevented residents from being able to access roads in order to attend important medical care and appointments.	Minimize disruptions to preventative medical care, routine medical care, and non-emergency medical care. Ascertain Emergency Medical Services access to critical patients in a timely fashion in order to improve patient outcomes. To achieve aforementioned would require new snow removal equipment, listed in order of priority: motor grader, backhoe, plow truck, snowblower, and a loader.	\$250K-\$1M	Other	Copper River Census Area; Southeast Fairbanks Census Area	Deferred or Not Advanced
Smart Health Network PBC	Cut Paperwork Not Care - Smart Health Infrastructure for Rural Alaska	NY	Alaska's healthcare system spends an estimated \$1.8–3.6 billion annually on administrative waste — and rural providers bear the heaviest burden. A physician in Nome or Bethel navigates Medicare, Medicaid, IHS, and multiple insurers through separate portals, paper forms, and faxes. Prior authorizations take 5–7 days. Coverage errors drive 15–20% of first-pass claim denials. Critical Access Hospitals spend 15+ hours per week on tasks unrelated to care. Nationally, 58% of rural hospitals reported negative operating margins in 2023. Administrative fragmentation is a primary driver. Alaska has a functioning clinical HIE — healtheConnect Alaska connects 170+ provider organizations for clinical data exchange. What has never been built is the administrative layer: real-time eligibility, electronic prior authorization, and claims automation across all payers simultaneously. The CMS Prior Authorization Final Rule takes effect January 2027, requiring electronic infrastructure most rural Alaska providers don't have. The window to build correctly — once, to federal standards, with neutral governance — is now. This is not a workflow problem. It is an infrastructure gap. Until the administrative layer exists, investments in telehealth, AI, and value-	Smart Health Network is healthcare's VISA: a neutral, three-way hub connecting providers, payers, and patients through a single standardized connection. Before VISA, every bank negotiated bilateral agreements with every merchant. Healthcare has the same problem — a Critical Access Hospital in Bethel manages separate portals, credentials, and workflows for every payer. SHN solves this the same way VISA did: connect once, transact with everyone. SHN deploys by layering onto healtheConnect Alaska's existing provider network — avoiding redundant connections and accelerating adoption by building on established trust relationships. The platform is proven at scale: 68M+ lives connected through CVS Aetna, Elevance Health, HCSC, Cleveland Clinic, and Sentara. Capabilities deploy in sequence, with providers seeing value within months: **Coverage verification (live by September 30, 2026):** Real-time eligibility in under 3 seconds, replacing 15–20 minute manual workflows. Eliminates 60–80% of coverage-related first-pass denials immediately. **Prior authorization (Year 2, ahead of the January 2027 CMS mandate):** FHIR-based electronic PA using Da Vinci standards. Coverage requirements surfaced at point of order — eliminating unnecessary submissions before they start. Real-time determination for routine requests. **Claims automation (Year 2):** Clean claims submission, denial management, pre-adjudication edits — reducing the 45–60 day A/R cycle and the 15–20% first-submission denial rate.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census	Deferred or Not Advanced

based care cannot reach their potential. SHN closes that gap.

Patient visibility is built in from day one. For the first time, Alaska patients — including Alaska Native community members served by ANTHC, SEARHC, YKHC, and Southcentral Foundation — have a unified view of their coverage, authorizations, and claims in real time.

Governance is constitutional. SHN's Public Benefit Corporation charter permanently separates Rules, Rights, and Rails — no single participant can capture or redirect the network. An Alaska stakeholder council including tribal health representatives ensures the infrastructure serves Alaska's needs.

After RHTP funding, SHN operates as a permanent self-sustaining utility at 0.05% of transaction revenue, with revenue-sharing with healtheConnect Alaska — no ongoing state appropriations required.

Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area

Smith Hall , Inc	Connection to Smith Hall -Fiber Burial	AK	Smith Hall currently relies on a 15+ year-old outdoor Ethernet cable to connect with the Shelter. This cable is not rated for outdoor use, is exposed to the elements, and is increasingly unstable, causing frequent network errors and disconnections. These disruptions affect critical services such as Rightworks, telehealth, care coordination, and staff communication, creating operational challenges and potential safety risks for residents. The opportunity is to replace this aging infrastructure with a buried fiber optic line, providing a reliable, long-term network connection. This upgrade will ensure uninterrupted access to essential services, improve the quality and efficiency of care, and strengthen the sustainability of Smith Hall’s operations for the rural and frontier community it serves.	To address the unreliable network connection between Smith Hall and the Shelter, we propose installing a buried fiber optic line from the Shelter’s main network to the 2nd-floor network rack at Smith Hall. This approach eliminates exposure to weather, physical interference, and latency issues inherent in the existing aerial cable and alternative line-of-sight solutions. The project will involve: Electrical work to connect the fiber to existing network equipment. Trenching and burial of the fiber line to ensure durability and long-term reliability. Installation and testing of the fiber connection to verify stable, high-speed network performance. This solution provides a robust, long-term infrastructure upgrade, ensuring uninterrupted access to digital services, telehealth, and care coordination systems, while supporting the sustainability of Smith Hall’s operations in a rural and frontier community.	Under \$50,000	Single Community	Juneau (City and Borough)	Deferred or Not Advanced
Smith Pierre LLC	The H. Sally Smith Healthcare Housing Center	AK	There is an urgent need for housing for healthcare workers in our region.	Our location is centrally located in the first and original hotel in the region centrally located in downtown Dillingham. We propose the total rehab of the historic area using a strategic approach preserving the historic heritage and design elements. We will modernize with contemporary materials and finishes all while retaining some original design appeal. H. Sally Smith was a prominent Alaskan healthcare leader, and redevelopment of this historic site honors her work and love for the people of the region.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bristol Bay Borough; Dillingham Census Area; Lake and Peninsula Borough	Deferred or Not Advanced

Snow Creek Consulting	Pathways to Rural Alaska Healthcare Workforce Development	AK	Alaska faces a persistent and growing healthcare access crisis that could be addressed by improving the workforce development system and training opportunities. Geographic isolation, combined with intersectional challenges such as poverty, limited educational opportunities, and systemic inequities, creates compounding barriers for residents seeking care, with rural and Indigenous communities bearing a disproportionate share of that burden. The demand for healthcare services is clear and well-documented. What is less developed are the integrated, non-siloed training pathways to meet it. Training opportunities for healthcare providers within the state remain limited, leaving a significant gap between need and capacity. This gap carries real costs. Alaska currently relies heavily on locum tenens providers, an expensive and temporary solution that cycles both dollars and skilled professionals out of the state. The result is a workforce that cannot sustain itself and an economy that exports the very resources it needs most. Addressing this is not just a health imperative, it is an economic one. Investing in research on the development of clear healthcare workforce pathways has the potential to change this. By identifying local training opportunities and building effective partnerships across education and healthcare systems, Alaska can cultivate providers who are rooted in the communities they serve.	The project approach is structured around all Alaska's geographic regions and delineated tribal health care service areas to ensure that data collection, analysis, and recommendations reflect the significant and region specific distinct workforce realities, cultural contexts, and community priorities of each area rather than defaulting to a statewide average that obscures local conditions. To obtain feedback from all 12 recognized regions of Alaska in the first year of the RHTFs, some of the regions are paired. The work unfolds across four phases. The first phase launches regional engagement alongside baseline data collection. Rather than starting at the state level and filtering down, the project initiates contact with tribal health organizations, regional health corporations, educational institutions, and community stakeholders in all 12 regions (some paired) from the outset. This ensures that the workforce needs assessment, shortage mapping, and retention barrier documentation are shaped by what communities themselves identify as most pressing. The second phase deepens regional presence through structured listening and inventory work. Each region participates in stakeholder interviews, focus groups, and local partner consultations to document existing training infrastructure and career pathway barriers. Engagement methods will be designed to reach remote and frontier communities within the real constraints of distance, limited broadband, and seasonal access. The third phase brings regional findings into dialogue. Cross-regional analysis identifies shared patterns and coordination opportunities while preserving place-specific recommendations. Regional partners will review draft findings before finalization, a built-in accountability step that keeps the study credible and community-facing. The fourth phase produces differentiated deliverables for each region alongside the statewide strategic roadmap, including workforce profiles and tailored recommendations that speak directly to each area's infrastructure and capacity. Throughout all phases, engagement is treated as continuous rather than transactional. Regional relationships built during the study are themselves an asset for implementation.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Social Intelligence Laboratory, Inc.	Pathfinder: Empowering People to Ask for Help	AK	People facing behavioral health crises and substance abuse struggle to ask for help. They typically cannot determine the specific nature of their concern (particularly at early stages when proactive response and reduction of long-term impact is most possible), do not know the right questions to ask, struggle to navigate resources, and fear negative stigmas and repercussions. Depression and anxiety (WHO: cost 12bn working days & \$1tn annually), substance abuse (SAMHSA: 18% of Americans directly impacted, 62% second-order impact), and sexual abuse/violence (NSVRC: 81% of women and 43% of men impacted) have a significant impact on community resilience and wellness. Navigating social services is incredibly challenging even where they are most available, let alone in rural and remote communities. Resources exist both in-state and nationally (i.e., clinics, behavioral health units within medical centers or ANTHC, hotlines, crisis services nonprofits, etc). However, individuals are rarely able to define their need until crises magnify, and caregivers and community leaders struggle to find the right questions. Even seasoned professionals often struggle to effectively and proactively connect individuals to supporting resources without cases falling through the cracks.	Pathfinder links the framework of the John Praed Foundation’s Crisis Assessment Tools (a gold standard in behavioral health/crisis assessment and response) with the available intake processes and resources of eligible supporting resources, in order to identify the key clarifying questions necessary to support individuals in need. These prompting questions will initially support community caregivers and leaders in rapidly responding to a broad array of needs, guiding, informing, and strengthening their efforts. The system can both support both periodic check-ins as well as direct conversations. Based on the data collected in response to these questions over just a few minutes of system interaction, Pathfinder then is capable of providing warm introductions to the right resource. Complex cases often co-occur, requiring follow-up referral to additional support structures, and the system is capable of virtually walking alongside the individual to retain the high-level of effective referral and prevent cases from falling through cracks. Trend-spotting drives higher resolution and lower incident rates, while informing communities, systems, and organizations of potentially unmet needs. Our preliminary efforts and approach is supported by collaborative research from the University of Alaska-Anchorage (Public Policy), University of Washington (Social Work), Denver University (Social Work), Stanford University (Behavioral Sciences), Stephen F. Austin State University (Psychology) University of Texas-Austin (Data Science), United States Air Force Academy (Crisis Management), University of Illinois-Urbana Champaign (Social Computing), and Syracuse University (Informatics).	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Matanuska-Susitna Borough; Nome Census Area	Deferred or Not Advanced

Sound Mental Health	The Fisherman's Knot	AK	The Fisherman’s Knot project addresses two interconnected challenges facing rural and remote communities in Alaska: limited access to quality mental health services and a shortage of well-trained, clinically supervised behavioral health providers. Geographic isolation, workforce shortages, and high provider turnover make it difficult for communities to recruit and retain qualified clinicians, leaving many residents without timely or consistent mental health care. At the same time, Alaska’s behavioral health workforce pipeline remains fragile, with many emerging clinicians lacking consistent access to high-quality supervision, mentorship, and structured professional development necessary to achieve licensure and long-term practice in the state. The Fisherman’s Knot initiative seeks to strengthen both service delivery and the behavioral health workforce pipeline. By expanding access to structured clinical supervision, mentorship, and hands-on training opportunities, the program supports emerging clinicians as they move toward licensure and independent practice. This investment in supervision and professional development helps cultivate a stronger pipeline of qualified practitioners who are prepared to serve in rural communities and remain practicing in Alaska. By addressing workforce development alongside community service needs, the Sound Mental Health team aims to improve both the availability and long-term sustainability of high-quality mental health care across the region.	Communities across Prince William Sound and the Copper River Basin face barriers to timely, culturally responsive behavioral health care. Geographic isolation, workforce shortages, provider turnover, and limited training pipelines create service gaps that disproportionately affect families and Alaska Native communities in Valdez, Cordova, Tatitlek, and Glennallen. These challenges, combined with limited professional opportunities in rural areas, contribute to workforce instability and unmet behavioral health needs. Alaska also faces a critical gap in the behavioral health workforce pipeline between graduation from a master’s-level clinical program and licensure. Post-graduate clinicians must complete 2,000 hours of supervised practice, yet supervision opportunities are limited and costly. Many graduates leave Alaska, avoid rural practice, or exit the profession before licensure—losses Alaska can no longer afford. Through the Rural Health Transformation Program, Sound Mental Health, with its nonprofit arm Safe Harbor Alaska, seeks funding to strengthen a regional behavioral health network that expands access while building a sustainable rural workforce. At the center is The Fisherman’s Knot, a workforce development and service model addressing care access and Alaska’s licensure pipeline gap. The program provides structured supervision, mentorship, and professional development for emerging clinicians, creating supported pathways from graduate education to rural practice. The Fisherman’s Knot connects clinicians and communities through coordinated supervision and service delivery anchored in a central hub. Clinicians remain linked to a supervisory and professional support structure that ensures clinical quality and workforce retention. The program will recruit bachelor’s- and master’s-level social workers, mental health clinicians, and case workers from the University of Alaska Anchorage and University of Alaska Fairbanks through rural-focused training pathways. Participants relocate to Valdez for structured supervision, licensure exam preparation, and training in rural, frontier, and Alaska Native-serving care systems. From Valdez, clinicians operate as a mobile, hub-based workforce, traveling to Cordova, Tatitlek, and Glennallen for clinical services and case management. After each deployment, providers return to Valdez for supervision, peer consultation, and professional development, reinforcing care quality and long-term workforce retention.	\$1M-\$5M	Private practitioner	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Copper River Census Area	Deferred or Not Advanced

Sound to Sea LLC	Diagnostic and therapeutic musculoskeletal ultrasound access for Southeast Alaska	AK	Musculoskeletal injuries are among the most common reasons patients seek care, particularly in communities where fishing, outdoor labor, and outdoor recreation place high demands on the body. Despite this need, many musculoskeletal conditions affecting tendons, muscles, ligaments, nerves, and joints require ultrasound access and sports medicine training not readily available in Southeast Alaska. Musculoskeletal ultrasound is one of the most effective tools for evaluating these injuries. Tendon injuries, nerve, muscle and some joint injuries are often best visualized with ultrasound because it provides high-resolution, real-time imaging of soft tissue structures that are difficult to assess with standard imaging or physical examination alone. In addition to diagnosis, ultrasound guidance improves the accuracy and safety of therapeutic procedures such as injections, aspirations, and hydrodissections. In some cases, these procedures can only be safely performed under ultrasound guidance. Effective musculoskeletal imaging requires high-quality equipment capable of distinguishing subtle differences between small and complex soft tissue structures and someone that can interpret these findings and make clinical decisions. I am the only primary care physician in Southeast Alaska who has completed additional fellowship training in sports medicine musculoskeletal medicine, of which a significant portion of my training involved diagnostic and therapeutic ultrasound use.	My proposed approach is to acquire a high-quality musculoskeletal ultrasound system that will allow me to fully utilize the diagnostic and procedural skills I developed during my sports medicine fellowship and bring this level of care to patients in Juneau and throughout Southeast Alaska. Musculoskeletal ultrasound is highly operator-dependent and requires specialized training and familiarity with the ultrasound platform being used. While many ultrasound systems exist, there is considerable variability in image quality, probe capability, interface design, and workflow. Learning to optimize image acquisition, recognize subtle abnormalities in tissues, and integrate ultrasound into procedures requires significant time and repetition. During my fellowship training, I used the Sonosite LX ultrasound system extensively in a high-volume musculoskeletal practice. This machine was in use for over a decade, delivering reliable and high-resolution imaging. Because I am already experienced with this system, acquiring the Sonosite LX will allow me to immediately implement musculoskeletal ultrasound into practice without the delay associated with learning a new system. With this equipment, I will provide both diagnostic and therapeutic services locally. An additional advantage of the Sonosite LX is its portability. The system is designed for point-of-care use and can be transported easily between clinical settings. This mobility would allow me to bring musculoskeletal ultrasound services to other communities in Southeast Alaska where access to specialty musculoskeletal care is even more limited. By acquiring a reliable ultrasound platform that I am trained to use, I can expand access to advanced musculoskeletal diagnosis and treatment, reduce the need for costly travel and specialty referrals, and deliver timely, high-quality care to patients throughout Southeast Alaska.	\$50,000-\$250,000	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

South Adult Day Services, LLC	South Adult Services Adult Day Program Infrastructure and Capacity Expansion Project	AK	South Adult Services seeks to address the growing need for adult day services in Anchorage and the surrounding region, where seniors and adults with disabilities face limited access to structured, community-based care. As Alaska's population ages and the number of individuals living with chronic conditions, cognitive impairment, and functional limitations increases, there is a critical need for services that support aging in place and reduce reliance on institutional care settings. Anchorage serves as Alaska's primary healthcare hub for both urban and rural populations. Many individuals from rural and remote communities relocate to Anchorage to access medical care, but often lack access to adult day services that provide supervision, cognitive engagement, and support necessary for safe community living. Without these services, individuals are at increased risk of hospitalization, emergency department utilization, and premature placement in long-term institutional care. This project presents an opportunity to expand healthcare system capacity by establishing adult day services infrastucture that improves access to care, enhances care coordination, and supports Medicaid beneficiaries and vulnerable populations. By providing structured supervision, safety monitoring, and participant-centered programming, South Adult Services will strengthen community-based care delivery, reduce healthcare system strain, and improve quality of life for participants and their families.	South Adult Services will address the identified gap in adult day services capacity by establishing a fully operational, community-based adult day care program in Anchorage serving up to (40) participants daily. The project approach includes infrastructure deployment, workforce implementation, and phased operational launch aligned with Medicaid Home and Community-Based Services (HCBS) standards. The First phase focuses on facility readiness, including installation of safety systems, furnishings, equipment, and commercial kitchen infrastructure necessary to support structured daily programming and participant supervision. Concurrently, the organization will recruit and onboard qualified staff, including program leadership and activity personnel, to insure appropriate staffing ratios and participant-centered service delivery. Following SDS site approval and Medicaid provider enrollment activation, services will begin with a phased participant enrollment strategy to safely ramp to full capacity. The program will provide structured cognitive engagement, social programming, safety monitoring, and coordinated support designed to prevent unnecessary hospitalization and premature institutionalization. The approach incorporates evidenced-based gerontology practices, structured daily programming, and modern safety infrastructure to improve participant outcomes and support caregivers. Referral pathways will be developed with local healthcare providers, social workers, and discharge planners to ensure continuity of care for Medicaid beneficiaries and rural Alaskan's residing in Anchorage for medical services. By combining infrastructure investment, workforce expansion, and sustainable reimbursement mechanisms, this project establishes a durable adult day services model that strengthens healthcare access, improves care coordination, and supports aging in place within Alaska's healthcare system.	\$250K-\$1M	Home-and communit y-based services provider	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

South Adult Day Services, LLC	South Adult Services Rural Medical Access Lodging Project	AK	Residents of rural Alaska frequently travel to Anchorage to access specialized medical services that are not available in their home communities. While Anchorage functions as the primary healthcare hub for the state, many rural patients and their caregivers face challenges securing short-term lodging while attending medical appointments, receiving treatment, or waiting for return travel to their home communities. Seasonal demand, high lodging costs, and limited availability can create barriers that complicate access to timely care. The South Adult Services Rural Medical Access Lodging Project addresses this need by developing fourteen temporary lodging units within an existing mixed-use facility in Anchorage. By expanding lodging capacity specifically for rural patients and caregivers traveling for healthcare services, the project will reduce barriers associated with medical travel and improve the ability of rural residents to access care in Anchorage. This project also presents an opportunity to efficiently utilize an existing facility that already supports community-based health services. The lodging units will operate with administrative coordination and facility support from South Adult Services staff located on-site, allowing the program to launch quickly and operate efficiently. During the initial two-year implementation period, the lodging units will be made available at no lodging cost to eligible rural residents traveling to Anchorage for healthcare.	The South Adult Services Rural Medical Access Lodging Project will address the need for temporary lodging for rural residents traveling to Anchorage for healthcare by developing fourteen lodging units within an existing mixed-use facility located at 7830 Old Seward Highway in Anchorage. The space has already been framed for lodging use and is fully sprinklered, allowing the units to be completed through the targeted renovation and installation of necessary plumbing, electrical, fixtures, and furnishings. Once completed, the lodging units will be available for rural Alaska residents who must travel to Anchorage for medical care, as well as caregivers accompanying patients. The facility will operate as temporary medical access lodging rather than commercial hotel accommodations, providing safe and reliable short-term lodging for individuals traveling for treatment, follow-up appointments, or coordination of care. Program administration and guest intake will be coordinated through the existing South Adult Services front desk located within the same facility. Administrative staff will oversee check-in and check-out procedures, maintain occupancy records, and coordinate scheduling. Housekeeping and facility support staff already operating within the building will provide room readiness and sanitation services. During the initial two-year implementation period, the lodging units will be made available at no lodging cost to eligible rural residents traveling to Anchorage for healthcare services. By utilizing an existing facility and operational infrastructure, the project can be implemented efficiently while providing immediate benefit to rural patients and caregivers who require temporary lodging while accessing medical care in Anchorage.	\$250K-\$1M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Copper River Census Area; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

South Peninsula Behavioral Health Services	Homer Youth Programming Everyday (HYPE)	AK	According to the Alaska After 3pm research from Oct. '25, the parents of over 82,000 children sought after-school programming, yet, only 17,516 were enrolled in 2025. 4 out of 5 kids did not partake. South Peninsula Behavioral Health Services (SPBHS) is coordinating a community initiative to support youth and families during out of school time (OST). SPBHS will be building on a model which includes partnership with Center for Alaska Coastal Studies, Kenai Peninsula Borough School District, Paul Banks Elementary, The City of Homer, Paul Banks PTA, Homer Community Recreation, The Homer Foundation, and The Southern Kenai Peninsula Resilience Coalition to provide stimulating and engaging out of school activities to the community. The program will offer low/no cost services to all children of the Southern Kenai Peninsula which will include academic support, recreational support, health support, mental health support, social activities, and nutritional support. The program will operate from 3pm to 6pm Monday through Thursday during the school year.	Children will be dropped off at our HYPE location and checked in by SPBHS Staff. A Program Director will oversee daily operations and Activity Staff will oversee specific activities/events on a daily basis. HYPE will partner with local specialists/professionals/volunteers to offer numerous programs and activities. A sample of a Thursday schedule is as follows: <table><tr><td>Day</td><td>3-3:15pm</td><td>3:15-4pm</td><td>4-4:45pm</td><td>4:45- 5pm</td><td>5-6pm</td></tr><tr><td>Thurs</td><td>Arrival</td><td>Coastal Std</td><td>Coastal Std</td><td>Clean-up</td><td></td></tr><tr><td>Open Gym</td><td></td><td>Nutrition</td><td>Academics</td><td>Taggames</td><td></td></tr><tr><td></td><td></td><td></td><td>Nature Hike</td><td>Art Class</td><td></td></tr></table> On this particular Thursday, the kids would arrive and get a healthy afternoon snack (nutrition). Then, at 3:15, they would attend either a Science Class with our partner the Center for Alaskan Coastal Studies, homework/academic enrichment time, or go on a nature hike. The sections offered by our partner organizations, in this case the science class from Coastal Studies, would be pre-determined at registration by the parent/caregiver. Or, if the parent prefers the child participate in homework/academic enrichment time, that would be determined at registration as well. Children not enrolled in either of those options would participate in the Nature Hike that day. At 4:00, the Coastal Studies class would continue for those kids enrolled. The other children would have the option of participating in some active Tag games or joining in the Art Activity. At 4:45, everyone comes together and helps clean up the spaces. And finally, at 5:00, parents may start picking up their children. The gymnasium will be open for supervised free play while the children await pick-up. Our plan is to be able to offer the specialized sections offered by our partner organizations at no cost to the families. However, due to the nature of some of these programs an additional cost at registration may be necessary. We will be exploring grant and funding options to help keep these specialized activities available to all. The Staff at SPBHS are also trained mental health clinicians and para-professionals. They will be leading and supporting the activities as well as identifying individuals in the community who may need additional supports to be successful and providing that support preventatively rather than reactively.	Day	3-3:15pm	3:15-4pm	4-4:45pm	4:45- 5pm	5-6pm	Thurs	Arrival	Coastal Std	Coastal Std	Clean-up		Open Gym		Nutrition	Academics	Taggames					Nature Hike	Art Class		\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced
Day	3-3:15pm	3:15-4pm	4-4:45pm	4:45- 5pm	5-6pm																												
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South Peninsula Hospital	Expand Healthcare Quality and Access Through Implementation of Robotic Surgery	AK	Residents of rural communities are often not able to receive gold standard surgical care close to home because most rural facilities do not have access to modern surgical technologies. When patients in the South Peninsula Hospital service area can't find the care they need locally, they must travel 150 miles roundtrip on a highway that is dark and icy half the year to the next closest hospital or seek care in Anchorage or beyond. This represents an extraordinary cost and inconvenience for many. For others, lack of local access means they delay or simply forego the care entirely. We have heard directly through Press Ganey surveys that patients in our region are seeking robotic surgeries elsewhere. This presents a risk to the future of healthcare as loss of revenues threatens already tight margins. The Kenai Peninsula is rapidly aging, and many urologic conditions increase with age (e.g., benign prostatic hyperplasia, incontinence, and kidney stones.) SPH is already seeing a huge increase in demand for urology services—up 123% since 2021. Urology is one of the fields in which robotic-assisted surgeries can be most effective. Our communities want and expect robotic-assisted surgery capabilities in their care. And SPH leadership and medical staff are enthusiastically onboard with integrating this new technology into their care.	To transform SPH's ability to address rising healthcare needs, SPH will purchase an intra-abdominal surgical robot and train its medical workforce to use it. These systems are commonly used for urological, gynecological, and general surgeries. Robot-assisted surgery has been broadly adopted by teaching hospitals and increasingly by hospitals around the country. Robotic surgeries offer finer dissection leading to a higher level of precision, less tissue manipulation and damage, lower pain levels, and easier healing. Today, robotic surgeries are standard of care for many types of common surgeries in this country (e.g., appendectomy, cholecystectomy, hernia repair), and patients as well as providers seek out these technologies when considering where to receive and provide care. The Kenai Peninsula's population is older than the state overall and the nation, and a continued rise in this population sector is projected—peaking in 2030 – 2035 at nearly ¼ of the population. This means that healthcare needs in our region are growing, and growing in complexity—the need for urology services (which typically address issues that increase with age), for example, has more than doubled since 2021. And as people age, the incidence of numerous disorders requiring abdominal surgery increase, such as gallstone disease, diverticular disease, and colorectal cancer. Our communities want robot-assisted surgeries. In 2024, SPH launched robotic orthopedic surgeries, and in the following year, saw a 45% increase in demand for total knee arthroplasties (knee replacements) relative to the average of the two years prior. Surgical robots will help stabilize SPH's surgical workforce and expand its capacity. Estimates indicate that this technology will increase urological volumes enough to hire a full-time urologist who can provide consistent care. Inevitably, locums surgeons take their patients to other facilities that have surgical robots, undermining overall healthcare sustainability. Robotic orthopedic surgery enabled SPH to triple its orthopedic staffing and expand the types of surgeries offered locally. Driven by strategies to address key findings of SPH's recent Community Health Needs Assessment, this project addresses Initiative #2, Health Care Access and is an allowable use of RHTP funds. This technology will position SPH to better provide a continuum of care for residents in the region, including dual eligible seniors and those with or at risk of chronic disease.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

South Peninsula Hospital	Expansion and Improvement of Rehabilitation Services to Support Continuum of Care Close to Home	AK	SPH currently lacks cardiopulmonary rehabilitation services. Patients recovering from myocardial infarction, coronary artery bypass grafting, heart failure, COPD, or other chronic cardiopulmonary conditions must travel 150 miles or more roundtrip for therapy. For many people—especially seniors and those with limited transportation or fixed incomes—travel barriers result in low participation or no rehabilitation at all. Alaska’s RHTP identifies chronic disease burden, limited specialty access, and insufficient long-term care capacity as major rural challenges. The Kenai Peninsula’s aging demographic intensifies this need. Without local rehabilitation services, patients face higher risk of deconditioning, preventable readmissions, functional decline, and institutionalization. At the same time, demand for inpatient PT and OT as well as speech therapy for pediatrics and adults remains strong. The SPH Long Term Care and Acute Care Departments rely on inpatient PT and OT to ensure the health of patients and residents, and speech therapy services are offered as both in- and outpatient care. Temporarily rehoused to make room for SPH’s new integrated women’s health clinic, these services are currently located in a temporary space within the hospital, awaiting final location in a purpose-designed location within hospital walls.	The Kenai Peninsula has a disproportionately high senior population (22%) compared to both Alaska (16%) and the nation (18%). Older adults experience significantly higher rates of cardiovascular and pulmonary disease and need cardiopulmonary rehabilitation to promote health. To truly transform health in Alaska’s rural communities, we must make healthcare accessible, high quality, and sustainable over the long-term. On the southern Kenai Peninsula, our communities prioritize local access to care. In many cases, if individuals can’t find the care they need at SPH, they must travel 150 miles on a highway that is dark and icy for half the year, or even farther to Anchorage. For many people, this isn’t just impractical, it is impossible. And for some types of care—especially rehabilitation and therapy, which typically require frequent visits over an extended period of time (twice weekly for 18 weeks)—local availability of care is the difference between patients receiving the services they need or not receiving them at all. Based on strategies developed to address key findings of recent SPH Community Health Needs Assessments, this project represents a proactive investment in to position SPH to provide essential services to the region’s aging population and existing inpatient and outpatient populations long into the future. This project will renovate 1,900 square feet of existing hospital space to support cardiopulmonary rehabilitation as well as physical, occupational, and speech therapy. This project will establish a cardiopulmonary rehabilitation program designed to meet evidence-based CMS standards. Design of the new space will be concluded this spring. Equipment purchases for cardiopulmonary rehab include a treadmill, recumbent ellipticals, stationary bikes, weights, and monitoring devices. SPH will: 1. Renovate 1,900 square feet of space recently vacated by behavioral health services for therapy and rehab. Equip space for a new cardiopulmonary rehab service line as well as continued PT/OT/speech therapy. 2. Recruit one new RN or therapist and cross-train existing therapists and nurses for cardiopulmonary rehab. 3. Technology Integration: Integrate wireless remote monitoring capabilities and data tracking tools within Epic. 4. Care Coordination: Develop referral pathways for cardiopulmonary rehab with SPH primary care, hospitalists, cardiology consultants, and Anchorage specialty providers to ensure seamless post-acute transition.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

South Peninsula Hospital	Leveraging Technology to Increase Workforce Sustainability and Improve Patient Care	AK	SPH, like other rural hospitals in Alaska, is in a Health Professional Shortage Area. Recruiting providers to our end-of-the-road community can be difficult and expensive, especially with local housing shortages, high cost of living, and limited workforce pipelines. Increasing administrative documentation demands pile onto these challenges, and serve as a barrier to long-term retention of existing healthcare workers. Providers at SPH’s Homer Medical Center routinely spend two to four hours beyond the work day on charting and inbox management. Many have to attend to these duties during evening and weekend hours. This situation is not sustainable. Note-taking burden is contributing to workforce burnout, recruitment challenges, and reduced appointment availability. To address these challenges, we will leverage an AI scribe system to capture and record provider-patient conversations and create detailed and accurate clinical notes in SPH’s Epic EHR system. Providers will be able to focus on patient interaction and care, rather than on note-taking. After appointments, they will merely need to review and edit AI scribe-created notes for corrections rather than creating them whole cloth. SPH’s pilot test of an AI scribe system found that it could cut note-taking time in half or more, a true game changer for our workforce.	This project represents a technology-enabled solution to deftly address two top findings of SPH's most recent Community Health Needs Assessment, conducted in collaboration with MAPP, the region’s health improvement coalition: shortages in healthcare workers and barriers to receiving primary care. SPH will implement an AI scribe system integrated into Epic across selected primary care and specialty providers in a phased rollout. The benefits of reduced administrative burden on providers will cascade to patients. Providers will interface directly with patients more and won’t be staring at a screen during appointments. And appointments will feel less rushed as providers will have more time to work directly with patients, without the burden of clinical notetaking impinging on visits. Implementation steps will include: 1. Release RFP for an AI scribe system 2. Develop and launch a patient survey and education plan to gauge patients’ perspectives and educate them on the benefits and limitations of the new system. 3. Purchase and install the system in a phased approach at SPH primary care and specialty clinics. 4. Carry out provider training on the new system. 5. Launch services with the new system in a phased approach. 6. Monitor performance of the new system by tracking data such as accuracy, note-taking time, provider time for corrections, provider and patient satisfaction, etc. 7. Carry out quality assurance by establishing review protocols to ensure documentation accuracy and compliance.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

South Peninsula Hospital	Modernize and Automate Medication Dispensing for Safety and Efficiency	AK	SPH’s medication distribution workflows rely heavily on manual processes and dated systems, which are labor-intensive and inefficient. Manual workflows increase risk of medication errors, consume valuable pharmacist and nursing time, and limit scalability as SPH seeks to expand infusion services and other areas of patient care to meet the rising needs. According to the American Society of Health-System Pharmacists, 97% of hospitals in the U.S. use AMDS. But many rural hospitals are left out of this technological advancement. Alaska’s RHTP identifies aging infrastructure, workforce shortages, and need for technology modernization as major rural health system challenges. This program presents a generational opportunity to modernize rural facilities to meet growing and changing healthcare demands, leverage opportunities provided by new technological developments, and implement facility and process improvements that support a strong, engaged, and sustainable workforce. On the Kenai Peninsula, an aging population and high chronic disease burden are increasing demand for specialty medications and infusion therapies. Now is the time for SPH to proactively invest in its pharmacy infrastructure as its population ages and as it seeks to expand infusion services, which have seen a sharp increase in demand in the last five years. Implementation of the AMDS will help SPH meet rising infusion demand safely and efficiently.	As healthcare demands in our region rise, SPH is limited in meeting these needs by infrastructure, process, and workforce constraints. The goal of this project is to modernize infrastructure, streamline processes, and use staff time more efficiently to enable a scaling up of Pharmacy capacity in order to meet the healthcare challenges in our region. These challenges include the expanding needs of an aging population that requires higher level care close to home, the large growth in demand for infusion, and the need to manage higher patient acuity while also expanding services lines to include, for example, cardiopulmonary rehabilitation and expanded urology procedures. An AMDS will position SPH to meet these challenges. Automated dispensing technology improves medication safety through barcode verification, real-time inventory management, controlled substance tracking, and standardized workflows. These capabilities are particularly critical in rural settings like ours where workforce shortages, supply chain disruptions, and limited redundancy increase operational risk. Without improvements to medication distribution workflows, expanding infusion services could strain staffing capacity and increase operational risk. Or SPH might be forced to increase staffing to address growing medication management needs, which would increase healthcare costs. This project addresses the opportunity to modernize medication management infrastructure to improve safety, efficiency, and readiness for expanded specialty services. SPH will purchase and implement this AMDS and integrate it into its Epic EHR. Key implementation components include: Equipment Acquisition & Installation 1. Release an RFP to support the purchase and installation of AMDS 2. Configure controlled substance management features 3. Integrate barcode verification and inventory tracking systems Pharmacy & Infusion Integration 1. Establish standardized medication preparation and dispensing protocols 2. Train staff and align workflows 3. Develop updated medication administration policies Data & Inventory Optimization 1. Implement real-time inventory monitoring 2. Improve formulary management This project is integral to strategies that address key findings of SPH’s recent Community Health Needs Assessments, which are developed with MAPP, the regional health improvement coalition, including the need to reduce barriers to specialty care and to develop services targeted to promote senior health.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

South Peninsula Hospital	South Peninsula Hospital Medical Service Expansion and Infrastructure Upgrade	AK	The Kenai Peninsula population is rapidly aging. This region now has a higher percentage of seniors than Alaska overall and the nation, and projections call for continued growth of this population sector, peaking at 24% in 2030. Our aging population means that healthcare needs in our region are changing, growing, and becoming more complex. As people age, rates of cancer, cardiovascular disease, diabetes, chronic lung disease, cognitive impairment, and other illnesses. Older adults are more likely to need infusion services as well as advanced imaging and other services. At the same time, according to the latest South Peninsula Hospital Community Health Needs Assessment, cancer was the leading cause of death in the region for the period 2007- 2020, with incidence rates higher than state averages, additionally driving the increased need for cancer care and a larger suite of imaging capabilities in the region. These challenges require proactive investment. And SPH has the organizational capacity and regional support to successfully carry out this project. Annual strategic planning shaped by results of regular, collaborate Community Health Needs Assessments drive this project, which has already been issued a State of Alaska Certificate of Need. The challenge for small hospitals like ours is securing capital to make such an investment. Once the new and expanded services are in place, we estimate an increase in revenues to offset the cost of expanded care.	This is a two-phased project. Phase 1 will focus on the Infusion and Oncology Department and the Hospital Pharmacy. Phase 2, scheduled for Year 2 of the RHTP, will focus on Nuclear Medicine. In Year 1, this project will relocate and expand SPH’s Infusion and Oncology Department, currently in a 960 square foot offsite building to 4,401 square feet of unprogrammed space within hospital walls. This project will double the number of infusion chairs, including doubling the number of chairs in a private room for added privacy and increased infection controls. The facility will have exam rooms, restrooms, a nurse’s station, registration desk, a med room, a staff rest area, and ancillary support spaces. Relocation of this facility within the hospital walls will enhance patient safety and comfort, as emergency services, the hospital cafeteria, and other support facilities are located in the main building. In addition, the SPH Pharmacy will be relocated to 1,437 square feet of unprogrammed space adjacent to the new Infusion and Oncology Department, more than doubling its size. The renovated Pharmacy will include two compounding rooms with dedicated compounding hoods that meet USP requirements. A biological safety cabinet will allow for the safe storage and handling of hazardous drugs, and a separate Pharmacy-dedicated air handling system will enable the facility to meet certification requirements. Staff workflow and security (including for pharmaceutical deliveries), will be improved in the new location. Co-location with the Infusion and Oncology Department will streamline delivery of medications and avoid outdoor transport of sensitive pharmaceuticals. The design process for this project is complete. SPH and the Kenai Peninsula Borough, which owns the hospital facility, are ready to move into the bidding phase. Construction is estimated to be completed in 12 months. This project addresses RHTP Initiative #2, Health Care Access, with the aim of expanding and sustaining essential health services in rural Alaska. While this project represents an extraordinary advance in the healthcare capacity for the region, the SPH footprint will not change. All of the structural and framing elements in the building are already in place to make this project a success. This project will carry out strategic reprogramming of existing space to meet project goals.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

South Peninsula Hospital	Digital Displays at South Peninsula Hospital	AK	Since Covid, communication channels are unpredictable and chaotic. Once-reliable local media cannot now be trusted for content, reliability or even availability. Staffing shortages cause local radio to replay news programs that are weeks old; and the local newspaper is so short staffed it closed its Homer office and the remaining reporter works from home. Additionally, the clinical experience changed. Waiting rooms removed paper and magazines, patients get roomed faster to avoid crowded waiting rooms, shifting long waits to sitting alone in an exam room. Patients are sent to the “patient portal” to do business, which eliminates conversation. SPH runs an active social media page, and publishes a monthly e-newsletter, but engagement with these tools is spotty. Printed materials are expensive and quickly outdate. The hospital’s growth has expanded our services into 13 buildings spread across the entire town. A patient might “interact” with SPH only at the functional medicine clinic, a small converted home approximately four blocks from the hospital, or at the outpatient rehab center, two miles from the hospital. The digital displays are critical in keeping patients and staff connected with the entire healthcare system, no matter what door they walk through or what waiting room they’re in. Whether waiting for a loved one, to be called in, or for results – the wait time is when we can both help a patient pass the time, and inform them about information related to their care.	Hospitals have always known the power of the screen – thus every hospital inpatient room has a television in it. The screen is just as powerful beyond the inpatient room. South Peninsula Hospital will purchase digital displays and mount on walls in waiting rooms and even in exam rooms that tend to have longer sit and wait times. We will use these monitors to display information about local providers and services, health tips, pertinent helpful information related to one’s care, engagement with the hospital “owner” (non profit entity), encourage patient satisfaction surveys to be completed and more. SPH supports a very robust health education program for the community which could easily be replicate on the screen. The majority of our outpatient clinic waiting rooms have recently been remodeled; so all waiting rooms have electrical power, wireless connection and a fresh coat of paint. The IT Department has already verified that our wireless network is robust enough to support this program. Monitors of varying sizes would have to be purchased and installed. Larger for bigger waiting rooms, smaller for key exam rooms. The hospital’s IT and maintenance departments are prepared to support the decision making, purchasing and installation. Numerous subscription software programs are available for this type of digital healthcare communication that come with canned programming, however none of them are Alaska lifestyle-friendly. SPH would purchase a bare bones version and handle content development on our own from the marketing department and health & wellness department. From board meeting announcements and even job recruitment, to welcoming a new specialist or explaining how to use the new patient portal, these digital screens will carry the power to connect, educate and inform.	Under \$50,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

South Peninsula Hospital	Friends and Food as Medicine in Rural Communities	AK	As we know in Alaska perhaps more than anywhere in the country, a meal is not just nutrients. It is culture, tradition, social connection, and health. But one in seven adult Alaskans—and one in six Alaska kids—are food insecure according to Feeding America. Healthy food can be hard to come by, especially in Alaska’s rural communities where grocery prices are often exorbitant and not everyone can harvest wild foods, and in many cases, the availability of wild foods is changing. The SPH 2023 Community Health Needs Assessment identifies food insecurity as a factor affecting health in the region. Our elders often face extra challenges accessing healthy food, including the challenges of affordability when on a fixed income, traveling to shop for groceries in harsh winter conditions, and just the difficulties of cooking and dining for those who live alone. At the same time, our communities are witnessing an epidemic of loneliness and its outcomes. According to a 2023 Health and Human Services report, about half of American adults experience loneliness. Loneliness is linked to chronic illness—increasing rates of cardiovascular disease, dementia, stroke, depression, anxiety, and premature death. Being socially isolated is as risky for your health as smoking up to 15 cigarettes a day, while social connection can help reduce the risk of chronic disease and serious illness. SPH is poised to help address these challenges by supporting healthy, shared meals in our community.	According to the National Council on Aging, seniors who share meals with others experience improved physical and mental health and a better quality of life. SPH supports meal-sharing among seniors and others through its programs and cafeteria lunchtimes. For example, SPH provides a free weekly from-scratch soup and bread dinner during its public Wellness Wednesday health education and outreach programs. We know from feedback that for some people in the region, especially the elderly, this is their once-weekly opportunity to eat in community. In addition, SPH provides free healthy meals at its annual Senior Wellness Day, and at its annual Community Resources Connect event, which provides support and services to people experiencing homelessness or economic instability (this event served 115 people this year). Additionally, SPH provides healthy snacks at regular events, such as a weekly indoor walking program that regularly hosts 60 or more individuals each week, spring-time community walking celebrations, and Brest Cancer Awareness month events. The SPH kitchen is the invisible workhorse behind these programs. Meals are, of course, also provided at the hospital cafeteria, which is open to the public 11 am - 1 pm daily. Over the last two years or so, the SPH cafeteria has become a popular gathering space for seniors looking for a place to share affordable, healthy meals with friends. Lunches served to the public have tripled since 2024. As demand for SPH meals for hospital patients and residents has increased with higher patient and resident censuses, and participation rates in our education and outreach programs have grown, the capacity of our food service infrastructure is maxed out. Alaska’s RHTP presents a generational opportunity for rural hospitals like ours to leverage the synergistic connection between high quality food and social connection to improve health in our region. SPH will purchase and install the following equipment: 1. Walk-in Cooler: SPH has run out of cooler space, and needs more capacity to support patient care as well as public meals and programs. 2. Double Oven: To double the capacity of SPH’s oven space to meet growing needs. Current oven space is maxed out, running nonstop morning through evening to prepare food in time for patient meals and public programs. 3. 10-Burner Range: This will nearly double SPH’s stove top capacity to meet current needs. 4. Steam Table: This piece of equipment helps keep hot meals hot.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

South Peninsula Hospital	Infrastructure Improvement to Support Patient Safety and Workforce Sustainability	AK	As in the state overall, the Kenai Peninsula population is rapidly aging. Between 2010 and 2020, the region’s overall population grew by 6%, but the number of residents 65 years and older surged by a staggering 80%. The Kenai Peninsula now has a higher percentage of seniors than Alaska overall and the nation, and projections call for a continued growth in this population sector. By 2050, projections estimate that the state’s population of 85-year-olds and older will increase 270%, and one-third of these individuals will suffer from Alzheimer’s or related dementia. Our aging population means that healthcare needs in our region are changing, growing, and becoming more complex. Long-term, skilled nursing care is essential to ensuring our elders can age safely close to home with dignity. SPH’s Long Term Care Department is well-positioned to meet the expanding needs for skilled nursing care long into the future. A national-award-winning facility, LTC employs about 80 dedicated employees with a robust staffing mix of RNs, LPNs, and CNAs on every shift. LTC has worked hard to build a strong, sustainable workforce through in-house training, tuition assistance, cross-training and other opportunities, which keep LTC’s nursing turnover rates consistently below state peers’. In addition, LTC’s clinical outcomes (including for depression, falls, and skin disorders) are consistently higher than state and national averages. A strong leadership team is ready to make this project a success.	Our current lift system has reached the end of its life and has started to fail. On top of that, it does not adequately accommodate bariatric patients. Our goal is to position South Peninsula Hospital’s Long Term Care facility to be able to serve our growing senior population long into the future. This goal demands proactive investment in infrastructure. Many residents who enter LTC have limited or no mobility. LTC must be adaptable to increasing resident acuity and an aging population. And the facility must be able to serve bariatric patients who, without this lift system, would need to be referred out to other facilities far from home. This lift system will ensure that resident rooms remain functional over time and help LTC avoid costly retrofits long into the future. And it will reduce the risk of injury to staff. SPH LTC is the only nursing home in the region. The 18,000 square foot facility has a day room, kitchen, library, therapy areas, and a private tub room. This facility ensures that elders can age close to home and supports residents in maintaining family and community ties. Family members are warmly welcomed into the facility—many stay for meals and come for frequent visits. In addition, the LTC van delivers residents to local events such as movies and parades. In addition, family, friends, and community groups are welcomed in for special events (e.g., Thanksgiving, Christmas, and Valentine’s Day dinners), live music performances, Halloween trick-or-treating, and other formal and informal gatherings that help residents maintain important family and social ties. This project is a strategy to directly address a key finding of SPH’s most recent Community Health Needs Assessment, a collaboration with MAPP, the regional health improvement coalition: to enhance services and support for seniors. SPH LTC will decommission the existing lift system and purchase and install a new, higher capacity patient lift system in every bedroom in the facility. The equipment will include ceiling tracks, lift motors, slings and transfer accessories. Installation will carry out structural reinforcements as needed, staff training, and development of standardized safe-handling protocols. SPH will launch an RFP process, procure the lift system, and work with the vendor to install it. SPH will ensure that there is no disruption to patient care.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

South Peninsula Hospital	Modernizing and Upgrading Facilities to Support Rural Healthcare	AK	SPH’s primary air handling system is a dinosaur. This energy hog is 41 years old, beyond its useful life, and just about impossible to find parts for. A failure of one of the system’s old three-phase motors leveled the system for nearly three weeks a few years ago because it took so long to find parts. This AHU serves more than one-third of the hospital building—including surgery, obstetrics, and neurology (about 35,000 square feet). When the system goes down, we lose adequate heating and cooling ability, the air stagnates—which can increase the threat of infection, and there's a risk of the fire alarm going off because of humidity issues. Typically, these systems last 15 - 25 years. An ancient, unreliable air handling system puts SPH at risk of state citation, if our temperature and humidity controls are out of compliance with CMS requirements. In addition to being crucial for patient and provider health and safety as well as staff comfort, this system handles the air in our server room, the IT and security hub for the hospital, which has very stringent environmental requirements. On top of this, the current air handler was installed decades before today’s seismic safety standards were established, and it remains vulnerable to failure in the event of an earthquake or other natural disaster. A major seismic event could cause the system to collapse or shut down—compromising patient health and safety and forcing closure at a time of greatest community need.	The RHTP presents small rural hospitals like SPH with an opportunity to invest in infrastructure that sustains healthcare for our communities long into the future. This project will replace our ancient AHU with a modern, code-compliant, energy-efficient system designed for healthcare environments and regional hazards. The new AHU will meet current standards for airflow, filtration, energy efficiency and natural disaster resilience. Enhanced system reliability will reduce unplanned shutdowns, improve environmental control in clinical areas, and support uninterrupted outpatient and inpatient care, which will reduce operational risk. SPH will replace the existing AHU that serves the bulk of the SPH main hospital building. The project will include engineering design, seismic and structural evaluation, equipment procurement, installation, commissioning, and integration with existing building management systems. The new system will: 1. Meet current healthcare ventilation and filtration standards 2. Improve energy efficiency and reduce operating costs 3. Include modern controls for monitoring performance and indoor air quality 4. Be designed with seismic bracing and other resilience features 5. Incorporate enhanced filtration capacity to address volcanic and other airborne hazards common to the southern Kenai Peninsula. We are ready to immediately launch this project. Project planning will include coordination with clinical leadership to ensure uninterrupted patient care. The timeline is as follows: 1. Facility & Engineering Assessment (6 wks): Evaluate existing system condition, load requirements, structural capacity, electrical capacity, infection control risks, and seismic considerations. 2. Design & Construction Documents (8 wks): Mechanical engineer develops stamped drawings and specifications to meet healthcare standards, energy code, and seismic requirements. 3. Permitting & Approvals (6 wks, overlaps with design): State plan review and local building permits. 4. Procurement of Equipment (12 wks): Order AHU 5. Pre-Construction Planning (2 wks, overlaps with procurement): Develop phasing plan to maintain hospital operations, infection control plan, and temporary ventilation strategy. 6. Installation & Construction (20 wks): Remove old system, set new units, ductwork, controls integration, and seismic bracing. 7. Commissioning & Testing (4 wks): Air balancing, controls programming, performance verification, and staff training.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

South Peninsula Hospital	Support Workforce Sustainability Through Streamlined Housing Support	AK	SPH’s two most recent, collaborative Community Health Needs Assessments identify housing as a top community priority alongside staff workforce shortages—underscoring that housing constraints are directly linked to healthcare capacity on the southern Kenai Peninsula. The Assessment also recognizes that stable housing can have significant impacts on health outcomes. SPH is one of the largest (if not the largest) institutional renters of housing units on the southern Kenai Peninsula, substantially adding pressure to an already-tight market. Over the last two and half years, as SPH has added new service lines and expanded existing departments and ancillary services, the organization’s workforce has increased 17%, from about 600 to 700. We’re likely to see continued workforce growth as SPH works to meet the growing healthcare needs of an aging population. Delivering these services—especially through expansion—requires an ample and flexible housing stock as SPH has relied on visiting and traveling clinicians as well as newly recruited providers relocating to the area. SPH currently rents 26 housing units in Homer to support traveling clinicians and new hires. Short-term clinicians require 2 - 10 days of housing, and SPH offers 3 - 12 months of housing for new employees relocating to the area. The ability to offer temporary housing is a meaningful recruitment lever in a highly competitive market. As with other rural Alaska facilities, SPH is in a Health Professional Shortage Area.	SPH has already taken meaningful steps to strengthen workforce recruitment and retention—and reduce its contribution to the local housing crunch—by partnering with a private contractor to construct 25 new SPH-dedicated housing units, which will be available in early summer but will not totally alleviate the hospital’s need to rent additional properties around the region. A dedicated housing coordination function is a direct mitigation strategy to reduce reliance on expensive stopgap staffing as well as a proactive strategy to support workforce and service expansion. Delays in securing housing can postpone start dates, increase vacancy periods, elevate contract staffing costs, and reduce service availability. This project addresses the opportunity to create a structured housing coordination model that removes a primary non-clinical barrier to workforce stability and rural access to care. SPH will hire a dedicated, 12-month Housing Coordinator responsible for securing, managing, and optimizing workforce housing inventory across Homer for temporary and relocating staff. Currently, these duties are split somewhat haphazardly between a fulltime Senior Recruiter in the Human Resources Department and a fulltime Executive Assistant in the Administration Department. As the need for housing coordination and management have grown, the demands of this work have exceeded the ability of these two positions to address them above and beyond their other duties. Hiring a dedicated Housing Coordinator will streamline these functions and position SPH for continued successful recruitment and retention of a strong workforce now and into the future. SPH will recruit a candidate with strong interpersonal skills, attention to detail, and commitment to serving the SPH mission. Core responsibilities of the new position will include: Housing Acquisition & Partnerships 1. Develop and maintain relationships with local property owners 2. Negotiate rental agreements 3. Build an inventory of flexible housing options Property Management Functions for SPH-dedicated housing and general housing units 1. Manage check-in/out processes, cleaning, and turnover 2. Address maintenance issues 3. Serve as primary liaison between SPH and property owners 4. Manage key hand-offs and documentation Establish Systems to Streamline Housing Coordination 1. Establish property management and coordination systems to support efficient housing coordination into the future as SPH scales up its workforce.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

South Peninsula Hospital	Telesitting: Leveraging Technology to Enhance Patient Safety and Optimize Workforce Efficiency	AK	According to the NIH, more than one in five U.S. adults—and more than one-third of young adults—live with mental illness. Alaskans face higher rates of mental illness than residents of other states, with suicide rates here triple the national average. Rural Alaska often faces starker mental health challenges than urban parts of the state while having fewer behavioral health resources. SPH frequently admits patients with behavioral health disorders who require 1:1 supervision for their safety. On top of this, our aging population means that a greater portion of our patients are a fall risk. During FY 2025, 4,650 hours of 1:1 observation care were required in SPH’s Acute Care Department. These needs are highly variable and impossible to predict. Staffing 1:1 supervision often requires overtime or reassignment of clinical staff, increasing costs and contributing to workforce fatigue. But recruitment of additional staff solely for intermittent observation isn’t practical. Like other rural regions in Alaska, the Kenai Peninsula is a Health Professional Shortage Area. Recruitment here can be especially expensive—involving costs for travel, temporary housing, and other factors not seen elsewhere. These conditions make technology-enabled solutions to expand staffing capacity even more valuable. Without a scalable solution, SPH faces increased staffing costs, staff burnout, and potential constraints on its ability to safely care for behavioral health patients locally.	This project directly addresses two key findings of the collaborative work of SPH and MAPP, the regional healthcare coalition, which identified behavioral health needs and healthcare workforce shortages as two of the top priorities in the most recent Community Health Needs Assessment. Telesitting allows trained observers to remotely monitor multiple patients simultaneously using secure audiovisual systems, intervening when necessary and alerting bedside staff in real time. This model improves patient safety while reducing reliance on costly, difficult-to-staff in-person 1:1 observation. This project addresses the opportunity to deploy technology-enabled patient observation to improve safety while strengthening workforce stability and fiscal sustainability. Key components of this project include: Technology Acquisition and Installation • Installation of in-room audiovisual monitoring units • Secure centralized monitoring station • Integration with existing hospital IT and privacy protocols • Compliance with HIPAA and hospital safety standards Clinical Workflow Development • Establish clear criteria for telesitting eligibility • Develop escalation protocols for bedside intervention • Integrate telesitting into behavioral health stabilization pathways Staffing Model Optimization • Train designated observation staff • Reduce reliance on overtime for 1:1 in-person supervision • Allow bedside nurses and CNAs to focus on clinical care Performance Monitoring • Track observation hours, overtime reduction, and safety events • Monitor patient outcomes and staff satisfaction This project aligns with RHTP Initiative #6 by deploying innovative technology to address rural workforce constraints, Initiative #5 by reducing burnout and improving retention, and Initiative #2 by ensuring safe local access to behavioral health stabilization services. By modernizing observation capacity, SPH strengthens its ability to safely care for vulnerable patients without unnecessary transfer, preserving access to care for the southern Kenai Peninsula.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

South Tongass Volunteer Fire Department	Building health habits and communities through restoration of the STVFD playground	AK	In 2023, the Ketchikan Gateway Borough released the Parks & Playground Master Plan. This plan identified hazards within the current playground and immediately had the playground shuttered. The Master Plan also identified the need for recreation along South Tongass. However, within the Master Plan, the STVFD Playground was not identified as a project to be funded in the next 10 years, leaving the south end, and a large, family-oriented neighborhood, without adequate recreational opportunities for the foreseeable future. Notably, the Borough does not claim this playground as one of its recreation properties, which is why it was a low priority for restoration. This project presents an opportunity to invest in infrastructure renovations and equipment in an existing community hub. By rehabilitating this space, we address the lack of dedicated space and resources to facilitate physical activity, ensuring the south end is no longer left without adequate recreational opportunities.	This application seeks to modify the space to allow efficient, dual-purpose use for extracurricular recreation and wellness activities. Our approach includes the removal of dangerous and defunct structures, site preparation, and the installation of a modern play structure. The project will leverage volunteer labor and in-kind donations to establish a wellness center atmosphere that promotes community health. By timing the playground's reopening with the reconstruction of the South Tongass Fire Station (expected late summer 2026), we create a unified, dual-purpose community asset. Once installed, minimal maintenance is required and would be managed through our volunteer membership and community collaboration.	\$50,000-\$250,000	Single Community	Ketchikan Gateway Borough	Deferred or Not Advanced

Southcentral Foundation	Chitina Community Health Clinic Expansion	AK	The clinic at Chitina is open again. Southcentral Foundation has an opportunity to impress the community and increase outreach. The challenge that the clinic in Chitina faces is not primarily some outdated emergency equipment (although those items we mention could certainly benefit from a refresh or update). The most significant challenge is a lack of encounters, which in turn leads to a lack of billable services, which places a burden on the program making it more difficult for the facility to remain current and usable. The community has self-reported some poor health, which indicates a pressing need for local services. Although individuals in the community may be traveling the 50 miles (>1 hr.) to the Robert Marshall health center in Glennallen, they may also be suffering without sufficient care. Since we know that another challenge in Chitina is transportation, it is likely that some health issues are simply not being addressed at all, and an outreach campaign, perhaps some transportation assistance, coupled with a more robust inventory of emergency equipment, could change that. As part of this project, SCF needs to secure better provider housing. Some in-clinic housing options, though rudimentary, will be available within the coming weeks. However, it would be a better idea for providers and the community if SCF could secure housing in the village, initially within the scope and allowable costs in this opportunity, and then expanded as encounters and income increase.	SCF has already updated most standard equipment in the Chitina clinic. The project manager would use program funds to update, replace, and supplement emergency response items (Stryker bed, cameras, etc.), transporting and installing them over the course of 12-15 months. For an outreach campaign, the clinic manager would partner with the Corporate Communications department to identify several ways to reach individuals in the community, explaining the available hours and services offered. These could include radio ad time, an updated Facebook (or other social media) page, or a word-of-mouth campaign. As previously stated, SCF is installing temporary sleeping quarters in the clinic itself within the upcoming weeks. However, it is not conducive to the care needed to ensure providers’ best service. SCF will be looking into the community for warmer, more comfortable and better-maintained quarters. The transportation issue is more complex and would need to be addressed in a secondary phase of the Chitina Clinic project.	\$250K-\$1M	Other	Single Community	Copper River Census Area	Advance to Implementation Application

Southcentral Foundation	Expanding Access to Pharmacy Services in the Mat-Su Valley	AK	Southcentral Foundation’s pharmacy services at the Benteh Nuutah Valley Native Primary Care Center (BNPCC) face growing pressure due to three key challenges: 1) the rapidly increasing demand for local healthcare services across the wide geographic area of the Matanuska-Susitna Valley; 2) the need for more convenient and accessible pharmacy options—especially outside normal business hours or for individuals with limited mobility; and 3) rising operational costs associated with meeting these expanding service needs. As the population grows and more families rely on BNPCC for their care, the current pharmacy model cannot fully support the demand for timely, consistent access to medications. Customer-owners increasingly need flexible, closer-to-home options for routine prescription pick-ups that do not require entering the pharmacy or waiting for staff availability. This project offers an opportunity to modernize pharmacy operations by investing in advanced technology and equipment that expand access and improve efficiency. Automated medication systems and secure pickup solutions reduce reliance on additional staffing, streamline refill workflows, and make medication access available beyond standard pharmacy hours. These improvements will lower operating costs, improve convenience, and enhance overall customer-owner experience while ensuring that high-quality services remain sustainable as community needs continue to grow.	The Pharmacy Technology project will fund essential equipment for the expanded Benteh Nuutah Valley Native Primary Care Center (BNPCC), ensuring the facility can fully support high-quality, safe, and accessible healthcare services. The project centers on improving access by using pharmacy medication lockers and automating processes. Pharmacist involvement in the medication use process significantly enhances safety and quality of care. Pharmacists provide direct oversight of medication selection, dosing, monitoring, and patient counseling—key functions that reduce medication errors and prevent adverse drug events. Integrating this expertise into BNPCC’s expanded operations ensures that growing patient volume can be supported without compromising safety or quality. The project incorporates advanced pharmacy medication locker technology to expand access to prescriptions. These secure, automated lockers allow SCF to dispense routine and refill medications at a convenient location, improving medication adherence. Lockers include live video support to maintain personal connections and ensure that customer owners can receive assistance from pharmacy staff, when needed. By shifting routine pickup encounters to this technology, pharmacy staff can focus more time on clinical care and complex medication needs, increasing overall efficiency. Together, pharmacist-driven oversight and medication locker technology create a streamlined, accessible, and patient-centered medication distribution system. This approach ensures BNPCC can meet the growing population demand for local pharmacy services, enhances convenience for customer owners, and supports better long term health outcomes through improved medication access and adherence.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Southcentral Foundation	Expansion of Statewide Child and Family Developmental Services	AK	Alaska's access to pediatric developmental specialists and therapies is extremely limited. Reliance on out-of-state providers that travel to Alaska intermittently creates minimal capacity and disjointed continuity of care. Travel out of Alaska to access services is limited to those with sufficient resources and those providers are restricted by licensing issues and generally cannot provide follow-up and in-person care. SCF's Child and Family Developmental Services (CFDS) clinic seeks to address the state limited capacity and access to timely and appropriate levels of care through a 5-year clinic expansion plan. The dearth of developmental services available in Alaska and the needs amongst its service population, have bolstered SCF's commitment to bridging the gap in access to care with a five-pronged approach. SCF will 1) recruit additional developmental service providers and shore up the therapies and support infrastructure; 2) increase opportunities to provide appointments through telehealth, which further expands rural reach; 3) expand clinic space to house the additional staff, which would require remodeling of clinic space currently housing other services; 4) create a pipeline for Child Life Specialists through a tuition reimbursement program, since recruiting for this position has yielded no qualified candidates; 5) develop a youth transition program to facilitate the timely shift to adult-based services.	Southcentral Foundation's (SCF) 5-year expansion plan is backed by a proforma that projects what is needed to right-size the Child and Family Developmental Services (CFDS) clinic. The proforma is ambitious and gradually adds FTEs to the clinic starting with an additional 31 employees in FY27; 45 in FY28; 56 in FY29; 60 in FY30 and 62 in FY31. The reality is that recruiting for the additional FTEs and establishing new service lines will take longer than the proforma depicts. The State's Rural Health Transformation Program (RTHP) funding would help to accelerate this timeline by supporting the new FTEs until they are covered fully by reimbursement to allow the next round of recruitment to begin earlier; a clinic space remodel; creation of a workforce pipeline for Child Life Specialists; modernization and expansion of clinic therapy supplies and minor equipment; acquisition of additional telehealth services equipment for the clinic; and implementation of a comprehensive, systematic transition plan for youth heading towards adulthood. The initial staff expansion for the 1st budget year of the Alaska RHTP funding would focus on the addition at least one Occupational Therapist, Physical Therapist, Speech Language Pathologist, Testing Psychologist, Registered Behavioral Technician, Nurse Case Manager, Case Management Support, Community Case Manager, Therapy Technician and Program Coordinator. Additionally, recruitment will start for a Geneticist; Pediatric Neurologist; Physical Medicine and Rehabilitation Physician; Developmental Behavioral Pediatrician; and Music Therapist, as these positions are harder to recruit and will require active recruitment until all of the positions are filled. Work on the telehealth service expansion; modernization of clinic supplies and equipment; the Child Life Specialist workforce pipeline; and the youth transition program would all begin in the 1st budget period. The clinic renovations are needed almost immediately, but will likely occur in year 2, as the space is currently occupied and a new location for that program needs to be identified. The right-sizing of the CFDS clinic would truly transform rural health care in Alaska, bringing in specialties and services not currently available or that have insufficient capacity. Components of this project are likely to impact non-tribally sponsored services and may develop replicable approaches that could be adopted and adapted throughout the state.	Over \$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Southcentral Foundation	Leveling the Playing Field: Expansion of Specialty Pediatric Services	AK	SCF’s Specialty Pediatric Clinic has identified significant gaps in care for Alaska Native and American Indian children, birth to age 18, with complex medical and developmental needs. Rural and remote communities face persistent shortages of pediatric specialists and high turnover of care coordinators, resulting in delayed diagnoses, fragmented care, and limited access to subspecialty services. To address these statewide gaps, the Clinic expanded its pediatric subspecialty team across 13 disciplines, including endocrinology, neurology, pulmonology, genetics, and gastroenterology, among others, that are rarely available outside Anchorage. While this expansion has improved statewide capacity, the rapid growth in referrals and the complexity of cases has created a parallel need to increase support staff. Currently, specialty providers are spending substantial time on case management, care coordination, travel logistics, discharge planning, and family education—tasks that limit the time they can devote to direct care and reduce overall clinic efficiency. Additional support staff is essential to ensure that providers can focus on delivering high-quality specialty services while families receive comprehensive, wrap-around support. This project presents an opportunity to strengthen access to specialty pediatric care statewide by expanding the support infrastructure needed to sustain the Clinic’s multidisciplinary model and meet rising demand from rural and frontier communities.	The proposed approach focuses on expanding the statewide Specialty Pediatric Clinic’s support team to enhance access, care coordination, and overall quality of services for Alaska Native and American Indian children—particularly those traveling from rural, remote, and frontier communities. Additional support staff is essential to improve case management, streamline clinic operations, and ensure families receive whole-person, culturally grounded care. Children who travel from regional hubs face different and more complex care coordination challenges than local families. While Integrated Pediatrics (PCC) coordinates care for Anchorage-based customer-owners, rural families must often navigate long-distance travel, multiple appointments, and transitions in and out of their home communities. Many of these children have medically fragile or highly complex conditions, creating additional needs around travel logistics, discharge planning, referrals, and follow-up support once they return home. Without dedicated support staff, specialty providers must fill these coordination gaps, reducing the time available for direct patient care. SCF will enhance the Specialty Pediatric Clinic by adding Clinical Medical Assistants (CMAs), Case Management Support (CMS), Nurse Case Managers, and Community Resource Specialists. These positions will provide comprehensive navigation, including care coordination, resource linkage, travel and lodging assistance, pre-visit planning, and school or community support. This multidisciplinary support structure will create a seamless, guided experience for families, reduce care fragmentation, and improve timely access to specialty services. The expanded staffing model offers a fully integrated approach that addresses physical, behavioral, developmental, and social needs within a single coordinated system. By allowing specialty providers to focus on complex medical care while dedicated staff manage care logistics, SCF will increase appointment access, improve continuity across regional and specialty services, and strengthen proactive management of chronic and high-risk pediatric conditions. This approach ensures that children across Alaska—regardless of location—can receive high-quality, coordinated specialty care.	\$1M-\$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Southcentral Foundation	Quyana Qenq'a Project	AK	The following opportunities currently exist in the provision of SPMI services to the population of Anchorage, including those who have relocated from Alaska's rural and remote regions to access those services. The most significant problems concern the fragmented care, access delays, and gaps in providing SPMI treatment services. Current SPMI care is fragmented due to the separate SCF programs of Quyana Clubhouse, Integrated Case Management (ICM), and Fireweed Behavioral Health Clinic, and the resulting difficulties coordinating services across these locations and service lines. There are also delays in care at API, prisons, etc., with access delays due to transitions from one program to the next and creating delays at every step. These delays can result in someone with SPMI completely dropping off the radar without care, as there are not enough Case Management personnel to coordinate and provide care at this level of service intensity. The SPMI population needs multiple interventions to receive appropriate treatment. Intensive workforce training is required, as Case Management personnel need comprehensive training in conflict management skills and training to work with the SPMI population in group settings or community settings - as opposed to just one-on-one treatment. Gaps in service include needed therapies for dual diagnosis; vocational rehabilitation; peer support services; and psychiatric rehabilitation services. There is no access to these services now.	SCF recognizes the growing need for expanded behavioral health services in Alaska. The Quyana Qenq'a project represents a critical step toward strengthening our system's ability to serve individuals experiencing the most acute behavioral health challenges. The new Quyana Qenq'a facility—meaning “Thank You House” in Dena'ina Athabascan—will offer a transformative space for healing when it opens in May of 2028. The building will bring together two essential programs under one roof: 1) Day Treatment Program: A therapeutic setting that blends integrated behavioral health and primary care with Alaska Native tradition, providing structured support within a nurturing milieu. 2) Intensive Case Management (ICM) Program: A community-based service that focuses on outreach, engagement, intensive community case management, individual therapy, medication management, and connection to other vital supports. By expanding treatment capacity, this project will help reduce strain on emergency departments and law enforcement while promoting coordinated, effective, and culturally centered pathways to wellness. The new facility is intentionally designed to meet individuals where they are in their health journey by providing immediate access to care, strong community connections, and support for basic needs, such as food and clothing. Its size and layout will allow both programs to operate effectively, creating an environment that is healing-centered and supportive of long-term recovery for individuals living with severe and persistent mental illness. SCF will be exploring the Flexible Assertive Community Treatment (FACT) approach for potential use in the Quyana Qenq'a facility. Within this approach, multi-disciplinary teams provide comprehensive, community-based care for individuals with SPMI, combining intensive, shared-caseload management (similar to standard ACT) for crisis periods with personalized, individual case management for stable periods. Within the FACT model each discipline brings their expertise and training to bear on treatment of individuals. Team structure consists of Psychiatry, Nursing, Therapists, Vocational Rehabilitation Specialists, Psychosocial Rehabilitation Specialists, Case Managers, Substance Use Specialists, and Peer Specialists. This model allows for fluctuating support levels within the same team, reducing the need to transition customers to a different team/program while also reducing hospitalization/emergency service utilization.	\$250K-\$1M	Family or primary care	Single Community	Anchorage (Municipality)	Advance to Implementation Application

Southcentral Foundation	Rural Elders Program	AK	Rural Alaska’s growing Elder population faces limited access to coordinated, preventive, and home-based healthcare. Geographic isolation, workforce shortages, transportation barriers, fragmented services, and aging housing stock contribute to preventable decline and unnecessary relocation from home communities. Elders often struggle to navigate benefits, arrange travel, coordinate dental and specialty care, complete advance care plans, or protect themselves from financial exploitation. Social isolation is common, and services are not consistently aligned to population-level need. Without structured local coordination—such as a dedicated Elder Resource Specialist—clinical recommendations may not translate into completed services. A coordinated, community-based aging-in-place model is needed to stabilize access, improve outcomes, and strengthen sustainability.	The Rural Elders Program implements a five-year phased redesign of elder care delivery, community-based Elder Resource Specialists (ERS) all to assist with aging in place in the local community. Each participating community will establish a part-time ERS who serves as the local anchor for coordination. A project lead for the ERS’s will be located in Anchorage. The ERS will: • Connect Elders to primary care, dental, PT, and specialty services • Arrange transportation • Assist with needs to keep elder in their home • Reinforce advance care planning • Coordinate housing modification referrals • Facilitate social gatherings and healthy wellness activities Care Teams will conduct structured in-home visits, completing standardized screening bundles (ADLs, fall risk, dental coordination, advance care planning). The ERS ensures follow-through after the visit. Complete an assessment of how physical therapy services will travel to rural locations on a scheduled basis with telehealth follow-up. Dental coordination will ensure annual exams and denture education. Transportation plans will be documented for every Elder. Housing safety assessments and age-friendly modifications will be coordinated in partnership with Tribes and housing entities. Social isolation will be addressed through strengthened gathering spaces, with ERS support for participation outreach. Data dashboards will track performance metrics.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Kenai Peninsula Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; Yukon-Koyukuk Census Area	Advance to Implementation Application

Southcentral Foundation	Rural Pharmacy Upgrade	AK	The challenges faced by Southcentral Foundation’s rural pharmacy services are 1) the medicine dispensing machines (PickPoint brand) are aging, and 2) temperatures in pharmacies in SCF’s rural communities are much too high for the providers and some medications. USP-NF (<659>) defines Controlled Room Temperature (CRT) for pharmacy storage as 20°C to 25°C (68°F to 77°F), with permitted brief excursions between 15°C and 30°C (59°F to 86°F). Some of the SCF CHC pharmacies require facility modifications to maintain appropriate medication storage area room temperature ranges. The Pick Point Remote Dispensing Unit Cabinet Design has been updated since the initial telepharmacy installations. All 14 locations have the older cabinet model; Nilavena has a combination of one old and one new RDS. A total of 15 RDS with corresponding modifications in clinic pharmacy networking technology are requested.	The involvement of a pharmacist in the medication safety process significantly enhances both medication safety and access to care in the rural clinic setting. Pharmacists provide critical oversight in medication selection, dosing, monitoring, and patient education, reducing the risk of medication errors and adverse events. The use of barcode technology, remote dispensing systems, and climate-monitored, pharmaceutical-grade refrigerators and freezers creates additional safety nets that support accurate dispensing and proper medication storage. These systems help ensure medication integrity, maintain cold chain compliance, and reduce the potential for human error. Maintaining a standardized clinic medication formulary tailored to the specific needs of the local community further strengthens access to essential medications. This proactive approach allows rural clinics to anticipate and stock critical medications needed for their patient population. It also improves resilience during periods of poor weather affecting transportation, mail delays due to weather or staffing shortages, and natural disasters such as earthquakes or volcanic eruptions. Together, pharmacist involvement, technology integration, and strategic formulary management create a comprehensive framework that supports safe medication practices and reliable access to care in rural communities.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Chugach Census Area; Copper River Census Area; Kenai Peninsula Borough; Lake and Peninsula Borough; Yukon-Koyukuk Census Area	Advance to Implementation Application

Southcentral Foundation	SCF Traditional Healing Project	AK	This project addresses a growing need for culturally grounded inpatient and community-based support for Alaska Native customer-owners traveling from rural communities, and a growing need for ceremonies, spiritual support, and cultural coordination within and beyond the Traditional Healing Clinic. Currently, staffing limitations restrict the department’s ability to meet these needs consistently, sustainably, or even at all. Additionally, in recent years there has been an increase in requests for staff to support pandemic responses, disaster relief, and other emergency situations. The opportunity is to formalize and expand Traditional Healing and its service delivery model through strategic items include: Staffing: a. Tribal Doctor Apprentices (10) b. Clinical Supervisor (1) c. Traditional Healing Cultural Advisor (1) d. Clinical Learning & Development Training Specialist (1) e. Case Management Support (1) f. Administrative Support (1) Training: a. Clinical Training (CME/CEUs) b. Non-Clinical Training c. Covering Staff Support Salaries d. Create a certified Tribal Doctor Certificate for SR roles to better educate and offer services within ANMC on understanding how we can better connect the Traditional Healing services This investment strengthens workforce capacity, improves cultural integration in care delivery, and builds long-term sustainability of Tribal Doctor services.	The proposed approach is a phased workforce expansion and infrastructure build-out during FY26–27 (through 9/30/2027). Staffing Plan: a. Hire 1 Clinical Supervisor to provide oversight, mentorship, and quality assurance. b. Hire 1 Traditional Healing Cultural Advisor to provide ceremonial and spiritual services support c. Hire 1 Clinical Learning and Development Training Specialist to provide Tribal Doctor Training services d. Hire 10 Tribal Doctor Apprentices to expand inpatient and village-based service delivery. e. Hire 1 Case Management Support staff member to coordinate care transitions and referrals. f. Hire 1 Administrative Support staff member to manage scheduling, reporting, and operational needs. Service delivery will expand in the following areas: a. Increased inpatient Tribal Doctor presence for customer-owners traveling from rural communities. b. Scheduled village visits to improve continuity, prevention, and relationship-building. c. Increased presence for ceremonies within and outside SCF for Traditional Healing practices Travel and training: Travel and training will include attending conferences and training for skill building. Data tracking will include service utilization, inpatient referrals, customer-owner satisfaction, and continuity of care indicators. This structured expansion ensures quality, workforce development, and system integration rather than ad hoc growth.	\$250K-\$1M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Southcentral Foundation	The Tinitun Qenq'a Pathway Home Project	AK	Residential behavioral health programs must continuously evolve to meet the needs of adolescents with complex behavioral health and co-occurring conditions. Addressing the increasingly acute needs of adolescents in today's society, is a primary need for SCF in successfully providing the appropriate treatments and environment for these youth to be successful in life. The Pathway Home seeks to advance its clinical model, implement evidence-informed therapeutic modalities with fidelity, strengthen workforce competencies, expand clinical supervision, and improve program operations and environment. An external consultant will provide comprehensive evaluation and recommendations for clinical model enhancement, supervision structures, fidelity monitoring, workforce development, and targeted environmental improvements. This project addresses the opportunity to provide more consistent, evidence-informed care, strengthen team-based care, and enhance outcomes for adolescents from across Alaska, including rural communities.	The project will advance The Tinitun Qenq'a Pathway Home adolescent residential program through an integrated approach of clinical, operational, workforce, and environmental improvements. Activities include: - o Engaging a consultant for program evaluation and recommendations on clinical model, therapeutic modalities, supervision, and operations - o Implementing or refining evidence-informed therapeutic modalities with fidelity - o Expanding clinical supervision and oversight for clinicians and paraprofessionals - o Developing structured competency pathways, trainings, and fidelity monitoring systems - o Enhancing integrated behavioral health team functioning and interdisciplinary care coordination - o Supporting staff participation in professional conferences and learning collaboratives - o Targeted environmental improvements, including furniture upgrades and sensory-supportive spaces, to align the physical setting with the clinical model This approach ensures the program is aligned with trauma-informed care principles, strengthens workforce competencies, improves consistency and quality of treatment, and enhances the therapeutic environment for adolescents, reinforcing the statewide behavioral health continuum.	\$1M-\$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Southcentral Foundation	Yeshjesh T'uh Crisis Project	AK	Demand for high-intensity crisis services has grown, and rural customer-owners often lack timely access to crisis stabilization and crisis residential care. Yeshjesh T'uh Crisis Project provides an opportunity to open fully prepared programs with trained personnel, integrated behavioral health teams, and structured supervision. Start-up funding for personnel, including co-located kitchen and pharmacy services, ensures operational readiness. Integrated pharmacists will enhance medication management, support staff in complex care decisions, and improve outcomes. Workforce development and supervision lay the foundation for high-quality crisis services that strengthen the statewide behavioral health continuum. Yeshjesh T'uh will address serious gaps in the continuum of mental health care in the State of Alaska's current system, which leaves Alaska Native and American Indian people with few options when experiencing a mental health crisis. If they do not require or need hospitalization, they are discharged from the Emergency Room back into the community without receiving the appropriate level of care, support, or coordination they need. Yeshjesh T'uh would remedy this inequity by providing individuals and their families with mental health crisis care with an open gateway to the appropriate level of behavioral health services and ensure less time is spent in first responder custody or jail.	The project will establish high-intensity crisis programs by addressing personnel readiness, workforce competencies, and integrated care. Key activities include: • Funding start-up personnel costs for clinicians, paraprofessionals, kitchen, and pharmacy staff prior to program opening • Incorporating integrated pharmacists into behavioral health care teams to provide direct consultation, medication management, and support for complex co-occurring conditions • Workforce training, structured supervision, and competency development for all clinical staff • Developing fidelity monitoring and quality assurance for evidence-informed crisis interventions This approach ensures staff readiness at opening, strengthens high-intensity crisis stabilization and crisis residential care, enhances rural customer-owner access, and supports seamless integration within the behavioral health continuum. Yeshjesh T'uh will provide a variety of operational and administrative efficiencies for multiple organizations involved in the process. Those efficiencies include the reduction in mental health crisis Emergency Room visits – reducing the strain on demand for Emergency Room services; reduction first responder or police involvement in mental health crisis events – freeing up first responder capacity and lessening the amount of time an individual spends in custody; reduction in overall costs with earlier intervention at a more appropriate level of care for the individual; and the delivery of appropriate tribal and community-based services for additional support, treatment, and referrals that lead to more efficient and appropriate treatment and better health outcomes	Over \$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Southcentral Foundation	Access and Entry Control System Modernization for Tribal Health Care Facilities	AK	SCF’s current building access control system is severely antiquated and poses significant security vulnerabilities that must be addressed to ensure the safety of employees, customer-owners and organizational assets. The current system relies on RFID badge technology that can be easily compromised using inexpensive, commercially available tools.	To bring SCF’s access control system up to current security standards, it will be necessary to update door entry systems, integrate organization-wide security system systems and functions, procure unique coded badges that cannot be cloned, replace all badge readers across the organization with compatible models, implement updated management software for secure credential issuance, monitoring and deactivation.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced
Southcentral Foundation	Building upon Maternal Child Home Visiting Services to Meet the Needs of Rural Communities	AK	Maternal child home visiting programs have a long history of improving birth, infant and early childhood health outcomes. The State of Alaska has identified home visiting as a protective factor for Sudden Unintentional Infant Death (SUID), which is disproportionately high amongst Alaska Native and American Indian families in Alaska's rural and remote communities. SCF's Nutaqsiivik program has launched a Safe Sleep initiative as the SUID deaths are on the rise in Alaska, most of which are preventable deaths. The Nutaqsiivik program has also demonstrated high rates of developmental screenings, immunization , timely well child visits, and postpartum care. The current program limitations for expansion to rural communities include it being a prenatal program, ending at the child's second birthday, requiring nursing staff, and expecting at least one visit a month while enrolled in services. Services are designed to be provided in-person, though telehealth was utilized with mixed results during the COVID-19 pandemic. SCF supplements the NFP model with in-home behavioral health support for families. The program currently serves around 260 families annually with 11 home visiting nurses and two nurse supervisors. Rural communities need similar home visiting services that are responsive to the needs of families and the environments in which they reside.	Southcentral Foundation (SCF) treats maternal child home visiting services as an extension of primary care. As such, SCF has sought to provide home visiting services through its network of FQHCs. Attempts have been made to develop a plan to move forward with alternative home visiting modalities with mixed success. The greatest limitation is the lack of staff dedicated to analyzing what SCF has already learned through its Indigenous Project Launch grant; 16 years of its Tribal Maternal Infant Early Childhood Home Visiting (MIECHV) grant; and four decades of service provision to families within the Nuka System of Care and its FQHCs. In-depth analysis and planning support is needed to map a way forward to deliver impactful home visiting services in rural communities . Additionally, SCF has worked on the development of Infant and Early Childhood Mental Health (IECMH) curriculum for providers system wide and built capacity to deliver Strengthening Families trainings for SCF staff, but full rollout and scalability of these trainings for SCF employees, including healthcare providers, is hindered by insufficient staffing to lead these trainings. Ensuring that providers serving families in any capacity take an IECMH informed, strength-based approach is paramount to developing a partnership with parents as they navigate pregnancy and parenting through the 1st five years of their children's lives. Home visiting can be a catalyst and protective factor for improving the health outcomes for Alaska Native and American Indian families and the development of a home visiting modality that provides a consistent, relational and impactful home visiting services in rural Alaska communities is long overdue. SCF is requesting funding for a planning grant that would support a Clinical Informatics Specialist, a Learning and Development Clinical Training Specialist, and a project lead for the Year 1 budget period, which would would allow for the rollout of IECMH and Strengthening Families trainings to health care providers and the development of a home visiting modality that incorporates evidenced-based programming and the tribal context of the rural and remote communities served by Southcentral Foundation.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality); Copper River Census Area; Kenai Peninsula Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Southcentral Foundation	Digital Security and Monitoring Modernization for Tribal Healthcare	AK	Rural Tribal healthcare delivery depends on efficient administrative operations and secure digital systems. Workforce shortages, geographic isolation, and increasing documentation requirements place significant strain on care teams. Emerging AI tools offer meaningful opportunities to reduce administrative burden and improve operational efficiency; however, safe implementation requires modernized security, monitoring, and data governance capabilities. Currently, legacy security platforms and fragmented monitoring tools limit SCF’s ability to responsibly deploy AI technologies while maintaining regulatory compliance and protecting customer-owner information. The opportunity is to modernize and consolidate digital security systems in order to safely enable AI-driven operational improvements that strengthen rural healthcare sustainability.	SCF proposes a phased modernization of its digital security and monitoring environment to enable safe adoption of AI-powered administrative tools that improve operational efficiency across rural healthcare services. The project will consolidate legacy cybersecurity systems into a unified, integrated platform that strengthens monitoring, improves incident response, and enhances protection of patient information. This modernization will establish the safeguards required to responsibly deploy AI tools that assist with documentation support, internal knowledge access, workflow coordination, and administrative task reduction. Key components of the approach include: - Implementing advanced monitoring and detection capabilities to reduce the risk of system disruption. - Strengthening data governance controls to protect protected health information (PHI) while enabling appropriate internal access. - Enhancing audit and oversight functions to maintain compliance and accountability. - Standardizing digital security architecture to reduce operational complexity and improve sustainability. - Deploying AI tools in controlled phases, beginning with administrative and operational workflows. This structured approach ensures that AI adoption enhances workforce capacity without increasing compliance risk or compromising customer-owner privacy. By aligning modernization with operational outcomes, SCF will improve system reliability, reduce administrative strain, and strengthen the long-term viability of rural healthcare services.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Southcentral Foundation	Electronic Health Record System Updates for Tribal Health	AK	SCF’s current health information infrastructure faces performance, interoperability, and workflow efficiency limitations that hinder the ability of care teams to fully utilize modern tools and technologies. These challenges are increasingly significant as the healthcare environment shifts toward telehealth, distributed care teams, integration of behavioral health, and more comprehensive data use. Rural and remote staff—particularly CHA/Ps, village based behavioral health providers, and mobile clinicians—often experience inconsistent system performance, delayed access to information, and limited ability to use emerging care delivery modalities. At the same time, SCF’s workforce needs more intuitive, efficient, and reliable systems to support growing demand and increasingly complex care needs. This project addresses the opportunity to modernize and optimize SCF’s core health information systems to better support rural care delivery, reduce workflow burden, and create a more scalable, sustainable foundation.	The project will take a phased, systems engineering approach to improving infrastructure, usability, and reliability across SCF’s clinical information ecosystem. Key elements include: • Infrastructure Modernization: Upgrading servers, storage, and network elements that support Cerner Millennium and ancillary systems, improving speed, stability, and uptime for both urban and rural users. • Workflow Optimization & System Redesign: Partnering with clinical and operational teams to streamline documentation, reduce redundancies, and standardize workflows—especially in telehealth, behavioral health, care coordination, and village-based services. • Enhanced Interoperability: Expanding interfaces, data-sharing capabilities, and clinical data reconciliation workflows to support more consistent, real-time information exchange with regional partners, tribal facilities, and remote clinic systems. • Telehealth & Remote-Care Enablement: Adapting the EHR to better support virtual visits, remote assessments, mobile charting, and technology that rural teams use in the field. • Testing & Training: Implementing structured training, communication, and adoption strategies to ensure staff can quickly incorporate improvements into daily workflows. This approach ensures immediate improvements while laying a scalable foundation for future enhancements.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Southcentral Foundation	Hub, Spokes and Wheels: Expanding Access to Care with Mobile Clinics	AK	Reliable and accessible transportation and child care coverage repeatedly rise as two of the most frequently cited reason for not utilizing primary care services and even health care in general. In Anchorage, the public transportation system continues to retrench bus routes, greatly increasing the wait times and walking distance between the stops and desired locations, increasing risks to customer-owners due to poorly maintained sidewalks and harsh weather, as well as the number of missed appointments. It also results in delayed care and an increase in ER visits. Medicaid vouchers for transportation are often not accepted by local cab companies or individual drivers. Ongoing efforts to increase accessibility in Anchorage has resulted in small clinics being set up at Covenant House, Brother Francis Shelter, Centennial Village, Quyanna Club House and SCF's Elder Program. However, space limitations and clinic locations have not sufficiently addressed the access issues. SCF does provide home health visits, but what they can do without clinic space is very limited. Outside of Anchorage, public transportation is virtually non-existent. SCF works to provide additional services to the rural clinics by sending providers out to the communities, but once again, space becomes an issue in the rural clinics. Mobile clinics will address clinic space, transportation, quality of care and child care coverage barriers, while also increasing the range of screening and prevention services.	Southcentral Foundation (SCF) is interesting in exploring the use of mobile clinics. Developing mobile clinics as a service delivery modality has been under consideration for some time, especially as the service population continues to outpace Indian Health Service and third-party payor resources. The migration of Alaskans from rural communities to regional hubs, the Matanuska-Susitna Borough and the Municipality of Anchorage over the past two decades requires further innovations in service delivery to address the ever growing needs of customer-owners (individuals that receive services from SCF). This will be a phased project. Phase 1 (Budget Year 1): -Determine the specifications for two mobile primary care clinics (Month 1) -Submit bid request for competitive equipment bid and RFP development (Month 2) -RFP Release (Month 3) -Bid process completion and contract awarded (Month 4-5) -Mobile clinic process and procedures developed (Months 6-12) -Mobile clinic received and initial service delivery trials initiated (Months 9-12) -Determine the number and types of mobile clinics to bring on line in the next phase (Months 3-6) Phase 2 (Budget Years 2-5): -Determine the specifications for second round of mobile clinics (Month 1) - Submit bid request for competitive equipment bid and RFP development (Month 2) -RFP Release (Month 3) -Bid process completion and contract awarded (Month 4-5) -Analyze outcomes from the additional mobile clinics to inform future mobile clinic requests (Months 6-9) -Mobile clinic process and procedures developed for additional mobile clinics (Months 6-12) -Mobile clinic received and initial service delivery trials initiated for new clinics (Months 9-12) Phase 3 (Year 5): -Evaluate the overall project implementation and mobile clinic service modality funded under the Alaska RHTP project (Months 1-9)	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Copper River Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced

