

Comments Received by the Alaska Health Care Commission during Public Comment Period (December 7 – December 28, 2009)

Updated: 12-30-09

Subject	Commenter	Summary of Comments	Form & Date
Commission Membership	Thomas Hendrix, PhD, RN; Anchorage	There should be a registered nurse on the Commission, as there are more RNs involved in the delivery of health care in Alaska than any other profession.	E-Mail 12-07-09
Delivery System/Trauma	Julia Heinz, MD; Haines	Has the Commission reviewed the American College of Surgeons report on Alaska's Trauma System?	E-Mail 12-08-09
Insurance; Access	Simon Claydon; Skagway	Medevac costs for Skagway residents are high; community working on innovative solution	Phone call 12-10-09
Quality Improvement	Patrick Anderson; Anchorage	"Lean Healthcare" management system is creating value in hospital and healthcare systems – Commission should advocate for adoption of Lean in Alaska and support funding for technical assistance. Commission should also examine Adverse Childhood Experiences Study conducted by Kaiser Permanente.	E-Mail 12-14-09
Public Health; Medicare; Health Planning; Oral Health	Brian Saylor, PhD; Anchorage	Representing Anchorage Health & Human Services Commission; Appreciates recognition of role of chronic disease in driving costs – should give more attention to support for public health infrastructure; Primary Care Innovation will help with Medicare access – but should also focus on meeting needs of Medicare population, e.g., gerontologists; Supports recommendation for statewide health board – should engage local gov't when it's established; Plan should address oral health too	Public Hearing 12-14-09
Delivery System/Primary Care	Shelley Hughes; Anchorage	Representing the AK Primary Care Association; The Community Health Center model aligns with Commission's vision and goals, and also with patient-centered model described on pg. 14 and are working on a Medicaid pilot with state; rec. A2a – add specific support for Medicaid medical home pilot project; look at recommendation AK Health Care Strategies Planning Council made for state support of CHCs and consider including; should also recommend that state explore development of accountable care organizations; rec B2a - add a seat for primary care safety net provider;	Public Hearing 12-14-09

		Workforce – add finding stating we’ll never be able to grow enough of our own to meet need and so must import; add rec. to investigate the licensing process; encourage innovative paraprofessional provider types for non-Tribal system; emphasize that loan repayment is the most effective approach and most immediate solution to MD/DO recruitment; Medicare – recommend that state support continuation and increase of the \$350K CHC Senior Access Program	
Medicare Access; Oral Health	David Morgan; Anchorage	With Southcentral Foundation (tribal and also CHC); Excellent report; Agrees with PACE recommendation; suggests oral health be included.	Public Hearing 12-14-09
Workforce	Suzanne Tryck; Anchorage	WWAMI payback provision will be problematic; should understand students pay tuition (\$20K/yr) over state contribution and already have debt burden (\$137K avg) – could increase debt to \$350K. WWAMI pmts from state are not a special subsidy – represents the state support of the state school like state GF that supports UAA, but goes to UW since we don’t have our own medical school.	Public Hearing 12-14-09
Workforce	Dennis Valenzano, PhD; Anchorage	WWAMI payback provision will be problematic; referred to recent article in Alaska Medicine – data indicating down-turn in AK WWAMI applicants, possibly due to 50% payback obligation; note that Pathman articles show that service obligation required at beginning of education is the least effective recruitment tool; we have the same goal – to increase docs in AK and primary care, but afraid the Commission’s proposed strategy will have the opposite effect. WY WWAMI is only other state with payback obligation for state share, and they are experiencing a significant decrease in applicant pool.	Public Hearing 12-14-09
Workforce; HIT	Tom Nighswander, MD; Anchorage	WWAMI payback provision will be problematic; UW highest proportion of graduates going into primary care – about 25%; AK already facing competition with all other states that have state sponsored loan repayment. Also, should include psychiatrists and general surgeons with primary care docs as specialties for which AK is experiencing a shortage. Re: HIT – Dr. N is V.P of AK EHR Alliance. Biggest concern for private docs is cost of new EHR systems. The Alliance is helping by vetting vendors – currently	Public Hearing 12-14-09

