



Alaska Rural Health Transformation Program (RHTP): Year 2 Funding Strategy

Care Coordination at Hospital Discharge Focus Area: Description for Implementation Pathway

A. Background and Transformation Vision

Alaska's long-term vision is to strengthen care coordination across providers, care managers, state programs, community-based organizations, patients, and caregivers. Over time, improved information exchange and shared workflows can support more effective coordination across care settings, and better use of available clinical, behavioral health, long-term services and supports, and community-based resources.

This Rural Health Transformation Program (RHTP) funding opportunity initially focuses on care coordination at the point of hospital discharge and transition-of-care activities as a starting point for broader care coordination improvements. Transitions from the hospital to home or other care settings represent a critical point in a patient's care journey, particularly for individuals with complex medical, behavioral health, or social needs. Effective discharge planning and timely follow-up can help ensure patients receive appropriate medications, services, supports, and community-based resources, while reducing the risk of fragmented care, avoidable complications, and unnecessary utilization. Strengthening the systems, information exchange, and workflows that support these transitions can improve both the patient experience and the ability of providers and care teams to coordinate care across settings. By focusing first on data exchange, training and capacity building, discharge-related workflows, and organizational readiness, DOH seeks to establish foundational capabilities that may be expanded in future years to support additional care coordination priorities. This approach is intended to help organizations build practical capacity during the initial funding period while positioning Alaska for broader statewide enhancements over time.

B. Transformation Strategy

Building Local Hospital Discharge Care Coordination Capabilities

Organizations involved in hospital discharge and post-discharge care have different technology, data exchange, and operational capabilities. This includes both organizations that discharge or transfer patients and those that receive patients and provide follow-up care. Both sides of a transition need capabilities to make it work, and each may need different investments to get there. While some hospitals and providers use electronic health records (EHRs), health information exchange (HIE) connectivity, and automated alerts to share patient discharge information and support post-discharge follow-up, others rely on manual processes to identify responsible care team members, transmit discharge information, and coordinate follow-up services and supports.

As organizations seek to further improve care coordination after hospital discharge—or for broader care coordination purposes—they may benefit from investments that strengthen capabilities such as:

- EHR adoption, optimization, and interoperability for discharge and transition-of-care workflows
- Onboarding and connectivity to statewide HIE capabilities
- Electronic admission, discharge, and transfer (ADT) notifications and other event-based alerts
- Information that helps identify a patient's care team, including the providers, care managers, and organizations involved in follow-up



- Data quality, standardization, exchange, and reporting
- Discharge planning workflows that identify who is responsible for a patient's follow-up care before the patient leaves
- Capabilities to transmit discharge information electronically to receiving providers and to confirm that follow-up occurred
- Workflow redesign, staff training, and change management needed to use shared information in routine discharge planning and follow-up

Building Statewide Care Coordination Infrastructure

While provider readiness is a critical component of effective discharge coordination, statewide infrastructure is also needed to ensure information can be exchanged consistently across organizations and care settings. DOH plans to invest in statewide HIE capabilities that complement provider investments and support more effective hospital discharge and transitions of care. These efforts build on existing HIE infrastructure, such as the Emergency Department Information Exchange (EDIE), and are designed to strengthen the flow of information across hospitals, receiving providers, care managers and other partners involved in supporting patients following hospitalization. Initial priority HIE capabilities are intended to improve visibility into which providers and/or organizations are supporting a patient's care, ensure timely awareness of key transition events, and facilitate use of shared information across organizations. Priorities include:

- **Care team visibility**, to help providers identify the hospitals, providers, care managers, state programs, and organizations involved in a patient's follow-up care after discharge.
- **Automated notifications**, to alert care teams to their patients' key events (e.g., hospital admission, readiness for discharge, or discharge), building on existing systems.
- **Technical and operational integration support**, to help organizations integrate these expanded statewide HIE capabilities into existing systems and workflows.

Together, these statewide capabilities and provider readiness investments will support more coordinated discharge planning, more timely discharge, smoother transitions across care settings, and improved follow-up after hospitalization. The following examples illustrate how Alaska-based providers may leverage the investments both and the provider and statewide levels to improve patient care. The first example illustrates an organization receiving patients after discharge; the second illustrates a hospital discharging them.

Example 1: Pediatric Clinic Uses ADT Notifications to Identify High-Risk Follow-Up Needs

Example Scenario	A pediatric clinic frequently learns about emergency department visits, hospitalizations, and discharges days or weeks after they occur, limiting its ability to conduct timely follow-up. The clinic wants to proactively identify children who may benefit from additional support after an ED visit or hospitalization, such as those with asthma, behavioral health conditions, so that follow-up care can be scheduled before a child's condition worsens.
Funding Uses	The clinic uses funding to connect to statewide HIE capabilities and begin receiving automated notifications when its patients are treated in participating hospitals. The clinic redesigns workflows so designated staff review alerts daily, identify patients requiring follow-up, notify the appropriate pediatrician or care team member, and schedule longer follow-up appointments when needed. Funding also supports staff



	training, workflow development, and integration of notifications into existing care management processes.
Link to Statewide Capabilities	As statewide care coordination capabilities expand, the clinic could receive richer event notifications, access more comprehensive care-team information, and incorporate additional alerts and patient data into routine population health and care management activities.