Southcentral Foundation	Increasing Access to Statewide Specialty Pediatrics and Anchorage Native Primary Care Clinic	AK	SCF’s Primary Care 2-South and Specialty Pediatric clinics opened in 2001 and have not been remodeled since. The current space no longer meets the needs of customer-owners and integrated care teams delivering relationship-based care. Exam rooms are too small to accommodate families—many traveling together from rural areas—resulting in crowded, stressful visits. Individuals using wheelchairs must navigate tight corners and narrow doorways, slowing movement and creating safety concerns. Staff must continually reposition furniture to make space, disrupting workflow, delaying access, and detracting from the quality and purpose of each visit. While minor cosmetic updates have occurred, the environment is outdated and inconsistent with SCF’s commitment to welcoming, culturally grounded healing spaces. Customer owners report dissatisfaction with cramped, uncomfortable rooms, especially compared to the facility’s updated areas. Furnishings and equipment are also aging and increasingly unreliable. Exam tables malfunction, cabinet locks fail, and frequent repairs lead to temporary room closures, reducing capacity and slowing operations. This significantly affects the statewide Specialty Pediatric Clinic, as families cannot reschedule due to limited travel windows. Upgrading technology—including medication dispensing machines, integrated diagnostic systems, power exam tables, and telehealth-ready exam rooms—is needed to support efficient, safe, high-quality care and improve access.	The redesigned Anchorage Primary Care 2-South and Specialty Pediatric clinics will modernize exam rooms and clinical spaces to meet SCF clinical standards, support fully integrated care delivery, and create an environment that honors Alaska Native people, culture, and wellness. SCF is beginning planning and design, using a progressive design-build approach to support collaboration, innovation, and value. The design work is scheduled for completion in early 2027. Construction is anticipated to begin in Summer 2027 and conclude in Summer 2028. The project will fully renovate 13,700 square feet in the outdated clinic areas. Improvements include acoustic upgrades, family-friendly layouts, and expanded 120-square-foot consultation areas designed to better serve families, rural residents, elders, and individuals with disabilities. The layout will enhance coordinated, integrated services provided by family medicine, behavioral health, pharmacy, nutrition, physical therapy, psychiatry, midwifery, and pediatrics. The statewide Specialty Pediatric Clinic has expanded its provider team to include 13 subspecialties, including pediatric pain management, pediatric endocrinology, genetic services, and other specialties. The remodel will improve access and efficiency during time-limited visits for families traveling from rural communities. The design also advances SCF’s transition from patient-centered to family-centered care. Technological capabilities will be significantly upgraded. Telehealth-ready infrastructure—including large displays, enhanced connectivity, and dedicated virtual care hubs—will expand access for rural and remote communities and enable physicians to seamlessly transition between in-person and virtual services. Additional automated systems, such as updated diagnostic equipment and medication dispensing technology, will enhance clinical efficiency, safety, and workflow. Throughout construction, SCF’s project manager will collaborate with clinic leadership and contractors to select equipment and design features to optimize room functionality and support culturally grounded, relationship-based care. Upon completion, customer-owners will have access to a modern, integrated clinic where physical, mental, and emotional needs can be met in a healing environment that supports improved access to high-quality, coordinated care focused on specialized medical services, prevention, and proactive chronic disease management.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Southcentral Foundation	Mobile Dental Clinic Launch Project	AK	SCF sends dental professionals into Head Start and other programs, but most dental work requires specialized equipment: a lot of it. A dentist and/or hygienist can perform basic screenings and offer education and outreach, but cannot more without the appropriate clinical environment. The need for more specialized dental services and equipment increases with the age of the teeth (and customer-owner), and yet adults and elders without sufficient dental care exist in our communities. Oral and dental health is often taken for granted until a negative event: a toothache or a tooth breaks. Without strong teeth, overall health suffers. Children can struggle academically. An NIH study in 2012 found that "Students with toothaches were almost 4 times more likely to have a low grade point average." Another NIH study in 2018 reports that among unhoused individuals, 30% could not eat because of dental pain, and 20% could not sleep. Individuals may also experience "Dental Shame" (NIH 2025), making social interactions more difficult in addition to any pain. Many individuals cannot make or keep dental appointments frequently due to time constraints or lack of transportation. They struggle to travel during clinic hours, especially if the clinic is rural or has otherwise limited hours for dental appointments. SCF aims to fill the gap by bringing a mobile dental clinic to them, promoting oral health and greater access.	SCF has been evolving the idea of mobile clinics already. SCF Dental Department proposes a mobile clinic, similar to mobile medical and mammogram mobile units. In addition to the planning and assessment for which this application supports, the full project would roll out in three different phases: The initial phase of acquiring and equipping a vehicle will take 1-2 years. This phase would involve selecting a vehicle (optimistically, one large enough for at least 2 operatories, built on a motor home chassis), publishing an RFP, purchasing the vehicle, establishing storage and maintenance options, and equipping the vehicle. A dental clinic will always need to include some radiology, which will require extra planning. Additionally, sterilization equipment poses its own set of questions as part of the exploration of this project. After the vehicle is purchased and outfitted, the second phase can begin. In this first year of service, SCF would evaluate and refine how it meets needs, and where gaps in service remain. This type of evaluation is not only part of SCF’s approach, but improves access as we further identify needs. The third and final phase of the project would allow SCF to expand services to new sites. Leadership in the Dental Department is considering including traveling to schools, congregate living spaces for elders, and expanding services for FQHCs and shelter clinics.	\$1M-\$5M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced

Southcentral Foundation	Rehabilitation Services Expansion & Transformation Project	AK	The demand for rehabilitative therapy at SCF continues to rise, leading to long wait times, capacity challenges, and a growing need for specialized services in chronic pain management and traumatic and acquired brain injury (TABI). Currently, customer-owners may wait more than 35 days for routine referrals and up to 28 days for urgent needs, delaying preventive treatment and prolonging recovery. SCF plans to hire additional therapists to address immediate needs. However, a long-term, right-sized, scalable therapy service is required to ensure timely and equitable access to care. Rehabilitative therapy is highly preventive and can reduce the need for surgery, hospitalization, and other intensive interventions when accessed early. Long waits can limit treatment effectiveness and slow recovery. Complementary services, such as exercise physiologists, further support chronic disease management and prevention but remain limited by current capacity. Most therapy is delivered onsite, requiring frequent travel that can be difficult due to weather, transportation barriers, or mobility limitations. Alternative delivery methods are needed to increase flexibility and reduce the burden on customer-owners, especially for episodic visits. This project presents an opportunity to expand capacity, modernize delivery models, and remove structural barriers to care—reducing wait times, supporting earlier intervention, and strengthening long-term wellness outcomes and system sustainability.	The Rehabilitative Therapy Expansion has three components designed to expand service and increase access to care: 1. Staffing & Service Expansion: SCF will hire additional therapy providers to reduce wait times and increase initial capacity. Additional therapies, such as chronic pain management support and pelvic physical therapy, which is available statewide, will be expanded to meet the demand for services. Expanding access to Cognitive Rehabilitation Therapy—currently limited to insured customer-owners—creates a more equitable service model and meets a growing need for TABI support. To ensure long-term capacity, SCF will also increase the number of support staff responsible for scheduling, referral management, and care coordination. These staff will work closely with integrated care teams to support continuity of care, assist customer-owners in navigating transportation or home visiting needs, and help remove barriers to timely access. 2. Delivery Methods & Scale: SCF is responsible for providing pelvic physical therapy statewide and supporting the rural CHCs it serves. To increase reach and access, SCF will explore alternative therapy delivery, such as expanding home visiting and hybrid telehealth in rural areas, and mobile therapy units that bring equipment and services directly to customer-owners. Group therapy delivered through learning circles will allow SCF to scale services efficiently while supporting cultural values, peer learning, and community-based healing. These approaches reduce travel burden, create more frequent touchpoints, and increase the number of customer-owners who can receive timely care. 3. Infrastructure & Equipment: To support the expanded workforce and service delivery model, SCF will remodel existing space to accommodate additional therapy providers and create a larger gym-like area for group services and learning circles. Telehealth-enabled spaces and mobile service hubs equipped with large screens will enable providers to seamlessly transition between in-person and hybrid visits or consultations. Additional therapy equipment is needed to support increased service volume and ensure providers can deliver high-quality, function-based assessments and interventions. Together, these strategies create a sustainable, flexible, and accessible model to increase capacity, reduce delays in care, and ensure customer-owners—especially those in rural and remote regions—receive timely, culturally grounded services.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Southcentral Foundation	Rural Dental Equipment Innovation	AK	While Southcentral Foundation strives to provide excellent service to everyone it serves, time passes and needs arise. Since taking on our rural sites and since its previous equipping, SCF’s dental equipment has been aging and is uncomfortable for providers and patients and is progressively more difficult to use. Equipment that is uncomfortable to customer-owners causes individuals to avoid encounters. They simply won’t make appointments or will wait until they travel into Anchorage. Equipment uncomfortable to providers creates exhaustion and burnout. The providers have to restrict the length of their travel visits and number of encounters per visit. Additionally, because of changes in the technology, SCF can no longer afford to maintain current equipment units that travel with providers, and changing the brand or type of equipment that SCF uses to provide dental services requires expansion funding.	The solution is that SCF needs to phase out some of the expensive, aging equipment that travels with dental providers and find a new vendor with a more sustainable cost point. Simultaneously, SCF will purchase and install updates of the more permanent and modernized dental equipment units in the clinics. Ideally, providers would also be able to store larger items on site. This refresh approach costs more initially but can increase billable encounters. New equipment will be sourced based on durability and repairability and will help the providers be able and willing to work for longer periods of time or more frequently out in SCF’s rural sites.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Chugach Census Area; Copper River Census Area; Kenai Peninsula Borough; Lake and Peninsula Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced
Southcentral Foundation	Sights and Sounds: Increasing Access to Optometry and Audiology Equipment, Services and Hardware	AK	The first aim is to protect and improve health outcomes for individuals needing access to clinically appropriate dry eye treatment, glasses, contacts in the communities served by SCF's Optometry clinics. Less than 1% of individuals diagnosed with dry eye disease have received treatment due to the prohibitively high out-of-pocket cost that ranges from \$500 to \$1,200 annually, as the treatment is not covered by most 3rd party payors. Untreated dry eye disease could cause corneal abrasion, infection, ulceration, scarring, and significant or permanent vision loss. Using glasses or contacts that do not meet the current eye conditions can lead to severe eye strain, debilitating headaches, dizziness, and nausea. For children, good vision is critical to learning and needs updating more frequently. Due to financial restrictions, glasses are kept at school hindering learning at home. The second aim is to secure hearing aids and Cochlear implants and processors for individuals served by SCF's Audiology clinics. At least 300 individuals are identified annually who need hearing aids, but can not afford the out-of-pocket costs. Hearing well is needed for children to learn and interact safely in the world around them. Adults with no or clinically inappropriate hearing aids risk accelerated cognitive decline, isolation and depression, safety risks, and employment challenges. The implications are more severe for	SCF's Audiology and Optometry clinics will be working with individuals receiving services to identify and address financial barriers to care. Funding will be provided to cover the out-of-pocket expenses for dry eye treatments, glasses, contacts, hearing aids and cochlear implants and processors for those without the ability to pay. The RHTP funds would be payor of last resort for these services. During village visits, Audiologists and Optometrists will identify individuals facing financial barriers to receive support under this project. The same is true for individuals seen in the Anchorage and Wasilla clinics. Additionally, support for new equipment to support dry eye treatment is being requested in year 1 to increase availability and treatment modalities needed to address the underlying cause of dry eye disease. Audiology supplies and equipment are also being requested to support service expansion. The estimated funding request for year 1 is approximately \$4 million, which would cover the equipment (not attached to a facility), minor equipment and supply costs to support this endeavor, along with approximately 300 sets of hearing aids; 20 Cochlear implants and processors; dry eye treatments for 1,170 individuals, 1,300 pairs of glasses and contacts for 440 people.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Fairbanks North Star Borough; Kenai Peninsula Borough; Kodiak Island Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; North Slope Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

individuals needing cochlear implants and processor updates.

Southcentral Foundation	Support for Health Appointment Travel	AK	The biggest roadblock, if you'll pardon the expression, preventing access to health care in the Anchorage Service Unit (ASU) is simply the challenge of getting from there to here when they're so far away. Southcentral Foundation's customer-owners in Anchorage, the Valley, and other communities on the road system (and off) consistently lack reliable transportation to and from appointments. This challenge is especially complex when you consider that many of the elders and those most in need of regular medical encounters live too far from busy roads to be expected to walk, bike, or ski to the nearest bus stop – especially if they are suffering from leg injuries, for instance.	The collaborative solution to this challenge is to explore funding sources and transportation assistance methods between VNPCC and ANPCC, and from an individual's home into town and back. By preference, SCF would contract out to a medical transportation service. Discussion is already underway to pilot such a program in the next two or three months. If the pilot is successful, SCF will need funds to expand the program. Another possibility, though not a popular one for facilities on the road system, might be to begin a bespoke shuttle service. This type of project would involve expanding SCF's services outside of its familiar scope from health care into public transit. SCF would need to purchase and insure handicapped-accessible vehicles, hire and insure reliable drivers, and manage routes. A third option might be to contract with Tribal Councils. In the past, the Knik Tribe has provided a car and driver for health appointments. They and other councils could provide the transportation and contract for full or partial reimbursement, or even pay for the transport themselves while SCF could create a position to coordinate or communicate with drivers or shuttles.	\$250K-\$1M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Kenai Peninsula Borough; Matanuska-Susitna Borough; Yukon-Koyukuk Census Area

Deferred or Not Advanced

Southcentral Foundation	Updating Call Systems to Enhance Tribal Healthcare Infrastructure	AK	For many customer owners, access to care starts with whether they can reach SCF by phone and connect quickly to the right team. In rural Alaska, where distance, weather, and geography create access barriers, dependable phone reachability is essential to being seen by a clinician or care team member. This project modernizes SCF from legacy fixed-location telephony to cloud calling, soft phones, and a modern contact center. Staff will stay reachable and coordinated even when away from desks or working remotely, improving routing speed, reducing avoidable wait times, and strengthening continuity during disruptions. It improves current access and creates the foundation for future multi-channel options such as chat, video, and callback. Updated phone systems are needed to respond to the changing needs of the workforce, including an increase in remote work. SCF has maintained and upgraded its current on-premises telephony/contact center environment, but the architecture is primarily designed around physical desk phones and is not optimized for location-independent communication at current scale. SCF’s workforce is increasingly mobile. Staff need to place and receive calls from the device that fits their role and location, including mobile phones, laptops, and physical desk phones where appropriate.	This project would allow SCF to continue to use desktop phones until they reach their end-of-life service duration, while also transitioning the workforce to a cloud solution for calls, video, file sharing, and integrating communications systems. SCF will use a staged migration over an estimated 18 months to move from on-prem Cisco telephony/contact center to cloud calling, soft phones, and SaaS contact center capabilities, avoiding a big-bang cutover. The work starts with planning/readiness and SOW-supported implementation services, followed by a pilot cohort of approximately 100 users to validate call flows, integrations, E911, recording, and support workflows. Based on pilot lessons, migration will continue in controlled waves to broader user groups and service queues until steady-state operations are established. The approach uses existing license value with step-up/trade-in mechanics and scales over time toward roughly 3,000 users/phone numbers.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Kenai Peninsula Borough; Lake and Peninsula Borough; Matanuska-Susitna Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Southcentral Foundation	Yeshjesh T'uh: Medical Detox Expansion	AK	Southcentral Foundation (SCF) Detox program aims to maximize the beds available to Alaskans 18 and over for residential withdrawal management. Detox is a Medically Monitored inpatient program supported by 24/7 with nursing and medical staff to ensure continual observation of the customer as they progress through withdrawal symptoms. Staff members use tools to assess withdrawal such as Clinical Opiate Withdrawal Scale (COWS) and Clinical Institute Withdrawal Assessment for Alcohol (CIWA) and have clear protocols for supporting each customer. The program is already working to provide services to those who frequently overuse critical medical services such as the Emergency Room. The program supports customers seeking medical withdrawal and the staff work to stabilize them medically, but also psychiatrically if needed. The program supports priority admissions set by the State of Alaska, but also works with individuals in the community who have confirmed placements in residential treatment to support improving bed utilization by ensuring customers are able to go bed-to-bed and have the clearance needed to enter a stepdown program. SCF Detox integrates Medication Assisted Treatments (MAT) into the program and works to ensure that customers who are requesting services such as Naltrexone, Vivitrol or Suboxone have access to and an appointment for ongoing services when they discharge.	The Yeshjesh T'uh is a 105,000 square foot facility and the Detox program will be the building's first occupants in Fall 2026. Yeshjesh T'uh is a critical project designed to enhance the behavioral health and substance use disorder services available in Anchorage and throughout the state. The SCF Detox program expansion works to address the ongoing and increasing need for state-wide medical detox services. The funding requested under Alaska's RHTP grant is to support the additional personnel and non-personnel expenses associated with the increase in beds from 16 to 30. The program will grow from 55 FTEs at present to 71 FTEs in July 2026. Because the existing program has sufficient oversight positions, economy of scale is achieved with only 16 FTEs being added rather than 30 or more that would be needed to expand the state's detoxification beds by another organization. The expansion will require the following additional staff: -Registered Nurses (RNs): 5 FTEs to complete admissions, screenings, medication administration based on protocols and withdrawal scales; -Nurse Practitioners or Physician Assistants (NP/PA): 4 FTEs to perform complete full examinations, review customers' psychiatric needs and address issues throughout treatment. A provider is on-call after hours to discuss any changes in a customer's conditions. They provide medical care beyond withdrawal, support customers getting back onto needed medication and work to ensure hand-off to specific primary care physicians when customers discharge from services. -Case Management Support: 2 FTEs to support the work of the clinical providers by assisting with care coordination; verbal and written communication; and information research and transfer. -Community Resource Specialists (CRS): 1 FTE to support case management, comprehensive discharge planning, biopsychosocial assessments, educational group services, needs assessments, access to Medication Assisted Treatment services, and establishing connections to healthcare services for follow-up care post discharge. -Behavioral Health Consultant (BHC): 1 FTE to provide assessment and brief intervention and support customers with co-occurring disorders. -Intake Program Coordinators: 2 FTEs to support customers and clinical staff through the intake process. -Integrated Pharmacist: 1 FTE to oversee medication needs and potential medication interactions. Funding for new Medical Monitoring equipment totaling \$200,000 will be needed in year 1.	\$1M-\$5M	Family or primary care	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Southeast Alaska Independent Living (SAIL)	SE Alaska Participant Directed Rural Health Access Project	AK	Southeast Alaska Independent Living (SAIL) is the designated Center for Independent Living, Aging and Disability Resource Center, Developmental Disability Resource Connection, and Traumatic and Acquired Brain Injury grantee for Southeast Alaska. SAIL has staffed offices in six communities, but over twenty rural, remote, and frontier communities across the region have little or no access to participant-directed care, independent living services, home assessments, assistive technology, or brain injury supports. Veterans, elders, and people with disabilities in places like Yakutat, Hoonah, Wrangell, and Kake often do not know these services exist. Alaska has the highest concentration of veterans in the nation, with eight to ten percent of the population having served. Many meet nursing home level of care criteria the state must provide. A full year in nursing home care in Alaska costs \$334,000 to \$436,000 per person. SAIL's VOICE program keeps veterans home through participant-directed care, averaging less than \$40,000 per year, saving hundreds of thousands of dollars per person annually. SDS is also preparing to launch Participant Directed Medicaid Waiver services, allowing nursing home-eligible Alaskans to remain home with caregivers of their choosing. This project will plan the expansion of these critical services to rural Southeast Alaska communities that currently lack access.	Participant Directed Rural Health Access is a one-year planning initiative that will lay the groundwork for SAIL to expand its full range of services across all of Southeast Alaska, including the six communities where SAIL already has staff and more than twenty additional rural, remote, and frontier communities from Metlakatla to Yakutat. SAIL will dedicate one existing staff member and hire 1.5 FTE new positions to carry out planning activities, with service delivery primarily through in-person travel, augmented by technology where connectivity allows. During the planning year, SAIL will conduct community needs assessments throughout the region, including communities such as Yakutat, Hoonah, Gustavus, Wrangell, Kake, Metlakatla, and villages across Prince of Wales Island, among others. These assessments will identify veterans eligible for the VOICE program, individuals who may qualify for the upcoming Participant Directed Medicaid Waivers, and residents who need independent living services, home assessments, assistive technology, brain injury supports, and aging and disability resource information. SAIL will identify local points of contact in each community, build referral relationships with tribal health organizations, local hospitals, long-term care providers, and community organizations, and develop outreach and education materials to prepare communities for the Participant Directed Waiver so that SAIL is ready to facilitate enrollment as soon as the Participant Directed waiver service launches. This planning phase will produce a detailed implementation plan for Years 2 through 4, including community-specific service delivery schedules, travel logistics across Southeast Alaska's ferry and air networks, staffing models, partnership agreements, and measurable goals. By investing in thorough planning, SAIL will be positioned to deliver sustained, high-quality participant-directed care and independent living services region-wide through a hub-and-spoke model that builds on its existing infrastructure.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

Southeast Alaska Independent Living (SAIL)	Future Ready: Workforce Readiness for Middle School Youth with Disabilities	AK	Youth in rural Southeast Alaska face increasing challenges related to mental health, social isolation, and limited access to prevention-focused programming that builds resilience and life skills. Communities like Juneau, Ketchikan, and Sitka are geographically isolated and have limited behavioral health resources. This makes early prevention and skill-building critical to supporting long-term health outcomes. The transition to middle school is a particularly vulnerable time for youth, as they navigate new social environments, increased academic expectations, and growing pressures that can affect their mental and emotional well-being. At the same time, youth with disabilities often experience additional barriers to participation in recreation, peer activities, and leadership opportunities. In rural communities, accessible and inclusive programming that allows these youth to build social skills, confidence, and independence can be limited. Future Ready addresses these challenges by creating structured, experiential opportunities for youth to develop communication, teamwork, emotional regulation, and problem-solving skills through outdoor recreation and challenge course programming. By focusing on prevention and resilience during early adolescence, and by ensuring youth with disabilities have inclusive opportunities to participate, this initiative aims to strengthen protective factors that support mental health, social connection, and long-term well-being in rural communities.	To address the need for youth resilience, social connection, and inclusive recreation opportunities in rural Southeast Alaska, Southeast Alaska Independent Living will implement a two-part youth development initiative that uses outdoor recreation and experiential learning to build critical life skills. First, all sixth-grade students in Juneau will participate in facilitated challenge course programming. During these sessions, trained staff guide students through structured activities designed to build communication, teamwork, leadership, problem-solving, and emotional regulation. The challenge course environment provides a safe and supportive setting where youth practice collaboration, trust-building, and healthy risk-taking while strengthening relationships with peers. This programming supports youth during the critical transition to middle school and helps build protective factors that contribute to long-term mental health and well-being. Second, Future Ready will provide ongoing high-adventure recreation programming for middle school youth with disabilities. Activities will include adaptive kayaking, biking, hiking, and overnight camping experiences. These programs are designed to build confidence, independence, and social skills while providing youth with disabilities opportunities to participate in outdoor recreation that may otherwise be inaccessible in rural communities. Through school-based experiences and skilled facilitation, participants will practice communication, leadership, and teamwork while forming supportive peer relationships. Together, these efforts create inclusive, community-based opportunities for youth to develop skills that support healthy development and resilience. By combining universal programming for all sixth-grade students with targeted opportunities for youth with disabilities, Future Ready expands access to health-promoting experiences while addressing barriers to participation. This approach strengthens protective factors such as social connection, self-confidence, and problem-solving ability, which are associated with improved behavioral health outcomes and stronger community well-being.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Southeast Alaska Independent Living (SAIL)	HomeMAP: Home Modifications for Aging in Place	AK	Southeast Alaska Independent Living (SAIL) developed and owns HomeMAP (Home Modifications for Aging in Place), a structured home safety assessment tool used statewide to help seniors and people with disabilities identify modifications needed to remain safely in their homes. The State of Alaska has funded three grantees — RurAL CAP, Anchorage NeighborWorks, and Alaska Community Development Corporation — who purchased HomeMAP assessments from SAIL and use them to guide home modifications for their clients. The HomeMAP assessment content remains accurate and effective, but the delivery platform has not been updated in over a decade. The tool currently requires an in-person visit to conduct each assessment, which severely limits reach in a state where most communities are off the road system and travel is expensive, weather-dependent, and time-consuming. As a result, a program that has completed hundreds of assessments over its lifetime has dwindled to approximately 10 this last year statewide. Alaska has the one fastest growing senior population in the country. The need for home safety assessments has not decreased — the platform simply cannot reach the people who need it. Seniors and Alaskans with disabilities who want to age in place, particularly those in rural, remote, and frontier communities, have no accessible way to evaluate their own home safety or understand what modifications would help them stay home.	SAIL proposes a one-year planning initiative to research, design, and scope a modernized digital version of the HomeMAP assessment tool. The core question this project will answer is whether current technology can enable HomeMAP assessments to be conducted remotely — without requiring an assessor to physically travel to the home — and if so, what the right platform and format would be. This could take the form of a consumer-facing app, a web-based guided self-assessment, a video-assisted remote walkthrough, or another approach identified during the research phase. The planning work will be carried out by a mix of SAIL staff and contracted technology and design consultants. Activities will include a comprehensive review of available technologies for remote home assessment, including photo-based and video-based tools, guided digital checklists, and emerging approaches. SAIL will gather input from the three current HomeMAP grantees — RurAL CAP, Anchorage NeighborWorks, and Alaska Community Development Corporation — who bring direct experience using the tool with clients across different regions of Alaska. Their feedback will inform what works in the current assessment, what barriers they encounter, and what a modernized tool would need to do. SAIL will also conduct user research with seniors and people with disabilities to understand technology access, comfort, and usability considerations, particularly for older Alaskans in rural communities. The planning phase will produce a feasibility assessment, a recommended platform and design direction, a scope of work for development, and a cost estimate for building the modernized tool. This deliverable will position SAIL to make an informed decision about whether to proceed with full development and to seek implementation funding.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

SouthEast Alaska Regional Health Consortium	Mammo On the Go Southeast	AK	One in eight U.S. women will be diagnosed with invasive breast cancer, and Alaska Native women have slightly higher rates than non-Native women in the state. Early detection through regular screenings is crucial for improving treatment outcomes however rural Alaskan women face significant challenges accessing regular mammograms due to geography, transportation limitations, weather, and socioeconomic factors. There are no mobile mammography coaches in Southeast region currently. Limited options for mobile mammography contractors, routine cancellations due to weather or transportation issues have hindered access to screenings. SEARHC previously contracted Fairbanks based providers, but services were limited to one month out of the year. Tight schedules, travel delays, and reduced appointment availability meant many women missed screenings. In 2024, only 207 of 370 needed appointments were available. Many went unfilled due to a short duration of access, and missed appointments weren't rescheduled so women delayed or missed annual screenings altogether. In 2025 the vendor increased contract costs 36% and reduced available appointments. SEARHC ended the contract opting to organize group travel for screenings, which involved complex logistics for flights, food, and transport in Juneau. Despite limited successes, overall screening numbers did not reach our target. Rural tribal women expressed a clear preference for local mobile mammography over traveling for care.	SEARHC proposes purchasing the first regional mobile mammography coach equipped with an Automated Breast Ultrasound System (ABUS.) Services will offer year-round breast cancer screening and diagnostic mammograms in remote Southeast communities, expanding continuous access to dedicated mammography services. The mobile coach will be 22 ft. for better maneuverability on ferries and remote road systems and feature a Hologic Mobile 3D Screening and diagnostic Mammogram unit as well as a GE Healthcare Invenia ABUS 2.0-Breast Imaging Ultrasound system. Since it is not possible to provide on-site diagnostic mammography, ultrasonography, or have a radiologist present, this technology eliminates the need for an on-site radiologist and enables enhanced screening capabilities for patients with previous screening or diagnostic results indicating dense breast tissue. The ABUS offers additional screening to detect potential malignancies and could decrease the number of women who must travel from remote or rural locations to urban centers like Juneau or Sitka for follow-up diagnostics. It also supports extra CPT billing codes. The coach will include mammogram and ultrasound imaging equipment, a reception area, and a private exam room. Staff will consist of two mammography technologists and a patient navigator. Additional support staff already working in the region will include Radiology and Imaging Services, Community Wellness Nurse Evaluation Specialist, RN Case Managers, and a Data and Evaluation Specialist. Radiologists will review transmitted images, while Primary Care Providers will offer further healthcare services and specialized referrals, supported by local healthcare staff. The Women's Health team, together with imaging staff, aims to deliver breast cancer screening, prevention education, and health counseling through regularly scheduled visits to remote communities along the Alaska Marine Ferry System and rugged roads of rural Southeast Alaska. The coach will be based in Juneau to allow flexible rescheduling during weather or ferry delays. Ultimately, the project seeks to reduce late-stage cancer diagnoses and mortality by increasing early detection and personalized care.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Hoonah-Angoon Census Area; Juneau (City and Borough); Prince of Wales-Hyder Census Area	Advance to Implementation Application

SouthEast Alaska Regional Health Consortium	SEARHC Health Information Exchange Standardization	AK	HIE systems are essential to securely sharing patient health information between providers and different entities, enhancing care coordination, and improving overall clinical efficiency. Alaska’s current HIE landscape, however, faces challenges related to interoperability, data quality, regulatory complexity, sustainability, and patient participation. Data from non-standardized systems often lacks semantic interoperability, meaning receiving systems cannot interpret the data accurately. Without standardized identifier systems, matching patients across different organizations is difficult often resulting in incomplete, inaccurate, or redundant information that is not useful for clinical decision-making. Different electronic health record (EHR) systems often use proprietary formats that do not communicate, making data exchange labor-intensive, costly and prone to data breach. By initiating a standardization SEARHC will create a framework that can be scaled for adoption statewide.	SEARHC will establish a contract with dedicated IT professionals to provide technical assistance and guidance in establishing the HIE framework between SEARHC and ANTHC as key partners serving overlapping patient populations. HealthEconnect Alaska and ANHB would be engaged during the process to ensure a framework that could be scaled statewide. Through implementation of initiative #2: Health Care Access and #6 Spark Technology and Innovation, this project will focus on: • Standardizing HIE between SEARHC and ANTHC • Ensuring adaptability across care settings • Strengthening sustainable, equitable information access • Supporting statewide adoption of interoperable exchange	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

SouthEast Alaska Regional Health Consortium	AI-Integrated Primary Care in Southeast Alaska: Coordinating Virtual, Remote & Community Services	AK	As SEARHC advances its initiatives to improve healthcare access in rural Southeast Alaska, the organization continues to address challenges related to standardizing care, sustaining workforce stability, and minimizing administrative burdens so providers can focus more efforts on direct patient care. SEARHC proposes to deploying Tom™, an AI-enabled primary care infrastructure platform, within our regional network. Rather than replacing current technology, Tom integrates with our electronic medical records (EMRs) and health information exchange (HIE) to strengthen coordination across primary, behavioral, maternal, and community-based services throughout Southeast Alaska. The platform functions as a digital force multiplier for our care teams. Through continuous analytics and AI-driven Best Next Actions, it identifies care gaps, rising-risk patients, and preventive needs, and can autonomously initiate outreach and care coordination within defined clinical protocols, enabling proactive chronic disease management, maternal follow-up, behavioral health coordination, and post-discharge outreach. This expands effective panel capacity, improves chronic disease interventions and health outcomes, and minimizes unnecessary travel for rural patients. Because it is integrated within existing platforms it is inherently HIPAA compliant.	Implementation will focus on aligning the platform within existing clinical workflows and priority service areas with measurable improvements in preventive outreach, chronic care coordination, and care team efficiency. It will streamline coordination activities, prioritizing actionable insights and reducing administrative strain. It assists care teams by simplifying coordination tasks, highlighting meaningful health indicators, and enabling healthcare providers to focus on practicing at the top of their license, especially in areas with limited workforce resources. Digital engagement complements, rather than replaces, in-person care and remains anchored within SEARHC’s regional delivery model and Tribal coordination framework. By modernizing interoperable infrastructure and embedding coordinated workflows across clinics, critical access hospitals, and community care providers, this approach reduces fragmentation, strengthens continuity of care, and builds durable infrastructure. Embedding Tom into the existing infrastructure also positions SEARHC with scalable AI capable of evolving over time, ensuring long-term adaptability and innovation without requiring system replacement. It advances RHT initiatives focused on Alaska’s Health Care Access, Healthy Communities, Strengthen Workforce, and Spark Technology & Innovation initiatives by expanding sustainable primary care capacity without requiring new physical infrastructure. What Lumeris does: Primary Care as a Service (PCaaS): Offers a technology-led model supporting primary care teams with AI tools, operational help, and compliance. AI-Powered Technology (Tom™): Tom™, their proprietary AI, integrates with EHRs to automate routine tasks and suggest next actions, aiding—rather than replacing—physicians. Value-Based Care Enablement: Supports health systems in managing risk, optimizing contracts, and improving performance through PHSO services. Data Aggregation: Integrates multiple EHR and payer data sources for real-time care decisions. Risk Management: Focuses on supporting organizations in managing high-risk and chronically ill populations.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

SouthEast Alaska Regional Health Consortium	Empowering Access: Self-Registration Kiosks for Southeast Alaska Healthcare	AK	Rural and remote healthcare clinics encounter several distinctive obstacles during the patient registration process, particularly when verifying personal information. One significant issue is the high rate of staff turnover, which frequently disrupts clinic operations and causes interruptions in the initial phase of service delivery. Staffing shortages further compound these challenges. With fewer staff available, clinics are more likely to experience longer wait times for patients and an increased likelihood of incomplete or illegible paper forms. These constraints often result in a rushed registration process, undermining the accuracy and completeness of collected patient information. In small communities where patients lack anonymity, individuals may feel hesitant to disclose personal details, particularly those related to social determinants of health. This reluctance can hinder the collection of critical information necessary for establishing accurate and comprehensive patient care during the onboarding process in a clinical setting. This hesitancy and the resulting incomplete or missing data can significantly impact a clinic’s ability to deliver holistic and effective care, emphasizing the importance of addressing these challenges in rural and remote healthcare environments.	SEARHC will address workforce shortages and enhancing efficiency by installing 35 self-serve registration kiosks in clinics across key communities. These kiosks automate check-in tasks, reduce front desk workload, lower patient wait times, and let staff focus more on direct patient care. They also provide patients with a safer, more private way to share confidential information that reveal social determinants of health which can be securely documented for clinical use. Key features include contactless check-in, digital signatures, instant badge printing, and multi-lingual options. After conducting an internal review, SEARHC provided sole source justification for selecting Luma Health as our chosen vendor. Luma Health was found to be the most qualified based on its product features, warranty options, and capacity to install kiosks at all sites. The company offers comprehensive proprietary integration with our Meditech electronic health record and full-service installation and warranty support, to ensure a smooth and timely startup. Key Benefits: • Self-service check-in updates the EHR and patient status in real time. • Digital intake, consent forms, insurance updates, and ID upload eliminate paper forms. • On-site scheduling allows patients to manage appointments. • SMS feedback collection links responses to EHR records; automated recalls support follow-up care. • Payment collection at the kiosk streamlines copay and balance payments. • EHR integration ensures accurate data and reduces manual entry, cutting administrative workload.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Prince of Wales-Hyder Census Area; Sitka (City and Borough); Wrangell (City and Borough)	Deferred or Not Advanced

SouthEast Alaska Regional Health Consortium	Southeast Regional Health Career Pathways & Training Center	AK	Southeast Alaska is home to approximately 71,000 people, with nearly half residing in the capital city. The region heavily depends on its year-round residents to sustain essential services, however increasing outmigration of younger generations due to limited opportunities contributes to aging communities and chronic workforce shortages. This demographic shift presents a critical opportunity to invest in healthcare training opportunities that grow our own workforce and provide meaningful careers close to home. Healthcare represents about 8% of the regional workforce, generating \$312 million annually, however roughly 18% of Southeast Alaska healthcare workers are nonresidents. Local opportunities for education are limited or non-existent. For example, demand for nurses statewide is 1,400 only 346 nurses graduate annually. Increasing reliance on locum tenens, or "traveler" services is cost prohibitive and increasingly unsustainable with healthcare wages in the region rising 79% just in the past decade. Establishing a training center open to all Alaskans will strengthen the economy, create living wage career opportunities, fill gaps in care for our aging population, and ensure that all rural Alaskan communities have reliable access to high-quality health services in their home communities.	In response to Goal 3: Drive Workforce and Technology Innovation in the State of Alaska RHTP plan, SEARHC proposes to establish a regional training center integrating accredited didactic instruction with clinical training and simulation. In the first year, SEARHC would propose a planning grant to further scope and refine this business model as SEARHC prepares the physical location for in-person, hands on training in a simulated lab environment. Funding for necessary medical equipment would be included in the year 1 funding request. This early procurement will allow site prep to happen in tandem with curriculum and accreditation development. The purchase of this equipment would be funded through the first-year RHTP funding allocation while SEARHC provides the facility and necessary renovations. This coordinated approach will allow for timely setup of training environments aligned with phased implementation planning and timely launch of training programs. Pima Medical Institute has proven success rates in delivery of hands-on, accelerated training for healthcare careers and multiple state and program specific accreditations. Securing their technical assistance will ensure timely accreditation and licensing. Pursuing accreditation will not exclude partnerships with other educational organizations but will allow for adapting to meet needs and availability of partnerships and training programs moving forward. Initial areas of focus will be: • Dental Assisting • Sterile Processing • Ophthalmic Aide/OMT • Certified Nursing Assistant/Medical Assisting • Limited Scope Radiology Technology • Customer Service/Cultural Orientation This initiative would be conducted in collaboration with tribal partners, community organizations, educational organizations, and healthcare providers ensuring that necessary resources and supports are in place to maximize benefits for students. The process will be phased, beginning in the first year with curriculum and accreditation development, procurement of essential equipment for all programs, renovation and site prep/installation and launching of initial, non-accredited training programs beginning with Certified Nursing Assisting and - upon accreditation - adding Dental Assisting, Sterile Processing, and Ophthalmic Aide. SEARHC maintains an outstanding record of success in strategic facility expansion, workforce housing provisions, and training program development and is proposing a timeline that confidently reflects this experience.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Southeast Childhood Collective	Develop Near Site Child Care for Bartlett Regional Hospital	AK	Reliable child care is a critical factor in recruiting and retaining health care professionals at Bartlett Regional Hospital (BRH). Like many hospitals across Alaska, BRH faces ongoing workforce challenges, and access to dependable child care is a significant barrier for many current and prospective employees. In Juneau, licensed child care is available for only a fraction of the children who need it, resulting in long waitlists and limited options that often do not align with the schedules of health care workers. Hospitals depend on a stable workforce to maintain services for their communities. Yet, child care shortages can make it difficult for employees to accept positions, remain in the workforce, or work the full schedules required in health care settings. These challenges are particularly acute for shift-based positions that require early morning, evening, or variable hours. This project creates an opportunity to strengthen the health care workforce by expanding child care options specifically accessible to BRH employees through a near-site child care program. By increasing access to reliable care for hospital staff, the project will support workforce recruitment and retention, reduce absenteeism related to child care disruptions, and help ensure that BRH can maintain consistent health services for the communities it serves across Southeast Alaska.	Southeast Childhood Collective (SCC) will collaborate with Bartlett Regional Hospital (BRH) and a licensed child care provider located within a few miles of the hospital to expand near-site child care capacity, prioritizing enrollment for BRH employees. SCC has already identified a recently opened licensed center whose owner is interested in designating a portion of its child care slots specifically for hospital workers. The project will provide targeted support to expand the provider’s capacity through modest facility improvements, equipment purchases, and operational support, enabling the program to add additional licensed child care slots. SCC will also work with the provider and BRH to identify priority age groups and scheduling needs, including care for school-age children, so the program aligns with the realities of hospital work schedules. SCC will coordinate implementation by working closely with the provider to ensure the program can scale quickly while maintaining licensing compliance and high-quality early learning environments. This will include technical assistance related to licensing requirements, staffing plans, and classroom setup as new spaces are added. BRH will support the effort by promoting the program to employees and prioritizing enrollment access for hospital staff. With these coordinated steps, the near-site child care program could begin serving BRH employees within months of receiving funding, providing a practical and near-term solution to a key workforce barrier for the hospital.	\$50,000-\$250,000	Single Community	Juneau (City and Borough)	Advance to Implementation Application

Southeast Childhood Collective	Expand the Child Care Apprenticeship Program	AK	Child care programs across Southeast Alaska face ongoing challenges in developing and retaining a qualified workforce. Even when individuals are interested in working in early childhood education, many lack access to structured training pathways that allow them to gain credentials while continuing to work. For small programs in rural communities, the time and cost required to support staff through traditional education programs can make workforce development difficult. The child care apprenticeship program offers a practical opportunity to strengthen the early childhood workforce by providing a structured, earn-while-you-learn pathway into the profession. Apprentices are employed in licensed programs while completing college coursework and supervised on-the-job learning that builds the competencies required for high-quality early learning environments. Expanding the apprenticeship program will allow additional child care programs and educators across Southeast Alaska to participate in this model. The program provides a scalable approach to workforce development that supports providers in building stable staffing pipelines while increasing the number of trained professionals working in early childhood education across the region.	Southeast Childhood Collective will expand participation in its federally registered Child Care Apprenticeship Program to recruit and train additional early childhood educators across Southeast Alaska. The program combines paid employment in licensed child care programs with structured on-the-job learning and college coursework, creating an earn-while-you-learn pathway into the profession. Apprentices complete the Occupational Endorsement Certificate in Early Childhood Development through the University of Alaska Anchorage while accumulating supervised on-the-job learning hours in licensed programs. Each apprentice is supported by a trained mentor who provides guidance, evaluates skill development, and helps connect classroom learning with daily practice in early learning environments. SCC coordinates the program by supporting apprentices, mentors, and participating employers to ensure progress toward completion. As the program expands, SCC will prioritize enrollment for educators working in child care programs that serve health care employees or are located near hospitals and medical facilities. Strengthening the workforce in these programs helps ensure reliable child care is available for health care workers whose schedules and workforce demands require stable care options. Through this approach, the project will expand the number of trained educators entering the field while building workforce capacity in programs that play a critical role in supporting the health care workforce across Southeast Alaska.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Sitka (City and Borough); Skagway (Municipality)	Advance to Implementation Application

Southeast Childhood Collective	Parents as Teachers 4th Trimester Initiative	AK	The Parents as Teachers 4th Trimester Initiative expands postpartum support to families across Southeast Alaska from birth through the first 16 weeks after delivery. The project addresses a critical gap in rural maternal and infant health services. Families in Southeast Alaska face significant barriers to postpartum care, including geographic isolation, transportation challenges, limited perinatal mental health services, and workforce shortages. Many parents return home from birth without access to consistent support during the most vulnerable months following childbirth. Alaska’s rates of perinatal mood disorders exceed national averages, increasing the risk of adverse childhood experiences (ACEs), disrupted parent-child attachment, developmental delays, and increased behavioral health service use later in life. The first three months postpartum are a critical window for maternal mental health, infant brain development, and family stability. Without early screening and support, postpartum depression and parental stress can escalate into crises requiring costly interventions across health, behavioral health, and child welfare systems. This initiative establishes a coordinated, prevention-focused maternal-child health model that connects families to Parents as Teachers home visiting immediately following birth, improving outcomes for rural families.	The Southeast Alaska 4th Trimester Initiative will expand evidence-based home visiting services region-wide using a hybrid delivery model that ensures equitable access across remote and frontier communities. Key components include: • Weekly home visits beginning at birth and continuing through 12 weeks postpartum • Standardized maternal mental health screening and early referral coordination • Infant developmental guidance and parent-child attachment support • Care navigation assistance (WIC enrollment, Medicaid enrollment, birth certificate processing, lactation access, behavioral health referrals) • Optional peer support groups (virtual and in-person) to reduce isolation • Telehealth integration to ensure continuity of service in geographically isolated communities The initiative will coordinate closely with regional hospitals, Tribal health partners, public health agencies, and community-based providers to create seamless referral pathways and avoid duplication of reimbursable services.	\$50,000- \$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough)	Advance to Implementati on Application

Southeast Childhood Collective	Art for Family Wellbeing	AK	The early years of parenting can be emotionally demanding, and many families experience stress, fatigue, and isolation during the transition to caring for a young child. In rural communities like those in Southeast Alaska, long winters, geographic isolation, and limited opportunities for family-centered activities can make it difficult for parents to find supportive spaces to connect with their children and other families. Early childhood represents an important opportunity to strengthen parent-child relationships and support healthy social and emotional development. Creative activities such as art provide a natural way for young children and caregivers to interact, communicate, and express emotions together. When parents engage in creative play with their children, it can strengthen attachment, support early development, and reduce caregiver stress. This project addresses that opportunity by creating a welcoming environment where parents and young children can participate in guided art activities together. By integrating creative expression with parent-child interaction, the classes will help families build stronger relationships, support early emotional development, and create opportunities for connection among families navigating the early stages of parenting.	Southeast Childhood Collective will offer a series of small-group parent-child art classes designed to support connection, creativity, and emotional well-being for families with young children. Classes will be held twice per month and will take place in a rented space at the local Makerspace, which provides a welcoming environment for hands-on creative activities. Each session will be led by a certified art teacher or art therapist who will guide families through simple, developmentally appropriate art experiences that parents and children can complete together. Activities will focus on creative exploration, sensory engagement, and opportunities for positive interaction between caregivers and their children. The small-group format will allow instructors to provide individualized guidance while fostering a relaxed, supportive environment for families. All art materials will be provided so families can fully participate without bringing supplies. Sessions will be accessible to parents with young children and will emphasize process-based art activities that encourage expression, curiosity, and shared creativity rather than artistic skill. By offering consistent opportunities for families to engage in creative activities together, the project will provide a supportive space for parent-child interaction while helping caregivers build confidence using art and creative play as tools for connection and emotional expression at home.	\$50,000-\$250,000	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Southeast Childhood Collective	Child Care Policy and Development Specialist Position at SCC	AK	Communities across Southeast Alaska are actively seeking solutions to persistent child care shortages that limit workforce participation and economic stability. The lack of reliable child care has become a major barrier to recruiting and retaining workers in essential sectors, including health care. Several Southeast communities have expressed interest in developing local child care grant programs or other sustainable funding mechanisms to support providers and increase the supply of licensed care. However, many communities lack the policy expertise, program design capacity, and administrative infrastructure needed to develop and implement these systems. The Southeast Childhood Collective (SCC) has successfully implemented and administered child care grant programs in partnership with local governments and has received requests from multiple Southeast communities for technical assistance in developing similar models. At present, SCC does not have dedicated staff capacity to support this regional policy development work. This project represents an opportunity to establish a Child Care Policy and Development Specialist position to work with communities across Southeast Alaska to design sustainable funding models, develop implementation plans, and build the infrastructure needed to support long-term child care capacity. Strengthening these systems will support workforce stability in sectors critical to rural access to health care.	This project will establish a two-year Child Care Policy and Development Specialist position at SCC to support Southeast communities in developing sustainable child care funding models and implementation strategies. The specialist will work directly with local governments, tribal organizations, providers, and community stakeholders to assess child care supply and demand, identify feasible policy options, and design locally appropriate funding mechanisms. This work may include exploring options such as municipal grant programs, employer-supported child care models, dedicated local revenue sources, or other community-based funding strategies. The position will also support the development of administrative structures needed to implement and manage local child care grant programs. This includes designing application processes, eligibility criteria, monitoring systems, and evaluation frameworks that ensure funds translate into increased child care capacity. The specialist will collaborate with communities already engaged in this work, including those participating in projects currently under consideration through the Rural Health Transformation Program. By providing coordinated technical assistance across multiple communities, the position will accelerate the development of child care systems that support workforce participation and strengthen access to rural health care.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Sitka (City and Borough); Skagway (Municipality)	Deferred or Not Advanced

Southeast Childhood Collective	Cooking Classes for New Parents	AK	Many new parents want to provide healthy, nutritious food for themselves and their babies, but often lack practical guidance on how to do so during the demanding early months after birth. The postpartum period can be physically and emotionally challenging, and families may rely on convenience foods or less nutritious options when time, energy, and resources are limited. In Southeast Alaska, high food costs and limited access to fresh ingredients in some communities can make healthy eating even more difficult. At the same time, the transition to parenthood creates an opportunity to build lifelong healthy habits that benefit both parents and children. Learning how to prepare simple, affordable meals that support postpartum recovery and infant nutrition can improve maternal well-being, strengthen family routines, and support healthy child development. This project addresses that opportunity by offering a year-long series of cooking classes designed specifically for new parents. The classes will focus on preparing healthy, whole-food meals, making homemade baby food, and creating bulk freezer meals that help families maintain nutritious eating habits during the early stages of parenting. By building practical food preparation skills and confidence in the kitchen, the project supports healthier outcomes for families with young children.	Southeast Childhood Collective will offer a year-long series of hands-on cooking classes designed specifically for new and expecting parents. Classes will be held three times per month at the local high school culinary classroom, which is equipped with six cooking stations that allow participants to cook alongside instructors in a practical learning environment. Each class will accommodate six parents who will prepare recipes together with guidance from experienced instructors. The curriculum will focus on affordable, whole-food meals that support postpartum recovery and early childhood nutrition. Topics will include preparing homemade baby food, cooking nutrient-dense meals for postpartum health, and preparing bulk freezer meals that families can store and use during busy periods after a child’s birth. All ingredients will be provided so participants can focus on learning skills rather than purchasing supplies. Participants will also receive practical tools, such as freezer containers and reusable baby food pouches, to continue preparing healthy meals at home. By combining instruction with hands-on cooking and take-home supplies, the classes will build practical skills and confidence that help families maintain healthy eating habits during the early years of parenting.	\$50,000- \$250,000	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Southeast Childhood Collective	Expand CBJ Child Care Grant Program to other Southeast Communities	AK	Across Southeast Alaska, communities increasingly recognize child care as essential infrastructure that supports workforce participation, economic development, and community health. When families have access to reliable, high-quality child care, parents, including health care workers, can remain in the workforce and contribute to their local economies. The City and Borough of Juneau (CBJ) has developed a successful child care operating stipend program that provides predictable financial support to licensed providers. This model helps close the gap between the true cost of delivering quality care and what families can pay, allowing programs to operate more sustainably while maintaining stable staffing and services. This project will adapt and extend the CBJ operating stipend model to Sitka, Ketchikan, Skagway, and Haines. With initial support from RHTP, Southeast Childhood Collective will work with each community to establish similar locally supported stipend programs designed to strengthen the financial viability of child care businesses. By adapting the proven Juneau framework to meet each community's needs, these programs will help stabilize existing providers and create conditions that make opening and sustaining a quality child care program a viable business opportunity. Strengthening the financial foundation of child care programs will expand access to care for working families and support critical workforce sectors.	Southeast Childhood Collective (SCC) will work with municipal leaders and child care providers in Sitka, Ketchikan, Skagway, and Haines to establish locally supported child care operating stipend programs modeled after the successful program implemented by the City and Borough of Juneau. SCC is already engaged with each of these communities on child care planning and system development, and local leaders have expressed strong interest in establishing operating stipends that strengthen the financial sustainability of child care programs. Through this project, SCC will help each community adapt the Juneau stipend model to its local context. This will include working with municipal leaders and providers to define eligibility criteria, determine stipend amounts, establish payment schedules, and clarify administrative roles. The goal is to ensure that stipends provide meaningful operating support that helps child care programs remain financially viable while keeping the program structure simple and practical to administer. SCC will then develop the tools and systems needed to implement the stipend programs, including provider application materials, verification procedures, payment tracking systems, and communication materials for participating programs. Once these systems are in place, SCC will support program launch by enrolling eligible providers and administering stipend payments. Initial grant funding from RHTP will provide the resources needed to launch the stipend programs while municipalities identify and secure long-term revenue sources to sustain the investment. Throughout implementation, SCC will track participation and gather provider feedback to help communities refine the program design and transition the stipend programs to sustainable municipal funding over time.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Sitka (City and Borough); Skagway (Municipality)	Deferred or Not Advanced

Southeast Childhood Collective	Expanding Circle of Security Classroom Program	AK	Child care teachers play a critical role in shaping young children’s social-emotional development, yet many early childhood educators have limited access to high-quality, relationship-based professional development. The Circle of Security Classroom (COSC) program, offered by Circle of Security International, provides evidence-informed training that helps educators understand attachment, strengthen teacher-child relationships, and respond effectively to challenging behaviors. However, the cost of COSC training presents a barrier for many child care programs, particularly those serving low-income families. Without financial support, teachers may be unable to access this training, limiting opportunities to improve classroom climate, reduce behavioral challenges, and promote secure attachments in early learning settings. This project seeks grant funding to cover the cost of COSC training for child care teachers in Southeast Alaska, increasing access to high-quality professional development and strengthening the social-emotional foundation for the children they serve.	With grant support, we will cover the registration costs for COS Classroom for participating providers who otherwise could not afford this investment in their professional growth. We will also provide a stipend for providers who complete the training. Allowing providers to access COS Classroom will: • Build understanding of attachment needs and emotion regulation strategies in early childhood settings. • Strengthen teacher confidence and competence in responding to challenging classroom dynamics. • Improve classroom climate and teacher-child relationship quality, which supports children’s school readiness and ongoing development. By removing financial barriers, this approach ensures that more early care professionals can implement evidence-informed practices that enhance both educator well-being and children’s social-emotional outcomes.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Sitka (City and Borough); Skagway (Municipality)	Deferred or Not Advanced

Southeast Childhood Collective	Expanding School Age Child Care in Juneau	AK	The Juneau School District historically operated the RALLY school-age child care program across multiple elementary schools, providing after-school and summer care for working families. In 2025, the district discontinued direct program operations, resulting in a significant loss of capacity. A private provider stepped in to launch programs at three school sites. However, current enrollment is only a fraction of previous capacity, and the programs are still navigating the licensing and startup phase. The loss of school-age child care has immediate consequences for the workforce. Parents without reliable after-school or summer care are forced to reduce hours, decline shifts, or leave the workforce entirely. This is particularly disruptive for health care providers who work fixed schedules, extended shifts, or critical coverage roles. This project addresses an urgent opportunity to stabilize and rebuild the school-age child care system within existing school district facilities. With targeted startup and stabilization support, current programs can reach sustainable enrollment levels and additional sites can reopen, restoring the child care capacity that working families, including health care workers, depend on.	This project will stabilize and rebuild school-age child care capacity within Juneau School District elementary school facilities by supporting the transition from district-operated programs to a sustainable community provider model. Funding will support the stabilization of three existing school-age programs currently operating in district buildings and the development of up to two additional sites. Investments will focus on startup and ramp-up costs that occur before programs reach stable enrollment, including staffing during program development, materials and equipment required for licensing and quality programming, and short-term operational support while enrollment builds. A key priority will be supporting the provider through the licensing process so the programs can accept families using the state Child Care Assistance program and become eligible for the state child care grant program. Access to these existing public funding streams is critical to long-term sustainability. The Southeast Childhood Collective will provide implementation coordination, including technical assistance with licensing navigation, enrollment systems, Child Care Assistance onboarding, and coordination with the school district and City and Borough of Juneau. This centralized support will reduce startup delays and help programs reach sustainable enrollment more quickly. By leveraging existing school district facilities and focusing on targeted startup barriers, the project will rapidly restore critical child care capacity for working families.	\$250K-\$1M	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Southeast Childhood Collective	Grandparent Connections: A Peer Network & Intergenerational Play Initiative	AK	Across Juneau, a growing number of grandparents are serving as primary or significant caregivers for young children. Some step into this role unexpectedly due to a family crisis, substance use, housing instability, deployment, or economic hardship. Others provide daily childcare so parents can remain in the workforce, helping stabilize families and sustain the local economy. Despite their essential role, grandparents often navigate caregiving in isolation. They are parenting in a different social, educational, and technological landscape than when they raised their own children. Many report challenges related to understanding current childhood development practices, navigating childcare and health systems, managing financial strain on fixed incomes, coping with stress and grief, and addressing trauma or behavioral concerns in children. Juneau’s childcare shortage—where licensed care is available for only one in three children—intensifies these pressures. Caregiver isolation and chronic stress are well-documented risk factors for poor mental health. Because caregiver mental well-being directly shapes child development and long-term community outcomes, strengthening grandparent caregivers is a preventive public health strategy. This project addresses the opportunity to support grandparents, strengthen their mental wellbeing, increase access to community resources, and build peer connection—recognizing them as a critical part of Juneau’s early childhood and health ecosystem.	We propose Grandparent Connections: A Peer Network & Intergenerational Play Initiative, a prevention-focused model designed to strengthen caregiver mental health as a pathway to improved child and community wellbeing. Healthy caregiver mental health supports consistent, responsive caregiving — a foundational protective factor against adverse childhood experiences and later behavioral health system involvement. This project intentionally strengthens that protective layer. 1. Monthly Peer Gatherings Informal, relationship-centered gatherings that build connection among grandparent caregivers. Sessions emphasize: • Shared lived experience and normalization of stress • Practical caregiving strategies • Stress reduction and resilience tools • Updates on local health and behavioral health services Peer connection itself is a proven protective factor for mental well-being, reducing isolation and buffering stress. 2. Monthly Intergenerational Play Groups Grandparents and children participate together in themed sessions focused on a variety of topics, like: • Literacy & Early Language • Movement & Brain-Body Health • Food & Nutrition Security • Arts & Emotional Expression These sessions model positive caregiver-child interaction, strengthen attachment, and promote early brain development. Strengthening relational health at this stage reduces long-term risk of behavioral health crises. 3. Quarterly Contracted Facilitation A licensed behavioral health or family wellness contractor will provide quarterly structured sessions addressing: • Trauma-informed caregiving • Caregiver stress and secondary trauma • Behavioral health system navigation • Burnout prevention 4. Community Resource Integration Each gathering includes a brief resource spotlight connecting caregivers to Medicaid navigation, early intervention, food supports, and behavioral health services, with warm referrals as needed. By strengthening caregiver mental health and relational capacity, this project addresses root contributors to poor child health outcomes and reduces long-term demand on rural behavioral health systems.	Under \$50,000	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Southeast Childhood Collective	Match to CBJ Child Care Grants	AK	While supply has been steadily increasing in recent years, Juneau continues to face a significant shortage of licensed child care, limiting families' ability to participate fully in the workforce. This shortage is especially acute for workers in essential sectors such as health care, where staffing stability is critical to maintaining access to services across Southeast Alaska. The City and Borough of Juneau currently supports child care capacity through an annual operating grant program administered by the Southeast Childhood Collective (SCC). These grants provide monthly per-child operating support to licensed providers and have proven to be one of the most effective tools available for stabilizing existing programs and encouraging expansion of new slots. However, the current funding for this program is a line item in the city's general budget and cannot be increased due to municipal budget constraints. At the same time, demand for child care in Juneau is increasing. The upcoming homeporting of the U.S. Coast Guard icebreaker Storis will bring additional families to the community, further intensifying pressure on an already constrained child care system. This project represents an opportunity to temporarily match the city's existing child care operating grants, accelerating the creation of new licensed child care slots, while the community works toward a long-term dedicated funding solution through a future local ballot initiative.	This project will provide matching funds to expand the existing City and Borough of Juneau Child Care Operating Grant Program administered by SCC. The program provides monthly operating support to licensed child care providers based on the number of children enrolled, helping programs offset the gap between the true cost of providing care and what families can afford to pay. By matching the city's existing investment, this project will immediately increase the resources available to support both new and expanding providers. Operating grants allow providers to hire additional staff, open new classrooms, extend hours of care, and maintain sustainable enrollment levels. Because the program is already operational, additional funds can be deployed quickly through the existing grant structure. This approach builds on prior experience with matched funding. When the CBJ program was previously supplemented with Innovation Grant funds, the additional investment resulted in a measurable increase in the supply of licensed child care slots. The same model can again be used to accelerate capacity growth. In parallel with this short-term expansion effort, community leaders are exploring the development of a dedicated local funding source for child care through a future ballot initiative, potentially funded through a modest excise tax or similar mechanism. Because the development and passage of such an initiative will take time, the proposed project fills a critical interim funding gap while the long-term funding strategy is established.	\$1M-\$5M	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Southeast Childhood Collective	On-Site Professional Development for Child Care Providers	AK	Child care providers often have limited access to meaningful professional development that directly improves their daily practice. Traditional training models typically require educators to attend workshops outside of work hours, which can be difficult for providers who already work full days caring for young children. As a result, many educators have few opportunities to receive individualized support to strengthen classroom management, support children’s development, and build confidence in their work. Relationship-based coaching offers an opportunity to provide professional learning that is practical, supportive, and immediately applicable. By observing classrooms, modeling strategies, and engaging educators in reflective conversations about their work, coaches can help providers strengthen their skills in real time as they work with children. This project will address the gap between traditional training and everyday practice by bringing professional development directly into child care classrooms. Through on-site coaching, educators will receive individualized guidance to support higher-quality early learning environments while strengthening workforce confidence and retention in the field.	Southeast Childhood Collective will provide relationship-based coaching to four teachers working in licensed child care centers in Juneau during the first year of the project. Coaching will be delivered by a local educator with extensive classroom experience and a master’s degree in early childhood education. This educator will work directly with participating teachers to provide practical, individualized support that strengthens classroom practice. Each participating program will receive weekly coaching sessions conducted during the teachers’ regular workday. Coaching will include classroom observations, modeling of developmentally appropriate strategies, and side-by-side support while teachers work with children. This approach allows educators to immediately apply new techniques and see how specific strategies affect children’s engagement and behavior. In addition to in-classroom coaching, the coach will facilitate reflective conversations with teachers outside of the classroom but still within their workday. These discussions will allow educators to process challenges, reflect on their practice, and identify goals for continued improvement. By combining observation, modeling, and reflective dialogue, the project will provide sustained, relationship-based professional development that strengthens teaching practice and supports high-quality early learning environments.	\$50,000-\$250,000	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Southeast Childhood Collective	Pre-Development Support For Fireweed Family Center	AK	The Fireweed Family Center will expand childcare capacity, strengthen the early childhood workforce, and create a hub where families with young children can access services and connect with one another. Juneau and other Southeast Alaska communities are experiencing growing demand for childcare and family support services. Demand is expected to increase as Juneau prepares for the arrival of additional U.S. Coast Guard families associated with the homeporting of the USCGC Storis icebreaker. The Fireweed Family Center presents an opportunity to strengthen the early childhood infrastructure that supports families and the regional economy. In addition to expanding childcare capacity, the center will provide a welcoming space for caregiver connection, addressing increasing concerns about family isolation. Southeast Alaska’s geography, long winters, and limited gathering spaces can intensify isolation for families with young children. The project builds on decades of collaboration among agencies that support families through Partnerships for Families & Children, a coalition supported by Southeast Childhood Collective. The Fireweed Family Center will bring childcare, family services, and community connection together in one place, strengthening coordination and access. SCC has purchased the construction site, completed early planning, including a construction estimate and a financial pro forma, and secured \$5 million in federal CDS funding, championed by Senator Lisa Murkowski.	Southeast Childhood Collective will advance development of the Fireweed Family Center through planning, design, and coordination activities that prepare the project for construction and long-term operation. This project does not fund the construction of the facility itself. Instead, RHTP support will ensure the project is fully prepared for construction by completing the remaining pre-development work needed to move the center from concept to a build-ready project. RHTP funding will support several key components of this preparation. SCC will complete architectural drawings and facility planning needed to finalize the building design and ensure the space supports childcare, workforce training, and coordinated family services. Funding will also support capital campaign management to coordinate fundraising efforts and secure the resources needed for construction. Additional planning work will include design of the indoor playground and family gathering spaces to ensure they are safe, developmentally appropriate, and usable year-round in Southeast Alaska’s climate. A dedicated project manager will coordinate architects, funders, nonprofit partners, and other stakeholders to maintain project momentum and move the development process forward. Limited travel and communications costs will support coordination with regional partners and preparation of materials for the capital campaign and community engagement. Significant progress has already been made toward developing the Fireweed Family Center. SCC has purchased the construction site, completed a formal construction cost estimate, developed a financial pro forma for the facility, and prepared a comprehensive case for support. SCC has also engaged a professional capital campaign manager to lead fundraising efforts. These steps position the Fireweed Family Center to move efficiently into construction once the remaining development work is complete and capital funding is secured. RHTP funding will ensure the project maintains momentum and advances toward construction of a facility that will expand childcare capacity, support workforce development, and strengthen services for families across Southeast Alaska.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Sitka (City and Borough); Skagway (Municipality)	Deferred or Not Advanced

Southeast Childhood Collective	Professional Development for Caregivers and Practitioners	AK	Professionals who support families with young children in Southeast Alaska often work in small teams across large geographic areas with limited access to ongoing professional development. Health care providers, social workers, and early childhood educators frequently encounter families experiencing stress, trauma, or behavioral health challenges, yet many have few opportunities to strengthen relationship-based skills or receive reflective support for this work. Workforce burnout and turnover are persistent challenges across these sectors, particularly in rural and frontier communities. Strong evidence shows that the quality of relationships between professionals and families is a key driver of improved maternal mental health, child development, and family stability. When professionals are equipped with tools that strengthen attuned communication, reflective practice, and leadership, they are better able to support families and coordinate care across systems. This project addresses that opportunity by providing a coordinated series of evidence-based trainings for professionals serving families across Southeast Alaska through the Partnerships for Families & Children coalition. Trainings will include Facilitating Attuned Interactions (FAN), Circles of Security for Providers, Dare to Lead, and reflective supervision, strengthening relationship-based practice, leadership capacity, and workforce resilience.	Please describe your proposed approach to the above problem or opportunity. Southeast Childhood Collective will coordinate a regional professional development initiative that brings evidence-based training opportunities to professionals serving families across Southeast Alaska. The project will begin by identifying and contracting qualified trainers certified to deliver models such as Facilitating Attuned Interactions (FAN), Circles of Security for Providers, Dare to Lead, and reflective supervision. SCC will work with training organizations and certified facilitators to schedule a series of learning opportunities over the project period. To ensure accessibility for rural participants, training will be offered in both in-person and virtual formats. In-person sessions will be scheduled strategically to coincide with existing regional gatherings or hosted in hub communities. At the same time, virtual offerings will allow participation from remote communities that cannot easily travel. This blended approach will expand access while maintaining opportunities for relationship-building and reflective practice. SCC will promote the training through the established Partnerships for Families & Children coalition network, which includes health care providers, behavioral health professionals, social service agencies, and early childhood programs throughout the region. Outreach will include direct invitations to partner organizations, coalition communications, and targeted outreach to agencies serving rural communities. To reduce barriers to participation, the project will also establish a stipend program that compensates participants for the time required to attend and complete the training. This approach recognizes the staffing constraints faced by rural service providers and ensures that professionals can participate without creating financial strain for their organizations. Through coordinated scheduling, broad outreach, and participant stipends, the project will expand access to high-quality professional development for the workforce serving families across Southeast Alaska.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Juneau (City and Borough); Ketchikan Gateway Borough; Sitka (City and Borough); Skagway (Municipality)	Deferred or Not Advanced

Southeast Childhood Collective	Strengthening Family Wellbeing Through Coordinated Community Engagement	AK	Families in Juneau rely on a range of services that support children, caregivers, and family well-being, including early childhood education, home visiting, public health, family support, and behavioral health. While these services are strong individually, families often experience them as separate systems rather than a coordinated network of support. This is especially challenging in rural communities, where geographic isolation, transportation barriers, and limited behavioral health capacity make coordination essential. Juneau faces shortages of behavioral health providers, making prevention and early support critical to reducing demand on strained crisis response systems. Alaska experiences high rates of Adverse Childhood Experiences (ACEs), which are strongly associated with long-term behavioral health challenges including depression, substance use disorders, and chronic disease. Strengthening family protective factors like caregiver resilience, social connection, and access to supportive resources can greatly reduce ACE risk and improve lifelong health outcomes. For twenty-eight years, the Juneau Partnership for Families & Children (PFC) coalition has brought together sixteen nonprofit and state agencies serving families with young children. Strengthening the coordination infrastructure of this coalition will improve cross-sector collaboration, increase system efficiency through coordinated service delivery, and expand access to preventive behavioral health supports.	This project will strengthen the collective impact infrastructure of the Juneau Partnership for Families & Children (PFC) coalition to improve cross-sector collaboration, expand community engagement, and strengthen preventive behavioral health supports for families. The Southeast Childhood Collective will provide backbone coordination for the coalition, enabling partner agencies to align outreach efforts, strengthen referral pathways, and implement collaborative strategies that increase the reach and effectiveness of family support services. A core component of this work will be coalition coordination and shared planning. Project staff will facilitate regular communication, collaborative planning, and shared decision-making among partner agencies. This backbone support allows organizations working across early childhood, public health, family services, and behavioral health to align their efforts and function as a more integrated support network for families. The project will also strengthen cross-sector service integration. By improving collaboration among agencies serving families, the coalition can enhance referral pathways, reduce duplication of services, and improve system efficiency through coordinated service delivery. Families will experience services as a connected network of support rather than isolated programs. Coordinated community engagement activities and family-centered events will serve as a visible entry point for families to connect with the network of services available to them. These events will provide welcoming opportunities for caregivers and children to participate in play-based activities, creative programming, and community gatherings while learning about resources offered by partner organizations. The coalition will also implement shared outreach and resource navigation strategies, ensuring families receive clear and consistent information about available services. Through coordinated messaging and outreach, agencies can extend the reach of their work while reducing barriers to access. Together, these strategies strengthen the coalition’s ability to operate as a coordinated support system that improves access to preventive services, strengthens family protective factors, and reduces downstream demand on crisis-driven behavioral health services in a region facing significant provider shortages.	Under \$50,000	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Southeast Conference	Ensuring Access to Health Care for Rural Remote Alaskans	AK	The project protects access to health care for rural and remote Alaskans who rely on the marine highway system to travel to appointments, for providers to travel to communities, and access to supplies. Over the last decade, marine transportation services for residents across the state have significantly declined. Currently, our Marine Highway Systems in Alaska suffer from a lack of qualified-trained workforce and access to training options. This lack of workforce prevents operators from fully crewing all available vessels in the fleet and thus reduces service. For example, AMHS has two vessels it is unable to operate due to a lack of available crew, meaning Yakutat will have another year without service. This condition limits the ability of residents to travel to and from health care services, the ability to move medical equipment, supplies and prescriptions to and from communities and the ability to move health care providers to and from communities. Flying not only has a limiting capacity; it is also often cost prohibitive for many Alaskans and is subject to more weather cancelations or safety concerns. Marine transportation is critical for ensuring affordable and reliable access to primary, specialized, behavioral and oral care for rural Alaska’s who do not live on the traditional road system. Without a strong marine transportation system, that state faces significant transportation barriers to health care access, this project aims to address this need.	Ensuring Access to Health Care for Rural Remote Alaskans Project supports continued affordable health care access for Alaskans helping marine transportation operators build and serve their workforce internally. This project provides key funding to support the marine highway workforce through funding for required training, scholarships to support crew to advance their licenses helping fill critical roles and enabling high level trainings within the state to help keep costs down and improve access to workforce development opportunities. The project includes funds for on-the-job training, security training, vessel and crew licenses and renewals, terminal staff training, and administrative training for Inter Island Ferry staff. Additionally, the project will provide funding for AMHS annual training budget, wheelhouse assessment plans, fleet wide culinary training, scholarships for 3rd assistant mate, AB to 3rd assistant mate, oiler to 3rd assistant engineer training programs to help crew move up. Funding is also utilized to build a 1600 GT license class for the University of Alaska Southeast’s Maritime Training Center and design and replacement of the center’s davit utilized for required safety training and lifeboat deployment. Finally, funds will be used to provide scholarships for Alaskan’s to achieve necessary training to enter job positions with Alaska’s Maritime transportation providers as well as conduct outreach to schools. Providing workforce development funding to ferry operators and the training organizations that support them helps ensure continued operation of critical access to health care in coastal Alaska. In 2019 on the IFA route alone 1,150 patients took 4,900 ferry rides for medical purposes.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Chugach Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Lake and Peninsula Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Southeast Conference	Southeast AK Regional Outdoor Recreation Planning for a Healthy Lifestyle and Residential Benefits	AK	Southeast communities are generally small places that provide almost immediate access to the outdoors. With almost 97% of the land in Southeast publicly owned, accessing public spaces doesn’t take much. These small communities also often lack indoor gyms or fitness classes that help maintain health. Furthermore, these small communities often offer a practical opportunity for residents to get around by non-motorized means. Conditions that mean the outdoors offer an effective opportunity to help residents maintain healthy lifestyles, prevent disease and attract and retain a strong health care workforce. Yet, despite these conditions, many outdoor recreation assets across the region have not been maintained, and useability is limited for many. Furthermore, Alaska has a high burden of chronic diseases and a mental health crisis, with a suicide rate twice the national average. Southeast’s population is comprised of many high-needs populations with 19% 65 or older and 17% under 15. The region’s median household income is 16% below the State’s median household income. All communities in Alaska have one or more Health Professional Shortage Area designations for primary, dental, or behavioral health care, and most rural areas experience high staff turnover and rely on temporary workers. Providing an opportunity to build healthy communities and increase community livability by holistically addressing outdoor recreation goals, active transportation networks and equitable assets.	Realizing a need and opportunity to address how Southeast Alaska and the Tribal, rural and remote communities of the region can build healthy communities, reduce chronic diseases and increase our residents’ quality of life. The Southeast AK Regional Outdoor Recreation Planning for a Healthy Lifestyle and Residential Benefits project will consist of a holistic and collaborative regional effort with the goal of providing resources to promote physical activity for all ages and levels, improve air quality, increase access to subsistence sources, and foster a regional culture of wellness through the outdoors. To ensure coordination across the region and State, the Southeast AK Regional Outdoor Recreation Planning for a Healthy Lifestyle and Residential Benefits project will build on existing regional and statewide plans and asset assessments, such as the Tongass Sustainable Trails Strategy, the Tongass Outdoor Recreation Partnership, the Statewide Comprehensive Outdoor Recreation Plan, Alaska Statewide Active Transportation Plan, and others work being done throughout the region in the outdoor recreation space. Working with regional communities and tribes, Southeast Conference will prepare a Regional Outdoor Recreation Plan, resources that further the implementation of this plan beyond the project period, community active transportation audits and active transportation action plans. To achieve these outcomes, Southeast Conference (SEC) will conduct outreach and engagement with communities and outdoor recreation stakeholders, including health care providers to understand needs and goals for outdoor recreation. SEC will work with the Tongass Outdoor Recreation Partnership and others across the region to help guide the project. A contractor will be hired to help build a comprehensive regional outdoor recreation plan that emphasizes benefiting residents and promoting healthy communities for all. SEC will work with the Department of Natural Resources to pilot a asset marking and measuring program. SEC will partner with the Walkability Action Institute to conduct walkability audits and action plans. Finally, SEC will work with a contractor to complete asset mapping and revitalize the Southeast Alaska Trails website to house resources and remain a central connection point for these efforts. This project will enable communities to create a locally driven and clear plan with greater regional coordination, strengthening each projects long-term success.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Southeast Island School District	Prince of Wales Island Rural Health Transformation & Workforce Pathway Program	AK	Prince of Wales Island faces significant barriers to healthcare access and workforce sustainability. Most communities do not have on-site nurses or physicians, and students must travel 60–80 miles to access clinics in Craig or Klawock. For students interested in healthcare careers, there is currently no CNA training program available on the island; they must travel approximately 100 miles to Ketchikan, on a different island, incurring transportation and lodging costs. At the same time, regional providers such as PeaceHealth and SEARHC report ongoing difficulty recruiting and retaining trained medical professionals. This project addresses both limited preventive healthcare access for rural youth and the absence of a local healthcare workforce pipeline. By establishing school-based nursing services and a regional CNA pathway across four Prince of Wales Island districts, the initiative improves early intervention, strengthens referral coordination, and creates a sustainable, locally rooted healthcare workforce opportunity for rural students.	This project establishes a four district consortium on Prince of Wales Island to simultaneously expand school-based health access and build a sustainable rural healthcare workforce pipeline. Southeast Island School District, Craig City Schools, Klawock City School District, and Hydaburg School District will collaborate to implement a coordinated regional model serving students across multiple remote communities. The core of the approach is hiring five Registered Nurses, each assigned to support designated district sites. These RNs will serve in dual roles as clinical health service providers and Certified Nursing Assistant instructors within district Career and Technical Education programs. On the clinical side, the RNs will embed preventive and early-intervention services directly within schools. They will coordinate and facilitate vision, hearing, dental, and behavioral health screenings in partnership with PeaceHealth, SEARHC, Community Connections, and Tribal partners including the Kasaan Haida Tribe and Hydaburg Tribal leadership. The nurses will oversee vaccination clinics, provide chronic condition monitoring for students with ongoing medical needs, deliver drug and alcohol prevention programming, and implement structured health education modules focused on nutrition and chronic disease awareness. They will also lead CPR and First Aid certification for students and staff and develop standardized trauma-informed response protocols across all participating districts. A shared data system will track screening participation, referral completion, follow-up care rates, telehealth utilization, and attendance impacts to ensure accountability and continuous improvement. On the workforce development side, the RNs will deliver CNA-aligned instruction locally, eliminating the current need for students to travel to Ketchikan to obtain certification. Each participating district will be equipped with essential CNA skills lab equipment and instructional materials. Students will complete foundational coursework, earn CPR certification, and be prepared for CNA testing and advancement into Certified Medical Assistant or higher-level healthcare training. Formal partnerships with PeaceHealth and SEARHC will support clinical exposure, mentorship, and internship opportunities, while collaboration with Tribal partners will ensure culturally responsive engagement and workforce outreach.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Prince of Wales-Hyder Census Area	Deferred or Not Advanced

Southeast Region EMS Council	Building Regional Learning Networks to Integrate EMS and Rural Healthcare in Alaska	AK	In many rural and remote Alaska communities, EMS is the most consistent point of healthcare contact. EMS teams respond to emergencies, bridge homes and clinics, and often serve as informal health navigators. Yet EMS systems remain structurally underfunded and poorly integrated into broader healthcare planning, data systems, and transformation efforts. At the same time, Alaska is investing in care coordination and expanded chronic disease monitoring. These efforts are vital, but monitoring without reliable emergency response capacity creates a structural gap. In many rural communities, EMS encounters are early indicators of poorly controlled chronic conditions such as diabetes, heart disease, respiratory illness, behavioral health and substance use complications. Without structured integration, these encounters rarely inform prevention strategies or care coordination. This project addresses a core opportunity: strengthening rural healthcare outcomes by intentionally integrating EMS into community health systems through structured Learning Health communities. We seek to test whether rural EMS measurably improves survival and community health—and whether those outcomes are strengthened when healthcare systems deliberately invest in and coordinate with local EMS. By building regional learning networks grounded in community ownership and incremental improvement, this initiative positions EMS not as peripheral, but as a critical component of rural health transformation.	This initiative will establish regional Learning Health Networks within Alaska’s EMS regions. Rather than deploying a single statewide program, communities will voluntarily opt in and convene local, cross-sector learning groups with assistance and facilitation from their EMS Region. Each participating community will form a multi-stakeholder learning group that may include EMS agencies, clinics, Tribal Health Organizations, Community Health Worker (CHW) programs, local government, and community representatives. The group will identify a shared and locally relevant problem involving EMS and at least one other healthcare partner. Participants will examine cases and baseline data to understand current performance, interpret findings collectively, test small and feasible changes, evaluate results, and iterate over time. Regional coordination will support cross-community learning while preserving local autonomy. Communities may voluntarily pursue deeper integration pathways such as EMS and Community Health Worker cross-training and role clarification, Mobile Integrated Health or Community Paramedicine collaboration, bidirectional data integration between EMS and Health Information Exchange systems, joint EMS and receiving facility teamwork training, and regional knowledge-sharing models. Funding will support facilitation, regional travel and relationship-building, participation stipends to reduce barriers, light-touch local documentation and evaluation, and a robust data evaluation plan. This is not a compliance model. It is a practical, incremental improvement structure designed to strengthen integration, improve EMS-sensitive outcomes, and build durable rural health system capacity over time.	\$250K-\$1M	Statewide	Denali Borough; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Southeast Region EMS Council	Rural EMS Readiness & Integration Infrastructure Initiative	AK	Providing EMS services in Southeast Alaska presents challenges unlike most of the Lower 48. Each community must be prepared to function as a self-contained system capable of stabilization and transport. Many communities have small or nonexistent tax bases yet must respond to cardiac arrest, trauma, pediatric emergencies, and complex medical crises without external support. Chronic underinvestment has left some agencies operating with outdated or inadequate transport vehicles and monitoring equipment. Emergency response cannot depend on bandaids and duct tape. It requires reliable transport, monitoring capability, and safe working conditions for responders. Before agencies can expand into community paramedicine, chronic disease response, or deeper health system integration, reliable emergency infrastructure must be in place. This proposal addresses that foundational gap by ensuring every community has the transport and life-saving equipment required to provide equitable emergency care and support broader rural health transformation efforts.	This initiative will stabilize and standardize EMS infrastructure across 34 Southeast Alaska communities through coordinated regional procurement. SEREMS proposes to purchase 26 ambulances, 6 patient transport vehicles, 33 monitor and defibrillators, 14 AEDs, 33 powered stair chairs, and 48 vacuum mattress and splint sets. Because of geographic isolation, communities must independently stabilize and monitor patients for extended periods while awaiting medevac or marine transport. Monitor and defibrillator systems will enable real-time cardiac assessment and transmission of data to higher-level providers, supporting appropriate triage and reducing unnecessary transport. Powered stair chairs and vacuum immobilization systems improve responder safety and patient outcomes. The project will confirm final equipment specifications with each agency, coordinate bulk purchasing to reduce cost and ensure compatibility, support delivery and deployment, and assist smaller agencies with maintenance and lifecycle planning. By establishing a minimum standard of emergency transport and monitoring capability across the region, this initiative strengthens rural health access and creates the infrastructure necessary for future integration and expanded EMS roles, with an estimated budget of 15 million dollars	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

Southeast Region EMS Council	Southeast Alaska Regional EMS Academy Network	AK	The Southeast Alaska Regional EMS Academy Network will establish distributed training hubs in Ketchikan, Sitka, and Juneau in partnership with local fire departments. This model leverages existing municipal infrastructure while creating permanent regional workforce capacity. In its initial phase, the Academy will deliver Emergency Trauma Technician and EMT-1 certification programs, refresher courses, and focused skills workshops, later expanding to EMT-2, bridge programming to Alaska AEMT, potential EMT-3 offerings, and structured instructor development. This tiered pathway creates an in-region advancement ladder that reduces relocation barriers and supports long-term retention. The Academy prioritizes responders from small and remote communities who lack access to local course delivery. Funding removes structural barriers by supporting participant travel and subsidizing municipal training sites. In addition to certification programs, the Academy will host intensive regional simulation workshops that include EMS providers and emergency department or receiving facility staff. These joint trainings strengthen field-to-facility communication and improve care transitions, supporting stronger integration across Southeast Alaska’s emergency care continuum.	The Southeast Alaska Regional EMS Academy Network will establish distributed training hubs in Ketchikan, Sitka, and Juneau in partnership with local fire departments. These municipal partners will provide classroom and training space while SEREMS coordinates curriculum, instructor staffing, recruitment, and regional logistics. During the first two years, the Academy will deliver Emergency Trauma Technician and EMT-1 certification programs, refresher courses, and focused skills workshops. In later years, the program will expand to include EMT-2, bridge programming to Alaska AEMT, potential EMT-3 offerings, and structured instructor development to grow Southeast-based teaching capacity. The Academy model prioritizes responders from small and remote communities who prefer in-person instruction or whose agencies cannot yet support local course delivery. Training will be delivered in cohort-based formats that allow participants to attend shorter, intensive sessions when feasible. Participants traveling from smaller communities may also complete structured ride-along shifts with host EMS agencies during their training period. These supervised field experiences will expose participants to higher call volumes, diverse case presentations, and real-time field-to-facility coordination, reinforcing classroom learning and strengthening regional professional relationships. Funding will support participant travel by air or ferry, lodging, and per diem to remove financial barriers. It will also support contract instructor pay, educational materials, simulation equipment, and subsidized use of training rooms and apparatus bays at host fire departments. Facility support recognizes the operational costs borne by municipal partners and ensures long-term sustainability of the regional hub model. In addition to certification programs, the Academy Network will host two- to three-day intensive regional simulation workshops for EMS providers. Some of these intensives will be targeted to include EMS and emergency department or receiving facility staff. These joint trainings will use scenario-based exercises and structured debriefing to strengthen field-to-facility communication, clarify expectations during high-acuity events, and improve care transitions. By embedding cross-setting training into the regional culture, the project supports stronger integration across the emergency care continuum.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Advance to Implementation Application