		negotiating a reduced price package with two national vendors. State investment would be helpful.	
Workforce	16 AK WWAMI 1 st -year Students	It's too early for second expansion of WWAMI – program needs to adjust to recent doubling; Proposed 100% payback provision will have opposite effect of Commission's goal – will drive more med students away from AK and from primary care.	Phone Call 12-16-09
Oral Health/Dental Svcs.	Robert Sewell; Juneau	Add oral health and/or dental services to measures	E-Mail 12-16-09
Workforce	Ryan McGhan, MD, MSPH, FCCP	Agree with most findings and recommendations, but WWAMI payback provision unlikely to achieve desired outcomes and may be counterproductive. Focus on increasing in-state training (GME) instead.	E-Mail 12-17-09
Healthy Lifestyles; Delivery System; Cost; Commission Membership	Paul Zimmer, MD, MPH; Kodiak	Good start; should include discussion of how community infrastructure and culture contribute to unhealthy lifestyles; should address ways to get the disparate healthcare systems in AK to work together better; Need to understand costs; Commission should have primary care representation.	E-Mail 12-17-09
Workforce	Dennis Valenzano, PhD; Anchorage	Letter submitted in response to e-mail from Ms. Erickson requesting clarification on a few questions in follow-up to public testimony presented on 12-14-09. Includes abstract from Journal of Rural Health 2008 article on study documenting competitive students likely to attend different medical school if payback programs are in place.	Letter 12-23-09
Workforce; Medicare Access	Jim Lynch; Fairbanks	Writing on behalf of Alaska Health Care Workforce Coalition; describes membership and work of the Coalition and also status of development of the Alaska Health Care Workforce Plan; need for mechanism to sustain focus on workforce assessment, planning and implementation; Agree with workforce as priority; Note severe shortages in other health professions – not just physicians; Agree with physician shortage findings and recommendations, but in future address distribution not just supply, and also other providers including human service workers; Consider supervisory responsibilities of physicians for mid-levels and support staff in determination of needed MD/DO supply;	Letter 12-28-09

		Especially supportive of Recommendation C2b for loan repayment and direct incentives; Supportive of strategy to improve supply of primary care providers to address Medicare access problem.	
Behavioral Health; Workforce	Alexander von Hafften, MD; Anchorage	Supports Commission; Severity of mental health and substance abuse problems in Alaska is a public health issue; There is a shortage of psychiatrists in Alaska and need for Alaska psychiatry residency; WWAMI recommendation to increase obligation to 100% will be disincentive – goal of emphasizing primary care could be achieved through loan repayment program.	Letter 12-28-09
Primary Care; State Health Planning Board; Workforce	Harold Johnston, MD, FAAFP; Anchorage	Notes Alaska Family Medicine Residency Program is in process of transforming into a patient-centered medical home; Commends Commission for identifying major issues in AK health care delivery; permanent health planning board long overdue; Agrees with physician shortage findings and recommendations except for WWAMI provision to increase obligation to 100% of state medical school support; also disagrees with Medicare Access recommendation E(a) third bullet to require practice obligation of WWAMI students. This new obligation would present a disincentive to students to enter WWAMI, other specialties are needed too, it is unjust and discriminates against medical students, it's unnecessary.	Letter 12-28-09

Record of Phone Calls Received During Public Comment Period

12-10-09 Simon Claydon, Skagway

A medevac from Skagway costs approximately \$30,000, and people with no insurance have to pay that cost out of their own pocket; even those with insurance end up with a deductible and co-pay expense that is usually around \$5,000. Mr. Claydon is part of a community group trying to raise \$32,000 by the end of January to get medevac insurance coverage for the whole community. He believes that if they're successful, it will lower health insurance premiums for Skagway residents over time because the medevac benefit could be removed from individuals' and businesses' health insurance plans. He wanted to the Commission to be aware of both this issue, and the community's innovative approach to try to solve the problem.