Example 2: Rural Hospital and Community Partners Improve Post-Discharge Follow-Up

Example Scenario	A rural hospital often struggles to discharge patients in a timely manner because of the difficulty identifying which other providers are engaged in the patient's care and to ensure patients successfully connect with primary care providers, behavioral health providers, home health agencies, or community-based services after discharge. Staff spend considerable time making phone calls and manually sharing information to coordinate follow-up care.
Funding Uses	The hospital uses funding to standardize discharge planning workflows, define staff roles and responsibilities, improve electronic sharing of discharge information, and train discharge planners and care coordinators. Funding also supports development of processes to identify post-discharge providers, convene local providers that are most often involved in patient care, and document agreed-upon referral and follow-up protocols.
Link to Statewide Capabilities	Future statewide HIE capabilities could help automate portions of these workflows by improving visibility into patients' care teams, supporting electronic information exchange across organizations, and facilitating more timely notifications to providers involved in follow-up care.

C. Funding Opportunity

Funding Objectives

Funding is intended to support organizations at varying levels of readiness to strengthen hospital discharge and transition-of-care capabilities through investments in data and system infrastructure and workforce capacity and readiness, including workflow redesign, training and implementation preparation, as further described in "Funding Uses." Launch or implementation of a specific care coordination program is not required during the funding period. Effective transitions depend on both the organizations that discharge or transfer patients and those that receive them. Applications are welcome from either perspective, as well as from organizations that do both. In the application, you will be asked to identify your organization's role in care transitions, and the readiness questions you receive will reflect that role.

Total Funding Available

DOH estimates an allocated target of \$10 million to subrecipient projects aligned with this focus area. This estimated allocation is separate/in addition to any care coordination-related open call applications.

Expected Applicants

Applicants expected to submit applications to this opportunity may include hospitals and health systems; Tribal Health Organizations; health centers and clinics; primary care, behavioral health, rehabilitation,



post-acute, home health, and long-term services and supports providers; care management entities; and other health care, governmental, or community-based organizations that have a defined role in supporting patients during or following hospital discharge.

Funding Uses

Applicants may use funding to address organization-specific data, technology, workforce, and workflow needs that support hospital discharge and transitions of care. Applicants may propose activities under one or more of the following tracks and should explain how each activity will improve readiness to exchange and use information across care settings.

Track	Purpose	Example Permissible Investments
1. Data and System Infrastructure	Build or strengthen data, systems, and technology architecture to share data on hospital discharge and post-discharge follow-up.	▪ EHR adoption and optimization: Purchase, implementation, configuration, licensing, upgrades, or optimization of EHRs and related care management tools needed to support structured discharge documentation, medication reconciliation, referral tracking, care plans, follow-up, and other transition workflows. ▪ Discharge information transmission: Capabilities to generate and electronically transmit discharge summaries, medication lists, and follow-up instructions to receiving providers and care managers. ▪ HIE onboarding and interfaces: Onboarding, interface development, system configuration, testing, and technical support needed to connect local systems to healthEconnect and relevant statewide capabilities. ▪ ADT and event notifications: Configuration and implementation of admission, discharge, and transfer notifications and related alerts for authorized providers, assigned care managers, or other responsible entities, building on existing systems. ▪ Patient and care team information: Capabilities and processes to submit, maintain, receive, and use information that identifies patients served by an organization and the providers, care managers, programs, or other entities involved in their care. ▪ System integration: Automated data feeds and integration of HIE alerts, discharge information, referrals, and care-team information into local systems and workflows. ▪ Data quality and standardization: Data mapping, patient matching, terminology alignment, validation, and other activities that improve the accuracy and usability of exchanged information.
2. Workforce Capacity and Readiness	Prepare staff and partner organizations to	▪ Workflow design and change management: Redesign of discharge, referral, notification, escalation, and follow-up



	incorporate shared information and statewide capabilities into routine hospital discharge and transition-of-care operations.	processes to define how information will be received, reviewed, assigned, documented, and acted upon. ▪ Staff training and technical assistance: Training for clinical, care management, discharge planning, administrative, and technology staff on new systems, HIE capabilities, information-sharing requirements, and transition workflows. ▪ Roles and accountability: Development of protocols, operating procedures, governance arrangements, and partner agreements that clarify who is responsible for specific transition activities and how handoffs will occur. ▪ Implementation planning and testing: Readiness assessments, project planning, vendor support, workflow simulation, testing, and phased implementation activities needed before operational launch.
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Funding Limitations

Funding is intended to support infrastructure, readiness, and system transformation. Funding limitations specific to this focus area include:

- Payment for currently reimbursable services.
- Routine clinical service delivery.
- Activities that duplicate or supplant services already funded by Medicaid, Medicare, HRSA, SAMHSA, CDC, IHS, or other federal or state programs.

Additional funding limitations applicable to all RHTP funding opportunities are described in the resources available on the DOH webpage [for RHTP Applicants](#).

Ongoing Technical Assistance and Collaboration

DOH may provide technical assistance, learning opportunities, and collaborative activities to support implementation. Awardees may be expected to participate in program-wide learning and information-sharing activities.

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