Southeast Region EMS Council	ETT (Emergency Trauma Technician) Program Expansion & Modernization	AK	For more than 45 years, Alaska’s Emergency Trauma Technician (ETT) program has provided foundational emergency response training tailored to rural and remote communities. However, the core curriculum has not been comprehensively updated since 2015, instructor capacity remains limited in remote regions, and access barriers persist for small communities and high school programs. Many of Alaska’s smallest communities rely on volunteer or low-frequency EMS responders who are unpaid or minimally compensated, limiting eligibility for traditional workforce development funding. At the same time, Rural Health Transformation efforts are investing in Community Health Aide/Practitioner and Community Health Worker pathways, increasing the need for a flexible, cross-trained workforce capable of supporting both emergency response and broader health system stability. This project modernizes and expands the ETT program as a shared, locally accessible workforce entry point for both EMS and CHA/P systems. By improving access, updating curriculum, and strengthening instructor capacity, the initiative will build sustainable emergency response capability, reduce barriers to entry, and strengthen recruitment and retention of locally trained providers who can serve, remain, and lead within their communities. In doing so, it aligns community-based workforce development with statewide rural health transformation goals.	This initiative will modernize and expand the Emergency Trauma Technician program through a phased five-year strategy designed to build long-term sustainability. Curriculum Modernization (Years 1-2) The project will complete a full revision of the ETT curriculum aligned with current National EMS Education Standards. Updates will integrate rural Alaska clinical realities and embed cross-cutting competencies such as teamwork, cultural humility, responder wellness, and a culture of safety. Online learning will be strengthened to improve accessibility and quality. ETT will be established as a recognized career and technical education pathway within Alaska high schools, creating a structured entry point into rural healthcare careers. Access and Subsidization (Years 1-3) To reduce financial and geographic barriers, the project will subsidize online training for Level 1 and Level 2 communities and expand availability through high school programs. Training equipment support and instructor travel for rural skills validation will ensure full participation regardless of local revenue constraints. Instructor and Local Capacity Development (Years 2-3) A structured pathway will certify high school teachers and local EMS personnel as ETT instructors. Instructor workshops and regional mentorship will strengthen local leadership and reduce reliance on centralized delivery. Sustainability Transition (Years 4-5) Beginning in Year 3 and expanding through Years 4 and 5, the program will transition to community-specific sustainability models. These may include sliding-scale tuition, formal adoption within high school CTE programs, alignment with workforce development funding streams, voluntary EMS and Community Health Worker cross-training, and regional training hubs supported by local EMS coalitions. Together, these strategies create a distributed training infrastructure that strengthens access, improves quality, and stabilizes the rural emergency workforce while supporting long-term system resilience.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Southeast Region EMS Council	Southeast Alaska Resilient Responders and Communities: Psychological First Aid & Disaster Support	AK	Rural and remote communities across Southeast Alaska regularly face traumatic events including medical emergencies, environmental hazards, and natural disasters such as landslides, severe storms, and extreme weather. Small communities often rely on volunteer-based or mixed volunteer-career response systems that must manage both the operational and human impacts of these events. Responders and community members may experience repeated exposure to traumatic incidents while having limited access to resilience training or psychological support resources. The Southeast Alaska Landslide Risk Reduction Strategic Plan identifies community preparedness, response coordination, and recovery capacity as key priorities for reducing the impacts of landslides and other geodisasters across the region. Recent landslides and disasters across Southeast Alaska have demonstrated that recovery requires not only physical response capacity but also tools that help responders and communities process trauma and support recovery following disasters. Strengthening the ability of responders and community members to recognize psychological distress, support one another during crises, and navigate recovery is therefore a critical component of disaster preparedness in Southeast Alaska.	This initiative will establish a regional disaster preparedness and resilience training program coordinated by SEREMS in collaboration with SLIPP and T&H. As the regional EMS coordinating body for Southeast Alaska, SEREMS brings extensive experience delivering responder training across remote communities and is well positioned to coordinate implementation of this initiative. The 2026 Landslide Risk Reduction Plan calls for training community members and responders in psychological first aid. This program will focus on practical, evidence-informed approaches to supporting individuals and communities during and after disasters. Training will emphasize psychological first aid and responder resilience skills that promote stabilization, practical support, and connection to resources. The program will prioritize geographically isolated Southeast Alaska communities and help responders recognize when professional behavioral health services are needed and connect individuals to appropriate care. The initiative will provide three complementary training tracks: Responder resilience and distress management training Training for EMS personnel, fire departments, search and rescue teams, Tribal emergency operations teams, and other frontline responders focused on recognizing stress injuries, strengthening peer support, and managing distress following difficult calls. Psychological First Aid training for community partners Training for educators, clinic staff, Tribal program staff, public works personnel, local government staff, and community leaders focused on recognizing distress, supporting individuals following disasters, and connecting people with appropriate resources. Community preparedness workshops Community-based workshops integrating disaster awareness, landslide risk awareness, and psychological first aid principles to strengthen local preparedness and recovery capacity. Training will use a hybrid model combining online learning with regional in-person workshops. The initiative will leverage existing regional convenings including the SLIPP landslide preparedness workshop and the SEREMS Symposium, which already bring together responders, Tribal emergency management leaders, scientists, and community partners to strengthen regional preparedness. Participating communities will also share lessons learned through a regional learning network to strengthen disaster preparedness and responder wellbeing across Southeast Alaska and support continuous improvement.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Southeast Urgent Care Inc	Empowering Healthier Communities: Integrating Culinary Medicine and Preventive Lifestyles	AK	In Juneau, a critical gap exists between medical guidance provided in the clinic and patients’ ability to implement those recommendations in their daily lives. While healthcare providers routinely prescribe heart-healthy and low-glycemic diets to manage and prevent chronic conditions such as diabetes and cardiovascular disease, many patients face barriers to following this advice. High grocery costs, limited access to nutrition education, a lack of practical cooking skills, and an absence of a good support network make it difficult for individuals and families to translate medical recommendations into affordable, healthy meals at home. This project addresses the opportunity to bridge that gap by establishing a permanent, certified teaching kitchen that integrates culinary medicine with preventive healthcare. The program will empower patients, community members, and healthcare workers with hands-on skills to prepare nutritious, culturally relevant meals using locally available foods—including subsistence resources such as seafood and berries—along with affordable pantry staples. Beyond improving culinary literacy, the teaching kitchen serves as a community gathering space that helps address social isolation, a major risk factor in rural communities like Juneau. By connecting clinical care with practical food preparation skills and social connection this initiative aims to improve long-term health outcomes and support healthier, more resilient communities in Juneau.	We propose a three-year phased initiative to establish a Culinary medicine Teaching Kitchen as a hub for preventative care. Phase 1: Infrastructure (Year 1 - \$250k): The priority is the renovation of an underutilized second floor space in our building. We will convert this area into a clinical grade teaching kitchen designed for patient education. Key components include: Infrastructure: Installation of electrical and plumbing lines to support multiple cooking stations, ventilation systems, and medical-grade sanitation surfaces. Educational Layout: Creation of a large central preparation island, surrounded by four fully equipped cooking stations for hands-on instruction. Accessibility: Installation of commercial chairlift and adjustable counter heights to accommodate elderly patients and mobility limited individuals. Phase 2: Program implementation (\$50k): With the operational kitchen, we will launch a “Culinary Prescription” pilot program that translates clinical recommendations into actionable, affordable, and culinary relevant meals. Initially the program will be accepting medically referred patients who will receive hands-on instruction and practical skills to implement heart-healthy and low-glycemic diets at home. Community members and family and friends of patients will be invited to participate, fostering social connection and addressing social isolation. Phase 3: Community expansion and sustainability(\$50k): The final phase focuses on scaling and long-term sustainability. Workforce development: Medical students, clinicians,and health care professionals will be invited to participate and build their own knowledge base for preventative health education. Cultural and Economic Relevance: Classes will focus on Southeast Alaska traditional foods and pantry staples to help combat grocery costs. Sustainability: We aim to establish local partnerships to create a rotating curriculum to ensure ongoing program impact and inclusivity of all age ranges. These partnerships and established client bases will ensure ongoing access beyond the grant period. This phased approach directly bridges the gap between clinical advice and daily practice, improves dietary behaviors, addresses social isolation, and strengthens community health.	\$50,000-\$250,000	Other	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Southeast Urgent Care Inc	Strengthening Rural Diagnostic Imaging Capacity in Urgent Care Setting	AK	Our small medical practice has served the Juneau community for nearly 35 years, providing walk-in healthcare seven days a week. Our clinic currently operates a digital X-ray system installed in the early 2000s. While it has served well, the technology is outdated and no longer serviceable if it fails. Replacing this aging system with a modern digital radiography unit is essential to maintaining high-quality diagnostic services, workflow efficiency, and service reliability for our community locally. Seven-day access to imaging is critical to reducing strain on the region’s only hospital and its limited emergency services. Patients with fractures, respiratory infections, or musculoskeletal injuries experience delay of care. Modern digital radiography offers higher resolution images, faster processing, and lower radiation exposure, allowing faster, safer diagnoses while reducing repeat imaging. Replacing an X-ray system represents a significant financial challenge for a small independent practice. The cost of modern imaging equipment far exceeds what can be sustained through routine clinic operations alone. Without grant support, maintaining this critical diagnostic service will become increasingly difficult. Upgrading to a new X-ray system will ensure that Juneau residents and visitors receive timely, high-quality walk-in diagnostic care, prevent unnecessary emergency department visits, and reduce overall healthcare costs, addressing a critical gap in rural healthcare access.	To address the urgent need for reliable, high-quality imaging in Juneau, our clinic proposes replacing the aging digital X-ray system with a modern digital radiography unit. This upgrade will allow us to continue providing walk-in diagnostic services seven days a week, ensuring timely evaluation and treatment for fractures, respiratory infections, musculoskeletal injuries, and other urgent conditions. The approach involves: Acquisition and Installation – Purchase a state-of-the-art digital X-ray system with enhanced detector sensitivity, rapid image processing, and low-dose radiation technology. Installation will be coordinated to minimize service disruption, ensuring continuous access to imaging during the transition. Integration with Clinical Workflow – The new system will be fully integrated with our electronic health records and image archiving systems. This will streamline workflow, reduce turnaround times, and allow immediate image review by our clinicians, improving diagnostic accuracy and patient care. Staff Training and Competency – Clinic staff will receive comprehensive training on system operation, safety protocols, and advanced image processing to maximize efficiency and ensure high-quality diagnostic output. This bolsters our local healthcare workers workforce skill set. Community Impact Monitoring – We will track metrics including imaging volume, turnaround time, repeat imaging rates, and emergency department diversions to measure the system’s impact on patient care and healthcare costs. This project ensures that our small private practice can continue to serve the Juneau community reliably and safely, reducing strain on the region’s only hospital and emergency services. By maintaining local, seven-day access to imaging, patients avoid delays, unnecessary travel, and additional healthcare costs. Upgrading to modern technology will strengthen the clinic’s capacity to provide high-quality, accessible diagnostic care, sustaining an essential community resource for years to come.	\$50,000-\$250,000	Family or primary care	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Southern Region EMS Council	H.E.A.T.™: Hypothermia Emergency Assess and Transport Initiative for Rural Alaska	AK	Rural Alaska faces significant environmental and geographic barriers to emergency medical care. Trauma incidents frequently occur in extreme cold conditions, and long scene times and extended transport distances increase the risk of hypothermia in injured patients. Hypothermia is a preventable but serious contributor to trauma mortality and complications, particularly in remote communities where advanced medical care may be hours away. Many rural response agencies currently lack standardized equipment and protocols for hypothermia mitigation in the prehospital setting. This project addresses the opportunity to strengthen rural trauma response by equipping responders with consistent tools and training designed specifically for Alaska’s cold-weather and remote operating environments.	Southern Region EMS Council proposes the implementation of the H.E.A.T.™ (Hypothermia Emergency Assess and Transport) Initiative, a statewide effort to improve hypothermia mitigation in Alaska’s rural prehospital trauma environment. The project will deploy 1,000 H.E.A.T.™ bags to established rural response agencies across Alaska, providing standardized equipment designed to prevent heat loss and support early hypothermia intervention during prolonged scene and transport times. Each kit will include insulated vapor barrier systems, warming packs, waterproof ground insulation, thermal head protection, and laminated hypothermia assessment and treatment guides designed for use in cold-weather trauma conditions. In addition to equipment distribution, the initiative will provide targeted training for frontline responders focused on hypothermia recognition, mitigation strategies, and integration with trauma care protocols. Implementation will occur over five years through a phased regional rollout, allowing for coordinated distribution, responder training, and program evaluation. Partnerships with the State of Alaska Office of Emergency Medical Services, 68Medical, and Carlile Transportation Systems will support protocol alignment, kit assembly, and statewide logistics. Through this approach, the initiative will strengthen rural trauma response capacity and improve patient outcomes in Alaska’s remote and environmentally challenging communities.	\$50,000- \$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Southwest Region School District	Expanding Access to Mental Health Services in Rural Southwest Alaska Schools	AK	The Southwest Region School District (SWRSD) serves eight rural communities in Southwest Alaska: Aleknagik, Clarks Point, Ekwok, Koliganek, Manokotak, New Stuyahok, Togiak, and Twin Hills—educating 601 PreK–12 students and employing 150 staff. These communities are remote (not connected to the road system), creating significant barriers to accessing health care services. Over 95% of SWRSD students are Alaska Native, and each community has an active Tribal Council, highlighting the importance of accessible and culturally responsive care. Mental and behavioral health services in these communities are limited, and individuals often must travel long distances to access care. Weather conditions, transportation costs, and provider shortages frequently delay or prevent timely support. These challenges can negatively affect student well-being, staff wellness, and the broader community. The project 'Expanding Access to Mental Health Services in Rural Southwest Alaska Schools' seeks to address these challenges by expanding access to mental health services through a combination of on-site school counselors, online resources, and regional providers. By strengthening and coordinating these supports, SWRSD aims to improve access to care, provide early intervention, and support the overall well-being of students and staff across our rural communities.	The Southwest Region School District (SWRSD) proposes a comprehensive approach to improving access to mental health services for students and staff across the eight rural communities we serve: Aleknagik, Clarks Point, Ekwok, Koliganek, Manokotak, New Stuyahok, Togiak, and Twin Hills. Recognizing the limited availability of behavioral health providers in rural Alaska, SWRSD aims to expand both in-person and virtual mental health supports within the school environment. SWRSD currently works with the Bristol Bay Area Health Corporation (BBAHC) and an independent counselor in addition to providing access to a 24/7/365 counseling app for secondary students (grades 6–12) and staff. This app connects users with certified counselors through text-based communication, providing immediate, confidential support regardless of location or time of day. Building on these existing supports, SWRSD seeks to employ school counselors who will provide on-site mental health services across schools in the district. These counselors will work directly with students and staff to provide individual support, early intervention, and prevention-focused services. Having counselors available within the school setting will significantly reduce barriers to care by eliminating the need for travel and allowing individuals to access support in a familiar and trusted environment. In addition to providing direct services, school counselors will collaborate with BBAHC, independent counselors, and other regional providers, to ensure coordinated and comprehensive care. This collaborative approach will allow students and staff who require additional services to be connected with appropriate community or regional resources. By combining school-based counseling, online counseling resources, and collaboration with regional health providers, SWRSD will create a coordinated system of support that expands access to mental health care, improves early identification of concerns, and supports the overall well-being of students and staff across our rural communities.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Dillingham Census Area	Deferred or Not Advanced

Special Olympics Alaska Inc	Inclusive Healthcare for Individuals with IDD - Phase 1	AK	Alaskans with intellectual and developmental disabilities (IDD) experience profound and preventable health disparities, including higher rates of untreated dental disease, vision and hearing conditions, obesity, neurological disorders, and premature mortality. In rural, remote, and frontier Alaska, these disparities are amplified by provider shortages, geographic isolation, limited specialist access, and fragmented referral systems. Families often travel out of state for specialized neurological care, while rural providers report limited training in IDD-informed practices. Preventative screenings are infrequent, and follow-up care is often inconsistent. Access to early intervention programs for physical fitness, such as the Special Olympics Young Athlete Program, is limited. This project addresses these gaps through a coordinated, statewide model that expands preventative Healthy Athletes® screenings into rural hub communities, strengthens referral-to-care systems within Alaska’s healthcare network, builds Community Health Worker (CHW) workforce capacity, expands the Youth Athlete Program and brings specialized neurological expertise directly to Alaska families. Rather than isolated events, this initiative creates an integrated rural health infrastructure designed to improve access, quality, and long-term sustainability of care for individuals with IDD.	In Phase 1 of this project, Special Olympics Alaska will implement a three-component Rural Health Transformation initiative designed to expand access, strengthen workforce capacity, and improve system coordination. Component 1: Expansion of Healthy Communities Programming We will expand Healthy Athletes® screenings to include a large-scale Summer Games event (200+ participants) and 2–3 regional hub screenings in communities such as Fairbanks, Kodiak, and Southeast Alaska. We will also strengthen targeted disciplines including podiatry (Fit Feet) and dental (Special Smiles) through established clinical partnerships. A key innovation is our embedded referral-to-care model in partnership with Providence Alaska, where athletes receiving referrals meet onsite with a dedicated care coordinator to schedule follow-up appointments before leaving the venue. We will replicate this model with additional partners, including Alaska Regional Hospital and Alaska Native Tribal Health Consortium, building a coordinated statewide referral network. Additionally, we will work on a statewide expansion of the Young Athletes Program (ages 2-10) through our partnership model with Infant Learning Program (ILP), specifically the Programs for Infants and Children (PIC), as well as expansion of our dryland fitness programming to strengthen preventative health engagement year-round. Component 2: Community Health Worker Workforce Expansion We will host an in-person CHW training in Anchorage for rural participants, develop partnerships with tribal health organizations and community clinics, launch a statewide online CHW training platform, and establish a recruitment and support pipeline. This builds sustainable, culturally responsive capacity within rural communities. Component 3: Access to Specialized Neurological Care In partnership with Dr. Jonathan Santoro and his research team, we will host 2–3 regional neurological screening events in Summer 2027, providing blood draws, transcranial Doppler testing, and baseline neurological assessments for individuals with Down Syndrome. This reduces costly out-of-state travel and integrates Alaska into national research initiatives. Together, these components transform episodic screenings into a coordinated, workforce-driven rural health model.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; Southeast Fairbanks Census Area	Advance to Implementation Application

SpheraNova	Improving Maternal Health, Infant Survival, and Family Stability in Alaska	AK	This project will pilot and refine a specialized regional workforce training program designed to strengthen the capacity of individuals who support pregnant and parenting people experiencing substance use and mental health challenges in rural Alaska. Many community-based providers, including Community Health Workers, doulas, Peer Support Specialists, and other frontline professionals, play a critical role in supporting families during pregnancy and early parenting but often lack access to training that addresses the intersection of maternal health, behavioral health, and peer-based support in rural service environments. The project will implement and evaluate the 10-module training program focused on recognizing early behavioral health concerns during pregnancy and postpartum, providing practical support strategies for families, and improving coordination between healthcare providers, behavioral health programs, and community services. The pilot training will be offered to a cohort of participants serving Southeast Alaska communities. Trainees will review the existing pilot curriculum and provide feedback on the relevance of training content, regional service realities, and workforce needs. Their input will guide targeted revisions to ensure the program reflects the health needs and service environments of Alaska communities. The refined training will create a scalable regional workforce development resource that can be expanded to additional rural regions of the state.	This project will implement an already developed 10-module training program designed to provide specialized training for frontline support professionals serving Alaska communities. The program will strengthen the knowledge and skills of community-based providers who may encounter or support pregnant and parenting individuals experiencing substance use and mental health issues. The training is intended to expand the capacity of this workforce to better recognize maternal behavioral health concerns, provide informed and supportive engagement, and connect families with appropriate services during pregnancy and early parenting. The training addresses key topics including maternal behavioral health, substance use during pregnancy, healing-informed approaches to care, stigma reduction, care coordination across healthcare and social service systems, and family support during the postpartum and early parenting periods. Emphasis will be placed on reducing stigma associated with substance use and mental health conditions during pregnancy so that professionals are better prepared to provide supportive, respectful, and informed care. Participants will engage in online virtual learning sessions, facilitated discussions, and case-based learning that reflect the challenges faced by professionals working in rural Alaska communities. These learning activities will focus on practical strategies to recognize early concerns, connect families with available resources, and strengthen collaboration across healthcare, behavioral health, and community support systems. During the Southeast Alaska pilot phase, the project team will gather feedback from professionals currently serving communities across the region. Participants bring firsthand knowledge of the barriers families face when seeking care. Structured feedback will be collected through participant surveys, facilitated discussions, and follow-up consultations and will be used to refine training modules to better reflect the needs of Southeast Alaska communities and rural service environments. Evaluation support will be provided through collaboration with ORAU to assess training outcomes and identify opportunities for program improvement. In Year 2, the project will expand to Southwest Alaska and continue building relationships with Traditional Healer Peers to help ensure the training reflects cultural knowledge and community practices important to Alaska families.	\$50,000-\$250,000	Maternal health	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Spine Care Specialist of Alaska	Rural Spine Care Access and Referral Optimization Project	AK	Residents of rural and frontier communities in Interior Alaska face significant barriers to accessing specialty spine care. Many patients must travel long distances to larger regional centers for evaluation of chronic back pain, radiculopathy, or other spinal conditions. These barriers often lead to delayed diagnosis, prolonged pain and disability, unnecessary medivacs /emergency department visits, and referrals that may not require surgical evaluation. At the same time, rural primary care providers often have limited access to specialty consultation when managing complex spine-related conditions. This project addresses this gap by expanding access to neurosurgical expertise through a traveling neurosurgery Physician Assistant who provides outreach clinics, referral coordination, and provider consultation. The program creates an opportunity to improve early evaluation, strengthen referral pathways, and support rural clinicians in managing spine conditions locally whenever appropriate, reducing unnecessary travel while ensuring patients who require surgical evaluation are identified in a timely manner.	This project will address gaps in access to specialty spine care for rural and frontier communities in Interior Alaska through a combined outreach clinic and telehealth consultation model led by a neurosurgery Physician Assistant (PA). The program will provide periodic in-person outreach clinics in designated regional hub communities, where the PA will conduct specialty evaluations for patients with spine-related conditions, review imaging, provide recommendations for conservative management, and identify patients who may require neurosurgical referral. In addition to in-person clinics, the program will incorporate telehealth consultations to expand access to neurosurgical expertise between outreach visits. Rural healthcare providers will be able to consult with the PA via telehealth or telephone during program work hours to discuss complex cases, review imaging, and receive guidance on patient evaluation and management. Telehealth visits may also be used for follow-up care, patient education, and coordination of referrals, reducing the need for patients to travel long distances for specialty input. The PA will also assist with referral management, surgical triage, and care coordination, ensuring that patients who require neurosurgical evaluation are identified and referred appropriately while supporting rural providers in managing non-operative conditions locally when appropriate. This approach is designed to improve the quality and appropriateness of referrals, increase surgical conversion rates, reduce non-operative specialty clinic burden, and support earlier identification of urgent spinal pathology. Program data will be collected to monitor patient encounters, telehealth consultations, referral patterns, and outcomes. By combining in-person outreach clinics with telehealth consultation and referral coordination, the project expands specialty access, strengthens collaboration between rural providers and neurosurgical services, and creates a sustainable model for delivering specialty care to rural and frontier communities.	\$50,000-\$250,000	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Sprout Family Services	Rural Community Family Engagement Project	AK	With the proposed Rural Community Family Engagement project we hope to engage those at risk and most vulnerable families that often fall through the cracks of society. Eventually these children enroll in schools with incredible functional deficits that were never addressed at a young age. This puts extreme strain on the families, schools and our state government. This grant would allow us to not only reach these children but also their parents, and over the course of months or years, be able to give the tools necessary to reach their fullest potentials and also be contributing members of society.	This Rural Community Family Engagement project would provide Sprout with the opportunity to engage at-risk children at a deeper level and to more intentionally support families whose children have experienced maltreatment. Through this funding, Sprout would be strengthening its partnership with the Office of Children's Services (OCS) and other partners across the communities we serve. The grant would expand our capacity to travel to outlying areas for information sharing, strengthen community partnerships, and increase collaboration among service providers. It would also allow us to designate a Referral Intake Specialist role to support Infant Learning Program referrals, enhancing timely engagement and connection to services. This focused intake support would help families access resources more efficiently and promotes overall family health, stability, and well-being while strengthening protective factors and reducing risk.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Kenai Peninsula Borough	Deferred or Not Advanced

Spruce Root Inc	Community-Led Regional Health Care Delivery Planning for Southeast Alaska	AK	Southeast Alaska encompasses over 35,000 square miles, with approximately 73,000 residents spread across more than 30 communities. Many smaller rural communities are accessible only by floatplane, small aircraft, or boat, and only three communities have road connections. Rural residents face some of the most severe health care access challenges in the state: provider shortages across primary, behavioral and dental care; long travel distances to reach specialty services; limited long-term care and aging-in-place supports; and chronic disease rates that exceed state averages among Alaska Native populations. While individual organizations may have developed their own strategic plans, the region currently lacks a comprehensive, cross-sector regional health care delivery plan that coordinates across Tribal, municipal, and provider entities in the way RHTP envisions. Without such a plan, communities and providers risk operating in silos, duplicating some efforts while leaving critical gaps unaddressed. Alaska’s RHTP Project Narrative explicitly calls for the development of “community-led regional health care delivery and system plans” to enable local innovation, coordinate new services, ensure sustainability of existing service lines, and align resources to meet regional and statewide health needs. This project will fill that foundational gap, creating the planning infrastructure necessary for the region to effectively access and deploy RHTP implementation funding in Years 2–5.	Project Goals: Understand the problem and barriers to healthcare in each community Identify and develop potential solutions Cross-collaboration and learning about what others are doing outside of region Create priority action list and assign roles/responsibilities and next steps to share with in-region and statewide healthcare providers The project accelerator framework centers ways rural, urban, and Indigenous communities come together to share knowledge by prioritizing dialogue. Each workshop is facilitated by Spruce Root staff with input from regional and local community partners to identify and invite community leadership, healthcare professionals, and patient representatives, ensuring each workshop meets community needs. Subject Matter Experts inform rural healthcare presentations and discussions during the workshops and provide technical expertise to carry workshop outcomes and implementation plans forward. RHTP Initiative project teams examine both surface and systemic-level facets of their project topics, diverge from traditional ways of identifying the causes, impacts, and resources, and converge upon tangible next steps and plausible solutions. Phase 1 (Years 1–2): Strategic Planning and Workshops The project will distribute baseline surveys and convene 25–50 local healthcare providers, patients, and leaders across twelve 3-day facilitated workshops. These sessions will focus on scenario planning for all six State RHTP initiatives, producing actionable reports and high-level implementation plans for local decision-makers. Phase 2 (Years 3–5): Sustainability and Ongoing Collaboration To sustain momentum and maximize access to technical assistance, Spruce Root will facilitate 2-hour monthly virtual meetings alongside annual relationship-building gatherings. To guarantee that the project continuously prioritizes and addresses community needs, progress will be tracked through annual stakeholder reports and biannual project staff debriefs. Spruce Root facilitators guide attendees through a project accelerator model with support from statewide and regional Subject Matter Experts (SMEs) for the following topics: Appropriate care availability Behavioral health Capital expenditures and infrastructure Consumer tech solutions Fostering collaboration Innovative care IT advances Prevention and chronic disease Provider payments	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Training and technical assistance
Workforce



Statewide Independent Living Council	AI Assistive Needs Technology Tool	AK	Assistive technology plays a critical role in healthcare, helping individuals manage chronic illnesses, adhere to medications, connect with providers through telehealth, and prevent injuries at home. Research shows that when assistive technology matches an individual's needs, well-being improves and caregiver burden decreases. However, only 8 to 38 percent achieve successful accommodation, often because recommendations are based on diagnosis alone rather than the whole person. Effective assistive technology must fit the individual's actual life: their preferences, living environment, physical capacity, and local conditions. In Alaska, this means considering whether devices work in extreme weather, function without reliable electricity, or fit in small rural homes. A person-centered approach accounts for these factors, but qualified assessors are scarce. SILC previously partnered with the Alaska Mental Health Trust and Mat-Su Health Foundation on a successful pilot for home modifications and assistive technology. The pilot was hampered by too few qualified assessors, leaving Alaskans waiting for technology that could improve their health. This shortage is acute in rural Alaska, where specialists are scarce and travel distances make in-person assessments impractical. Rural Alaskans may lack medication reminders, fall prevention devices, or telehealth equipment that could keep them healthier.	SILC proposes to develop an AI-powered assistive technology needs assessment tool built on a person-centered approach. Rather than matching individuals to technology based solely on diagnosis, the tool conducts conversational assessments that consider the whole person: their symptoms, functional needs, personal preferences, and real-world environment. The tool will assess factors including weight and portability preferences, desired functionality, available space in the living environment, usage capacity and physical abilities, whether devices need to withstand indoor or outdoor use, durability for Alaska weather conditions, and whether the person has reliable electricity. This individualized approach ensures recommendations fit the person's actual life, not just their medical profile. The tool will provide recommendations across health-related domains including chronic illness management, medication adherence, telehealth connectivity, fall prevention, and home safety. It will identify funding sources such as ATLA, Medicaid Waivers, and DVR, and refer users to experts for follow-up review and device demonstrations. Users include individuals with disabilities and chronic conditions of all ages, family caregivers, direct support professionals, CIL staff, schools, businesses, job coaches, and healthcare providers unfamiliar with assistive technology options. Year 1 is a discovery phase for stakeholder engagement and viability assessment. Year 2 focuses on prototyping with Delve Group. Year 3 begins a pilot with supplemental funding for participants to acquire recommended technology and be surveyed on health outcomes. Year 4 expands the pilot and develops sustainability. Year 5 launches statewide. SILC has extensive experience developing AI tools with Delve Group, including our Person-Centered Planning Assistant. This project applies that expertise to health-focused assistive technology.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Statewide Independent Living Council	Community Partners Improving Home Accessibility	AK	Falls are the leading cause of serious injury, fatal and non-fatal injury, and long-term disability among Alaskans 65 and older. A 2023 survey found 32.3 percent in that age group fell within the last year. For those with a mobility disability, 49.1 percent fell, and for those with an independent living disability, 69.2 percent. Nationally, non-fatal older adult falls cost \$80 billion per year, projected to exceed \$101 billion by 2030. Home accessibility is critical to preventing these falls, yet thousands of Alaskans lack safe entry access. Existing pathways to home modifications are complex, leaving many waiting years for solutions they urgently need. Wooden ramps last only three to five years in Alaska's climate. Freeze-thaw cycles cause screws to back out, boards to warp, and coatings to peel. Many become non-compliant within months. Some homes lack sufficient land for a ramp footprint, leaving residents with no path to accessibility. Modular ramps and platform lifts from durable aluminum and composite materials solve this. They include custom features for snow, freeze, rain, and frost heave, last multiple generations, and can be installed in winter. Platform lifts serve homes where terrain or lot size cannot accommodate a ramp. SILC demonstrated this through our Rural Ramp Pilot from 2020 to 2021, and ramps from that pilot remain fully functional over five years later. With Alaska's 85-and-older population the fastest growing demographic, demand will only increase.	SILC proposes a statewide modular ramp program that installs durable, ADA-compliant aluminum and composite ramps at the homes of Alaskans with disabilities and aging Alaskans who need safe access to remain in their homes and communities. The program builds on SILC's successful Rural Ramp Pilot, carried out from 2020 to 2021 with support from the Alaska Mental Health Trust Authority, and is ready to launch statewide the moment funds are available. The core innovation is a community ownership model. Rather than making ramps the property of individual homeowners, each ramp is held as a community asset by a local partner organization. When a ramp is no longer needed by the original recipient, it is repurposed at a new home for a fraction of the cost of a new installation — as little as 10 percent within the same community or 25 percent to another community. SILC will develop clear repurposing agreements with each community partner that establish need-based criteria for reallocation, ensuring ramps are directed to individuals with the greatest need. This creates a sustainable reverse supply chain where modular ramps continuously serve changing community needs across their multi-generational lifespan. Ramps are built using standardized modular sections that can be customized for each location's specific requirements. In Year 1, SILC will pre-purchase materials and shipping containers and focus on building as many modular sections as possible to establish an inventory ready to send to identified locations. Pre-purchasing materials in Year 1 mitigates expected price increases over the life of the project. Alaska's four Centers for Independent Living carry out the frontline work. CILs identify individuals needing ramp access, conduct site assessments, determine site preparation needs, and gather measurements for ramp configuration. SILC coordinates with Kasilof Wood and Metal to load shipping containers with standardized modular components, reducing per-unit costs for multiple installations in the same region. SAIL can store containers at four to six sites in Southeast Alaska, and Arctic Access has locations in Kiana, Kotzebue, Unalakleet, and Nome, creating staging points across the state's most remote regions. Local community members install the ramps with no professional construction experience required. Arctic Access maintains a waiting list of more than 100 individuals needing ramps in the Northwest Arctic.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Statewide Independent Living Council	Advancing Independence Through Innovation	AK	Alaskans with disabilities face two interconnected barriers that undermine their autonomy, particularly in rural and frontier communities. First, despite having one of the nation's most robust Supported Decision-Making Agreement statutes, Alaska has one of the highest guardianship rates in the country. Public guardians with the Office of Public Advocacy carry caseloads so extreme that many can dedicate only 15 minutes per person per month. Very few organizations support individuals through the SDMA process, and access is even more limited rurally. The result is unnecessary guardianship, loss of autonomy over health care, finances, relationships, and daily life, and institutionalization for individuals who could live independently with support. This costs the state significantly through guardian caseloads, institutional care, and ongoing court oversight. Second, youth with disabilities in rural Alaska lack person-centered planning tools that build self-determination. SILC's Person-Centered Planning Assistant (PCPA) has tripled workshop capacity, doubled completion rates, and produced more thorough goal development, but it requires computer lab access — scarce or nonexistent in most rural communities. Both barriers share a common thread: Alaskans with disabilities lack accessible, technology-enabled tools to take charge of their own lives. SILC has invested over \$85,000 developing AI-powered solutions and proven they work. This project takes those tools to scale statewide.	SILC proposes a five-year project to develop, test, and deploy two AI-powered tools and a shared database that expand decision-making support and self-determination for Alaskans with disabilities. The first tool is the Supported Decision-Making Agreement Assistant. SILC completed Phase 1 with Anne Applegate, Alaska's foremost SDMA expert. This closed AI solution is trained on expert-curated content, ensuring privacy, accuracy, and safety. It guides staff through helping individuals create SDMAs as alternatives or companions to guardianship, covering decisions about health care, finances, education, relationships, and medication management. The Disability Law Center of Alaska has agreed to review output during each pilot to ensure guidance does not cross into legal advice. Phase 2 deploys the tool to four to six facilitating organizations including CILs, Aging and Disability Resource Centers, and Developmental Disability Resource Connection offices (DDRCs) for pilot testing. Phase 3 launches real-world use statewide via virtual service delivery. Phase 4 develops a consumer-facing version individuals can access independently. The second tool is a mobile and voice-enabled upgrade to the Person-Centered Planning Assistant (PCPA), used in SILC's Youth Leadership Forum. The PCPA helps youth develop SMART goals across five life areas including health and wellness but requires computer lab access. This upgrade enables mobile devices with typed and verbal interaction. Enhancements will be completed in Year 1 for the Summer Youth Leadership Forum. The AI tools are developed with Delve Group, SILC's confirmed Alaska-based development partner. The two tools connect through a deliberate pipeline. PCPA sessions with transitioning youth surface conversations about autonomy, and SILC will connect interested youth to the SDMA Assistant, creating a pathway from self-advocacy to formal supported decision-making. The project also develops a cross-tool database tracking users across all SILC AI tools, managing referrals to community partners and state agencies, compiling reports, and collecting outcomes data for RHTP reporting. A database development partner will be identified during the scoping phase. Two full-time staff join in Year 2 to oversee deployment, the pilot, and training. Year 5 delivers training to disability organizations, state agencies, and court staff on SDMAs and statutory changes including potential provisions under SB190.	\$50,000- \$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Statewide Independent Living Council	Alaska Rural Airports Accessibility Project	AK	Eight in ten Alaska communities are not connected to the road system. Air travel is the only way to reach medical care, transport patients in emergencies, and connect to the rest of the state. Yet only 20 of more than 700 FAA-registered airports and airstrips in Alaska fall under the Air Carrier Access Act, which requires accessible boarding for passengers with disabilities. The rest have no accessibility requirements. Department of Transportation analyses acknowledge that passengers with disabilities sustain injuries, including fatalities, during physical transfers at airports, and that even light injuries before departure cause larger complications because remedies may not be available in flight. These analyses also document passengers being dropped, having clothing disarrayed, and body parts exposed. In rural Alaska, where passengers are transferred through cargo doors with no equipment, these risks are acute. Medevac teams face the same challenges loading patients, sometimes causing dangerous delays. Some individuals avoid seeking medical care entirely. The COVID-19 pandemic exposed how inaccessible air transportation undermines both healthcare access and emergency response in rural Alaska. No commercial solution exists. The few aircraft boarding ramp manufacturers worldwide design for large aircraft with 60 or more passengers. Their products are prohibitively expensive and impractical for gravel runways, extreme weather, and limited ground crews.	SILC proposes a five-year project to design, manufacture, and install ADA-compliant boarding ramps at rural Alaska airports and airstrips, making air travel accessible for passengers with disabilities who depend on small aircraft to reach healthcare and emergency services. If there is an expressed need in a community, SILC may also build mechanical versions of ramps for locations that require them. Year 1 is a planning phase. SILC will hire a dedicated project lead to identify airport possibilities and establish community contacts and relationships, including travel to communities for listening sessions. The project lead will also establish relationships with air carriers and medevac teams who will use the ramps, and will be responsible for gathering ongoing feedback from carriers, medevac teams, and communities on their experiences using the equipment, including boarding efficiency and injury reduction. SILC will acquire shipping containers for future ramp transport and storage. Two past SILC council members from Bethel and Utqiagvik have agreed to help identify community airstrips within their regions to prioritize for the project and provide contacts necessary to assess community readiness and buy-in. Alaska's four Centers for Independent Living have agreed to conduct outreach to rural communities to identify need and local contacts across their service areas. Toward the end of Year 1, Kasilof Wood and Metal will build eight ramps, with four installed at remote locations to gather feedback on design, any needed modifications, and operational considerations before larger implementation. Building these early ramps also locks in material pricing. The ramp design proven at the Nome airport is compatible with a wide range of aircraft common across rural Alaska through a high level of adjustability built into each unit. If additional modifications are needed to accommodate specific aircraft at a particular location, Kasilof Wood and Metal can make those adjustments on a case-by-case basis. Equipment is built for Alaska conditions: functional on tarmac and gravel, durable in extreme weather, easy to operate and store. SILC will use shipping containers to transport ramps and to provide storage at airports that lack it. Multiple ramps may be shipped to a regional hub at one time to save on shipping costs. Kasilof Wood and Metal trains local community members on operations at each site.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Statewide Independent Living Council	Individual Reentry Planning for Alaskans with Disabilities	AK	Alaskans with disabilities are significantly overrepresented in the state's correctional system. Nationally, over 40 percent of people in state prisons have a disability, and one in five justice-involved individuals has a serious mental illness. When these individuals are released, they return to communities—many of them rural, remote, or frontier—without a coordinated plan for reconnecting with the health services critical to their stability. This includes behavioral health care, substance use disorder treatment, medication continuity, and primary care. The gap between discharge and connection to community-based health services is a period of acute vulnerability. Prison case managers are stretched thin, with ratios averaging 45 to 1, resulting in generic discharge information that fails to address individual needs. There is no adequate screening for traumatic brain injury in corrections, leaving many individuals undiagnosed. Without coordinated, health-focused reentry planning, individuals with disabilities cycle through emergency services, crisis behavioral health interventions, and re-incarceration—straining rural health systems and producing poor outcomes. Alaska's Centers for Independent Living already serve people with disabilities transitioning to independent living, but currently lack a structured, health-focused framework for supporting individuals reentering from correctional settings.	SILC proposes a two-year planning and development project to create an Individual Reentry Plan framework for Alaskans with disabilities leaving incarceration. This framework will be a structured, person-centered process that CIL staff facilitate with individuals preparing to reenter Alaska communities from correctional settings, with a focus on health service continuity. Year 1 is a short discovery phase running through September 2026. Activities include stakeholder engagement sessions with Alaska's four Centers for Independent Living to assess current reentry practices and capacity; a needs assessment focused on health-related reentry challenges for people with disabilities in rural communities; framework design for the Individual Reentry Plan covering behavioral health continuity, SUD treatment access, medication management, and primary care connections; technology scoping for an AI-assisted planning tool; and partnership development with the Department of Corrections, Department of Juvenile Justice, tribal health organizations, and community behavioral health providers. SILC will work with a consultant from the Alliance of Disability Advocates in North Carolina, which operates a CIL-based reentry program that has achieved an 11 percent recidivism rate compared to the state average of 47 percent. This proven model will be adapted for Alaska's unique context, including our extreme rural geography and tribal health system. Year 2, running October 2026 through September 2027, focuses on developing an AI-assisted Individual Reentry Plan tool in partnership with Delve Group, an Alaska-based technology company. SILC has extensive experience developing AI tools with Delve Group, including our Person-Centered Planning Assistant and Supported Decision-Making Agreement Assistant. The Year 2 phase includes in-house testing with CIL staff followed by a pilot with individuals being released from DOC or DJJ facilities. The deliverable is a fully developed, tested intervention ready for statewide implementation funding in a future request.	\$50,000-\$250,000	Statewide	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area	Deferred or Not Advanced

Statewide Independent Living Council	Self Directed Individualized Learning Programs with Health Objectives	AK	The Individualized Education Program process is intended to ensure students with disabilities receive tailored support, yet families often struggle to participate as equal partners. The process is largely driven by school professionals, and students are rarely meaningfully involved in shaping their own goals. Parents may not know what they can ask for, how to articulate their child's needs across academic, functional, and health domains, or how to translate their knowledge into the structured language IEP teams use. Health-related needs are particularly underserved. IEPs can legally include goals for chronic condition management, medication adherence, mental and behavioral health, and healthcare navigation, but these objectives are rarely incorporated because families lack a practical way to identify and request them. Research shows that students who develop health self-management skills early are better equipped to live independently as adults, require less costly care, and place less strain on the healthcare workforce. In Alaska, these challenges are amplified. Workforce shortages mean fewer specialists to support IEP development, and rural families face additional barriers accessing advocacy resources. When youth with disabilities enter adulthood without skills to manage their education, health, and daily living, they require higher levels of support that are more expensive and harder to access in a state with significant workforce constraints.	SILC proposes to develop a free, AI-powered web-based tool that helps families prepare for IEP meetings by working through the full scope of their child's needs — academic goals, functional performance, accommodations, related services, transition planning, and health-related objectives including physical health, mental and behavioral health, chronic condition management, and healthcare navigation. The tool takes a whole-person approach to IEP preparation while ensuring that health needs, which are often overlooked, are included as an integral part of the plan. The tool has two parts. First, a parent documents their child's conditions, functioning, strengths, challenges, and support needs. The AI then adapts the language complexity of a student-facing section so the child can engage directly to answer questions about their own goals, preferences, and priorities at an appropriate level. The output gives families prepared IEP goals they can bring to their meeting, arriving as informed, equal partners. If the tool identifies that assistive technology may benefit the student, it directs families to appropriate resources. Some districts have AT Specialists on staff, and the AT assessment tool will enable Special Education teachers to more easily participate in the At assessment process. For districts without these resources, the tool points to external organizations including CILs and those using SILC's AT Needs Assessment Tool developed under a separate RHTP project. Many forms of assistive technology have direct health implications, including tools like mobility aids, magnification, communication devices, and listening devices. Families access the tool through partners including Stone Soup Group, The Arc of Anchorage, and LINKS, whose parent navigators help with setup. Alaska's four CILs provide statewide access. SILC will conduct outreach to school districts and tribal educational systems to encourage referrals. The five-year phased approach includes discovery in Year 1, prototyping with Delve Group in Year 2, a small pilot in Year 3, expansion with Section 504 functionality in Year 4, and statewide launch in Year 5. Accessibility features will be developed with the Brain Injury Council of Alaska and the Alaska Center for the Blind and Visually Impaired.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

StationMD	Specialized Telehealth and Telepsychiatry for Alaskans with IDD who Lack Coverage	NJ	About 2,700 Alaskans who have IDD are receiving services under the two Home and Community Based Services waiver programs operated by the state (IDD waiver and Individual Supports waiver). These waivers cover some on-demand telehealth services and other services and supports that enable them to live independently and to perform activities of daily living required for self care. Another 700+ individuals with IDD are on waiver waitlists or registries, waiting for a slot to open so they can join Medicaid waiver programs. About half live in rural areas. They do not have access to all the services and supports they need so are at increased risk for preventable hospital admissions and Emergency Department (ED) use, reduced quality of care and life, and increased costs of care. Individuals with IDD represent an outsized share of healthcare service use and spending – they’re twice as likely to visit the ED, more likely to have a mental health condition, and have higher costs than other populations. Relying on hospitals and Emergency Medical Service (EMS) providers to serve these individuals introduces preventable workforce strain and service expenditures, and it threatens quality of care. Typical telemedicine and innovation solutions are not effective for people with IDD. A specialized solution is needed to address barriers related to communication, social challenges, mobility, support systems, and co-morbid medical and psychiatric conditions.	We propose to provide STAT – Specialized Telehealth and Assessment Team – services to individuals with IDD who are on Medicaid waiver waitlists or registries for the two Home and Community Based Services waiver programs operated by the state – the IDD waiver and the Individual Supports waiver (ISW). We will also provide this service to up to 100 other Medicaid-enrolled or uninsured individuals with IDD identified by the Alaska Department of Health or its designees. STAT furnishes a right-on-time telehealth assessment and triage when the individual’s primary care physician is unavailable or unable to determine the best clinical course of action, often avoiding unnecessary emergency department (ED) and urgent care visits. Clinicians are available 24/7 and specially trained to serve individuals with IDD. Below we describe the typical STAT patient encounter: - Change in Condition: Individual/caregiver notices a change and decide to initiate a STAT encounter. - Activate StationMD: Staff and individual initiate the encounter together. - Clinician Assessment and Triage: Next, the medical encounter is initiated by the clinician. During the encounter, If it is determined that the issue can be resolved without urgent in-person care, a detailed medical encounter is performed, including establishment of a diagnosis, plan and testing or prescription if necessary. (Note: For those with Medicaid or other insurance coverage, the cost of the visit is excluded from this proposal.) Our median call-to-clinician face-to-face encounter is <8 minutes, so all cases are seen extremely quickly. - Warm Handoff: In cases where the individual immediately requires a physical visit to a hospital ED, StationMD provides a “warm handoff” to the ED physician – clinician-to-clinician. - Sharing Documentation: Formal encounter documentation distributed after every visit. - Aftercare/Care Coordination: StationMD’s service includes follow-up consultations with the treated individual and provider, in the appropriate timeframe, depending on the issue after the initial call. - STAT+. For individuals who have co-occurring psychiatric conditions, we offer STAT+, which includes facilitation and scheduling of telepsychiatry appointments to assure timely access to necessary psychiatric assessment and treatment by psychiatrists, psychiatric nurse practitioners, or psychiatric physician assistants who have completed the specialized training required of all STAT+ providers.	\$250K-\$1M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Step-In Autism Services of Alaska, LLC	Statewide Telehealth Behavioral Stabilization & Caregiver Services for Rural Alaska	AK	Rural Alaska families raising children with autism, intellectual/developmental disabilities, or other behavioral needs face major barriers to timely support for communication, daily living skills, and safety-related behaviors. In many communities, families wait months or years for services because providers are scarce, travel is difficult, and specialty care is concentrated in hub communities. These delays create a costly pattern: needs intensify, caregiver stress rises, and children are more likely to require crisis response or high-acuity services, including inpatient or residential placements and law-enforcement involvement. Families also miss early intervention windows, where practical support can have the greatest long-term impact on functioning and stability. Applied behavior analysis (ABA) is an evidence-based approach for reducing challenging behavior and teaching functional skills, but access in rural Alaska remains limited. National cost growth and reliance on high-intensity service models make care harder to reach and harder to sustain in rural settings. This leaves Alaska with a clear opportunity: improve early access in rural communities while using state dollars more efficiently and reducing long-term crisis-related costs.	Step-In Autism Services (SiAS) will develop and launch a HIPAA-compliant statewide telehealth service line with onsite buildout to serve children and families in rural Alaska. The project targets children whose challenging behaviors place them at risk for escalation to higher-acuity services when support is delayed or unavailable. SiAS will use a tiered service pathway to match care intensity to clinical need. • Tier 1: Prevention and caregiver capacity-building. SiAS will provide caregiver guidance and community training through telehealth and rural hub sites. All Tier 1 families will have access to KALi, a mobile app that uses evidence-based visual supports and prompts to help prevent escalation. • Tier 2: Assessment and individualized support. Licensed behavior analysts (LBAs) will complete assessments, develop behavior support plans, and provide individualized telehealth coaching and intervention in the child’s natural environment when clinically indicated. • Tier 3: Rapid stabilization. For children at risk of emergency department use, psychiatric admission, law-enforcement involvement, or out-of-home placement, LBAs will lead real-time de-escalation protocols, safety planning, and cross-setting coordination. SiAS will activate community-based supports to prevent system escalation. When hands-on services are needed, locally trained behavior technicians will deliver in-home and community-based support under LBA oversight. SiAS will compile and monitor a dataset to measure clinical outcomes and cost-effectiveness. SiAS will analyze outcomes across tiers, service modalities, and participant characteristics to identify which approaches produce the best results for which children and families. These findings will inform future value-based care and payment models. RHTP funds will support planning, capacity-building, start-up, innovative payment model data set development and analysis activities only. They will not fund ongoing operating expenses or payer-covered services.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

StethX Inc	SeismicPatch™ for Rural Health Asthma Control and Mgmt - Data Collection to train our algorithm	GA	Rural and frontier communities face unique challenges in managing asthma—limited access to specialists, long travel distances, and delayed recognition of worsening symptoms that often lead to emergency department visits and preventable hospitalizations. These gaps in care take a toll not only on patients’ health but also on families, schools, and small care teams already stretched thin. Our project recognizes that where someone lives should not define the quality of care they receive. SeismicPatch™ offers a practical, human-centered solution: a small wearable device that helps patients and clinicians detect early respiratory changes and act before emergencies occur. By turning real-time data into timely action, it empowers patients to better manage their asthma and enables care teams to intervene sooner—even from miles away. Beyond improving asthma outcomes, this project builds trust and connection within rural healthcare systems. It supports self-management, strengthens the patient-provider relationship, and replaces crisis-driven care with proactive, preventative support. In essence, SeismicPatch™ gives rural communities a powerful tool to take control of their health and breathe easier. We are in the testing phase of developing our patch, and need to collect data (wheeze signatures, cough frequency, respiratory and heart rate, and work of breathing) to train our algorithms to correctly identify these sounds.	Our project will use the Alaska Rural Health Transformation Program to conduct an observational validation study of SeismicPatch™, an ultra-low profile, chest-worn respiratory sensor for adults with asthma in rural and frontier communities. In Alaska, our sole focus is data collection to train and refine the device’s detection algorithms, not broad clinical deployment or commercialization at this stage. Working with rural and Tribal partners, we will enroll adult asthma patients, collect continuous real-world physiologic data (wheeze signatures, cough frequency, respiratory and heart rate, work of breathing), and evaluate performance during activities of daily living and within existing primary care and tele-health workflows. This staged data collection will generate the evidence needed to validate SeismicPatch™ in frontier conditions, assess feasibility of integration into rural care settings, and build the foundation for future commercialization and scale. StethX has developed this approach to tightly align with Alaska’s Spark Technology & Innovation initiative and its goals to strengthen access, workforce, and preventive chronic disease management in rural communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Stone Soup Group	Expansion of Mentor Advocate Partner (MAP) Program	AK	Rural families raising children with intellectual and developmental disabilities (IDD) and complex medical needs face significant gaps in coordination across Alaska’s hub-and-spoke healthcare system. Specialty care is concentrated in Anchorage, Fairbanks, Juneau, and out-of-state centers like Seattle, requiring families to travel long distances for diagnosis, treatment, and extended hospitalization. When returning home, families often lack coordinated support to implement medical recommendations and navigate services across healthcare, education, and community systems. Critical transitions—such as hospital discharge, new diagnoses, and pediatric-to-adult care transitions—frequently occur without clear communication between hospital teams, local providers, and school systems. Schools are expected to implement complex medical and developmental supports but rarely receive structured guidance from healthcare providers. As a result, families must translate medical plans into educational supports and coordinate care across systems without formal assistance. Rural workforce shortages and turnover further weaken continuity of care. These gaps contribute to fragmented services, delayed implementation of care plans, caregiver burnout, and preventable health crises that increase emergency department utilization and higher-cost interventions. These systemic challenges highlight the need for coordinated navigation that bridges healthcare providers, schools, and community supports	Stone Soup Group will expand our existing MAP (Mentor, Advocate, Partner) Program to strengthen coordinated care for families with loved ones who have intellectual and developmental disabilities (IDD) and complex medical needs. The project will develop a statewide network of trained Mentor Parents—family leaders with lived experience—who will augment SSG’s professional Parent Navigation staff and will work alongside families as trusted guides and connectors between healthcare providers, schools, and local community resources. SSG will hire a full-time MAP Coordinator to oversee the expansion of the MAP Program. Consultant, Rain Van Den Berg, will advise on the adaptation of the existing MAP training curriculum—the current curriculum is focused on a one-to-one mentoring model—into a broader community navigation model to support program expansion. SSG’s current partnership with Southcentral Foundation, where a SSG Parent Navigator is embedded on their campus and in their pediatric specialty clinics, will further guide and inform the expansion of our MAP Program. SSG will recruit, vet and train cohorts of Mentor Parents from rural communities. Training will be a combination of distance-delivered and in-person sessions. Trained Mentor Parents will support families during critical points, including diagnosis, hospital discharge, medical travel, and transitions between pediatric and adult healthcare systems. Mentor Parents will also help families understand medical recommendations and how to implement care plans across healthcare providers, schools, and community services. Partnership Agreements with key organizations will be used to facilitate collaboration and reduce barriers for families. Having local Mentor Parents available as guides and resources helps to minimize isolation which can too often lead to tragic outcomes. Caregiving for a loved one with complex and demanding needs can be overwhelming and exhausting and we often see families disconnect and isolate because they feel they no longer belong. Sometimes the simplest intervention of connecting families to a trusted support person can have the greatest positive impact. By supporting non-clinical needs, Mentor Parents allow healthcare providers to work at the top of their licenses, knowing that the other needs are going to be addressed with the Mentor Parent. They are a partner to healthcare providers and families working to reduce avoidable crises and build strong support networks.	Under \$50,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Strategic Command Centers	Alaska Remote Clinic Security Research Program: Rural and Tribal Workforce Safety	NJ	Remote and village healthcare clinics across rural and Tribal Alaska face a security challenge that no existing national policy framework addresses. These facilities operate with minimal staff in extreme geographic isolation, often hours from law enforcement, in communities where weapons-carrying is a normalized part of the subsistence lifestyle. Behavioral health crises and substance use encounters are common, psychiatric services are scarce, and evacuation options are severely limited by weather and terrain. Healthcare workers at these facilities frequently leave not because of compensation, but because they do not feel physically safe and have no institutional framework to guide their response to threats. This workforce attrition directly undermines Alaska's RHTP investment in rural healthcare access. The problem cannot be solved by adapting existing hospital security policies as it requires original research followed by purpose-built standards.	Baseline Research Study: A comprehensive study conducted in partnership with an Alaska institution of higher education, combining quantitative surveys of remote facility administrators with qualitative stakeholder interviews including clinical staff, Tribal health leadership, and Alaska State Troopers. The study maps the actual threat landscape before any standards are written, ensuring solutions are grounded in evidence rather than assumptions. Standards Development: Based on research findings, a custom policy library is developed for remote and village clinic settings. Policies address workplace violence prevention adapted for limited law enforcement backup, weapons management protocols that respect the subsistence lifestyle, active threat response for extreme isolation, behavioral health crisis encounters, emergency communications with limited connectivity, and Tribal community coordination frameworks. GRC Platform with Quarterly Updates: Because these are first-generation standards never tested in practice, the GRC platform includes quarterly refinement cycles throughout the performance period. Implementation feedback from participating facilities drives continuous standards improvement, evolving the framework from theoretical to field-tested. Longitudinal Research Program: Annual research studies conducted through Alaska university partnerships measure implementation effectiveness, track workforce retention trends, and validate standards refinements. This produces a multi-year dataset demonstrating RHTP workforce impact that ACF can report to federal funders.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Strategic Command Centers	Rural Hospital Workplace Safety: Workforce Retention Through Security Policy Standardization	NJ	Alaska faces a critical workforce challenge where clinicians frequently leave hospitals because they do not feel physically safe in isolated settings. Limited operational resources currently prevent rural hospitals from developing the professional physical security and emergency management standards necessary to protect their staff and their federal funding.	This project consists of three main parts designed to modernize hospital security infrastructure: Metapolicy Library: A comprehensive resource for all hospitals, providing a physical security and emergency management framework that is 95% applicable across the network while being optimized for rural settings. GRC Platform: This system ensures continuous compliance and demonstrates Evidence of Implementation (EOI) for federal oversight. It provides direct alignment with 2026 CMS Emergency Preparedness standards, Joint Commission Accreditation 360 (2026) requirements, and DNV NIAHO accreditation pathways. Research Partnership: This component establishes a partnership with an Alaska institution of higher education to scientifically validate how these security standards impact healthcare workforce retention and rural hospital security.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Strategic Impact Consulting	Strategic Impact Technical Assistance and Training	AK	Remote communities in Alaska face persistent barriers to accessing high-quality, sustainable health care. Geographic isolation, limited infrastructure, workforce shortages and high operating costs make it difficult for organizations to expand services and implement innovative care models. Many Tribal Health Organizations, Tribes and rural providers also operate with limited administrative capacity, which can hinder their ability to compete for and manage complex funding opportunities that can address these gaps and barriers. The RHTP provides critical resources to improve care delivery, strengthen health systems and expand access to services; however, many eligible entities lack technical expertise and staffing capacity necessary to develop competitive applications and successfully implement projects. Without targeted TA and training, these organizations may be unable to fully access or utilize resources intended to strengthen health care systems and improve health outcomes. This project addresses these challenges by providing TA and training to RHTP eligible entities to strengthen their capacity to develop high-quality funding applications and successfully implement funded initiatives. By building administrative, planning and project management capacity, the project will support rural organizations in securing funding, implementing innovative health initiatives and improving access, quality and sustainability of health care services for Alaska’s remote communities.	The proposed approach will deliver training and TA through a phased model designed to strengthen the capacity of RHTP eligible entities to successfully implement funded initiatives and develop competitive projects for future funding opportunities. During the initial phase, the project will prioritize training and individualized technical assistance for RHTP awarded grantees to support successful project implementation. This support will include guidance on project management, financial oversight, compliance with program requirements, performance monitoring and reporting. The project team will work directly with funded entities to address implementation challenges, strengthen administrative systems and ensure projects are delivered effectively and in alignment with RHTP goals. Following this initial implementation support, the project will expand training and outreach to other eligible entities interested in participating in RHTP. Introductory training sessions will provide an overview of RHTP priorities, program requirements and key elements of successful project design. These sessions will be delivered through accessible virtual formats, including webinars, workshops and written guidance to ensure organizations in remote communities can participate. Entities preparing for future RHTP submissions will have access to individualized technical assistance tailored to their project concepts. This support will include guidance on project planning, partnership development, budgeting, data strategies and aligning initiatives with RHTP priorities to support strong Year 2 proposals. Throughout the program, training and TA will focus on building sustainable organizational capacity. Toolkits, templates, and best practice guidance will support improvements in grant management, program evaluation and health system innovation. Due to the anticipated number of participating entities, the project team will establish transparent criteria to prioritize organizations that may benefit from more intensive technical assistance. Core training will be available to all eligible entities, with individualized support provided based on prioritization criteria and, when appropriate, on a first-come basis. By combining implementation support for awarded grantees with training and project development assistance for future applicants, this approach will strengthen the pipeline of high-quality RHTP projects and support sustainable health initiatives across Alaska’s communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Strategic Prevention Solutions	Art-Based Storytelling: Bridging Recovery Readiness and Service Access in Alaska Native Communities	AK	Across rural Alaska, Alaska Native people seeking mental health and substance use services frequently encounter a critical gap between the moment they are ready to engage in services and the point at which those services are actually available. This gap—driven by provider shortages, geographic isolation, long wait lists, and fragmented referral systems—results in missed treatment opportunities, deteriorating health, and deepening distrust of the health care system. Despite widespread recognition of this problem among providers and communities, there is limited systematic documentation of how individuals experience this gap, what happens during the waiting period, and what supports or interventions could bridge the divide. This project addresses that gap in understanding by using culturally appropriate, community-centered methods to capture the voices and stories of those most affected.	Our team will employ art-based storytelling methodologies—including visual art, oral narrative, and creative expression workshops—to gather personal stories from Alaska Native people in rural communities who have experienced the gap between treatment readiness and service access. The project unfolds in three phases: Phase 1 — Community Engagement and Design (Months 1–4): SPS will lead the development of the research framework and data collection protocols in collaboration with Christina Love Consulting and Black & White Raven Company. Christina Love and Chloey Cavanaugh will engage community members and local leaders in rural Alaska to co-design the art-based storytelling workshops, ensuring methods are culturally grounded and community-approved. This phase includes institutional review, partnership formalization, and logistical planning for community-based workshops. Phase 2 — Art-Based Storytelling Workshops and Data Collection (Months 5–12): Christina Love and Chloey Cavanaugh will facilitate a series of art-based storytelling gatherings in selected rural communities. These workshops will create culturally safe spaces where participants can share their experiences through visual art, spoken narrative, and other creative modalities. SPS will provide research support including qualitative data collection, documentation, and preliminary analysis of emerging themes. Workshops will explore questions such as: What was happening when you were ready for help? What barriers did you face? What would have made a difference during the wait? Phase 3 — Analysis, Synthesis, and Guidance (Months 13–18): SPS will lead the thematic analysis of all collected stories and data, identifying patterns in the mental health, addiction and recovery services access gap and community-identified solutions. The team will synthesize findings into a final report and a set of actionable guidance documents designed to inform the development of interventions that address the gap in services. Findings will be shared with participating communities, health care providers, tribal organizations, and state agencies to support evidence-informed system improvements.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Prince of Wales-Hyder Census Area; Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Straw For Dogs	Healthy Communities Through Healthy Pets	AK	The problems that the majority of our rural communities throughout Alaska face with having to live amongst packs of ferrel dog and cat populations are not only physical, mental, and emotional health issues, but also financial hardships that add to the anguish. Other associated downstream effects such as, spread of zoonotic disease risks, added strain to an already limited local health system and public safety resources, bites on humans, disproportionate impacts on remote Alaska Native communities, reduced neighborhood safety and walkability especially amongst children to engage in outdoor activities for fear of bites on human and attacks on livestock that sustain a foods source for isolated communities. The objective of this project is to provide access to spay and neuter services to areas throughout Alaska where this service is not readily available, in an effort to reduce the overpopulation of stray/ferrel animals that are causing these problems listed above.	The Healthy Communities through Heathy Pets Project will successfully combat and mitigate the problems associated with overpopulations of ferrel animals by using several methods. All methods are effective independently, however when all three are implemented in tandem that is when our goal will be achieved and better sustained. The three pillars of our Program are: Education, Access, and Sustainability. We all know that "education" is critical when identifying and resolving any problem, that is why bringing awareness and information about the issues associated with the negative health effects that living with populations of ferrel animals has on a community is an important element in the success of this Program. Once understanding through education is recognized, the element of "access" will be the physical work portion of the Program. Once both of these elements have taken root, the "sustainability" key is more easily accomplished because communities will have seen and felt the results of what living life without the fears of being forced to live with ferrel packs of animals is like. With the infusion of RHTP funding to an already established non-profit driven system that includes education, access, and sustainability elements by being able to perform more and better organized regular scheduling of spay/neuter/vaccination/care clinics to these most difficult to reach rural, disproportionate native communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Southeast Fairbanks Census Area; Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Strong Solutions, LLP	Public-Private Partnership AI Innovative Care Model	AK	Rural Alaska’s health crisis is driven by an "Innovation Gap." While Silicon Valley leads the world in AI, these solutions rarely survive the realities of the frontier. This gap forces the relocation of high-acuity rural Alaskans to urban centers, away from their homes. The opportunity is to capitalize on a Public-Private Partnership AI Innovative Care Model that bridges this gap. Strong Solutions is leveraging 14 winters of Kodiak "Living Lab" data to attract additional capital into a specialized AI Innovative Care Model. Our model is supported by a \$2.5M private capital commitment, ensuring that RHTP funds are used exclusively for community deployment and workforce scaling, while the private sector bears the primary risk of technical development and engineering. We are offering the Department of Health a seat at the table in an existing Frontier-to-Incubator Feedback Loop—including access to our Ivy League research and Silicon Valley engineering teams—to solve the Workforce and Spark Tech crises. We are offering the DOH a partnership in the world’s most advanced rural health R&D engine.	Pre-existing patent-pending/trademarked tech was developed via private R&D. RHTP funds will scale deployment, not primary research. Our approach centers on a Reciprocal Innovation Cycle between Alaska providers and our AI Innovative Care Lab (based in Palo Alto, CA). We utilize a Public-Private Partnership to pilot and scale solutions for Alaska Healthcare providers. 1. AI Innovative Care Lab: We’ve engaged global innovators to develop frontier-ready tools like "The Guardian" (PIERS). Currently in prototype, it uses Edge Technology and Zero-Knowledge agents for 24/7 safety and federal match audit loops, unlike cloud-dependent tech. We will utilize a 'Learning & Adaptive Management' framework where data from our Yale University Research Fellow is reviewed quarterly to pivot technical protocols and workforce training modules in real-time, ensuring the model evolves alongside beneficiary needs. 2. Lived Experience Exchange: We ensure tech is built with Alaskans. Kodiak residents pilot tech in Palo Alto; a Yale Research Fellow joins our Living Lab this summer to validate outcomes. This ensures IP, like "This Is Me" (TIM), is grounded in rural care reality and digital literacy. 3. Peer DSP/LRI Workforce: We integrate our tech with proven Peer DSP/LRI programs. Training Alaskans with disabilities and LRIs to use AI Aide’s tools transforms care recipients into "Tech-Enabled" providers—creating a permanent, high-wage local workforce that overcomes traditional staffing turnover. 4. Sustainability & Integrity: Backed by \$2M+ private equity, we optimize federal matches (1915(k)/1115/IHS). Our patent-pending Fraud Signaling allows patient-verified care via wearables, providing the DOH a revolutionary Medicaid integrity tool. By 2031, this AI Innovative Care Model will be self-sustaining and attractive to private investment, reducing the long-term burden on Alaska’s budget.	Over \$5M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Struct, Inc	Alaska Coalition of Integrators (ACI) Certification & Rural Health Resilience Program	AK	Rural Alaska communities face chronic workforce shortages in utilities, infrastructure, and allied health roles and frequently must pay to import engineers and consultants for maintenance, planning, and emergency response—incurring high costs and delayed service. Structure proposes a statewide, scalable certification and workforce pipeline delivered from a Yakutat training facility that trains local personnel to perform technical tasks, reducing reliance on external contractors. By creating locally accredited credentials aligned to employer needs, the program increases community resilience, lowers long term costs, and builds a replicable model for other rural Alaskan communities. Yakutat is an off the road system village that is uniquely positioned with daily jet service, strong tribal partners, a rich history, and worldclass outdoor opportunities. Yakutat Tlingit Tribe recently opened a modern health clinic that serves the entire community. Like many rural communities, Yakutat’s population has been declining largely due to lack of investment in the local school system. This project will deliver high skilled training in a rural location, helping reverse outmigration, serve as a model for problem solving and economic stability, and overall community health.	The program will: 1) co design competency based curricula with Yakutat and statewide partners for utilities operations, infrastructure maintenance, allied health support, and technical problem solving; 2) deliver blended cohorts combining on site practicums in Yakutat, remote ECHO style tele mentoring, simulation, and asynchronous microlearning; 3) establish credentialing, apprenticeships, and employer aligned pathways with ANTHC, SHI, YTT, CBY, and regional employers to ensure local job placement and replace external contractor use; 4) implement instructor training and train the trainer models to localize delivery and enable statewide replication; and 5) evaluate credential attainment, job placement, retention, reductions in external consultant/engineer expenditures, service continuity metrics, and contractor dependence. Structure leads curriculum and program operations; YKI leads facility renovation and repurposing; YTT, CBY, AVEC, ANTHC and SHI provide employer partnerships, practicums, and technical input. Quarterly governance and data sharing will drive iterative improvement and statewide scaling.	\$250K-\$1M	Statewide	Bethel Census Area; Bristol Bay Borough; Juneau (City and Borough); Sitka (City and Borough); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Struct, Inc	Health OT Network Operations Center — Remote Infrastructure & Clinical Data Operations Monitoring	AK	Rural Alaska clinics face combined threats to access from infrastructure failure (HVAC, generators, water, refrigeration) and degraded clinical communications (tele-health outages, high latency, device interoperability failures, cybersecurity events). Because facility uptime and communication integrity equal access in remote Alaska, there is an urgent need for an integrated Health OT NOC that monitors both physical and clinical data operations to prevent service loss and enable data-driven continuity of care. Without reliable infrastructure, maternal and child health services, behavioral health access, chronic disease management, and telehealth-enabled specialty care for Alaska Native communities and rural elders are disrupted.	Deploy Structure SCADA as a Health OT Network Operations Center for participating clinics: - Monitor physical infrastructure: HVAC, backup generators and fuel levels, water/sanitation, vaccine refrigeration (temp excursion alarms), medical gas inventory, remote pharmacy dispensers, tele-health kiosk status and uptime. - Monitor data operations backbone: ingest clinic/device/tele-health telemetry, monitor interface health, track latency and communications integrity (CommsVault connectivity), and detect cybersecurity intrusion events. - Provide multi-protocol device normalization, real-time system health dashboards, alarm correlation, and Geographic visualization (GIS overlays) to show clinic and device geography and status. - Surface Alaska-relevant operational indicators to stakeholders: clinic online/offline status, connectivity health, tele-health session capacity (concurrent session capacity and current utilization), device fleet health, and intrusion/cybersecurity alerts. - Integrate tiered alarm routing (SMS/email/IVR) to local staff, tribal/regional ops, and on-call technicians; enable remote diagnostics and over-the-air updates to reduce emergency dispatches. - Produce compliance-ready logs and automated reports to support value-based care metrics, population health analytics, and detection of fraud/waste patterns. - Connectivity: hybrid cellular/satellite gateways with store-and-forward for intermittent networks. - Pilot: Chignik Lagoon + two rural clinics; LKSD and City partners engaged for coordination. - Partner with Alaska workforce development programs to create “grow our own” Health OT technician pipelines. Provide structured mentoring and continuing education to sustain local operational expertise. - Engage THOs and clinics as co-designers: ensure community-driven implementation that respects local priorities, preserves Tribal data governance and provider autonomy, and supports the enhancement and expansion of Tribal health programs.	\$1M-\$5M	Statewide	Bethel Census Area; Bristol Bay Borough; Juneau (City and Borough); Sitka (City and Borough); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Struct, Inc	Structure SCADA for Rural Health Access – Secure Clinic Infrastructure and Community Resilience	AK	Across rural Alaska, clinics and regional health hubs depend on aging power, water, heating, and telecom systems that lack modern remote monitoring, predictive alerts, or robust cybersecurity. When these systems fail, clinics close unexpectedly, telehealth visits are cancelled, vaccines and medications are compromised, and patients are transferred for non clinical reasons because local sites cannot safely operate. These disruptions directly undermine Initiative Health Care Access by limiting timely, integrated primary and specialty care by interrupting routine prevention and chronic disease management. At the same time, rural health employers struggle to recruit and retain staff due in part to unpredictable working conditions. This contributes to persistent provider shortages and reduced service hours in high need communities. There is a clear opportunity to apply proven industrial SCADA and control technologies—already standard in critical infrastructure—to health serving facilities so that clinics, telehealth nodes, and community wellness spaces can operate more reliably and efficiently. By pairing resilient remote monitoring with targeted workforce supports, the project can reduce downtime, protect clinical assets, and stabilize the workforce, thereby advancing RHTP goals for expanded access, stronger community based prevention, and more sustainable rural health systems.	The project deploys Structure's cloud-enabled, edge-capable SCADA platform to monitor and manage critical infrastructure at rural clinics and regional hubs in a multi-community hub-and-spoke model, initially prioritizing confirmed partners Yakutat Health Clinic and Chignik community health clinic with Juneau, Sitka, Wrangell, ANTHC in discussion and SEARHC arranging discussion. Key technical components include: Unified real-time dashboards integrating power, generators, HVAC, water, refrigeration, and connectivity status across participating health facilities. Edge controllers maintaining autonomous safe modes during connectivity loss, with store-and-forward telemetry ensuring no data gaps when links restore. Configurable alerts and automated routines (load shedding, generator start, temperature adjustments) preventing outages from escalating into clinic closures or cold-chain failures. Integration modules linking infrastructure telemetry with scheduling and telehealth platforms to proactively reroute appointments when site capacity drops. A Juneau/Sitka-based remote operations center provides 24/7 monitoring, alert triage, and field response coordination, reducing mean time to detection and resolution. Local staff, including tribal health and municipal partners, receive role-based training, SOPs, and ongoing coaching so communities manage daily operations while relying on Structure for higher-tier support. To reinforce Health Care Access, the project prioritizes sites where improved reliability directly increases primary, behavioral, and dental care availability and supports telehealth connections to regional specialists. To advance Healthy Communities, the project coordinates with local public health organizations so reliable power, water, and climate control support prevention programs, chronic disease management, and community wellness activities in clinic and shared spaces. Where Structure is employer or formal partner, the project pilots employer-provided healthcare and subsidized childcare for operations staff. Throughout the 18-24 month pilot, the team tracks uptime, appointment continuity, telehealth usage, workforce retention, and community indicators to refine automation, training, and benefit models before scaling.	\$1M-\$5M	Statewide	Bristol Bay Borough; Juneau (City and Borough); Sitka (City and Borough); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Structured Communication Systems, Inc.	(AK) Rural Health Transformation Program	OR	Alaska-Specific Design Principles • Consider edge-first architecture: local cache, store-and-forward, and graceful offline operation. • Lean staffing: automate, standardize, and centralize where possible; keep local workflows simple. • Sovereignty by design: embed consent, data-use governance, and auditability in all systems. • Cyber as a clinical safety risk: treat cybersecurity events as patient-safety events. • Urban–Rural interconnectivity as a design norm: ensure core systems, monitoring, and specialty consult platforms can extend seamlessly between Alaska’s hub cities (Anchorage, Fairbanks, Juneau) and rural/tribal sites. • Funding harmonization: align with federal Telecommunications and HCF programs, including consortium models that enable cost-effective scaling. • Dedicated/symmetric performance guarantee: design networks to deliver consistent, predictable performance with symmetric upload/download speeds to support telehealth, imaging, and cloud-based health records.	Alaska’s Rural Health Transformation Cybersecurity and EHR Management Overview Alaska’s rural and Tribal health providers face extraordinary barriers in maintaining secure, resilient, and interoperable health IT systems. Without intentional investment, Alaska’s rural and Tribal health providers remain at high risk of cyberattacks, system outages, and data silos that undermine patient care. A comprehensive Rural Health Transformation Cybersecurity and EHR Management initiative would harmonize with the FCC’s RHC program funding. Effective harmonization would further the following: • Reduce health disparities by ensuring secure, reliable data flows. • Safeguard patient privacy and clinical records. • Build resilient networks capable of supporting advanced telehealth. • Empower communities through shared governance and consortium-driven cost savings. By strengthening cybersecurity, EHR interoperability, and network resilience, Alaska’s Rural Health Transformation initiative will not only improve access and outcomes but also drive down healthcare costs across the system, primarily through remote patient monitoring, tele-imaging tele-stroke, avoided medevacs, fewer hospitalizations, reduced duplication of services, and shared IT efficiencies.	Under \$50,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Stryker Medical	Advancing Breast Health Programs	CA	Access to breast health can be difficult in small communities, especially when it comes to surgical procedures. Using MOLLI, a wire free tumor localization platform, and SPY PHI, a real time lymphatic mapping and perfusion assessment tool, patients can have access to innovative, reliable care within their community. SPY technology can also be used in a wide range of surgical procedures to assess perfusion which makes it a perfect fit in smaller hospitals when other resources may be limited.	The approach is to combine MOLLI and SPY PHI Technology to make breast surgery more accessible and easier for patients. MOLLI is a wire free soft tissue localization device used commonly in lumpectomies to identify lesions. Unlike current systems, MOLLI will not break, deactivate and is detectable even with calcifications and hematomas that correct technologies get interference from. MOLLI's user interface is simple with 3D directionality to guide surgeons to their lesion in real time for removal. This simple device will allow confidence in surgical teams to use wire-free technologies safely and effectively. Using SPY Technology for lymphatic mapping in breast cases allows surgeons to visualize lymphatic mapping in real time for sentinel node identification. There are many barriers in current methods including scheduling conflicts or accessibility issues with nuclear medicine, and allergic reactions with other dyes. SPY addresses these barriers and is research backed. Furthermore, in addition to lymphatic mapping, SPY technology also offers perfusion assessment which supports majority of other surgical services.	\$50,000-\$250,000	Statewide	Anchorage (Municipality); Denali Borough; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Matanuska-Susitna Borough; Sitka (City and Borough); Southeast Fairbanks Census Area	Deferred or Not Advanced

Sunrise Community Living	Alaska IDD Complex Needs Resource Center	AK	Alaska faces a significant shortage of services for individuals with intellectual and developmental disabilities (IDD) who have high acuity medical or behavioral support needs. Many communities lack the workforce, facilities, and stabilization resources required to safely support individuals when care needs increase. When providers cannot stabilize situations locally, individuals may experience emergency placements, hospitalizations, or disruptive relocations away from their home communities. These disruptions are especially challenging for individuals living in rural or remote regions where provider capacity is limited and specialized supports are difficult to access. Alaska currently serves more than 2,300 individuals through the IDD waiver system, and providers frequently report limited ability to support individuals with dual diagnosis behavioral health conditions or higher medical acuity. Without access to stabilization resources and trained staff, providers often have few options when needs escalate. This project addresses an opportunity to strengthen Alaska’s community-based care system by expanding stabilization capacity, improving provider coordination, and increasing workforce training focused on complex IDD care. Expanding these resources will help providers maintain services locally, reduce disruptions, and allow individuals to remain connected to their families and communities whenever possible.	Sunrise Community Living proposes development of a regional stabilization and service hub designed to expand Alaska’s capacity to support individuals with complex intellectual and developmental disability (IDD) needs while strengthening the statewide provider network serving rural communities. The project renovates an existing commercial or institutional facility in Anchorage to establish a center providing residential services, stabilization placements, workforce training, and provider consultation. Sunrise Community Living is evaluating facilities suitable for renovation. Using an existing structure reduces development timelines and allows services to launch faster than new construction. The center supports residential pods serving Medicaid HCBS waiver recipients with intellectual and developmental disabilities whose needs exceed what traditional community residential programs can safely support. The facility provides capacity for up to 24 residents through specialized six-bedroom pods serving individuals with high acuity needs, individuals with co-occurring IDD and behavioral health conditions, and short-term stabilization placements for providers or families managing complex situations. The stabilization component allows individuals from rural communities to receive short-term support when service disruptions occur or when additional clinical coordination is required. These placements support stabilization, assessment, and care planning that allows safe return to services within the individual’s home community whenever possible. This approach helps prevent unnecessary hospitalizations, out-of-state placements, and loss of residential capacity within rural communities. The center also strengthens Alaska’s rural provider network through workforce development and provider consultation. Training space supports high-acuity care training for direct support professionals, rural providers, and community partners. Telehealth consultation and coordinated care planning allow rural providers to access guidance and stabilization resources when complex situations arise. By combining residential stabilization services, workforce development, and provider support within a single hub, this project expands statewide service capacity while strengthening Alaska’s community-based care system and improving access for rural Alaskans.	\$1M-\$5M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Sunrise Community Living	Alaska IDD Rural Clinical Consultation and Stabilization Support Network	AK	Across Alaska, providers supporting people with intellectual and developmental disabilities (IDD) frequently encounter complex behavioral health (BH) and medical situations without access to specialized clinical consultation or stabilization resources. This challenge is especially acute in rural and remote communities where providers operate small programs with limited access to clinicians experienced in high-acuity IDD care. When complex situations arise, providers may struggle to stabilize people locally. Without timely consultation and coordinated stabilization support, situations can escalate to ER visits, service disruption, or relocation outside the person’s home community. While Alaska has strong community services, the system lacks a coordinated statewide mechanism allowing providers to quickly access specialized expertise when complex situations occur. This gap strains rural providers and contributes to avoidable hospitalizations, provider burnout, and loss of residential capacity in rural communities. This project strengthens Alaska’s IDD service system by creating a statewide consultation and stabilization support network that allows rural providers to access specialized guidance and coordinated stabilization resources when complex situations arise. Expanding access to clinical expertise and crisis coordination helps providers maintain services locally and improve continuity of care for people with complex needs.	Sunrise Community Living proposes development of a statewide clinical consultation and stabilization support network designed to strengthen Alaska’s ability to support people with intellectual and developmental disabilities (IDD), particularly in rural and remote communities where access to specialized clinical expertise is limited. The program will establish a coordinated consultation network connecting rural providers with clinicians experienced in high-acuity IDD care and co-occurring behavioral health (BH) conditions. Through secure teleconsultation services, providers will be able to request timely guidance when complex situations arise, including behavioral escalation, medication coordination, and crisis response planning. Consultation services will assist providers with stabilization strategies, care planning, and identification of appropriate interventions that allow individuals to remain safely supported within their home communities whenever possible. When situations require support beyond local capacity, the network will assist providers in coordinating stabilization resources and transition planning so individuals can safely return to services in their home region following stabilization. In addition to real-time consultation, the program will provide scheduled case consultation sessions and technical assistance focused on high-acuity IDD and IDD/BH populations. These activities will help providers strengthen internal capacity to manage complex situations and improve long-term service stability within rural communities. The consultation network will also serve as a coordination and learning resource for Alaska’s IDD provider system. Program data and case experience will help identify recurring service challenges, support provider collaboration, and inform improvements in stabilization planning across the provider network. By combining real-time consultation, stabilization coordination, and ongoing provider support, this project expands access to specialized expertise while strengthening the statewide IDD service system serving rural Alaska. Earlier access to clinical expertise can help providers intervene sooner when complex needs emerge, reducing avoidable hospitalizations, preventing service disruption, and helping individuals remain safely supported within community-based settings.	\$1M-\$5M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Sunrise Community Living	Alaska IDD Workforce Training and Provider Capacity Initiative	AK	Alaska faces a growing workforce challenge in supporting individuals with intellectual and developmental disabilities (IDD) who have high-acuity medical or behavioral support needs. Many providers, especially in rural and remote communities, lack access to specialized training needed to safely support individuals with complex needs. As a result, providers may struggle when care needs escalate. Individuals with complex needs can experience service disruption, hospitalization, or relocation away from their home communities when local providers lack the training or support needed to stabilize situations safely. Alaska currently has more than 2,300 individuals receiving IDD waiver services, and providers across the state report limited ability to support individuals with dual diagnosis behavioral health conditions or high medical acuity. Alaska benefits from foundational workforce programs, but providers serving high-acuity IDD populations often need more specialized training and consultation than existing programs typically provide. This creates an opportunity to strengthen Alaska’s community-based care system by expanding specialized workforce training, provider consultation, and technical support so rural providers can safely support individuals with complex needs within their home communities whenever possible.	Sunrise Community Living proposes development of a statewide workforce training and provider support initiative designed to strengthen Alaska’s capacity to serve individuals with intellectual and developmental disabilities (IDD) who have complex behavioral health or medical needs. The project will establish specialized training, consultation, and technical assistance focused on high-acuity IDD care and co-occurring behavioral health conditions. Training programs will provide direct support professionals and provider organizations with practical skills in crisis stabilization, behavioral support strategies, trauma-informed care, and safe response practices for individuals with complex needs. Training will be delivered through a combination of in-person instruction, remote learning, and teleconsultation so providers in rural and remote communities can participate regardless of location. This model allows providers across Alaska to access specialized workforce development that is often difficult to obtain due to geographic distance and limited local training infrastructure. The initiative will operate as a shared training resource available to provider agencies, direct support professionals, and community partners statewide. In addition to structured training programs, the project will offer consultation and technical support that allows providers to receive guidance when complex situations arise. Access to expert consultation and practical training helps providers stabilize situations locally and maintain services within community settings. This project complements Alaska’s existing workforce development efforts by expanding specialized training resources focused specifically on high-acuity IDD and IDD/behavioral health support. By strengthening workforce skills and expanding access to consultation, providers will be better equipped to safely support individuals with complex needs within their communities. Over time, this approach strengthens Alaska’s provider network, improves workforce retention, and expands the number of providers capable of safely supporting individuals with higher needs. The result is a more stable community-based service system that improves care continuity and helps individuals remain connected to their families and communities across Alaska.	\$250K-\$1M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Sunrise Community Living	Alaska Rural IDD Residential Capacity and Community Readiness Initiative	AK	Across Alaska, individuals with intellectual and developmental disabilities (IDD) living in rural communities often have limited access to residential support options when family or informal care arrangements change. While small community-based residential programs could meet these needs in many locations, providers frequently lack the information necessary to determine whether expansion into rural communities is feasible. Key factors such as local demand, workforce availability, community support, and housing suitability vary significantly across Alaska’s rural communities. Without a coordinated process to assess these factors, providers face substantial uncertainty when considering rural expansion. This uncertainty can prevent development of residential services even in communities where they may be viable. This project addresses the opportunity to strengthen Alaska’s IDD service system by conducting a statewide assessment of rural communities to determine where residential programs could be successfully developed. By identifying communities with the highest readiness for residential services, the project will reduce risk for providers and help guide future investments that expand community-based care options for individuals with IDD across rural Alaska.	This project will establish a structured statewide process for evaluating rural communities in Alaska to determine where small residential programs serving individuals with intellectual and developmental disabilities (IDD) could be successfully developed. The initiative will begin with statewide data review and consultation with service coordinators, providers, and state agencies to identify rural communities where individuals may benefit from additional residential service options. These findings will guide targeted outreach and community engagement. A project manager will coordinate community-level assessments across multiple regions of the state. Engagement will include discussions with families, providers, tribal organizations, and local government leaders to evaluate demand for residential services and assess community readiness to support them. Site assessments will evaluate potential housing options, renovation feasibility, infrastructure considerations, and estimated development costs. The project will also assess workforce considerations and potential partnerships that could contribute to long-term service sustainability. Information gathered through these assessments will be used to develop a statewide rural residential capacity roadmap. Communities will be evaluated based on factors including demonstrated service demand, community support, housing feasibility, workforce availability, and estimated development costs. The final roadmap will identify communities with the highest probability of successfully supporting small residential programs. This work will complement broader efforts to strengthen Alaska’s IDD service system, including stabilization resources that allow individuals with complex needs to receive short-term support and return safely to services within their home region. By reducing uncertainty and providing clear feasibility data, the project will strengthen Alaska’s ability to expand residential services in locations where they can be sustainable and responsive to community needs. The final roadmap will also provide implementation guidance that allows providers, tribal organizations, and state agencies to prioritize future rural residential development in communities where services can be successfully sustained.	\$250K-\$1M	Home- and community-based services provider	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Sunshine Community Health Center	Mat-Su Rural Teaching Health Center: Family Medicine Residency Program Development	AK	Alaska faces a physician workforce crisis conventional recruitment cannot solve, ranking last nationally in residency training slots per capita with an over-reliance on out of state recruitment with high turn over. The Mat-Su Valley experiences persistent primary care physician shortages, high turnover, reliance on locum tenens staffing, and growing unmet demand for primary care. Workforce gaps constrain every other aspect of rural health transformation. Access expansion, chronic disease management, behavioral health integration, maternal-child health, and value-based care models all require a stable, skilled physician workforce. Without a structural solution, Alaska will continue to see physician turn-over that undermines transformation investments. The opportunity is to build a permanent physician workforce pipeline for rural Alaska through a community-based Teaching Health Center residency program. Evidence consistently demonstrates that physicians who complete residency in a community are far more likely to remain in that community to practice. A Mat-Su-based Family Medicine residency, embedded in the FQHC and community settings where rural Alaskans receive care, will create a self-sustaining workforce infrastructure. RHTP funding for the development and early clinical ramp-up phase is the catalytic investment that launches this pipeline. Once operational, the program is designed to be fully financially sustainable through federal GME funding and clinical revenue.	SCHC will develop a new Rural Teaching Health Center Family Medicine residency program through a sequenced, accreditation-driven process governed by Accreditation Council for Graduate Medical Education (ACGME) requirements. RHTP funding supports the essential development-phase work and early clinical ramp-up that must occur before a single resident can be recruited or trained. Months 1–6, Development Foundation (Apr–Sep 26): Foundational development launched with contracted Program Director and Residency Manager, begin ACGME Sponsoring Institution accreditation, initiate curriculum development, establish the Graduate Medical Education Council, and begin training site identification. Program Development Consultant provides accreditation technical assistance and project management throughout. Months 7–12, Accreditation and Leadership Build (Oct 2026–Mar 27): Program Director and Residency Manager transition to permanent employment. ACGME accreditation process advances. Curriculum framework finalized. Training site agreements developed with partners. DIO provides institutional oversight. Financial systems support ensures GME-ready fiscal infrastructure. Months 13–18, Clinical Ramp-Up and Faculty Launch (Apr–Sep 27): 2 core faculty physicians hired and begin establishing continuity clinics. Clinic support staff hired. Faculty clinics begin generating clinical revenue, with productivity ramping through the period. Residency program application submitted to ACGME. Clinical readiness coordination aligned with facility development being led by the Mat-Su Health Foundation. Post-RHTP Period, Residents and Full Sustainability: First resident class begins Jul 1, 29. Federal Teaching Health Center/CMS funding begins. By Year 5, program reaches full operational complement with full financial sustainability achieved through combined federal GME funding and clinical revenue. The curriculum will emphasize community-based care, cultural competency, use of technology, and specific clinical skills necessary for rural Alaska practice, including broad-scope family medicine, behavioral health integration, prenatal and pediatric care, chronic disease management, and emergency stabilization. The program is being developed as a community-based partnership with Mat-Su Health Foundation (facility development), Mat-Su Health Services, Southcentral Foundation, and Mat-Su RMC, each with a defined role and a seat on the program’s Graduate Medical Education Council (GMEC).	\$1M-\$5M	Federally qualified health center	Statewide	Matanuska-Susitna Borough	Advance to Implementation Application