12-16-09 16 Alaska WWAMI 1st-year Medical Students

The 100% payback was their primary concern. Most of them are from Alaska (Bethel, Homer, Juneau, Tanana, Anchorage), and most of them want to go into primary care.

- They explained that this program has two purposes: 1) to increase the physician supply for Alaska, and 2) to provide a medical school opportunity for Alaskan kids who want to be doctors. They don't want us to forget that second purpose while we're working on the first. They pointed out that, by attaching an obligation to the state's contribution to support of the medical school, which virtually no other state does (Wyoming followed Alaska's lead after we implemented the 50% payback), we're unfairly penalizing Alaskan medical students – "no other state requires students to stay and practice in their state just because they attended a state-sponsored medical school."
- They thought we should be focused on trying to attract doctors who *want* to be primary care doctors, instead of forcing someone who doesn't want to be a primary care doctor to enter that field under threat of a financial penalty.
- They recommended that we focus on incentivizing primary care doctors to come to Alaska to practice here through educational loan repayment, rather than "punishing" Alaskan students for not choosing to stay in Alaska to practice primary care.
- They expressed concern that the requirement would have the opposite effect of what the Commission intends – that it would actually limit the pool of quality candidates who will apply to AK WWAMI, and that it would drive more students to choose high-paying specialties. They noted that many other states and organizations have loan repayment programs that could potentially cover the increased debt burden the proposed requirement would impose and draw new graduates away.
- They also thought it wasn't fair to expect a medical school applicant to commit before they even start medical school to a particular specialty. They learn so much about different options and opportunities throughout their medical school experience they shouldn't be required to commit to a particular career path before they've had a chance to learn and be exposed to the various options.

- They thought we shouldn't necessarily focus just on increasing the supply of primary care physicians – the specialists who come to present to them in their classes point out the shortages they believe Alaska is facing in their various specialties. (Kristen from Bethel noted that rural Alaska needs all the doctors they can get – regardless of their specialty).
- One young man commented on the expansion part of the recommendation – to increase the class size from 20 to 24. He felt that the program is still catching up from the 10 to 20 seat expansion and that faculty resources are stretched pretty thin. He thought the increase to 24 seats should wait a little while until the program has a chance to catch-up from the last expansion.

Alaska Family Medicine Residency
1201 E. 36th Avenue
Anchorage, Alaska 99508
t: (907) 561 4500
f: (907) 561 4806
www.akfmr.org



December 28, 2009

Deborah Erickson
Executive Director Alaska Health Care Commission
3601 C Street, Suite 902
Anchorage, AK 99503-5923
Email: Deborah.erickson@alaska.gov

Dear Commissioners:

This letter is offered as a public comment on the preliminary draft of the Alaska Health Care Commission's findings and recommendations entitled "Transforming Health Care in Alaska." Thank you for the opportunity to offer my thoughts on your report.

By way of background, I am a lifelong Alaskan and the founding director of the Alaska Family Medicine Residency. I went to college at the University of Alaska and medical school in the Alaska WWAMI program. Prior to entering practice as a physician educator I was a staff physician and medical director at the Anchorage Neighborhood Health Center. Currently my professional role, in addition to directing the Alaska Family Medicine Residency, includes membership on the Alaska WWAMI steering committee, the Director of Graduate Medical Education planning and administration for Providence Alaska Medical Center, and former co-chair of the Alaska Physician Supply Task Force. As a family physician I also practice primary care and serve a substantial population of Medicare patients. Our practice at the Family Medicine Residency is currently in the process of transforming into a patient-centered medical home in accordance with the "new model of practice."

First of all, I would like to congratulate the commission on an excellent effort. I believe you have successfully identified many of the major issues in Alaska health care delivery, and selected critical ones for your attention in the short period of time you have had to do your work. I believe the recommendations on primary care inundation are very wise and important for the future of health care in Alaska. I also believe that a permanent health planning board with a focus on workforce development is long overdue.

As my area of professional expertise is in training physicians for practice in Alaska I would like to focus my comments on this area of your draft report. Regarding physician shortage, findings C2a through e I believe are well taken. Your draft recommendations, especially recommendation C2a to strengthen the supply of primary care physicians, I

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believe is also essential. My only criticism is in recommendation C2c. I support the growth of the WWAMI program from 20 to 24 seats with future expansion as needed; however, the last recommendation of that paragraph to change the WWAMI service requirement I believe is seriously mistaken. In fact of the entire report that is the only area with which I strongly disagree. Although the goal is to increase the number of doctors practicing primary care in Alaska it is certain to have the opposite effect. In addition if you look at recommendation E(a) bullet 3 on Page 22 of the report there is also a suggestion to require WWAMI program participants to serve Medicare patients. This is also seriously mistaken for the same reason.

My objections to this provision fall into four areas:

1. That such a provision would disincentivise students to enter the WWAMI program.
2. That specialties other than primary care are much needed in Alaska.
3. That such a provision is unjust and discriminates against medical students compared with other university students.
4. That such a provision is unnecessary in encouraging physicians return to the state to practice.

Let me detail each of these:

1. Medical students do not generally know what specialty they would like to practice when they enter medical school. The choice of a specialty is a process of experiencing diverse practices and exploring one's own talents and proclivities. Most medical students contemplating entering the WWAMI program would reject a medical school that requires them to pre-select primary care as their specialty. Alaska WWAMI students have the opportunity to enter medical schools anywhere in the United States. At any medical school they incur an average of \$120,000 in student debt. Adding this requirement to the WWAMI program would effectively double the student debt they would have to repay, even if they came back to Alaska but did not practice primary care. The effect of this provision will be to drastically reduce the number of highly qualified individuals applying to the WWAMI program, and thereby make it virtually impossible for us to fill the 20 to 24 seats that we currently have authorized with quality physicians. The result may be vacant positions in the class, or students who struggle with their medical education and are not likely to be the best physicians. In my opinion as a medical educator this provision will certainly NOT result in an increase in the number of primary care physicians practicing in Alaska.

2. Even though primary care is a great focus of need for the state of Alaska, and as your report demonstrates, an essential component in a cost-effective health care system, it is not the only area of medicine we need. Psychiatrists, general surgeons, and subspecialties of internal medicine such as rheumatology and neurology, to name a few, are greatly needed throughout the state. As the state grows and develops and the workforce changes other specialties are certain to become needed in the future. Your recommendation would limit our medical student supply to primary care and would be counterproductive in developing a diverse workforce.
3. In addition to the impracticality of the recommendation, there is an issue of basic fairness raised as well. Students at Universities in Alaska are educated at public expense as part of the cost of operating the University. Their tuition payments do not cover this entire expense. The policy of the State and the University is not to require students who graduate to repay to the State through residency requirements any portion of the cost of their education. Students pay tuition, for which many of them incur debt, but apart from tuition they are not required to make any monetary or service compensation to the State. However, this recommendation (and the current 50% payback clause) does just that; it selects medical students as a unique class of students supported by the state of Alaska who are required not only to pay tuition but also to pay back some of the cost of their education through service or monetary reimbursement. The State Legislature has chosen to support medical education through a partnership with the University of Washington in the WWAMI program, rather than to fund and develop and maintain our own medical school. If we had our own medical school we would charge tuition for the students, but we would not in addition require them to serve in the state after graduation. The legislature through creating a payback provision is "having its cake and eating it too." It avoids the cost of creating and maintaining our own medical school by the much lower cost option of partnering with the University of Washington, AND attempts to get the value of this expense reimbursed by the individual physicians after they graduate by requiring of them in-state service or cash reimbursement. This is unique in higher education in Alaska and in my opinion highly inappropriate. It also, as noted above, creates a disincentive for the best students to participate in our medical education system.
4. More importantly the payback provisions are not required to accomplish the goal. The WWAMI program, before any payback provisions were enacted, had one of the nation's best records at in-state retention of its graduates. In addition the leveraging of the five-state WWAMI program adds to our physician recruitment immeasurably by exposing doctors in training from other states to the opportunities for practice in Alaska. The history of the Alaska Family Medicine

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Residency also demonstrates that creating an excellent training curriculum is in itself the most powerful incentive in retaining graduates in the state. At Family Medicine we do not attempt to "strong arm" the residents in any way. We attract them to an excellent training program and allow them to make their own decisions after experiencing the opportunities and understanding the needs of the state. Both the WWAMI program and our Family Medicine Residency following this strategy, have some of the best in-state retention of graduates of any place in the United States.