Sunshine Community Health Center	RN Care Management Billing Innovation & Outcomes Analytics Infrastructure	AK	Rural health system sustainability in Alaska requires structural transformation, not incremental change. SCHC communities face high chronic disease burden, limited specialty access that drives avoidable escalation and transfers, workforce shortages that require team-based care at top of license, growing pressure to demonstrate outcomes under value-based contracts, and persistent crisis-driven utilization patterns that increase cost without improving health. As Alaska shifts toward value-based care, rural providers must have infrastructure to coordinate care proactively, secure reimbursement for care management, measure outcomes and cost avoidance, and sustain models beyond grant funding. SCHC’s RN care managers currently deliver essential coordination—managing high-risk patients, preventing hospitalizations, and coordinating specialty care—but there are no reliable reimbursement pathways to sustain this work. At the same time, SCHC lacks the population health analytics needed to stratify risk, track value-based performance, and demonstrate the financial impact of care coordination. This project addresses a foundational gap: building the payment and data infrastructure needed to sustain SCHC’s broader RHTP transformation investments beyond the grant period. Without durable reimbursement mechanisms and measurement capacity, clinical expansions funded by RHTP cannot persist.	SCHC proposes a 3-phase Pay for Value initiative designed to build sustainable rural value-based care infrastructure over the full RHTP funding horizon. This LOI covers Phase 1 (through Sep 2027), which establishes the analytics and documentation foundation. Phases 2 and 3 will be submitted as separate LOIs in future cycles. 3-Phase Overview: Phase 1 (this LOI, through Sep 2027): Build analytics infrastructure and care management documentation systems. Begin capturing data. Phase 2 (Oct 2027 – Sep 2029): Produce comprehensive business case, conduct formal payer engagement, and initiate pilot billing arrangements. Phase 3 (Oct 2029 - Sep 2031): Execute full billing pilot, validate reimbursement model, and produce replicable framework for Alaska rural providers. Phase 1 Detail—Foundation (18 months, this LOI): Component A: Outcomes Analytics and Population Health Infrastructure (Months 1–12): SCHC will build the data foundation for value-based care by deploying pop health analytics and risk stratification tools. This includes implementing risk stratification to identify and prioritize high-risk/high-utilizer patients, building integrated dashboards aligned with RHTP metrics and value-based performance indicators, automating data aggregation to reduce manual reporting burden, and strengthening interoperability across SCHC’s clinical systems. This infrastructure will serve as the measurement backbone for all RHTP investments. Component B: RN Care Management (CM) Documentation and Activity Capture (Months 3–15): SCHC will implement standardized systems to document and quantify RN CM activities that currently go untracked. This includes establishing structured documentation workflows that capture every coordination touch, patient outreach, care plan development, specialist coordination, post-discharge follow-up, and crisis prevention. It also includes building activity volume and time-tracking data to quantify CM work, and linking activities to patient outcomes through the analytics infrastructure. Component C: Baseline Data Collection and Preliminary Analysis (Months 6–18):, Collect 12 months of structured baseline data on CM activities, patient outcomes, utilization patterns, and preliminary cost trends using the analytics infrastructure and documentation systems. By Sep 2027, SCHC will produce a baseline data report and a preliminary landscape analysis of existing CM billing codes identifying reimbursement gaps specific to SCHC’s rural care management model.	\$50,000-\$250,000	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Sunshine Community Health Center	Rural/Frontier Access & Outreach, Stabilization, Workforce Advancement, & Oral Health Modernization	AK	SCHC’s service area experiences high reliance on emergency transport and costly transfers for conditions that could be managed locally with appropriate diagnostic, stabilization, and in-home intervention tools. Patients travel long distances to access specialty services including ophthalmology, wound care, and advanced dental care. Limited local tools for assessment and acute events mean that conditions requiring rapid evaluation often result in expensive transfers to Wasilla or Anchorage rather than lower-cost local treatment. Specific access gaps include: no point-of-care laboratory testing capability for rapid diagnostics and lab spaces designed for specimen collection rather than expanded on-site testing; staff lacking training in portable ultrasound equipment; diabetic retinal screening availability limited to once per month; limited wound care specialty service, increasing risk for hospitalizations; aging dental diagnostic and fabrication infrastructure that requires patient travel for crowns; and no ability to physically reach patients in roadless communities, leaving the most isolated, highest-risk patients without access to in-home care. These gaps create avoidable costs, unnecessary patient burden, and preventable health deterioration. This project addresses the opportunity to build comprehensive treat-in-place capacity, frontier outreach infrastructure, local specialty access, modern dental services, and the trained workforce to operate every new service line.	Expand essential services through 8 coordinated investments: 1. Rural Diagnostic Expansion: Expand on-site diagnostics through lab remodels and purchase of rapid diagnostic tools to enable point-of-care testing for real-time decision making. 2. Portable Ultrasound Training: Provide training so providers can perform bedside ultrasound-guided evaluations utilizing SCHC’s current ultrasound equipment. 3. Specialty Access Expansion - Diabetic Retinal Screening: AI-enabled retinal screening integrated into routine visits so patients can be screened on any clinic day to improve early detection and prevent vision loss. Funding covers the first-year subscription while SCHC builds screening volume for sustainability. 4. Rural Specialty Service Line - Wound Care Program: Establish a wound care program focused on chronic diabetic wounds to prevent amputations and reduce hospitalizations. Investments include specialized clinical training, advanced wound therapy tools, and care tracking infrastructure. 5. Rural In-Home Care Access - Mobile Integrated Health Vehicle: Purchase a Toyota 4Runner to expand MIH services across the remote service area. This will facilitate in-home care for chronic disease management, post-discharge follow-up, high-risk patient stabilization, and preventive intervention to reduce emergency department and hospital admissions. 6. Frontier Access for Roadless Residents - SHERP AT Vehicle: Acquire a SHERP AT vehicle for year-round access to patients in Upper Su’s roadless frontier communities, enabling outreach to isolated patients managing chronic disease, recovering from hospitalization, or at risk of acute deterioration.. 7. Clinical Workforce Advancement and Top-of-License Training: Strengthen workforce capacity through diabetes education certification for 6 nurses, mentorship for new MAs and nurses, and top-of-license training for RNs, LPNs, and MAs in wound care, telehealth protocols, chronic disease management, and clinical stabilization. Wellness coaching and nutrition training will expand preventive care capacity. 8. Oral Health Access Modernization: Modernize dental services using 4 investments: • A 3D panoramic X-ray system with training to eliminate patient travel for cone beam scans; Intraoral scanners for crowns, bridges, and dentures; Advanced prophylaxis equipment with certification training for hygienists; Chairside 3D printers enabling same-day fabrication of crowns and dental appliances to reduce reliance on external providers.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Advance to Implementation Application

Sunshine Community Health Center	Cybersecurity, Connectivity Resiliency, Clinical Workflow Modernization, & Teleconsult Partnerships	AK	Rural health transformation in Alaska cannot occur without secure, resilient, and interoperable digital infrastructure. SCHC’s rural communities face frequent connectivity disruptions due to weather and infrastructure instability, cybersecurity threats that jeopardize continuity of care, limited internal IT capacity, provider administrative burden, specialty access gaps requiring tele-enabled support models, and increasing expectations for interoperability, reporting, and digital accountability. Every other RHTP priority - expanded clinical access, maternal-child tele-specialty, remote patient monitoring, value-based analytics, patient engagement platforms - depends on secure, reliable digital infrastructure. Without modern cybersecurity, connectivity resiliency, and innovation-enabled workflows, SCHC cannot safely expand telehealth, manage data-driven care models, or sustain transformation investments. A single cybersecurity incident could compromise patient data and halt clinical operations across multiple sites. Provider burnout from documentation burden undermines workforce retention. And every new software platform SCHC deploys through RHTP increases the computational demands on end-user hardware that is already aging, creating bottlenecks at the point of care delivery that undermine the full portfolio investment. This project addresses the foundational opportunity to build the digital backbone that supports and protects every other RHTP transformation investment.	SCHC proposes a cohesive Spark Technology initiative modernizing rural digital infrastructure through four integrated investment workstreams organized by priority: 1. Cybersecurity and Access Security: SCHC will implement centralized cybersecurity monitoring through a SOC/SIEM platform providing continuous threat detection, alerting, and incident response across all systems. A single ransomware attack on a rural FQHC can shut down care for an entire region. SCHC will also deploy comprehensive identity and access management including universal MFA, conditional access, role-based provisioning, and fully automated account lifecycle management — ensuring new hires receive appropriate access immediately and departing staff lose access completely without manual intervention. 2. Compliance Automation and Independent Security Testing: SCHC will implement the Drata compliance management platform, retain EdenData as ongoing compliance consultants, and conduct regular third-party penetration testing. This replaces manual evidence collection and reactive audit preparation with repeatable, sustainable compliance processes while providing independent validation that RHTP-funded cybersecurity investments function as designed. 3. Internet and Telephony Resiliency: SCHC will deploy Starlink failover internet at both clinic sites and migrate to SIP trunk telephony with session border controller infrastructure. Starlink ensures clinical operations continue during connectivity outages common in rural Alaska. SIP/SBC migration ensures patients can reliably reach care. SCHC will also engage a network consultant to validate the existing Ubiquiti deployment following an incomplete Cisco transition, ensuring the foundation is sound before layering additional RHTP-funded investments. 4. Clinical Workstation Modernization: (Phased: 3 RHTP Cycles) SCHC will replace approximately 50 laptops and 5 docking stations per RHTP cycle across its 150-unit fleet, prioritizing staff operating the most demanding RHTP-funded platforms. Every RHTP technology investment increases computational demands on end-user hardware; deploying advanced software on outdated hardware creates bottlenecks that undermine the full portfolio investment. Modern workstations also position SCHC for emerging AI capabilities that will deliver enhanced clinical decision support, automated workflow optimization, and operational efficiencies that produce measurable time savings and cost reduction.	\$250K-\$1M	Federally qualified health center	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Sunshine Station Childcare Center	Closing the Gap: Final Funding for a New Rural Daycare Facility	AK	Rural communities across Alaska face a significant shortage of licensed childcare, limiting opportunities for families to live and work in these communities. Our current licensed daycare facility can serve a maximum of 26 children, which does not meet the growing demand from families in our area. Many parents face long waitlists or are unable to secure childcare at all, creating barriers to maintaining employment, accessing healthcare services, and supporting their families. Our organization has secured \$4.5 million in federal funding through the office of Lisa Murkowski to build a new childcare facility that will better serve our growing rural community. However, an additional \$2 million is still needed before construction can begin and the project can be completed. The new building will include four classrooms and a multipurpose room and will allow us to increase our capacity from 26 children to approximately 60. As a licensed childcare provider, we are also able to accept Child Care Assistance, allowing us to serve families across a wide range of income levels. Completing this project represents an important opportunity to expand access to reliable childcare in our rural community. By increasing capacity and maintaining a licensed program that accepts Child Care Assistance, we will be able to support more working families, create additional local jobs, and provide a safe, nurturing environment where children can learn and grow.	Our approach is to expand access to licensed childcare in our rural community by constructing a new childcare facility designed to meet the growing needs of local families. Our organization has secured \$4.5 million in federal funding through the office of Lisa Murkowski to support the development of this project. To move forward with construction and complete the facility, we are seeking an additional \$2 million in funding. The new facility will include four classrooms and a multipurpose room and will allow us to increase our capacity from 26 children to approximately 60. This expanded space will enable us to serve more families while maintaining a safe, structured, and high-quality environment that supports early childhood development and family stability. As a licensed childcare provider, we will continue to accept Child Care Assistance, ensuring that families across a range of income levels are able to access care. This approach supports working families by providing reliable childcare, allowing parents to maintain employment, pursue education, and access healthcare services when needed. Expanding our childcare capacity will also allow us to hire additional qualified staff, strengthening the early childhood workforce in our rural community. By creating a larger, stable childcare program that serves more families regardless of income, this project supports the goals of rural health improvement by promoting family stability, reducing stress for working parents, and ensuring children have access to a safe and supportive environment during critical stages of development.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Sunshine Station Childcare Center	Nutritional Sustainability	AK	Rural communities face significant barriers to accessing affordable, nutritious food. Rising food costs and the additional expense of transporting groceries from create ongoing challenges that are often more costly. Due to these barriers we often struggle to consistently provide fresh, healthy food. This project addresses the opportunity to strengthen food sustainability by alleviating the burden on our small, non-profit daycare. Funding would allow reliable food purchasing strategies and partnerships that reduce transportation burdens. SSCCC will be able to ensure that children in our care receive balanced, nutritious meals and families know they have a reliable food security option for their children while in our care. Establishing positive eating habits at a young age helps children develop lifelong healthy behaviors. By investing in sustainable nutrition for young children today, this project contributes to building a healthier future for families and the Upper Susitna community.	Our approach focuses on ensuring consistent access to nutritious foods while teaching young children healthy eating habits during their early developmental years. As the only licensed daycare in our community, we have a unique opportunity to positively influence children’s relationship with food and nutrition at a critical stage of growth. Our program will also engage families by sharing information about healthy eating and meal ideas that can be used at home, helping extend healthy habits beyond the daycare setting. By supporting both children and families, we aim to create lasting changes in eating patterns that promote long-term health and healthy relationships with food. Grant funding will support sustainable food purchasing practices and strategic ordering to reduce transportation costs and supply disruptions. These improvements will help ensure that healthy foods such as fresh fruits, vegetables, whole grains, and balanced proteins are consistently available for the children in our care.	Under \$50,000	Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Sunshine Station Childcare Center	Supporting Rural Families with Childcare Tuition Assistance	AK	Rural families in Alaska face significant barriers to accessing reliable, high-quality childcare. While our licensed daycare accepts Child Care Assistance, families are often responsible for covering the remaining tuition costs, which can make childcare unaffordable for many households. This financial gap can limit access to care, leaving parents without reliable childcare and creating challenges for maintaining employment, attending school, or accessing healthcare services. This project addresses the opportunity to expand access to childcare by providing tuition assistance for families who would otherwise be priced out of care. By reducing financial barriers, we can ensure that children have consistent, nurturing, and developmentally appropriate care, while parents can maintain stable employment and support household health. This approach strengthens both family stability and the sustainability of our childcare program in our rural community.	Our approach is to provide tuition assistance to families who struggle to cover the portion of childcare costs not covered by Child Care Assistance. By offering this support, we reduce financial barriers that might otherwise prevent children from accessing licensed, high-quality care. Families will apply for tuition assistance through a simple, equitable process, ensuring that funds are distributed based on need. This support allows children to maintain consistent enrollment, which is critical for early childhood development, including emotional regulation, social skills, and learning outcomes. Providing tuition assistance also strengthens workforce stability and family well-being. Parents can continue working, attending school, or accessing healthcare services without the stress of unaffordable childcare costs. By reducing financial stress for families and supporting consistent enrollment, this project promotes a sustainable, reliable childcare program that benefits children, parents, and the broader rural community	Under \$50,000		Single Community	Matanuska-Susitna Borough	Deferred or Not Advanced

Sunshine Station Childcare Center	Sustaining Quality Childcare Through Staff Retention and Compensation Support	AK	Rural childcare providers face significant challenges in recruiting and retaining qualified staff due to high living costs, limited workforce availability, and wages that often do not reflect the true cost of living in rural Alaska. We can not raise wages without raising tuition which would likely price many families out of childcare altogether. These challenges can lead to high staff turnover, which affects the stability and quality of care that young children need during critical stages of development. For our small, nonprofit daycare, maintaining a consistent and experienced staff is essential to providing a safe, nurturing, and high-quality environment for the children and families in our care. However, without the ability to offer livable wages, it can be difficult to retain skilled, trained and dedicated caregivers who are committed to long-term employment. According to a recent THREAD convention, the average childcare provider stays in the field for less than 1.5 years primarily due to low wages. This project addresses the opportunity to strengthen community health by supporting livable wages for childcare staff, improving staff retention, and creating a more sustainable workforce. When caregivers are able to earn stable, fair wages, they experience improved financial security, reduced stress, and a higher quality of life. This contributes to a healthier, more resilient workforce that is better able to provide consistent, high-quality care for young children.	Our approach focuses on strengthening workforce stability in our rural childcare program by investing directly in staff retention through improved wages and compensation support. Funding from this project will be used to supplement staff salaries, helping our nonprofit daycare offer more competitive and livable wages that reflect the cost of living in rural Alaska. By improving wages, this project will reduce staff turnover and retain experienced caregivers who are trained, dedicated and understand the culture and mission of our daycare. Maintaining a stable team of caregivers allows children to build secure, trusting relationships with the adults who care for them each day. These stable relationships are essential for emotional well-being, healthy development, and positive early learning outcomes. This approach also supports the health of our caregivers and their families. When we are able to pay our staff comparable livable wages, they experience greater financial stability which reduces stress and improves quality of life. Supporting the well-being of caregivers strengthens the overall childcare culture and contributes to a healthier, more resilient community. In rural communities where childcare options are limited, dependable services allow parents to maintain employment, support their households, and access essential health and community resources. Through this approach, the project will support a vital infrastructure for our rural community. Creating stability, quality, and sustainability of childcare services will support the broader health and well-being of children, caregivers, and families in our rural community.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced
Sunshine Transit	Sunshine Transit	AK	Sunshine Transit is currently a public transit service that is limited by local funding match resources. With additional resources, we would be able to offer more services and expand service hours. Sunshine Transit is currently a certified Medicaid Transportation provider. The problem is that many residents that need help, do not have Medicaid coverage. Medicare does not cover transportation cost to healthcare appointments.	With additional funding sources, Sunshine Transit can expand services. We currently operate 27 transit vehicles and have the opportunity to purchase 10 more within the next year through a 5339 Bus & Bus Facilities grant from AK DOT.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Matanuska-Susitna Borough	Deferred or Not Advanced

Sunstar Clinical Virtual Behavioral Solutions, LLC	Connecting Alaska: 24/7 Behavioral Health Without Geographic Barriers	WA	Recent statewide assessments have detailed Alaska's unique health care challenges specific to the behavioral health crisis services continuum of care, the behavioral health crisis strain of Alaska' emergency departments, and limited access to acute behavioral health services, among others. Contributing factors related to Alaska's vast geography and adverse weather, community remoteness, workforce shortages, and high costs of care delivery are well known. Alaskan's living in rural, remote, or frontier communities face persistent inequities, including shortages of behavioral health providers, impaired access to emergency services, and fragmented care coordination across agencies. These barriers contribute to delayed crisis assessments and poorer patient outcomes for adults and youth. Our approach addresses long-standing gaps in emergent behavioral health access for Alaska's remote and rural medically underserved communities and populations, including Alaska Native peoples and youth, among others. Alaska's health care providers are actively seeking ways to better meet patient needs. For example, in 2024 we received an unsolicited inquiry from PeaceHealth Ketchikan Medical Center interested in expanding their behavioral health crisis assessment and stabilization services utilizing Sunstar's virtual model and services. Through RHTP's Spark Technology and Innovation Initiative, Sunstar has opportunity to strengthen Alaska's telehealth infrastructure and virtual care access.	By integrating virtual crisis assessment into existing emergency workflows, the project will improve access to timely behavioral health care, support overstretched rural providers, and create a scalable model that strengthens crisis response across Alaska’s geographically dispersed health systems. There will be implementation focus on rural and remote hospitals, tribal health organizations, and community clinics where psychiatric coverage is limited or unavailable and there is unmet need. Sunstar's approach ensures that patients in crisis receive timely, expert care while supporting hospital teams with specialized psychiatric assessments and recommendations. Better outcomes are realized for patients and providers alike. Our approach includes three strategies: expanding telehealth for emergent behavioral health assessments, strengthening partnerships with rural committees, health care providers, and tribal health organizations to co-design culturally responsive crisis systems, and investing in Alaska telehealth infrastructure development. Sunstar will intentionally prioritize collaboration with hospitals, health care providers, tribal health organizations, and regional partners to ensure culturally responsive care and alignment with existing crisis systems. Telehealth services will complement—rather than replace—local behavioral health resources, strengthening community-based capacity while extending access to specialized crisis clinicians. As an innovative healthcare organization created by clinicians, Sunstar has experience tailoring services to meet the needs of patients, partnering organizations, and communities. While we have a proven virtual emergency behavioral health assessment model with strong outcomes (i.e., measurable reductions in emergency department (ED) boarding, faster crisis evaluations, and fewer unnecessary interfacility transfers) validated in both urban and rural settings in the PNW, we recognize that intentionally adapting and scaling the model in consideration of Alaska's unique and varied operating environment is crucial. To effectively expand access to care while leveraging existing resources, we will pursue a phased approach that includes implementation planning and partnership development in year one and piloted implementation and evaluation by a third-party evaluator in year two. If successful, Sunstar would seek to expand its services and strengthen sustainability efforts during project years three through five.	\$50,000-\$250,000	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Susitna Women’s Health	Strengthening Rural Maternal Health Access Through Preconception, Prenatal, and Telehealth Services	AK	Alaska Native mothers experience significantly higher pregnancy-related acuity compared to the national average across multiple clinical domains. They are 13% more likely to develop intrahepatic cholestasis of pregnancy, three times more likely to have preexisting or gestational diabetes, three times more likely to experience hypertensive disorders of pregnancy, and four times more likely to experience postpartum hemorrhage. These disparities contribute to increased maternal morbidity and neonatal complications. These elevated risks are compounded by a critical shortage of specialized women’s health providers across Alaska, particularly in rural and frontier communities. Limited access to timely prenatal and preventive care results in prolonged wait times, delayed diagnosis and intervention, increased travel burden to Anchorage-based facilities, fragmented care coordination, and potentially avoidable emergency department visits and hospital admissions. This project addresses the opportunity to expand early, consistent, and locally accessible women’s health services through a hybrid in-person and telehealth model serving the Mat-Su region and surrounding rural communities. By increasing surveillance capacity, improving care coordination, and providing evidence-based management of high-risk conditions, this initiative aims to reduce preventable complications, strengthen continuity of care, and improve maternal and neonatal outcomes for Alaska Native and rural families.	This funding will enable Susitna Women’s Health to accelerate implementation of a hybrid care delivery model that expands access, strengthens early surveillance of pregnancy-related complications, reduces avoidable emergency department visits and hospital admissions, and improves maternal and neonatal outcomes across rural Alaska. The proposed investment represents a strategic use of RHTP funds to build sustainable clinical infrastructure that will continue serving Alaskan families beyond the grant period. The model emphasizes preventive well-woman care, access to contraception, preconception counseling, and early first-trimester entry into prenatal care to identify and manage high-risk conditions such as preexisting or gestational diabetes, hypertensive disorders of pregnancy, and intrahepatic cholestasis at earlier stages. Standardized, evidence-based clinical protocols will guide screening, monitoring, and escalation pathways to ensure timely intervention and coordinated multidisciplinary care when higher-acuity conditions are identified. Telehealth will be intentionally integrated to shorten appointment wait times, increase visit frequency for high-risk patients, provide timely follow-up between in-person visits, and reduce travel burden for rural and frontier families. By strengthening surveillance capacity, improving care coordination, and expanding access to specialized women’s health services closer to home, this initiative advances safer pregnancies, improved maternal and neonatal outcomes, and more sustainable health system utilization across Alaska’s rural communities.	\$250K-\$1M	Maternal health	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

SvoCo LLC	Aeromedical Access Assessment for Rural Southeast Alaska and NGO Feasibility Study	AK	Over the past several years, Southeast Alaska’s aeromedical transport landscape has experienced structural shifts in base distribution, aircraft platform configuration, and service coverage. Changes in fleet capabilities, particularly related to runway compatibility and operating models, may affect access dynamics for certain rural communities. Seasonal population fluctuations, increased visitor activity contribute to system demand. In Southeast Alaska, where communities are isolated, aeromedical transport is not a convenience but a necessity—often serving as the decisive factor in critical medical outcomes. Public reporting indicates continued reliance on rescue resources, including the USCG, for certain categories of patient transport. While these assets remain essential to regional safety, there has been no comprehensive regional analysis evaluating current patterns of aviation reliance, cost exposure, or structural vulnerabilities in the transport system. As a result, Southeast Alaska lacks consolidated, decision-grade data to assess how today’s aeromedical configuration compares to prior years, or to evaluate whether complementary civilian transport models could strengthen rural healthcare access. This project seeks to provide a structured, assessment of current aeromedical transport reliance in Southeast Alaska and to model feasible configurations that may enhance resilience and continuity of care and will evaluate an opportunity for an aeromedical NGO model.	This 4–6 month assessment will use a multi-source data collection and modeling framework to evaluate aeromedical transport reliance in Southeast Alaska. Timeline flexibility will account for data availability from participating organizations. Phase 1 – Data Aggregation & Access Mapping The project will request aggregated, de-identified operational data from aeromedical providers, hospital transfer reporting, and publicly available federal records. Data elements will include annual mission counts, origin communities, documented access limitations, reported delays or cancellations, and federal rescue activation frequency. Where datasets are incomplete, structured stakeholder interviews and public reporting will supplement analysis. Phase 2 – Transport Reliance & Trend Analysis Data will be categorized by community, access constraints, and mission characteristics to evaluate trends over the past 3–5 years. The analysis will identify high-dependency communities, runway compatibility considerations, and patterns of federal resource reliance. Phase 3 – Feasibility Modeling & Blueprint Development Using aggregated findings, the project will develop comparative modeling of the current transport configuration and a conceptual, mission-driven aeromedical nonprofit framework. Exploring the feasibility of a nonprofit air medical program allows for examination of whether a community-oriented, access-first model could enhance regional coverage, reduce strain on federal assets such as USCG medevac, and improve system-wide coordination without displacing existing providers. The blueprint will outline governance structure, aircraft capability assumptions, staffing framework, activation criteria, regulatory considerations, high-level financial projections, and risk analysis. This blueprint will serve as a decision-support tool rather than an implementation proposal. Phase 4 – Synthesis & Reporting Deliverables will include a Regional Transport Reliance Report, feasibility modeling, blueprint documentation, and structured decision-support materials for policymakers. The project will remain focused on regional systems resilience and long-term access stability.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Petersburg Borough; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough); Yakutat (City and Borough)	Deferred or Not Advanced

Talkspace Provider Network PA	Talkspace for Rural Alaska	NY	Many rural, remote, and frontier communities across Alaska face major barriers to timely behavioral health care. Geographic isolation, limited transportation infrastructure, severe weather, and ongoing workforce shortages make it difficult for residents to access consistent mental health services. In many areas, individuals must travel long distances—sometimes by plane or seasonal routes—to see a provider, delaying care or preventing it altogether. These challenges contribute to unmet behavioral health needs, delayed treatment, and added strain on local health systems, including emergency departments and primary care providers that may lack the capacity or specialized training to address complex mental health conditions. Demand for behavioral health services continues to rise, especially in rural communities where stigma, limited provider availability, and logistical barriers further reduce access. This project addresses the opportunity to expand access to high-quality behavioral health services through a scalable, technology-enabled model that connects individuals in rural and frontier communities with licensed clinicians regardless of location. By reducing travel barriers and expanding the available provider network, the project helps ensure residents can access timely mental health support while strengthening Alaska’s broader behavioral health infrastructure.	To address barriers to behavioral health access in Alaska’s rural, remote, and frontier communities, Talkspace proposes a virtual behavioral health program that enables residents to connect with licensed clinicians through a secure platform accessible by smartphone, tablet, or computer. Through the Talkspace platform, individuals can access therapy via asynchronous messaging and scheduled live video sessions, allowing them to engage in care in a flexible format that accommodates varying schedules, connectivity limitations, and comfort levels. This model removes the need for long-distance travel and allows residents to receive support privately from their own communities. Participants will be matched with licensed therapists through Talkspace’s QuickMatch™ algorithm, which pairs individuals with providers based on clinical needs, preferences, and therapist expertise. This process helps individuals begin care quickly—often within 24 hours—while expanding access beyond the limited pool of local providers available in many rural areas. Talkspace will support outreach and engagement in partnership with local health systems, community organizations, and regional stakeholders to help ensure residents are aware of and able to enroll in services. The platform also includes a library of self-guided mental health resources for individuals who may be hesitant to begin therapy immediately or who benefit from supplemental tools alongside clinician care. Clinical quality and outcomes will be monitored through Talkspace’s evidence-based care framework. Participants complete validated assessments such as PHQ-9 and GAD-7 at regular intervals to track symptom improvement, while Talkspace’s Quality Management program monitors provider performance, engagement trends, and satisfaction metrics. These insights support ongoing program evaluation and continuous improvement. Additionally, Talkspace’s AI-assisted suicide risk detection system, developed in collaboration with NYU Grossman School of Medicine, helps identify potential safety concerns in therapy communications so clinicians can intervene quickly and connect individuals with appropriate crisis resources when needed. By combining flexible virtual care delivery, evidence-based clinical oversight, and collaboration with local stakeholders, this project will expand access to timely behavioral health support and help ensure residents in rural and frontier communities can receive care regardless of geographic barriers.	\$250K-\$1M	Behavioral health/su bstance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Tanaina elemetary	Health, Education and Community focus grant	AK	Schools in Alaska often serve as critical access points for health services, family support, and educational stability. In semi-rural communities, these needs are often amplified as schools serve not only local students but also students who transition from more remote rural villages for educational opportunities. These transitions can create gaps in health care access, social supports, and educational resources. Our school community serves a diverse population of students, including those who have relocated from rural communities where access to healthcare and specialized educational supports may have been limited. When students transition into our school system, they may arrive with unmet health needs, limited winter clothing, and gaps in communication or literacy development due to disruptions in services or differences in available resources. Alaska’s unique geographic challenges and dispersed population have long contributed to barriers in accessing consistent healthcare services. Many families must travel significant distances to reach medical providers, and in some cases routine care is delayed or unavailable. Schools frequently become the first place where health concerns can be addressed. In addition our community needs support in communication and literacy development, particularly those who are adjusting to new learning, or due to disabilities ,environments or who require structured supports to build reading and writing skills.	This proposal seeks funding for a five-year initiative designed to strengthen student health services and provide essential supports that allow students to fully participate in school. The initiative focuses on three key areas: school-based healthcare access, essential clothing resources, and communication and literacy support tools.. School-Based Health Services Grant funding will support the presence of a qualified school nurse who can provide consistent, on-site health services for students. The school nurse will serve as a critical link between families, healthcare providers, and the school community. Key responsibilities will include: Addressing immediate health needs and minor injuries Monitoring chronic health conditions such as asthma, diabetes, and allergies Assisting with medication management Providing preventative health education Supporting students transitioning from rural communities who may not have established healthcare connections locally Coordinating care with families and healthcare providers Access to a school nurse helps ensure early identification of health concerns, reduces unnecessary emergency visits, and supports improved student attendance and readiness to learn. Essential Clothing and Basic Needs Support Funding will also support the creation of a school-based clothing resource that provides students with essential cold-weather gear when needed. Items will include: Winter coats Snow pants Gloves or mittens Hats	\$50,000- \$250,000	Other	Matanuska-Susitna Borough	Deferred or Not Advanced

	Warm socks
	Boots
	For many students, particularly those newly arriving from rural communities or experiencing economic hardship, access to warm clothing can make a significant difference in their ability to attend school regularly and participate fully in outdoor activities. Ensuring students have proper winter gear promotes physical health, emotional well-being, and inclusion in school activities. Communication and Literacy Support Tools The grant will also support the acquisition of tools that help students develop communication, reading, and writing skills. . Possible resources include: Communication supports and assistive technology
	Visual communication systems
	Literacy intervention materials
	Structured reading and writing supports
	Instructional tools for small-group learning
	These tools will help students strengthen foundational literacy skills while also building confidence in their ability to communicate and participate in the classroom.

Tanana Chiefs Conference	“Strong Traditions, Healthy Communities” Lifestyle and Preventive Medicine Initiative	AK	Alaska Native communities served by TCC experience disproportionately high chronic disease burdens: obesity affects 42% of adults (vs. 31% statewide), diabetes 11%, and metabolic-associated steatotic liver disease (MASLD) is a leading cause of liver morbidity. Preventive screening remains critically low—colorectal cancer screening near 48%, cervical cancer screening below 55% in remote villages. Geographic isolation across 27 villages spanning 235,000 square miles, combined with workforce shortages, high provider turnover, food insecurity, and transportation costs exceeding \$500 per round-trip visit, creates persistent barriers to preventive care. Current healthcare delivery prioritizes acute, episodic care over integrated prevention, delaying diagnosis and widening health disparities. This project addresses a critical opportunity to embed culturally grounded, evidence-based screening, risk assessment, and lifestyle medicine into clinical workflows across all TCC sites. By strengthening prevention infrastructure, TCC will improve early detection, increase preventive service utilization by 50%, build durable rural workforce capacity, and establish a scalable prevention-focused care framework aligned with Alaska’s Rural Health Transformation Program priorities.	This initiative integrates Lifestyle Medicine and Clinical Prevention across all TCC sites, embedding evidence-based screening, risk reduction, and culturally grounded intervention into clinical workflows. Year 1 establishes infrastructure and pilot implementation at hub clinics; Years 2-5 scale protocols to all 27 villages. Lifestyle Medicine addresses chronic disease through six pillars—nutrition, physical activity, risky substance avoidance, sleep, stress management, social connectedness—integrated with Alaska Native healing practices and traditional foods education. Intensive obesity and cardiometabolic risk reduction combines medical evaluation, team-based care, and structured follow-up. Dietitians provide subsistence nutrition counseling; group visits incorporate Elders' knowledge; care plans honor seasonal rhythms and land-based wellness. Clinical Prevention expands screening for colorectal cancer, cervical cancer, diabetes, and MASLD through equipment investment, workforce training, and mobile outreach. Community Health Aides (CHA)/Practitioners lead village-level screening supported by telehealth consultation and hub-based specialty services. Early identification triggers seamless Lifestyle Medicine referral, creating a closed-loop system from screening to treatment. Scalable workflows adapt to all clinic sizes. Workforce training for physicians, APPs, nurses, dietitians, and CHAs builds rural capacity. Quality metrics (Uniform Data System {UDS}, Government Performance and Result Act {GPRA}, patient-reported outcomes) track outcomes and inform continuous improvement. Partnerships with Tribal health organizations and Alaska public health infrastructure align resources. This approach advances RHTP priorities: lifelong prevention, rural systems strengthening, workforce sustainability, and technology-enabled access. By Year 5, this model serves as a replicable framework demonstrating how culturally grounded prevention achieves health equity in frontier communities.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; North Slope Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Tanana Chiefs Conference	AI Powered Community Health Aide Manual	AK	Alaska’s frontier care environment is unique: roughly 733,000 residents are spread across 570,000 square miles, and most remote communities are disconnected from the road system. Within the ATHS, clinics deliver care where internet outages can last for months. Rural Alaska faces challenges driven by geography, workforce shortages, and limited access to specialty care. Community Health Aides frequently serve as the only clinical provider and must manage complex needs while navigating significant documentation requirements. Frontline providers face a documentation crisis known as "pj" hours, spent reconstructing notes after-hours, a primary driver of burnout and high vacancy rates. The eCHAM currently functions as a static reference requiring manual searching and duplicative data entry. This cognitive workload slows care and limits structured data capture needed for 1115 waiver quality reporting. Nearly 75% of Alaskans have chronic conditions, requiring high-fidelity monitoring that is currently difficult to track in isolation. eCHAM-AI addresses this gap by transforming the manual into a structured, edge-capable clinical workflow platform. It supports voice-enabled documentation and reliable data capture even when connectivity is degraded, allowing CHAs to practice at the top of their certification in environments where they are often the sole provider.	The eCHAM-AI initiative will be implemented through a phased five-year strategy focused on developing and deploying a statewide AI-enabled clinical workflow platform. Year 1 - focuses on governance led by the Academic Review Committee (ARC) and the Community Health Aide Program (CHAP) Directors. These standing committees will establish the Alaska AI Clinical Council (A2C2) as a technical subcommittee to serve as the human-in-the-loop oversight body, ensuring AI outputs remain strictly within the authorized eCHAM scope. This ensures Tribal leadership retains direct control over clinical safety while meeting federal requirements for AI governance. We will also implement "Indigenous Language Tokenization" to ensure symptoms are described in culturally appropriate ways that maintain "Language Trust" with Tribal members. Year 2 - Platform Development and Integration: Expand structured protocol content, strengthen voice-enabled workflows, develop human-in-the-loop AI documentation support, and build Health Level Seven (HL7) Fast Healthcare Interoperability Resources (FHIR) integration pathways with Oracle Cerner Millennium (MIL) and statewide Health Information Exchange (HIE) environments. Year 3 - Pilot Implementation and Validation: Deploy in selected rural clinics representing different connectivity conditions; measure usability, documentation time, protocol adherence, and clinical safety; and refine the platform using pilot feedback. Year 4 - Regional Deployment: Expand to additional Tribal Health Organizations (THOs), support workforce training, advance regional interoperability and reporting functions. This phase includes the initial hardware refresh for pilot sites. Year 5 - Statewide Optimization and Sustainability: Scale implementation, optimize workflows for performance measurement, and transition to a shared-service operating model for long-term sustainability. Across all phases, the project remains grounded in authorized eCHAM protocols, local workflow co-design, edge reliability, and continuous monitoring. We will implement Indigenous Language Tokenization to ensure the AI respects culturally specific symptom descriptions and maintains "Language Trust" with Tribal members. The platform functions as permanent statewide rural health infrastructure rather than a standalone software tool.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Tanana Chiefs Conference	Community Health Aide (CHA) and Behavioral Health Aide (BHA) Training Center	AK	Rural clinics face persistent CHA and BHA vacancies, limited training slots, continuing education (CE), and fragmented competency assessment pathways. The expense of operating a health aide training center for most is cost prohibitive. Recruiting instructor staff to work in remote areas combined with smaller patient populations limiting where it is feasible to operate a clinical training site. Yet Employers duplicate effort to meet required recertification and skills checks. The result is longer vacancies, higher turnover, variable quality assessments, and increased travel or medevac costs for patients who could otherwise be managed locally. After 60 years of operations and growth, statewide Community Health Aide Program (CHAP) leadership has identified a need for standardized orientation and field operations. This project will develop and provide training tailored for clinical and administrative staff new to CHAP. This project will standardize a mentorship model, expand throughput, and support field-based CE to close these critical gaps.	We will establish a training center of Excellence for CHA/BHA training. Key components: (1) expand session-based training throughput with additional licensed instructors; (2) develop field training, CE, skills evaluation biannually in addition to asynchronous sessions; (3) establish CHAP Clinician Orientation for physicians, advance practice providers and licensed BH providers; (4) develop a mobile BHA float pool to support communities where local ties complicate care; (5) identify a shared learning management system (LMS), common curriculum and shared evaluation tools across partner tribal health organizations (THOs); Culture: Assess priority of needs through survey and focused groups to co-develop relevant curriculum with tribal partners and CHAP Certification standards, embed Alaska unique models and recruit CHAP alumni as adjunct faculty. Technology: deliver tele-simulation over low-bandwidth pathways for live and asynchronous learning options.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

Tanana Chiefs Conference	Healthy Beginnings: Comprehensive Prenatal & Postpartum Care for Alaska Native Families	AK	Rural and remote families across 27 villages face a critical maternal health crisis: Alaska Native women are 2.3 times more likely to die from pregnancy-related causes than non-Hispanic White women, and nearly half of these deaths are linked to healthcare access barriers. With 75% of Alaska communities lacking road connectivity to hospitals, pregnant families struggle to obtain coordinated prenatal and postpartum care. Current services are fragmented and episodic, leaving gaps in postpartum depression screening, substance use disorder support, and infant health monitoring. These gaps contribute to intergenerational cycles of trauma and adverse childhood experiences that compromise lifelong health outcomes. The Healthy Beginnings program addresses this need through a comprehensive, evidence-based maternal and infant care model serving approximately 300 mother-baby dyads annually across TCC villages. The program integrates prenatal education, postpartum home visits, lactation support, developmental screening, doula services, and coordinated maternal–pediatric care, while strengthening behavioral health connections for mothers experiencing postpartum depression or substance use disorder. By hiring and training local certified lactation consultants and CMAs, Healthy Beginnings builds a rural maternal health workforce. This approach strengthens prevention-focused care, improves birth outcomes, supports family stability, and advances health equity for Alaska Native families.	The program delivers a comprehensive, community-centered maternal and infant care model across TCC's 27-village service area throughout pregnancy, birth, and the postpartum period, integrating clinical care, Alaska Native midwifery practices, behavioral health support, and home visiting. Core Service Delivery: IBCLC-certified nurses and CMAs conduct prenatal and postpartum home visits for medical monitoring, breastfeeding support, newborn health assessment, and early complication identification. Village-based outreach and prenatal classes prepare families for childbirth and infant care. Doula support improves birth outcomes and maternal well-being. A maternal home model near emergency obstetric care provides a safe environment prior to delivery, supporting health education, peer connection, and clinical monitoring. The program incorporates developmental screening, maternal-pediatric care coordination, and pregnancy loss support. Cultural Integration: Community Health Aides trained in Alaska Native birthing traditions lead culturally responsive care, ensuring traditional knowledge informs evidence-based clinical protocols. Behavioral Health: Screening and support services for postpartum depression, plus coordinated care and recovery support for mothers experiencing substance use disorder, connect families to appropriate treatment and community resources. Phased Implementation: Year 1 establishes the Fairbanks hub with maternal home model and workforce recruitment, piloting 100–150 mother-baby dyads. Year 2 scales to 300 dyads with expanded village outreach through trained IBCLC nurses and CMAs, including subregional integration at Tanana and Galena. Years 3–5 sustain 300-dyad capacity and achieve full financial sustainability through continued regional care network integration. Workforce Development: The program creates career pathways for Alaska Native community members through competitive hiring of IBCLC nurses and CMAs, with training in lactation support, behavioral health, and cultural competency. Outcomes and Sustainability: Serving 300 mother-baby dyads annually by Year 2, target metrics include 80% postpartum visit completion and 60% breastfeeding initiation by Year 3. Prevention-focused design reduces complications and improves care engagement. Medicaid and third-party reimbursement support a scalable, financially sustainable framework that improves access, quality, and long-term maternal and infant health outcomes across rural Alaska.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; North Slope Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Tanana Chiefs Conference	Indigenous Healing Integration & Rural Wellness Transformation Initiative	AK	Novel models integrating Alaska Native and Indigenous healing methods are urgently needed. Traditional healing improves outcomes but sits outside formal healthcare systems—inconsistent, inaccessible, non-reimbursable—while communities call for services honoring Indigenous knowledge. The opportunity is structural integration into clinical operations, workforce development, and prevention infrastructure. TCC will establish a Department of Indigenous Healing with credentialed Alaska Native practitioners delivering billable services within the rural health system. Hire a physician trained in Western and Indigenous medicine; train two PAs in healing methodologies within six months, creating immediate scalable workforce. Services include hands-on healing, botanical remedies, indigenous lifestyle counseling, Alaska Native birthwork, and substance use recovery—guided by a regional Council of Advisors ensuring cultural integrity and community governance. Infrastructure investments (steam bath, teaching kitchen) create dedicated healing environments, moving services from informal to sustainable, scalable care. Timing is urgent: without integration now, an aging healer workforce may retire before knowledge transfer occurs, permanently widening health inequities.	Our approach integrates Indigenous healing directly into TCC’s clinical operations so patients can access Western and traditional medicine through one coordinated, documented, and reimbursable care pathway. We will establish a Department of Indigenous Healing and embed services into primary care, behavioral health, prenatal care, and recovery across our hub and subregional system. Integrated Traditional and Clinical Care Model Establish a dedicated traditional healing clinical space to include rooms enabled with telehealth technology. Employ a Tribal Medical Director, Indigenous Healers, and support staff. Provide hands on healing, distance healing, indigenous lifestyle medicine, and coordinated behavioral health referrals. Develop culturally appropriate documentation, consent and safety procedures, EHR workflows, and billing and integration protocols. Rural Telehealth and Technology Expansion Install telehealth equipment in hub and subregional village sites. Deliver virtual Indigenous healing sessions and cultural education programming. Implement immersive technology tools to strengthen rural engagement and continuity. Improve data collection and outcome tracking systems. Community Based Cultural and Recovery Programming Offer biannual land-based healing camps (summer and winter). Provide recovery supports including steam bath, talking circles, and peer recovery support. Establish a Healing Garden and medicinal plant cultivation program. Deliver traditional foods programming through a renovated kitchen space to strengthen prevention and wellness. Workforce and Apprenticeship Development Employ Indigenous Healers and establish apprenticeship pathways. Provide cultural humility and integration training for clinical staff. Partner with behavioral health teams for coordinated trauma informed care. Support participation in regional cross cultural medicine workshops. Monitoring and Improvement We will track encounters, referrals, rural access by site, patient experience and cultural safety, and prevention and recovery indicators using EHR data, standardized surveys, and community feedback. Quarterly review and continuous quality improvement will ensure services remain effective, culturally grounded, and scalable. This approach embeds prevention, treatment, culture, technology, and workforce development into a single coordinated rural health framework that can be replicated across rural Alaska	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; North Slope Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Tanana Chiefs Conference	Patient Travel Modernization: Integrating intake, reservations, communication into a single platform	AK	TCC is modernizing its patient travel program to reduce delays in care due to travel requests that are not coordinated in time or not coordinated at all. Salesforce was implemented in 2024, and Phase 2 is in progress, delivering functional enhancements, integrations, and automation to streamline work. Additional planned capabilities are needed to complete the solution. TCC has already purchased the required licenses; the remaining gap is unfunded implementation services. In CY2025, travel no-shows/cancellations attributable to communication gaps were approximately 50% lower than prior years—demonstrating the value of modernization and the opportunity to extend impact. The next set of enhancements includes: • Integrated collaboration/communication tooling tied to operational data • Modernized call management and intelligent routing/documentation • Expanded integrations and AI-enabled workflow support to prevent missed requests • Salesforce-to-Salesforce integration between TCC and ANMC to reduce manual re-entry, errors, and coordination delays RHTP alignment: This project advances Alaska’s RHTP initiatives of Health Care Access, Healthy Communities, and Spark Technology & Innovation, and supports allowable uses including IT Advances, Consumer tech solutions, Innovative care, and Appropriate care availability by improving care coordination, reducing missed/delayed care, and increasing scheduling efficiency for rural residents who must travel for specialty services.	Transformation potential: This initiative modernizes patient travel as a system-level capability—integrating intake, scheduling, reservations, communication, and care coordination into a single operational platform. The architecture is repeatable and scalable, enabling shared approaches and future interoperability with other Tribal Health Organizations and regional partners. ANMC integration, standardized workflows, and unified patient profiles create a durable foundation for regional coordination and long-term modernization. TCC has already secured the software licenses required to build this solution. This request is for implementation funding. Delivery will follow Agile best practices with iterative development, user validation, and early releases to production to accelerate impact. Discovery (confirm and plan): • Confirm goals and key value levers (KPIs) and how they will be measured and reported in Salesforce. • Conduct workshops and user interviews with functional areas to document processes and requirements. • Capture, prioritize, and sequence requirements into a roadmap and release plan; evaluate solution options; and produce a high-level design. • Conduct a Discovery Readout (Design Overview) to ensure alignment on scope and near-term releases. Build (iterate and deliver): • Configure and develop prioritized features and integrations in short sprints; demo working software; and incorporate feedback. • Test continuously (unit/integration/UAT) and refine/reprioritize the backlog as learning occurs. • Deliver early production releases for high-impact capabilities, followed by incremental enhancements and additional integrations. Validate (prove end-to-end fit): • Execute client-led testing; triage and resolve defects; confirm the solution supports end-to-end business processes. • Finalize readiness for each release (training, cutover, support). Enable (launch and stabilize): • Deliver role-based training; deploy to production; support go-live stabilization and troubleshoot critical issues. • Provide final documentation and knowledge transfer. Monitoring and adaptive management: Establish KPI dashboards (access, timeliness, no-shows, cost avoidance, call center performance, notification reliability); review bi-weekly during build/test and monthly post go-live. Use structured issue triage for rapid iteration, with quarterly stakeholder reviews to validate rural impact and reprioritize enhancements.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; North Slope Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Tanana Chiefs Conference	Village and Home Based Culturally Grounded End of Life Care	AK	Remote Tribal communities in Interior Alaska face persistent gaps in timely, culturally aligned palliative and end of life care. Currently Tanana Chiefs Conference provides comfort kits, limited supplies, caregiver binders, and telephonic case management. However, current support is not enough for Tribal members with an estimated life expectancy of six months or less. Families often lack hands on training, real-time clinical guidance, and respite, leading to caregiver fatigue, unmanaged symptoms, and preventable medevacs. Limited village-based staffing and the absence of a structured tele-palliative model force some patients to leave their home communities to receive appropriate care. At the same time, community feedback and case trends demonstrate a strong desire for village end of life care and expanded remote palliative services. National evidence shows that tele palliative models can reduce avoidable transfers and improve symptom control in rural settings. TCC is well positioned to build on its current foundation to deliver a more comprehensive, culturally grounded model that integrates telehealth, remote monitoring, and village-based caregiver support. This project directly addresses a critical, well-informed need by transforming limited, reactive services into a coordinated, high-quality system of care. The model will improve access, decrease unnecessary travel, and allow more Elders to remain at home with comfort, dignity, and family presence in their final months.	Tanana Chiefs Conference (TCC) proposed approach responds directly to a clearly documented regional need. Rural Tribal communities face major barriers to timely symptom management, culturally aligned end-of-life support, and consistent caregiving resources. Geographic isolation, limited clinical staffing, and high medevac rates cause fragmented care and prevent many patients with a life expectancy of six months or less from safely remaining at home. Community feedback, clinical trend data, and regional planning efforts consistently highlight urgent gaps in palliative care access, caregiver support, and coordination across settings. This project offers a coordinated, evidence- informed solution tailored to these realities. TCC will implement a comprehensive, culturally grounded tele palliative care model designed to stabilize symptoms, strengthen caregiver capacity, and reduce avoidable transfers. A Palliative Care Clinical Dyad, a Palliative Care Medical Provider partnered with an RN Case Manager, will deliver structured assessments, chronic disease co-management and advance care planning via telehealth and periodic in-village clinics. This ensures timely specialty input for even the most remote communities while maintaining continuity with primary care and local teams. The Village Caregiving Track addresses the urgent need for hands-on, locally delivered support. An itinerant CNA, supervised by the Home Care RN, will provide caregiver skills training, monitor changes in condition, and deliver scheduled respite to reduce caregiver burnout, one of the most frequently reported community concerns. Regular reassessments and equipment recommendations ensure care plans stay responsive as needs change. A telehealth first model, with audio only capability, ensures reliable access regardless of bandwidth constraints, reduces travel burdens, and enables family participation from multiple locations. Remote Patient Monitoring (RPM) and Chronic Care Management (CCM) offer daily insight into symptom trends, enabling early intervention and reducing crisis-driven medevacs. Enhanced enabling supports including Comfort Kits related to diagnoses, supply boxes, and an education binder ensure families are equipped, informed, and confident. This approach fills documented gaps, strengthens village-based capacity, reduces costly emergency utilization, and delivers culturally aligned care that allows more Elders to remain at home with comfort and dignity.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; North Slope Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Tanana Chiefs Conference	Pharmaceutical and Medical Supplies Drone Transportation System For Interior Alaska Villages	AK	Interior Alaska's rural healthcare system faces significant challenges in providing reliable access to medications, especially during winter. TCC operates 28 village clinics in 42 communities where pharmaceutical deliveries depend on regular or charter flights that are vulnerable to extreme temperatures, chain of custody risks, and frequent delays. Transportation records show that 15% of deliveries are delayed more than 48 hours, with winter delays often lasting 5-7 days. These gaps lead to insulin rationing, untreated infections that escalate to hospitalizations requiring costly medical evacuations, and chronic disease flare ups caused by missed medications. The geography of Alaska worsens these problems. Villages have no road access, winter temperatures reach –35 to –70°F, and limited daylight shortens flight windows to 4-6 hours. Traditional aviation cannot overcome these constraints. A promising solution is to use Arctic tested drone technology from UAF's ACUASI and integrate pharmaceutical temperature control systems developed with Merck for drone-based vaccine delivery. Implementing this approach requires planning to meet Federal Aviation Administration (FAA) Beyond Visual Line of Sight (BVLOS) regulations, Department of Transportation (DOT) and Drug Enforcement Administration (DEA) requirements, hazardous materials protocols, weather related safety standards, medical grade technical needs, community engagement, and long-term financial sustainability.	This concept formation project will develop a comprehensive implementation plan through intensive partnership with the University of Alaska Fairbanks' Alaska Center for Unmanned Aircraft Systems Integration (ACUASI) and federal regulatory agencies. The first 6-7 months will focus on critical planning and preparedness activities to ensure safety and regulatory compliance, recognizing that any issues with FAA authorization will significantly impede future success. Year 1 priorities include: (1) Regulatory Framework Development - engaging FAA Alaska Region and DOT on BVLOS waiver requirements, flight decision-making protocols, and FAA legislative/regulatory advocacy; consulting with DEA on controlled substance transportation protocols; coordinating with Alaska Board of Pharmacy on pharmaceutical handling standards. (2) Safety and Compliance Planning - developing comprehensive policies and procedures for chain of custody workflows, hazmat shipping compliance for pharmaceutical transport, safety procedures and redundancy planning, contingency protocols for adverse weather (fog, icing, wind, Instrument Flight Rules {IFR} conditions), and temperature maintenance testing during flights. (3) Technical Feasibility Assessment - partnering with ACUASI to evaluate Arctic-hardened drone capabilities, leverage Merck Pharmaceuticals' temperature maintenance technology from their vaccine drone delivery partnership, conduct initial flight testing at short distances based out of ACUASI's Nenana hangar facility, identify optimal aircraft configurations, and determine infrastructure requirements. (4) Community Engagement - consultation with tribal councils across 42 villages to address cultural considerations and identify priority communities. (5) Partnership Development - establishing formal agreements with ACUASI and exploring collaboration opportunities with Merck Pharmaceuticals' leadership team (Vice President level) who are championing vaccine drone delivery technology that could be adapted for our pharmaceutical needs. This planning phase will produce detailed specifications for Year 2 defined approach activities and Years 3-5 implementation readiness.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; North Slope Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Planning

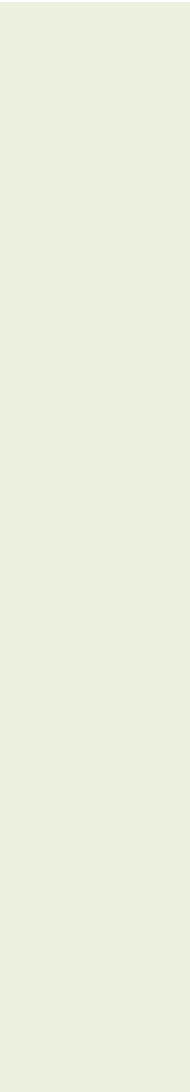
Tanana Chiefs Conference	Licensed Provider Triage Line	AK	Reliance on rural clinics to manage community needs after-hours is proven to be unsustainable and is identified as a primary source of provider burn-out. Contracted vendors for triage call services are based on a nursing model. The advice a nurse can offer a patient is restricted to the nursing scope of practice. In rural Alaska, this creates unmet need and patients not feeling heard or cared for. A diagnosis or 2nd opinion then encumbers calling the local provider or patient travel. The project establishes a replicable, LIP-led after-hours care model with standardized protocols, Electronic Medical Record (EMR)-integrated documentation, and telehealth billing workflows. This creates a foundational architecture for after-hours of care that can be adopted by other services providers using a hub and spoke system. By shifting the statewide after-hours paradigm away from outsourced nurse protocol models toward integrated clinical triage, this project drives durable structure change and amplifies the goals of multiple RHTP initiatives. Contracting vendors for this service is an expense with no opportunity to recoup dollars through revenue-generating encounters. This model moves from an expense only line item to a framework for not only cost avoidance but revenue capture.	This approach for after-hours triage is a TCC managed extension of primary care operations. Utilizing TCC licensed providers to staff on the after-hours triage line is an innovative solution to mitigate several issues identified by clinical staff, administrative leadership, and patients. Currently, a patient calling in after-hours in most cases will be told, ‘go be seen at your local clinic’ or ‘call 911’. Most of the rural communities do not have 911 separate from the clinic. In places 911 does exist, the patient, if transported, is brought to the local clinic. Either way, the patient is still waking up with the local clinic provider. In this typical scenario, there is no value added by paying for a contracted triage system. Staffing a triage line with licensed providers creates a workflow where a diagnosis and treatment plan can be made in real time. No transfer, no call back, no referral. This model has demonstrated success at other tribal health organizations with a similar hub and spoke model of care in remote Alaska. Contrary to paying a contracted vendor for nursing level advice, some visits will convert to a billable telehealth encounter. Access to higher-level clinical decision-making through LIPs enhances patient safety by reducing delays in appropriate care. Providers familiar with Alaska’s complex and resource-limited healthcare system are better equipped to recognize high-risk presentations, navigate logistical constraints, and initiate timely interventions. Earlier, context-informed decision-making has the potential to reduce preventable complications and improve overall health outcomes. Acceleration (FFY 2026): (1) Hire project manager and lead provider, (2) Develop protocols for call management and referral, (3) Identify and procure technology infrastructure. Monitoring: Design metrics to track call answering time, calls resolved, calls converted to telehealth, transfers avoided, patient satisfaction, and attrition. Risks & Mitigation: Workforce shortages will necessitate creative solutions. Technology failures necessitate downtime policies. Adaptive Management: quarterly assessments to evaluate metrics. FFY 2026-2027: (1) Finalize standard operating procedures, (2) integrate with EMR, (3) hire 3-5 licensed providers. This project will provide lived scenarios to inform future growth in areas such as network expansion, remote patient monitoring, and workforce needs.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; North Slope Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Tanana Chiefs Conference	Rural Clinic Vehicle Transportation	AK	Offroad communities encounter limited access to local transportation. Without typical road infrastructure large items must be barged or air lifted. The added expense of shipping makes vehicles unattainable for most rural residents in communities with high rates of low-income households. The lack of local transportation in rural Alaska is a defining social determinant of health limiting access to healthcare services particularly in times of emergency or subzero temperatures when walking is not safe. Lack of reliable transportation directly correlates to missing appointments. The rural staff are the ‘911’, with no dedicated transportation, response time is delayed when time is most critical. Closing the rural disparity gap includes support for operations. Caring for patients in a rural site entails daily, sometimes multiple times a day, trips from clinic to local air landing strip. Interruptions in ability to meet aircraft result in expensive wastage of temperature/time sensitive items and delays in patient care. Lack of reliable clinic transportation limits when labs can be drawn and if they are delivered in time to be processed at referral lab. Responding to emergencies. Staff and a building are only part of the care process for rural patients. A vehicle for clinic operations eliminates barrier for patient access and mitigates challenges of logistics the rural clinics navigate when caring for patients.	Purchase and deploy vehicles dedicated to rural clinic operations. Create recurring schedule for pick-up/drop-off for elders needing transportation.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Tanana Chiefs Conference	Rural Primary Care Initiative – Effective Care Coordination Across Interior Alaska	AK	Village-based patients face significant health disparities and higher rates of chronic diseases. While the cause is multifactorial, one modifiable factor is the system in which they seek care. Care is delivered in a wide range of settings – specialists in Fairbanks, Anchorage, or out-of-state; clinicians traveling to the village from Fairbanks or subregional clinics; and village clinics that may be staffed by a health aide full-time or only intermittently. Different coverage rules for IHS or Veteran beneficiaries and rural non-IHS patients add additional layers of complexity. Reliance on flights often affected by weather delays or cancellations can create a chain reaction of no shows, rework, or loss to follow-up. Without dedicated care coordination, this complexity results in fragmented care, duplicative work, missed opportunities, unnecessary travel, higher costs, frustrated patients, and burned-out clinical staff. Effective care coordination has been proven to improve health outcomes and reduce costs, yet current referral tracking processes rely on manual workarounds. The time spent managing these manual processes could be directed toward meaningful, patient-centered support and proactive village travel preparation. The Rural Primary Care Initiative aims to strengthen care coordination and employ population health principles to improve preventive care and provide robust preparation for village medical travel, improving efficiency and overall patient care.	Our approach builds a structured care management program that strengthens preventive care, chronic disease management, and referral coordination across the region. To implement this model, TCC will hire one Registered Nurse (RN) and one Certified Medical Assistant (CMA) to form a dedicated care coordination team alongside our existing Clinical Pharmacist. This team, acting as an extension of the medical primary care team, will use population-health methods to identify patient needs, reduce care fragmentation, and ensure timely follow-up across settings. Once hired, the RN will focus on higher-risk patients, providing disease-specific education, proactive check-ins, and advanced care coordination, including support for village-based patients receiving end-of-life care. The CMA will manage foundational care coordination tasks for rural patients and plan village medical travel with consistent, proactive follow-up. The clinical pharmacist will continue providing medication management and routine education to improve adherence and health outcomes. This model is supported by strong evidence and TCC’s own demonstrated results. A recent two-year pilot in three remote villages significantly improved key quality measures – including preventive screenings, chronic disease control, and healthy lifestyle counseling. Across 11 metrics, scores increased by 23.4% in year one and an additional 15.3% in year two. The pilot demonstrated the need for additional nursing and clinical support staff, which has not been added due to lack of available funding. RHTP support is essential to launch and scale this model. In addition, we will conduct a Rapid Improvement Event to map current referral processes, identify gaps, and guide selection of a software solution that streamlines referral tracking, reduces duplication, and integrates real care-coordination tasks into daily workflows. We will also partner with a physician to analyze patterns of excessive travel use and develop corrective strategies, beginning with Return-to-Village Clearance protocols and targeted high-utilization review. Year 1 will focus on hiring the RN and CMA, protocol development, workflow design, refining pharmacist billing processes, and completing software discovery. Year 2 will implement the selected software and refine workflows. These improvements will clarify future workforce needs and establish the foundation for expanding into Remote Patient Monitoring (RPM) and Chronic Care Management (CCM).	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; North Slope Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Tanaq Technical Services, LLC	One Tanaq Rural Health Transformation Initiative	AK	Alaska’s Rural Health Transformation Program presents a historic opportunity to modernize healthcare delivery across rural and frontier communities where geographic isolation, workforce shortages, and infrastructure limitations create persistent barriers to care. Many rural providers face challenges including limited access to specialty care, fragmented health data systems, cybersecurity vulnerabilities, limited telehealth capacity, and challenges managing chronic disease across dispersed populations.	The One Tanaq initiative proposes to address these challenges through the implementation of a secure, interoperable rural health technology and care coordination platform designed to support healthcare providers, community health workers, and patients across Alaska. This initiative integrates expanded telehealth capabilities connecting rural patients with specialty care; remote patient monitoring technologies supporting chronic disease management; secure cloud-based health data platforms enabling interoperability and analytics; population health dashboards supporting data-driven decision making; and community health worker engagement tools supporting prevention and care coordination.	\$250K-\$1M	Statewide	Anchorage (Municipality)	Deferred or Not Advanced
Tangirnaq Native Village	Tuknisqat Ilat, Tuknisqat Acigtat (Strong Families, Strong Foundations)	AK	Our community faces ongoing challenges in ensuring consistent access to maternal, child, and preventative behavioral health services across the rural Kodiak Archipelago. Geographic isolation, weather-dependent travel, high transportation costs, and limited local service availability contribute to delays in care and fragmented coordination between community-based supports and regional providers. Pregnant and postpartum women often leave their community for services, and families may encounter barriers to early behavioral health engagement. At the same time, our community holds strong cultural foundations that serve as protective factors for long-term wellness. This project represents an opportunity to strengthen place-based, culturally grounded prevention systems rooted in Sugpiaq values, kinship, and land-based learning. By delivering prevention programming locally, formalizing referral pathways, and improving coordination with regional partners, TNV can expand access, strengthen continuity of care, and build sustainable Tribal infrastructure that supports healthy families and strong generations while advancing rural health system responsiveness.	Tangirnaq Native Village proposes a Tribal-led, prevention-centered approach that strengthens maternal, child, and family wellness by building durable community systems rooted in Sugpiaq values, kinship, and land-based knowledge. Year 1 will serve as a planning and foundation-building year. TNV will engage community leadership and families to refine a culturally grounded maternal and family wellness framework. The Tribe will formalize partnerships with regional providers, establish referral and communication pathways, identify service gaps affecting pregnant and postpartum women, children, and families, and develop evaluation measures to guide long-term sustainability. This planning phase strengthens Tribal infrastructure and coordination capacity while maintaining TNV’s role as a sovereign government, not a clinical provider. In Years 2–3, TNV will implement place-based prevention programming. Maternal and family wellness gatherings will strengthen early protective factors, provide parenting education grounded in Sugpiaq values, and support prevention-focused behavioral health referrals. Programming will incorporate land-based learning and intergenerational engagement as core elements of long-term wellness. Embedding prevention within trusted community settings increases early engagement, reduces stigma, and supports families before challenges escalate. Throughout the project, TNV will reinforce coordinated partnerships that align community prevention with regional clinical services. Rather than duplicating healthcare systems, the Tribe will strengthen referral alignment and follow-up practices to ensure smoother transitions across rural systems of care. In Years 4–5, TNV will expand participation, deepen partnerships, and strengthen sustainability through durable infrastructure and continued advocacy for improved rural access. Evaluation findings will guide refinement and support replication across the Kodiak Archipelago. Through sovereign leadership, culturally grounded prevention, and coordinated system-building, Tangirnaq Native Village will advance a	\$250K-\$1M	Single Community	Kodiak Island Borough	Advance to Implementation Application

responsive rural health framework that expands access, strengthens continuity of care, and supports healthy families and strong generations for the long term.



TeleTracking Technologies, Inc.	Rural Alaska Operations Hub: Unified Access & Patient Flow Across the Frontier	PA	Alaska faces a frontier health access challenge: care is often available somewhere, but not always visible, coordinated, or reachable in time. Distance, weather, workforce shortages, limited local services, and fragmented communication can delay referrals, transfers, maternal care, behavioral health access, pharmacy support, and follow-up for rural patients. In this environment, even small operational breakdowns can create major clinical and financial consequences. The opportunity is to build a more connected rural health operating model for Alaska—one that helps providers, referral sites, and regional partners better see capacity, coordinate movement, and connect patients to the right care setting faster. Rather than relying on isolated sites to solve these problems alone, this project would create stronger statewide and regional coordination across hospitals, clinics, EMS, and other partners. For Alaska, this is not just a technology opportunity; it is an opportunity to improve access, reduce avoidable delays, support vulnerable populations, and make better use of scarce workforce and infrastructure across remote communities.	Our proposed approach is to help Alaska build a Boundaryless Healthcare operating model for rural and frontier care—one in which distance, organizational silos, and handoff failures no longer define the patient experience. Rather than asking each site to solve access challenges alone, we would help create a connected coordination framework across participating providers and regional partners, including systems such as Providence Alaska, Alaska Native Tribal Health Consortium, Southcentral Foundation, Yukon-Kuskokwim Health Corporation, Norton Sound Health Corporation, Foundation Health Partners, Bartlett Regional Hospital, and Bristol Bay Area Health Corporation.. Using TeleTracking’s platform, the project would establish shared operational visibility across hospitals, clinics, referral partners, EMS, and other stakeholders. This would support real-time insight into capacity, transfer needs, referral pathways, patient movement, and operational bottlenecks. In Alaska, where weather, geography, and workforce shortages can quickly turn a routine care issue into a serious access problem, this kind of visibility is essential. The work would begin with an assessment and design phase focused on Alaska-specific use cases, participating partners, workflow gaps, and data requirements. From there, we would configure the model around the state’s highest-value priorities: rural access, maternal care, behavioral health, pharmacy coordination, and inter-facility transfer management. The goal is not just better technology, but a better operating system for statewide care coordination. Our approach also emphasizes governance, workflow standardization, and partnership alignment. Technology matters, but success depends on clear escalation paths, agreed operating protocols, role clarity, and stronger collaboration across regional and Tribal health networks. This is especially important in Alaska, where a failed handoff may mean another flight, another delay, or another patient unable to receive timely care close to home. Where appropriate, the model could incorporate advanced analytics and AI-enabled decision support through TeleTracking and partners such as Palantir and Faculty AI to identify bottlenecks, forecast demand, and strengthen planning over time. This approach is designed to help Alaska move from fragmented access points to a more coordinated frontier care network—more visible, more resilient, and more capable of delivering timely care across the state.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Terawatt, Inc.	ANCHOR: Alaska's Network for Community Health, Outcomes, and Retention	CT	Rural Alaska does not have a recruitment problem. It has a retention and culture problem. Providers leave because of their experiences inside facilities. Management culture and toxic environments are the top drivers of staff exits, outranking geographic isolation (Linzer et al., 2009; Labrague, 2023; NSI, 2025). The fiscal consequences are severe. Each RN departure costs \$61,110. Locum replacements cost more and deliver 2–6 week rotations that destroy care continuity for AI/AN communities already facing 25%+ vacancy rates. Alaska projects a 40% primary care shortage by 2030, yet policy responses remain focused on recruitment. Why us: Nine years of validation at Poudre Valley Hospital System (turnover 23% → 4%; \$32M retained earnings). Terawatt's vetted coach network activates immediately while Dr. Thomas builds an Alaska-specific cohort for local ownership. Dr. Sarnecki's Unangan relationships make Year 1 credible rather than extractive. Why now: RHTP's five-year window is precisely the timeline psychological safety research requires. ANCHOR measures progression using the Edmondson Psychological Safety Scale at Months 1 and 12, with Provider Retention tracked at 6, 12, 24, and 36 months. By Year 5, the retained savings fund will care for delivery itself — advancing Initiative #4 (Pay for Value) and creating a rural health economy no longer dependent on federal subsidy.	ANCHOR operates through a hub-and-spoke delivery model, launched in Year 1 in Unalaska and replicated across six additional hubs by Year 5. Every element of the approach is operational, not aspirational. How delivery works: Terawatt's network of 80+ vetted coaches, selected through written content review, online presence audit, structured interview, and background screening, delivers facilitated group coaching sessions at each hub. Sessions are held in-person at neutral community venues, beginning with the Unalaska Community Center in Year 1, welcoming all healthcare-touching staff regardless of employer or role. This cross-functional design is deliberate: psychological safety requires a shared and inclusive environment. We reach satellites: Atka, Nikolski, and St. George receive quarterly in-person coach visits, coordinated through existing APIA CHA/P relationships. CHA/Ps serve as permanent on-the-ground cultural anchors, not logistical conveniences. Their community presence makes delivery credible rather than extractive. When weather disrupts travel, a Digital Twin virtual curriculum (live virtual sessions replicating in-person content exactly) activates immediately. No session is lost. Alaska owns the curriculum: Dr. Tommy Thomas trains Alaska's inaugural coach cohort in Opposite Strengths, a communication-first methodology. Alaska holds a lifetime license from Year 1. The curriculum belongs to Alaska permanently, eliminating vendor dependency as a sustainability risk. Sequencing: C-suite and senior leadership receive training first. When frontline staff see that supervisors have already participated, curiosity drives enrollment without mandates. This sequencing drove nine years of uninterrupted gains at Poudre Valley Hospital System. Track outcomes: Columbia University Professor Solange Charas provides quarterly human capital analytics that correlate cultural shifts with financial outcomes, including locum tenens spend reduction, HCAHPS improvement, Edmondson Psychological Safety Scale scores, and provider retention at 6, 12, 24, and 36 months. Reported quarterly to RHTP administrators. Phased expansion: Year 1 establishes Unalaska as the replication template. Hub 2 launches Year 2, selected by vacancy rates, HPSA scores, and community readiness indicators from Year 1. All seven hubs are active by Year 5. Tribal Health Organization coaches deliver and certify independently by Year 6, permanently independent of federal funding.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Nome Census Area; North Slope Borough; Northwest Arctic Borough	Deferred or Not Advanced

The Alaska Hospitalist Group, LLC	Mat-Su Rural ICU Physician Housing Support Program	AK	The project will also enhance quality of care for patients in rural and frontier communities served by Mat-Su Regional Medical Center. When ICU physicians are housed locally during service rotations, commute times, often exasperated by weather conditions, are reduced and physicians are more readily available to respond to patient needs in the ICU. This proximity improves response times for emergent situations, supports greater participation in multidisciplinary rounds, and allows for stronger collaboration with hospital staff, hospitalists, and nursing teams. Increased on-site availability also strengthens continuity of care and allows intensivists to remain engaged in quality improvement initiatives, protocol development, and provider education, all of which contribute to better clinical outcomes for critically ill patients.	TAHG would provide housing with close proximity to the hospital that ICU physicians would use when on service.	Under \$50,000	Private practitioner	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced
The Alaska Hospitalist Group, LLC	Rural Physician Workforce Retention and Housing Support Program	AK	TAHG has experienced significant challenges with recruiting and retaining physicians to the Kenai Peninsula. In 2023, we experienced a 50% turnover rate of our physicians. This was devastating to our group and the Kenai Peninsula. We have been working to replace those physicians while staffing up to meet the growing needs of the hospital. We continue to experience turnover each year.	Our approach to the physician workforce shortage is to offer a retention bonus for individuals willing to commit to an additional five years of service with TAHG in the Kenai Peninsula.	\$250K-\$1M	Private practitioner	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

The Alaska Hospitalist Group, LLC	Telehealth Innovation/Care Coordination for Hospital Post Discharge Patients	AK	Alaskan patients discharged from hospital care often face delays in follow-up appointments due to limited provider availability, travel challenges, and geographic isolation. These gaps in care can result in medication errors, worsening conditions, and avoidable hospital readmissions. Rural patients are particularly vulnerable when timely primary care follow-up is not available. The Alaska Hospitalist Group (TAHG) would like to help bridge that gap with tele-health services.	This project proposes the creation of a Post-Discharge Telehealth Program designed to provide short-term follow-up care after hospital discharge. Key elements of the program include: • A medical provider available through a telehealth platform to provide outreach to patients shortly after discharge. • Visits scheduled within a defined timeframe following hospitalization for patients identified as higher risk for readmission or those experiencing barriers to timely primary care follow-up. • The program would operate several days each week and serve patients until they are able to establish care with their primary care provider. Services may include: • Medication reconciliation • Symptom monitoring and clinical reassessment • Reinforcement of discharge instructions • Coordination with primary care and specialty providers and the patient’s care teams	\$250K-\$1M	Private practitioner	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

The Arc of Anchorage	Electronic Health Record and Technology Alignment Project	AK	Currently, several of The Arc’s technology systems including health records, documentation platforms, scheduling tools, and communication systems operate across multiple platforms that are not fully aligned. This fragmentation creates inefficiencies for staff, increases administrative workload, and contributes to higher operational costs for the organization. It also creates barriers for individuals and their guardians who must navigate multiple systems to complete intake steps, submit documentation, and communicate with care teams, often from rural communities with limited connectivity. This project presents an opportunity for The Arc to partner with technology and health IT experts to better align these systems and improve the overall technology infrastructure that supports service delivery. By creating more integrated systems and expanding consumer-facing digital tools, The Arc can reduce administrative burden, improve care coordination, and make it easier for individuals and families, particularly those from rural Alaska—to initiate and maintain services without unnecessary travel or administrative barriers.	The Arc proposes to partner with experienced health technology and systems integration experts to evaluate, align, and modernize the organization’s technology infrastructure that supports behavioral health and community-based services. The goal of this project is to create a more integrated and efficient technology ecosystem that improves care coordination, reduces administrative burden, and expands digital access for individuals and families across Alaska. The project will begin with a comprehensive assessment of The Arc’s current technology environment, including clinical documentation systems, scheduling platforms, communication tools, and consumer-facing systems used by individuals and their guardians. This assessment will identify opportunities to better align platforms, improve interoperability between systems, and streamline workflows that currently require duplicative administrative work across multiple platforms. Based on the findings of this assessment, The Arc will work with technology partners to implement system alignment and integration strategies that allow information to move more efficiently between systems. This may include improving data integration, modernizing user interfaces, strengthening communication tools used by staff and families, and implementing solutions that simplify administrative processes such as intake, documentation submission, and care coordination. A key component of the project will focus on enhancing consumer-facing digital tools so individuals and their guardians can more easily complete intake steps, upload required documentation, communicate with care teams, and participate in care planning remotely. These improvements are particularly important for individuals and families in rural and frontier communities who often face travel barriers and limited access to local services. Because The Arc serves as a hub provider for individuals coming from communities across Alaska, the project will prioritize solutions that function effectively in low-bandwidth environments and support remote engagement with care teams. By improving system alignment and expanding digital access, this project will strengthen operational efficiency, reduce administrative costs, improve coordination among care teams, and make it easier for individuals and families, particularly those in rural and remote communities, to initiate and maintain services.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Deferred or Not Advanced

The Dome	Preserving The Dome for Community Health	AK	The Dome addresses a statewide gap in year-round athletic and health infrastructure in Alaska. Due to harsh winter conditions and limited indoor facilities, many Alaskans, particularly those from rural, remote, and frontier communities, have few opportunities to train, stay active, or participate in organized athletic programming during much of the year. As the only full size indoor track and field facility in Alaska operating year round, The Dome provides a critical hub where athletes, teams, and community members from across the state can access safe indoor space for physical activity, training, and competition. Each year, individuals from communities including Bethel, Nome, the North Slope, and Southeast Alaska travel to Anchorage to participate in athletic events, training programs, and statewide competitions hosted at The Dome. These opportunities support both physical health and mental wellbeing, enabling rural athletes to compete and prepare at the same level as their peers elsewhere in the state. Many rural Alaskans also travel to Anchorage for medical appointments and specialty care. Through The Dome’s Community Health Initiative, these individuals and families can access the facility free of charge for walking, light exercise, and recovery activity. The Dome’s air supported fabric structure has reached the end of its service life and requires replacement. Replacing the Dome fabric will ensure that this infrastructure remains available for rural Alaskans.	The proposed approach is to complete a fabric replacement for The Dome’s air supported structure in order to preserve this critical statewide health and athletic facility. The Dome has worked with Yeadon Fabric Domes, Davis Constructors, and Kuna Engineering to develop the scope and execution plan for this capital project. The Dome has advanced the project to approximately 35 percent architectural documentation and is ready to proceed once funding is secured. Replacing the fabric will ensure the continued operation of Alaska’s only year round full size indoor track and field facility. The Dome enables athletes, teams, and community members from across the state to participate in physical activity, training, and events that support both physical and mental health. Many rural Alaskans travel to Anchorage for medical appointments and specialty care. Through scholarships and complimentary memberships, rural residents who regularly utilize The Dome will have access to the facility for preventive health activity, physical recovery, and safe indoor exercise while they are in Anchorage. Maintaining The Dome through this fabric replacement will ensure that these programs and services remain available to rural Alaskans in a safe, weather protected facility that supports long term community health.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Kenai Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough	Deferred or Not Advanced

The Eskimo Ninja	Bridging Mental Stability through Physical Activity	AK	Rural Alaskans and Alaskan Native people are literally the youngest culture to alcohol - our low tolerance leads to some of the highest domestic violence rates, suicidal ideation and completions, and homeless/multi-generational homes in the country - our purpose has been lost in a bottle. Our program is an opportunity to revitalize that purpose and build an understanding of how important it is to bridge the gap between our traditional ways and modern living. Living a healthy lifestyle and choosing to be the change is the key to overcoming this challenge in our villages.	Our approach is simple. Coach. As Alaskan Natives we have a unique ability to connect with the communities we visit - we literally are the demographic we hope to inspire. By traveling to communities across Alaska it gives us a chance to truly put boots on the ground and connect with the people. The draw: an American Ninja Warrior and Traditional Native Games residency. We bring or build Ninja Warrior style obstacles in the villages we visit and show them the importance of physical activity, but more importantly we work one on one "talking circle style" with the community to help them understand the unique challenges they face, and how to overcome them.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

The Glory Hall	CRITICALLY NEEDED Supportive Treatment Housing	AK	Our organization has been providing housing for people NOT in recovery since 2017, at the Forget-Me-Not-Manor facility, which now consists of 92 apartments. We developed the apartments in 3 phases, together with our partners Bartlett Regional Hospital and Southeast Alaska Regional Health Consortium and we used a community referral process to fill every single unit. The outcomes are impressive, particularly in the context of health care. Hospital admissions and interactions with emergency services drop dramatically for our tenants, almost right at move in. What is also notable is the length of hospital admissions. Even if individuals are admitted to the hospital, discharge is great because their is a home to discharge to. People do not spend weeks and months unnecessarily at the hospital because they have a home. Most outcomes are better. What we want to do is use the same model but for people in recovery. The problem we are addressing is profound and simple. How can we make recovery last? How do we end the revolving door of people going to rehab over and over again only to return to using, crime committing, often homelessness as soon as they come out of treatment or jail? We solve the problem through housing. We add critically needed units to the starved housing market and we ensure that supports are on site and that partnerships with major healthcare providers are in place and that recovery is supported through housing, partnerships, and expertise.	Our approach is simple: 1. We finalize our building design and solidify our partnerships, clearly defining roles. Juneau Housing First Collaborative is uniquely qualified to do this. We developed 99 units of housing and built a shelter/care center facility in the last 8 years. We have an great an established partner relationship with both Bartlett Regional Hospital and with Southeast Alaska Regional Health Consortium. Both organizations work closely with us and understand that patients benefit immensely through housing and collaboration. 2. We construct Phase 1 of the project, 34 units and support offices. The more funding we can secure through this opportunity, the faster we can build without having to leverage additional funds. However, we understand that the need is great and are committed to leveraging other funds if necessary. Phase 1 (34 units) will cost approximately 11 million dollars to develop, subsequent Phases will be slightly less due to the design, site prep, and utilities to site, as well as permitting, achieved in Phase 1. 3. As Phase 1 is getting built, we will formalize the tenant selection process, the operational structure, and partner roles, creating a robust program for people in recovery. This program will rely on intensive case management and intensive collaboration with Bartlett Regional Hospital and SEARHC. 4. Simultaneously, we will establish an excellent evaluation plan to ensure that the project is truly meeting our objective of being a model of recovery housing success which contributes to health care cost reduction and can be replicated in other communities in Alaska. 5. We will secure operating resources, housing vouchers and other supports in order to operate the project. Other communities often partner with healthcare providers to receive operating subsidies in exchange for a place which can provide stability and appropriate level of care, thus limiting critical care readmissions.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough)	Deferred or Not Advanced

The Greater Fairbanks Community Hospital Foundation	Advancing Specialty Access in Interior Alaska: Vascular, Cardiac & Wound Care Expansion	AK	Fairbanks is the sole provider of Vascular Surgery, Cardiology and Wound Care specialty services north of Anchorage. Fairbanks Memorial Hospital (FMH) serves as the regional hub for multiple rural and tribal communities. Approximately 8% of local patients have diabetes, a condition that contributes to poor wound healing and other comorbidities commonly managed within these specialty clinics. Cardiovascular demand in our region is growing faster than our system can keep pace. In 2024, the Center recorded 2,507 vascular encounters and by August 2025 had already reached 2,156, projecting a 29% annual increase, year over year. Cardiac needs are rising as well with 22,820 cardiac encounters in 2024 and continued growth expected. While these represent encounters rather than individuals, more than 4,000 unique heart patients required care last year. This rapid escalation highlights an urgent need for expanded capacity to ensure timely, high-quality cardiovascular care for our community. As a result, demand across all three specialty areas at FMH now exceeds available capacity, leading to long wait times, delayed diagnoses, preventable complications and frequent travel to Anchorage or out of state for essential care. Rural and tribal communities, many of which rely on Fairbanks as their closest specialty hub, face the greatest barriers due to long distances, limited transportation options, and higher burdens of chronic disease such as diabetes, heart failure, and vascular disease.	Foundation Health Partners (FHP) will address urgent specialty-care access gaps in Interior Alaska through a coordinated, multiyear strategy that expands clinical capacity, modernizes care delivery, and strengthens readiness for value-based care. The approach centers on three strategies: expanding clinic infrastructure, implementing redesigned team-based specialty care models, and deploying digital tools to reach rural, remote, and frontier communities. FHP is requesting \$8.5 million in first-year funding—\$8 million for clinic expansion and \$500,000 for care-model redesign and workforce development. These investments launch a multiyear transition toward value-based care by establishing the infrastructure, staffing, and technology required for long-term sustainability. 1. Expand and Modernize Clinical Infrastructure FHP will renovate and expand the Porter Heart & Vascular Clinic to increase capacity across Vascular Surgery, Cardiology, and Wound Care. Upgrades include redesigned patient flow, additional procedure and consult rooms, and integrated space for pharmacists, dietitians, and nurse navigators. Expansion will reduce wait times, support timely diagnoses, and ensure patients can access specialty care without leaving the region. 2. Implement Redesigned, Team-Based Specialty Care Models Integrated care teams will enhance chronic disease management, medication optimization, and adherence support. Pharmacists will provide disease-management programs and point-of-care testing; dietitians will expand wound care support, vascular risk counseling, and home-based services for older adults; and Nurse Navigators will strengthen follow-up and coordination for rural patients. A dedicated Heart Failure Clinic will support early intervention, reduce preventable complications, and decrease readmissions. 3. Expand Digital Health and Remote Monitoring Capabilities To improve access for distant communities, FHP will expand virtual specialty visits, remote monitoring tools, and AI-enabled diagnostic and point-of-care equipment. These technologies will support early detection, reduce unnecessary travel, and allow chronic-condition management closer to home. Prescription-delivery pilots will assist frontier communities, while enhanced analytics will strengthen real-time monitoring, risk stratification, and regional care coordination.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