In summary, I believe the recommendation C2c, changing the WWAMI service requirement from 50% payback to 100% payback for not doing primary care, would be a serious mistake. It would reduce the quality and numbers of people in the WWAMI program, it would make it harder to recruit doctors to specialties other than primary care (directly undermining the goals of some of the other recommendations in your report, such as direct financial incentive programs), it is unjust and it is unnecessary. The recommendation I would like to see in your report is to eliminate the 50% payback that currently exists for the WWAMI program, not to make it more onerous. We have an excellent physician training program that accomplishes its goals. This provision would weaken that.

Again I want to congratulate you on an excellent report and an excellent set of recommendations. I hope you will agree with me that the one recommendation I mention above should be changed. I would be happy to provide further comment or answer any questions at your pleasure. Thank you for the opportunity to comment. Thank you for the excellent work you have done on the part of the health care system in Alaska.

Sincerely,



Harold Johnston, MD FAAFP
Clinical Professor of Family Medicine
Director of Alaska Family Medicine Residency

HJ/jao

**Providence Health & Services Alaska
Area Operations Administration
3760 Piper Street, Suite 3013
P.O. Box 196604
Anchorage, Alaska 99519-6604**

December 28, 2009

Deborah Erickson
Executive Director, Alaska Health Care Commission
3601 C Street, Suite 902
Anchorage, AK 99503-5923
deborah.erickson@alaska.gov

Dear Ms. Erickson,

The Alaska Psychiatry Resident Steering Committee supports Governor Palin's and Parnell's efforts to develop a statewide plan to improve health care quality, accessibility, and availability for all Alaskans.

Mental health is public health. Alaska has the highest rate of suicide of those aged 15-24, second highest rate of suicide overall, and second highest rate of non-fatal suicide attempts requiring medical hospitalization. Alaska has the second highest rate of illicit drug abuse and eighth highest rate of heavy drinking. Alcoholism and chemical dependency are considered to be Alaska's primary behavioral health challenges. Many mental health problems in children and youth are related to family violence and parents' chemical addiction and mental illness. It is estimated that 70% of all cases of child abuse and 80% of all incarcerated men and women are there because of a drug or alcohol related crime. Untreated and inadequately treated mental illness and addictions decrease educational attainment, decrease earnings potential, decrease productive labor supply, increase medical and addiction co-morbidity, increase homelessness, and increase incarceration.

The Steering Committee's proposal to create an Alaska psychiatry residency is consistent with the Commission's Health Care Transformation Strategy. We believe that the shortage of psychiatrists in Alaska contributes to the ongoing public health crisis. We believe that creating an Alaska psychiatry residency should be one of Alaska's highest workforce development priorities. The Alaska psychiatry residency should train and recruit psychiatrists with specific interest and skill in primary care consultation, telebehavioral health, and transcultural psychiatry.

The Steering Committee discourages the draft recommendation to increase the WWAMI medical student service obligation from 50% to 100%, and to restrict qualifying practice to primary care. These changes would likely be disincentives to prospective medical students. The goals of emphasizing primary care and increasing retention could be achieved through other means such as the loan repayment options currently being considered by the Department of Health and Social Services.

The Alaska Psychiatry Residency Steering Committee would be happy to meet with the Alaska Health Care Commission.