The Greater Fairbanks Community Hospital Foundation	Fairbanks Addiction Medicine Inpatient Consultation Program	AK	The 2025 Fairbanks Community Health Needs Assessment identifies substance use disorder as a top community health priority. Excessive alcohol use affects 22% of adults, compared to 20% statewide. Drug overdose deaths in the Fairbanks North Star Borough rose sharply among American Indian and Alaska Native residents from 18 per 100K in 2019, 72 per 100K in 2021 and reaching 100 per 100K in 2025. This project addresses a documented gap in the continuum of care. Patients discharged from inpatient care at FMH often struggle to engage in outpatient treatment due to severity of illness, cognitive impairment, transportation barriers, limited internet access, and fragmented care systems. Although outpatient services are able to support these patients, many are still lost to follow-up after discharge. There is a need for an inpatient addiction medicine consultation program to assess hospitalized patients, provide timely intervention, and coordinate ongoing care after discharge to reduce the chance of being lost to follow-up. Currently, inpatient physicians at FMH request occasional consults from the Addiction Medicine Clinic; however, without a consistent process, many fall through the cracks during this transition. There is a need for case management support to ensure patients leave the hospital with a clear treatment plan, confirmed follow up appointments, and coordinated communication among care teams.	To address these challenges, Foundation Health Partners (FHP) is requesting \$500,000 in year one as the initial phase of a multi-year effort to establish a dedicated inpatient addiction-medicine consult service integrated with case management and care coordination. The program will stabilize patients during hospitalization, initiate evidence-based treatment such as medication-assisted treatment (MAT) and provide guided support through the high-risk post-discharge period. By proactively addressing barriers such as transportation, connectivity limitations, and fragmented systems, the program creates a reliable care pathway linking inpatient services, outpatient providers, and community supports. The model centers on a specialized team composed of two Addiction Medicine physicians, a full-time Advanced Practice Provider (APP), a case manager, and a care coordinator. This team will provide consistent daily bedside consultations at Fairbanks Memorial Hospital. A dedicated APP ensures reliable coverage, reduces demands on hospitalists, helps prevent burnout, and delivers focused patient support. This structure standardizes consult response times and ensures all eligible patients receive timely, evidence-based addiction-medicine evaluation. Integrating patient navigation and case management into the inpatient workflow allows the program to address common logistical and social-determinant barriers. Patient identification follows a structured dual-pathway process to ensure no eligible patient is missed. Screening criteria determine whether patients “screen in” for SUD services. Identification occurs through both passive and active pathways: inpatient providers apply screening criteria and place consult orders, while the SUD team proactively reviews new admissions and diagnoses to identify patients who may benefit. As systems evolve, EHR-based automation and alerts may further strengthen this process. Once a consult is ordered, the SUD provider meets the patient at bedside, conducts an assessment, discusses treatment options, and may initiate medication assisted treatment during hospitalization. Case management roles secure follow-up appointments before discharge, coordinate warm handoffs to Tribal Health Organizations and community providers, and ensure robust documentation of transition plans—reducing the risk that patients are lost during the vulnerable post-discharge period.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

The Greater Fairbanks Community Hospital Foundation	Launch PET-CT services in Interior Alaska	AK	Interior Alaska currently has no local access to PET-CT imaging, a critical diagnostic tool for accurate detection, staging, and monitoring of cancer and cardiac disease. Residents of the Interior region must travel to Anchorage or Seattle for these scans, creating significant barriers to timely care. Travel is especially burdensome for medically fragile patients who require multiple scans each year, often leading to delays, incomplete diagnostic workups, and higher overall costs to patients and payers. At the same time, demand for PET-CT imaging in the Interior is substantial and growing. Based on current estimates for Interior Alaska, there are 400 new cancer patients per year and 40% or 160 of those patients would benefit from PET-CT scans. As far as cardiac patients, Fairbanks Memorial Hospital’s Porter Heart Center sees about 4,170 patients per year and an estimated 37% or 1,542 patients would benefit from PET-CT scans. This project presents a critical opportunity to establish the region’s first PET-CT service line, improving access to advanced diagnostics, supporting earlier and more accurate treatment decisions, reducing travel burdens, and strengthening health equity for the 100,000 residents of Interior Alaska.	Foundation Health Partners will expand access to advanced diagnostic care by establishing Interior Alaska’s first PET-CT service line. The project focuses on bringing essential cardiac and oncology imaging closer to home for rural, remote, and frontier residents who currently must travel long distances for these services. Currently, this project has raised \$3.2 million in donations and is requesting \$4.2 million for the remainder of the funding needed to complete this project. The approach begins with completing the remaining project design, which is already 65% finished and scheduled for final approval by March 2026. Construction will begin once design is final and full funding is secured. The project reconfigures the existing Nuclear Medicine suite within the Fairbanks Imaging & Breast Center, avoiding the cost and delays of new construction. After remodeling, the Siemens Biograph Trinion EP PET-CT scanner and the necessary hot-lab equipment will be installed and tested. This phase includes vendor coordination, regulatory checks, and environmental preparation to ensure safe and compliant operations. Once the equipment is installed, staff training, radiation safety reviews, and workflow validation will prepare the team for clinical launch. The service will be supported through cross-training existing nuclear medicine personnel and by using established radiopharmaceutical supply chains. Within the first year, the project aims to reach steady operations of about 10 scans per day—five cardiac scans each morning and five oncology scans each afternoon—allowing rural patients to receive timely imaging without leaving the region. Strong regional partnerships will support referrals and care coordination, including Bassett Army Community Hospital, Chief Andrew Isaac Health Center, and local cardiology and oncology clinics. Overall, this approach provides a clear, phased path to bringing high-quality PET-CT imaging to Interior Alaska. By reducing travel burdens, improving diagnostic timeliness, and establishing a sustainable service model, the project will significantly enhance care for rural and medically vulnerable populations across the region.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

The Greater Fairbanks Community Hospital Foundation	Maternal Health Planning in Interior Alaska	AK	Fairbanks serves as the maternity care hub for Interior Alaska seeking to meet local maternity and pediatric needs without requiring transfers. This project seeks to conduct planning to address two maternal health needs. Families face significant barriers to accessing essential Maternal-Fetal Medicine (MFM) and pediatric subspecialty care. High-risk patients—including those with gestational diabetes, hypertension, complex fetal anomalies, and infections—frequently travel over 300 miles for specialized treatment. These trips often exceed \$1,000, causing immense financial, physical, and emotional strain on families due to travel costs, missed work, and childcare needs. Currently, the lack of local subspecialty care leads to delayed diagnoses and emergency air evacuations. Access to advanced diagnostics, such as MFM-level sonography and perinatal genetics, falls short of the standard of care. Out-of-state laboratory analysis adds additional financial burdens through inconsistent insurance coverage. The identification and care of pregnant people and newborns affected by substances during the perinatal period is a high priority in the region. By leveraging Alaska Perinatal Quality Collaborative (AKPQC) strategies and resources, this project will establish comprehensive, culturally responsive policies for universal screening and newborn toxicology testing. This approach ensures consistent, respectful care that honors community values and supports Alaska’s diverse families.	Foundation Health Partners is requesting \$300,000 for a collaborative planning project will fund a new dedicated maternal health planning position and provider time to develop the operational, clinical, and technological foundations needed to improve maternity care in the Interior region. The planning will focus on two specific needs: Develop a sustainable model for visiting and telemedicine subspecialty clinics to enhance high-risk pregnancy care at Fairbanks Memorial Hospital. Develop policies and processes to utilize the Alaska Perinatal Quality Collaborative Substance Affected Pregnancies Initiative (SAPI) tools and recommendations and the recommendations for newborn toxicology testing to improve prenatal and postpartum care in the setting of psychosocial perinatal risk. The planning project will coordinate with Tribal partners, statewide Maternal Fetal Medicine (MFM) teams, AKPQC, pediatric specialists, IT, imaging services, and community stakeholders to design a sustainable, culturally responsive model for delivering maternity subspecialty care and impacting perinatal substance use. The project will develop a formal partnership with the Alaska Native Medical Center to provide MFM physician access through a "shared model". This MFM specialist will provide a physical presence in Fairbanks and offer 24/7 remote consultation. This collaborative approach builds medical and cultural bridges between Anchorage and Fairbanks to serve a diverse population, including Tribal partners, military families, and rural residents. The project will develop plans for a telemedicine and IT system that will streamline communication and data transfer, improve clinical safety, and reduce travel. We will conduct a needs assessment for high-level fetal ultrasound equipment, sonographer training, and clinical space requirements to facilitate a multifunctional environment for pediatric and obstetrical specialists. This project will develop the policies and processes needed to implement a standardized approach to screening and brief intervention for perinatal substance use and for newborn toxicology screening. The planning process will seek agreement among providers on the tools, process, and training needs for universal screening during pregnancy. The planning will emphasis culturally responsive, high-quality care as the regional standard and ensure every pregnant person and newborn receives consistent care regardless of geography.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

The Greater Fairbanks Community Hospital Foundation	Purchase an Intuitive da Vinci robotic surgical system	AK	In October 2026, the current Intuitive da Vinci robotic system at Fairbanks Memorial Hospital will reach the end of its lifecycle and require replacement. The system is integral to providing minimally invasive surgery for patients across Interior Alaska, supporting employed and community general surgery, urology, and gynecology providers. Updating this equipment will ensure patients continue to receive innovative, high quality surgical care close to home. The technology also serves as both a recruitment asset and a retention tool for surgeons who rely on advanced platforms to deliver modern, evidence-based care. Without replacement, patients may face reduced service availability, delays in care, or the need for costly travel outside Alaska for complex procedures. This need is also closely tied to workforce stability. Robotic surgery is now a standard expectation in surgical practice, and FMH’s ability to recruit and retain high quality surgeons depends on maintaining up to date robotic capability. Replacing the current system preserves advanced surgical services, supports strong patient outcomes, and ensures Interior Alaska residents can continue receiving evidence-based care locally.	Fairbanks Memorial Hospital is requesting \$ 2.8 million for the Intuitive da Vinci robotic surgical system that needs replaced before it reaches end of life in October 2026 to ensure uninterrupted access to minimally invasive surgery for Interior Alaska. Early coordination with the vendor will secure timely production and delivery, so surgical services are not disrupted. As the purchase progresses, FMH’s facilities, biomedical engineering, and perioperative teams will prepare the operating room, complete infrastructure checks, and ensure the environment is ready for installation. After delivery, the system will be installed and tested to confirm it is safe and fully functional for clinical use. Training will be a key part of the transition. Surgeons and operating room staff will participate in vendor supported training, hands-on simulation, and familiarization sessions to adopt the upgraded technology safely and confidently. Once the system is in place, FMH will focus on stabilizing operations and supporting providers as they transition to the new platform. The upgraded system will help maintain surgical volumes, preserve clinical quality, and support recruitment and retention of high-quality surgical professionals. FMH will assume ongoing operational and maintenance costs after the RHTP grant period to ensure long term sustainability. The hospital will continue monitoring outcomes, access metrics, and workforce impacts to ensure the technology delivers lasting benefits to rural communities. This approach protects uninterrupted access to advanced surgical care, strengthens the local workforce, and supports long term alignment with evidence-based standards of care.	\$1M-\$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

The Greater Fairbanks Community Hospital Foundation	Team-Based, Value-Driven Primary Care Transformation in Interior Alaska	AK	The limited availability of primary care has been identified as one of the most pressing issues in the Community Health Needs Assessment for the Fairbanks region. Foundation Health Partners (FHP) is one of the few organizations in the region accepting Medicare, Medicaid, and uninsured patients without caps. FHP currently delivers primary care through its Internal Medicine & Senior Care Clinic and the TVC Family Medicine Clinic, but existing capacity is insufficient to meet community demand. Outdated clinic space, ongoing workforce shortages, and a lack of integrated technology contribute to inconsistent care quality, delayed diagnoses, and preventable complications. These challenges disproportionately affect rural residents who must travel long distances for even basic health services. FHP seeks to address limited primary care capacity available to serve rural and remote communities of Interior Alaska. Traditional reimbursement for primary care does not generate sufficient revenue to cover the investments needed to build the infrastructure and care teams to support a new model of care. Building a robust value-driven primary care model is the foundation for a phased adoption of an alternative payment model that will offer financial sustainability of primary care services. This project makes a significant investment in primary care by reconfiguring the clinic space, enhancing IT systems, and building the workforce to provide primary care for the future.	This is Foundation Health Partners (FHP) top transformation project. It is an ambitious, costly investment in an interdisciplinary, team-based primary care transformation. The project has been in the planning phase for many years and is ready to launch with funds from RHTP. FHP is requesting up to \$23.9 million during year one. FHP has the capacity to complete this project by Oct 2027 as the first phase of a multi-year effort to transition to value-based care. FHP will build the infrastructure to deliver proactive, technology-enabled care to 26,100 adults, strengthening chronic disease management and coordination for Interior Alaska. Year 1 investments focus on three pillars: 1. Clinic Reconfiguration (\$15M): Modifying existing 3rd-floor hospital space to support team-based care and expanded access. Upgrades to lighting, plumbing, and layout will convert underutilized areas into high-functioning clinical space with improved accessibility. 2. Digital Infrastructure & EHR (\$8.2M): Enhancing the EHR to unify health IT across care settings. This includes patient-facing tools, telehealth, HIE connectivity, and population health analytics. AI-enabled decision support will improve risk stratification for cancer, cardiovascular disease, and suicide, while ensuring medication safety and preventive care adherence. 3. Workforce Development (\$700K): Training and recruiting for redesigned roles, including medical assistants, pharmacy technicians, care navigators, and community health workers. FHP will also hire a dedicated Improvement Specialist to lead the transformation. The model emphasizes prevention and early intervention, including cancer screening, smoking cessation, weight management, behavioral health, diabetes education, and medication optimization. High utilizing patients will receive intensified services such as quarterly provider visits, annual wellness visits, semiannual pharmacy education, medication reconciliation, and care navigation. This project will allow FHP to partner with the Department of Health for a phased adoption of new primary care payment models that shift from volume-based reimbursement to value-based payment. Developing this clinic, IT, and workforce infrastructure will establish the core competencies necessary for long-term participation in value-based care arrangements.	Over \$5M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

The Greater Fairbanks Community Hospital Foundation	Integrated Tele Nursing Support System	AK	Fairbanks Memorial Hospital (FMH), operated by Foundation Health Partners (FHP), is a Sole Community Hospital (SCH) serving a vast catchment area of over 100,000 individuals in Interior Alaska. As the primary provider of acute and emergency services for this region, FMH faces a critical intersection of geographic isolation and a tightening nursing labor market. FMH provides nursing services in every unit and every department across the hospital. The hospital faces ongoing nursing workforce challenges, including staffing shortages, rising patient acuity, high turnover, and burnout. Nurses are increasingly stretched thin by safety monitoring, documentation demands, and the need for constant observation of high-risk patients. This project seeks to address workforce demands while improving patient safety. Currently, nurses are burdened by high-acuity patient loads and a staggering administrative volume. Patient falls remain a persistent safety challenge; traditional 1:1 "sitter" monitoring is resource-intensive and often unscalable during staffing shortages. Virtual nursing solutions can help relieve these burdens by extending staff capacity and improving patient safety. This project presents an opportunity to address staffing constraints by implementing virtual options to augment clinical operations. AI-powered telesitter technology will allow for virtual patient monitoring and reduce the need for the hospital to assign a staff person to sit in a patient's room.	FMH is requesting \$288,000 in year one for an integrated Nursing Tele Support system to be deployed across inpatient units and the Emergency Department. The approach leverages a dual strategy—virtual sitter and virtual nursing solutions—to create a digital safety net that supports both patients and clinicians. CareView Remote Patient Monitoring is an AI-driven patient monitoring system designed to enhance patient safety in hospitals. It uses high-definition cameras, 2-way audio, and real-time analytics to allow staff to monitor up to 35 patients simultaneously from a central hub. It helps detect falls, prevent elopement, and reduces the need for in-person sitters. It utilizes mobile carts, portable, and ceiling mounted cameras with night vision and 360-degree views. This technology will reduce the need for traditional patient sitters that require a one-to-one staff-to-patient ratio for monitoring. The focus will be on high-risk patients such as those with delirium, dementia, or high fall risk and will allow one nurse to monitor multiple patients simultaneously. The AI features will identify subtle movements or patterns, such as a patient attempting to exit a bed, and trigger immediate alerts. This "predictive safety" model has been shown to reduce fall-related injuries by enabling staff to intervene before an adverse event occurs. This reduces the need to pull clinical staff away from high-acuity tasks for basic observation, ensuring bedside resources are deployed where they are most critical. To combat burnout and improve retention, the project will also introduce a Virtual Nursing Solution designed specifically to offload non-physical clinical tasks. These virtual nurses will handle time-consuming administrative burdens which allows bedside nurses to return their focus to "top-of-license" clinical care. This approach can create alternative work settings. For experienced nurses desiring a less physically demanding environment or flexible hours, virtual nursing offers a pathway to remain in the workforce, preserving institutional knowledge that might otherwise be lost to retirement or disability. Virtual nurses provide essential real-time support as a "second set of eyes" for high-stakes procedures, such as medication double-checks and sepsis bundle compliance audits, directly improving the hospital's overall quality metrics. This approach provides integrated methods for improving patient safety as well as increasing retention of staff.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

The Greater Fairbanks Community Hospital Foundation	Podiatry Services for Medicaid Patients in Interior Alaska	AK	Under federal Medicaid rules, podiatry services are optional for states to cover. Alaska recognizes podiatrists (DPMs) as licensed medical professionals. Alaska’s Medicaid program covers podiatry services for children, but does not cover podiatry services for adults. Because they will not be reimbursed, Alaskan podiatrists generally do not serve adult patients who have Medicaid as their primary insurance. Alaska is one of only four states with a restriction on adult use of Podiatry. This gap creates a critical access issue for adult enrollees who require specialized care for foot and ankle trauma and chronic diseases. The lack of coverage often results in untreated conditions that escalate into emergency department visits, inpatient stays, and significant morbidity, including avoidable amputations. This is particularly critical for diabetic patients; the Alaska Department of Health notes that uncontrolled diabetes can lead to disability and limb loss, yet the specialists best trained to treat these complications are excluded from Medicaid. Evidence from other states shows that integrating podiatry into Medicaid systems improves patient outcomes while reducing overall costs by shifting care from expensive emergency settings to cost-effective specialty clinics. By aligning with the 46 other jurisdictions that provide adult podiatry benefits, Alaska can support its medical community’s desire for better referral options and provide care to its most vulnerable residents.	In 2022, the Alaska Medical Care Advisory Committee (MCAC) made a recommendation to the Commissioner to add podiatric physicians as a covered provider for adults in the Alaska Medicaid system and outlined the regulatory language to allow adults on Medicaid to receive Podiatry services. The recommendation was not adopted, and the need to conduct a cost-benefit analysis was identified. This project requests \$200,000 to provide pilot podiatry services to adult Medicaid patients and complete a cost-benefit analysis to demonstrate the value of adding podiatry services to Alaska’s state Medicaid plan. Adults on Medicaid with foot and ankle issues often do not get the care they need, and their untreated conditions can result in emergency department visits and inpatient stays. Lack of podiatric coverage is resulting in significant morbidity (including below the knee amputations) and unnecessary deaths. Access to Podiatric expertise is an essential part of the multidisciplinary team involved in the amputation prevention efforts. FHP has added Dr. David Huntsman, DPM a board-certified podiatric physician with advanced surgical training to the orthopedic team at Fairbanks Memorial Hospital. (FMH) The hospital is committed to making podiatry services available to all patients including the Medicaid population despite the lack of payment by Medicaid for providing this care. FMH estimates 20% of the patients seen by the podiatrist will be covered by Medicaid and no payment will be received for their care. This project is requesting funding to pay 20% of the podiatric physician salary to cover the cost of caring for Medicaid patients. To evaluate the costs and benefits of adding podiatrist services to Medicaid, FHP will fund a contract to gather data in partnership with the Alaska Medicaid program. The project will conduct a formal cost-benefit analysis. This study will evaluate if providing preventative and specialized podiatric care to adult Medicaid patients improves health outcomes at a lower cost than the current reliance on emergency department triage and inpatient surgery. The consultant will survey Alaskan podiatrists to gauge support for the recommendation to add podiatrists to Medicaid. This ensures that the medical community is aligned and ready to serve this population. FHP will work with the M to ensure the necessary evidence is gathered to implement a sustainable cost-effective expansion.	\$50,000-\$250,000	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

The Institute for Individual and Organizational Change (IFIOC)	Fidelity Based Motivational Interviewing as an Evidenced Based Practice	WA	Rural Alaska faces high rates of chronic disease, behavioral health needs, and substance use disorders alongside workforce shortages and geographic isolation. Even when services exist, disengagement, ambivalence, and treatment dropout limit effectiveness. Traditional workshop based training improves knowledge but rarely produces sustained clinical skill or measurable outcome change. Research demonstrates that without structured feedback and coaching, initial gains erode and performance plateaus. This creates a persistent gap between workforce education and system level outcomes. The opportunity is to close that gap by embedding fidelity based Motivational Interviewing implementation directly aligned with RHTP deliverables. Rather than adding new programs, this initiative strengthens the effectiveness of existing services by improving how providers engage patients in care. By measuring workforce proficiency and correlating it with engagement and retention metrics, Alaska can convert communication into a measurable lever for improving access, quality, and sustainability across rural systems.	This 12 month initiative implements a structured fidelity based Motivational Interviewing model across participating rural and frontier sites. Phase One establishes foundational and advanced skill through live interactive training that integrates contemporary neuroscience and trauma informed principles. Providers learn how chronic stress, historical trauma, and ambivalence influence executive functioning, adherence, and health decision making, particularly in Indigenous and frontier communities. Phase Two embeds structured fidelity measurement and individualized coaching using the MICA. Practitioners submit recorded sessions for confidential review and receive strengths based feedback focused on skill acquisition. Research consistently demonstrates that structured coaching produces significantly greater and more durable skill development than training alone. Participating agencies receive transparent proficiency reporting and guidance on correlating workforce skill metrics with operational indicators such as retention, medication adherence, treatment initiation, and patient satisfaction. The performance chain is explicit and measurable: as workforce proficiency increases, fidelity increases; as fidelity increases, engagement and adherence increase; as engagement and adherence increase, RHTP performance outcomes improve. The initiative also supports development of internal champions who can sustain fidelity processes within supervision and quality improvement structures. Tele coaching models ensure frontier communities can participate without geographic barriers, strengthening equitable access statewide.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

The Last Frontier Lodge	I AM SOMEBODY - Transitional Living Program for Youth Aging Out of Foster Care	AK	In Alaska, youth aged 14–24 aging out of foster care face a critical shortage of stable housing and access to essential life-skills coaching. Approximately 2,400–2,500 youth are in foster care at any time, with about 40 aging out each year. While the Office of Children’s Services provides Independent Living supports, it does not operate housing facilities. Existing transitional housing programs run by nonprofits like Covenant House, Youth Advocates of Sitka, Choosing Our Roots, VoA Alaska, and Bethel Housing and Homelessness Coalition serve broader populations and have extremely limited capacity, typically 10–25 beds per program. Statewide, fewer than 150 beds are available for youth exiting foster care, forcing many to rely on temporary solutions like college dorms, apartments with case management, or general youth homelessness programs. The I AM SOMEBODY Transitional Living Program for Youth will provide 5–10 dedicated transitional beds, combined with structured life-coaching and case management, mental/physical health care, giving young adults a supportive environment to build the skills/confidence needed for independent living. The programs focus on measurable outcomes, like housing stability, educational/employment engagement and independent-living readiness. By addressing this gap, the program reduces the risk of homelessness/instability, ensures participants have a clear pathway to self-sufficiency, and strengthens long-term outcomes for a population at high risk.	This project establishes a health-centered transitional living program for youth aging out of Alaska’s foster care system, addressing a critical gap in housing, health, and life-skills support. Youth exiting foster care face housing instability, limited access to health care, and social isolation, placing them at high risk for long-term physical, behavioral, and social health challenges. I AM SOMEBODY program combines safe, stable housing with health and supportive services to improve wellbeing, increase access to care, and strengthen pathways to independence. The Lodge has been identified as the location for the proposed transitional living program. All required permits and approvals will be explored and obtained as needed during the start-up period. The program will partner with child welfare agencies and local organizations to identify youth approaching age-out. Youth will participate in individualized assessments to determine housing needs and readiness for services. A review team will prioritize youth with the greatest need, enrolling 5–10 participants per cohort. Removing barriers to participation including transportation, documentation, and service navigation ensures equitable access for all eligible youth. Participants will live in safe, housing units with basic updates to meet living standards. Program funds will support housing stabilization services, transportation to health services, utilities, and other allowable housing-related supports that promote safe, stable, and independent living. Case management, life-skills coaching, transportation to health services, access to education and employment resources will further strengthen participants’ ability to thrive. Each youth will work with a trained community health worker to coordinate care, provide health education, and navigate preventive, primary, and behavioral health services. Housing stability will serve as the foundation for improved health outcomes. Measurable goals include 90% of participants maintaining stable housing for 12 months, 100% completing health screenings, 75% engaging in ongoing primary or preventive care, 50% reduction in emergency health utilization, and 80% participating in education, employment, or independent living programs. By integrating partnerships, evidence-based care, this program creates sustainable, outcome-driven model that addresses housing as a social determinant of health, and empowers Alaska’s youth to achieve long-term stability and self-sufficiency.	\$1M-\$5M	Statewide	Anchorage (Municipality)	Deferred or Not Advanced

The LeeShore Center	Child Enhanced Services	AK	Research has shown that children directly experiencing or witnessing domestic and sexual violence not only suffer from traumatic stress and ongoing emotional and behavioral problems they are at risk of suffering lifelong health issues as adults as well as using violence in later relationships themselves or entering into an abusive relationship. The rates of child sexual assault in Alaska are 6 times the national average and 1 in 3 youth experience teen dating violence. The Adverse Childhood Experiences (ACEs) study looked at childhood trauma and maltreatment, occurring between the ages of 0-17, and later-life health and well-being. Traumatic events included experiencing violence, abuse, neglect, witnessing violence and other traumas such as attempts of suicide by a family member, mental health problems, parental separation or incarceration of a parent, sibling or other family member. The more trauma a child experienced, the higher the risk of experiencing one or more behavioral, social, or physical problems later in life. ACEs can disrupt brain development, compromise immune systems, and lead to unhealthy behaviors, such as substance misuse. Chronic health issues later in life include diabetes and heart disease as well as depression, anxiety and suicidal tendencies. Early intervention is critical, providing mental health treatment and on-going support to children experiencing or witnessing violence can help build resiliency and better protect their health and well-being.	Children coming into LeeShore's emergency and transitional housing shelters have either witnessed or experienced domestic violence or sexual assault. They come with a variety of ills, including anxiety, sleeplessness, nightmares, stomachaches, high activity levels, aggression, worry, emotional detachment, depression; older youth may have issues with substance misuse, feel shame or guilt, are hypervigilant, or withdrawn and have poor concentration. The LeeShore Center proposes to contract out with a mental health clinician specializing in providing trauma-informed, evidenced-based treatment to traumatized children. The clinician would provide therapy services 1 x per week in-house (up to 8 hours per week) to children and youth up to age 18 residing in our emergency and transitional housing facilities. Services would include age-appropriate guided play therapy, therapeutic therapy, risk assessments, and individualized therapy to help address and lessen trauma symptoms. Mental health treatment can offer interventions that mitigate the negative effects of early adversity and trauma; interventions such as helping children feel safe, allowing them to talk about their fears, providing skills and strategies that can help them cope more effectively with stress, and mentoring parenting skills for the non-offending parent that can lead to healthy childhood development.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

The Raven Collective Thriving Community Initiative	Sustainable Tribal Health Systems in Alaska: Workforce Infrastructure and Technology-Enabled Care	IL	Rural and remote Alaska communities face persistent structural barriers to accessing timely, high-quality health care. Workforce shortages, provider turnover, transportation barriers, limited specialty care access, and infrastructure constraints create ongoing challenges for communities that are geographically isolated and weather-dependent. Tribal Health Organizations (THOs) serve as the backbone of health care delivery in many of these regions, yet they often operate within resource-constrained systems that must continuously adapt to maintain services. While many THOs have implemented innovative approaches—including telehealth expansion, community health worker models, and integrated care strategies—these efforts are often fragmented or difficult to sustain due to workforce instability, infrastructure limitations, and funding complexities. This project addresses an opportunity to strengthen Tribal health system infrastructure and sustainability through a collaborative initiative focused on workforce stabilization, telehealth expansion, and systems integration. By partnering with 1–2 Tribal Health Organization partners, the project will identify scalable solutions that improve access to care, enhance coordination across services, and build durable systems capable of supporting long-term rural health transformation in Alaska.	The Indigenous Rural Health Systems Strengthening Initiative will bring together The Raven Collective and 1–2 Tribal Health Organization partners to design and implement systems-level solutions that improve access, quality, and sustainability of rural health care. The project will begin with a structured systems assessment and strategic planning process with participating Tribal partners to identify priority workforce, technology, and service delivery challenges. This process will evaluate existing telehealth infrastructure, workforce capacity, care coordination pathways, and fiscal sustainability considerations to identify opportunities for improvement and scaling. Based on this assessment, the project will support three core areas of transformation: Workforce Infrastructure Strengthening: Participating partners will develop strategies to improve recruitment, retention, and support of rural health workers, including integration of community health workers, Community Health Aides, Behavioral Health Aides, and other frontline providers. Workforce stabilization planning will focus on improving continuity of care and reducing disruptions caused by high turnover. Technology and Telehealth Expansion: The project will strengthen telehealth capacity to improve access to specialty care, behavioral health services, and care coordination across geographically isolated communities. This may include telehealth workflow integration, infrastructure enhancements, and improved connectivity between local providers and regional referral systems. Systems Integration and Sustainability: The initiative will support Tribal partners in strengthening care coordination between primary care, behavioral health, and community-based services. Fiscal sustainability strategies—including reimbursement alignment, infrastructure planning, and operational efficiencies—will be explored to ensure improvements can persist beyond the project period. Throughout the initiative, The Raven Collective will provide facilitation, technical assistance, and project coordination support. Lessons learned from participating partners will be documented to inform scalable rural health system strategies that may benefit other Tribal and rural communities across Alaska.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Ketchikan Gateway Borough; Northwest Arctic Borough	Deferred or Not Advanced

The Recruiting Squad, LLC	Final Consolidated Draft: Alaska RHTP Letter of Interest	DE	Field 1: Project Title HiringOS™: A Decentralized Fulfillment Engine for Alaska’s Rural Clinical Workforce	Field 2: Project Description TRS will deploy HiringOS™ as the primary technical infrastructure for Alaska’s rural healthcare facilities. The platform functions as a direct Fulfillment Engine for local Hiring Managers at hospitals, FQHCs, and Tribal clinics, putting high-velocity recruitment capabilities directly into the hands of local facility leaders. Position Activation: Hiring Managers can activate a clinical vacancy in under two minutes via their dedicated dashboard. Instant Budgetary Estimates: Upon activation, the system generates an immediate Budgetary Estimate based on our usage-based model, providing facilities with instant cost-certainty for RHTP fund allocation. Direct Talent Delivery: Only "Interview-Ready" candidates—vetted for clinical credentials and the federal 5-year rural service mandate—are delivered directly to the facility dashboard for immediate review.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

The Rural Behavioral Health Institute	Screening Linked to Care: School-based Virtual Suicide Prevention for Alaska Youth	MT	Suicide is the second leading cause of death for rural youth in America, yet fewer than half of youth with treatable mental health conditions receive care. Alaska is the epicenter of this crisis. The state's overall suicide rate of 29.7 per 100,000 is the highest in the nation and has increased 34% over the last decade. Alaska Native young people bear a disproportionate burden, with the highest suicide death rates of any population nationally. With 57% of Alaskans living in designated mental health care shortage areas, most rural and remote youth have no pathway to support until they are in crisis. In remote regions, crisis care often does not exist. Untreated mental health conditions among youth are associated with increased school absences, poorer academic performance, lower graduation rates, and greater involvement in child welfare and juvenile justice systems—with lasting implications for entire communities. Early identification and care connection are essential to break this cycle. Alaska is uniquely positioned to be a pioneer in prevention. The state leads the nation in rural healthcare innovation, with dedicated state leadership, growing behavioral health infrastructure, and demonstrated success at designing care that works in the most remote and challenging conditions in the country. RBHI's Screening Linked to Care (SLTC) program is a scalable early identification program that can plug into and activate these existing networks, reaching youth before a crisis.	Alaska has an opportunity to set a national standard for rural youth mental health care through RHTP — and RBHI's Screening Linked to Care (SLTC) is a proven, technology-enabled piece of that puzzle. SLTC provides a ready solution that addresses the complete pathway from screening to appropriate intervention and ongoing care. Grounded in SAMHSA's evidence-based Screening, Brief Intervention, Referral to Treatment (SBIRT) framework, SLTC removes the barriers that prevent rural families from accessing care by bringing bi-annual universal mental health screenings, same-day care for high-risk students, and care navigation support directly to students in grades 3–12 at their schools. Our fully virtual model was built for the realities of rural and frontier communities. Since piloting in one Montana school in 2021, RBHI has delivered 66,000+ screenings in 150+ schools in four states and provided same-day care to more than 4,400 students with elevated suicide risk. Year-over-year, repeat students report more than three-fold reductions in suicidality and 29%+ decreases in severe depression and anxiety, proving that technology-enabled care can improve health equity via enhanced care access for youth in rural and underserved communities. SLTC is modular by design. Schools with existing clinical partnerships use our screening platform and manage follow-up themselves. Schools needing comprehensive support access our full suite of services. In every configuration, schools are in charge. They make all implementation decisions, adapt the program to their community's needs, and own their data. RBHI staff serve as facilitators and are available year-round. Every program component has been co-designed with schools and families: screener selection, real-time school dashboards, consent processes, same-day safety check-ins, and a care navigation platform that families and schools can access at any time. RBHI continuously collects and incorporates feedback from school and community partners to reduce implementation barriers and meet emerging needs. This approach has produced 95%+ school retention because partners genuinely own the work. SLTC is designed to strengthen Alaska's hub-and-spoke infrastructure, connecting schools, Tribal health organizations, local providers, and community organizations around a shared early identification system. SLTC is an early identification tool Alaska's behavioral health infrastructure can use to increase its impact on youth mental health.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

The TEARS Foundation	Amelia and Kannon’s Assistant	AK	Families in Alaska who experience the loss of a child often face immediate and overwhelming financial and logistical barriers, particularly in rural, remote, and frontier communities. Funeral and burial expenses can range from several thousand to tens of thousands of dollars, and costs are often significantly higher in Alaska due to transportation, limited service providers, and geographic isolation. Many families must also manage travel for medical care, the return of a child to their home community, or transportation of family members, creating additional financial strain during an already devastating time. For many families, there are few resources available to help with these urgent expenses. Assistance programs are limited, inconsistent, or difficult to access quickly, leaving families to rely on community fundraisers, loans, or personal savings while navigating intense grief. This gap in support can delay services, increase financial hardship, and add unnecessary stress during the earliest stages of bereavement. Amelia and Kannon’s Assistance was created to address this critical gap by providing immediate financial support to families after the loss of a child. The program helps cover funeral, burial, and related expenses so families can focus on honoring their child and beginning the grieving process rather than worrying about how to pay for essential services. By providing timely assistance and compassionate support, the program helps ensure families across Alaska	AK Afterglow addresses this gap through the Amelia and Kannon’s Assistance program by providing timely, compassionate financial support to families following the loss of a child. The program offers direct assistance for funeral, burial, cremation, and related memorial expenses, helping ensure that families can honor their child with dignity without facing overwhelming financial burden. The approach focuses on rapid response and accessibility. Families, hospitals, social workers, or community partners can submit requests for assistance, allowing the program to respond quickly during a time when decisions and arrangements must be made within days. Funds are distributed directly toward funeral homes or service providers whenever possible to ensure the support is used for its intended purpose and to streamline the process for grieving families. AK Afterglow also works collaboratively with hospitals, care providers, community organizations, and volunteers across Alaska to identify families in need and connect them with available resources. These partnerships help ensure that families in rural, remote, and underserved communities are aware of the program and can access support when it is needed most. In addition to financial assistance, AK Afterglow provides compassionate outreach and connections to grief support and remembrance opportunities, helping families feel supported beyond the immediate loss. This approach strengthens community networks of care while reducing financial and emotional barriers during one of the most difficult moments a family can face.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

THE WSDM NETWORK	WSDM Network: Artificial Intelligence (AI) Integrated Rural Behavioral Health Transformation	AK	In rural Alaska, the behavioral health crisis is compounded by a "technological and logistical desert." Current models of care are reactive and limited by the extreme scarcity of on-site clinicians. For Alaskans in remote or frontier communities, the wait time for intake often exceeds the window for effective crisis intervention. There is a critical lack of digital tools that allow for immediate self-regulation, triage, and trauma-informed screening at the point of need. To fulfill the RHTP mandate of system-level change, Alaska must move beyond traditional telehealth toward an integrated, AI-supported ecosystem that "sparks innovation" by bridging the gap between clinical demand and workforce capacity.	The WSDM Network, leveraging decades of clinical expertise from Wisdom Traditions Counseling Services (WTCS), proposes a transformative project designed specifically to align with RHTP Section 6 (Spark Technology and Innovation). We will test a new delivery modality: a novel Agentic AI-Supported Care Model that prioritizes the "ethical and appropriate use of AI" as a clinical assistant rather than a replacement. This initiative focuses on: • Enhancing Telehealth: Moving beyond simple video calls to interactive, AI-guided behavioral health exercises and supports. • Appropriate AI Use: Utilizing narrow AI models for intake automation and multi-perspective evaluation summaries to reduce provider burnout. This system would be created to flag specific items that a clinical oversight personnel would review and respond to. • Data Sharing & Interoperability: Designing the platform to facilitate seamless clinical documentation and data sharing between rural hubs and specialists. • Cybersecurity: Implementing a framework that secures sensitive behavioral health data in remote, low-bandwidth environments.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

THEMA Health, Inc	Rural & Tribal End-of-Life Access Expansion	AZ	Alaska can seize a scalable, home-based care opportunity that replaces long, costly travel with reliable services at home and earlier, culturally respectful end-of-life support. A hub-and-spoke footprint with mobile clinicians and RPM enables continuous management of chronic illness and smooth transitions into palliative and hospice care even where roads are seasonal or air travel is required. Because rural residents enroll in hospice less often and later, expanding home-based palliative and hospice closes a well-documented quality-of-life gap. The opportunity extends beyond clinical gains: local workforce development (full-time plus per-diem to cover low-density areas), formal referral pathways with rural hospitals, RHCs/FQHCs, tribal and IHS facilities, and reduced reliance on costly medevacs. The model is tailored to Alaska’s frontier context and directly aligns with RHTP initiative areas (Access, Workforce, Technology/Innovation, Pay for Value) to build durable community capacity and long-term system resilience.	We will deploy a regionalized hub-and-spoke clinical operations model built for Alaska’s frontier geography. Hubs in accessible population centers house clinical leadership, care coordination, and telehealth/remote patient monitoring (RPM). Interdisciplinary field teams composed of RNs, LPNs, CNAs/HHAs, therapists, medical social workers, and chaplains that are dispatched from hubs to rural and tribal communities, ensuring reliable coverage where many villages lack on-site physicians and depend on air transport. Care follows an evidence-based continuum: home health to stabilize chronic conditions and reduce acute episodes; palliative care for early symptom control and goals-of-care planning; and hospice for end-of-life management, caregiver training, and culturally aligned support. This directly targets known disparities in rural hospice use, patients entering later and less often than urban peers. Operational reliability is maintained through RPM for daily physiologic checks and rapid triage during weather-limited travel; route optimization and per-diem staffing pools preserve visit adherence across vast distances. Workforce development prioritizes clinicians residing within or near service regions, structured onboarding, and Alaska Native–specific cultural competency. Formal MOUs with rural hospitals, RHCs/FQHCs, and tribal/IHS facilities establish coordinated referral pathways, data sharing, and appropriate use of respite/GIP levels of care, aligning with RHTP’s access, workforce, and technology priorities.	\$1M-\$5M	Home- and communit y-based services provider	Multi- Community or Participating in Regional Hub-and- Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Therapeutic Health and Home LLC	The Arctic Rehabilitation & Telehealth Utility (ARTU)	AK	Rural Alaska currently relies on a costly medevac and charter model for rehab-preventable conditions, directly undermining community health and economic stability. Mothers with sepsis are flown to Anchorage; Elders with unaddressed fall risks suffer hip fractures requiring hospitalization; children with developmental delays are waitlisted for years, missing critical neuro-developmental windows. This reactive system is the main driver of excess healthcare costs and forces residents to leave their support networks for basic care. The opportunity is to operationalize a "Last-Mile" logistics utility that transitions the state to an evidence-based "Treat-in-Place" model. By deploying specialized physical, occupational, and speech therapists directly into villages, we shift the focus to prevention and functional recovery. A hybrid approach including telehealth and RTM fosters consistent presence and empowers individuals to take control of their health. This approach does more than save money; it keeps communities healthy and productive. Providing immediate, local lactation support allows mothers to remain in the workforce. Conducting home safety assessments allows elders to age in place as cultural anchors. Early intervention for pediatric delays ensures the next generation enters school ready to learn. ARTU replaces the breakage-and-repair model with a sustainable infrastructure of prevention, ensuring that health care strengthens the community rather than extracting its members.	Operational Logistics & Infrastructure: Success in rural Alaska is a logistics problem. ARTU utilizes a Year 1 Capitalization Strategy to secure the supply chain immediately: Housing: Utilizing Year 1 funds, we execute Master Leases on 60+ units (Hub Triplexes/Village 4-plexes), stabilizing housing for our workforce without waiting for new construction. Aviation: We secure dedicated Aviation Block-Space (3,000+ segments) on regional carriers, guaranteeing access regardless of freight backlogs. Digital Mesh: Deployment of 100 Starlink High-Performance terminals creates a "Digital Clinical Backbone" for Remote Therapeutic Monitoring (RTM). Train and employ village liasons for set up and ongoing operation of telehealth/RTM locations. Administrative Staffing: We will deploy a C-Suite Executive VP with deep healthcare logistics expertise. The team includes Regional Directors for local oversight, Logistics Coordinators, a Grant Compliance Officer, and a Medical Director. This support ensures clinicians focus solely on patient care. Workforce Ramp-Up & Retention: We deploy 60 specialized clinicians (PT/OT/SLP) in three strategic waves (Months 4, 8, 12). Recruitment is secured through national search firm partnerships with priority given to local candidates. Retention is engineered into the model: our "14-on/14-off" rotation prevents burnout, while a \$20k annual retention bonus incentivizes five-year commitments. Crucially, we fund specialist training pathways, training clinicians into Certified Breastfeeding Specialist (CBS) and Pelvic Rehabilitation Practitioners to directly address the RHTP "Healthy Beginnings" priority. Hybrid Clinical Model: We utilize a hybrid "Treat-in-Place" approach. High-intensity in-person visits address complex needs (manual therapy, neuromuscular re-education, functional training), while the Starlink mesh enables continuous Remote Therapeutic Monitoring (RTM) between visits. This ensures daily adherence to recovery plans, preventing the regression common in sporadic fly-in/fly-out models. Revenue Transition & Sustainability: The project is designed to wean off grant funding. Years 1-2 focus on "Capitalization" and non-billable prevention, training, and educational services (trust-building). Years 3-5 transition to high-volume Fee-for-Service billing and RTM revenue. By Year 6, the utility is fully self-sustaining through commercial revenue and Value-Based (APM) contracts with payers, requiring no further state subsidy.	Over \$5M	Private practitioner	Statewide	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

thread	Alaska’s Child Care Expansion Program	AK	Alaska faces a significant shortage of quality early childhood education options, with a gap of needed services for over 23,000 Alaskan children. Communities, businesses, and individuals regularly seek thread’s guidance in child care start up support. However, comprehensive services are not available for navigating and supporting communities with child care solutions that fit their needs. Creating and starting a child care in rural communities is complex, expensive, and often involves important and specific facility, staff, and safety requirements, program design and materials, and risk and liability. Alaska’s Child Care Expansion Program will develop a line of business for services designed for communities interested in expanding child care spaces. Child care is an economic driver for rural communities across our state, but many communities are facing shortages of child care spaces or any available child care services at all. thread’s Child Care Expansion Project will create a facilitated community focused service that includes an innovative community engagement process designed to increase the supply of high quality affordable child care in rural communities. The purpose of the Child Care Expansion Project is to guide communities in identifying the scope and size of their child care challenges, and to empower and support communities to develop solutions to address these challenges.	thread seeks to expand the availability of quality child care by creating new and innovative community solutions. Alaska’s Child Care Expansion Program will help communities successfully navigate and plan for addressing child care needs through targeted supports and services. With a focus on rural Alaska, thread will partner with local community stakeholders to assess child care needs, design child care solutions, create community responsive supports and services, and create a user-friendly process designed to generate more child care for families across Alaska. The goal will be for communities to have ownership of their child care solutions including a plan for sustainability and support for long term success. thread will begin with planning to design, create and build agency capacity for this new line of business. This will include contracted expertise to ensure a strong and viable program design and model. The Child Care Expansion Program model will be designed to address the challenges of rural child care through the lens of economic development. thread will design and use a comprehensive, multi-month, community engagement process designed to identify right-sized solutions to increase the supply of high quality affordable child care in rural communities. By mobilizing community members and empowering the creation of community-based solutions, rural communities can preserve existing child care businesses and add new child care spaces designed with their preferences and needs. thread will aim to partner and serve up to five communities through this project period. Through the planning, thread will seek communities identified with RHTP partners and specific rural health challenges that would benefit from child care service expansion. Ready communities will identify with child care challenges impacting health and economic development. Child care shortages have a broad impact beyond the family/health care professionals, and communities will be supported to address these issues with right-sized solutions that meet the unique aspects of the community. Alaska’s Child Care Expansion Program will strengthen the state's early education infrastructure and foster health care economic growth through small business development and enabling more families to work and sustain their families to live, grow, stay, and thrive in Alaska.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

thread	Alaska Early Childhood Educator Wellness Project	AK	Alaska continues to face significant challenges in ensuring access to affordable, high-quality child care. Families statewide struggle to find licensed and regulated care, as the number of available slots does not meet community needs and costs remain prohibitive for many. A severe workforce shortage, driven by ongoing difficulty recruiting and retaining qualified early childhood educators, further limits access to child care. Educators earn low wages, often without paid leave, health coverage, or mental health benefits, contributing to stress, burnout, and turnover. Many early educators rely on public assistance to meet basic needs. These conditions weaken program stability and reduce the quality of care available to children and families. By increasing access to health and wellness supports, and program improvements that strengthen quality and best practices, the early childhood workforce will be better equipped to remain in the field. When educators have the tools and supports to maintain their physical and mental health, they are more likely to seek preventive care, manage stress effectively, and build long-term resilience. This leads to stronger job satisfaction, higher retention, and more stable child care programs. Ultimately, healthier educators contribute to healthier communities and a stronger early childhood system statewide.	The Alaska Early Childhood Educator Wellness Project will strengthen the health, wellbeing, and retention of Alaska’s early childhood workforce by expanding access to wellness and prevention supports and improving program environments statewide. thread will contract with an external evaluation partner to survey early educators and child care programs about the benefits they currently receive and those that most effectively support workforce stability. These findings will guide future strategies to improve recruitment and retention in the field. To promote preventive care and improve access to health services, thread will host 15 Health Fairs and Wellness trainings in identified communities in Alaska over the course of the grant. A prior pilot partnership with the Municipality of Anchorage (MOA) served approximately 35 educators at no cost, providing health screenings and a three-hour wellness training, followed by distribution of wellness items such as air purifiers, HEPA vacuums, electric toothbrushes, and Insta-pots. Thread plans to build onto this successful model and provide travel support so rural and remote educators can participate too. The project will also expand access to mental health and wellness tools by providing Calm app subscriptions to early educators. A previous pilot reached more than 1,500 educators and offered a wide range of meditations, movement activities, sleep supports, and classroom-appropriate resources. Subscriptions include two virtual wellness trainings and the ability for educators to share the resource with up to five family members or colleagues. To encourage physical activity, thread will also distribute pedometers to track, incentivize, and increase daily movement. Finally, thread will administer improvement funds to child care programs to strengthen health and safety conditions for staff, children, and families. Drawing on successful implementation of similar funding during COVID-19, these resources will help programs make meaningful upgrades that support workforce wellness, improve environments, and enhance long-term program sustainability.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

thread	Alaska Early Childhood Mental Health Project	AK	The mental health of young children, educators, and families is critical to positive, lifelong physical and mental health outcomes. Growing research suggests many educators may experience inequitably high levels of stress compared to other adults in the United States. This stress may lead to morbidity and mortality in educators, affects educator retention, and can lead to poor mental health in children, as well as increased expulsion and adverse childhood experiences. Young children are expelled at 3 times the rate of K-12 students from state-funded preschool; private and community childcare programs expel children at more than 13 times the rate of K-12. Children expelled or suspended are more likely to experience academic failure and face juvenile incarceration. Reasons linked to exclusionary practices include educator stress & wellbeing, implicit bias, & lack of skills & knowledge. To address this need, thread proposes expanding the access of early childhood programs, families, and behavioral/mental health professionals to the Pyramid Model, which is designed to support young children’s mental health & reduce exclusionary practices. This project also will promote access to GoNAPSACC (State of Alaska, Department of Health program) mental health training. Coaching is critical to the implementation of any training, and this project will increase access to trained coaches via the Relationship Based Professional Development Credentialing System and online coaching system.	To achieve long-term outcomes and goals, thread will promote the project to early childhood educators, behavioral/mental health professionals, and families, providing access to training and coaching supports. thread will provide a variety of asynchronous and conference trainings to educators, behavioral/mental health professions, and families, including a contract to Pyramid Model Consortium to expand access to emodules as well as travel and registration reimbursements to attend the NW Pyramid Early Learning Summit taking place in November 2026 in Anchorage. Early childhood educators will also have access to coaching to unpack and implement knowledge gained from training and thread will work to increase number of professionals with early childhood coaching certification (Relationship Based Professional Development (RBPD)) via training and mentor coaching thread will also evaluate the impact of educator and behavioral health professionals' knowledge and use of Pyramid Model practices in their work with families and young children to reduce exclusionary practices and increase healthy social emotional development. To further support educators, children, and families, thread will promote use of and completion of GoNAPSACC mental health modules. thread, in partnership with The Alaska Department of Health, Physical Activity and Nutrition Unit (DOH PAN), will offer early educators the Go Nutrition and Physical Activity Self-Assessment for Child Care (GoNAPSACC) program. Through this program, early educators receive technical assistance from thread to plan and support the health, nutrition, and physical activity of the children in their program. GoNAPSACC has released an additional module on social emotional development that thread will be promoting and providing to early educators.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

thread	Growing Professional Development for Alaska’s Early Childhood Educators	AK	Alaska’s early care and learning system is facing significant workforce recruitment and retention challenges that directly impact the wellbeing of children, families, and the broader rural health ecosystem. In many communities, particularly those that are remote or medically underserved, consistent staffing is essential to supporting healthy child development and reducing caregiver stress. National best practices demonstrate that stable educator child relationships contribute to improved developmental outcomes and strengthen protective factors within families. Despite this need, many early childhood programs across Alaska continue to operate with chronic understaffing, limiting their ability to provide high-quality onboarding, training, and ongoing professional support for new educators. These workforce shortages are especially pronounced in rural communities, where limited local training infrastructure and high turnover hinder continuity of care and place additional strains on families and community health systems.	To address these gaps, the proposed initiative seeks to establish a comprehensive professional development continuum designed to stabilize and strengthen the early childhood workforce statewide, with a focus on rural program needs. The project will deliver structured onboarding, coordinated year one training, stackable micro credentialing opportunities, and support for achieving the Child Development Associate (CDA) credential. Post CDA technical assistance will further promote workforce advancement and long-term retention, helping build a sustainable pipeline of qualified educators in areas where health and social services capacity is already stretched. To ensure accessibility for programs located in rural and remote communities, project implementation will utilize a multimodal delivery approach that includes in-person sessions, virtual instruction and coaching, and asynchronous learning opportunities. When necessary to support full participation and program effectiveness, the initiative will provide travel assistance, lodging, and program stipends—reducing common barriers faced by rural educators and ensuring that critical workforce development activities are available statewide. Through this initiative, thread aims to strengthen early learning capacity as a foundational component of rural community health, support family stability, and improve long-term wellbeing outcomes for Alaska’s youngest children.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

thread	Unified Child Care/Early Education Data System for Alaska	AK	Alaska’s child care and early education data systems operate in silos, with no secure or automated way to share information between thread and State of Alaska departments such as DEED and DOH. thread’s system maintains program data, SEED information, Learn & Grow levels, and family referral data, while the State’s Division of Public Assistance holds licensing and subsidy data. DEED maintains a separate database for Head Start, Early Head Start, and pre-elementary programs. Because these systems can’t communicate, families, providers, and staff must duplicate data entry, ask for data from each other, and wait longer to access the data needed to deliver or receive services. This also prevents the state from having a unified, accurate view of child care/early education in Alaska. *This proposal is for child care/early education it would be nice to do a project to have all early childhood data linked together (ie: WIC, ILP, behavioral health, etc.).	This project will use a structured, collaborative process to identify a secure and effective way for thread and the State of Alaska to share child care and early education data. This project will begin with a discovery phase to map how the SOA and thread databases currently collect and store information. This includes understanding thread’s Salesforce database on professional development, child care/early education programs, and family referrals; the Division of Public Assistance data on licensing and subsidies; and DEED data on Head Start, Early Head Start, and pre-elementary programs. Through interviews, workflow reviews, and data analysis, the project will identify where duplicate entry, inconsistent information, and gaps are creating challenges for families, providers, and agencies. Based on this assessment, thread and the SOA will research and identify technology that would close those gaps and silos in data, and ideally, then purchase technology(ies) to implement. Strengthening the child care/early education data system will also support and improve Alaska’s broader health care system. Reliable child care/early education is essential for health care workers, family stability, participation in the workforce, and children’s healthy development. When health care workers and families have accurate information about available child care/early education, they are better able to maintain employment, attend medical appointments, and access preventive care. Additionally, the project would help policymakers better understand the child care/early education sector.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Thriving Within, LLC	Alaska Clinical Supervision Access Project: Supporting LCSW and LPC Licensure in Rural Communities	AK	Alaska faces a persistent shortage of licensed behavioral health providers, especially in rural and remote communities. The state is federally designated as a Mental Health Professional Shortage Area, and workforce analyses estimate Alaska must recruit over 9,000 new health workers annually to meet demand and replace turnover. In rural areas, limited licensed clinicians contribute to long wait times, service gaps, and reliance on temporary or traveling providers. A key barrier to expanding the behavioral health workforce is limited access to the clinical supervision required for licensure. Early-career clinicians report difficulty obtaining supervision due to cost, limited supervisor availability, and scheduling constraints—barriers intensified in rural and isolated communities. Many clinicians experience delays completing licensure or leave Alaska to access supervision elsewhere, contributing to workforce instability. This project will pilot a stipend-supported individual and group clinical supervision program to expand access to licensure-quality supervision for mental health professionals across Alaska. In addition to supporting licensure, structured group supervision provides mentorship and peer connection for clinicians in isolated settings. These supports reduce professional isolation, strengthen clinical practice, and improve retention, helping providers remain in rural communities while completing full licensure.	This project will pilot a stipend-supported group clinical supervision program designed to increase access to supervision required for clinical licensure in Alaska. The pilot will operate over a thirty-month period and will be implemented in three phases: Foundation and Training, Implementation and Rolling Recruitment, and Evaluation and Sustainability. Phase 1: Foundation and Training (Months 1–3): The initial phase will focus on program development, supervisor preparation, and outreach. Contracts will be finalized with Alaska-based Licensed Clinical Social Workers who have post-licensure clinical experience in Alaska. Participating supervisors will complete required continuing education related to supervision standards under Alaska regulations and engage in additional coursework to support supervision of clinicians pursuing multiple forms of clinical licensure. Outreach and recruitment will begin through partnerships with behavioral health agencies, Tribal health organizations, rural clinics, school districts, and university social work and counseling programs. Phase 2: Implementation and Rolling Recruitment (Months 4–27) Following program launch, the project will provide two to three remote group supervision sessions per month, with each group serving approximately six to eight clinicians. Through a rolling recruitment model, new clinicians will be admitted as participants complete licensure requirements or openings become available. Supervision sessions will incorporate ethical practice consistent with the NASW Code of Ethics, trauma-informed care principles, reflective supervision, and culturally responsive approaches relevant to Alaska’s diverse communities. Sessions will include case consultation, ethical decision-making, professional development, legal and regulatory requirements and licensure preparation as required by Alaska. Phase 3: Evaluation and Sustainability (Months 28–30) The final phase will focus on program evaluation and sustainability planning. Supervision hours will be documented using standardized attendance logs and verification forms aligned with Alaska licensure requirements. Evaluation will monitor supervision hours delivered, participant progress toward licensure, and participant satisfaction. Findings will inform recommendations for sustaining and expanding the supervision model to strengthen Alaska’s behavioral health workforce, particularly in rural and underserved communities.	\$50,000-\$250,000	Private practitioner	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Thriving Within, LLC	Integrating Social Work and Public Health to Strengthen Rural Health Care Systems	AK	Alaska’s rural health system faces persistent workforce shortages that limit the ability of public health centers to address both clinical needs and the broader social determinants influencing health outcomes. Public health nurses frequently serve as frontline providers managing prevention services, care coordination, and population health initiatives, yet the complexity of community needs—particularly those related to social determinates of health—often requires additional workforce capacity and specialized knowledge of services. Master of Social Work (MSW) providers are well positioned to support these efforts. MSW clinicians receive extensive training and practicum experience prior to graduation, allowing them to deliver high-quality case management and community services in a cost-efficient manner, as salary for MSW providers are typically lower than those for public health nurses. At the same time, many recent MSW providers face limited access to structured supervision and early-career professional development in rural areas where licensed clinical supervisors are scarce. This gap can delay licensure progression and discourage long-term rural practice. This project proposes a proof-of-concept program integrating recent MSW providers, including those from the dual MSW/MPH program at the University of Alaska Anchorage, into public health centers across Alaska with structured supervision and training to support prevention-focused and community-based health interventions.	The proposed project would implement a supervised workforce development model placing MSW providers, including those from the MSW/MPH dual-degree program at the University of Alaska Anchorage, within public health centers across Alaska. In this role, social workers would collaborate with public health nursing teams to address social determinants of health, support care coordination, strengthen community partnerships, and assist with prevention-oriented initiatives. Participants would receive a cost-of-living salary stipend and additional training stipend in exchange for a one-year service commitment within participating public health centers. This structure is intended to support recruitment while improving workforce stability in communities that often experience high turnover. Clinical supervision and consultation would be provided by an experienced Licensed Clinical Social Worker with experience in behavioral health and community-based practice. Supervision would include telehealth-based individual supervision, group consultation, and interdisciplinary case collaboration with public health teams to support professional development and quality of care. MSW providers would contribute to public health activities including social needs screening, resource navigation, care coordination, prevention programming, and partnerships with local organizations. Providers with dual MSW/MPH degree would also contribute skills in population health analysis, program development, and evaluation. Technology-enabled supervision would allow participants in rural and remote communities to remain connected to professional support networks. The project would be implemented as a three-year pilot. Phase one focuses on program development, including establishing workflows, supervision structures, and collaboration with public health teams. Phase two places MSW providers in 2-3 public health centers to support prevention and community-based interventions. Phase three evaluates workforce feasibility, integration within public health teams, and improvements in care coordination and community health interventions.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Juneau (City and Borough); Matanuska-Susitna Borough	Deferred or Not Advanced

TigerConnect, Inc.	Connecting Alaska: A Unified Clinical Communication Network from Village Clinics to Regional Hubs	CA	Alaska's healthcare landscape is defined by vast distances, isolated communities, and a fragmented network of regional hospitals, critical access hospitals, and tribal clinics spread across some of the most remote terrain in the US. For patients in rural and village settings, fragmented communication between providers is not a minor inefficiency, it is a barrier to timely, potentially life-saving care. When a village health aide needs to escalate a critically ill patient, or a rural clinician needs a specialist consult from Anchorage, the current reality is phone tag, fax machines, and disconnected systems with no shared visibility into patient status. These communication gaps have direct clinical consequences: delayed consults, slow care escalation, missed transfers, and an inability for leadership to identify where patients are falling through the cracks. Rural communities bear the highest burden of these delays, facing the greatest geographic barriers while also experiencing the highest rates of conditions where timely communication determines outcomes including stroke, trauma, cardiac events, and behavioral health crises. TigerConnect serves as ANTHC's enterprise clinical communication platform, yet communication across hospitals, independent health systems, and rural and tribal clinics remains inconsistent and fragmented. There is a opportunity to extend this proven platform statewide, creating Alaska's first unified clinical communication network.	TigerConnect proposes building a unified, statewide clinical communication network across Alaska, connecting every hospital and clinic on a single HIPAA-compliant platform so that care teams at any level can communicate securely, escalate patients rapidly, and coordinate transfers without switching systems. The goal is ensuring that no Alaskan patient's care is delayed because their provider lacked a reliable way to reach the right specialist at the right moment. The model is built around a hub-and-spoke structure. Each region's anchor hospital serves as the communication hub, with affiliated critical access hospitals and rural clinics connected as spokes. Regional tribal organizations including Yukon-Kuskokwim Health Corporation, Norton Sound Health Corporation, and SEARHC would each serve as regional hubs, alongside health systems such as Providence Alaska, Fairbanks Memorial, Bartlett Regional, and Mat-Su Regional. Connections are established based on clinical need transfer corridors, shared specialist networks, and referral pathways not blanket connectivity. Because all facilities operate on a single platform, care teams can securely message specialists in real time, escalate urgent cases, share clinical information, and coordinate transfers seamlessly. TigerConnect's workflow automation further streamlines care escalation by automatically routing urgent messages, triggering escalation protocols, and ensuring time-sensitive cases reach the right provider without manual intervention. Centralized analytics will capture communication volume, response times, and escalation patterns, giving leadership actionable data to improve care coordination statewide. ANTHC, as an existing TigerConnect partner, provides the proof of concept for this initiative. TigerConnect already serves over 7,000 healthcare organizations nationally, and its lightweight, cloud-based, mobile-first architecture is well-suited for Alaska's low-bandwidth, remote clinic environments.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

TigerConnect, Inc.	Transforming EMS-to-ED Communication Across Alaska with TigerConnect PreHospital	CA	Alaska's EMS landscape presents unique and persistent challenges. EMS providers including village health aides, regional ground crews, and air medical teams routinely transport high-acuity patients across some of the most remote and vast geography in the nation to regional critical access hospitals and major referral centers. Communication between EMS providers and receiving emergency departments relies heavily on radio and telephone calls that are frequently unreliable, unstructured, and inefficient. These limitations contribute to: • Prolonged EMS handoff times and delays at receiving facilities • Delayed clinical decision-making due to incomplete patient information • Unprepared ED teams, resulting in reactive rather than proactive care • Slower treatment for time-sensitive conditions including stroke, trauma, STEMI, and sepsis. Where patients travel hours by air or boat before arriving at an ED, even small communication delays can materially affect outcomes. A statewide solution is needed one that delivers structured, real-time clinical information from any EMS provider to any receiving facility, regardless of location or transport modality. TigerConnect Prehospital is proven nationwide, including in rural areas facing similar challenges. Deployments show improved handoff times, ED throughput, door-to-provider times, reduced staff workload, and gains in bed-days saved, transfer revenue, readmission rates, mortality index, LOS, and patient and provider satisfaction.	This initiative proposes deploying TigerConnect PreHospital as a unified, statewide EMS-to-ED communication platform connecting field providers, regional hospitals, and major referral centers across Alaska. Smaller scope deployments, like Anchorage area hospitals and local EMS, are also possible as project guidelines. The Alaska Native Tribal Health Consortium (ANTHC) is a current TigerConnect customer, utilizing the enterprise communication platform for care communication and collaboration across its network. The addition of TigerConnect PreHospital represents a complementary, easy to implement and enhancement to an existing enterprise relationship, with ANTHC/ANMC as the intended Phase 1 pilot site. The intuitive user interface (UI) of the platform, in addition to the very low IT and implementation resource requirements, makes it a very easy platform to scale between single implementations and state-wide initiatives, so that it can fit to whatever desired Phase 1 scope would work best. TigerConnect PreHospital is widely used around the country already as the main communication pathway for 911 prehospital communication for 120+ facilities and 500+ EMS agencies. It has currently powered over 2.5 million cases, showcasing deep levels of adoption by both EMS and hospitals for their daily communication needs. Users span all environments and organization types, from small rural critical access hospitals and their volunteer EMS partners to large urban hospitals and private and municipal EMS entities. TigerConnect Prehospital enables EMS providers to transmit HIPAA compliant, secure reports about incoming patients in seconds, and is agnostic to mobile devices commonly used in the field by EMS. Notifications include powerful clinical data like: • Clinical summaries and patient identification • Trauma scene images and stroke assessment videos • Real-time 12-lead ECG transmission • Telehealth consult integration. Receiving ED teams access secure, HIPAA-compliant case data via a centralized dashboard with real-time GPS tracking of inbound ambulances and aircraft, enabling early triage, proactive specialty activation, and optimized resource deployment before patient arrival. All case communications are automatically captured to support quality assurance, performance benchmarking, and continuous improvement, with the implications of statewide data capture leading to significant analysis that can help drive and support further initiatives and improvements.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Dillingham Census Area; Fairbanks North Star Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

TigerConnect, Inc.	Transforming Interfacility Patient Transfers Across Alaska with TigerConnect Transfer	CA	Alaska's extreme geography makes interfacility transfers uniquely high-stakes. Regional hospitals routinely transfer high-acuity patients to larger referral centers for specialty care, coordinating across vast distances with limited tools. Current workflows rely on excessive phone calls, manual coordination, and paperwork, with limited visibility into bed availability. These inefficiencies delay treatment, prolong bed occupancy, increase wait times, and contribute to major referral centers frequently reaching divert status limiting access to critical care for rural Alaska Native communities. When a remote village patient requires specialty care, every hour spent navigating a fragmented transfer process is an hour lost to treatment. For stroke, trauma, STEMI, and sepsis patients, that delay can mean the difference between recovery and permanent impairment. A unified, digitized transfer coordination platform purpose-built for Alaska's distributed health network would eliminate these inefficiencies, moving patients to the right level of care faster and with reduced administrative burden on stretched rural clinical teams. TigerConnect is ANTHC's enterprise clinical communication platform. That existing foundation, shared infrastructure, platform familiarity, trusted partnership makes ANMC the natural pilot site to prove this model before expanding statewide. ANMC is the intended pilot site, subject to capacity following RHTP grant awards.	TigerConnect Transfer is a cloud-based SaaS platform that unifies bed sourcing, transport scheduling, and real-time clinical communication into a single, intuitive solution. When a regional facility identifies a patient requiring transfer, care teams digitally share case information with receiving specialists and transfer centers in real time, enabling proactive preparation before the patient arrives. Transfer teams gain live visibility into available beds across facilities, order ambulance and medical transport services directly, and track transfer and discharge status in real time. Automated workflows reduce coordination burden on clinical staff, while built-in reporting and analytics track key metrics including transfer times, transport vendor performance, and throughput, providing leadership with actionable insights for quality assurance and continuous improvement. The platform requires no on-premises infrastructure and is optimized for low-bandwidth environments, making it well-suited for Alaska's remote regional facilities. TigerConnect intends to pilot this solution within the ANTHC network, connecting ANMC as the primary receiving facility with rural regional hospitals and village clinics that initiate transfers. A successful pilot demonstrating measurable reductions in transfer coordination time and divert events at ANMC is intended to build the evidence base for broader adoption across ANTHC's full regional network, though network-wide expansion will depend on ANTHC organizational prioritization following the pilot. Final implementation timing will be confirmed in coordination with ANMC and ANTHC leadership following grant award, as ANTHC may be managing a high volume of concurrent RHTP initiatives.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Tribal Health, LLC	Alaska Wellbeing Care Community: Digital Care Coordination & Community Health Infrastructure	AZ	Alaska’s healthcare system includes rural and Tribal clinics, hospitals, behavioral health providers, and community-based organizations that often operate across independent systems without shared operational infrastructure for coordinating referrals or tracking connections to community services. The state has made important investments in clinical data sharing through the statewide health information exchange operated by healthEconnect Alaska, and integrated care models such as the Nuka System of Care demonstrate the effectiveness of coordinated care within individual healthcare organizations. However, coordination challenges frequently occur between organizations, particularly when patients require services outside the healthcare system such as behavioral health treatment or community-based social services. The Alaska Wellbeing Care Community initiative addresses this gap by implementing an innovative technology platform that enables healthcare providers, Tribal health organizations, behavioral health agencies, and community-based organizations to coordinate services through shared workflows and closed-loop referral tracking. This approach complements Alaska’s existing health information exchange and care delivery systems by supporting operational collaboration across independent organizations while allowing each organization to maintain its own governance and care delivery models.	The Alaska Wellbeing Care Community (AWCC) initiative will establish a statewide digital care coordination infrastructure that enables hospitals, Tribal health organizations, community health centers, behavioral health providers, and community-based organizations to collaborate through shared referral and coordination workflows. The initiative will utilize the Wellbeing Care Community digital coordination platform as the core technology solution. Through this model, the State of Alaska would support deployment of a shared coordination infrastructure that allows participating organizations to access common tools for referrals, communication, and service tracking without requiring each organization to independently procure separate systems. This approach reduces implementation barriers while creating a consistent statewide coordination framework. Tribal Health will serve as the operational and program management partner responsible for implementation and adoption. Responsibilities include conducting readiness assessments, onboarding participating organizations, mapping care coordination workflows, and providing training and technical support. Tribal Health will also help develop local super-users within participating organizations to support long-term sustainability and adoption. The platform will support closed-loop referral management across healthcare and community organizations, documentation of social determinants of health needs, behavioral health referral coordination, and secure communication between providers and community partners. Population-level dashboards will provide insight into service utilization, referral outcomes, and unmet needs, helping organizations and state partners better understand community health challenges. Implementation will occur through a phased approach beginning with stakeholder engagement, readiness assessments, and onboarding of initial participants. Later phases will expand participation statewide while supporting ongoing performance monitoring and workflow refinement. By combining shared technology infrastructure with coordinated implementation support, the AWCC initiative will strengthen collaboration across Alaska’s healthcare and community service sectors and improve the ability of providers to connect patients to the services they need.	Over \$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Tribal Health, LLC	CARE Team + KATE AI: Strengthening Rural Emergency Triage & Workforce Stabilization	AZ	Emergency departments across rural & frontier Alaska face persistent workforce shortages, geographic isolation, limited specialty access, and significant behavioral health service gaps. Clinicians in these facilities must rapidly triage and stabilize complex patients with limited backup support and prolonged transfer timelines. Variation in Emergency Severity Index (ESI) triage assignment, delayed recognition of time-sensitive conditions, and limited behavioral health consultation can slow critical decision-making in these settings. Earlier identification of conditions such as sepsis, stroke, myocardial infarction, obstetric emergencies, and acute behavioral health crises is essential to safe stabilization when specialty care or rapid transfer is unavailable. This project addresses the opportunity to strengthen frontline emergency care through standardized triage support, workforce capacity building, and integrated decision support tools. CARE Team + KATE AI combines AI-enabled clinical triage assistance with embedded emergency medicine expertise to reduce clinical variability and improve early risk recognition. The model also creates a structured pathway for integrating telebehavioral health consultation into emergency department workflows, improving crisis evaluation and disposition planning where psychiatric coverage is limited.	The CARE Team + KATE AI initiative combines AI-enabled clinical decision support with embedded emergency medicine integration to strengthen stabilization capacity in rural & frontier emergency departments. The initiative incorporates KATE AI, a clinical risk intelligence platform that enables recognition of high risk presentations & supports objective ESI triage assignment through structured triage assessments & EHR data. The platform is deployed across U.S. health systems, including Adventist Health & UMass Memorial Health, & supports more than 4.6 million emergency visits annually across 40+ hospitals. Implementations demonstrate earlier identification of high-risk conditions & improved escalation of critically ill patients. In rural Alaska settings where specialty consultation & rapid transfer may be limited this capability strengthens recognition of time-sensitive medical & behavioral health conditions. Technology deployment is paired with Tribal Health’s CARE Team, which embeds emergency clinicians within participating facilities to translate decision support into sustainable practice change. The CARE Team conducts readiness assessments, maps triage workflows, integrates clinical protocols, & provides on-site nurse training, simulation-based reinforcement, & bedside coaching. This approach strengthens workforce confidence, reduces variability in triage decisions, & builds durable clinical capacity within local teams. Facilities may also integrate telebehavioral health consultation within emergency department workflows. Under this model, telebehavioral services may be delivered through FasPsych, a sister portfolio company to Tribal Health specializing in emergency telepsychiatry, with unified program oversight and clinical integration maintained by Tribal Health. The CARE Team supports participating facilities in embedding telebehavioral consult pathways directly into triage & stabilization processes, including development of activation criteria, staff training, documentation alignment, & structured evaluation & disposition pathways. Implementation follows a phased model including facility engagement, workflow mapping, EHR integration, clinical training, telebehavioral health integration where selected, & performance monitoring. Through coordinated technology deployment and workforce development, the initiative strengthens access to specialty-informed care while improving consistency & resilience within Alaska’s rural emergency departments.	\$1M-\$5M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Tribal Health, LLC	Moms & Minis Alaska: Rural and Indigenous Maternal Health & Workforce Transformation	AZ	Alaska Native mothers experience disproportionately high maternal morbidity and mortality, with many deaths considered preventable. Rural communities face severe geographic isolation, workforce shortages, and limited access to maternal and perinatal behavioral health providers. In many regions, pregnant individuals must travel long distances or temporarily relocate for prenatal care or delivery. These barriers contribute to delayed care, untreated perinatal mental health conditions, preventable complications, and costly emergency medical transport. The current system relies heavily on reactive hospital-based care rather than preventive, community-based maternal health services. This project addresses a critical opportunity to transform rural maternal care delivery by expanding locally accessible services, strengthening Indigenous workforce capacity, and leveraging telehealth-enabled care. By combining mobile maternal services with behavioral health screening, referral coordination, and community-based workforce development, Moms & Minis Alaska aims to improve maternal and infant outcomes while expanding access to care in remote communities.	Moms & Minis Alaska is a maternal health and workforce transformation initiative centered on a technology-enabled mobile maternity clinic model, complemented by pop-up and in-home outreach. The project includes four integrated components: 1. Mobile Maternity Clinics as Hub Extenders Fully equipped mobile maternal health units will be purchased or leased and will travel to rural and tribal communities in coordination with Tribal Health Organizations and rural/regional providers. Units will deliver prenatal and postpartum assessments, infant wellness checks, perinatal depression and substance use screening, basic ultrasound capability where appropriate, remote fetal monitoring, and care navigation. In communities with existing clinics, the mobile unit augments local capacity and specialty access. In communities without facilities, it functions as a temporary clinic, reducing travel burden and improving early risk detection. 2. Indigenous Workforce Development The mobile clinic serves as a training and mentorship platform for locally recruited tribal members. Tribal Health will provide structured learning modules, tele-mentorship with maternal and behavioral health specialists, and coordination with Alaska’s Community Health Aide Program referral systems. This “grow your own” model builds sustainable local capacity while strengthening cultural alignment and workforce retention. 3. Tele behavioral Health & Specialist Access Each mobile unit will be equipped with secure telehealth connectivity to enable real-time consultation with OB/GYN, CNM, and psychiatric providers. This expands access to perinatal mental health and substance use disorder services in regions without specialty care and reduces provider isolation. 4. Technology & Data Integration Mobile services will incorporate remote patient monitoring tools and AI-supported decision guidance to assist frontline staff in identifying high-risk pregnancies earlier. Clinical data will integrate with existing EHR systems to support continuity of care and regional planning. Together, this model shifts maternal care from reactive emergency transport to proactive, community-based prevention while strengthening Alaska’s Hub & Spoke framework.	\$1M-\$5M	Maternal health	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Tri-Valley Volunteer Fire Dept	Tri-Valley Volunteer Fire Department Emergency Medical Response Modernization	AK	TVVFD provides fire and EMS response to the Denali Borough, serving approximately 1,600 year-round residents with a fully volunteer workforce responding to fires, medical emergencies, trauma incidents, highway collisions, and seasonal tourism-related calls. TVVFD lacks modern emergency response equipment, reliable communications, and accessible training resources needed for a volunteer EMS and fire department to safely and effectively respond to emergencies in a remote region. This project seeks to address three core issues to increase health care access and strengthen the workforce: - Outdated and insufficient medical equipment: Aging cardiac monitors, lack of video laryngoscopes, and manual stretchers limit patient care capability and increase injury risk for volunteers. - Unreliable communications infrastructure: Radio coverage issues, aging handheld radios, and changing RF conditions reduce the reliability of emergency coordination and medevac activation. - Limited training access for a volunteer workforce: Geographic isolation and lack of training equipment make it difficult for volunteers to maintain critical emergency response skills. These critical gaps threaten the sustainability of the volunteer workforce serving a remote community.	Phase 1: Equipment Modernization: To improve the quality of care provided, TVVFD will modernize diagnostic equipment with three LIFEPAK 35 units at an estimated cost of \$80,000 per device. Upgrading to the LIFEPAK 35 will provide improved ECG clarity and diagnostic capability, enhanced cardiac arrest management tools, integrated CPR feedback, expanded data capture for quality improvement, greater durability and long-term lifecycle support. TVVFD will purchase two video laryngoscopes at an estimated cost of \$5,000 per unit. In a volunteer agency where intubation is infrequent but high risk, video laryngoscopy improves outcomes while strengthening provider confidence and competency. To protect and preserve the health of its workforce, TVVFD will purchase three powered self-loading cots from Stryker at an estimated cost of \$75,000 per unit. Powered cots will reduce lifting-related injuries, protect aging volunteers, allow safe patient loading with smaller crews, and improve patient stability during movement. To improve provider confidence and competency through repetitive, hands-on practice, TVVFD will purchase specialized task trainers (approximately \$50,000) for advanced airway placement, IV and IO access, difficult airway scenarios, and trauma procedure reinforcement. These tools will allow repetitive, hands-on practice within the TVVFD station, strengthening skill retention in a low-volume rural system and reinforcing training tied directly to the new clinical equipment. Phase 2: Communications Infrastructure Modernization: TVVFD proposes to purchase and install seven Pyramid SVR Vehicular Repeaters in frontline apparatus to improve signal strength, mitigate structural interference, and strengthen Alaska Land Mobile Radio (ALMR) interoperability. The estimated cost is \$30, 673. TVVFD will also purchase 15 ALMR-compatible handheld radios (estimated cost of \$75,000). Lastly, TVVFD will ensure seamless connectivity in remote response areas by purchasing six Starlink Mini systems with Satgear PM4 roof mounts and cabling for approximately \$4,250. Phase 3: Workforce Development and Training: To reduce the financial burden on its volunteer workforce, TVVFD is seeking to expand its capacity to host instructors in Healy. Hosting training locally allows TVVFD to significantly lower training costs, train multiple providers simultaneously, reduce time away from families and employment, and increase participation among volunteers who may otherwise be unable to travel.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough	Deferred or Not Advanced

True North Recovery, Inc.	Anchorage Launch Pad	AK	Behavioral health crises often escalate not because services do not exist, but because individuals cannot easily access or navigate them when needed. For Alaskans experiencing mental health or substance use crises, the default entry is emergency rooms, police, or no care at all. This gap is reinforced by Providence Alaska’s 2024 Community Health Needs Assessment, which identified increasing mental health and substance use access as top community priorities. True North Recovery (TNR), in partnership with the Anchorage Police Department HOPE Team, has gained direct insight into how some of the community’s most vulnerable members seek crisis services in Anchorage. Outreach consistently reveals untreated behavioral and substance use conditions among those experiencing houselessness. These interactions underscore the need for a low-barrier community access point offering immediate support and service connection. To address this gap, TNR proposes the development of the Anchorage Launchpad. This project establishes a low-barrier crisis and navigation access point in downtown Anchorage. Using a walk-in Peer Living Room model, individuals experiencing behavioral health crises can receive immediate peer-led engagement, stabilization, and connection to services in a welcoming, peer-led environment. Launchpad advances the RHTP initiative, Health Care Access, by expanding access to behavioral health services.	This project is currently in the Ready to Launch phase. The Anchorage Launchpad has secured \$750,000 in capital support from the Municipality of Anchorage, allowing the project to move forward while RHTP funding supports Year 1 operational costs and specialized training. The Anchorage Launchpad will operate as a peer-led crisis and navigation access center grounded in the Peer Living Room model. Certified Peer Support Specialists serve as the first point of engagement, providing crisis de-escalation and practical assistance while helping individuals identify immediate needs and next steps. This peer-led approach creates a welcoming environment where individuals feel respected and understood, reducing stigma that often prevents people from seeking help. To support this model, Launchpad integrates access to behavioral health clinicians for clinical evaluation and suicide risk assessment while offering behavioral health screening and walk-in integrated behavioral health assessments. Individuals can receive immediate peer support while also connecting to clinical evaluation when needed. True North Recovery operates a regional hub-and-spoke network with facilities in the Mat-Su, Fairbanks and Ketchikan, allowing individual service needs to be supported across the TNR continuum. This statewide access is especially relevant in Anchorage, which serves as a hub city and often receives individuals who arrive for specialty care or other services and later find themselves in crisis. Through peer engagement and rapport building, Launchpad can help individuals reconnect with appropriate services, often closer to home through the broader TNR network. Launchpad’s design aligns with the Crisis Now framework, reflecting nationally recognized crisis response best practices that emphasize rapid access to behavioral health support, stabilization in community settings, and coordinated care. As Anchorage continues developing its crisis continuum, Launchpad will function as a complementary access point supporting individuals who do not require high acuity crisis stabilization while also providing step-down support for those transitioning from higher levels of care. This approach creates opportunities for earlier intervention, shifting crisis response away from emergency departments and police, by establishing a local option for outpatient behavioral health crisis support and navigation services.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Advance to Implementation Application

True North Recovery, Inc.	Ketchikan Launch Pad	AK	Ketchikan faces significant gaps in behavioral health crisis response, often forcing residents to rely on law enforcement or the emergency department. In this geographically isolated island community, a lack of early intervention can exacerbate crises and result in traumatic off-island transports for stabilization. While the Fire Department’s Mobile Integrated Health team provides vital outreach, the community lacks a dedicated, voluntary access point for support outside of emergency systems. The Launchpad project addresses this by establishing a low-barrier crisis and navigation center in downtown Ketchikan. Utilizing a "Peer Living Room" model, it provides immediate peer-led engagement and stabilization in a welcoming, non-clinical setting. This approach shifts crisis response away from police and hospitals, providing a local alternative for early intervention. By connecting rural Alaskans to outpatient services and community resources, Launchpad expands access to timely, localized behavioral health support.	Launchpad addresses Ketchikan’s crisis response gap by establishing a community-based access point where individuals can receive immediate support, assessment, and navigation. Building on True North Recovery’s experience across Alaska, the model recognizes lived experience as a vital asset in crisis engagement. Located in downtown Ketchikan, the site uses peers as the first point of contact to provide trauma-informed support and de-escalation. When clinical intervention is required, licensed clinicians are available for suicide risk assessments and integrated behavioral health evaluations. This peer-led approach represents a meaningful transformation in how the community addresses behavioral health emergencies. Through a hub-and-spoke model, Launchpad utilizes telehealth to connect rural Alaskans with specialized clinical professionals while maintaining local stabilization. This ensures that even in isolated frontier areas, residents can access high-level care without leaving their community. By offering a voluntary alternative to police-led or emergency department responses, peers help individuals identify immediate needs and coordinate "warm handoffs" to outpatient treatment, detox, housing, and recovery supports. The model aligns with "Crisis Now" principles and Alaska Department of Health recommendations by providing timely engagement close to home. This continuum of care—from initial stabilization to ongoing follow-up—reduces the likelihood of repeated crisis cycles. Ultimately, this project fulfills the Rural Health Transformation Program’s goal of expanding behavioral health access and ensuring essential crisis support is available in remote Alaskans' own backyards.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Single Community	Ketchikan Gateway Borough	Advance to Implementation Application

True North Recovery, Inc.	Palmer Women's Trauma Residential	AK	Mat-Su Borough is experiencing rapid population growth, but available services have failed to keep pace with rising population needs. The 2025 Mat-Su Health Foundation Community Needs Assessment describes an urgent demand for comprehensive behavioral health care. System barriers such as limited access to services, a shortage of Medicaid providers, and a lack of specialty treatment options make early engagement difficult, causing people to seek help only when their needs are most severe. These service challenges affect the community, with women particularly those with both substance use and mental health issues facing greater barriers to treatment. As a peer-led organization serving the community for a decade, True North Recovery (TNR) brings direct experience and insight into the needs of the local population and operates a hub-and-spoke network that provides regional perspective on service needs. This experience has shown the increasing demand for specialized residential treatment services for women with trauma histories and co-occurring mental health and substance use disorders. True North Recovery proposes development of a 16-bed residential substance use treatment program located in Mat-Su providing gender-responsive care for adults with co-occurring disorders. The program integrates trauma-focused approaches including Brainspotting alongside evidence-based programming delivered by clinicians and peers trained in trauma specialization.	This project is currently in the Ready to Launch phase. Funding will support first-year operations, including specialized workforce training. TNR has secured a 7,000-square-foot house on 16 acres. The property is nestled among trees with private walking trails, creating a calm environment that supports recovery. This program is Alaska’s first statewide residential substance use treatment initiative that integrates trauma treatment as a central component specifically addressing the needs of women through a peer-led model. The program serves adults aged 18 and older experiencing substance use disorders, trauma, and co-occurring mental health challenges. Because substance use, trauma, and parenting often intersect, women enter treatment while navigating Office of Children’s Services (OCS) involvement, intimate partner violence (IPV), housing instability, and intergenerational trauma. In frontier Alaska, specialized treatment services for women are scarce or nonexistent. This makes these challenges even greater, particularly for those experiencing IPV and substance use in areas lacking domestic violence shelters or safe places to stabilize. The program is designed to acknowledge the complex roles and circumstances women shoulder while pursuing recovery. Services integrate gender-responsive, trauma-specific, and co-occurring capable care within a structured residential environment. Programming supports women who have experienced trauma, including IPV and other complex circumstances that intersect with addiction. Weekly programming emphasizes emotional safety, inclusion, and culturally responsive practices that build on each participant’s strengths and lived experiences. Staff are trained to recognize how trauma, stigma, and caregiving responsibilities shape treatment engagement and recovery pathways. Clinical services further integrate evidence-based treatments such as Hazelden’s Co-Occurring Disorders curriculum, Seeking Safety, and Brainspotting, a specialized trauma-processing technique. These approaches assist with addiction recovery, safe trauma processing, emotional regulation, parenting skills, and resilience. Participants also access wraparound supports through the TNR continuum, including primary care, MOUD, and housing and recovery supports. This integrated, trauma-responsive model creates a healing environment closer to home where women can stabilize, reconnect with their strengths, and build pathways to long-term recovery.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Ketchikan Gateway Borough; Matanuska-Susitna Borough	Advance to Implementation Application

True North Recovery, Inc.	TNR Technology Suite	AK	True North Recovery is implementing a coordinated suite of technology upgrades to strengthen behavioral health services and data management across its rural and regional service locations. This modernization initiative includes the customization of a new Electronic Health Record (EHR), a transition to Hazelden’s upgraded Learning and Resource Center to expand telehealth-enabled SUD and adult mental health services, the development of AI-enhanced data analytics infrastructure, and the deployment of an in-house Voice-over-IP (VoIP) communication system. TNR has strategically transitioned away from the State-supported EHR (AKAIMS) to implement a self-managed clinical documentation infrastructure that aligns with its specific hub-and-spoke service model. While core platforms have been selected and implementation planning is underway, specialized technical expertise is required to ensure systems are interoperable and configured effectively. Rather than utilizing state-provided assistance, TNR will contract a private systems engineer to develop the data analytics framework and a dedicated contractor for cybersecurity IT system upgrades. This expertise ensures that EHR data is translated into meaningful operational and outcomes reporting while meeting rigorous cybersecurity standards. RHTP funding will support the deployment and specialized engineering required to establish this coordinated infrastructure, ultimately increasing evidence-based service delivery and program monitoring	The data modernization initiative at True North Recovery is positioned at a Ready to Launch stage, with core platforms already selected and the organization fully prepared for activation. The execution focus is on a coordinated, sequenced implementation rather than adopting systems independently, ensuring they function as a unified, integrated environment. The requested funding covers the full roll-out and customization of a new EHR, the transition from a legacy Hazelden platform to an upgraded learning platform to expand telehealth SUD and adult mental health services, the development of AI-enhanced data analytics infrastructure, and the implementation of an in-house managed VoIP phone system. To ensure comprehensive data continuity, the new EHR will be configured to communicate with AKAIMS, maintaining strict alignment with the State’s minimum data set requirements. This integration allows TNR to move away from the State-supported clinical infrastructure while remaining compliant with mandatory reporting standards. Execution will require funding for deployment and subscription fees within a 12-month period. Instead of state-provided technical assistance, TNR will contract specialized experts including a systems engineer for data architecture and a cybersecurity contractor—to guide configuration, reporting, and system reliability. These experts will manage the coordinated rollout, troubleshooting, and staff adoption while providing necessary knowledge transfer to TNR’s internal IT staff. This approach is critical to TNR’s hub-and-spoke service model, which relies on consistent communication and shared clinical data between rural sites. By activating tools in a deliberate sequence, TNR maintains operational continuity and avoids fragmented systems. Ultimately, this strategy focuses on making data highly usable by linking the EHR with AI-enhanced analytics and building automated reporting capacity. This approach directly aligns with Alaska’s Rural Health Transformation Program Initiative 6, which emphasizes leveraging technology to strengthen health system performance and support data-informed decision-making.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

True North Recovery, Inc.	Wasilla Crisis Stabilization Center	AK	Behavioral health crisis systems work best when Alaskans can access the right support at the right time. However, community-based alternatives are limited, and those in crisis often encounter police or hospitals as their first contact. While necessary, these contacts can be jarring, stigmatizing, and can escalate situations. Creating safe alternatives to divert individuals from police or hospital intervention is crucial to meeting the rising demand for community-based services in the Mat-Su Region. To meet this need, True North Recovery (TNR) proposes an innovative peer crisis residential respite pilot, the first 24/7 peer-led respite in the state. Peers serve as core staff, providing de-escalation, safety planning, and recovery connections for those needing stabilization who do not meet inpatient criteria. TNR, a peer-led organization, has expanded since 2016 to offer a full array of residential and detox services through an extensive hub-and-spoke network. At the center is our integrated campus housing the Day One Center and Dylan’s Place, serving as the primary hub for seamless service delivery. This model allows for immediate changes in Level of Care (LOC), moving fluidly between the Day One Center's walk-in "living-room" crisis services and the 3.7/4.0 detox services at Dylan’s Place. Alongside our mobile outreach team and Wasilla Launchpad, these integrated services ensure the new pilot is perfectly positioned for maximum impact.	The pilot represents the defined approach stage of planning and development for a peer crisis residential respite in Mat-Su Valley. Funding will support phased planning, development, and implementation. Phase one focus includes operational modeling, service flow, staffing, and facility safety design aligned with accreditation standards. Phase two supports service activation and full operational support for years one through three, allowing the model to be tested within the crisis continuum. A strong focus includes data collection on operations and utilization to guide future funding strategies for services that currently lack reimbursement options. This phased pilot supports the evolving rural crisis response system by introducing a local, low-acuity, short-term option. It enables early intervention that complements current and planned services—including Mobile Crisis, stabilization centers, and hospital expansion—without duplicating efforts. The model aligns with the Crisis Now framework by providing a safe place to go during a behavioral health crisis. This pilot introduces Alaska’s first peer-led crisis respite. Services are person-centered, trauma-informed, and recovery-oriented, utilizing lived experience as a therapeutic asset. Staffing includes onsite access to mental health clinicians for assessment and intervention. TNR has secured a facility connected to its current campus that houses the Day One Center and Dylan’s Place Detox for seamless service integration. To ensure project readiness, TNR has made a \$600,000 cash investment in the facility, plus an additional \$1.3 million in guaranteed financing for the building purchase. The site is strategically positioned to support: • Step-up and step-down care within the regional hub-and-spoke system. • Hospital transitions and emergency department diversion. • Day One Center (Launchpad) clients who require more support than outpatient crisis access. • Mobile Crisis Team resources when stabilization in the community isn't possible. The four-year pilot focuses on launching in Year 1, adjusting staffing based on trends in Year 2, and evaluating usage and costs in Year 3 to assess Medicaid feasibility. By Year 4, services will transition to an approved Medicaid reimbursement model or another billable level of care.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Single Community	Matanuska-Susitna Borough	Advance to Implementation Application

True North Recovery, Inc.	TNR Workforce Development Programs	AK	The True North Recovery (TNR) Workforce Development Project is a multi-tiered initiative designed to bridge the gap between clinical treatment and long-term economic stability for Alaskans with behavioral health and substance use disorders. The project addresses two critical needs: the severe shortage of entry-level behavioral health providers in rural Alaska and the lack of supportive employment opportunities for individuals reentering the workforce during recovery. To achieve this, the project utilizes three integrated pathways that offer "grace to work out the kinks" in a supportive environment: Clinical Internship Pathway: Provides 20 paid positions (\$20.00/hr) for a minimum of 90 days to equip soon-to-be graduates with essential competencies like ethics, boundaries, and clinical documentation. Interns are paired with mentors in residential settings to ensure they are field-ready. Job Training Program (TNR Enterprises): Offers 20 paid positions (\$20.00/hr) within internal micro-businesses—including maintenance, janitorial, administrative, and vehicle repair shops. This pathway allows participants who may not yet be ready for clinical roles to gain trades and documented references. TNR Training Academy: A curriculum-based hub developed in partnership with NAADAC to provide virtual and in-person CEUs specifically aligned with the Alaska framework for Chemical Dependency Counselor (CDC) and Peer Support certifications.	1. Clinical Internship Pathway This track focuses on a "mentor-first" model for soon-to-be graduates. Structured Mentorship: Interns are placed within a True North Recovery (TNR) residential program for 12 weeks, working alongside mentors who model core competencies in ethics, boundaries, safety, and clinical documentation. Professional Readiness: After 90 days of paid training at \$20.00/hour, each participant undergoes a formal evaluation to certify their readiness for entry-level behavioral health positions. Holistic Support: TNR assists candidates with resume building, background check variance applications, and obtaining letters of recommendation from clinical teams. 2. Vocational Training (TNR Enterprises) This pathway provides a supportive "micro-business" environment where participants can gain technical skills without the immediate pressure of external employment. Diverse Trade Exposure: Participants engage in paid roles (\$20.00/hour) across various sectors, including janitorial, maintenance, administration, and vehicle repair. Future plans include expanding into specialized fields like IT and medical billing. Strategic Independence: To bypass the delays caused by background check variances for non-clinical roles, TNR is contracting legal and financial advisors to establish these enterprises under a separate EIN. This allows participants to build documented job history and technical skills independently. Work-Force Bridge: TNR partners with local businesses to conduct interviews for participants, facilitating a smooth transition into the broader Alaska workforce. 3. TNR Training Academy & Holistic Stability The approach extends beyond immediate jobs to long-term career and life stability. Certification Access: Through a partnership with NAADAC, the Academy provides an array of virtual and in-person classes specifically aligned with Alaska-specific requirements for Chemical Dependency Counselor (CDC) and Peer Support certifications. This fills a critical gap left by the closure of previous state training programs. Integrated Stability: Recognizing that housing is a "vital component" of success, participants can utilize SOR-funded workforce housing. This allows them to build a documented rental history, preparing them for independent living. True North Recovery Has invested to date approximately 1.2million dollars into the development of this multifaceted project.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Ketchikan Gateway Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

TrueNorth Medical Staffing LLC	Southeast Alaska Specialty Care Access Initiative	AK	Southeast Alaska's approximately 60,000 residents are distributed across a 500-mile island archipelago with no road connections between communities. The region has no permanent, independent ophthalmology practice. Residents requiring specialty eye care — including treatment for diabetic retinopathy, glaucoma, age-related macular degeneration, and other sight-threatening conditions — must travel by float plane or ferry to Juneau or leave Southeast Alaska entirely, creating delays that frequently result in preventable vision loss. Diabetes prevalence among Alaska Native populations in the region is significantly above the national average, driving elevated rates of diabetic retinopathy — a leading cause of blindness that is highly treatable when caught early and managed consistently. Geographic isolation makes that consistency nearly impossible under the current model of care. This project addresses that gap by establishing a permanent ophthalmology hub in Juneau with the infrastructure to extend care regionwide through tele-ophthalmology and mobile clinic deployments — converting a fragmented, travel-dependent system into a coordinated, accessible regional network.	This project establishes a permanent ophthalmology clinic in Juneau as the hub of a regionwide specialty eye care network serving all of Southeast Alaska. The approach operates through three integrated components. Brick-and-Mortar Hub: A dedicated ophthalmology clinic in Juneau will provide comprehensive eye care including medical and surgical management of cataracts, glaucoma, diabetic retinopathy, age-related macular degeneration, and retinal disease. The clinic builds on an established patient base and referral network developed through years of practice at Bartlett Regional Hospital, ensuring immediate community impact from day one. The hub serves Juneau's 30,000 residents directly while functioning as the coordination center for regional outreach. Tele-Ophthalmology Network: The clinic will establish remote screening and consultation partnerships with rural clinics, tribal health organizations, and community health aides across the archipelago. AI-assisted diagnostic imaging analysis will be integrated into the screening workflow, enabling automated detection of early diabetic retinopathy, glaucoma, and macular degeneration from retinal photographs taken at remote sites — flagging high-risk patients for priority specialist review and dramatically expanding the volume of screenings the network can support. Mobile Ophthalmology Clinics: Periodic deployments to regional communities will bring comprehensive eye care — including dilated exams, disease monitoring, laser treatments, and intravitreal injections — directly to patients who cannot reliably travel. Communities served will include Haines, Hoonah, Ketchikan, Petersburg, Sitka, Skagway, and Wrangell. Together these three components transform the current fragmented, travel-dependent model into a coordinated, technology-enabled regional network built on permanent infrastructure and a long-term commitment to Southeast Alaska.	\$1M-\$5M	Specialist	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Wrangell (City and Borough)	Deferred or Not Advanced

Truentity	Advancing Networked Care for Health Outcomes in Rural Communities (ANCHOR) in Alaska	NC	Rural and frontier communities across Alaska face significant barriers to consistent healthcare access. Long travel distances, limited provider availability, and infrequent clinical visits make it difficult for residents to receive ongoing support for chronic conditions such as hypertension and diabetes. As a result, many patients go long periods without monitoring or care coordination between visits, increasing the risk of complications and avoidable hospital utilization. At the same time, community pharmacies are often among the most accessible and trusted healthcare locations in rural communities. Patients interact with their pharmacist far more frequently than with other healthcare providers, yet pharmacies are rarely equipped with the digital infrastructure or care frameworks needed to support ongoing clinical engagement. This project addresses that gap by enabling community pharmacies to serve as technology-enabled access points for continuous monitoring, early risk identification, and care coordination. Through the ANCHOR model, pharmacies are equipped with connected devices, digital workflows, and clinical protocols that allow them to support patients between traditional clinic visits. By strengthening the role of pharmacies as accessible community care hubs, this approach expands access to chronic disease support while helping rural residents remain connected to care closer to home.	This project will be implemented through Truentity’s ANCHOR (Advancing Networked Care for Health Outcomes in Rural Communities) model, a pharmacy-centered care framework designed to expand access to healthcare services in rural, remote, and frontier communities. The approach activates Alaska-based community pharmacies as local care delivery hubs. Participating pharmacies provide technology-enabled clinical services that support continuous monitoring, early risk identification, medication optimization, and care coordination for patients with chronic conditions such as hypertension, diabetes, and heart failure. Patients enroll through participating pharmacies and use connected monitoring devices and structured digital workflows to capture key health indicators such as blood pressure, glucose readings, medication adherence, and symptom data. This information is securely transmitted to the ANCHOR platform, where analytics identify trends and potential risks. When readings exceed established clinical thresholds, alerts are generated and reviewed through physician-governed clinical protocols. Pharmacy teams conduct patient outreach, reinforce treatment plans, and coordinate with primary care providers or other healthcare partners when escalation is required. This enables earlier intervention and more consistent follow-up between traditional healthcare visits. The model is designed to deploy quickly using existing community infrastructure. Because services are integrated into pharmacy operations, sites can typically be onboarded and operational within weeks. Truentity provides the digital platform, standardized care workflows, training, and operational support needed for pharmacies to integrate these services into their daily practice. This approach expands the effective rural healthcare workforce by enabling pharmacists and pharmacy teams to operate at the top of their license while maintaining coordination with physicians and other providers. By embedding continuous care and monitoring within trusted community pharmacies, the model improves access to care, strengthens care coordination, and supports better management of chronic disease across Alaska’s rural and frontier communities.	\$1M-\$5M	Statewide	Denali Borough; Fairbanks North Star Borough; Ketchikan Gateway Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Southeast Fairbanks Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

Trusted Connections	Trusted Connections: Healing Trauma — Together	AK	Multigenerational trauma in Alaska damages family structures and leads to internalized oppression, boarding-school informed parenting, and unhealthy coping through addiction. Systemic racism continues today. Tens of thousands of Alaska Natives have lost vital connection with home and culture. We see the trauma of people living cold on the street, addicted to substances, and dying by suicide at three times the national average. Many end up in prison, are trapped in domestic violence, or become our Missing and Murdered Indigenous Relatives. Support from within Native community is the single strongest protection against these catastrophic outcomes. Establishing trusted relationships helps people feel safe to identify problems and heal in community. Our primary tool is Trauma Healing Circles. We do not treat trauma — instead we help people walk through trauma so they can experience their own healing. We prevent new trauma and support hurting people on their path to hope with holistic, Indigenous-centered Trauma Healing Circles led by local community peers throughout the state. People choosing a healing path and a life respectful of self, family, and culture leads to reduced isolation, increased identity awareness, expanded peer access, shared advocacy, and self-care.	When a friend cares enough to walk with us as we face our deepest challenges, many things that have been overwhelming—even paralyzing—become possible. Trusted Connections is a grassroots effort led by people whose families, communities, lives, and culture were greatly harmed by intergenerational trauma. We have walked with pain. We are committed to building a network of Indigenous Trauma Healing Circle peer facilitators who serve in their Alaskan communities. We have seen dramatic positive outcomes for dozens of clients—on the streets of Anchorage, in Trauma Healing Circles, and through village connections—by providing high engagement, culturally sensitive, trauma-responsive peer support services. Our team builds trust and connection during Trauma Healing Circles and with people we support in the community. These relationships create a path for healing. We care enough to take time. To be present. To sit in quiet support when someone shares their pain. To listen to voices that have been brushed aside. To acknowledge each person's immense value. We address healing now in ways that help prevent future trauma. Logistics — we will implement our approach through building capacity, direct service, Indigenous-centered curriculum, and supporting healthy resilience in staff. Build Capacity Establish administrative and evaluation infrastructure capacity, set up website/social media presence, and grow contributor pool. Lease and set up a dedicated drop-in space in Anchorage. Acquire and equip a vehicle to bring pop-up mobile services to the community. Train Indigenous peers to facilitate Trauma Healing Circles and support connections in their communities (create a statewide network). Relational work w/partner orgs. Share facilitator training with communities as we are invited. Direct Service Address immediate individual needs arising from multigenerational trauma. Develop culturally sensitive care protocol that can be adapted for use in rural, remote, and frontier communities. Curriculum Design, create, test, and refine holistic customizable Alaska Native / Indigenous-centered Trauma Healing Circle facilitator training curriculum for online and in-person delivery. Support Healthy Resilience Provide training and holistic supports for healthy resilience of staff	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Sitka (City and Borough)	Deferred or Not Advanced

(including community-based peer facilitators) to sustain organic growth. Mutual support networking/gatherings.



Tundra Womens Coalition	Tundra Women's Coalition Multidisciplinary Expansion	AK	Western Alaska has the highest rates of domestic and sexual violence in the country. Half of adult women in the Yukon-Kuskokwim Delta have experienced intimate partner violence, sexual violence or both, in their lifetime. The true rates are likely higher than what is reported because of the limited access to law enforcement and medical forensic services available to people in the YK Delta. The area is rural, remote, and off the road system. Interpersonal violence can impact every system in the body, sometimes for a lifetime, so the need for forensic examinations, medical treatment, follow-up medical treatment, and routine medical care for survivors of violence is critical. SART call-outs can take up to six hours depending on the case, the number and extent of injuries, and what sort of impact the trauma has on the survivor. This region’s MDT sees 75-100 adult sexual assault responses and 100-150 child sexual assault responses each year. The lack of an adequate response to contributes to cycles of continued harm on the Alaska Native population and the communities in which they, and their children, live. A poor response or absent response prevents healing and oftentimes leaves people vulnerable to additional victimization. Beyond looking at the high rates of sexual and domestic violence the impact of sexual violence can be inferred in the high rate of death by suicide, substance misuse, economic poverty, and mental health issues.	Tundra Women's Coalition hosts the multidisciplinary response to violence for the region in partnership with law enforcement and the Yukon Kuskokwim Health Corporation. YKHC has make-shift office space at TWC to provide forensic examinations, medical treatment, follow up medical, and regular medical checks for families and people impacted by violence. The increased collaboration between YKHC and TWC through the years has greatly increased this region's access to medical and forensic services after violence and almost entirely stopped people from having to fly to Anchorage to be seen. Only medically complicated cases have to be seen in Anchorage now. The Team wishes to design a new wing of Tundra Women's Coalition that would allow for MDT members to work in the same space. This wing would allow for medical services, interview space for law enforcement, and a space to conduct telehealth services for people stranded in village communities, unable to get to Bethel because of inclement weather. In those cases the opportunity to collect evidence is lost and many people opt not to report because of the length of wait time. Many sexual assaults are not reported because of the hassle of having to fly into Bethel when weather could leave you stuck in your village community, and then later stuck in Bethel. People's access to medical after violence would greatly increase if the MDT could work closer together, and also create a space that telehealth consults could happen. Currently when a telehealth appointment is happening the provider has to go to their home for better internet connectivity. Besides the response to crime that includes forensic medical services, YKHC has begun offering medical services to residents living at TWC. This is greatly increases victims of violence access to medical care like women's health check ups, general check ups, TB screening (for when people are seeking treatment), vaccinations, and follow up for things like head trauma and injury checks. YKHC is working out of make shift space for this currently and would greatly benefit from specifically designed space. TWC office space has been maxed out due to YKHC's presence. Additional space would take the pressure off of everyone and ensure more confidentiality for medical services.	\$250K-\$1M	Single Community	Bethel Census Area	Deferred or Not Advanced

Turnagain Social Club	Home and Community Based Waiver Association	AK	Alaska’s Home and Community-Based Services (HCBS) system plays a critical role in allowing older adults and individuals with disabilities to remain in their homes and communities rather than entering costly institutional care. However, HCBS providers across Alaska often operate independently with limited coordination, shared resources, or structured communication with state agencies and health systems. This fragmentation creates challenges for providers—particularly in rural, remote, and frontier communities—where workforce shortages, geographic barriers, and limited access to training or technical assistance already strain the system. Without a coordinated structure to support HCBS providers, opportunities to improve care coordination, share best practices, strengthen workforce capacity, and address system gaps are often missed. These challenges can affect the stability of community-based services that many rural Alaskans rely on to maintain their health and independence. This project presents an opportunity to establish a Home and Community-Based Waiver Provider Association that strengthens collaboration, communication, and system support for HCBS providers across Alaska. By creating a coordinated network focused on training, technical assistance, and provider engagement, the association will help strengthen community-based care delivery, support rural providers, and improve the stability and effectiveness of services that allow Alaskans to receive care closer to home.	The proposed project will establish a Home and Community-Based Services (HCBS) Waiver Provider Association to strengthen coordination, communication, and support for providers serving older adults and individuals with disabilities across Alaska, including rural, remote, and frontier communities. The association will create a structured network that connects HCBS providers, allowing them to collaborate, share best practices, and access training and technical assistance that support consistent, high-quality service delivery. The association will focus on several key strategies. First, it will provide education and workforce development opportunities to strengthen provider capacity, particularly for rural providers who often have limited access to training, technical assistance, and professional support. Second, it will facilitate information sharing and collaboration among providers, care coordinators, hospitals, and health system partners to improve care coordination and continuity of services for individuals receiving HCBS supports. Third, the association will serve as a central resource and communication hub, helping providers navigate regulatory requirements, implement best practices, and address operational challenges that affect service delivery in rural areas. This will include sharing tools, guidance, and resources that help providers strengthen services while maintaining compliance with state and federal requirements. Finally, the association will support data sharing and collaborative problem solving, enabling providers to identify trends, workforce challenges, and service gaps that affect rural communities. By strengthening communication and collaboration across the HCBS system, the association will help stabilize the provider network and improve the delivery of community-based services. Through training, collaboration, and improved system coordination, this approach will strengthen the long-term sustainability and effectiveness of community-based care services that allow rural Alaskans to receive needed care closer to home.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Turnagain Social Club	Medical Model Adult Day Care	AK	Alaska’s long-term care system has a critical gap for older adults and individuals with complex chronic medical conditions who need ongoing clinical monitoring but do not qualify for skilled nursing facility placement and cannot be adequately supported through fragmented community services. Many individuals living at home or in assisted living homes experience worsening chronic diseases—such as diabetes, heart failure, COPD, and dementia—because routine medical oversight and care coordination are limited in community settings. While services such as home health, therapy, meals, case management, and transportation exist, they are often delivered by separate providers with little integration, leading to communication gaps, inconsistent disease management, and delayed recognition of health changes. These gaps frequently result in preventable emergency department visits, hospitalizations, and rising healthcare costs for the State of Alaska. This project proposes piloting a medical model adult day care that integrates nursing oversight, chronic disease management, therapy services, case management, meals, and transportation in one coordinated setting. Through regular monitoring, early intervention, and continuity of care, this model shifts care from costly crisis response to proactive disease management, improving outcomes while reducing avoidable hospital utilization and generating long-term cost savings.	The proposed project will pilot a medical model adult day care program designed to improve chronic disease management and continuity of care for older adults and medically complex individuals living in the community. The program will integrate clinical oversight, nursing assessments, care coordination, therapy services, meals, and transportation into a single coordinated setting. Participants will attend the program regularly, allowing licensed nursing staff to monitor chronic conditions, manage medications, identify early changes in health status, and coordinate care with primary care providers, specialists, and care coordinators. By bringing multiple services together under one roof, the program reduces fragmentation and ensures consistent communication between providers involved in a participant’s care. The model emphasizes preventive care and early intervention, enabling health issues to be addressed before they escalate into emergency department visits or hospitalizations. In addition to clinical monitoring, participants will receive structured therapeutic activities, nutrition support, and social engagement that contribute to overall health and stability. By shifting care from episodic crisis response to ongoing disease management and coordinated community-based support, the program aims to improve health outcomes, reduce avoidable hospital utilization, and demonstrate a more cost-effective model of care for the State of Alaska.	\$1M-\$5M	Home- and community-based services provider	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Turnagain Social Club	Transportation Fleet & Brokerage	AK	Alaska’s health care system faces significant challenges related to transportation barriers, particularly for patients traveling to Anchorage for medical care. Many individuals from rural and remote communities must travel to Anchorage to access specialty care, hospital services, dialysis, and other treatments that are not available locally. Once in Anchorage, reliable transportation between the airport, lodging, medical facilities, pharmacies, and follow-up appointments is often difficult to coordinate. These gaps frequently result in missed appointments, delayed care, and disruptions in treatment. When patients are unable to attend scheduled appointments or access follow-up care, chronic conditions can worsen, leading to preventable emergency department visits and hospitalizations. Hospitals in Anchorage are already experiencing capacity challenges, and avoidable emergency visits place additional strain on the health care system. This project addresses the opportunity to create a coordinated health care transportation brokerage and fleet service that improves transportation access for patients receiving care in Anchorage. By improving transportation coordination, the project aims to reduce missed appointments, improve continuity of care, and reduce avoidable emergency department utilization.	The proposed project will establish a health care transportation brokerage and fleet service based in Anchorage to improve coordination and reliability of transportation for patients traveling to Anchorage for medical care. The brokerage will work with hospitals, health systems, tribal health organizations, assisted living homes, and home and community-based service providers to coordinate transportation for individuals traveling between airports, lodging, medical facilities, pharmacies, and follow-up appointments. The project will develop a centralized scheduling and coordination system that allows providers and care coordinators to arrange transportation more efficiently. A dedicated fleet will support scheduled medical transportation and help ensure patients can attend appointments, receive follow-up care, and access community-based services while in Anchorage. By improving coordination of transportation resources and reducing missed appointments, the project will support better continuity of care and chronic disease management. Over time, improved transportation access is expected to reduce preventable emergency department utilization and hospitalizations while supporting more efficient use of health care services for rural patients receiving care in Anchorage.	\$250K-\$1M	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

Tyonek Tribal Conservation District	“Tyonek Grown” Restoration and Readiness for Site-Based Wellness Outcomes	AK	Tyonek is a rural village community without a grocery store. To supplement diminishing subsistence foods, households order foods online and fly them in by plane. The cargo rate of \$0.70/pound, as well as high rates of un/underemployment, incentivizes the purchase of processed food items. As a result, residents experience higher rates of diabetes, heart disease, and other chronic illnesses. These challenges also contribute to mental health concerns, especially among youth and elders. Our 1.25-acre community produces over 2,500 pounds of produce and provides garden plots for 12 households, but aging infrastructure has become both a human safety concern and barrier to increasing production. Once the growing season is over, Tyonek has lacked the storage facilities to maintain vegetable inventory into the winter as well as a consistent method for community members to preserve more than a minimal amount of foods as shelf-stable or frozen items. Tyonek shareholders living primarily outside of the village are also experiencing high rates of health concerns and food insecurity. While those in urban areas have closer access to a variety of retail food products, many express food insecurity through a lack of access to traditional subsistence foods from the village. Expressions of well-being are often related to the ability to access opportunities for growing, harvesting, and creating these food items.	The Tyonek Grown community garden is a site-based wellness center, contributing to preventative health care in the summer and fall by providing both fresh vegetables and opportunities to gather, learn, and participate in the production of fresh foods. We propose to amplify our impact on human health in the community of Tyonek, Anchorage, Mat-Su, and the Kenai Peninsula through the following activities: • Restoration of infrastructure at the Tyonek Grown community garden: wash shed, plumbing and irrigation, solar panel and battery shed, high tunnels, compost bin, cold storage, accessible pathways, gathering space, fence line, and food processing work spaces. These repairs will increase participation by providing safe accessibility to production, education, processing, and storage activities for community members. These restorations will also provide “site readiness” for TTCD to provide healthy food production technical trainings and outreach at the farm. Audiences would include the Tyonek community and school, our local summer interns, Kenai Peninsula School District students and teachers, Shareholder primarily residing in Anchorage and the Mat-Su, and Tribal Conservation District staff from around the state. • Connecting Tyonek Grown resources to outcomes measured by the Indian Creek Health Department: The garden is across the road from the health department and clinic in the village. Creating accessible pathways and gathering spaces in the garden, as well as providing direct outreach on how outdoor gardening activities and making healthy food choices contribute to specific health goals, are anticipated to have a positive impact on ICHD’s community health objectives. We propose to create an MOU with ICHD to co-create these pathways and metrics. • Increasing native plants and “food forest” production to increase diversification of healthy foods as well as provide culturally relevant harvesting opportunities. • Conduct a Tyonek Shareholder Food Assessment for shareholders primarily residing in Anchorage and the Mat-Su. This will be supplemental to the Tyonek Community Food Assessment that we are completing in 2026. The Shareholder Assessment will inform the inclusion of initiatives that connect shareholders to the Tyonek Grown program through on-site outreach and harvest opportunities, fresh produce deliveries, and the preservation of subsistence foods for winter and spring pantries.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

U.S. Renal Care Inc., DBA Alaska Dialysis	Comprehensive Kidney Care for Alaskans	TX	Alaska’s rural kidney disease population faces significant geographic, socioeconomic, and access barriers. Many patients must travel long distances for specialty care, often without reliable transportation or predictable weather conditions. Specialty resources are unevenly distributed, and many communities do not have consistent primary or specialty care support. These realities contribute to delayed diagnosis, faster disease progression, avoidable hospitalizations, and limited access to dialysis options, including home therapies that could allow people to remain in their communities. The program aligns with the State of Alaska’s Rural Health Transformation Program (RHTP) and seeks to address long standing structural barriers in the State’s kidney care ecosystem, particularly those affecting rural, remote, and frontier communities. U.S. Renal Care, Inc. dba Alaska Dialysis and its nephrology partners bring decades of kidney care experience delivering high quality kidney care across the state, serving more than 600 ESKD patients at seven dialysis centers and thousands of CKD patients statewide. The proposal builds on proven outcomes from participation in Medicare’s Kidney Care Choices (KCC) advanced payment model, which has shown measurable improvements in mid-to-late-stage kidney disease progression, reduced hospitalizations, and quality indicators including home dialysis, optimal starts, permanent access, outpatient starts, as well as transplant related metrics.	Our approach has been tested and validated over the last four years in the Kidney Care Choices (KCC) program, a model administered by the Centers for Medicare and Medicaid Innovation (CMMI), including patients across Alaska. Analysis from NIH United States Renal Data System (USRDS) shows improvements in all relevant quality measures across 2022-2023 performance years. These improvements represent lower morbidity, mortality, improved quality of life, and lower cost of care for the patients we serve. Here's how our model achieves this: The model focuses on four approaches: 1. Early Identification 2. Cessation or Delay of Disease Progression – including Rural Interdisciplinary Teams (IDTs), Complex Chronic Disease Management and Specialized Technology 3. Smooth Transitions to ESKD Care 4. Improved Outcomes and Quality of Life with Lower Resource Utilization Partnerships with Communities, NGOs and Critical Access Hospitals (CAHs) Alaska Dialysis will partner with communities, NGOs and CAHs to evaluate and support the expansion of locally delivered dialysis in communities that have traditionally lacked the infrastructure or population to support in-center or home dialysis care, such as Kodiak, Bethel, Nome, Stika, Ketchikan and other communities across the state. This prevents care delays and eliminates the need for patients to travel long distances to receive life sustaining treatment. It also expands access to home dialysis, allowing patients to remain in their local communities. Within each of these four areas, the initiative includes investments to support recruitment, training, and retention of the rural healthcare workforce. Using US Renal Care’s GROW, SUPPORT, and RETAIN framework, the program creates advancement pathways and career opportunities for rural residents. These skilled providers are an important element of ensuring effective care can be delivered to residents in rural areas in a sustainable manner.	Over \$5M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

U.S. Renal Care Inc., DBA Alaska Dialysis	Improving Access & Quality of Dialysis Treatment for Alaskans	TX	End-stage kidney disease presents a significant and growing healthcare challenge in Alaska. Dialysis is a life-sustaining treatment that must be delivered consistently several times per week. However, rural communities face structural barriers that make delivering reliable dialysis care more difficult. Workforce shortages are one of the most pressing challenges. Recruiting and retaining dialysis nurses, technicians, and support staff in rural areas is increasingly difficult due to workforce competition, geographic isolation, and limited local training pipelines. Staffing shortages can limit treatment availability and increase operational strain on existing teams. Dialysis delivery requires specialized infrastructure including dialysis machines, water purification systems, infection control environments, emergency power capabilities, and IT / cybersecurity infrastructure. Facilities require ongoing modernization to maintain reliability and support safe care delivery. By addressing both workforce capacity and facility resilience, this project can improve treatment access, reduce avoidable hospitalizations, and support sustainable kidney care services across rural Alaska.	Alaska Dialysis is the leading provider of chronic kidney disease and end-stage kidney disease (ESKD) in the state of Alaska, with two decades of experience serving citizens of the state. Alaska Dialysis and its nephrologist partners treat more than 600 ESKD patients across seven dialysis facilities, including Juneau, Soldotna, Fairbanks and Wasilla and state wide home dialysis programs and thousands of CKD patients in communities across the state. First, Alaska Dialysis will expand workforce development initiatives designed to build a sustainable rural kidney care workforce. These efforts will strengthen recruitment, training, and retention of dialysis clinicians and support staff, including nurses, Patient Care Technicians (PCTs), pharmacists, care navigators, and community health workers. Through partnerships with local training institutions and community organizations, Alaska Dialysis will expand apprenticeship and training-to-employment pathways, including paid PCT apprenticeship programs that allow rural residents to enter the healthcare workforce while remaining in their communities. These programs will also create advancement pathways for existing staff and support providers practicing at the top of their license. Second, the project will modernize dialysis infrastructure across Alaska Dialysis facilities. Dialysis delivery requires advanced treatment equipment, specialized water purification systems, temperature-controlled environments, and reliable emergency power systems. Targeted investments will upgrade dialysis machines, water treatment systems, isolation rooms, and facility infrastructure to support patient safety, infection control, and treatment reliability. Together, these efforts will strengthen Alaska’s rural dialysis care delivery system, expand treatment capacity, and improve the reliability and quality of dialysis services statewide.	\$1M-\$5M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Umoja Coworking & Incubator	Rural Alaska Health Provider Hub & Community Innovation and Housing Center	AK	We are writing to express our interest in partnership with the Alaska Community Foundation to develop the Rural Alaska Health Provider Hub & Community Innovation and Housing Center, a collaborative initiative designed to strengthen the rural health workforce, expand telehealth infrastructure, and improve access to care for communities across rural Alaska. Rural Alaska faces persistent barriers to health care access due to geographic isolation, workforce shortages, and limited training infrastructure. Providers traveling to rural villages often lack centralized support systems, while community health workers and new providers entering Alaska frequently struggle to find training opportunities, housing, and collaborative networks that help them succeed and remain in rural communities. To address these challenges, Umoja Coworking and Incubator and Umoja Cultural School propose establishing a central hub where health providers, community health workers, nonprofits, and telehealth specialists can collaborate, train, and deliver services that reach rural communities across the state. This initiative would advance two key priorities for Alaska’s health systems: strengthening the rural health workforce and sparking technology and innovation in health delivery.	establishing a hub where health providers, community health workers, nonprofits, and telehealth specialists can collaborate, train, and deliver services that reach rural communities across the state. Components of the Hub Provider Coworking and Collaboration Space The hub will provide shared workspace for visiting professionals including physicians, nurses, behavioral health providers, veterinarians, social workers, and public health specialists. Providers traveling through regional hubs such as Anchorage or Fairbanks will be able to use the space between rural deployments to coordinate services and collaborate with other organizations. Features will include: • shared and solo offices • meeting/training rooms • telehealth stations • secure patient consultation rooms • childcare access for providers and trainees Training/Workforce Development Center A dedicated training center will support the development of rural health workers and community health leaders. Training programs may include: • Community Health Aide training • behavioral health support training • telehealth technology use • maternal and child health support • emergency response training • veterinary and animal care services Telehealth & Digital Health Innovation Center A technology hub within the facility will expand digital health capacity for rural providers. Capabilities will include: • telemedicine consultation rooms • digital diagnostic equipment • remote patient monitoring systems • wearable health device training • secure data-sharing infrastructure These tools will support emerging approaches to care delivery and align with statewide priorities to expand telehealth and digital health services. Community Education & Wellness Space The hub will also serve as a flexible community education space offering prevention and wellness programming such as: • parenting classes • mental health support groups • nutrition and healthy living education • community health workshops • cultural wellness programs These programs will help support healthy communities and preventative care across Alaska.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Fairbanks North Star Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kodiak Island Borough; Matanuska-Susitna Borough; North Slope Borough; Northwest Arctic Borough; Sitka (City and Borough); Southeast Fairbanks Census Area	Deferred or Not Advanced

Rural Provider Housing and Support Services

Housing remains one of the largest barriers to recruiting and retaining providers who travel to rural Alaska. The hub will provide short-term overnight accommodations and logistical support for providers rotating through rural communities.

- temporary housing
- childcare partnerships
- workspace and training access
- travel coordination

United Way of Anchorage	Alaska Employer Child Care Cost Share: Statewide Model Design & Regional Hub Development	AK	Alaska loses \$305 million annually due to child care challenges. Fifty-one percent of Alaska families — up from 25% in 2019 — cannot fully participate in the workforce because of child care. Over 61% of Alaskans live in child care deserts. In hub communities like Kotzebue, Dillingham, and Bethel, licensed child care centers have closed or never existed. Alaska employers lose an estimated \$152 million annually in productivity due to child care-related absenteeism and turnover. In 2025, United Way of Anchorage commissioned what we believe is the nation's first community-specific pre-implementation feasibility study of an employer cost share model prior to program launch — focused on Anchorage. Eighty-four Anchorage employers were surveyed and administrators from six states with operating programs were interviewed. A February 2026 peer review with national experts from five states validated the concept. The Governor's Task Force on Child Care formally recommended this model in December 2024, and SB 95 (2025) established a legislative framework supporting employer child care incentives statewide. No employer cost-sharing model exists anywhere in Alaska. The opportunity: translate a validated Anchorage concept into a statewide, regionally-differentiated design — built honestly around Alaska's provider landscape, employer density, and the distinct realities of regional centers and hub communities.	United Way of Anchorage proposes a Year 1 planning and design initiative to develop a statewide Alaska Employer Child Care Cost Share model — organized around Alaska's geographic reality of regional centers and hub communities — moving from a validated Anchorage concept to a statewide implementation-ready design. Year 1 includes four workstreams: 1. Statewide employer and provider landscape study: Commission an independent contractor to extend the Anchorage feasibility methodology statewide. Survey employers and assess licensed child care provider capacity across regional centers (Fairbanks, Juneau, Sitka, Kodiak, Kenai, Ketchikan, Mat-Su) and hub communities (Bethel, Nome, Kotzebue, Dillingham, Utqiagvik). Assess which communities have sufficient provider infrastructure now and which require parallel supply-side investment first. The Anchorage feasibility study cost approximately \$70,000 — this statewide effort will be appropriately scoped. 2. Tiered readiness architecture: Using study findings, tier communities into: Tier 1 — regional centers ready for Year 2 implementation; Tier 2 — communities viable with provider development support; Tier 3 — hub and remote communities where alternative models are needed first. 3. Model design and policy alignment: Convene a statewide design team to finalize program parameters — contribution structure, no-income-restriction eligibility, payroll deduction mechanics, third-party administrator requirements, and facilitator criteria. Align with SB 95, CCAP, and ACCEE Fund structures. 4. Implementation playbook: Produce a replicable facilitator guide as the operational foundation for Year 2+ launches. UWA's role is statewide convener and model architect throughout.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

United Way of Anchorage	Strengthening Alaska 211: Community-Led Care Coordination for Rural Health Transformation	AK	Alaska's rural and frontier communities face a structural gap: Alaskans with the greatest health needs have the fewest pathways to coordinated care. Primary care, behavioral health, social services, and tribal health organizations operate in parallel — referrals disappear, people retell their stories at every door, and providers cannot see whether help was received. Providers across Alaska have begun building coordination capabilities, but siloed efforts duplicate cost and effort without creating the shared infrastructure needed for true system-level change. A Community Information Exchange (CIE) is a shared infrastructure that connects health care, social services, tribal organizations, and community providers so that care follows the person—not the system boundary. For a mother in a remote community navigating prenatal care, a CIE means her tribal clinic, regional hospital, and community supports share a single care record. A CIE also generates the closed-loop outcome data that value-based payment models require—making it foundational to Alaska's health system transformation, not just a coordination tool. Alaska 211 is the natural backbone for a statewide CIE. With 19 years of operation, 8,000+ resources across 1,000+ agencies, 30,000+ annual requests, it already has the reach and relationships a CIE requires.	Phase 1 - Build Foundation: Rather than deploying technology prematurely, we carefully design a CIE that communities will adopt and sustain, doing the following: Governance/Engagement: Create a steering committee of UWA, tribal health organizations, hospitals, behavioral health providers, and community leaders. Develop data agreements and co-governance frameworks grounded in CARE principles. Conduct a statewide needs assessment to document service gaps, connectivity constraints, and provider readiness. Identify initial pilot communities and providers in a community-led selection process. Sustainability: Treat sustainability as a design decision that must be made at the beginning of the project. Establish the economic foundation for sustainability. Quantify with a statewide value/needs assessment where today’s fragmentation creates financial loss, operational burden, and missed performance incentives. Explore economies of scale, partnerships and value-based models to fund the CIE beyond RHTP. Define Operating Model: Establish (1) shared governance across health, social services, tribal, and community partners; (2) shared language for care coordination and health/social integration; (3) secure information exchange connecting critical systems without replacing existing platforms; (4) mapped service gaps with measurable improvement targets; (5) data governance frameworks for community-level equity insights. Assess interoperability with EMRs, Alaska HIE, Medicaid, and tribal health records. Document requirements for low-connectivity environments. Phase 2 – Launch Pilots: Phase 1 findings confirm sustainability of the CIE and create a solid foundation for governance and operating model. Based on this framework, implement 2 Pilots, bringing the CIE to life and impacting real health outcomes. We configure tools for Alaska's operating context; enact data governance policies and consent workflows; baseline metrics for pilots; finalize pilot site agreements, provider onboarding plans, and workforce training frameworks for care navigators and community health workers; produce playbook for deployment; and launch the pilots. Phase 3 - Expand: Launch Pilot 3 and expand. Scaling requires intensive change management and technical expansion. We apply structured adoption principles to build desire and knowledge across new partner communities. As the model grows, continuous plan-do-check-act cycles refine training, partner recruitment, communications, and outcome measurement.	\$50,000-\$250,000	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementation Application

United Way of Anchorage	ALICE in Action: Building Financial Stability Resources for Alaska’s Regional Communities	AK	Alaska is different. Residents navigating fragmented systems for housing, food, health care, and employment face the compounding challenges of limited infrastructure, geographic isolation, and capacity gaps that urban models cannot solve. At United Way of Anchorage (UWA), we know that economic instability creates barriers linked to poorer health outcomes, increased stress, and higher use of emergency and crisis services. UWA and Alaska 211 have spent more than a decade building programs that treat financial security as a core social determinant of health — Eviction Diversion, Landlord Housing Partnerships, and closed-loop referral services that connect Alaskans to housing, health insurance, and federal benefits before financial stress becomes a health crisis. These approaches work in Anchorage. But the families who need them most — in regional hub communities across the state — often have no equivalent local resource to be referred to. In fall 2026, UWA will release United for ALICE: the first statewide dataset on financial insecurity in Alaska, more actionable than the Federal Poverty Level and specific enough to guide targeted community investment. This project uses that data to answer what data alone cannot: what financial stability resources are missing in Alaska’s regional communities, what interventions fit each community’s context, and who are the right local partners to build and sustain them?	Financial stability resources work best when they are designed with communities, not delivered to them. In Anchorage, UWA’s combination of community trust, provider relationships, and a resource backbone — supported by Alaska 211’s closed-loop referral infrastructure — enabled programs like Eviction Diversion and the Landlord Housing Partnership to stabilize hundreds of households. The experience showed what works. It also showed what’s missing elsewhere: in many regional hub communities, there is no equivalent resource for Alaska 211 to refer families to, no local program to activate, no community partner equipped to address financial instability before it becomes a health crisis. This project stands on its own: Alaska 211’s existing referral infrastructure, UWA’s operating programs, and the United for ALICE data provide everything needed to identify resource gaps, design community-level interventions, and connect families to help. This project stands on its own. In the planning year, UWA will cross-reference United for ALICE data with Alaska 211’s statewide resource database to map where financial insecurity is concentrated and where resource gaps are most acute. UWA will then work directly with providers, community organizations, and local partners in regional hub communities to understand what interventions are feasible given local infrastructure, workforce capacity, and community readiness. Solutions may include community-based personnel, technology-enabled navigation tools, peer networks, adapted versions of UWA’s existing program models, or collaborative partnerships — the planning process determines what fits each community, rather than assuming a single model statewide. The result of the planning year will be a differentiated implementation plan for multiple hub communities: what financial stability resource or intervention each community will develop, who the local host or partner will be, how it connects to Alaska 211’s referral network, and what a sustainable funding model looks like beyond RHTP. This approach reflects UWA’s founding role as Alaska’s trusted convener — providing the data, program expertise, and resource backbone while communities lead the design of solutions that fit their own context.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

United Way of Anchorage	Home for Good - Permanent Supportive Housing expansion	AK	Alaska has an opportunity to build on the proven success of the Home for Good project to address persistent homelessness for residents with the most complex needs. Many of these individuals cycle repeatedly through crisis and emergency systems—including jails, hospitals, and emergency shelters —while remaining unhoused. For the past five years, Home for Good has worked with more than 20 system partners to provide intensive case management and stable housing to residents in Anchorage experiencing long-term homelessness and are cycling through emergency services. In preliminary data from the project’s final evaluation, Home for Good participants spent a substantial amount of time stably housed and remained in a lease over 90% of the maximum number of days at 18 months after HFG enrollment. Use of emergency services declined significantly – when comparing 12 months before and 12 months after participants’ first lease date, participants had an 84% reduction in shelter stays, 71% reduction in intakes to the Anchorage Safety Center, 54% reduction in arrests, and 18% reduction in calls to the Anchorage Fire Department for EMS transport. United Way of Anchorage is now seeking support to expand this proven model and house an additional 100 participants over five years. With a strong focus on outcomes and an investment in permanent supportive housing, people in Anchorage with the most complex barriers to housing can achieve housing stability.	Home for Good (HFG) provides supportive housing to Anchorage residents experiencing persistent homelessness with complex needs, often including multiple disabling conditions. Building on five years of proven success, HFG seeks to expand its reach to house an additional 100 participants over the next five years. The project uses an evidence-based approach, combining housing assistance with intensive case management and behavioral health services to stabilize participants and connect them to long-term supports.	\$1M-\$5M	Single Community	Anchorage (Municipality)	Deferred or Not Advanced

United Way of Mat Su	Building a Healthier Mat-Su	AK	Residents of the Mat-Su Borough face significant health disparities driven by geographic isolation, limited access to preventive services, and growing population pressures on health infrastructure. Many communities lack accessible public spaces that promote physical activity, social connection, and healthy development for children and families. At the same time, families with young children and older adults often struggle to navigate available services or access programs that support long-term health and well-being. These challenges contribute to higher risks of chronic disease, developmental delays in early childhood, and increased social isolation among teens, adults, and older adults. Without coordinated community-based solutions, health and wellness systems in Mat-Su face increasing demand for costly reactive care rather than preventive support. However, the Mat-Su region also has a strong network of community organizations, local governments, and health partners working collaboratively to address these challenges. This project presents an opportunity to strengthen and coordinate these efforts to build healthier environments, improve early childhood outcomes, improve teen health and wellbeing, and support aging populations in rural communities.	United Way of Mat-Su will implement a coordinated community health and wellbeing approach focused on prevention, connection, and community infrastructure through initiatives aligned with Healthy Beginnings and Healthy Communities. Key components include: Early Childhood: Strengthening early childhood initiatives that support families, promote developmental screening, increase space spaces for play time and for parents/caregivers to socially connect with other parents/caregivers, and connect parents with resources that foster healthy child development. Parks and Playgrounds: Expanding access to safe, inclusive outdoor spaces that promote physical activity, social engagement, and healthy childhood development across Mat-Su rural communities. Healthy Aging Initiatives: Supporting programs that reduce social isolation and increase social engagement among older adults, increase opportunities for physical activity and engagement, and connect seniors with services that support independence and well-being; Bolster senior supports through fall prevention education and outreach. Thrive Mat-Su: Leverage the coalition's youth substance abuse primary prevention work to align partners across sectors, share data, and coordinate strategies that improve community health outcomes; build on community engagement and readiness to build protective factors and positive youth development approaches and practices in the community; integrate resilience and mental health supports into all programming; increase youth events and youth activities to increase overall opportunities for youth. Youth 360: Launch a new afterschool teen club at Palmer Junior Middle School building upon the success and implementation of the Icelandic Prevention Model; Currently operate four teen afterschool clubs and an out of school summer camp focused on social connections, building life skills and resilience skills, refusal skills, youth voice and youth leadership development; program addresses equity and barriers by providing food, basic needs assistance, and transportation for participants. Community Collaboration: Strengthening partnerships with health providers, local governments, tribal partners, and community organizations to build sustainable systems that address social determinants of health. This approach integrates prevention, community engagement, and cross-sector collaboration to create lasting improvements in community health infrastructure.	Under \$50,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

University of South Florida	DISTA: Modernizing Workforce Through Strategic Training in Applied Public Health	FL	Strengthening the rural public health workforce is essential for improving disease prevention and response across Alaska’s geographically dispersed communities. The University of South Florida (USF) seeks to partner with Alaska public health stakeholders to strengthen training for Disease Intervention Specialists (DIS) and other frontline healthcare and public health professionals serving rural and geographically dispersed communities. Through Driving Impact through Strategic Training in Applied Public Health (DISTA), USF proposes to work with Alaska partners to adapt and implement a competency-based training model that strengthens workforce readiness, supports rural public health practice, and builds sustainable training capacity across the state. Established in 2022 as a collaboration between USF and the Florida Department of Health, DISTA addresses critical workforce training gaps identified through statewide assessments of Disease Intervention Specialists and other frontline public health professionals. The program integrates academic expertise with real-world public health practice to build a scalable workforce training infrastructure focused on competency development, applied skills, and career progression. DISTA currently offers a large selection of online modules in public health, interview skills and counseling, infection-specific content, social behavioral health, and leadership and management as well as online synchronous and in-person training opportunities.	The proposal would begin with a workforce training needs assessment conducted in partnership with Alaska public health stakeholders, including state and local agencies and community partners. Particular attention would be given to Alaska’s geographic barriers, rural workforce distribution, and travel constraints that influence access to training opportunities. Based on these findings, DISTA would work with Alaska partners to adapt the training curriculum and implement a hybrid training model that may include self-paced online learning modules, live virtual training sessions, in-person experiential workshops, mentorship opportunities, and a Train-the-Trainer component designed to build sustainable local training capacity. By strengthening workforce readiness, expanding access to training across geographically dispersed regions, and establishing local instructor capacity, this initiative would support Alaska’s efforts to strengthen disease investigation capacity and public health response systems in rural communities. Since its launch, DISTA has trained over 258 frontline public health professionals throughout Florida, including a significant proportion of early-career staff engaged in disease investigation and community outreach, underscoring the necessity for structured onboarding and applied skills training. Participants’ knowledge assessment scores statistically significantly increased from 69% to 95%, and confidence improved across essential investigation skills. Experiential learning activities, such as simulations, mock interviews, and case scenarios, reinforced practical competencies, including case management and field safety. Workforce outcomes also improved: 80% of DISTA-trained staff remained employed compared to 42% under previous training models, and there was a 10.2 percentage-point reduction in first-year separation, suggesting enhanced workforce readiness and retention. DISTA’s curriculum is organized as a tiered learning pathway combining self-paced online modules with experiential training. This hybrid structure allows learners to progress from foundational skills to advanced leadership competencies while accommodating workforce schedules and geographic constraints. DISTA competencies align with national public health certification frameworks, including Certified in Public Health (CPH), Community Health Worker (CHW), and Certified Health Education Specialist (CHES), ensuring alignment with broader workforce development standards.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

University of Washington	Rural Point of Care Ultrasound Initiative-Bringing Healthcare to Alaska’s Most Remote Communities	WA	Rural regions of Alaska suffer from increased morbidity and mortality, in part due to challenging distribution of higher-level resources and specialists. Spoke and hub models like ANTHC have addressed these odds with easy escalation to critical access hospitals and specialty care. However, persistent gaps in imaging lead to unnecessary transfers, delayed care, and missed diagnoses creating substantial costs. X-ray, computed tomography and standard ultrasound are not feasible in most rural Alaskan communities given the expense of transporting, maintaining, and training providers to operate complex machinery. POCUS at scale can drastically improve care with a rapid, low-cost and evidence-backed solution where access to advanced diagnostics is limited. Providers from community health workers to physicians have successfully used the technology and research has shown that competency attainment for the most basic POCUS scans can be as low as 10 studies. However, a major component of expanding capacity to rural sites is linking the images to a robust network. It can only be achieved with solutions that scale across settings and priorities, not single departments. This requires deployment of probes, software integration, and clinical education. The funding required to establish high quality POCUS deployment is not feasible for a healthcare network serving patient populations that largely rely on tribal assistance and Medicaid. RHTP funding can bridge this implementation gap.	We plan to expand ultrasound diagnostic capabilities to rural sites with delivery of portable probes, curated curriculum, longitudinal education, technological support and integration into already existing electronic medical records. This will start with initiatives in already identified tribal health organizations (THOs) with the eventual goal of widespread adoption throughout ANTHC. Over the past three years we have been running a small pilot program in partnership with SouthEast Alaska Regional Health Consortium (SEARHC). We will use this experience to expand into Southcentral Foundation (SCF) and Maniilaq Health Center (MHC). Both THOs have on site staff facilitating POCUS expansion. First steps involve creation of a central image repository integrated into each location’s electronic medical record (EMR) and picture archiving and communication system (PACS). This integration as well as probe delivery will be accomplished through partnership with Butterfly Network, Inc - an American health technology company that manufactures chip-based ultrasounds alongside a comprehensive, cloud-based software system. In parallel we will begin educational sessions for rural providers with already established credentialing guidelines trialed in SEARHC. A combination of UW emergency medicine and Alaska Native Medical Center (ANMC) ultrasound faculty and fellows will provide on site and telehealth guided training sessions. We will employ additional ultrasound teachers through programs like the global ultrasound institute (GUSI) should the training sessions exceed the capacity of these educators. UW ultrasound faculty and fellows will oversee image review for quality assurance and improvement. Collaborators from Butterfly will aid in informatics to continually reassess usage and reorient education to match need and utilization. Next steps of the project will include expansion to additional THOs as well as more providers within each site. We will also grow partnerships on a more structural level within the larger ANTHC network with the goal of improved interoperability between sites using cloud imaging software as well as a centralized learning center within ANMC. This stage will involve equipping educators with probes and phantom models. It will also involve partnering with ultrasound trained faculty, community health aide (CHA/P) directors, and administrators within the network to establish formalized clinical guidelines and advanced local resources.	\$250K-\$1M	Hospital	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Dillingham Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Ketchikan Gateway Borough; Kuskilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

University of Washington dba Airlift Northwest	Airlift Northwest Air Medical-Expand Access to Essential Health Services in Rural Communities	WA	Alaska’s geography, severe weather patterns, and vast distances create some of the most complex health care access challenges in the nation. Many communities lack road connectivity and rely entirely on aviation to access advanced medical care. Patients requiring trauma services, burn care, advanced cardiac intervention, neurosurgery, high-risk obstetrics, complex pediatric services, transplant evaluation, or other quaternary-level care must be transported rapidly and safely to higher levels of care. Demand for interfacility critical care transport from Southeast Alaska continues to grow. Weather variability, limited aircraft availability, and increasing clinical acuity create capacity constraints that can delay access to definitive care. A third Learjet based in Juneau will directly address these access gaps and ensure reliable system capacity. The addition of this aircraft will: • Expand reliable access to tertiary and quaternary care for rural and frontier communities. • Reduce time to definitive care for trauma, stroke, STEMI, sepsis, high-risk maternal, pediatric, and other complex patients. • Improve system redundancy during weather disruptions and peak demand periods. • Support small rural hospitals and critical access facilities in stabilizing and transferring patients safely. • Strengthen Alaska’s statewide referral network and continuity of care.	We propose the placement and operation of a third Learjet based in Juneau, Alaska, dedicated to expanding access to tertiary and quaternary health care services for patients across Southeast Alaska and surrounding rural and frontier communities. Funding from the Rural Health Care Transformation Fund will support: • Acquisition and operational deployment of a third Learjet dedicated to the Juneau base. • Staffing with specialized critical care transport clinicians. • Expanded 24/7 coverage capacity to reduce transport delays. • Increased throughput to tertiary and quaternary care centers. This aircraft will serve 200 or more patients annually, representing critically ill or injured Alaskans who require services not available in their home communities. These funds will support aircraft readiness, clinical staffing, aviation operations, maintenance, and rural access stabilization necessary to maintain consistent 24/7 service to Southeast Alaska and surrounding frontier communities. The addition of this aircraft will: • Expand reliable access to tertiary and quaternary care for rural and frontier communities. • Reduce time to definitive care for trauma, stroke, STEMI, sepsis, high-risk maternal, pediatric, and other complex patients. • Improve system redundancy during weather disruptions and peak demand periods. • Support small rural hospitals and critical access facilities in stabilizing and transferring patients safely. • Strengthen Alaska’s statewide referral network and continuity of care. This investment directly advances the Fund’s goal of expanding and maintaining essential health services in remote communities by ensuring patients can reach the care they need, when they need it.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Juneau (City and Borough); Ketchikan Gateway Borough; Petersburg Borough; Sitka (City and Borough); Wrangell (City and Borough)	Deferred or Not Advanced

Upper Susitna Fitness Center	Upper Susitna Valley Wellness Center (USVWC): Readiness and Planning Project	AK	The approximately 6,000 residents of the Upper Susitna Valley have no access to a year-round indoor fitness and wellness facility. This is not a gap in convenience - it is a gap in preventive health infrastructure; one that affects residents of all ages, from youth facing higher obesity risk to working adults managing chronic conditions to elders who need structured programming to maintain independence. The nearest public gym is over 70 miles away in Wasilla, and Alaska's extended winters make outdoor exercise difficult for much of the year. A 2025 community survey received 224 responses across the service area and confirmed strong, cross-generational demand. Top health goals were general health improvement (65%), stress reduction (54%), and weight loss (51%). Top requested amenities included strength training equipment (65%), cardio machines (51%), and group fitness classes (49%). The opportunity is clear: documented community demand, a facility committed for future use by a local partner organization, and engaged clinical and community partners together create the conditions to establish the region's first fitness and wellness center - directly aligned with RHTP's Healthy Communities initiative and its emphasis on evidence-based prevention and chronic disease management.	This Letter of Interest requests readiness funding to build the organizational, planning, and partnership foundations necessary to bring a community wellness center in the Upper Susitna Valley from concept to implementation-ready status. The first priority is establishing the organization itself. We will formally incorporate the USVWC as a registered Alaska nonprofit corporation with 501(c)(3) tax-exempt status, establish a governance board, adopt bylaws, and build the financial management and administrative infrastructure required to responsibly manage federal grant funds. A part-time project coordinator will be hired to manage readiness activities, coordinate with partners, and maintain community engagement throughout this phase. Equally critical is securing the facility. The Sunshine Station Childcare Center Board has committed to making their current building available for use as a community wellness center once construction of their new facility is complete, projected for 2028. While that commitment is clear, the terms have not yet been formalized in writing. Putting a written facility agreement in place is a key deliverable of this readiness phase and essential before any capital planning can proceed. Once secured, we will commission a licensed structural engineer to assess the building's capacity to support fitness equipment and programming use, identify code compliance requirements, and provide renovation cost estimates. Simultaneously, we will formalize partnerships with Sunshine Community Health Center (SCHC), the Northern Valley Health Coalition (NVHC), Wasilla Physical Therapy, Sunshine Transit, and area community councils through written memoranda of understanding that define roles, shared wellness goals, and coordinated programming. These readiness activities will produce concrete, foundational outcomes: a legally incorporated nonprofit, a formalized facility agreement with the Sunshine Station Childcare Center Board, and a professional structural assessment with cost estimates that define the scope of renovation. Together with signed partnership memoranda of understanding and a project plan identifying the health outcomes the center will track once operational, these deliverables will position the USVWC as a shovel-ready project prepared to pursue implementation funding. We welcome RHTP technical assistance in project management and reporting as we build this foundation.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced

Upskilled Evolution LLC	Building Alaska's Rural Health Future: Workforce Development and Technology Innovation	AK	Alaska's rural and tribal healthcare organizations face a workforce crisis threatening the survival of essential community health infrastructure. Hundreds of clinical and support positions sit vacant across rural Alaska, not because qualified candidates don't exist, but because small organizations lack the administrative capacity, recruitment expertise, and financial resources to compete for talent against large urban health systems. The consequences are severe. Patients in remote communities lose access to consistent care. Overworked staff burn out and leave. Organizations resort to expensive temporary staffing contracts that extract value from communities without building them. Upskilled Evolution exists to close this gap. By providing completely free, professional recruitment services exclusively to rural and tribal healthcare organizations, we level a playing field that has long been tilted against Alaska's most underserved communities. Every placement is a permanent direct hire, a new Alaskan who becomes an organizational employee and community member from day one. This project seizes a critical opportunity created by the RHTP to scale this model statewide, reaching tribal health corporations, Critical Access Hospitals, FQHCs, and rural clinics that would otherwise have no access to professional workforce support, and delivering that support at zero cost to the organizations that need it most.	Upskilled Evolution addresses Alaska's rural healthcare workforce crisis through a three-part approach: permanent direct-hire recruitment, organizational capacity building, and technology-enabled service delivery. Recruitment Services form the core of our model. We provide end-to-end recruitment at no cost to partner organizations, including candidate sourcing, screening, interview coordination, background checks, moving expense support, and onboarding assistance. Our tiered incentive structure prioritizes the most remote and underserved placements, with enhanced relocation support and retention bonuses for Tier 1 communities. Every candidate placed becomes a permanent employee of the hiring organization from day one, not a temporary contractor, not an agency employee, but a committed new Alaskan invested in organizational and community success. Organizational Capacity Building ensures our impact outlasts the grant period. We provide hiring manager training to 100 or more healthcare leaders across partner organizations, building internal recruitment and retention expertise that strengthens workforce infrastructure permanently. Organizations we serve will continue attracting and retaining quality permanent staff long after our direct engagement ends. Technology Integrationthrough our consortium partner Remote Hands Alaska equips rural organizations with the IT infrastructure, telehealth capabilities, and cybersecurity foundations needed to operate efficiently and extend their reach across Alaska's challenging geography. Our tribal outreach partner, Far North Strategies, ensures that Alaska Native communities and tribal health organizations receive culturally competent, prioritized access to all services, with dedicated statewide engagement across Alaska's 229 federally recognized tribes. Together, these three service lines create a comprehensive, sustainable workforce solution that transforms how rural and tribal Alaska recruits, retains, and builds the permanent healthcare teams their communities depend on. Rural Alaska does not need more temporary fixes. It needs permanent people, permanent teams, and permanent investment. Upskilled Evolution is not a staffing agency passing through. We are an Alaska woman-owned small business building the workforce infrastructure this state has needed for decades, one permanent placement, one empowered organization, and one thriving rural community at a time. This is a commitment to Alaska's future.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Upstream Family Medicine Inc	Upstream Family Medicine OB Capacity Building Initiative	AK	The Central Kenai Peninsula faces an imminent obstetric care crisis. The region’s two OBGYNs are at retirement age and a third is approaching retirement. When they leave, specialist OB backup disappears, and full responsibility for obstetric access falls to the Soldotna Physician Collaborative, the area’s only remaining OB-capable primary care group. The SPC physician group delivers approximately 200 babies annually, holds a formal tribal OB contract with the Kenaitze Indian Tribe, and shares call coverage among its physicians. That model works today. It will not hold without specialist backup. Rural physicians develop critical obstetric and newborn skills through scattered, infrequent exposure, not the structured repetition that sustains competency. Last year, Upstream providers attended 6 resuscitations at delivery and 9 critical care infants. An additional 54 deliveries involved low Apgar scores: 33 with a 1-minute Apgar of 6 or below and 21 with a 5-minute Apgar of 7 or below. Across multiple physicians sharing call, each individual encounters these events rarely. When they occur, there is no specialist to defer to. Structured advanced training replaces scattered exposure with deliberate, supervised repetition. The Kenai Peninsula’s 2022 CHNA identifies maternal health as a top unmet priority, and 23.9% of Kenai Peninsula women are not receiving first-trimester prenatal care. This grant directly addresses both gaps.	Upstream will implement a OB Capacity Building Initiative: recruiting a fellowship-trained FMOB physician and providing advanced clinical training to 2 to 3 existing SPC physicians in Year 1, with training continuing in Year 2. Year 1: FMOB Recruitment and Advanced Clinical Training USFM will recruit a Family Medicine Obstetrics fellowship-trained physician through the American Board of Physician Specialties. The ABPS FMOB fellowship produces family physicians with advanced training in obstetrics, labor and delivery, and newborn care, exactly the clinical profile the Central Kenai Peninsula needs as specialist OB backup retires from the region. The recruitment package will include a sign-on bonus, a housing incentive, and a childcare incentive where applicable. Recruitment will be active immediately upon award with a target start date within 12 months. Year 2: Continued Advanced Clinical Training Two to three existing SPC physicians will travel to an out-of-state facility, likely in Washington state, for advanced L&D and newborn specialty training in weekly rotations over several months. Physicians will obtain licensure and credentialing prior to rotations. Grant funding covers travel, lodging, licensure, credentialing, and training costs. Upstream will confirm fellow coverage through UW connections to maintain practice continuity during absences. Year 2 funding will support continued advanced training rotations for the same physicians, deepening clinical competency through additional supervised weeks at the same facility. Continuation builds on Year 1 credentialing and faculty relationships, maximizing the investment. This initiative directly advances three RHTP priority areas. Strengthen Workforce: Recruiting a fellowship-trained FMOB physician through ABPS and providing advanced L&D and newborn specialty training to 2 to 3 existing SPC physicians builds the rural physician capacity and clinical depth the Central Kenai Peninsula will need as specialist OB backup retires. Healthy Beginnings: sustaining obstetric access for Alaska Native women under tribal contracts and protecting first-trimester prenatal care access for rural women who have no alternative provider. Healthy Communities: A stable rural OB safety net directly supports maternal and newborn health outcomes for the Central Kenai Peninsula. Physician recruitment incentives and clinical training costs are permissible RHTP uses under CMS guidelines to support rural workforce development.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Advance to Implementation Application

Upstream Family Medicine Inc	Healthy Beginnings and Communities Immunization Infrastructure Project	AK	Rural clinics on the Peninsula face frequent power disruptions and limited infrastructure capacity that create ongoing risk to vaccine storage integrity. In 2025, the region experienced 75 power outages, a frequency that exposes cold-chain systems to repeated temperature excursion risk. USFM administered 1,601 vaccine injections in 2025. Without adequate cold-chain protection, a single prolonged outage could compromise inventory, disrupt immunizations, and require costly vaccine replacement. The urgency of this investment is reinforced by regional immunization coverage data from the AK Childhood and Adolescent Immunization Report. Across the Gulf Coast region, only 34% of adolescents aged 13–17 are vaccinated for HPV, only 47% of kindergartners have completed the recommended kindergarten series, and only 52% of children aged 19–35 months have completed the recommended childhood series. These rates fall well below national targets and reflect the compounding effect of rural access barriers and service disruption risk. Protecting maternal immunization infrastructure is also critical to infant health outcomes. The RSVpreF vaccine, administered during pregnancy, provides passive immunity to newborns and reduces the risk of severe RSV disease in infants by approximately 50–60%. Cold-chain compromise directly translates to preventable infant illness a particularly high-stakes consequence in a rural region where neonatal and pediatric specialty care is geographically distant.	The proposed approach strengthens rural vaccine cold-chain reliability through coordinated infrastructure investment, real-time risk monitoring, updated operational protocols, and formalized regional collaboration. First, the project will procure and install one CDC-compliant, technology-enabled medical-grade vaccine refrigerator/freezer unit equipped with continuous digital temperature monitoring and automated alarm capability. A dedicated backup power system will be installed to ensure uninterrupted refrigeration during outages. These capital improvements directly address the region’s documented frequency of power disruptions and the current absence of reliable backup storage protection. Second, the clinic will implement real-time remote temperature monitoring with automated alert notifications to designated staff. This system enables rapid identification and response to temperature excursions before vaccine integrity is compromised. Updated written vaccine storage and handling policies will be aligned with CDC guidelines to standardize procedures, documentation, and corrective action protocols. Third, the project will formalize Memorandums of Understanding (MOUs) with neighboring clinics to establish a coordinated vaccine storage and emergency transfer network. These agreements will define activation triggers, response timelines, contact protocols, and documentation standards to ensure rapid redistribution when primary storage is compromised. A validated portable vaccine transport carrier will support safe emergency transfers. This structured coordination transforms isolated clinic response into a regional continuity strategy, fostering collaboration. Fourth, staff training will ensure consistent operational readiness. Training will cover equipment use, emergency response procedures, documentation requirements, and communication protocols. By combining durable infrastructure investment, real-time monitoring, defined response procedures, and regional partnership agreements, this approach creates a layered protection model that reduces vaccine loss risk, strengthens quality oversight, and ensures uninterrupted immunization access for rural communities.	\$50,000- \$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Upstream Family Medicine Inc	Upstream Family Medicine Rural Diagnostic Modernization Initiative	AK	The Central Kenai Peninsula faces a well-documented diagnostic access crisis. The 2022 Central Kenai Peninsula Community Health Needs Assessment found that 45% of local households left the area for medical care in the past year. Among those who left, 53.4% said the service was not available locally, and 19.5% cited outdated equipment or technology as the reason. Pulmonology and radiology appear among the top services sought outside the region. The Peninsula has only 107 primary care physicians per 100,000 residents, below Alaska’s rate of 133.6. With 4 residents per square mile, patients in communities like Sterling, Kasilof, Nikiski, Ninilchik, and Seward already travel significant distances to reach primary care. When a referral pushes them further out of the region, that burden compounds. Chronic disease rates make proactive in-clinic monitoring urgent. Diabetes affects 11.6% of residents, compared to 7.6% statewide. Obesity is 42.9%, exceeding state and national benchmarks. Lung cancer incidence is higher than both state and national rates. High blood pressure affects 37.2% of the population. These are the conditions where earlier detection and continuous monitoring produce measurable clinical impact. Without expanded diagnostic infrastructure within primary care, rural patients remain dependent on out-of-region specialty access, increasing delays, fragmenting care, and driving preventable deterioration in outcomes.	Through the Upstream Family Medicine Rural Diagnostic Modernization Initiative, the clinic will expand in-clinic diagnostic capacity and implement remote monitoring technologies to strengthen proactive management of chronic and high-risk conditions in rural primary care. In collaboration with Katy Sheridan, MD, and Jennifer Wooley, MD, Upstream will deploy advanced diagnostic and monitoring equipment through a shared utilization model across participating clinics. This coordinated equipment-sharing structure will maximize access to specialized tools while reducing unnecessary duplication of investment across rural sites. The Initiative will focus on technologies that support early identification and monitoring of respiratory disease, dermatologic abnormalities, maternal and neonatal risk factors, pediatric developmental and preventive screening needs, and metabolic health indicators. Remote monitoring tools will enable ongoing assessment between visits, allowing providers to identify concerning trends earlier and intervene more promptly. All equipment will integrate with each clinic’s existing EMR system to ensure secure data transfer, continuity of documentation, and interoperability without requiring a full system replacement. Structured workflow integration and staff training will support seamless adoption within routine primary care operations. By expanding in-clinic diagnostic capabilities and implementing coordinated, shared access to equipment, the Initiative shifts care from episodic, referral-dependent assessments to earlier detection and ongoing monitoring within the rural primary care setting. If this model demonstrates that independent rural primary care practices can share diagnostic infrastructure without duplicating investment, Upstream will document and share the framework through RHTP networks as a replicable model for other rural primary care networks across Alaska.	Under \$50,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Upstream Family Medicine Inc	Upstream Family Medicine Rural Technology Modernization Initiative	AK	Upstream Family Medicine operates in a rural healthcare environment where aging technology infrastructure, cybersecurity vulnerabilities, and inefficient administrative workflows threaten operational stability and patient data security. Rural clinics are increasingly targeted by cyber threats but often lack modern cloud-based infrastructure and advanced endpoint protection. Legacy server systems and outdated hardware increase risk exposure, create maintenance burdens, and strain limited workforce capacity. In 2025, the clinic delivered 34 telehealth appointments representing less than 1% of total visit volume. This significantly underrepresents the telehealth demand in a geographically dispersed rural region and reflects technology infrastructure limitations rather than patient preference. Manual intake processes, paper-based screening forms, and manual entry of screening data into the EMR consume patient, clinical, and administrative time. Staff must scan, upload, and re-enter information, increasing the risk of documentation errors and workflow delays. These inefficiencies extend check-in times, contribute to longer patient wait times, and reduce screening compliance. Limited telehealth infrastructure further restricts access in a geographically dispersed region. These technology gaps increase operational risk, contribute to staff burnout, and limit the clinic's ability to deliver secure, efficient, and technology-enabled rural primary care services.	Through the Upstream Family Medicine Rural Technology Modernization Initiative, Upstream Family Medicine will implement a comprehensive infrastructure modernization and cybersecurity enhancement project in partnership with PNC IT, which will provide secure implementation and ongoing technical support. The initiative will begin with the deployment of advanced cybersecurity protections, including ThreatLocker application control and enhanced endpoint security tools, followed by the removal of legacy on-site server infrastructure and the transition to secure cloud-based systems. Cloud migration will reduce vulnerability, strengthen data redundancy, and improve disaster recovery capacity for rural operations. Twelve workstations (computer not included) will be equipped with upgraded monitors and secure docking stations to improve display quality, ergonomics, and workflow flexibility. High-resolution monitors with blue-light reduction features will protect staff vision and reduce fatigue during prolonged EMR use. Privacy screen technology will be incorporated to safeguard patient information and reinforce HIPAA compliance in clinical and administrative spaces. The telehealth suite will be modernized with upgraded video and audio equipment to improve the quality of visits and expand reliable access for patients in geographically dispersed communities. AI integration will include both equipment and structured training for all staff. Training will provide in-depth education on medical AI use, beginning with foundational AI literacy and progressing to advanced tools such as AI-supported documentation and dictation. Equipment and software necessary for secure AI utilization will be deployed across clinical workstations. The program will emphasize safe implementation, human oversight, data security, and appropriate clinical application to ensure AI enhances efficiency without compromising quality or compliance. Digital intake and screening forms will be developed and integrated directly into the EMR, eliminating manual scanning and re-entry. This integration improves workflow efficiency, reduces wait times, and increases preventive screening compliance while avoiding recurring subscription fees.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Upstream Family Medicine Inc	Upstream Family Medicine Rural Workforce Stability Program	AK	Upstream Family Medicine has served the Central Kenai Peninsula since 2013, building a clinical and administrative team that delivers 6,755 patient visits annually in a region where healthcare access is limited and the cost of losing experienced staff is high. The Central Kenai Peninsula currently has 22 open medical assistant positions. In a labor market this competitive, retaining experienced rural healthcare workers requires active, meaningful investment beyond competitive base wages. Upstream already provides an annual compensation bonus as part of its standard staff package. This grant supports an additional retention incentive on top of that existing commitment, sending a clear signal to every member of the team that their experience, their relationships with patients, and their dedication to rural practice are recognized and valued. Beyond retention, this grant supports professional development through APCA no-cost certified programs and approved programs of each staff member's choosing, and AI-in-healthcare training for all staff and providers through PNC. Investing in staff growth builds engagement, strengthens competency, and creates long-term rural healthcare careers beyond individual grant cycles. Upstream has built something rare on the Central Kenai Peninsula: a stable, trusted, high-functioning rural primary care team. This grant protects it.	Upstream Family Medicine will implement a two-component Staff Retention and Development Initiative across all clinical and administrative positions. Staff Retention Incentives Upstream currently provides an annual compensation bonus as part of its standard staff package. This grant supports an additional retention bonus on top of that existing commitment for all current clinical and administrative staff: 5 providers, 3 medical assistants, 3 receptionists, 1 clinic manager, and 1 medical biller. In a labor market with 22 open medical assistant positions on the Central Kenai Peninsula, this additional investment directly addresses the competitive pressure that puts experienced rural healthcare workers at risk of departure. Retention bonuses will be distributed upon award, with a second distribution at the grant midpoint to reinforce continuity throughout the full grant period. Professional Development and AI Training All staff will have access to professional development opportunities through the Alaska Primary Care Association and other approved educational programs of their choosing. APCA offers rural-focused training at no direct cost to the clinic; grant funds will support wage adjustments at program midpoints and completion milestones, and tuition for approved programs outside APCA's no-cost offerings. Staff will select programs aligned with their individual roles and career goals. Giving staff a meaningful voice in their own development strengthens engagement and long-term commitment to rural practice. Grant funding supports AI-in-healthcare training for all staff and Upstream physicians through PNC, building full organizational readiness for AI-assisted rural practice. Together these two components address both the financial and professional drivers of retention, creating a workplace where experienced rural healthcare workers choose to build careers. This initiative directly advances two RHTP priority areas. Strengthen Workforce: retention incentives and professional development address the financial and career drivers that cause rural healthcare workers to leave, building the long-term workforce stability the Central Kenai Peninsula depends on. Health Care Access: retaining the experienced team that delivers 6,755 patient visits annually is a direct protection of access for rural patients with chronic disease, complex care needs, and limited alternatives.	\$50,000-\$250,000	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Kenai Peninsula Borough	Deferred or Not Advanced

Uwill, Inc.	Expanding Access to Behavioral Health Care for Youth and Young Adults in Rural Alaska	MA	Many youth and young adults living in rural, remote, and frontier communities across Alaska face significant barriers to accessing timely behavioral health care. Limited local provider availability, geographic isolation, transportation challenges, and long wait times often delay or prevent individuals from receiving the mental health support they need. These challenges are particularly pronounced for adolescents and young adults, a population that is experiencing rising rates of anxiety, depression, and suicide risk nationwide. At the same time, many communities are actively working to strengthen local behavioral health systems but continue to face persistent workforce shortages and gaps in specialty services. This creates an opportunity to expand access to care through telehealth-enabled services that can supplement existing providers and extend the reach of licensed clinicians. By leveraging telehealth and partnering with Tribal health organizations and community behavioral health providers, this project seeks to reduce barriers to care, connect youth with licensed clinicians more quickly, and support a more coordinated and sustainable behavioral health system for young people across Alaska.	Uwill proposes to expand access to behavioral health services for Alaskans ages 13–24 by delivering telehealth-based counseling, telepsychiatry, and 24/7 crisis support through a secure, accessible platform. This approach is designed to supplement existing behavioral health resources and help address workforce shortages that can limit timely access to care in rural, remote, and frontier communities. Through Uwill’s platform, youth and young adults will be able to quickly connect with independently licensed clinicians for video or phone appointments, allowing them to receive care from home, school, or other safe locations. By reducing geographic and scheduling barriers, telehealth enables individuals in underserved areas to access licensed behavioral health providers without requiring travel or long wait times. To ensure services are integrated within Alaska’s existing care system, Uwill intends to partner with a Tribal health consortium and/or a Certified Community Behavioral Health Clinic (CCBHC). These partnerships will support culturally responsive care and enable coordinated referrals when individuals require additional or ongoing services. Telehealth services would function as an extension of local behavioral health infrastructure, helping expand capacity while maintaining continuity of care. Uwill’s integrated model includes teletherapy (Umatch), telepsychiatry (Upsych), and 24/7/365 crisis support (Uhelp), allowing individuals to access different levels of support through a single platform. This coordinated structure helps reduce fragmentation across services while ensuring individuals can receive appropriate care as their needs change. In addition to direct services, Uwill provides realtime data reporting through its Ucollaborate platform, enabling partners to monitor utilization, identify emerging trends, and better understand community needs. These insights can help inform planning and support ongoing program improvement. By leveraging telehealth technology, expanding clinician reach, and coordinating with local partners, this project aims to improve timely access to behavioral health care while supporting a more sustainable and connected behavioral health system for young people across Alaska.	\$250K-\$1M	Other	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

V Fit & Wellness	Community health education & prevention	AK	Alaska faces many barriers to healthcare access, particularly in rural communities where specialty services are limited or unavailable. Even in Fairbanks, access to specialty care for chronic conditions such as diabetes, cardiovascular disease, and stroke can be delayed or fragmented during acute health crises. As a result, preventable complications, avoidable hospitalizations, and long-term functional decline are common. The opportunity exists to intervene earlier, before chronic conditions escalate into emergencies. Prevention, education, and sustained community-based support are largely absent in the current rural healthcare infrastructure, which is heavily focused on acute care rather than long-term wellness and disease management. This project addresses that gap by establishing a community-centered preventive health model focused on chronic disease education, wellness education, nutrition access, and year-round physical activity. By engaging youth, families, adults, elders, and individuals with disabilities through individualized goal setting, family support systems, and structured group programming, this initiative shifts the focus from reactive care to proactive health care. Strengthening our community preventive services will reduce adverse outcomes, improve functional independence, and enhance long-term health resilience in Interior Alaska.	My approach will be a phased approach to build a community preventative health and wellness center. This center would incorporate an indoor field house facility for youth (and/or adult) sports to play year round, an adaptive gym for patients recovering from injury, illness, and/or unable to attend typical gyms, education classroom and kitchen for nutrition classes, heated greenhouse/high tunnels to support year round fresh food access, and clinical/specialty care wing. Phase 1 (year 1) - Secure property, design and start building center working with an engineer and design team. Goal would be field house development first, adaptive gym, classroom and kitchen, greenhouse, and clinic. Develop community partnerships and outreach to local resources (University of Alaska, FMH, TCC, Youth Sports, specialty providers, primary care practices). Recruit for soft launch of preventative outreach programs as structure and staffing are coming together. Mobile outreach trailer to be able to bring preventative services to people's homes (physical fitness equipment for people with disabilities, ability to have small groups for physical fitness and wellness education, wheelchair accessible). Phase 2 (year 2-3) - Begin to launch more preventative programs; health screenings, chronic disease prevention programs, nursing-led wellness coaching, care coordination services, prevention classes, senior restorative programs, youth physical activity programs, nutrition classes, CPR classes. Start working with insurance companies/CMS to become an approved provider, develop MOA's for fee scale with options for sliding scale as income/non-profit status is reviewed, begin high tunnel and indoor farming for year round access to fresh food. Partner with FFA, 4-H, local farmers, farmers market, UAF agriculture department. Phase 3 (year 4) - Review sustainability and revenue streams. Refine processes to continue to make physical fitness and healthy food accessible but sustainable long term. Focus on community and partnerships to continue to grow. Start local produce production for use in stores, farmers markets, nutrition classes. Phase 4 (ongoing) - Continuous improvement process on sustainability (PDCA), develop relationships with the community and outreach providers to potentially offer options of specialty care options.	Over \$5M	Home- and community-based services provider	Single Community	Fairbanks North Star Borough	Deferred or Not Advanced

Valley Allergy and Asthma, LLC	Allergy & Asthma Outreach, Awareness and Treatment	AK	Timely diagnosis of allergies and asthma is often delayed by non-specific symptoms that mimic common colds, the intermittent nature of flare-ups, and limited access to specialized testing like spirometry in primary care. Addressing this requires a shift from reactive to proactive management through technology and integrated clinical pathways. Improving diagnostic timelines also depends on systemic changes in how healthcare providers and patients interact. Identifying at-risk children through birth cohort data and early-life risk factors (e.g., wheezing frequency, FeNO levels) allows for primary prevention before asthma becomes chronic. In Alaska, approximately 6% to 8% of the population has asthma, and about 20% suffer from allergies. Food sensitization in infants significantly increases the risk of developing asthma later in childhood*. 42% Alaska Native children and 19% of adults are more likely to have asthma than the general U.S. adult population**. Allergies among Alaskans are also widespread, with environmental and food-related triggers being common. Approximately 20% of Alaskans have some form of allergy and about 65.9% of children with asthma in Alaska also have a co-occurring allergy***. We would like to improve the health of Alaskan's by raising awareness and facilitating early interventions and management of these diagnoses. * (aafaalaska); ** (American Lung Assoc); *** CDC	There are several ways to improve awareness and create pathways to early intervention, preventative and continued care. *We would like to integrate with Health e-Connect Alaska (AK HIE) so that important patient clinical data regarding asthma and allergy diagnoses, as well as treatment plan and recommendations, are available in real time to our patients' other health care providers. *Utilize Telehealth in a greater capacity: Integrate e-Consults with urban specialists to support local PCPs in managing complex cases and expediting patients to greater care when clinically indicated. We propose making changes to our patient portal to allow secure and encrypted access to follow-up visit via telemedicine. *Implement Autoimmune Therapy at Extender Sites: This is a service we have done infrequently and have had success with it. As a new service, we would like to collaborate with rural clinics who have expressed interest in providing therapeutic injections and perform monitoring during hours when we are available for immediate consultation. We would like to define how this service delivery will work to build a sustainable model, which initially will require resources that we hope to access through this grant. *Create Informational Videos for Distribution: We would like to have professionally created videos for distribution to the public through social media platforms, to school nurse programs and to tribal and rural health clinics. These videos are intended to raise awareness on symptoms that may require immediate attention to avert serious and potentially life-threatening emergencies. *Track Outcomes: Employ data tracking for asthma-related emergency department visits and hospital readmission rates. This will allow us to define our collaboration efforts, ensuring measurable impact. *We will need to hire additional staff to assist with implementing infrastructure for these initiatives as we work toward building sustainability beyond the life of the RHTP project.	\$250K-\$1M	Private practitioner	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kenai Peninsula Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Southeast Fairbanks Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