Sincerely,



Alexander von Hafften, M.D.
Chair, Alaska Psychiatry Residency Steering Committee



Banner Health

Denali Center
Fairbanks Memorial Hospital

1650 Cowles Street
Fairbanks, AK 99701
Phone 907-452-8181
Fax 907-458-5324
www.fmhdc.com

December 28, 2009

Deborah Erickson, Executive Director
Alaska Health Care Commission
3601 C Street, Suite 902
Anchorage, AK 99503-5923

Dear Ms. Erickson and Commission Members:

The Alaska Health Care Workforce Coalition (Coalition) is an affiliation of over 20 health care organizations with a commitment and interest in health care workforce. Members represent organizations such as Providence Health and Services, Fairbanks Memorial Hospital, Alaska Workforce Investment Board, Alaska State Hospital and Nursing Home Association, University of Alaska, Alaska Mental Health Trust Authority, Department of Health and Social Services and Department of Education and Early Development, Department of Labor and Workforce Development, and the Anchorage School District. We joined together to develop the Alaska Health Care Workforce Plan - a comprehensive statewide, industry-led plan to ensure a qualified and adequate health care workforce in Alaska.

The Coalition has been meeting since July 2009 and plans to have its initial plan completed by February 15, 2010. The Coalition has identified four major strategies:

1. Engage Alaskans in health care workforce development;
2. Train Alaskans for health care employment;
3. Recruit qualified candidates to fill health care positions; and
4. Retain a skilled health care workforce.

In addition, the Coalition has had considerable discussion about creating a mechanism to sustain the focus on workforce assessment, planning and implementation. The Coalition is working over the next several weeks to identify more specific action steps and priorities related to these strategies.

The initial roll out of the plan occurred at the Alaska State Hospital and Nursing Home Association sponsored Workforce Summit on November 11- 13, 2009. An updated plan was presented at the Alaska Health Summit on December 8, 2009. Feedback from conference participants as well as Coalition members has been incorporated into subsequent drafts. The Workforce Plan will be presented to the Alaska Workforce Investment Board on February 24.

The Coalition wants to make sure that the Alaska Health Care Commission (Commission) is aware of the Coalition's work. We offer an initial early draft of our plan for your consideration (<http://sites.google.com/site/akhcwfdev>). There is much similarity in the strategies identified by both the Coalition and the Commission.

In regards to the Alaska Health Care Commission's draft report, we offer the following comments:

- We agree that health care workforce development is one of the most critical priorities (IICC, p. 7) in assuring health care access in Alaska.
- While it is understandable that the Commission focused initially on physicians, there are severe shortages in other health professions. We encourage the Commission to work with industry to address these needs as well.
- The Coalition also agrees generally with the Commission's Findings and Recommendations related to physician shortages (HCC, p. 18). Attention in future drafts need to address the challenges with both supply and distribution of physicians and other health care providers, including human service workers.
- The Coalition has deliberated the need for supervisory/oversight providers and their impact on other essential occupations. Future drafts also need to consider the supervisory and oversight responsibilities that are required of physicians for physician assistants and other medical support staff. Increasing mid-level and medical support staff is likely to require more physicians to take on oversight roles. Therefore, there must be some balance in increasing physician supply along with other occupations.
- The Coalition is especially supportive of Recommendation C2b (HCC, p. 18) on loan repayment and direct incentives but think it is important that other providers in addition to physicians be eligible for these resources.
- The Coalition also acknowledges the growing problem of Medicare patients accessing primary care and supports your recommendation that improving the supply of primary care providers is a strong strategy in addressing this problem.

Since the Coalition and Alaska Health Care Commission have similar strategies and commitments to address our needs in health care workforce, it is important that we work collaboratively to share information, findings and best practices. Let us know if we can provide additional information for you at this time. Otherwise, as we finalize our workforce plan, we will make it available to the Commission.

Sincerely,



Jim L. Lynch
CFO, Fairbanks Memorial Hospital/Denali Center
Chair, Alaska Workforce Investment Board



December 23, 2009

Deborah Erickson
Executive Director
Alaska Health Care Commission
3601 C Street, Suite 902
Anchorage, AK 99503-5923

Dear Ms. Erickson:

I am writing to respond to the questions that you posed in a recent e-mail message to Alaska WWAMI. In addition to answering the questions, I have attempted to provide the sources for the data contained in the answers. Finally, I am appending the abstract from an article that appeared in the *Journal of Rural Health*. The article describes a study that evaluates the effect of a service obligation, or payback, on applicants to medical school in Alaska, Montana and Idaho. The results show that a large fraction, 47%, of applicants reported that a payback requirement would cause them to attend a different medical school and the most qualified applicants were most likely to assert this view.

- What is the national average ratio of medical school seats to total population? I calculate that Alaska's ratio is 1:8,497 (based on 2008 population estimate by Department of Labor (679,720) and 80 total seats in the program (I know we're not at 80 seats total until the first 20-seat class is in their 4th year, but it's what we have locked in statute now) – let me know if you think that's incorrect. (or is a better comparison the number of graduates annually to population?)

Your calculation for Alaska, assuming 80 seats over 4 years, is correct. This ratio is typically expressed as seats per 100,000 population.

Medical Students per 100,000 population

26.6 – US national average

11.9 – Alaska (= 80 students/6.7 x 100,000 population)

[Source: Key Physician Data by State, AAMC, January 2006]

- Is the current 50% payback requirement 50% of the \$150,000 paid to UW for years 2-4? Or more (including the state contribution to the UA supporting the student's first year)?

The service obligation, i.e. "payback," is 50% of the state contribution for years 2-4 to UW.

It does NOT include the support to UA for the 1st year.

- How many other states have payback requirements for the state's share of the medical school support (beyond Wyoming)?

We know of no others. University of Washington Vice Dean for Academic Programs, Tom Norris, also reports knowledge of no others.

CRITICAL DISTINCTION: This should not be confused with states that offer scholarships to support tuition and other expenses. There are programs in other states that support tuition and other expenses, but no other states require repayment of the portion of university funding that is attributable to medical education.

- What is the national average for state support of medical students that is paid to support operation of the medical school?

\$103,045 – National Average State Support/Student

[Source: LCME part I-A Annual Financial Questionnaire and part II survey]

\$ 56,086 – Average cost of state support to UW per student per year (2nd -4th year)- FY 2008

Please feel free to contact me or other members of the Alaska WWAMI Steering Committee if you or members of the Healthcare Commission need additional information or clarification of any of the answers provided.

Sincerely,



Dennis Paul Valenzano, Ph.D.

Director and Professor, Alaska WWAMI Biomedical Program
Associate Dean for Medical and Premedical Programs
3211 Providence Drive, ENGR 331
University of Alaska Anchorage
Anchorage, AK 99577

(907) 786-4789

Fax: (907) 786-4700

E-mail: afdvp@uaa.alaska.edu

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Relevant quote from abstract, below: **“Forty-seven percent of students reported that they would attend a different medical school if a required payback program were in place.** Students who were more competitive at the time of admission to medical school were significantly more likely to say they would attend another medical school than were less competitive students.”

The Effects of Payback and Loan Repayment Programs on Medical Student Career Plans

John Bernard Miller M.D., M.P.H. Robert A. Crittenden M.D., M.P.H.

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ABSTRACT: Many states have considered implementing payback programs on state-subsidized medical education to increase the rate of graduates returning to those states to practice. An alternative is for states to offer and expand loan repayment programs to entice medical school graduates from rural states to return to their home states. The goal of this study is to determine and contrast the impact these two types of programs might have on medical school choice and students' intentions to return to their home states. Two hundred twenty-nine medical students were surveyed (response rate 80 percent). The questionnaire collected background information on the students and addressed the possible impact of payback and loan repayment policy proposals on student plans. Forty-seven percent of students reported that they would attend a different medical school if a required payback program were in place. Students who were more competitive at the time of admission to medical school were significantly more likely to say they would attend another medical school than were less competitive students. In contrast, 48 percent of students reported that they would be more likely to return to their home states if expanded loan repayment programs were available for service in areas of need. The findings suggest that payback programs may dissuade more competitive students from entering medical schools with such requirements, compromising the pool of students most likely to return to rural areas. Conversely, medical students appear willing to consider loan repayment programs upon completion of their training.