Valley Charities	Reentry Coalition Capacity Development - Mat-Su Borough, Juneau, Ketchikan, and Kodiak	AK	Alaska’s local reentry coalitions play a pivotal role in supporting individuals returning to their communities after incarceration. These coalitions—made up of nonprofits, tribal organizations, state agencies, faith groups, and community volunteers—work together to reduce recidivism and promote long term stability for returning citizens. Their impact reaches far beyond individual success stories; they strengthen public safety, support economic growth, and advance federal reentry objectives. At the heart of their mission is collaboration. Alaska’s vast geography and unique cultural landscape make coordinated support essential. Local coalitions help bridge gaps in housing, employment, behavioral health services, transportation, and identification—barriers that often determine whether someone successfully reintegrates or cycles back into the justice system. By tailoring solutions to local needs, these coalitions ensure that reentry support is culturally responsive and accessible, especially in rural and Indigenous communities.	The Reentry Coalition’s work directly aligns with federal priorities outlined by agencies such as the U.S. Department of Justice and the Federal Interagency Reentry Council. Federal policy emphasizes reducing recidivism, improving access to treatment, expanding employment opportunities, and strengthening community based partnerships. Alaska’s coalitions operationalize these goals on the ground. They help implement evidence based practices, coordinate grant funded programs, and ensure federal resources reach the people who need them most. The benefits ripple outward. When returning citizens secure stable housing, find meaningful work, and access treatment, communities experience lower crime rates and reduced correctional costs. Families remain intact. Employers gain reliable workers. Rural communities—often disproportionately affected by incarceration—see improved social and economic stability. In a state where vast distances, limited infrastructure, and rich cultural diversity create unique challenges, Alaska’s local reentry coalitions serve as a critical bridge between federal policy and real-world outcomes. Their work not only transforms individual lives but also strengthens communities across Alaska and advances national reentry goals—reducing recidivism, enhancing public safety, and empowering individuals to successfully rebuild their lives.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Juneau (City and Borough); Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Valley Medical Care PC	Improving Southeast Alaska’s Diagnostic Infrastructure to Improve Rural Access and Care Coordination	AK	Our organization serves as a regional access point for patients from smaller Southeast Alaska communities and functions within Alaska’s broader referral network to Anchorage and other tertiary care centers. Patients frequently travel significant distances for diagnostic imaging and specialty evaluation, making timely interpretation critical to reducing delays and unnecessary travel. Our physician-owned family practice provides full-spectrum care including primary care, inpatient hospital services, obstetric care and deliveries, and procedural services such as colonoscopy and upper endoscopy. As one of the few independent practices in the region offering this breadth of services, we play an essential role in sustaining local and regional access to comprehensive care. Reliable diagnostic imaging infrastructure is necessary to safely maintain these services and reduce the need for patients to leave Southeast Alaska for care that can be provided locally. Our organization provides approximately 1500 imaging services annually. Our current PACS is outdated and approaching end-of-life support, limiting interoperability and timely sharing of studies with consulting radiologists and care partners. Even in Juneau, specialty availability is limited, and many patients ultimately require referral to Anchorage. Modernizing our PACS will strengthen regional and statewide diagnostic coordination, reduce delays to treatment, and improve efficient use of Alaska’s limited healthcare resources.	We propose implementation of a modern, secure, and interoperable PACS platform that will strengthen diagnostic imaging infrastructure and support coordinated care across Southeast Alaska and the statewide referral network. Project activities will include: • Selection and procurement of a PACS system designed for high reliability, interoperability, and secure digital image exchange • Integration with existing imaging equipment and the electronic health record • Development of secure, digital, image-sharing capabilities with referring providers in smaller Southeast communities and tertiary care centers, including Anchorage-based specialists. • Vendor-supported installation, testing, and phased implementation to minimize disruption to patient care • Comprehensive staff training to ensure efficient adoption and optimized workflows • Establishment of ongoing maintenance and support agreements to ensure long-term system stability The new PACS will allow imaging studies to be rapidly transmitted for specialist interpretation and shared seamlessly with referral partners. This will improve diagnostic turnaround time and allow treatment planning to occur more efficiently before patients return to their home communities or travel for higher levels of care. Enhanced interoperability will strengthen coordination between rural clinics, our organization, and tertiary care centers by ensuring imaging is immediately accessible across care settings. This will reduce repeat imaging, prevent delays in referral processing, and support more timely specialty intervention when needed. By modernizing core diagnostic infrastructure, this project strengthens regional capacity while also improving connectivity across Alaska’s healthcare system. It ensures that patients traveling within Southeast Alaska and onward to Anchorage receive coordinated, timely, and high-quality diagnostic services that support improved clinical outcomes.	\$50,000-\$250,000	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Juneau (City and Borough)	Deferred or Not Advanced

Valley Medical Care PC	Improving Timely Diagnosis and Rural Care Access Through Portable Ultrasound Modernization	AK	Our organization serves as a regional access point for patients from smaller Southeast Alaska communities who often travel significant distances for care. Timely diagnosis during these visits is essential to ensuring patients can complete evaluation and treatment planning without unnecessary repeat travel or delays. Our physician-owned family practice provides full-spectrum care including primary care, pediatrics, inpatient hospital services, obstetric care and deliveries, and procedural services such as colonoscopy and upper endoscopy. Many clinical evaluations benefit from immediate ultrasound imaging to support diagnosis and treatment decisions at the time of visit. Modern portable ultrasound units will allow providers to obtain high-quality imaging at the bedside during examinations, enabling immediate diagnosis and treatment planning. Point-of-care imaging can reduce delays in diagnosis, minimize repeat visits, and support completion of care in a single visit. This is of particular value for patients traveling from smaller Southeast communities outside of Juneau. Upgrading to modern portable units will reduce delays, allow for expanded local services, improve patient experience, and support more efficient use of Alaska’s limited healthcare resources.	We propose acquisition and implementation of two modern portable ultrasound units to improve bedside diagnostic capability and support timely clinical decision-making across clinic and inpatient settings. Project activities will include: • Procurement of two portable ultrasound units designed for high-quality point-of-care imaging • Integration into clinic, obstetric, and procedural workflows • Provider training and competency development for optimal use • Integration with documentation and imaging systems as appropriate • Establishment of maintenance and lifecycle planning Portable ultrasound will be used by providers during patient encounters to support real-time diagnostic assessment and procedural guidance. Improved image quality and portability will enhance evaluation of obstetric concerns, abdominal pain, soft tissue conditions, vascular concerns, and other clinical needs where immediate visualization supports timely care decisions. Point-of-care imaging will allow many patients traveling from smaller Southeast communities to complete evaluation and treatment planning in a single visit whenever clinically appropriate. Immediate access to high-quality imaging will also support more efficient coordination with referral partners and tertiary care centers when higher-level care is required. By modernizing bedside imaging capability, this project will strengthen our ability to deliver timely, efficient, and coordinated care while reducing delays and unnecessary repeat travel for patients across Southeast Alaska.	\$50,000-\$250,000	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Juneau (City and Borough)	Deferred or Not Advanced

Valley Medical Care PC	Protecting Clinical Operations Through Core Server Infrastructure Replacement	AK	Our organization serves as a key regional access point for patients from smaller Southeast Alaska communities and operates within Alaska’s broader referral network to Anchorage and other tertiary care centers. Reliable access to secure clinical systems is essential for coordinating care across this system, particularly for patients who must travel significant distances for services. Our physician-owned family practice provides full-spectrum care including primary care, pediatrics, inpatient hospital services, obstetric care and deliveries, and procedural services such as colonoscopy and upper endoscopy. Sustaining this breadth of services requires dependable server infrastructure capable of supporting electronic health records, diagnostic data, and secure communication across care teams. Our current server environment is aging and approaching end-of-life support, creating increased risk of system instability, downtime, and reduced performance. Without replacement, these limitations could impact timely access to patient records, diagnostic results, and care coordination across organizations. Even in Juneau, specialty access is limited and patients require referral to Anchorage for specialized services. Reliable core infrastructure is essential to ensuring patient information moves efficiently across care settings. Replacing aging servers will strengthen system stability, protect continuity of care, and support more efficient use of Alaska’s limited healthcare resources.	We propose to modernize core server infrastructure to ensure secure, reliable, and scalable support for clinical operations and coordinated care across Southeast Alaska and the statewide referral network. Project activities will include: • Procurement and installation of updated server hardware and secure data storage systems • Migration of existing clinical and operational systems to modern server infrastructure • Strengthening cybersecurity protections and backup capabilities • Integration with electronic health record, imaging, and billing systems • Testing and phased implementation to prevent disruption to patient care • Establishment of maintenance and support agreements for long-term stability Modernized servers will improve speed, reliability, and security of clinical systems that support daily patient care. Providers will have more consistent access to patient records, diagnostic results, and communication tools necessary to coordinate care across locations. Improved system performance will reduce downtime risk and ensure continuity of operations for both in-person and remote coordination. Enhanced infrastructure will also strengthen secure information exchange with referring providers and tertiary care centers, including Anchorage-based specialists. Reliable data access will support more efficient referral processing, reduce duplication of services, and improve continuity of care when patients transition between communities and levels of care. By investing in foundational technology infrastructure, this project strengthens regional capacity while supporting more coordinated, efficient healthcare delivery across Alaska.	\$50,000-\$250,000	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Juneau (City and Borough)	Deferred or Not Advanced

Valley Neighborhood Dental Center	Bridges to Care: Rural Alaska Comprehensive Dental Access Initiative	AK	Rural communities in the Matanuska-Susitna Borough face persistent barriers to essential dental services, even though providers are present in the region. For many residents—especially seniors, individuals with chronic disease, people with disabilities, and low-income households—transportation is the primary obstacle to obtaining routine and preventive dental care. Long travel distances, limited demand-response transit, unreliable or unavailable vehicles, and difficulty using app-based transportation result in missed appointments, delayed treatment, and avoidable progression of dental conditions. These challenges are most pronounced in outlying communities such as Willow, Talkeetna, Glennallen and other communities where residents travel significant distances to reach care. Needs that could be addressed through preventive or early restorative services often go untreated until they require urgent or emergency intervention, driving poorer outcomes, higher costs, and inefficient use of acute care resources. This project addresses a clear Health Care Access gap by integrating transportation into the dental care delivery model. Through partnerships with community-based and on-demand transportation providers, it will coordinate no- or low-cost rides for high-need rural patients. By reducing non-medical barriers, the project will improve appointment adherence, expand access for underserved residents, and strengthen the sustainability of dental services in the Mat-Su.	This project will address persistent barriers to dental care access in rural Matanuska-Susitna communities through a coordinated, transportation-enabled dental care model that strengthens workforce capacity and improves care efficiency. It recognizes that limited access in rural areas is driven not only by provider availability but also by transportation challenges, workforce shortages, and the burden of multi-visit treatment for patients traveling long distances. The first component is integrating transportation into the dental care delivery model. The project will establish partnerships with community-based and on-demand transportation providers to ensure reliable rides for patients. Transportation coordination will be embedded into clinic workflows, aligning scheduling with available transportation. Priority will be given to rural residents and high-need populations, including seniors, individuals with chronic disease, people with disabilities, and low-income households in outlying Mat-Su communities. This reduces missed appointments, improves continuity of care, and expands the effective service area of existing providers. The second component focuses on strengthening local workforce capacity. Funding will support recruitment and onboarding of a new dentist in the Mat-Su, increasing service availability and reducing wait times. The project supports long-term retention by improving practice sustainability, stabilizing patient flow through reduced no-shows, and investing in modern clinical infrastructure, ensuring that access gains from transportation support are matched by sufficient provider capacity. The third component is targeted investment in modern dental equipment and technology to improve efficiency and reduce the need of multi-day visits. Advanced diagnostic and treatment tools allows more comprehensive care to be delivered in a single visit when appropriate. This is especially important for rural patients who face significant travel burdens and depend on coordinated transportation. Fewer visits improve treatment completion, reduce hardship, and lower system costs. Together, these components shift care from crisis-driven, episodic visits toward routine, preventive, and planned care. By addressing transportation barriers, workforce capacity, and care efficiency simultaneously, the project improves access, strengthens sustainability, and advances equity for rural Mat-Su residents while aligning with the RHTP Health Care Access initiative.	\$250K-\$1M	Dental	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Matanuska-Susitna Borough	Deferred or Not Advanced

Valley Upright Imaging LLC	Establishing Alaska’s First Medical Cyclotron to Improve Access to PET Imaging Isotopes	AK	Alaska faces significant challenges in accessing PET imaging radiopharmaceuticals due to its geographic isolation and the short half-life of many diagnostic isotopes. Currently, most PET tracers must be transported from facilities outside the state, often requiring long-distance flights that are vulnerable to weather delays and logistical disruptions. These limitations can result in cancelled scans, delayed diagnoses, and reduced access to advanced imaging for patients, particularly those living in rural and frontier communities. The opportunity addressed by this project is the establishment of a local cyclotron facility capable of producing PET radiopharmaceuticals within Alaska. Local production would create a reliable and sustainable supply of diagnostic isotopes, reduce dependence on out-of-state shipments, and significantly improve access to timely PET imaging services. This would allow healthcare providers to diagnose and manage serious conditions such as cancer, neurological disorders, and cardiovascular disease more effectively for patients across the state, including those in remote regions.	Once operational, the facility will produce commonly used PET isotopes such as fluorine-18 (F-18), which is used in PET imaging for cancer detection, neurological disorders, and cardiovascular disease. Local production will eliminate reliance on long-distance transport of short-lived isotopes, ensuring a more reliable and consistent supply for healthcare providers across the state. The project will also establish distribution and coordination systems with hospitals, imaging centers, and rural healthcare providers throughout Alaska to ensure timely access to PET imaging services. By integrating with existing healthcare networks and imaging providers, the cyclotron facility will support improved diagnostic capabilities while reducing delays caused by weather, transportation barriers, and supply interruptions.	Over \$5M	Clinic	Statewide	Anchorage (Municipality); Fairbanks North Star Borough; Haines Borough; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Sitka (City and Borough); Southeast Fairbanks Census Area	Deferred or Not Advanced

Valley Upright Imaging LLC	Upgrade our existing GE Logiq E10 ultrasound system.	AK	Currently, no providers in our region offer bone density screening using non-ionizing radiation. Most bone density testing relies on DEXA technology, which uses ionizing radiation and is typically only available at larger medical centers. This creates a barrier for many rural Alaska residents who must travel long distances to receive bone health screening, and some patients may avoid testing due to concerns about radiation exposure. This project creates an opportunity to introduce ultrasound-based bone densitometry, which provides bone density assessment without ionizing radiation. By upgrading our existing GE Logiq E10 ultrasound system, Valley Imaging Center will be able to offer a safe, convenient, and locally available bone density screening option for patients in Wasilla and surrounding rural communities, improving early detection of osteoporosis and other bone health conditions.	Valley Imaging Center will address this opportunity by upgrading our existing GE Logiq E10 ultrasound system to enable ultrasound-based bone densitometry. This upgrade will allow our clinic to provide bone density screening that does not use ionizing radiation, making testing safer and more accessible for patients in rural Alaska. Grant funding will be used to purchase the required software upgrade, hardware components, installation, and staff training necessary to implement this capability. Once installed, our clinical staff will integrate ultrasound-based bone density testing into routine imaging services and make it available through referrals from local primary care providers and rural clinics. By utilizing existing equipment and infrastructure, Valley Imaging Center will be able to quickly implement this service and provide a convenient, radiation-free bone health screening option for residents of Wasilla and surrounding rural communities. This approach will expand preventive screening and improve early detection of osteoporosis and low bone density in our region.	\$50,000-\$250,000	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Valley Upright Imaging LLC	Upgrade our PACS and develop HL7 connectivity with remote clinics	AK	Many rural healthcare providers in Alaska face challenges accessing diagnostic imaging results quickly and efficiently due to limited interoperability between imaging systems and electronic health records (EHRs). Our current PACS system has limited ability to share imaging data seamlessly with the EHR systems and patient portals used by rural clinics. This can create delays in transferring medical information, which slows care coordination and clinical decision-making for patients who often travel long distances for imaging services. This project presents an opportunity to modernize our imaging data infrastructure by upgrading our PACS system and implementing HL7 connectivity. Doing so will improve the secure exchange of imaging reports and clinical data with rural healthcare providers and patient portals, improving access to information, reducing delays in care, and strengthening healthcare coordination for rural and frontier communities in Alaska.	Valley Imaging Center will upgrade its existing PACS system by implementing modern hardware, software, and secure cloud-enabled infrastructure designed to support interoperability with regional healthcare systems. As part of this upgrade, we will develop and implement HL7 interfaces that allow imaging reports and related clinical data to be automatically transmitted to electronic health record (EHR) systems and patient portals used by referring providers and rural clinics. The project will include vendor selection, system installation, HL7 interface development, cybersecurity configuration, and testing with partner healthcare organizations to ensure reliable and secure data exchange. Once implemented, the system will allow imaging reports and results to be delivered electronically and in near real-time to referring providers and patients. This approach will significantly improve communication between Valley Imaging Center and rural healthcare providers, reduce delays in information transfer, and enhance care coordination for patients in rural and frontier communities across Alaska.	\$250K-\$1M	Clinic	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Valley Women and Children Clinic	Valley Women and Children Clinic	AK	Alaskan families in the Mat-Su region and beyond have to navigate fragmented services across multiple locations to access prenatal care, postpartum support, behavioral health services, and preventative care. Transportation barriers, workforce shortages, and limited coordination between providers can make it difficult for families to access timely care.	Repurpose the former urgent care facility on KGB into a collaborative health hub focused on women’s and children’s healthcare. The model would provide shared clinical space and infrastructure that allows independent providers to operate their own practices while benefiting from coordination and shared services. Services could include prenatal and postpartum care, a community birth center operated by independent midwives, behavioral health therapy, pelvic floor therapy, lactation support, family medicine, nutrition services, lab services, telehealth, and community education classes. The facility could also provide shared resources such as nurse support services, transportation assistance for patients, and connections to community support services.	\$1M-\$5M	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Matanuska-Susitna Borough	Deferred or Not Advanced
Vantage Technology Holdings, Inc	Rural Mobile Surgical Access Initiative for Cataract and GI Preventive Services	IL	Many rural Alaska hospitals lack the capital resources and workforce capacity to offer specialty procedures such as cataract and gastrointestinal ("GI") procedures. The cost of purchasing endoscopy towers, ophthalmologic surgical equipment, and maintaining specialized technical staff makes local delivery economically infeasible in low-volume frontier settings. As a result, patients must travel out of region for routine preventive and diagnostic care. This leads to delays in colorectal cancer screening, untreated cataracts, increased fall risk among elders, and higher long-term system costs. The opportunity is to establish a shared, mobile surgical infrastructure model that allows multiple rural hospitals to access specialty services without individually bearing the full cost of ownership and staffing.	Vantage will implement a Rural Mobile Surgical Access Initiative that expands cataract and GI diagnostic capacity across participating rural Alaska hospitals. The approach includes: Capital Infrastructure Deployment Vantage will purchase and maintain ophthalmology and GI procedural equipment, including endoscopy towers, scopes, sterilization systems, cataract instrumentation, and related supplies. Mobile Deployment Model Equipment will be transported between hospitals using customized transport systems. Resources are centrally staged and deployed on scheduled service days across participating facilities. Specialized Workforce Retention Vantage employs and retains certified surgical technologists and operations managers who travel with the equipment. This removes the burden on rural hospitals to recruit and retain full-time specialty staff. Shared Resource Scheduling Service days will be coordinated across hospitals to optimize utilization and ensure consistent access. Hospitals commit to minimum procedure volumes per visit. Preventive Focus GI services will prioritize colorectal cancer screening and diagnostic follow-up. Ophthalmology services will focus on cataract evaluation and surgery to restore vision and reduce fall risk among elders. Operational Integration	\$1M-\$5M	Other	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality)	Deferred or Not Advanced

Vantage will integrate scheduling, inventory management, quality assurance, and reporting systems to ensure compliance and performance monitoring.

This model transforms fixed-cost capital burdens into scalable shared infrastructure, making specialty preventive services economically viable in rural Alaska.



Veridian Strategies	Alaska Rural Health Care Integrity and Oversight Initiative	AK	Alaska's Rural Health Transformation Program represents a five year, 1.36 billion dollar investment flowing through a subrecipient administrator to hundreds of organizations of varying administrative maturity, creating significant risk from fraud, waste, abuse, and noncompliance. Documented weaknesses reinforce this concern: a 2023 HHS OIG inspection identified serious deficiencies in Alaska's Medicaid Fraud Control Unit, and a 2024 CMS Program Integrity Review found inconsistent state oversight practices. CMS is simultaneously expanding AI enabled program integrity initiatives, signaling heightened federal expectations for proactive detection and deterrence. Veridian's proposal fills a precise structural gap that no existing entity addresses. The ACF performs no fraud investigations, risk assessments, or compliance training. The Alaska DOH holds oversight authority but operates no dedicated investigative or analytical FWA function within RHTP as yet known. The Alaska MFCU's statutory mandate under 42 CFR Part 1007 is limited to Medicaid provider fraud and does not extend to federal grant compliance, RHTP subrecipient monitoring, or proactive integrity functions. No existing entity performs the integrated combination of pre award due diligence, AI driven analytics, investigative services, compliance training, and value based care integrity assurance this initiative delivers — ensuring every RHTP dollar reaches rural Alaska's communities.	Our proposed approach is to establish a dedicated, statewide Alaska Rural Health Care Integrity and Oversight Initiative that embeds program-integrity infrastructure alongside RHTP investments from the outset, rather than relying on after-the-fact audits or overextended enforcement bodies. We will deploy a 28-FTE multidisciplinary team in four integrated programs—Investigations, Analytics, AI & Machine Learning, and Provider Support—supported by specialized contractors in value-based payment, forensic accounting, coding and billing audit, IT security, tribal governance, and independent evaluation. This gives each RHTP initiative tailored integrity capabilities that are provider-facing, preventive, and capacity-building rather than punitive. The Investigations Program will be the field engine of the initiative, turning analytic signals, complaints, and referrals into structured casework that protects RHTP funds and strengthens internal controls. Senior and mid-level investigators will conduct complex investigations into alleged fraud, waste, abuse, and noncompliance through interviews, site visits, and targeted record reviews, while entry-level investigators support with research and documentation. A Health Care Coding and Billing Audit Specialist and a Forensic Accounting and Complex Financial Analysis Consultant will deepen casework by identifying improper billing, quantifying potential overpayments, and detecting schemes such as self-dealing and procurement irregularities. Operational Support Technicians will serve as case coordinators, keeping files complete, organized, and compliant. In parallel, the Provider Support Program will deliver training that explains, in practical terms, what can and cannot be done with RHTP funds, billing rules, and required internal controls, using in-person and remote formats to reach rural, remote, and frontier providers. Each session will be documented (who attended, where, when, duration, key interactions), creating a clear record of expectations if a participant later engages in FWA. Trainings will also function as a discreet tip line: participants often approach trainers privately to share concerns, and we will convert credible disclosures into formal leads for the Investigations and Analytics teams. This creates a continuous loop from data to investigation to corrective action, training, and new tips, building durable program-integrity infrastructure that can be sustained beyond the grant period.	Over \$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Via Vita Health Project, Inc.	AI-Enabled Rural Diagnostic Imaging and Women’s Health Access Expansion for Interior Alaska	AK	Rural and frontier communities across Interior Alaska face persistent barriers to accessing timely diagnostic imaging services. Patients frequently travel long distances for specialty ultrasound and women’s imaging services, often requiring flights, weather-dependent transportation, time away from work, and additional financial burden. These barriers contribute to delayed diagnostic evaluation, later detection of disease, and fragmented follow-up care. Diagnostic ultrasound plays a critical role in early disease detection, prenatal monitoring, and management of chronic health conditions. However, many rural health systems rely on aging imaging equipment that limits diagnostic quality, reduces workflow efficiency, and constrains service capacity. Workforce shortages further strain rural diagnostic infrastructure and contribute to delays in care. This project represents an opportunity to modernize regional diagnostic infrastructure by expanding AI-enabled ultrasound systems, Automated Breast Ultrasound (ABUS), portable ultrasound technology, and integrated digital imaging workflows. These upgrades will increase local diagnostic capacity, improve care coordination with referring providers, reduce costly medical travel and delayed diagnosis, and support earlier detection of disease.	This project will establish a modernized diagnostic imaging model designed to strengthen access to high-quality imaging services for rural and frontier communities in Interior Alaska. The project will invest in advanced imaging infrastructure including next-generation AI-enabled ultrasound platforms, an Automated Breast Ultrasound (ABUS) system to enhance breast imaging capability, a portable ultrasound system to support flexible service delivery, and Trophon high-level probe disinfection systems for infection control. These technologies will replace aging imaging equipment and expand diagnostic imaging capacity. AI-enabled ultrasound technology improves image acquisition consistency, supports standardized scanning protocols, and increases workflow efficiency. Improved imaging capability allows sonographers to complete examinations more efficiently while maintaining diagnostic quality and clinical accuracy. Automated Breast Ultrasound improves evaluation of dense breast tissue and expands access to supplemental breast imaging for patients who may benefit from additional screening beyond traditional mammography. The project will also implement information technology upgrades including imaging workstations, secure image transfer systems, laptops, and scheduling integration tools that improve workflow efficiency and communication with providers. Equipment installation will occur within existing clinical space already configured for diagnostic imaging, allowing rapid deployment without construction delays while ensuring compliance with electrical, infection-control, and imaging workflow requirements. Portable ultrasound capability will allow flexible imaging deployment for patients who cannot easily travel to centralized imaging locations, improving access for rural referrals and high-risk patients requiring timely diagnostic evaluation. Workforce sustainability is also a key component. Recruiting and retaining imaging professionals in rural Alaska requires modern equipment, efficient workflows, and opportunities for professional development. Updated technology and training reduce burnout, improve efficiency, and support long-term workforce retention. Implementation will occur in phases including procurement, installation, training, workflow integration, and performance monitoring. Outcomes will be measured through increased diagnostic throughput, reduced referral-to-imaging wait times, decreased costly medical travel, and improved workforce stability.	\$1M-\$5M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Via Vita Health Project, Inc.	Arctic Advancement: EMR for Rural Alaska Ultrasound Clinic with Epic-Integrated with AI-Enabled EHR	AK	Rural and Interior Alaska face significant barriers to timely diagnostic imaging and coordinated health records. Fairbanks Ultrasound Clinic lacks certified HITECH-compliant electronic medical record (EMR) systems and integrated imaging platforms. Our ultrasound clinic operates without a fully integrated EMR, limiting the ability to share records electronically with referring providers, coordinate care efficiently, and provide patients secure access to their health information. These gaps can delay diagnosis, require duplicate testing, and increase patient travel to larger hospitals for services that could be provided locally. This project will purchase and implement a HITECH-compliant EMR for Via Vita Health Project dba Fairbanks Ultrasound and connect it to a shared Community Epic environment hosted in partnership with Providence Medical Center. This integration will allow the clinic and participating providers to access unified patient records, MyChart, and structured imaging reports, improving care coordination and timely diagnosis. The project will also upgrade the clinic’s infrastructure—including network capacity, hardware, and secure communication systems—to support cloud-based imaging, AI-assisted ultrasound workflows, and telehealth. These upgrades align with Alaska Rural Health Transformation Program and CMS goals to expand access, improve care coordination, and strengthen sustainable health technology infrastructure for rural communities.	This project addresses critical barriers to diagnostic care by establishing Via Vita Health Project dba Fairbanks Ultrasound as a community Epic-hosted diagnostic hub. By integrating Inteleraad’s cloud-based PACS with Community Epic, along with AI-assisted ultrasound, secure VoIP, and HIPAA-compliant Zoom telehealth, clinicians will have faster imaging access, automated measurements, and immediate access to patient records for rural providers and patients. Via Vita Health Project dba Fairbanks Ultrasound will partner with Providence Medical Center’s Community Epic hub and integrate with Inteleraad’s cloud PACS to expand access to high-quality imaging and electronic health records in rural and Interior Alaska. This approach combines advanced ultrasound technology, AI-assisted imaging, secure communication tools, and a shared EHR model to improve access, quality, and sustainability. Centralized Epic Access for Rural Clinics: The clinic will serve as a Community Epic partner, enabling small clinics and health centers to connect through a shared model. This expands access to MyChart, unified patient records, and structured reporting without requiring each clinic to maintain costly infrastructure. Cloud-Based Imaging and AI Integration: Ultrasound studies will use AI-assisted measurements for OB, vascular, and general imaging. Images are automatically routed through Inteleraad to Epic, enabling faster reporting, quality assurance, and secure access for clinicians and patients. Telehealth and Communication Systems: HIPAA-compliant Zoom and secure VoIP will support remote consultations, real-time image review, and improved patient-provider communication, reducing travel for rural patients. Workflow Optimization and Training: Staff will receive training on Epic, Inteleraad, and AI-assisted imaging to standardize protocols, reduce errors, and improve efficiency. Continuous quality monitoring and remote support will ensure reliable operations. Sustainability and Scalability: Cloud-based systems allow remote radiologists to interpret studies, support disaster recovery, and enable regional expansion. Partnerships with surrounding clinics, tribal health centers, and primary care providers will strengthen care coordination and expand access across Interior and rural Alaska.	\$1M-\$5M	Maternal health	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough	Deferred or Not Advanced

Via Vita Health Project, Inc.	Interior Alaska Diagnostic Imaging Workforce Stabilization and Access Initiative	AK	Interior Alaska faces diagnostic access instability driven by sonographer shortages, geographic isolation, and limited staffing. Diagnostic ultrasound supports prenatal monitoring, vascular assessment, and abdominal and pelvic diagnostics. Alaska’s workforce pipeline is limited, with only one accredited diagnostic medical sonography training program and ongoing difficulty recruiting sonographers to rural regions. Fairbanks Ultrasound serves as a diagnostic imaging hub for Interior Alaska, supporting a hub-and-spoke referral network linking rural clinics across the Fairbanks North Star Borough and surrounding communities. The clinic completed 1,834 diagnostic ultrasound examinations in the past year with two sonographers, serving approximately 1,800–2,200 unique patients annually. Routine referral-to-imaging wait times average 3–4 weeks due to strong demand and limited capacity. Urgent obstetric referrals are prioritized and completed within 24–72 hours, with most reports returned within 24 hours. When access is disrupted, patients face delayed diagnosis, fragmented care coordination, or costly travel to Anchorage. This project will strengthen rural diagnostic infrastructure through workforce stabilization, a grow-our-own sonographer pipeline, ergonomic injury prevention, and technology-enabled workflow improvements. Expanding capacity will reduce wait times and allow patients to receive timely ultrasound services within Interior Alaska rather than traveling out of state.	This project strengthens diagnostic imaging access for rural Interior Alaska through coordinated workforce stabilization, technology-enabled workflow improvements, and regional care coordination centered at an established diagnostic referral hub. The approach focuses on improving timely access to ultrasound services for patients from rural and frontier communities while stabilizing the regional imaging workforce and strengthening rural diagnostic infrastructure. Fairbanks Ultrasound functions as a regional imaging hub within a hub-and-spoke referral network supporting providers and clinics across the Fairbanks North Star Borough and surrounding rural communities. The project will increase stable diagnostic capacity, improve scheduling throughput, and strengthen coordination between referring providers and imaging services. Workforce stabilization will be achieved through structured service agreements and retention incentives supporting core sonographer roles, reducing reliance on temporary staffing and improving continuity of care. A grow-our-own workforce pipeline will sponsor a trainee through an accredited sonography training program with defined milestones including coursework completion, supervised clinical competencies, and certification preparation under clinical preceptor oversight. Operational improvements will focus on technology-enabled care and workflow modernization. AI-assisted documentation tools, digital referral and scheduling systems, and performance dashboards will reduce administrative burden, improve room utilization, and support faster diagnostic turnaround for referring providers. Ergonomic equipment upgrades and training will reduce repetitive strain injuries that contribute to workforce attrition and workforce shortages. Together, these strategies will increase imaging throughput, reduce referral-to-scan delays, improve regional care coordination, and allow more patients to receive diagnostic ultrasound services within Interior Alaska rather than traveling out of region for imaging. By strengthening workforce stability and operational efficiency, the project advances rural health system sustainability and supports timely diagnostic services for communities across Interior Alaska.	\$250K-\$1M	Clinic	Multi-Community or Participating in Regional Hub-and-Spoke	Denali Borough; Fairbanks North Star Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Via Vita Health Project, Inc.	MOBILE IMAGING CLINIC PROJECT	AK	The vast geographic distances which define Alaska constitute a real barrier to care for patients. This only becomes more formidable for those with health conditions, disabilities, and other challenges. As the medical services many seek are hard to establish, fund, and staff in Alaska, the best options for care for many patients involve financially costly transportation and lodging. Journeying to one of a few distant cities, patients not only suffer from whatever primary medical condition drove them to initially seek care, and the financial burden associated with receiving such, but worse still, must endure said journey itself. These expeditions in search of health care commonly press beyond simple inconvenience, to the very point of agony itself. Consequently, many simply abandon their pursuit of health care, before it even begins. Early detection of a broad range of maladies, paired with oft-modest medical interventions, can result in miraculously positive outcomes for patients; miracles denied to those who have been abandoned to the fringe of medical access. A medical industry which clings too rigidly to conventional brick-and-mortar models of healthcare is simply not viable for all Alaskans. These obstacles compound to create a strife-laden medical experience so adverse, many seek care all-to-late, or, even more tragically, not at all. The heart-breaking truth is this; many Alaskans suffer more, and perish sooner, than they ought, from simple lack of logistical efficiency.	The Mobile Imaging Clinic Project will deliver diagnostic imaging services directly to rural communities using a mobile service model supported by the clinical expertise and operational infrastructure of FAIRBANKS ULTRASOUND LLC. Mobile clinics will travel to rural communities on scheduled service days, allowing patients to receive diagnostic imaging services closer to where they live. Imaging studies will be performed by qualified imaging professionals using portable diagnostic equipment. Imaging orders will continue to be submitted electronically by referring providers, consistent with current healthcare workflows. Completed imaging studies will be securely transmitted to radiologists for interpretation. Final reports will then be delivered electronically to the referring provider, allowing continuity of care and timely clinical decision making. This model reduces the final barrier to diagnosis for many rural patients. Ordering and reporting of imaging studies already occur digitally; therefore, providing local imaging appointments allows patients to complete the diagnostic process without traveling to urban centers.	\$250K-\$1M	Specialist	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Village of Solomon	Solomon Tribal Wellness	AK	Our rural tribal community faces significant health disparities driven by geographic isolation, limited access to preventive services, workforce shortages, transportation barriers, and high rates of chronic conditions such as diabetes, hypertension, and obesity. Many residents must travel long distances for care, resulting in delayed treatment and avoidable emergency visits. Youth have limited access to structured physical activity opportunities, and substandard housing conditions contribute to respiratory and cardiovascular health issues. Additionally, there is a shortage of locally trained healthcare professionals, limiting continuity and culturally responsive care. This project addresses the opportunity to shift from a reactive, crisis-driven system to a proactive, community-based model that strengthens prevention, builds local workforce capacity, improves home environments, and expands access to healthy lifestyle supports—ultimately improving long-term health outcomes and system sustainability in our rural community. The Tribe has offered small financial support to such activities proposed under this opportunity; the Traditional Council understands the need and the desire from receiving more and more applications for tribal wellness activities although the tribe has had limited funding resources to support all requests. Preventative approaches are one of the best ways to educate and encourage life long healthy and safe lifestyles	Our proposed approach is a holistic, community-driven rural health transformation model that integrates prevention, early intervention, workforce development, youth engagement, and environmental health improvements. Rather than relying solely on facility-based care, the project brings health supports directly into homes, schools, and community spaces. The approach includes removing financial barriers to physical activity through extracurricular and sport-related scholarships; deploying portable diagnostic tools to support home-based monitoring of chronic conditions; and offering culturally grounded whole-health education such as nutrition, food sovereignty, CPR, and first aid training. Youth programming for children under age 10 emphasizes early physical activity and healthy habits to reduce long-term chronic disease risk. To ensure sustainability, the project invests in medical certificate training scholarships to build a local healthcare workforce and partners with the Residential Weatherization Program to improve home environments that directly impact respiratory and cardiovascular health. Together, these coordinated strategies create an integrated, preventive, and sustainable health system tailored to the realities of rural and frontier tribal communities.	\$50,000-\$250,000	Single Community	Nome Census Area	Deferred or Not Advanced

Virta Medical PC	Reversing metabolic disease- type 2 diabetes, pre diabetes, obesity and overweight in rural areas	CO	Virta directly addresses chronic diseases: type 2 diabetes, pre diabetes, obesity and overweight members (metabolic disease). Virta indirectly addresses: inflammation, cardiovascular disease, liver disease, kidney disease, muscle skeletal issues, mental health and sleep. Through Virta's approach, we're able to help members that face barriers to care have access to doctors and endocrinologists in their pocket 24/7. Given the size of Alaska and the rural nature of the State, Virta will enable members that traditionally have challenges accessing care have the care they need at their fingertips. Virta's approach will enable Alaskans to take charge of their health with medical supervision and as member's health improves- when clinically appropriate- their Virta doctors will start to titrate down and deprescribe medications including Insulin and GLP-1s. Not only can we improve the health of Alaskans, Virta can also improve their access to care, will leave them feeling better (less medications- many of our members have a new outlook on life due to the health improvements they experience) and help the State spend less on expensive medications (members will no longer need these drugs) and medical claims as members improve no only their metabolic health, but their overall health.	Virta's proposed approach is simple- offer Virta as a covered benefit to anyone with metabolic disease- members who have type 2 diabetes, pre diabetes, obesity or are overweight (BMI of 25 or greater). Virta would collaborate with the State on an engagement approach designed to engage all members. Virta is always an opt in program- we would then provide our medically supervised nutrition therapy to members who opt in and complete their clinical intake call. There is no artificial graduation date or time limit. Members who remain engaged with Virta stay in the program as long as they need. If a member becomes disengaged or self-graduates Virta then discharges that member from our care and transitions care back to the member's previous provider. Virta's approach is medically supervised personalized nutrition therapy tailored to each member. Our approach is based on getting the nutrition right for each member's metabolism. Our approach is based in decades of research and outcomes and based on low carbohydrates, moderate protein and high healthy fats. Virta can launch in just 90 days from contract completion and all that is needed to implement Virta is eligibility information, billing setup and member marketing and communications alignment. Most of our public sector contracts have a term of between 3 to 7 years.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Virtual Telemedicine, LLC	Expanding Telemedicine Access for Primary Care and Cancer Prevention in Rural Alaska	AK	Rural communities in Alaska face significant barriers to accessing primary care and preventive health services. Long travel distances, geographic isolation, severe weather conditions, and provider shortages often make it difficult for residents to receive routine care and recommended cancer screenings. Many patients must travel long distances by road or air to access services, which can delay care and reduce participation in preventive health programs. Improving access to primary care, cancer prevention, and chronic disease management through telemedicine can help reduce these barriers and improve health outcomes for rural populations.	This project will expand telemedicine services led by a nurse practitioner to improve access to primary care, cancer prevention, and healthy weight counseling for rural Alaska residents. Funding will support the hiring of a medical biller and a nurse case manager to improve care coordination, patient follow-up, and insurance billing processes. The nurse case manager will assist patients with chronic disease management, preventive care education, and coordination of recommended cancer screenings. Funding will also support essential office operations, development of a patient-accessible website, and outreach efforts to inform rural residents about telemedicine services. In addition, the project will implement a HIPAA-compliant electronic medical record system to support secure telehealth services, documentation, scheduling, and billing. These improvements will allow the practice to expand telemedicine capacity and serve more rural patients who currently face barriers to accessing care.	\$50,000-\$250,000	Private practitioner	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

VOA Alaska	Value Based Care: Back Office Improvement, IT Modernization, Analytics, Workflow Transformation	AK	Rural, remote, and frontier Alaska families face a persistent gap in access to safe, high-quality youth and young adult behavioral health services because options are limited or unavailable. Alaska’s behavioral health landscape for youth and adolescents is profoundly defined by a huge need for services, lack of crisis response, and not enough capacity creating a mental health crisis for the most vulnerable population. This project is an opportunity to modernize and strengthen internal back-office infrastructure including billing, claims management, scheduling, eligibility verification, compliance, and reporting to more effectively manage Medicaid and commercial payors, stabilize cash flow, and sustain access to care in underserved communities. Improved back-office capacity is foundational to VOA’s ability to expand services, participate in value-based care models, and remain financially viable in rural and frontier settings. These investments enable deeper integration of physical health, behavioral health, and social services particularly in rural and frontier communities. Strengthening this infrastructure will allow VOA Alaska to improve care coordination, enhance quality and outcomes, reduce avoidable costs, and shift care to more appropriate, lower-cost settings, while positioning the organization for long-term financial sustainability under evolving payment models.	Funds proposed would be used for a capacity building analysis to enhance VOA Alaska operationally and ensure the agency is technologically ready for a value-based care and/or alternative payment model, along with centralized and streamed back-office functions, all of which improve outcomes for rural Alaskans. As it stands, VOA Alaska has outdated IT infrastructure, limited interoperability, manual spreadsheet reporting which create delays in access, care coordination, claims management workflow gaps, operational deficiencies, and need to strengthen performance benchmarks. RHTP funds will support a consultant to lead modernization efforts to identify and implement ways to strengthen data governance, analytics, workflow efficiency, and reporting capability, so we can reliably track outcomes, manage populations, and meet payer and state performance requirements. Outcomes include: -Enhanced quality and outcomes: Data-driven population health tools allow proactive care management. -Improved care coordination: Seamless integration of physical, behavioral, and social services. -Increased access to appropriate care settings: Reduces avoidable hospitalizations and shifts care to lower-cost, community-based settings. -Improved financial sustainability of essential behavioral health services, reducing risk of service disruption or program closures -Enables more reliable and timely access to care by supporting stable staffing and operations -Reduces administrative burden on clinical staff, allowing providers to focus more time on patient care -Supports expansion of services to rural and frontier communities by ensuring reimbursement systems can scale effectively -Strengthens long-term capacity to participate in innovative payment models that benefit rural populations -Workforce efficiency: Staff can work at the top of their license, improving responsiveness and patient satisfaction. -Long-term sustainability: Strengthened infrastructure ensures continued delivery of high-quality care under evolving payment models.	\$250K-\$1M	Behavioral health/su bstance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Advance to Implementati on Application

VOA Alaska	Adolescent Residential Center for Help SUD Residential Safety, Workforce, and Family Connection	AK	Rural, remote, and frontier Alaska families face a persistent gap in access to safe, high-quality adolescent residential substance use treatment because options are limited or unavailable. Substance use disorder continues to plague Alaska youth, with Alaska ranking as one of the top states facing this particular crisis. The 2023 YRBS indicated that 17.3% of Alaska high school students reported vaping, and 16.9% reported drinking in the past 30 days. Complicating matters more, sadly Alaska’s youth sit in the shadow of a fentanyl overdose epidemic with 6.1% of Alaskan youth reporting misuse of prescription pain medication in the last 30 days. Outdated or constrained facility safety features restrict residential facilities from consistently meeting high acuity needs, while limited resources for ongoing staff training can contribute to variability in care quality. VOA Alaska is positioned to sustain and strengthen ARCH's role within Alaska's behavioral health system by further engaging in safety updates and enhancing clinical expertise. ARCH plays a critical role in reducing out-of-state placements and supporting long-term stability for youth and family across Alaska as ARCH is the only in-state residential options for adolescents with complex substance use and mental health needs.	Funds will be used to complete critical safety upgrades and care-environment enhancements at Alaska’s only adolescent co-occurring residential program that is non-tribally funded. ARCH meets the critical statewide need by serving youth from rural communities and Tribes across Alaska. ARCH serves over 30% of clients from high need rural regions statewide. The facility functions as a statewide resource when local options are limited or unavailable. Funding would support targeted safety renovations and operational enhancements, to include: -Pharmacy consultant to strengthen medication management practices; -Renovation of the medication room to improve security and compliance; -Training dollars to ensure staff maintain the skills needed for high acuity adolescent care through curriculum for: The Seven Challenges, Eye Movement Desensitization and Reprocessing (EMDR), and Internal Family Systems; -Use technology to implement Caring Contacts to reduce suicide risk for adolescents who discharge from ARCH; -Configuration study of ARCH to better address client safety and trauma informed environmental setting; and - Fund for safety improvements across the facility: access control, acoustic tiling, anti-ligature hair dryers, walking loop improvement, basketball fence, anti-shatter windows. All together this investment lowers risk, improves quality, and strengthens a reliable pathway to treatment for rural youth and families who must travel long distances to access residential care.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

VOA Alaska	Rural Behavioral Health Outpatient Program	AK	Rural, remote, and frontier Alaska families face a persistent gap in access to safe, high-quality youth and young adult behavioral health services because options are limited or unavailable. Alaska’s behavioral health landscape for youth and adolescents is profoundly defined by a huge need for services, lack of crisis response, and not enough capacity creating a mental health crisis for the most vulnerable population. Recent statewide Youth Risk Behavioral Survey (YRBS) trends show that 43.2% of Alaska high school students reported feeling so sad or hopeless for a least two weeks resulting in stopping usual activities, 22.6% seriously considered attempting suicide, with 19% attempting suicide in the last year. This project addresses a clear opportunity to close persistent rural access gaps by delivering a scalable outpatient behavioral health model, telehealth paired with planned on site care to communities where local psychiatric and clinical capacity is limited and when travel is not possible. By developing a team dedicated to rural Alaska for outreach and care coordination, the agency can identify needs earlier, sustain engagement with rural populations, and strengthen continuity of care close to home.	Funds will be used to establish a team to deliver consistent, culturally responsive care primarily to rural communities across Alaska, with a focused emphasis on Tribal partners and Alaska Native and American Indian peoples. The program will be staffed with a: - Medical Care Team Coordinator to manage health needs and continuity across systems for improved outcomes; - Psychiatrist to provide psychiatric evaluation, psychotherapy, medication management, and clinical consultation, including regular in-person supports to the Mat-Su region and the Lake and Peninsula School District; - Rural Health Outreach Manager / Tribal Liaison dedicated to rural outreach, and partnership-building -2 rural mental health clinicians who will provide a blend of telehealth and on-site services, including regular in-person supports to the Mat-Su region and the Lake and Peninsula School District; and -Contractor to support evaluation and assist with long-term sustainability when RHTP funds end. By meeting communities where they are – through school linked access points, coordinated referrals, and telehealth options – this program will reduce barriers created by geographic distance, improve continuity of care after crisis or hospitalization, and strengthen early identification and treatment of youth and families. The expected impact includes increased outpatient access and care coordination, improving symptom stability, and ensuring rural communities and systems have long-term supports.	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Walgreens	Pharmacist-Led Hypertension & Chronic Disease Management	IL	Alaska's rural chronic disease crisis faces high cardiovascular mortality rates, disproportionate diabetes burden in Alaska Native populations, and severe medication access gaps which demands a pharmacist-led solution that meets patients where they are. Alaska's RHTP explicitly funds pharmacist test-and-treat, alternative payment models for pharmacists, medication management, and adherence support. Walgreens brings a documented, implementation-ready Hypertension Management Program with AI-driven patient stratification, multi-modal engagement (in-person, telephonic, digital), and a remote pharmacist team achieving 65%+ engagement rates. This is not a theoretical proposal; Walgreens operates outcomes-based payment models with payers today. Walgreens will partner with PwC to for their advisory and actuarial services. Alaska's progressive pharmacy practice laws (collaborative practice agreements; pending SB 147 prescriptive authority expansion) create the regulatory environment to immediately deploy pharmacist-led disease management at scale. PwC's actuarial expertise ensures these models are structured for Medicaid and Medicare Part D reimbursement sustainability.	Walgreens leads clinical delivery while PwC leads value-based care design and program infrastructure. Population Identification & Stratification (Walgreens): Deploy Walgreens' machine learning and AI algorithms to identify Alaska patients most likely to benefit from hypertension management support. Incorporate healthEconnect HIE data to identify patients requiring escalation. Reassess population monthly to trigger timely follow-up. Stratify outreach by care intensity needed. Clinical Service Delivery (Walgreens): Conduct hypertension screening at all 10 Alaska locations (in-person and telephonic). Provide evidence-based counseling on disease management, medication adherence, nutrition, and lifestyle. Deploy Walgreens' dedicated remote health outcomes pharmacist team for telephonic disease management reaching patients in communities without a Walgreens location. Under Alaska collaborative practice agreements, initiate bridge refills and therapy adjustments for patients without PCPs. Expand to A1C testing, lipid screening, and COPD management alongside hypertension in subsequent years. Digital Engagement (Walgreens): Deploy myWalgreens platform for refill management, adherence reminders, and virtual pharmacist consultation. Adapt for Alaska's low-bandwidth environments. VBC Payment Design (PwC): Structure outcomes-based reimbursement with partial payment for service delivery and majority payment contingent on: blood pressure control per clinical guidelines; medication adherence and reduction in preventable hospitalizations. Perform actuarial modeling for Alaska Medicaid and Medicare Part D sustainability. Build analytics dashboards for DOH performance monitoring. Care Coordination (PwC): Establish referral pathways to local PCPs for medication titration needs. Connect tribal pharmacies and FQHCs into shared care protocols.	\$1M-\$5M	Pharmacy	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Walgreens	Pharmacy Workforce Recruitment, Retention and Scope Expansion	IL	Alaska faces compound pharmacy workforce challenges: rural recruitment is difficult, retention is poor due to isolation and limited career development, and scope-of-practice limits prevent pharmacists from billing for the clinical services they are trained to provide. CMS Administrator Mehmet Oz has explicitly called on governors to expand pharmacist scope, stating that pharmacists should work at the height of their licensure. Alaska's SB 147 pending pharmacist prescriptive authority expansion creates the right moment for a comprehensive workforce investment. Walgreens' Pharmacist Recruitment and Retention Program offers scholarship and loan repayment, PharmStart tuition assistance for pre-pharmacy students, rural PGY1 residency tracks, milestone bonuses, and remote pharmacist coverage to relieve understaffed rural stores. PwC supports scope-of-practice optimization, policy design, billing framework development, and implementation of SB 147 — ensuring expanded pharmacist authority translates into reimbursable clinical services.	Walgreens leads workforce investment. PwC leads policy design and program evaluation. Pharmacist Pipeline (Walgreens): Deploy PharmStart program in partnership with Alaska pharmacy schools and colleges; identifying pre-pharmacy students with rural service interest and providing employer-sponsored tuition assistance. Engage Walgreens' National Deans Advisory Council to develop Alaska-specific rural pharmacy pipeline programming. Partner with University of Alaska system and Washington State University and Idaho State University for recruitment. Loan Repayment & Retention Incentives (Walgreens): Recruit high-performing technicians for paid training tied to guaranteed pharmacist roles at Alaska Walgreens locations. Rural PGY1 Residency Track (Walgreens): Develop a rural Alaska PGY1 pharmacy residency or fellowship with hybrid virtual preceptorship, focused on ambulatory care competencies for preventive and chronic disease delivery in frontier settings. Remote Pharmacist Staffing: Expand Walgreens' remote pharmacist coverage program to relieve Alaska stores with staffing constraints — ensuring continuity of pharmacy services during vacancies. Scope-of-Practice Optimization (PwC): Design billing and reimbursement frameworks aligned with Alaska's current and pending pharmacy scope laws. Develop collaborative practice agreement templates for Alaska provider settings. Support DOH in SB 147 implementation — translating expanded prescriptive authority into reimbursable clinical service codes. Provide workforce gap analysis by region to guide recruitment targeting. Evaluation (PwC): Track rural pharmacist retention, staffing level achievement, clinical service volume growth, and return-on-investment of incentive programs.	\$1M-\$5M	Pharmacy	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

Wasilla Workforce Development Initiative	Alaska Rural Healthcare Workforce Access Hub Stabilizing Medicaid-Serving Facilities	AK	Alaska’s rural healthcare system faces ongoing instability that directly impacts Medicaid beneficiaries. Rural clinics, tribal health facilities, and critical access hospitals depend on reliable facility infrastructure, transportation systems, and trained local workforce to maintain continuity of care. In remote communities, when electrical systems fail or skilled personnel are unavailable, Medicaid-covered services may be delayed, reduced, or suspended. Rural residents face disproportionate barriers to workforce certification, including geographic isolation, high travel costs, limited local credentialing options, and caregiving responsibilities. These barriers restrict access to clinical and infrastructure workforce pathways essential to sustaining healthcare facilities. Without scalable workforce access infrastructure including hybrid training and short-term residential access, Medicaid-serving facilities will continue to experience staffing gaps and contractor dependency that undermine healthcare access across rural Alaska. There is a clear opportunity to align workforce certification delivery with rural healthcare system needs through a coordinated statewide model. By expanding credential access, strengthening retention, and equipping participants to return to their home communities with industry-recognized certifications, Alaska can stabilize clinical and operational capacity while protecting reliable access to Medicaid-covered services in rural and frontier regions.	The Wasilla Workforce Development Initiative proposes Phase 1 implementation of a statewide Rural Healthcare Workforce Access Hub designed to strengthen the clinical and operational capacity of Medicaid-serving healthcare facilities across Alaska. WWDI will expand certification pathways across both entry-level healthcare and infrastructure workforce tracks. Existing Patient Care Technician and Pharmacy Technician programs leading to state licensure currently operate at full capacity with active waitlists. Phase 1 will increase access to these clinical certifications while scaling electrical pre-apprenticeship, construction and facilities maintenance, marine systems technology, and related technical trades that support rural clinics, tribal health facilities, emergency transport systems, and telehealth infrastructure. The model integrates online coursework with three- to five-day in-person certification intensives hosted at a Wasilla-based training campus. Participants complete academic and theoretical components remotely and travel for hands-on instruction and competency assessment. To reduce geographic and caregiving barriers, WWDI will provide travel stipends, childcare during intensives, meal support, and short-term family-friendly residential access. Six time-limited residential training units and shared training space will function exclusively as workforce access infrastructure during scheduled intensives and train-the-trainer programs. These units are structured supports that enable participation from remote communities. In addition to credential attainment, WWDI will implement a Workforce Navigation and Retention Program providing individualized mentorship, employer alignment prior to completion, and structured post-placement follow-up focused on long-term workforce stability. Select participants will complete train-the-trainer preparation to expand local workforce delivery within their home regions. Over 36 months, the hub will scale multiple annual cohorts, formalize partnerships with tribal health organizations and rural clinics, and implement measurable placement and retention tracking aligned with Medicaid system stabilization goals.	\$1M-\$5M	Statewide	Anchorage (Municipality); Bethel Census Area; Fairbanks North Star Borough; Kenai Peninsula Borough; Kusilvak Census Area; Matanuska-Susitna Borough; Nome Census Area; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

WEKA LLC	Alaska Behavioral Health-SecureTransport Initiative:	AK	Rural Alaska’s geographic reality presents significant barriers to accessing behavioral health crisis services. Many communities lack local inpatient psychiatric care, requiring individuals experiencing acute mental health emergencies to be transported long distances to regional hub cities where Designated Evaluation and Treatment (DET) facilities provide evaluation and stabilization. Alaska’s vast land area, limited transportation infrastructure, and remote communities make timely access to care particularly challenging. A critical bottleneck occurs when individuals in crisis must wait for placement availability at receiving facilities before transport can occur. Secure transport providers must maintain trained personnel ready to respond across large service areas, yet transports may be delayed when beds are unavailable. Once placements open, transport requests can surge rapidly, requiring immediate response to ensure individuals receive timely care. The Alaska Behavioral Health Secure Transport Initiative addresses this challenge by strengthening transport readiness capacity for rural communities. By maintaining trained personnel capable of responding quickly when placements become available, the project will improve timely access to behavioral health services, enhance safety for patients and responding officers, and strengthen the long-term sustainability of Alaska’s behavioral health crisis response system.	The Alaska Behavioral Health Secure Transport Initiative will strengthen the capacity of Alaska’s behavioral health crisis response system by expanding secure transport readiness for rural communities. The project will focus on increasing workforce capacity, improving response readiness, and ensuring that individuals experiencing behavioral health crises can be transported safely and without delay once placement at a designated facility becomes available. Grant funds will be used to recruit and hire additional trained transport personnel, including both male and female staff, to ensure appropriate staffing for a wide range of patient needs and safety considerations during secure transport operations. Expanding the workforce will allow transport providers to maintain adequate staffing levels to respond quickly across Alaska’s large and remote service areas. WEKA understands the difference between operational costs and using the available funds for increasing and sustaining a correct workforce, ready to go when needed. The funds will also assist in de-escalating possible threats to the community and our officers. The project will support workforce stability by allowing providers to retain trained personnel during periods when transports cannot occur due to placement availability or authorization delays. Maintaining this readiness capacity ensures that experienced staff remain available to respond immediately when transport requests arise, reducing delays once psychiatric placements become available. In addition, the initiative will support the acquisition of additional secure transport vehicles equipped to safely escort individuals experiencing behavioral health crises. Expanding the available vehicle fleet will increase operational capacity and improve the ability to respond simultaneously to multiple transport requests across rural regions. Together, these investments will strengthen Alaska’s behavioral health transport infrastructure by increasing surge capacity, improving response times, and supporting a sustainable workforce capable of safely serving rural and frontier communities.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

WEKA Medical	REACT (Rural Emergency Access and Coverage Timeliness) Initiative	AK	Rural, remote, and frontier communities across the Fairbanks, Mat-Su, Anchorage, Kenai Peninsula, and Valdez service regions face persistent barriers to timely emergency medical access due to vast geographic distances, limited transportation infrastructure, and environmental conditions that extend response and transport intervals. Many communities operate with minimal EMS redundancy, often relying on a single ambulance to support both emergency response and interfacility transport. When transport to regional hub facilities is required, local emergency coverage may be temporarily unavailable, creating service gaps and increasing risk exposure for residents. Terrain challenges, seasonal travel constraints, and communication dead zones further complicate dispatch coordination and continuity of care during transport. These conditions present a clear opportunity to strengthen rural health system reliability through expansion of EMS transport capacity that preserves community response readiness while supporting access to higher levels of care. The project will address coverage fragility and improve continuity of emergency medical services across participating rural communities.	The REACT (Rural Emergency Access and Coverage Timeliness) Initiative will address rural EMS coverage gaps and transport barriers through expansion of advanced life support ambulance capacity across the Fairbanks, Mat-Su, Anchorage, Kenai Peninsula, and Valdez service regions. The project will support acquisition, equipping, and deployment of additional ambulances strategically positioned to maintain local emergency response readiness while simultaneously enabling interfacility and specialty transports to regional hub facilities. Each unit will be outfitted with standardized advanced life support equipment, including cardiac monitoring and defibrillation capability, intravenous therapy resources, and stabilization equipment appropriate for prolonged rural transport intervals. Standardized equipment deployment will support consistent clinical capability across units and enhance the ability of EMS personnel to deliver evidence-informed pre-hospital care in remote and frontier environments. Deployment planning will be informed by service utilization patterns, geographic coverage needs, and coordination with regional health partners to ensure units are positioned where they can most effectively preserve community response capacity and reduce service gaps created by transport demands. Integration with existing dispatch and operational infrastructure will allow expanded fleet capacity to be incorporated into routine response coverage models without disruption to established workflows. The initiative will also support strengthened coordination with hospitals, clinics, and referral partners by improving predictability of transport availability and reducing delays associated with limited fleet redundancy. Enhanced transport capacity will facilitate more efficient patient movement between community providers and regional facilities, supporting continuity across the care continuum and improving access to specialty and higher-acuity services for rural residents. Through targeted expansion of EMS capacity, standardized clinical capability, and integration with regional care networks, the REACT Initiative will strengthen reliability of emergency medical response, preserve local coverage during transport events, and enhance access to time-sensitive care for rural and frontier communities.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Anchorage (Municipality); Chugach Census Area; Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Kenai Peninsula Borough; Matanuska-Susitna Borough; Southeast Fairbanks Census Area	Deferred or Not Advanced

Well Alaska Physical Therapy LLC	Community Access to Self-Administered Digital Wellness Screening and Targeted Home Programs	AK	Rural and frontier communities in Alaska face limited access to healthcare due to geographic isolation, small populations, and limited healthcare practitioners. At the same time, many residents experience lifestyle-related chronic conditions, such as poor nutrition, physical inactivity, inadequate sleep, and musculoskeletal limitation, without awareness that their health is suboptimal. These factors contribute to impaired mobility, functional limitations, and early-stage chronic disease, which reduce quality of life and increase reliance on an already overextended local healthcare workforce. This convergence of limited access, unrecognized health risks, and workforce constraints creates a critical need for scalable, preventive solutions that empower individuals to assess and manage their own health, while supporting community well-being.	To address these challenges, this project will provide rural Alaskan communities with access to a self-administered digital wellness screening through theSymmioplatform. Community members will complete a comprehensive assessment of movement quality, breathing patterns, physical activity, sleep, nutrition, behavioral health, injury history, and body composition using a smartphone, tablet, or computer. The app then identifies each individual’s two areas of greatest need and generates a personalized home program, including guided exercises, health behavior strategies, and functional mobility support. By empowering individuals to assess and manage their own wellness, the project expands preventive care access in communities with limited healthcare practitioners, promotes early identification of chronic disease risk factors, and supports functional health. This scalable, technology-enabled approach also helps reduce pressure on the rural healthcare workforce while fostering long-term community well-being and resilience.	Under \$50,000	Private practitioner	Single Community	Juneau (City and Borough)	Deferred or Not Advanced

Welldoc	Transforming Rural Alaska Chronic Care through Digital Health Innovation	MD	The Problem: Rural and frontier Alaskans face disproportionate rates of chronic cardiometabolic conditions, including diabetes and hypertension. Traditional care delivery is hampered by extreme geography, high travel costs (medevacs/flights), and a critical shortage of specialized clinicians. Consequently, patients in remote villages often lack the daily support needed to manage complex conditions, leading to avoidable acute crises and high-cost emergency interventions that strain the state’s healthcare budget. The Opportunity: This project introduces a Digital Force Multiplier to Alaska’s hub-and-spoke healthcare model. By deploying Welldoc’s 11+ FDA-cleared, AI-driven platform, we have the opportunity to transform chronic care from an intermittent, clinic-based model to a continuous, home-based model. Key Transformation Pillars: Spark Technology & Innovation: We will bridge the "distance gap" by providing patients with real-time, clinical-grade digital coaching that functions offline and syncs when connectivity is available. Workforce Optimization: Our AI prioritizes patient data, allowing overextended rural nurses and Community Health Aides to focus their limited time on the highest-risk patients, practicing at the top of their license. Healthy Communities: By stabilizing chronic conditions locally, we reduce the necessity for travel to urban centers, keep care within the Tribal Health System, and improve long-term health outcomes for Alaska’s most vulnerable populations.	1. Strategic Alignment: The Digital Force Multiplier Our approach transforms chronic disease management from an episodic, clinic-bound model into a continuous, home-based support system. By deploying Welldoc’s 11+ FDA-cleared, AI-driven platform, we provide a "Digital Force Multiplier" for Alaska’s rural health workforce. This aligns with the RHTP’s Spark Technology and Strengthen Workforce initiatives by automating routine data collection and patient coaching, allowing Community Health Aides (CHAs) and nurses to practice at the "top of their license" by focusing only on high-risk alerts. 2. Implementation Framework: The "Hub-and-Spoke" Integration Welldoc will integrate seamlessly into Alaska’s existing delivery system: The Hub (Regional Centers): We provide regional clinicians with a population health dashboard that prioritizes patients based on real-time biometric trends (glucose, BP, weight). The Spoke (Village/Frontier): Patients receive the Welldoc app, which provides AI-driven, real-time coaching. Crucially for Alaska, the platform supports offline functionality, syncing data once the user reaches a Wi-Fi "hub" or cellular signal. 3. Three-Phase Execution Plan (Sub-6 Month Deployment) Phase I: Configuration (Month 1): We collaborate with Alaskan partners (THOs/FQHCs) to define clinical protocols and "co-brand" the digital experience to ensure cultural relevance and local trust. Phase II: Workforce Upskilling (Months 2-3): We conduct "Train-the-Trainer" sessions for local care teams. Our goal is to minimize administrative burden through EHR interoperability, ensuring that digital health data flows directly into existing workflows. Phase III: Scaled Enrollment (Months 4-6): Rapid patient onboarding via SMS and in-clinic prompts. We prioritize "High-Utilizers" to drive immediate ROI by reducing emergency medevacs and hospitalizations. 4. Sustainability & Fiscal Responsibility To meet the RHTP Pay for Value goal, our approach includes a roadmap for long-term solvency. We will assist partners in utilizing Medicaid Remote Patient Monitoring (RPM) codes and chronic care management (CCM) reimbursement to offset program costs. By stabilizing patients in their home communities, we reduce the aggregate cost of care, making the model self-sustaining beyond the initial grant period.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Whale Tail Pharmacy	Six Innovative Programs for Medication Compliance, Foster Healthy Living, and Reduce Cost	AK	1. Medipaks – Lack of long-term care and recent ending of home health services has caused an increasing need for patients with a substantial compliance hinderance to have medipaks. 2. TOC - Due to high provider turnover, low patient health literacy, and overtaxed local health entities, there is great need for intervention post-discharge related to a significant event with high risk for readmission (i.e. stroke, cardiac event, COPD, diabetes). 3. Tobacco Cessation – Alaska’s Tobacco Quit Line is a valuable partner, but for POW this program lacks timely accessibility, provides only 2 weeks of products, and impact is limited by the lack of personal relationships. 4. Nutrition and Healthy Living – Limited resources on POW result in higher level of dietary deficiencies that can be easily improved through multivitamins and education. 5. DME and Home Health Packs – POW has no long-term care nor home health services and medical supplies can take weeks for delivery. 6. Medicare and Medicaid Counseling – Two healthcare entities on POW provide some level of assistance with Medicare and Medicaid enrollment, but these resources are almost exclusively available through calling a person off POW or only during specific times when a person visits plus they are often overtaxed by the needs. Most patients on POW respond better to working with local people they trust and the success of these current services falls short when patients need support at a time of coverage crisis.	1. Medipaks - Pharmacists prepare medications into individualized weekly medipaks that divide all scheduled medications into daily sections for morning, midday, evening, and bedtime. Additionally, there is a monthly review of patients’ medical plans with their primary care clinic. 2. TOC - This program includes a first encounter between a patient and WTP pharmacist, which includes physically reconciling patient medications between pre and post discharge, checking vitals, medication counseling, discussing lifestyle changes, and provision of a collaboratively built individual health plan. After this encounter documentation is sent to their primary care provider and there is further collaboration as needed. Within a month there is a second patient encounter to determine patient’s satisfaction and compliance with their individual health plan with further follow up as needed. 3. Tobacco Cessation - Discussions with local law enforcement have revealed the need for cessation counseling and products for inmates. A similar program is needed for low-income patients who do not qualify for Medicaid. This includes providing 2-6 months of products given monthly with patient specific tailored cessation counseling at each encounter. 4. Nutrition and Health Living - WTP’s strong community relationships can be used for impactful improvements to pediatric health. First, through provision of free monthly vitamins those 2-18 years of age and vitamin D drops for patients under 2 years of age with counseling on healthy living at each monthly encounter. Second, WTP will provide education at local schools, pre-schools and after-school programs on diet, exercise, sleep, hydration, hygiene, and screentime. 5. DME and Home Health Packs - A DME lending program will allow patients to receive supplies when needed and overall healthcare costs are reduced by reusing equipment. Including home health supply packs specific for disease states can ensure patients have the supplies and education needed, such as keeping a diabetic ulcer from turning into an amputation. 6. Medicare and Medicaid Counseling - WTP has a known successful history of aiding patients for Medicare during open enrollment and throughout the year. WTP can better help patient access if there were more than 1 counselor and included Medicaid counseling, thus allowing patient local personalized counseling assistance 6 days/week 52 weeks/year.	\$250K-\$1M	Pharmacy	Single Community	Prince of Wales-Hyder Census Area	Advance to Implementation Application

Whale Tail Pharmacy	Three Services to Increase Access and Monitoring	AK	1. CLIA-Waived Test and Treat - Current clinics have high provider turnover/overload, which results in long waits and high cost for appointments. In line with other Alaska pharmacies, WTP is preparing for test to treat in order to expand timely access, improve early detection and treatment rates for common infectious diseases, and reduce unnecessary emergency visits and costs. 2. Remote Disease State Monitoring - For years WTP's professional staff has regrettably observed inadequate outcomes due to insufficient chronic disease state monitoring. WTP has made best efforts by loaning equipment, providing free monitors when needed, typing personalized patient monitoring charts, and providing free vital measurements. While clearly impactful, these efforts have fallen short of needs. This issue is multifaceted from deficient patient education and/or buy in, inability for patients to purchase or locate monitoring supplies, high provider turnover/overload, and patient transportation barriers. 3. 24-Hour Prescription Pick Up Access - The POW community faces barriers due to the lack of resources, geographical constraints, and weather-related emergencies. For 26 years, WTP has accommodated patients by having pharmacists arrange to meet them after hours when patients cannot pick up necessary medications during operational hours and have even used boats to deliver medications to patients after landslides. While this system has been meaningful it remains deficient for the needs.	1. CLIA-Waived Test and Treat - WTP's exceptional reputation of service, well-trained tenured staff, and ongoing collaboration with community partners, uniquely positions WTP to offer rapid, point-of-care testing for conditions such as influenza, strep throat, COVID-19, and other common health concerns that are CLIA-waived. These services reduce barriers to timely diagnosis and treatment, particularly for underserved and rural populations. WTP has already been contacted by an Alaska licensed Doctor of Osteopathy with residence on POW to partner in this project and WTP has secured a CLIA Certificate of Waiver. CPESN consultant is visiting WTP March 16th to help develop the framework for this service in anticipation of funding. 2. Remote Disease State Monitoring - WTP is in a pivotal position to provide at home disease state monitoring given patients frequent visits to and trust in WTP, as well as WTP's close collaboration with local providers and related entities. Building upon current unfunded efforts, WTP is ready and able to put in place a sustainable program that equips POW patients to successfully monitor disease states at home thus improving health outcomes and preventing burden on the medical system for emergency care. WTP is partnering with Truentity Health to provide the framework for this service. 3. 24-Hour Prescription Pick Up Access - Directly beside WTP's location is an indoor temperature controlled unlocked entryway containing an ATM machine and behind this entryway is the Alaska State Troopers POW post, thus providing an ideal place to install a prescription pick-up locker (most likely containing 12 units). Once installed, WTP's policy will be to have the vast majority of prescriptions being picked up in person to maintain our contact time with patients. However, when specific needs arise having 24-hour access will remove a barrier to care and support overall patient health. WTP has arranged for the location with the plaza owners and is currently getting multiple quotes to establish the best price on the locker, delivery, installation, and technology.	\$50,000-\$250,000	Pharmacy	Single Community	Prince of Wales-Hyder Census Area	Advance to Implementation Application

White Wave Counseling, LLC	Rural Youth Digital Health Initiative	AK	Across rural Alaska, educators, families, and healthcare providers are often the first to observe changes in youth behavior that may signal emerging mental health concerns. However, many community members lack the training needed to recognize early warning signs or understand how newer risk factors—particularly those related to digital technology use—can influence youth well-being. Increased use of social media, gaming, and other digital platforms has introduced behavioral health challenges that many communities are still learning how to address. Excessive screen use can contribute to sleep disruption, emotional dysregulation, reduced in-person social connection, and increased vulnerability to substance misuse and other mental health concerns. In rural communities already facing elevated risks of substance abuse and suicide, these factors can compound existing vulnerabilities. While these issues often appear first in schools, homes, and primary care settings, these adults may not have the tools to identify maladaptive patterns early or respond effectively. This creates a gap between the emergence of behavioral health concerns and timely intervention. This project addresses that gap by increasing community-wide awareness of technology-related behavioral health risks and equipping educators, families, and healthcare providers with practical tools to identify concerns earlier and respond appropriately, strengthening local capacity to support youth mental health in rural Alaska.	This initiative will implement a cohort-based learning and implementation model across 3–4 rural Alaska communities during the first year, with a primary focus on strengthening digital wellness awareness and youth behavioral health prevention. Participating communities will engage in a structured series of trainings delivered by Alaska-based clinicians with experience serving rural populations. The training series will center on how digital technology use—including social media, gaming, and constant connectivity—affects youth sleep, emotional regulation, social development, and behavioral health risk. Sessions will provide educators, families, and healthcare providers with practical strategies to recognize unhealthy technology patterns, understand how digital behaviors influence mental health, and support healthier technology habits for youth. Additional training topics will include early warning signs of behavioral health concerns, emotional regulation, sleep and mental health, substance use risk pathways, and suicide prevention. Each topic will be delivered consistently across participating communities to ensure continuity and efficient use of the limited behavioral health workforce. The initiative will utilize a hybrid delivery model combining virtual sessions, limited in-person engagement, and recorded learning modules to maximize access for remote communities. Participants will also receive practical tools that can be applied in classrooms, primary care visits, and family settings. By integrating digital wellness education with broader youth behavioral health prevention strategies, the project strengthens coordination between schools, families, and healthcare providers and builds practical skills within the existing community workforce	\$250K-\$1M	Behavioral health/substance use disorder treatment	Other	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Whitecoat Technologies, Inc	Sustainable Clinical Workforce Readiness, Talent Pipeline, and Standardized Onboarding	TN	The Problem: Nationally, our country is facing significant and persistent health care workforce shortages that directly impact timely access to care, continuity of services, and long-term system stability. In Alaska, metro, rural, remote, and frontier communities face persistent health care workforce shortages that reduce access to care and strain care delivery. A major driver of this challenge is a fragmented clinical training-to-employment pipeline: learner training, competency development, clinical placement, and workforce hiring are often managed in disconnected systems with limited shared visibility. As a result, educators, clinical sites, and workforce leaders have difficulty tracking learner readiness, identifying skill gaps early, coordinating transitions into practice, and planning for future workforce needs. This fragmentation contributes to delayed hiring, inconsistent preparedness of new clinicians, increased early career turnover, and limited ability for states and rural health systems to make strategic, data-informed workforce investments. The problem we are seeking to solve is the lack of a coordinated, competency-based, and data-visible pathway from learner to practice-ready clinician -especially in rural settings where workforce shortages are most acute, and the margin for staffing disruption is smallest.	How the Platform Will Address These Challenges The Whitecoat Platform addresses these challenges by creating a connected, competency-based infrastructure that links clinical education, training sites, and workforce planning into a single, shared pathway from learner to practice-ready hire. 1) Improves visibility into the rural workforce pipeline The platform gives educators, clinical partners, and state/regional leaders a clearer view of where learners are training, how they are progressing, and when they may be ready to enter practice. This shared visibility helps rural stakeholders move from reactive staffing decisions to proactive workforce planning. 2) Standardizes competency development and readiness tracking The platform supports structured competency tracking, real-time feedback, and longitudinal learner records across training experiences. This helps reduce variability in learner preparedness and provides a more consistent way to assess readiness for practice in rural care settings. 3) Identifies gaps earlier and enables targeted support By capturing training progress and performance data in one system, the platform helps stakeholders identify skills gaps, training bottlenecks, or placement issues earlier. This allows for targeted remediation, upskilling, and support before those issues become hiring delays or early-career performance challenges. 4) Strengthens transition-to-practice and early-career success The platform helps bridge the gap between education and employment by carrying forward verified competency and experience data into onboarding and early workforce development. This supports smoother transitions into practice, improved confidence for new clinicians, and better alignment between learner preparation and employer expectations. 5) Supports “grow-your-own” rural workforce strategies Rural communities often need to develop and retain local talent. The platform supports this by helping organizations build intentional pathways from local learner recruitment to clinical training to employment, making it easier to cultivate a durable pipeline of clinicians who are more likely to serve rural communities long term. In summary, the platform solves these challenges by replacing fragmented, siloed processes with a shared, data-informed system that improves coordination, strengthens learner readiness, and enables more reliable rural workforce development over time.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

White's Incorporated	After Hours Access to Pharmaceuticals	AK	We have a very busy cruise ship season, and this often deters patients from coming into the pharmacy on those busy days and can delay treatment. Additionally, patients who have limited access and for any reason cannot use our delivery service will be able to access their medications after-hours at the pharmacy with only a call.	We plan to add a secured locker for medications that will verify the patient picking up and open to allow them to access the required medication (and ONLY their medication).	Under \$50,000	Pharmacy	Single Community	Sitka (City and Borough)	Advance to Implementation Application
WIM Tracking LLC	Telehealth Utilization Infrastructure Pilot – Alaska	SC	Rural healthcare systems increasingly rely on telehealth to deliver care across remote communities, yet most states lack a standardized way to track telehealth utilization across providers and programs. As a result, state and regional leaders have limited visibility into where telehealth services are being delivered, how frequently they are used, and where gaps in access remain. Telehealth service locations across Alaska are already mapped through the Find Telehealth platform, but there is currently no consistent infrastructure for collecting and analyzing telehealth utilization data across providers. Without this information, it is difficult for healthcare leaders and policymakers to evaluate telehealth programs, identify underserved regions, or make informed investments in rural healthcare access. This project builds on telehealth utilization reporting methods first developed through collaboration between the South Carolina Telehealth Alliance and WIM Tracking and expands that model to support statewide telehealth intelligence. By establishing a standardized system for reporting telehealth utilization and service delivery across rural providers, Alaska will gain a clearer understanding of how telehealth is used across remote communities and where opportunities exist to strengthen access to care.	This project will develop the Telehealth Utilization Infrastructure in Alaska by enabling rural healthcare providers to report telehealth utilization and telehealth service location data through a secure reporting platform developed by WIM Tracking. Participating providers will submit standardized information on telehealth visits, service specialties, and delivery locations. In return, the system will provide immediate value to providers through automated leadership reports, program benchmarking against similar rural organizations, and longitudinal trend analysis that supports internal planning, grant applications, and board reporting. Financial incentives will support rural providers for the time required to submit and maintain utilization and site data. These incentives will help establish a cohort of participating organizations representing hospitals, community health centers, tribal health organizations, and other rural providers delivering telehealth services across Alaska. The platform will build on telehealth site data already collected across Alaska through the Find Telehealth project since 2022. Integrating utilization reporting with existing site mapping will allow Alaska to better understand where telehealth services are delivered and how those services are used across rural and frontier communities. The project will also generate aggregated, de-identified datasets that provide state leaders with a clearer view of telehealth adoption across regions, helping inform policy decisions, identify gaps in access, and guide future telehealth investment. Implementation will be supported through partnerships with the Northwest Regional Telehealth Resource Center, national Telehealth Centers of Excellence, the Telehealth Technology Assessment Center, and GIS partner Sanborn. Together, these partners will support provider engagement, technical implementation, data quality, and long-term sustainability of the telehealth utilization reporting infrastructure.	\$250K-\$1M		Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Wisdom Traditions Counseling Services LLC	Generative Healing for Women, Veterans, Alaskans & Alaska Native People Addressing Trauma & SUD	AK	Statement of Need Women, veterans, elderly, Alaskans and Alaska Native people experience disproportionately high rates of trauma exposure, military sexual trauma (MST), intergenerational trauma, and substance use disorders (SUD). Rural isolation, limited culturally responsive specialty care, and gaps in gender-specific and veteran specific services create barriers to sustained recovery. For many, lack of purpose, and inability to attain a purpose-fulfilled life is a barrier to a healthy and productive life. This program addresses co-occurring trauma and SUD through an integrated, culturally grounded model that moves from treatment to career development, education/training and certification as a Peer Mentor, Traditional Peer/Counselor Healer or SUD Counselor. This Generative Healing Program operates through a four-phase model: Stabilization & Safety, Trauma Processing, Identity Rebuilding, and Generativity. Participants transition from receiving care to becoming peer mentors, counselors, community leaders, and contributors to sustainable economic initiatives. By combining behavioral health treatment with cultural restoration and workforce development, this program addresses root causes of trauma, reduces relapse rates, increases employment outcomes through career development, and strengthens intergenerational resilience.	Program Design and Implementation This program aligns with SAMHSA’s Strategic Prevention Framework and Trauma-Informed Care principles. Services integrate evidence-based practices (EMDR, IFS, somatic therapies and ketamine assisted psychotherapy (KAP), Medically Assisted Treatment (MAT) as appropriate, recovery support, and culturally grounded healing modalities. Core Components: • Integrated trauma and SUD treatment • Peer recovery support and mentorship pipeline • Cultural healing circles and land-based practices • Workforce development, education and training and leadership training Program Logic Model Inputs • Licensed clinical staff (trauma & SUD specialists) * PNP/PA staff for medical evaluation and support * Case Management and referral • Cultural advisors and elders (Dr. Gary Ferguson, Bobby Dorton, and Don Coyhis) • Peer mentors with lived experience (Wisdom Warriors) • Facility space (treatment & healing individual spaces, group space, vocational training) • Grant and braided funding sources Activities • Trauma-informed therapy (EMDR, Internal Family Systems Therapy (IFS), somatic modalities and comprehensive ketamine assisted psychotherapy (KAP), Brainspotting, Native Prayers & Wisdom) • Substance use treatment and Relapse Prevention • Cultural healing circles and land-based practices (Dr. Gary Ferguson, Bobby Dorton and Don Coyhis) • Leadership, mentorship and SUD training • Establishing careers in SUD through workforce development	\$1M-\$5M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Wise Solutions	Rural Community Resilience & Conflict Resolution Initiative	AK	Rural and frontier communities in Alaska often face limited access to conflict resolution services, family support resources, and structured dispute resolution systems. When conflicts between family members, community members, or co-parents go unresolved, they can escalate into chronic stress, family instability, behavioral health challenges, and increased involvement with courts, child welfare systems, or other crisis-driven services. These outcomes place additional strain on already limited rural health, behavioral health, and community resources. At the same time, many Tribal governments and local communities are seeking culturally appropriate approaches to address disputes, strengthen families, and support community well-being, but may lack access to trained mediators, conflict resolution education, or systems that support early intervention. This project presents an opportunity to expand access to mediation, conflict resolution services, and community education for rural and remote communities through a combination of tele-services and travel to provide in-person support. By partnering with Tribal governments, Tribal courts, and local organizations, the initiative will help build community capacity to address conflict constructively, strengthen family relationships, and support healthier, more resilient communities.	Our proposed approach combines tele-services, in-person outreach, and community partnerships to address conflict, family instability, and gaps in local dispute resolution systems in rural and frontier Alaska communities. We will provide mediation, parenting coordination, reunification support, and family coaching to help families resolve conflicts early, reduce chronic stress, and improve child and family well-being. To strengthen communities more broadly, we will collaborate with Tribal governments, Tribal courts, and local organizations to provide culturally responsive support, training, and education in conflict resolution. This includes offering workshops, coaching, and guidance for community leaders and court staff to build local capacity for constructive dispute resolution. Services will be delivered through a hybrid model, combining virtual sessions for accessibility with periodic travel to rural communities for in-person mediation, education, and capacity-building. By integrating direct family support with community-level education and Tribal court collaboration, the initiative addresses both individual and systemic needs, helping families, communities, and local systems work together to prevent conflicts from escalating and strengthen overall community resilience.	\$50,000-\$250,000	Statewide	Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Nome Census Area; North Slope Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Women In Safe Homes Inc (WISH)	Sustaining Services for Domestic Violence & Sexual Assault Survivors in Southern SE Alaska	AK	Rural communities face persistent barriers to recruiting and retaining qualified professionals, particularly in specialized fields of crisis intervention, behavioral health and legal services for victims of domestic violence and sexual assault. This project will recruit and retain these professionals to provide barrier-free services in response to incidents of domestic and sexual violence. By addressing historical barriers to rural recruitment and retention, including geographic isolation, housing limitations, and financial constraints, WISH will ensure consistent, long-term access to high-quality legal services without gaps in care. To recruit and retain high-need professionals, WISH will offer structured incentives tied to a five-year service commitment, including upfront recruitment bonuses weighted toward later years of service and repayment requirements if the obligation is not fulfilled. The project will also coordinate housing placement with local partners and provide time-limited housing and childcare stipends to reduce relocation barriers and support long-term provider stability in our rural community. This project will also implement a structured retention strategy for existing employees, projecting support and incentives over the next five years to strengthen workforce stability, reduce turnover, and sustain the capacity needed to provide reliable, trauma-informed services to survivors in our rural community.	Recruit Professionals: WISH will implement a targeted, multi-faceted approach to recruit and retain professionals in the fields of crisis intervention, behavioral health and legal services, to serve survivors of domestic violence and sexual assault in Southern Southeast Alaska. Recognizing the persistent challenges of geographic isolation, high cost of living, and limited housing, this project combines national recruitment, financial incentives, and community support to attract highly qualified professionals and ensure their long-term retention. To expand the applicant pool beyond Alaska, WISH will contract with professional recruitment agencies. Recruitment efforts will be paired with structured incentives tied to a five-year service commitment, including upfront hiring bonuses and incremental payments weighted toward later years, with repayment requirements if obligations are not fulfilled. This approach encourages sustained service and reduces turnover. Relocation barriers will be addressed through WISH’s long-standing relationships with local landlords, housing providers, and childcare agencies, allowing hired professionals to secure housing and childcare prior to arrival. Time-limited housing stipends and childcare support further ease relocation, helping the individual settle quickly and focus on service delivery. Retain Existing Employees: Current employees will be eligible for retention bonuses distributed in phases over the five-year project period. These incentives will be tied to continued employment milestones of their annual service benchmarks, to encourage long-term commitment and reduce turnover. The project will allocate resources for continuing education, advanced certifications, and specialized training related to trauma-informed care, victim advocacy, crisis response, and legal services for survivors of domestic and sexual violence. Supporting staff in maintaining credentials and expanding professional expertise will strengthen service quality while increasing job satisfaction and long-term retention.	\$50,000-\$250,000	Multi-Community or Participating in Regional Hub-and-Spoke	Ketchikan Gateway Borough; Prince of Wales-Hyder Census Area; Wrangell (City and Borough)	Deferred or Not Advanced

World Wide Technology	Building the commercial and operational framework required to manage Microsoft solutions.	AK	WWT, through its fully integrated Softchoice Microsoft organization, brings the experience, scale, and operating discipline required to procure and enable Microsoft solutions. Microsoft solutions encompass innovative products and services such as AI, cloud computing, productivity tools like Microsoft 365 and Teams, and advanced hardware like Surface devices, designed to enhance personal and business efficiency, creativity, and connectivity. WWT can support the RHTP Program (and Healthcare Partners) in negotiating and structuring Microsoft Enterprise Agreements, as well as build the broader commercial and operational frameworks required to manage Microsoft successfully over the life of the relationship. A Microsoft agreement must support more than procurement. It must create a stable foundation for: • Secure statewide collaboration • Identity modernization • Endpoint and device governance • Security and compliance expansion • Cloud adoption and optimization • Future AI readiness Without a disciplined commercial structure and governance, organizations often end up with fragmented purchasing, limited transparency, pricing exposure, duplicated services, or agreement terms that do not align with actual modernization priorities. WWT helps prevent this by ensuring the commercial model is built to support the technology strategy, not work against it.	WWT would serve as the Alaska RHTP Program's strategic Microsoft commercial advisor and program partner. Our role is: • Understand the most appropriate Microsoft agreement structure based on current needs and future modernization goals • Establish a like-for-like baseline of licensing, cloud usage, support constructs, and projected growth • Evaluate Enterprise Agreement, Microsoft Customer Agreement, and Cloud Solution Provider options with clear trade-off analysis • Guide commercial negotiations with Microsoft using fact-based benchmarks and governance • Build a long-term management framework for renewals, true-ups, optimization, support alignment, and ongoing commercial transparency Our approach is designed to remove ambiguity, reduce risk, and ensure the RHTP participants enter Microsoft negotiations with a clear understanding of what it has, what it needs, and what commercial structure best supports its long-term objectives. WWT would help the Alaska RHTP Program (and Healthcare Partners) through the full Microsoft commercial lifecycle: 1. Discovery and Baseline We begin by understanding the State's current environment, planned modernization roadmap, organizational structure, projected user base, and existing Microsoft or adjacent technology investments. The goal is to establish a clear and defensible baseline of current and future need. 2. Scenario Modeling We then evaluate the available commercial paths. This includes modeling Enterprise Agreement versus other Microsoft channels, identifying where price protection matters most, and aligning commercial options to the State's operational realities and funding profile. 3. Negotiation Readiness WWT prepares the State for commercial engagement with Microsoft through pricing transparency, market perspective, benchmark validation, and clear recommendation of the preferred structure. 4. Negotiation Support WWT can operate as first chair or second chair in Microsoft discussions, depending on the State's preference. In either posture, our role is to help drive disciplined, fact-based negotiation and avoid unnecessary commercial complexity. 5. Ongoing Governance After the agreement is established, WWT remains engaged to support lifecycle management, reporting, optimization, true-up preparation, roadmap alignment, and future renewal planning.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

WWT’s strength is that we stay engaged beyond the initial transaction and help clients actively manage the agreement over time.



World Wide Technology	Microsoft Enablement and Solutions Delivery	AK	Healthcare delivery across Alaska is challenged by geographic isolation, limited specialist availability, and fragmented technology environments that make collaboration between regional hospitals, clinics, and public health organizations difficult. Many providers rely on disconnected communication tools, legacy identity systems, and inconsistent device management models, which limits the ability of clinicians to securely access systems, consult with specialists, and coordinate care across organizations. These constraints are particularly impactful in rural and frontier communities, where clinicians must often operate with smaller teams and limited on-site expertise. This project presents an opportunity to establish a secure, modern Microsoft-based healthcare collaboration platform that connects providers across Alaska and enables clinicians to access expertise, information, and collaboration tools regardless of location. WWT, in partnership with Microsoft, will implement an identity and collaboration foundation built on: -Microsoft Entra ID, Microsoft 365, and modern endpoint management with Intune -Microsoft Teams (Telehealth), SharePoint, Dragon Copilot (Ambient Listening for Clinician/Patient Transcription/Summarization) -Microsoft’s security framework, including Conditional Access and Microsoft Defender, enabling secure remote access for healthcare professionals working in distributed locations -Support for innovation such as AI-assisted clinical workflows	WWT proposes a structured five-year modernization program designed to strengthen collaboration, security, and operational sustainability across Alaska’s healthcare ecosystem while ensuring uninterrupted care for rural and frontier communities. We recognize this transformation must balance modernization with the realities of geographically dispersed care delivery, limited local technical resources, and existing infrastructure constraints. The program begins with a focused Discovery and Assessment phase, where WWT collaborates with RHTP AK Program leadership, regional hospitals, and clinical stakeholders to evaluate the current technology landscape across identity, endpoint management, collaboration platforms, security posture, and cloud readiness. This assessment identifies barriers preventing clinicians from securely accessing systems, collaborating across organizations, and efficiently coordinating care—particularly in rural environments where staff and technical resources may be limited. Following discovery, WWT will lead a Solution Architecture and Design phase establishing a secure, scalable Microsoft platform leveraging Microsoft Entra ID, Microsoft 365 (Teams, SharePoint, OneDrive), Microsoft Intune, Microsoft Defender, Microsoft Purview, and Azure cloud services. Together these technologies allow clinicians to securely communicate, share information, and access systems regardless of location while maintaining strict governance over sensitive healthcare data. To ensure reliability across Alaska’s diverse infrastructure environments, WWT will validate key components through targeted proof-of-concept deployments before statewide rollout. Implementation will follow a phased rollout model, prioritizing foundational capabilities such as identity modernization, secure collaboration, and endpoint management. Later phases expand Telehealth, Clinical Workflow enablement (including Dragon Copilot), security, data governance, and cloud capabilities through Defender, Purview, and Azure to support long-term scalability and innovation. WWT will also leverage insights from successful urban/rural/tribal healthcare programs. Through this approach, WWT and Microsoft will establish a secure collaboration platform that expands access to expertise, strengthens care coordination, improves Clinician productivity and improves healthcare delivery for communities across the state.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

World Wide Technology	Sovereign Health Program: Intelligent Edge, Secure SD-WAN Network & AI-Driven Observability	AK	Rural healthcare facilities face challenges in enhancing the ability to deliver quality care efficiently, effectively and securely. Connectivity and Bandwidth Limitations: WWT's Intelligent Edge Solution (IE) optimizes the use of available bandwidth by dynamically routing traffic over multiple connections, such as broadband, LTE, and MPLS, ensuring reliable connectivity. This is crucial for telemedicine services, which require stable, high-speed internet for video and data sharing. Ineffective Management of Resources: IE allows IT teams to manage the entire network from a single interface, reducing the need for on-site technical support. Security: Healthcare facilities handle sensitive HIPAA patient data. IE enhances security by integrating advanced security features such as encryption, firewalls, and intrusion prevention systems directly into the network. Scalability and Flexibility: IE provides the flexibility to add new sites and services without significant infrastructure changes. This is beneficial for rural healthcare providers looking to expand telehealth services. Cost Efficiency: IE reduces costs by allowing the use of more affordable broadband connections while maintaining performance and reliability. Improved Application Performance: An IE prioritizes critical healthcare applications, ensuring they receive the necessary bandwidth required. This is essential for EHR systems, which need to be accessible and responsive to support patient care.	In order to meet this challenge, we must take the Wide Area Network (WAN) in its totality. An architecture that encompasses SD-WAN, Firewalls, East/West Traffic Management, along with circuit management/telemetry, AI, Observability. An approach which has proven itself within Alaska's largest provider, Providence Health. Our approach, while holistic is not bound by any one technology OEM. The WWT ATC can support the proving out of any specific use case we have not already vetted across infrastructure, data, and AI, security, and cloud. The ATC is where we partner in the testing of products and architectures to help Healthcare leaders make informed technology decisions. North America Integration Center (NAIC) Much like the pre-fabrication of buildings shipped to the North Slope, WWT has the ability to pre-fabricate technology and deliver it to remote locations. This reduces technology and supply chain challenges in rural sites, while delivering an operationally excellent outcome. IE can leverage other funding mechanisms to support Bandwidth and Cloud Adjacency. Universal Service Administration Co. (USAC) Rural Healthcare support for broadband has been a rural enabler, offsetting 65% of the Underlay/Overlay costs. We have yet to fully appreciate the impact of Alaska's Broadband Equity, Access, and Deployment (BEAD) and how this will support Rural Broadband. WWT is currently in discussions to better understand 2026 BEAD Program potential impact. 24/7 operational support of this service is another critical component of an IE and WWT proposes phased options. These options include leveraging what is already in place, to building this capability within AK, to leveraging the Providence Global Center (PGC) capability who supports the Infrastructure and Helios (AI/Observability Platform) for Providence AK. In order to drive efficient change, we are proposing a three phased delivery methodology: Phase 1: Requirements and Design definition builds a foundation of scope, aligned to expected outcomes. Phase 2: Enablement begins once we define the outcome and agree upon the work/effort/cost involved in its achievement, we ensure compliance with RHTP/DOH policy and manage funding/outcome. Includes Solution Development, Testing and User Group Enablement. Phase 3: Operate confirms the solution operates to a set of SLA's in	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

combination with a Continuous Improvement process so that the solution continues to meet Rural Healthcare’s evolving needs.



Wrangell Public School District	Grow Our Own: VR-Enabled K-12 Healthcare Certification Pipeline for Rural Alaska	AK	Alaska’s RHTP Strengthen Workforce Initiative has explicitly identified “Grow Our Own” pipelines as a top priority, calling for programs that prepare rural students for healthcare certification while allowing them to remain in or near their home communities. Two intersecting barriers block that STEM continuum: the absence of local, advanced-level health science instructional expertise, and the digital divide in villages like Wrangell. WPSD has a dedicated science teacher, but they lack the specific background to teach advanced subjects like anatomy and physiology. Consequently, our rural students have limited exposure to foundational healthcare concepts, creating an inequitable gap in career-connected learning. This lack of early exposure directly exacerbates our health workforce shortages, as fewer rural youth are inspired or prepared to pursue healthcare careers. Without foundational coursework available locally, rural students have limited opportunities to build the knowledge base needed to pursue certification as CNAs, EMTs, BHA/Ps, CHA/Ps, DHATs, & CHAs — the roles most critically understaffed in remote Alaska. The opportunity is to eliminate both barriers simultaneously by bringing advanced-level health-related instruction directly to students via VR technology, creating high school certification programs, and retaining local talent to provide healthcare services in a single deployment.	Our approach is to implement a healthcare professional career track in Wrangell Public School District’s (WPSD) middle school and high school that provides (a) students with instruction for healthcare careers, (b) teachers with training to support advance-science content courses, (c) offers the potential for dual credit and micro-credentialing to students, and (d) partners with local healthcare professionals for student training. We will leverage syGlass technology, an innovative VR technology K-12 to Medical School STEM instructional model, across the program. WPSD will distribute the VR technology and headsets, instantly transforming any space into an advanced science/health learning environment. WPSD will conduct a 5-year program: Year-1 pilot implementation to optimize a syGlass technology and curriculum deployment; Year 2 WPSD full-program implementation, partnership expansion with neighboring school districts, and local healthcare systems (e.g., Southeast Regional Hospital); and Years 3-5 ongoing WPSD implementation, implementation in neighboring school districts and regional school district consortium, and dual credit and micro-credentialing with Alaska colleges/universities. To ensure successful adoption, we will use our phased Pre-Launch, Launch, and Sustain implementation framework. Students will be guided through highly detailed, interactive 3D anatomical models by world-class experts, ensuring they receive the highest quality instruction regardless of their geographic location. The curriculum goes beyond passive viewing by integrating active learning experiences and formative assessments directly within the 3D VR environment. Students must demonstrate their understanding by completing spatial and conceptual assessments in VR. The curriculum is aligned to Alaska K–12 Science Standards, CTE Health Science pathway standards (Perkins V-eligible), and supports direct entry into certification pathways including CNA, CHA/P, EMT, BHA/P, DHAT, CHW, and Medical Laboratory Personnel. We will coordinate our program with existing healthcare workforce programs (e.g., Alaska AHEC). We will provide teachers with synchronous and asynchronous job-embedded professional learning to advance their skills and content development, as desired. syGlass’s 96.6% student engagement rate and proven instructional outcomes, combined with WPSD’s STEM and CNA training program, position this program to build a local healthcare workforce pipeline in Wrangell and beyond.	\$250K-\$1M	Single Community	Wrangell (City and Borough)	Advance to Implementation Application

xpio group health, llc	Alaska Rural Behavioral Health Technology and Data Transformation	WA	Alaska's rural behavioral health providers operate on fragmented, poorly optimized technology that prevents effective care coordination, outcomes measurement, and participation in value-based payment models. Community mental health centers and substance use treatment providers across rural and frontier Alaska use EHR systems that are misconfigured for their clinical workflows, cannot exchange data with hospitals, tribal health organizations, or state agencies, and lack basic cybersecurity protections for the highly sensitive data they hold under 42 CFR Part 2 and HIPAA. The result: clinicians cannot see what happened to a patient in crisis who was treated at another facility. DOH cannot track follow-up rates for Medicaid youth after behavioral health hospitalization. Providers cannot generate the quality data needed to shift toward value-based care. And every technology investment the state makes sits on an insecure foundation vulnerable to breach. This project addresses that gap by optimizing EHR systems, deploying interoperable data exchange connecting rural behavioral health providers to statewide health information infrastructure, and establishing cybersecurity baselines — building the technology foundation Alaska needs to achieve its RHTP goals across Initiatives #2, #4, and #6.	Xpio Health will leverage our existing relationships with 25 Alaska behavioral health providers and ABHA to execute a phased project across three workstreams. EHR Optimization: Conduct assessments at participating rural behavioral health providers to identify configuration gaps in clinical documentation, billing, quality reporting, and data capture. Deliver hands-on remediation including workflow redesign, staff training, and system configuration so providers can capture complete, accurate data — the prerequisite for everything else. Interoperability & Data Exchange: Design and deploy standards-based interfaces connecting rural behavioral health providers to Alaska's statewide HIE and state reporting systems. Priority use cases include behavioral health care transitions, crisis notifications, medication reconciliation, and outcomes reporting. We bring proven capability here — Xpio's leadership operates Idaho's statewide HIE, where we delivered 1.5 TB of FHIR data at a 99.96% patient match rate across rural and frontier providers. Our Pryzma platform provides Mirth Connect open source integration and automated state reporting already in production for behavioral health systems. Cybersecurity & Compliance: Perform HIPAA Security Risk Assessments and cybersecurity evaluations at each participating provider. Establish incident response plans, 42 CFR Part 2 compliance frameworks, and ongoing monitoring through our Xpio+Vanta compliance platform. This protects sensitive behavioral health data and ensures RHTP investments are sustainable. Timeline: Months 1-8 focus on EHR optimization and cybersecurity baselines. Months 6-18 deploy interoperability infrastructure. Months 15-24 support value-based care readiness and document a replicable model for scaling to additional regions in RHTP Years 2-5. Because Xpio already works with these providers, and with ABHA, we can begin immediately with no procurement delays or relationship-building ramp-up.	\$1M-\$5M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yakutat Air	Alaska Bush Medicine Training Initiative: Strengthening Alaska’s rural emergency response network.	AK	Alaska’s vast geography and limited transportation infrastructure mean that many remote communities, wilderness tourism sites, and lodges are located hours from the nearest medical services. In these high-risk environments, bush pilots, wilderness guides, and lodge operators are often the first on scene during medical emergencies including injuries, hypothermia, drug overdose. However, they typically have little or no formal emergency medical training, and delays in initial stabilization can significantly affect patient outcomes. Alaska’s aviation network includes an estimated 2,000 bush pilots and air taxi operators who transport people to remote locations not connected by roads. The state also hosts hundreds of remote fishing lodges and wilderness tourism operations that rely on aviation access. The Alaska Bush Medicine Training Initiative will strengthen Alaska’s rural emergency response network by providing bush pilots, wilderness guides, and remote tourism operators with immersive simulation training and practical emergency stabilization tools. Using a virtual Reality training platform capable of remote instruction and operation in offline environments, the program will deliver realistic emergency training to remote, difficult to reach locations. By expanding the capacity of non-medical responders to stabilize patients until evacuation is possible, the project will improve early response capability and help save lives in Alaska’s most remote regions.	The Alaska Bush Medicine Training Initiative will expand rural emergency response capacity by delivering immersive virtual reality (VR) training and emergency stabilization tools to wilderness operators, bush pilots, and remote tourism providers across Alaska. Yakutat Air will lead the initiative, coordinating scenario development, program deployment, and training distribution in partnership with SimX, which will develop the immersive VR simulations and provide the training platform. In Year 1, Yakutat Air and SimX will collaborate with experienced bush pilots, wilderness guides, and emergency response professionals to develop five VR training scenarios tailored to medical emergencies commonly encountered in Alaska’s remote environments. Core scenarios will include severe bleeding and tourniquet use, hypothermia and cold-water immersion, opioid overdose and Narcan administration, bear or wildlife attack trauma, and remote patient stabilization while awaiting evacuation. These simulations will replicate realistic environments and allow participants to practice recognizing emergencies, making rapid decisions, and performing basic stabilization steps before professional medical evacuation arrives. In Years 2 and 3, the program will deploy VR training equipment and emergency stabilization kits through a hybrid delivery model. Yakutat Air will serve as a permanent training hub, while additional VR headsets will rotate among remote lodges, air taxi operators, and wilderness tourism operators throughout Southeast Alaska and other rural regions. Yakutat Air will use its aviation network to deliver equipment and facilitate training sessions at remote sites that are difficult to reach through conventional training programs. Each participating location will receive access to immersive training modules as well as Remote Emergency Stabilization Kits containing essential tools such as tourniquets, Narcan, glucose, and emergency blankets. By pairing hands-on tools with simulation-based training, participants will gain both the knowledge and resources needed to stabilize affected individuals. Project evaluation will measure the number of remote locations served, the number of wilderness operators participating, the number of individuals trained, and improvements in emergency response knowledge and simulation performance. These findings will inform refinement of the training program and support potential expansion to additional rural regions across Alaska.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Chugach Census Area; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Skagway (Municipality); Yakutat (City and Borough)	Deferred or Not Advanced

Yakutat Tlingit Tribe	Yakutat Workforce & Enhanced Rural Care Initiative	AK	Aligned with the State’s focus on improving health outcomes for all Alaskans, Yakutat’s North Star in this project is improving overall health outcomes for chronically ill patients, many of whom are elders. Yakutat is a remote, isolated community accessible only by plane or boat. Geographic isolation, weather disruptions, housing shortages, and high operational costs create persistent barriers to healthcare access. Recruiting and retaining qualified providers is challenging, and reliance on outside workforce models is not sustainable long-term. At the same time, our population is aging, and chronic disease rates continue to rise. Patients often experience gaps in follow-up between visits, and elders and high-risk individuals are especially vulnerable during emergency events. While telehealth expansion during COVID improved access, rural residents continue to value in-person care and trusted provider relationships. Many emerging care models attempt to replace traditional delivery with virtual services; however, that approach does not fully address rural Alaska’s realities. The opportunity is to strengthen traditional care by building local workforce capacity and enhancing continuity of care. By developing Community Health Workers from within the community and pairing them with strategically applied remote support tools, we can improve access, quality, and long-term sustainability without sacrificing relationship-based care.	Our approach is workforce-first and community-based. We will build local healthcare capacity by recruiting and training Community Health Workers (CHWs) from within Yakutat. These CHWs will be trained to support chronic disease management, conduct wellness checks, assist with care coordination, and provide follow-up between provider visits. To strengthen clinical capability and emergency response integration, CHWs will receive EMT-level training (ETT, EMT, or EMT-I), either through an onsite training partnership or contracted instructors brought to Yakutat. Training locally addresses two barriers at once: workforce shortages and housing limitations that make recruitment difficult. By developing our own workforce, we create sustainable career pathways for residents while expanding healthcare access. The Yakutat Senior Center will serve as a community health hub and operational base for CHWs. Targeted infrastructure and equipment upgrades will support training, coordination, and service expansion. The Center will also function as a support location during emergencies, improving resilience for elders and high-risk individuals. This project does not replace traditional care delivery. In-person provider relationships remain primary. We will implement remote monitoring strategically—only where clinically actionable—to support provider decision-making between visits. CHWs will assist patients with understanding and using monitoring tools, ensuring technology enhances rather than replaces relationship-based care. Daily review of physiologic data with defined intervention thresholds and structured provider notification protocols. CHWs will also support transitional care management following hospital discharge to reduce preventable readmissions and ensure safe recovery in the home setting. We will work closely with the Yakutat Community Health Center and EMS partners to develop coordinated workflows and compliant third-party billing pathways for eligible services delivered in community or alternate settings. This integration strengthens access, improves continuity of care, reduces preventable emergency utilization, and builds long-term financial sustainability. Medication reconciliation and coordination with primary care providers to support timely titration and care plan adjustments By combining local workforce development, enhanced care coordination, and strategic technology support, this approach strengthens traditional rural healthcare delivery.	\$250K-\$1M	Single Community	Yakutat (City and Borough)	Advance to Implementation Application

Yakutat Tlingit Tribe	Yakutat Community Health Center Dental Clinic Service Expansion Improvements	AK	Yakutat’s geographic isolation creates significant barriers to specialty dental care. Due to limited equipment, many procedures cannot currently be performed in the community. Patients must travel by commercial air to receive higher-level care, resulting in: High transportation and lodging costs Weather-related delays Missed school and subsistence activities Delayed or deferred treatment Increased risk of preventable dental infections Oral health disparities in rural Alaska include high rates of untreated decay and advanced periodontal disease. Due to historical trauma in remote villages of Alaska, dental phobia is high and trust is hard earned. Dental anxiety is a significant barrier that prevents many individuals from seeking timely treatment, often leading to more complex oral health issues. The current equipment limitations restrict the visiting dentist’s ability to provide comprehensive care, increasing outside referrals and avoidable system costs. The opportunity is to transform the local dental program from a limited-service clinic to a more comprehensive rural dental hub capable of providing advanced care in-community.	We propose to expand in-community dental service capacity through strategic capital investment in: Electronic Patient Record that communicates with the existing Medical Patient Record Prosthodontic instrumentation and equipment for implants Surgical instrumentation and equipment for complex extractions Orthodontia scanner and clear aligner program fees Guided Biofilm Therapy unit for Periodontics Equipment and practices installed to reduce dental fear These upgrades will allow the visiting dentist to perform procedures that are currently referred out. Implementation steps include: Equipment procurement and installation Staff training and calibration Workflow redesign to maximize visiting provider productivity Data tracking of referral reductions and travel cost avoidance The approach focuses on cost-effective infrastructure enhancement rather than workforce expansion, making it sustainable within Yakutat’s existing staffing model.	\$250K-\$1M	Federally qualified health center	Single Community	Yakutat (City and Borough)	Deferred or Not Advanced

Yakutat Tlingit Tribe	Yakutat Community Health Center Improved Care Capacity through Health Warehouse renovation	AK	The clinic facility is stocked with medical, maintenance, and equipment supplies. The emergency vehicle garage cannot be used for its primary purpose as it is filled with essential equipment and supplies needed to operate the facility. Limited space has required several versatile rooms to be used for storage rather than for medical care. Additional impacts include improper storage of medical gas, occasional egress infringements, and off-site storage of patient transportation and facility maintenance vehicles. Energy costs in Yakutat are very high, significantly higher than most communities in S.E. Alaska, with fuel costs exceeding \$5 per gallon and continuing to rise. Heating costs for the existing warehouse are estimated to exceed \$12,000 per year. The proposed project is anticipated to reduce heating costs by approximately \$8,000 annually by connecting the facility to the heat recovery district heating system. The current warehouse facility lacks dedicated water service. Maintenance tasks such as vehicle cleaning and equipment repair are difficult. Water must be supplied through a hose from the health center across the parking lot or hauled in. This limits water availability, particularly in winter, reducing maintenance efficiency. Providing dedicated maintenance space and storage with a low-cost operational model will allow YCHC to expand care options, reduce safety and code concerns, improve operational efficiency, and lower costs in both the short and long term.	The solution to the proposed project is to build simple, cost-effective, and collocated storage space for the Health Center's benefit. The proposed project will renovate the interior to include a mezzanine within the YCHC Warehouse facility, add piped water service, and a piped connection to the existing waste heat recovery district heating system for the facility. This project improves access to care and sustainability by renovating existing storage space to drastically expand healthcare facility maintenance and storage capacity, providing collocated emergency vehicle storage, reducing facility operations costs, and expanding available space for care provision in the Health Center. This will reduce heating costs by 66% in the facility and expand supplies/equipment storage by 1,000 square feet. Additionally, improved maintenance space and vehicle storage will extend the useful life of equipment, improve efficiency and efficacy of building maintenance functions. The additional storage space will open up multiple rooms within the Health Center for expanded and improve space allocation for medical services.	\$250K-\$1M	Federally qualified health center	Single Community	Yakutat (City and Borough)	Deferred or Not Advanced

YMCA of Alaska	Alaska Rural Youth Injury Prevention & Safe Sport Infrastructure Initiative	AK	According to the Alaska Department of Health, Alaska has the highest drowning rate in the nation, with rural regions experiencing the highest rates in the state. Unintentional injury remains a leading cause of death among youth, and extended EMS response times in remote communities increase the importance of local emergency response capacity. While youth sports and recreation provide critical protective benefits, many rural communities lack standardized safety protocols, certified responders, and trained officials. Emergency preparedness during community sporting events is inconsistent. This initiative establishes a structured, deployable injury prevention model that strengthens rural community safety infrastructure through training, certification, and workforce development. By integrating emergency response capacity into youth sports systems, the project reduces preventable injury risk while creating paid youth employment pathways.	The YMCA of Alaska will deploy a traveling Youth Injury Prevention Team to 4–6 rural Alaska communities annually. RHTP funds will support: - Deployment of certified CPR/AED instructors to rural sites - Training of volunteer coaches and youth officials in First Aid, concussion protocols, and emergency response - Development of standardized Emergency Action Plans for participating facilities - Creation of a Youth Referee Certification & Paid Placement Pipeline - Training-of-trainers model to build local certification capacity - Workforce scholarships for youth participants - Injury prevention data tracking and evaluation systems Each participating community will receive comprehensive in person training sessions, written safety protocols, and follow-up support to ensure sustained implementation. The initiative combines injury prevention education, workforce development, and emergency response readiness into a replicable rural safety infrastructure model.	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Bristol Bay Borough; Kenai Peninsula Borough; Kodiak Island Borough; Kuskilvak Census Area; Nome Census Area; Northwest Arctic Borough	Deferred or Not Advanced

YMCA of Alaska	Alaska Statewide Aquatics Safety & Lifeguard Workforce Initiative	AK	Drowning is a major, preventable injury burden in Alaska. Alaska DOH surveillance recorded 342 drowning deaths during 2016–2021 and noted Alaska had the highest age-adjusted drowning rate in the U.S. in 2021. Rates are disproportionately high in rural regions (Southwest 31.1 per 100,000; Northern 26.8 per 100,000). At the same time, Alaska lacks a coordinated, scalable in-state system to deploy certification instructors to rural communities on a regular cycle—limiting local capacity to staff pools safely, provide consistent swim and water-safety programming, and maintain rapid response readiness for water emergencies. This project addresses a clear rural health transformation opportunity by building public safety infrastructure through workforce credentialing that is deployable, measurable, and sustainable.	The YMCA of Alaska will establish and deploy a traveling aquatics certification team to deliver industry-recognized credentials to rural and regional Alaska communities (initially 6–10 communities in year one, with expansion in subsequent cycles). This approach is designed as injury prevention infrastructure and public safety workforce development, not construction. Activities include: Delivering lifeguard, CPR/First Aid, and rescue-related certification courses locally (reducing travel barriers for rural residents) Building a rural youth/young-adult employment pipeline through credential attainment and job readiness Supporting community facilities’ ability to operate safely by increasing the supply of certified staff Strengthening emergency response capacity by expanding the number of trained responders present in communities Tracking certifications and participation as measurable outputs tied to injury-prevention objectives Integrating DOH-informed prevention emphasis. DOH surveillance shows 39% of non-occupational drownings involved boating and PFD non-wear reached 88% in boating-related drownings (2019–2021), underscoring the need for practical safety skill-building and reinforcement of preventive behaviors.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Nome Census Area	Deferred or Not Advanced

YMCA of Alaska	YMCA of Alaska – Lake Otis Preventative Health Activation Project	AK	Alaska faces persistent challenges in chronic disease prevalence, workforce shortages, youth behavioral health concerns, and limited preventative infrastructure capacity. Community-based prevention systems are critical to reducing long-term healthcare costs and supporting rural health stability. The Lake Otis YMCA has reached physical capacity and cannot expand preventative health programming, physician-referred services, or youth protective engagement initiatives. Current space constraints limit enrollment, reduce referral acceptance, and require rental of external facilities for youth sports. This project presents an opportunity to activate expanded preventative health capacity within an existing community institution to strengthen access, workforce stability, and rural continuity of care.	The YMCA of Alaska will activate expanded prevention infrastructure at its Lake Otis facility through a hybrid capital activation and program integration strategy. While construction of a 20,400-square-foot addition is being funded through diversified sources, RHTP funds will support activation of the expanded space for health system transformation outcomes, including: • Development of formal healthcare referral pathways with Alaska-based hospital systems • Expansion of chronic disease prevention and physician-referred wellness programming • Transition support for cardiac rehabilitation and post-acute recovery patients • Expansion of youth sports as behavioral health protective factors • 24-hour access to structured fitness to accommodate healthcare workforce shift schedules • Workforce family stabilization through expanded childcare capacity • Equipment acquisition and program staffing to operationalize expanded capacity • Data tracking and evaluation infrastructure to measure prevention impact Statewide construction partners Watterson Construction and Bettisworth North are leading the design and build process, reinforcing Alaska-based collaboration and economic sustainability. The project will provide 24-hour facility access to accommodate healthcare workforce shift schedules and reduce barriers to preventative wellness participation. Expanded childcare capacity and scholarship support will reduce workforce strain and help retain clinical staff serving Alaska’s rural communities.	\$250K-\$1M	Statewide	Anchorage (Municipality); Kodiak Island Borough; Matanuska-Susitna Borough	Deferred or Not Advanced

You Aesthetics LLC	Healthcare Access Expanding Essential Services in Remote Frontier Areas	AK	Rural and frontier Alaskan residents face significant barriers to specialized preventative care for chronic conditions such as obesity, prediabetes/type 2 diabetes risk, and women's hormonal imbalances. Limited local access contributes to higher preventable disease rates, poorer outcomes, and elevated long-term healthcare costs. As an Anchorage-based clinic specializing in GLP-1 therapies and women's hormone health, we are well-positioned to extend evidence-based preventative services via telehealth to bridge these gaps.	You Aesthetics proposes expanding our evidence-based telehealth program to deliver GLP-1 agonist therapies for weight management and chronic disease prevention, combined with women's hormone health optimization. Funds will support: (1) enhanced secure telehealth infrastructure and remote monitoring tools, (2) targeted training for rural clinic staff, and (3) outcome tracking (e.g., weight reduction, improved metabolic markers, symptom relief). This enables sustainable, locally supported preventive care for rural patients without requiring travel to Anchorage.	\$250K-\$1M	Clinic	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Youth Advocates of Sitka Inc	Coastal Haven - Increasing Access to Mental Health Treatment for Our Youth	AK	Rural children and adolescents in Alaska face many barriers to seeking mental health and substance use treatment, including stigma and limited resources such as women's shelters or domestic violence support. Alaska Native youth are more likely to experience adverse childhood experiences that have a significant impact on future violence victimization and perpetration, and lifelong health and opportunity. Alaska Native girls and young women have historically experienced high rates of rape, domestic violence, sexual assault, suicide, mental health, and substance use. These experiences create vulnerable youth that can easily become homeless or trafficked, or worse, becoming another statistic for missing and murdered indigenous women and girls. These youth may have experienced a history of foster care involvement, child poverty, child abuse or neglect, human trafficking, juvenile justice involvement, or substance use. Many of these youth come from a variety of settings such as residential treatment centers, homeless youth or youth living in unsafe environments. Often these youth find themselves living in unsafe environments. Many of these youth experience severe emotional disturbances or mental health challenges, and are often diagnosed with fetal alcohol spectrum disorder, autism spectrum disorder, or other developmental disabilities. Support services are limited for homeless youth, youth that have been trafficked, and youth at-risk throughout the state in general.	The overall goal of the Coastal Haven program is to prevent and reduce victimization of youths who are at risk for trafficking and homelessness. Youth Advocates of Sitka will provide delivery of multiple beneficial services such as providing basic needs, including immediate shelter, skills training, connecting individuals to employers, and providing access to long-term mental health treatment services. Coastal Haven will serve up to 10 youth at one time, who are homeless, at risk of homelessness, and human trafficking. Coastal Haven will provide basic needs, including immediate shelter, housing, skills training, connecting individuals to employers, and providing access to long-term mental health treatment services. The average length of stay in the program is about 6 to 9 months. Additionally, youth who prefer or are recommended for residential treatment at Coastal Haven have the option to matriculate to the Transitional Living Program upon discharge, ensuring programming and service availability to youth and furthering the continuum of care. The Transitional Living Program can provide safe housing for 5 youth ages 18 to 25, for up to 540 days.	\$250K-\$1M	Behavioral health/substance use disorder treatment	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yukon Koyukuk Elder Assisted Living Consortium	The Yukon-Koyukuk Elder Assisted Living Facility (YKEALF) Expansion Plan	AK	The Yukon-Koyukuk Elder Assisted Living Facility is now 17 years old and requires significant heating infrastructure improvements. Currently, we are using blankets on outside doors, plastic on windows, and 2" foam board on the dining room windows to manage the cold. The individual client's rooms have unused electric ranges and kitchen sinks that we would like to remove to allow our clients to have a safer space and more room for their belongings. The staff housing for our caregivers and cooks is approximately 40 years old and also needs upgrades, particularly for doors, windows and boiler maintenance. Regarding our residents, about 70% are affected by ADRD, and we would like to offer annual training to staff and families to assist with their care. We also want to provide our newer administrative staff with leadership and administrative training. In our Medication room, our locked cabinet needs to be replaced with a ventilated locked cabinet. Finally, as our operations are almost entirely digital, we need to ensure our IT infrastructure is secure. We purchased three new computers last year and want to ensure all devices are properly networked and maintained through professional IT support. We would like to have a website designed for potential clients and employees of YKEALF to apply and learn about our services.	Louden Council has applied for the VEEP grant on behalf of YKEALF that would cover some of the project, if awarded. (The proposed project for the VEEP grant will reduce the use of diesel fuel by replacing the non-functioning wood fueled boiler to serve as the primary heat source, repairing and optimizing the diesel fueled boiler systems to serve as back up heat source only and repairing the Energy Recovery Ventilator to ensure outside air is pre-heated before entering the building. An energy audit for the facility is also needed to specify upgrades to the building thermal envelope, windows, doors and lighting as currently there is significant air infiltration causing uncomfortable living conditions for the community elders.) We can potentially use the same auditor and construction company to do work on staff housing. (The renovation of the windows and doors of YKEALF and control panel will be in phase 2 of the VEEP grant if awarded.) Sustainable Energy of Galena Alaska, Inc. (SEGA) has done the renovation of one unit, removing the electric range and sink) and know the process of renovating other units. The cabinet will be purchased from ULINE. It is a ventilated locking cabinet. The training will be provided by Alzheimer's Association of Alaska and University of Alaska Anchorage trainers. Other trainings would be "training the trainer" so that we could eventually lead a more in house training. The administrative and leadership trainings would be courses, trainings and workshops that will cover all topics of ALH Administration such as business, management, human resources, Food Service and specialized health care. The IT support would be provided by IT Guys. The website will be done by WEB907.	\$50,000-\$250,000	Home- and community-based services provider	Multi-Community or Participating in Regional Hub-and-Spoke	Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon West Defense Technologies LLC	Mountain Village RX Kiosk	AK	Mountain Village faces ongoing barriers to timely prescription access, particularly for patients who must navigate long travel distances, transportation challenges, weather-related disruptions, workforce shortages, or limited pharmacy availability. These barriers can delay treatment, interrupt continuity of care, and make it harder for patients to begin and maintain prescribed therapies. In some cases, patients receive a prescription during a care encounter but still face significant obstacles to obtaining the medication in a timely and reliable way. The RX Kiosk is intended to address that gap by creating a more accessible, dependable, and patient-centered medication access pathway. The opportunity is to strengthen how our organization supports the community after a prescription is written, especially in cases where traditional pharmacy access may be limited or inconsistent. By improving access to medications closer to where patients live and receive care, we can reduce delays between prescribing and dispensing, support continuity of care, and improve the overall patient experience. This project also represents an opportunity to build a more sustainable rural access model by using practical infrastructure and local partnership to better meet the needs of our community.	Our proposed approach is to implement a secure automated prescription access model as part of a broader effort to strengthen medication access and care delivery in Mountain Village. The project will be designed to complement existing clinical and pharmacy services by creating a structured, technology-enabled pathway for eligible patients to obtain prescribed medications more efficiently. Implementation will focus on several core elements. First, we will identify the highest-priority use cases for the project based on community need, care delivery goals, and patient access challenges. Second, we will work with relevant pharmacy, clinical, operational, and technology stakeholders to define the appropriate operating model, site placement, workflows, and oversight structure. As part of this process, we will identify and evaluate an appropriate vendor partner with experience in secure automated prescription access technology and determine the solution that best fits our clinical, operational, and community needs. Third, we will plan for the operational components needed to support implementation, including system integration, staff training, patient education, and ongoing monitoring. This approach is intended to ensure that the project is not implemented as a standalone technology purchase, but as part of a coordinated care access strategy that fits our local environment and supports existing services. We expect the project design to reflect the realities of our service area, available partnerships, and long-term sustainability goals.	\$50,000- \$250,000	Single Community	Kusilvak Census Area	Deferred or Not Advanced

Yukon-Koyukuk School District	Pathways for Alaskas Technical Healthcare Careers - PATH	AK	YKSD serves remote Alaska villages where geographic isolation, workforce shortages, and limited emergency response capacity restrict access to care. Many communities depend on traveling providers, expensive medevac services, and clinics with few staff. Managing chronic illnesses, supporting behavioral health, and preparing for emergencies remain ongoing challenges. Healthcare support jobs make up a large part of the U.S. workforce, with about 1.4 million nursing assistants employed nationwide (BLS). Nursing assistants rank third among healthcare roles, after RNs and home health aides, highlighting the high demand for them. Although growth is modest at around 2% through 2034, there will be over 200,000 job openings each year for replacements, due to ongoing turnover and the need for a steady supply of credentialed workers (BLS & ONET). In rural Alaska, local workforce development is essential. Without structured pathways, students lack accessible routes into credentialed careers, and villages remain dependent on external staffing. Additionally, rural clinics increasingly deploy telehealth and remote patient monitoring devices, yet lack trained local support for setup and troubleshooting. This project directly addresses rural workforce shortages, strengthens technology-enabled care capacity, and enhances community-level emergency preparedness across the Doyon region of Alaska partnering with multiple school districts.	YKSD will implement a three-year Rural Health Workforce & Emergency Readiness Initiative beginning August 2026. The program integrates clinical training, behavioral health awareness, remote patient monitoring support, and emergency response readiness to strengthen rural healthcare delivery in Yukon-Koyukuk communities. CNA & Clinical Pathway: Students complete Medical Terminology, First Aid/CPR, Basic Life Support, Emergency Trauma Care, Teen Mental Health First Aid, and Certified Nursing Assistant coursework aligned with the University of Alaska Fairbanks Community & Technical College. Dual credit creates a direct pathway to postsecondary healthcare careers. Behavioral Health Foundations: Training in trauma-informed care, crisis awareness, and behavioral health fundamentals prepares students to support early identification and referral for mental health needs in rural communities. Remote Patient Monitoring & Telehealth Support: In partnership with Remote Hands Alaska and T3 Alliance, students earn micro-credentials in telehealth device setup, remote patient monitoring support, and HIPAA data practices. Supervised Work-Based Learning placements that assist village clinics and residents with device installation and troubleshooting. Emergency Response Readiness: Students receive training in triage awareness, incident support, and documentation protocols that strengthen community readiness during health emergencies. Stackable Credentialing: Competency-based digital badges lead to industry-recognized credentials that support employment in one of the nation’s largest healthcare support sectors while expanding the rural clinic workforce and technology capacity	\$250K-\$1M	Multi-Community or Participating in Regional Hub-and-Spoke	Copper River Census Area; Denali Borough; Fairbanks North Star Borough; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Koyukuk School District	WRAP: Wellness, Resilience, and Prevention Initiative	AK	Yukon-Koyukuk School District serves approximately 4,500 students and staff across village schools and Raven Homeschool, where these communities face limited access to consistent behavioral health support, prevention-based mental health resources, and structured social-emotional intervention. Recent mortality data estimates the suicide rate in the Yukon-Koyukuk Census Area at approximately 69.7 deaths per 100,000 people, more than double the U.S. rate. In the past two years alone, the district and surrounding education community have experienced approximately six deaths by suicide among students and members of the education community. Contributing factors include geographic isolation, limited access to behavioral health professionals, intergenerational trauma, substance misuse, seasonal affective disorder (SAD), and limited prevention-focused supports. Because schools are often the most consistent anchors within these communities, strengthening school-based behavioral health capacity offers a practical pathway for earlier identification, prevention, and connection to care.	Our proposed approach is to strengthen school-based behavioral health access across Yukon-Koyukuk School District’s remote communities by building a practical, locally anchored support system that helps students and staff receive earlier intervention, stronger prevention services, and more consistent pathways to care. Because many communities face significant transportation and accessibility limitations, schools often serve as the most consistent setting for identifying behavioral health needs and linking families to support. This project would strengthen that role by adding qualified counselors and social work capacity within the district while also equipping school staff with clearer protocols for response, curriculum, referral, and ongoing coordination when concerns arise. The approach combines direct intervention with prevention-focused systems. Counselors and social workers would provide services such as individual support, family coordination, crisis response, and referral navigation when higher levels of care are needed. In parallel, the project would strengthen school-wide prevention through evidence-based social-emotional learning (SEL), staff training, and structured supports that build resilience, emotional regulation, and positive peer relationships. The project aligns with the Healthy Beginnings initiative by expanding access to evidence-based mental and behavioral health supports in communities where access to such programming is limited. It reflects the initiative’s emphasis on strengthening mental health resilience, family engagement practices, and positive social connections as core drivers of better long-term health outcomes for youth, while using schools as trusted local settings for prevention-focused support. [2] Where possible, services would be coordinated with regional providers, tribal partners, and family supports so schools function as a practical entry point into broader care systems rather than operating in isolation. This also supports local delivery models that respect community priorities and strengthen coordination across existing support networks. Over time, this approach supports sustainability by building internal staff capacity, clearer referral pathways, and school-based systems that remain valuable beyond the grant period while helping communities respond earlier to behavioral health concerns before they escalate into more serious educational, social, or health outcomes.	\$1M-\$5M	Statewide	Anchorage (Municipality); Chugach Census Area; Fairbanks North Star Borough; Juneau (City and Borough); Matanuska-Susitna Borough; Southeast Fairbanks Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yukon-Kuskokwim Health Corporation	Bridge to Home: Behavioral Health Step-Down Care	AK	Stabilization is a critical component of care for individuals experiencing a mental health crisis, but the time required for stabilization varies based on factors such as medication adjustments, behavioral health needs, and the availability of a safe home environment. In many cases, patients may no longer require the intensive care provided in a stabilization unit but would benefit from additional monitoring and support before safely returning home. In the Yukon-Kuskokwim region, patients experiencing a mental health crisis are typically treated in the Emergency Department (ED) or the Designated Evaluation and Stabilization (DES) unit and discharged shortly after the acute crisis resolves. While this approach addresses the immediate episode, patients may still require additional time to stabilize on medications, receive care coordination, and prepare for a safe transition home. These challenges are particularly significant for individuals returning to rural villages, where transportation to and from Bethel must be coordinated and delays can create additional barriers to care. Because the ED and DES units are designed for acute stabilization, they are not structured to support longer recovery or transition periods. Establishing a behavioral health step-down unit would address this gap by providing a supportive environment where patients can continue stabilizing and safely transition back to their communities.	The proposed approach is to develop a behavioral health step-down unit that provides a supportive transition environment for patients who have stabilized from an acute mental health crisis but are not yet ready to safely return home. This unit would serve as an intermediate level of care between the crisis stabilization unit and discharge to the community. The step-down unit would allow patients additional time to stabilize on medications, participate in therapeutic activities, and build behavioral coping skills before returning to their home environment. Clinical staff would monitor patients during this transition period while providing care coordination, discharge planning, and support for reintegration into their communities. By transferring stabilized patients to the step-down unit, additional capacity would be created within the crisis stabilization unit, allowing it to remain focused on patients experiencing active mental health crises. This approach helps improve patient flow, reduces unnecessary use of emergency department resources, and ensures patients receive the appropriate level of care throughout their recovery process. Additionally, the step-down setting allows for rapid intervention if a patient experiences a recurrence of symptoms, enabling clinical staff to respond quickly without requiring a new admission through the emergency department. An initial step in implementing this model will be identifying appropriate space for the step-down unit and determining the staffing, operational protocols, and care pathways needed to support this level of service within the Yukon-Kuskokwim health system.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Kuskokwim Health Corporation	Bringing Psychiatric Care Closer to Home in the Yukon-Kuskokwim Region	AK	In the Yukon-Kuskokwim region, psychiatric services are currently provided through contracted external providers. While this arrangement ensures some level of access, it creates challenges for patients and providers, including limited continuity of care between visits, heavy reliance on tele-behavioral health services that may miss important clinical cues, and gaps in medication management and follow-up for patients transitioning from inpatient care. Establishing an in-house psychiatric care team would strengthen care coordination, improve continuity between inpatient and outpatient services, and allow patients to receive more consistent, culturally responsive behavioral health care closer to home. Building a dedicated in-house psychiatric workforce would address these challenges while improving the overall quality and accessibility of mental health services in the region.	This project proposes establishing in-house psychiatric services by recruiting and hiring two full-time psychiatrists and five advanced practice providers (APPs) with specialized psychiatric training. This staffing model would support 24-hour inpatient psychiatric coverage and strengthen coordination between inpatient and outpatient behavioral health services. Bringing psychiatric services in-house would allow patients to receive care closer to home while improving continuity of care across the treatment continuum. Local psychiatric providers would be able to oversee medication management, coordinate with behavioral health teams, and ensure appropriate follow-up after inpatient stays. This approach would reduce fragmentation in care and improve communication between providers and patients. In-person psychiatric care is particularly important for behavioral health treatment. Face-to-face visits allow providers to observe physical and behavioral cues that may not be evident during tele-behavioral visits, enabling more accurate assessments and more effective treatment planning. Having providers embedded in the community also supports culturally responsive care, as clinicians become more familiar with the local population, cultural context, and community needs. By establishing a dedicated in-house psychiatric workforce, this project will improve access to mental health services, strengthen care coordination, reduce reliance on tele-behavioral health, and support more consistent patient-provider relationships. Over time, these improvements are expected to increase medication adherence, reduce stigma associated with seeking behavioral health care, and ensure that patients can receive high-quality psychiatric services within their own region.	\$50,000-\$250,000	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Kuskokwim Health Corporation	Building a Foundation to Support Food as Medicine	AK	Food insecurity is a major barrier to health in the Yukon-Kuskokwim Delta. High food costs, limited availability of healthy foods, and transportation challenges make it difficult for many families to consistently access nutritious food. These conditions contribute to chronic disease, complicate treatment plans, and reduce the effectiveness of medical care. Although food insecurity is increasingly identified through routine screening in health care settings, many patients struggle to navigate complex application processes for safety net programs such as SNAP, WIC, and Medicaid, and providers often lack the time or resources to connect patients with these services. Even when applications are successfully submitted, it can take weeks before benefits begin. During this period, many families continue to face food shortages. This program will provide healthy emergency food support while patients wait for benefits to begin. When possible, these food boxes will include culturally relevant and traditional foods such as fish, moose, and reindeer. This project addresses this gap by piloting a patient navigator model that provides short term nutritional support while helping patients access long term assistance programs and appropriate health care services. The program represents an opportunity to better integrate social needs screening with care coordination and to develop a scalable model for addressing food insecurity within rural and frontier health systems.	YKHC will pilot a patient navigator program to support patients who have screened positive for food insecurity. This pilot will fund 5 registration/scheduling specialists and 6 care navigators who will work directly with individuals and families identified through routine screening. Navigators will provide culturally relevant food boxes as a short-term, stabilizing measure while helping patients apply for longer-term safety net programs for which they may be eligible, including Medicaid, WIC, and SNAP. Navigators will also work with patients to identify preventive health and chronic care services they are eligible for and assist with scheduling those appointments. They will work closely with providers, case managers, and community health aides to integrate food insecurity interventions into existing continuity of care models and to standardize scheduling and referral workflows so the program can be sustained beyond the pilot period. This pilot builds on lessons learned from the YKHC prescription produce program and is intended to inform work with the State of Alaska to evaluate this model as a potential framework for Section 1115 “food is medicine” waivers that reflect the realities of rural and remote health systems. This transformative program requires highly trained staff familiar with regional and statewide services, complex eligibility processes, and one-on-one patient support. YKHC is requesting \$1.2M in staffing and \$1.4M in food boxes to implement and evaluate this pilot.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Kuskokwim Health Corporation	Deployment of Virtual Care Units to Expand Telehealth in Village Clinics	AK	This project provides the opportunity to expand the available services in the remote village clinics operated by YKHC. Through the deployment of Virtual Care Units, village clinics will be able to provide access to specialty care and higher acuity care via telehealth. YKHC will deploy Virtual Care Units in village clinics to enable reliable telehealth connections between patients and remote providers. Each unit will consist of a secure Dell Pro 24 ThinOS all-in-one telehealth workstation designed for clinical use. The devices are remotely managed and optimized for low-bandwidth environments, making them well suited for rural settings where connectivity can be limited. Once installed, these units will allow clinic staff to connect patients with providers located in Bethel or other facilities, supporting specialty consultations, follow-up care, and higher-acuity evaluations. Training will be provided to clinic staff to assist patients with connecting to remote providers and to support basic troubleshooting when needed. The Virtual Care Units will integrate with YKHC’s broader digital health infrastructure, helping expand telehealth services and improve care coordination across the regional healthcare system.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Kuskokwim Health Corporation	Expanding Community Health Aide Training Capacity in the Yukon-Kuskokwim Region	AK	The Yukon-Kuskokwim Health Corporation operates the first and largest Community Health Aide Training (CHAT) program in Alaska. The CHAT Center in Bethel trains most of the Community Health Aides (CHAs) serving the Yukon-Kuskokwim Delta, and YKHC employs the largest number of CHAs of any tribal health organization in the state. CHAs play a critical role in delivering healthcare in rural communities by providing routine, acute, and emergency direct patient care in village clinics. The Basic Training program for CHAs consists of four training sessions that typically progress over a two-year period and include both didactic instruction and clinical experience. Each session expands the level of care that CHAs are able to provide in their communities, with those completing the third and fourth session able to support emergency birthing services in the clinics prior to transport to a higher level of care. After a successful preceptorship and examination, they receive the Community Health Practitioner (CHP) Certification. Demand for training currently exceeds available capacity. The program maintains a growing waitlist for each training session, with the Session I waitlist averaging 36–40 trainees. Increasing the training capacity of the CHAT Center in Bethel represents an opportunity to expand the regional healthcare workforce, improve access to care in rural communities, and strengthen the long-term stability of the healthcare system across the Yukon-Kuskokwim Delta.	To increase training capacity at the CHAT Center, YKHC proposes expanding both staffing and classroom space to support additional trainees. The project will include hiring additional instructional and support staff to deliver classroom education, supervise clinical training, and manage administrative responsibilities associated with a larger student cohort. These positions may include advanced practice providers (APPs), community health practitioners (CHPs), and administrative support staff. In addition to expanding staffing, YKHC will renovate existing hospital space to create additional classroom facilities for the CHAT program. Space currently used by other departments will be reconfigured and remodeled to support training activities, allowing the program to accommodate more students and conduct additional training sessions each year. By increasing both instructional capacity and classroom space, the CHAT Center will be able to reduce trainee waitlists and expand the number of Community Health Aides trained to serve rural communities across the Yukon-Kuskokwim Delta.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Kuskokwim Health Corporation	Expanding Rural Diagnostic Imaging Access Through MRI Technology	AK	Currently, patients in the Yukon-Kuskokwim region must travel outside the region to obtain MRI imaging services. This creates significant delays in care and places a substantial travel burden on patients and their families. Non-urgent MRI referrals can take between six and nine months before imaging is completed. In addition to long wait times, patients often must travel hundreds of miles to Anchorage to access imaging services. These delays can lead to prolonged symptoms, delayed diagnoses, and postponed treatment for patients requiring specialty or surgical care. Establishing local MRI services in Bethel represents an opportunity to significantly improve diagnostic capabilities in the region. Providing MRI imaging locally will reduce travel requirements, shorten diagnostic timelines, and improve access to timely care for patients across rural communities.	The project proposes renovating existing space within the Bethel hospital to create a dedicated MRI suite and procuring MRI equipment to establish a new diagnostic imaging service line. The approach includes preparing or renovating space to accommodate MRI equipment, procuring an MRI machine suitable for rural healthcare environments, and integrating the new service into existing clinical workflows and health information systems. The team is exploring self-contained MRI technology similar to equipment used in other rural Alaska communities that reduces infrastructure requirements and supports reliable operation in remote settings. Implementation will occur in several phases, including planning and design, renovation or construction of the MRI suite, equipment procurement and installation, and operational readiness activities. Operational readiness will include workforce recruitment and training, development of imaging workflows, and coordination of radiology interpretation services. Preliminary capital estimates suggest that installation of a new MRI suite would require approximately \$2–4 million in total project costs, including equipment procurement, site preparation, and installation. Based on a preliminary vendor quote, the estimated cost for the MRI equipment alone is approximately \$1,207,284. These estimates are informed by comparable recent imaging equipment projects currently underway at the hospital, including the replacement of a CT scanner estimated at approximately \$1 million utilizing existing space.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Kuskokwim Health Corporation	Healthcare Express: Increasing colonoscopy access to patients in remote locations	AK	Alaska Native populations experience significantly higher rates of colorectal cancer and require preventive screenings earlier than the general population. In the Yukon-Kuskokwim (YKD) region, geographic isolation creates substantial barriers to accessing routine colonoscopy services. Patients must often travel by plane to Bethel to complete the preparation, procedure, and recovery phases of a routine colonoscopy. Travel requirements create challenges for patients and the health system. Weather conditions and flight delays contribute to a colonoscopy no-show rate of approximately 30%. Patients must leave their home communities during the preparation and recovery phases of the procedure, which can discourage participation in screening. The need for improved colorectal cancer screening access is particularly urgent in the YKD region, where colorectal cancer rates are more than double the state average (102.4 cases per 100,000 people in the YKD compared to 41.3 cases per 100,000 statewide). Screening rates are also significantly lower among YKHC patients (40%) compared to the Alaska state average (63.8%). This project presents an opportunity to improve access to preventive screenings by sending a medical team to subregional clinics to perform routine colonoscopies. Providing services closer to patients’ home communities will increase screening participation, support earlier detection and prevention of colorectal cancer, reduce no-show rates, and improve access to timely care.	The proposed approach is to establish a traveling colonoscopy service that allows a clinical team to provide colorectal cancer screening at subregional clinics across the Yukon-Kuskokwim region. Rather than requiring patients to travel to Bethel for routine procedures, the clinical team will travel to subregional clinic sites with the necessary equipment to perform colonoscopy services safely in a rural setting. The traveling clinical team is expected to include a gastroenterology provider or surgeon, anesthesia support such as a CRNA, nursing staff, and additional clinical support personnel as needed. Portable colonoscopy equipment and high-level disinfection systems will be used to ensure procedures can be performed safely while meeting infection prevention standards. Patients will be identified and scheduled in advance through coordination with subregional clinics. Local clinic staff will assist with patient preparation, scheduling, and follow-up care, allowing procedures to be completed efficiently during scheduled clinic visits. Equipment and supplies will be transported to subregional clinics and maintained according to established infection control protocols. Implementation will occur in phases. Initial planning will focus on identifying appropriate portable equipment and high-level disinfection solutions suitable for rural clinic settings. The project will then develop clinical workflows and train staff on equipment use and infection prevention procedures. Pilot colonoscopy services will be conducted at one subregional clinic before expanding services to additional sites across the region. This traveling service model will allow the health system to deliver colorectal cancer screening closer to patients’ home communities while improving access to preventive care in rural areas.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Kuskokwim Health Corporation	Modernizing Village Clinic Network Infrastructure to Support Telehealth and Cloud Systems	AK	YKHC operates 48 village clinics across a remote and geographically dispersed region where reliable network connectivity is essential for delivering modern healthcare services. Much of the existing network infrastructure in these clinics is aging and approaching end-of-life, which increases the risk of performance issues, cybersecurity vulnerabilities, and unreliable connectivity. Outdated network equipment limits the ability of clinics to fully utilize telehealth services, access cloud-based electronic medical record (EMR) systems, and support emerging technologies such as AI-assisted clinical tools. These limitations can disrupt care delivery and reduce the reliability of systems providers depend on to serve patients in rural communities. This project presents the opportunity to replace aging network infrastructure across village clinics with modern, secure equipment that supports reliable connectivity, strengthens cybersecurity protections, and enables the technology platforms needed to support telehealth, cloud-based systems, and data-driven care.	YKHC will replace aging network infrastructure in village clinics with modern routers, switches, and wireless access points designed to support secure and reliable connectivity. These upgrades will improve network performance and ensure compatibility with cloud-based systems and telehealth platforms used throughout the healthcare system. The project will include assessment of existing network infrastructure, procurement of updated equipment, installation and configuration of new devices, and testing to ensure stable connectivity across each clinic location. The upgraded infrastructure will support secure access to cloud-based EMR systems, enable real-time data exchange from remote monitoring tools, and improve system reliability for telehealth visits and other digital health services. By modernizing the network infrastructure, YKHC will strengthen cybersecurity protections while ensuring that providers in village clinics can access the digital tools required to support proactive and coordinated care for patients across the region.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Kuskokwim Health Corporation	Strengthening the Rural Health Workforce Through Recruitment and Retention Incentives	AK	The Yukon-Kuskokwim region faces ongoing workforce shortages in rural health clinics and community health programs, particularly in village-based roles. While many individuals in these communities have strong cultural knowledge, language skills, and community ties, there are not enough trained healthcare workers to meet the needs of patients across the region. Staffing shortages contribute to high turnover rates, increased workload for existing staff, and disruptions in continuity of care. This project seeks to address the opportunity to strengthen the rural healthcare workforce by creating incentives that attract and retain healthcare workers in both village-based and Bethel-based roles. By supporting recruitment bonuses, housing assistance, travel support, and training opportunities, the initiative will help build a stable workforce that reflects the communities it serves and can provide consistent care to rural and remote populations.	This project will establish a recruitment and retention incentive program designed to attract and support healthcare workers serving rural communities throughout the Yukon-Kuskokwim region. The program will prioritize local Alaska Native hires and individuals from the communities served, recognizing the importance of cultural knowledge and community relationships in delivering effective healthcare. Funding will support recruitment bonuses and incentives for healthcare workers in both Bethel-based and village-based roles. To strengthen long-term retention and ensure workforce stability, recruitment bonuses may be tied to a five-year service commitment. Additional support may include housing assistance, relocation support, travel funding, and training opportunities to help new employees transition successfully into rural healthcare positions. The program will also focus on developing workforce pipelines through partnerships with schools, nursing programs, and other healthcare training institutions. These partnerships will help identify potential candidates early and create pathways for individuals interested in pursuing healthcare careers that serve their communities. By providing targeted incentives and workforce support, the project aims to increase recruitment, reduce turnover, and create a more stable healthcare workforce across rural communities.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Kuskokwim Health Corporation	Transforming Tuberculosis Screening, Detection, and Treatment in the YK Delta	AK	Between 2014 and 2021, the YK Delta averaged approximately 25 new cases of active TB disease each year. In 2022 and 2023, there were over 50 cases annually in communities throughout the region. In 2024 and 2025, more than 200 cases of latent TB infection were identified, six times the 2014–2018 average, reflecting expanded screening and a critical opportunity to prevent future TB disease. After TB disease is identified, the State provides directly observed therapy in partnership with YKHC providers and RN case managers, requiring hundreds of staff hours per case. Earlier identification reduces treatment intensity and long-term staffing demands. With State support, YKHC purchased several mobile chest X-ray units and evaluated their effectiveness in partnership with the University of Washington. We have now incorporated them into our standard of care. YKHC is also working with Tribes and communities to pilot wastewater testing to identify TB disease earlier. These approaches are promising, but limited staffing and travel capacity prevent consistent deployment in high-risk communities. This request is for \$1.2 million annually to support salaries, recruitment, and retention incentives, and travel to expand screening over the next five years. This investment transforms TB care in the YK Delta by shifting from late detection and intensive treatment to early identification and prevention, reducing disease burden while making TB control sustainable over time.	This project expands the existing proactive tuberculosis (TB) detection and prevention in high-priority communities across the Yukon-Kuskokwim Delta. YKHC will increase travel to villages to conduct targeted screening in communities with elevated risk, using mobile chest X-ray units and community-based outreach to identify TB disease and latent TB infection earlier. These added screening efforts will be guided by epidemiologic data and coordinated with Tribal leadership and local health providers to ensure activities are focused where they will have the greatest impact. YKHC will partner closely with the State of Alaska to strengthen case finding and align screening, treatment, and public health response efforts. This collaboration will help ensure that individuals with suspected TB are identified quickly, linked to care, and supported through evaluation and treatment. The project will also provide enhanced pilot support for patients with complex needs, particularly those experiencing substance use disorders or behavioral health challenges that can make treatment adherence difficult. Through coordinated care management with the State and collaboration with behavioral health and substance use services, the project will test strategies to improve medication adherence and continuity of care. Improving adherence reduces treatment interruptions and helps prevent ongoing transmission of TB within households and communities. By combining expanded village screening, novel screening tools, strengthened partnerships for case finding, and targeted support for high-risk patients, this project aims to identify TB earlier, improve treatment completion, and reduce the spread of disease across rural communities.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Advance to Implementation Application

Yukon-Kuskokwim Health Corporation	Building Immunity through Community: Immunization remodel for permanent space within the hospital	AK	The Immunization program was recently relocated from an offsite location into the hospital within the Infusion Clinic. The original offsite location created several operational and safety challenges, including inefficient staff transportation between facilities and the absence of 24-hour on-call monitoring for vaccine storage. Without continuous monitoring, temperature fluctuations outside safe ranges could risk the loss of high-value vaccines and disrupt immunization services. While the move into the hospital addressed these immediate concerns, the program was placed in temporary space within the Infusion Clinic. This has created ongoing space constraints and operational inefficiencies for both programs, limiting workflow efficiency and reducing available capacity for infusion services. Identifying and establishing a permanent space for the Immunization program within the hospital will resolve these operational challenges, protect vaccine storage requirements, and allow both the Immunization and Infusion programs to operate efficiently while supporting timely vaccine delivery for patients and surrounding communities.	This project will identify, renovate, and allocate a permanent location for the Immunization program within the hospital. Establishing a dedicated space will improve operational efficiency, ensure appropriate infrastructure for vaccine storage, and support program growth. Locating Immunization within the hospital will provide several operational benefits. The program will have improved proximity to the hospital loading dock, enabling more efficient delivery and handling of vaccine shipments. It will also allow vaccines to be stored and administered within the same facility where more than half of vaccinations already occur. In addition, staff who travel to surrounding villages will have improved access to vaccine supplies prior to departure. The proposed space will also allow the program to meet mechanical and environmental requirements necessary for vaccine storage equipment, including ventilation, cooling, and temperature monitoring systems. By situating Immunization within the hospital, facilities staff can maintain continuous 24-hour monitoring of vaccine storage conditions, ensuring compliance with safety standards and protecting valuable medical inventory.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yukon-Kuskokwim Health Corporation	Ears, Noses, Muscles & Bones: Bringing specialty care of ENT, Cardiology & Orthopedics close to home	AK	This project provides an opportunity to expand specialty care services in the Yukon-Kuskokwim region by adding cardiology, otolaryngology, and orthopedic services at Yukon-Kuskokwim Delta Regional Hospital in Bethel, while also providing visiting specialty services to sub-regional clinics in Aniak, Emmonak, Hooper Bay, St. Mary’s, and Toksook Bay. Currently, patients requiring specialty care are referred to Alaska Native Medical Center (ANMC) in Anchorage. The selected specialties represent the most frequently referred services, accounting for approximately 1,200 referrals annually. This referral process often results in significant delays in care, with patients waiting up to 176 days to be scheduled and up to 198 days before their appointment. Patients must also travel more than 400 miles to Anchorage to receive care, creating a substantial travel burden for individuals and families in rural communities. Providing specialty services closer to home will improve access to care, reduce delays, and offer greater flexibility when travel is disrupted due to weather or other challenges common in the region.	The proposed approach is to expand access to specialty care within the Yukon-Kuskokwim region by recruiting additional specialty providers and expanding the diagnostic capabilities needed to support specialty services locally. New specialty providers will deliver services using existing clinical space and exam rooms, allowing services to begin quickly once providers are hired. Expanding the local specialty workforce will reduce delays in care associated with referral processes, decrease patient travel to Anchorage Native Medical Center (ANMC), and shorten wait times for specialty appointments. In addition to provider recruitment, the project will include the acquisition of specialty diagnostic equipment needed to support expanded services. For example, equipment such as echocardiography machines will allow providers to complete diagnostic testing locally rather than referring patients to outside facilities. Expanding local diagnostic capabilities will allow specialists to practice at the top of their license and provide more comprehensive care within the region. Together, the addition of specialty providers and equipment will allow more patients to receive timely care closer to home, improving access to specialty services for communities across the Yukon-Kuskokwim region.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yukon-Kuskokwim Health Corporation	Expanding Patient Lodging Capacity at Qavartavik Customer Lodge	AK	A significant barrier to accessing healthcare in the Yukon-Kuskokwim region is the limited availability of patient lodging in Bethel. Patients often travel long distances from remote villages to receive care and require overnight accommodations while completing appointments, procedures, and follow-up visits. Currently, the Qavartavik Customer Lodge operates over capacity for much of the week, particularly during the winter months. Reports indicate that the lodge frequently exceeds its room capacity between Monday and Thursday and must use an average of 10 to 25 cots per night to accommodate patients. In some cases, patients are referred to Anchorage for care due to limited lodging availability in Bethel. As healthcare services expand and specialty care availability increases, demand for patient lodging is expected to grow. Without additional lodging capacity, the ability to provide timely care for patients traveling from rural communities will remain constrained. This project presents an opportunity to improve healthcare access by expanding the Qavartavik Customer Lodge through architectural planning and design for additional patient lodging capacity.	The proposed project will focus on architectural and engineering planning to support the expansion of the Qavartavik Customer Lodge in Bethel. This phase will evaluate options to add approximately 60 additional patient lodging rooms to the existing facility in order to better accommodate patients traveling from remote villages for medical care. The planning phase will include architectural design, engineering assessments, and the development of construction-ready plans to support a future expansion project. The design process will evaluate space requirements, patient flow logistics, and the supporting infrastructure needed to accommodate increased lodging capacity while maintaining a safe and comfortable environment for patients and families. Completing architectural and engineering planning through this initiative will position the organization to pursue future construction funding through additional grants, partnerships, or internal capital planning processes. Having completed design and engineering documentation will allow the expansion project to move forward more efficiently once funding becomes available. Expanding lodging capacity will allow more patients traveling for care to remain in Bethel long enough to complete multiple appointments, procedures, and follow-up visits during a single trip. Additional lodging will also improve coordination of specialty care services and preventative screenings by reducing the need for patients to return to their home villages before completing necessary care.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yukon-Kuskokwim Health Corporation	Implementing a Centralized Infection Control Module to Improve Infection Surveillance	AK	The hospital’s current electronic health record system does not provide a centralized method for collecting, monitoring, and reporting infection-related data. This creates challenges in identifying abnormal laboratory results, tracking potential infection events, and ensuring timely communication among clinical staff. As a result, infection monitoring and response efforts may be delayed, increasing the risk of healthcare-associated infections and creating additional reporting burdens for staff. Implementing an infection control module within the Cerner system presents an opportunity to strengthen infection surveillance and response across the health system. The module will provide a centralized platform for monitoring infection indicators, tracking abnormal results, and supporting timely clinical intervention. In addition, the module will enable interoperability with national reporting systems for hospital-acquired infections, improving the efficiency and accuracy of required reporting while reducing administrative workload for staff.	The proposed approach is to implement Oracle Health’s centralized infection control module within the hospital’s electronic health record system. This module will integrate infection surveillance data across multiple clinical systems, including laboratory results, patient records, and reportable condition tracking, into a single centralized platform. Implementation will include configuring the infection control module, integrating it with existing clinical and laboratory workflows, and developing reporting dashboards that allow clinicians and infection prevention staff to quickly identify abnormal laboratory results, potential infection events, and other reportable conditions. The system will support automated alerts and streamlined reporting to help staff monitor infection risks and respond more efficiently. The project will also include staff training and workflow development to ensure clinical teams and infection prevention personnel can effectively use the system for monitoring and reporting. Once implemented, the centralized platform will improve internal communication, strengthen infection surveillance, and enable more efficient reporting to state and national systems.	\$250K-\$1M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yukon-Kuskokwim Health Corporation	Migrating the Oracle Health Millennium EMR to Oracle Cloud to Strengthen Rural Healthcare Delivery	AK	Yukon-Kuskokwim Health Corporation seeks RHTP funding to migrate its on-premise Oracle Health Millennium electronic medical record (EMR) system to Oracle Cloud. YKHC serves a geographically dispersed region of 48 remote villages where reliable digital infrastructure is essential to delivering coordinated, high-quality care. The current on-premise environment limits system performance, scalability, and the ability to support modern care delivery tools needed in rural settings. Migrating the EMR to Oracle Cloud will provide a secure, scalable platform that improves system reliability and enables expanded telehealth services, AI-supported clinical workflows, and advanced analytics to support chronic disease management and care coordination. These capabilities are critical to strengthening access to care and improving outcomes across remote communities. Protecting sensitive patient information remains a core priority. Transitioning to a modern cloud architecture enhances data security while improving operational efficiency for both patients and providers. The migration will include a secure Citrix virtualization layer, along with Citrix licensing and compatible endpoint hardware, to ensure reliable and secure access for clinicians across YKHC’s regional network.	YKHC will transition its existing on-premise Oracle Health Millennium electronic medical record (EMR) system to Oracle Cloud through a phased migration that prioritizes system stability, data security, and uninterrupted clinical operations. The project will include cloud migration planning, system configuration, secure data transfer, testing, and final system cutover to ensure a smooth transition for providers and staff. To support secure and reliable access to the cloud-based EMR across YKHC’s regional network, the project will implement a Citrix virtualization layer along with required Citrix licensing and compatible endpoint hardware. This infrastructure will enable clinicians in remote village clinics to securely access the EMR while maintaining system performance in low-bandwidth environments. Once implemented, the cloud-based platform will support expanded telehealth services, remote monitoring, and patient portal engagement across 48 villages. It will also enable advanced capabilities such as AI-assisted documentation, clinical decision support, prior-authorization automation, and improved data governance. Training and technical support will be provided to ensure clinical and administrative staff can effectively adopt the new system. By improving system reliability, reducing downtime, and enabling more efficient clinical workflows, the project will enhance provider productivity and support workforce retention while strengthening access to care for rural communities.	Over \$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yukon-Kuskokwim Health Corporation	Modernization of IT Infrastructure to Support Healthy Communities	AK	Yukon-Kuskokwim Health Corporation operates 48 village clinics across a geographically dispersed and remote region of Alaska. Many of these facilities require on-site upgrades to telehealth equipment, replacement of aging network infrastructure, and preparation for cloud-based electronic medical record (EMR) and enterprise data warehouse (EDW) systems. Due to the rural and remote nature of these clinics, many of these upgrades cannot be completed remotely and require technical teams to travel to each facility. This project will support the professional services, travel, and logistical coordination necessary to deploy technical teams to each village clinic to complete critical modernization work. These upgrades will ensure village clinics are equipped to support telehealth services, secure network connectivity, and future cloud-based systems that strengthen healthcare delivery across the region.	YKHC will implement this project by deploying technical teams to each of the 48 village clinics to complete on-site installation, system upgrades, and infrastructure improvements. Site visits will include installing Virtual Care Units, replacing or upgrading network infrastructure, and preparing clinic environments for cloud-based EMR and EDW systems. During each deployment, technical teams will assess existing infrastructure, complete required installations, configure equipment, and test system connectivity to ensure reliable performance. In addition to the technical work, staff at each clinic will receive training to support adoption and ongoing use of the new technology platforms. This approach ensures that each village clinic receives consistent upgrades and support necessary to enable telehealth services, improve real-time data exchange, support remote monitoring and chronic disease management, and strengthen system reliability. By completing this work through coordinated field deployments, YKHC can efficiently modernize infrastructure across its regional network while minimizing disruption to clinical operations.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yukon-Kuskokwim Health Corporation	Strengthening Healthcare Workforce Career Pathways in the Yukon-Kuskokwim Region	AK	Yukon-Kuskokwim Health Corporation (YKHC) operates 41 village clinics, five subregional clinics, and a large outpatient clinic in Bethel. Clinics across the region face persistent staffing shortages that limit access to care and increase strain on providers. In many cases, providers must perform nursing and medical assistant duties in addition to clinical responsibilities, resulting in longer visits and reduced patient capacity. Recruitment is also difficult due to the region’s remote geography and limited local training pipelines. YKHC currently supports several workforce development opportunities, including scholarships for Dental Health Aide Therapy training and apprenticeships through the Alaska Primary Care Association. However, many programs remain underutilized due to limited awareness and lack of coordination. This project will strengthen and expand career pathways for local residents by coordinating existing workforce development resources and increasing awareness of healthcare training opportunities. A centralized Career Pathways Academy will help expand participation in training programs, support development of additional pathways such as medical assistants, and strengthen the local healthcare workforce across the Yukon-Kuskokwim region.	To address workforce shortages and improve access to care, this project will establish a coordinated Career Pathways Academy that centralizes workforce development resources and expands local training opportunities for healthcare careers. The initial phase will focus on planning and coordination activities to map existing workforce training programs currently supported by Yukon-Kuskokwim Health Corporation and partner organizations. This process will identify gaps in training opportunities and areas where programs may overlap or require additional support. The project will work with education providers, workforce organizations, and regional partners to strengthen collaboration and develop a more coordinated pathway for community members to enter healthcare careers. This includes evaluating current scholarship programs, apprenticeships, and training partnerships and identifying opportunities to expand programs such as Certified Medical Assistant (CMA) training. In addition, the project will develop strategies to improve awareness and accessibility of workforce development opportunities. This will include creating centralized communication and promotion of career pathway programs so that community members can more easily identify training options and enrollment processes. The planning process will also identify key supports needed for trainees to successfully participate in workforce programs, such as housing, travel support, and access to required testing or certification resources. By coordinating existing programs, identifying gaps, and developing a structured framework for career pathways, the project will create a scalable model for expanding the local healthcare workforce and increasing participation in training programs across the region.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yukon-Kuskokwim Health Corporation	Strengthening Workforce Infrastructure to Support Rural Healthcare Access	AK	Rural healthcare systems face significant workforce recruitment and retention challenges due to geographic isolation, workforce shortages, and limited training pipelines. Yukon-Kuskokwim Health Corporation (YKHC) serves a large and geographically dispersed region where the availability of qualified healthcare professionals directly affects access to care in village clinics and regional facilities. As YKHC expands services and advances the One System of Care (OSS) model, the demand for workforce recruitment, onboarding, training, and workforce planning continues to grow. The current Workforce Division structure has evolved over time and was not originally designed to support the scale and complexity required for a regional healthcare system serving remote communities. This project provides an opportunity to strengthen and modernize workforce infrastructure to support recruitment pipelines, workforce development programs, improved onboarding processes, and enhanced workforce data systems. By strengthening workforce capacity, YKHC will improve its ability to recruit, develop, and retain healthcare professionals needed to sustain healthcare services across the Yukon-Kuskokwim region.	YKHC will implement a phased approach to strengthen and modernize its Workforce Division to better support recruitment, training, workforce planning, and employee support systems. The first phase will include a comprehensive assessment of current workforce operations, staffing structure, and supporting systems to identify gaps in recruitment capacity, workforce development, employee relations, and HR technology infrastructure. Findings from this assessment will inform a strategic workforce infrastructure plan aligned with the organization’s long-term service expansion and the One System of Care model. The second phase will focus on modernizing workforce systems and operations. Key activities will include strengthening recruitment infrastructure, improving onboarding and training programs, expanding workforce development initiatives, and enhancing HR information systems and workforce analytics capabilities to support data-driven decision making. The final phase will focus on long-term workforce sustainability by strengthening partnerships with educational institutions and workforce development programs, expanding leadership development initiatives, and integrating workforce planning into the organization’s long-term strategic planning. This phased approach allows YKHC to strengthen workforce infrastructure while maintaining continuity of operations.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Yukon-Kuskokwim Health Corporation	YKHC Immunization Backlog Reduction and System Improvement Project	AK	Pre-COVID-19, YKHC consistently achieved on-time childhood immunization rates above 80% and in some years exceeded 90%. In recent years, these rates have declined substantially. While YKHC can still reach on-time coverage above 80% among younger children, we have been unable to resolve the backlog of children who fell behind during the pandemic. The electronic health record (EHR)/VacTrAK interface and vaccine inventory management issues have led to high documentation and reconciliation error rates. These errors burden YKHC and State of Alaska staff and contribute to inaccurate forecasting in the EHR. As a result, providers are not flagged when children are overdue, and staff face increased risk of missed vaccination opportunities and vaccine waste. YKHC has worked with ANTHC to identify an inventory management solution that integrates with Cerner and VacTrAK and is expected to reduce errors by approximately 80%, saving thousands of staff hours each year. YKHC has also identified a method to import complete VacTrAK records into the EHR to resolve forecasting and due list issues. These system improvements and addressing the immunization backlog require a temporary increase in nursing capacity. YKHC is requesting \$1.3 million annually to support temporary staff, travel, and lodging. This short-term investment will reduce ongoing inefficiencies that cost YKHC and the State thousands of staff hours each year and improve patient care by reducing missed opportunities and vaccine waste.	YKHC proposes a coordinated approach that combines system improvements with targeted clinical outreach to resolve the childhood immunization backlog created during the COVID-19 pandemic and improve long-term immunization program performance in the Yukon-Kuskokwim Delta. First, YKHC will implement an inventory management solution that integrates with Cerner and VacTrAK to significantly reduce vaccine documentation and reconciliation errors. This system improvement is expected to reduce inventory discrepancies by approximately 80 percent and eliminate thousands of hours of staff time currently spent correcting errors. Improved inventory accuracy will reduce vaccine waste, improve forecasting, and ensure clinics maintain appropriate vaccine supplies. Second, YKHC will complete a manual registry import process to correct historical immunization records in the electronic health record. Staff will systematically import vaccination records from VacTrAK into the YKHC EHR, beginning with the youngest children and progressing to older age groups. This process will involve reviewing and importing more than 50,000 immunization records to ensure the EHR contains complete and accurate vaccination histories. In addition, YKHC will develop a monitoring system to routinely identify and correct discrepancies between VacTrAK and the EHR so records remain synchronized over time. Once accurate records are established in the EHR, YKHC will be able to fully utilize built-in forecasting tools to identify when children are due or overdue for vaccines, similar to other clinical follow-up needs tracked in the EHR. This will allow providers and clinic staff to see accurate immunization alerts during patient visits and reduce missed vaccination opportunities. Finally, the EHR will be used to generate community level lists of children who are past due for immunizations. These lists will allow YKHC to plan targeted outreach and send nursing staff to specific villages to conduct catch up vaccination clinics. This approach replaces current VacTrAK reminder and coverage reports, which have been found to miss up to 80 percent of children due for vaccines when compared to manual record review. Despite several years of collaboration with VacTrAK staff to address these limitations, the reporting issues have not been resolved. By maintaining accurate immunization records in the EHR, YKHC will be able to generate reliable due lists and restore high on-time vaccination coverage across the region.	\$1M-\$5M	Family or primary care	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Kusilvak Census Area; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Zender Environment al Health and Research Group	Reducing community exposures to toxic chemicals via landfill worker safety and health interventions.	AK	The project targets about 120 remote, "frontier" communities, or 'villages' of populations between 100 and 1,000, with State inspection scores of less than 80, all of whom with which we have active working relationships through training, assistance, and Backhaul Alaska. Serious health risks are present.. Lacking a containment liner, leachate collection and treatment, and cover to control vectors and reduce waste contact, with passive burning of the full municipal wastestream as a volume reduction method, chemical contact and inhalation (and ingestion) exposures are unavoidable. Health studies specific to these sites indicate an extreme 4.3 positive odds ratio of certain congenital anomalies. Surrogate exposure studies indicate dose response relationships of 2 to 4 times greater risk of a variety of short term health symptoms such as eye and ear irritation, stomach upset, coughing, and more from just visiting these sites, from burning trash near homes. Living within one-half mile of the site or smelling the it at home also was associated with increased health risk. These results are supported by research for 3rd world communities living near open waste sites. Toxic chemical and PM 2.5 exposures via dermal, inhalation, and ingestion routes can precipitate, worsen, or predispose residents, to a range of chronic disease for which the population has increased prevalence, such as COPD, asthma, certain types of cancers, and diabetes (lead exposure).	There are two associated factors for improved site inspection scores, both correlating with exposure eliminations: 1. Experienced landfill workers that ensure waste burning occurs with favorable wind direction, site access is clear of waste, hazardous waste is separated, the salvage yard surface is free from trash such as diapers, and lead an petroleum soaked soil from fluids, batteries, etc., and waste is covered when possible -- all of which reduce toxic exposures. 2. Better community disposal practices. But trained, experienced landfill workers are very rare, with high turnover and unfilled positions because of working conditions. Target landfills lack a warming or rest shelter. Workers are in the dark and cold in winter throughout the work day, presenting grave risk of cold over-exposure as well as dehydration and heat exhaustion in summer, risking fatigue and stress related injury and illness. And 2. Community disposal practices are often subpar. With a poor economy of scale supporting a landfill utility, and one that has little design performance integrated into its infrastructure, community decisions regarding willingness to pay for operators, and individual decisions on when and how often to visit the sites, whether to separate out and drop off hazardous waste at storage sites if available, to bring children and infants, to unload waste at the designated area or to unload it in a way that impairs access and expands the site, all contribute to, or minimize, exposures. This project provides prefabricated container shelters to site at landfills, with lighting as well as generator supplied heat source, PPE, eyewash station, and hand sanitation station. Our idea would be to purchase and ship out these interventions to 20 to 25 communities each year, such that over a 5-year period, every landfill worker now at risk would be protected, greatly enhancing their productivity and retention, and in turn improving the landfill condition and exposure risks present. The project also would develop a public awareness campaign with various culturally relevant posters similar to the successful Kids Don't Float effort that would result in improved respect for landfill workers and reduced site and waste exposures for children, infants, and pregnant women. A coloring book with scenes from around rural Alaska of recycling, trash segregation, and waste collection would also increase familiarity with other regions. The book would be distributed via schools.	\$1M-\$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Bethel Census Area; Dillingham Census Area; Kusilvak Census Area; Lake and Peninsula Borough; Nome Census Area; Northwest Arctic Borough; Yukon-Koyukuk Census Area	Deferred or Not Advanced

Zero Overdose Corp	Strengthening Rural Alaska Healthcare with Integrated Suicide and Overdose Safety Planning	NY	Suicide remains a significant public health challenge in Alaska, which has one of the highest suicide rates in the United States (CDC, 2023). Approximately 200 Alaskans die by suicide each year, underscoring the need for strengthened prevention strategies across healthcare systems. Healthcare settings represent a critical opportunity for intervention. Research indicates that more than 50% of individuals who die by suicide have a healthcare visit within the month prior to death, highlighting the importance of equipping healthcare providers to identify and respond to risk during routine care encounters (Ahmedani et al., 2020). At the same time, suicide and drug overdose risks often overlap and share common drivers. Individuals with substance use disorders frequently experience elevated suicide risk, yet prevention efforts addressing suicide and overdose are often implemented separately within healthcare systems (American Public Health Association, 2022; Olfson et al., 2018). This project presents an opportunity to strengthen rural healthcare systems across Alaska by integrating suicide safer care and overdose safety planning into collaborative care models within primary care clinics, hospitals, and community health settings. By equipping healthcare teams with evidence-based safety planning tools and integrated care workflows, this initiative aims to improve identification of individuals at risk and support earlier, coordinated interventions across Alaska’s healthcare system.	This project will strengthen Alaska’s healthcare system by implementing a collaborative care model that integrates suicide safer care and overdose safety planning into routine healthcare delivery across primary care clinics, hospitals, and community health settings. The approach focuses on strengthening frontline providers’ capacity to identify and respond to overlapping suicide, overdose, and social risk factors during routine patient encounters. 1. Integrated Safety Planning Training for Healthcare Providers Healthcare providers and care teams will receive training in an integrated safety planning framework that combines evidence-based suicide prevention practices with overdose risk identification and response strategies. The training incorporates the Stanley & Brown Safety Planning Intervention, which has demonstrated reductions in suicidal behavior and increased engagement in outpatient mental health care when combined with follow-up support (Stanley et al., 2018). Additional research shows safety planning interventions can reduce suicidal behaviors by more than 40% (Marshall et al., 2022). A key innovation is training clinicians to create one coordinated safety plan addressing suicide risk, overdose risk, and relevant social drivers, rather than developing separate plans for each risk domain. 2. Integration into Clinical Workflows Participating healthcare organizations will receive implementation support to integrate safety planning practices into existing clinical workflows, including incorporating screening, collaborative safety planning, and referral coordination into routine patient visits. This workflow-focused approach allows providers to deliver effective interventions within time-limited clinical encounters. 3. Strengthening Collaborative Care Systems The project will strengthen coordination between primary care providers, behavioral health professionals, and community resources to ensure individuals identified at risk receive appropriate follow-up care and support. 4. Implementation Support and Technical Assistance Zero Overdose will provide implementation guidance, training materials, and technical assistance to support adoption of integrated safety planning practices. The approach is designed to be adaptable across diverse healthcare environments and scalable across rural and frontier communities in Alaska.	\$250K-\$1M	Statewide	Aleutians East Borough; Aleutians West Census Area; Anchorage (Municipality); Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced

Zoya Ratner Consulting LLC DBA Rural Healthcare Financial Partners	Primary-to-specialty Access Through Harmonized Workflows for Accelerated Year-round Services-Alaska	AK	Alaska’s Rural Health Transformation Program (RHTP) identifies access barriers and workforce shortages as key drivers of vulnerability in rural health systems. Limited appointment availability contributes to delayed or forgone care among rural Alaska Native individuals with Indian Health Service access, reflecting constrained outpatient capacity (Jacobson et al., 2025). Studies of rural and predominantly rural primary care systems report no-show rates of approximately 6–8%; when late cancellations are included, total missed-appointment rates can exceed 13%, reducing effective clinic capacity (Shour & Onitilo, 2023; Shour et al., 2023; Tuan et al., 2025). These challenges are compounded by administrative burden. Physicians spend nearly two hours on EHR data entry and administrative tasks for every hour of direct patient care, reducing clinical capacity (Arndt et al., 2017). In rural and Tribal health systems reliant on small clinics, this burden translates into fewer available appointments and delayed care (Kozhimannil et al., 2025). Administrative workload further constrains throughput, driving after-hours work and, in some settings, leading clinics to shorten schedules or close appointment slots (Budd, 2023; Wu et al., 2024). Large portions of Alaska remain designated Health Professional Shortage Areas for primary care, reflecting persistent provider gaps (HRSA, 2024). Addressing these problems would improve access to healthcare for rural Alaskans.	PATHWAYS-AK will apply the Theory of Constraints (TOC) to streamline outpatient care pathways and improve timely access to primary, specialty, and behavioral health services in rural Alaska. The project optimizes patient flow from first contact to definitive care so services are delivered earlier and in appropriate settings, reducing reliance on emergency department services. TOC improves healthcare access by managing the system’s core constraint, provider capacity. In rural Alaska, this capacity is often reduced by inefficient scheduling and workflows, high no-show and cancellation rates, and administrative burden that limits clinician-to-patient time. The methodology increases efficiency through streamlined scheduling, coordinated referrals, prioritization of higher-risk patients, and aligned processes that optimize clinical time. A systematic review found that TOC has been successfully applied in healthcare, improving capacity and timeliness of care (Bacelar-Silva et al., 2020). Implementation will begin with two pilot sites that provide primary and specialty care services and, where feasible, behavioral health care. Pilots will include locally guided assessments, co-designed workflows, repeatable operating practices, targeted EHR configuration changes, implementation of TOC-enabling technologies, and staff training, with tools designed for re-use. Financial reviews and adjustments will align operational changes with revenue and cost structures. Tribal, municipal, and private health systems will serve as implementation partners, contributing local operational knowledge, clinical leadership engagement, and access to frontline teams. Accountability will be maintained through site-level improvement leads, shared performance dashboards, and cross-site learning reviews. TOC will be applied through defined patient-flow boundaries, optimized scheduling templates, standardized intake, urgency-based triage, and flexible access models. Alaska healthcare experts will be trained and certified in TOC to build in-state capability. Following the initial pilots, the project will expand to 10 or more concurrent improvement initiatives. Progress will be measured using operational metrics (see details in the next section), which will be aggregated to support learning and alignment with Alaska’s RHTP priorities. PATHWAYS-AK will coordinate with existing access, workforce, and technology initiatives to ensure improvements complement other RHTP-funded efforts.	Over \$5M	Multi-Community or Participating in Regional Hub-and-Spoke	Aleutians East Borough; Aleutians West Census Area; Bethel Census Area; Bristol Bay Borough; Chugach Census Area; Copper River Census Area; Denali Borough; Dillingham Census Area; Fairbanks North Star Borough; Haines Borough; Hoonah-Angoon Census Area; Juneau (City and Borough); Kenai Peninsula Borough; Ketchikan Gateway Borough; Kodiak Island Borough; Kusilvak Census Area; Lake and Peninsula Borough; Matanuska-Susitna Borough; Nome Census Area; North Slope Borough; Northwest Arctic Borough; Petersburg Borough; Prince of Wales-Hyder Census Area; Sitka (City and Borough); Skagway (Municipality); Southeast Fairbanks Census Area; Wrangell (City and Borough); Yakutat (City and Borough); Yukon-Koyukuk Census Area	Deferred or Not Advanced