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Erickson, Deborah L (HSS)

From: Paul Zimmer [kodiakzimmers@yahoo.com]
Sent: Thursday, December 17, 2009 7:27 AM
To: Erickson, Deborah L (HSS)
Subject: Comments on Alaska Health Care Commission report.

I was able to read the Preliminary Draft of "Transforming Health Care in Alaska", and I have the following comments:

- Overall, it is a good start on addressing a complex problem.
- It lacks a discussion of how community infrastructure and culture contribute to unhealthy lifestyles, and how to address this. For example, lack of recreational facilities, road design that does not allow for walking, food choices available, etc.
- It should address the many disparate healthcare systems in our state, and how to get them to work together better. Many communities have private, native, CHC, and military systems that operate side by side, and duplicate services.
- There is a need to understand costs: where does all the money go? How much goes towards administration/overhead/pharmaceuticals/inpatient care/outpatient care, etc.
- Your commission should have primary care representation. Is there anyone on your commission that works in the trenches and really understands how healthcare is delivered?
- Alaska is one of the few states with the resources to tackle health care reform, given the political will to do so.

Thanks for your work

Paul Zimmer MD, MPH
Kodiak

Erickson, Deborah L (HSS)

From: Ryan McGhan [ryanmcghan11@hotmail.com]
Sent: Thursday, December 17, 2009 3:43 AM
To: Erickson, Deborah L (HSS)
Subject: public comment

Ms. Erickson--

I am writing to comment on the Commission's "Draft 2009 Findings and Recommendations." If you are able to convey these remarks to the Commission, I would appreciate it.

As a physician born and raised in Alaska, with a background in public health, I would like to thank the commission for their thoughtful attention to the unique challenges facing the delivery of healthcare in our state. For the most part, I agree with the findings and recommendations in the report.

However, as a former WWAMI student and current WWAMI instructor, I think that some of the recommendations regarding support for the WWAMI program (C2c and E(a)) are unlikely to achieve the desired outcomes, and may in fact be counterproductive.

I believe the goals of the WWAMI program have been, since its inception, to increase the physician workforce in Alaska, especially in primary care specialties. The program has been extremely successful at achieving these goals, despite the fact that for most of its existence there has not been an explicit "payback requirement" for the state's financial support. For example, in my class (E95), there are at least 8/10 of us back in practice in Alaska; we did not have any payback requirement.

Although the payback requirement already instituted by the state will likely increase the number of WWAMI graduates returning to practice in the state, it is likely to alter the composition of the class. Already, the number of applicants has fallen from the 80's to the 60's, presumably due to the fact that students with alternatives will seek less restrictive training options. If the goal is for further increases in class size, the reduced applicant pool may become problematic. Certainly, further restrictions in terms of increasing the dollar amount of the payback requirement and narrowing the scope of acceptable work will discourage many Alaskans interested in practicing medicine from participating in WWAMI, and may make it very hard to recruit for the current class size, let alone future increases in class size.

The most effective way of getting physicians to stay in Alaska is to provide them with training options within the state. We should be increasing the number of opportunities for in-state training, rather than decreasing them. While we need to encourage more Alaskans to enter primary care specialties, I believe a far more effective strategy will be developing additional residencies in primary care, particularly in internal medicine. Such training efforts will require the participation of a broad range of physicians, including non-primary care fields such as Ob/Gyn, psychiatry, surgery and its subspecialties, and the subspecialties of internal medicine. For example, I am board certified in a primary care specialty (internal medicine) as well as subspecialties (pulmonary and critical care), and have been an instructor for the family medicine residency for years.

I am extremely grateful for the training opportunities I have been given both outside and most especially inside Alaska. I would like to believe that my classmates and I are making good on the investment that the people of Alaska made in our education, even if only 3 of us practice exclusively in primary care (2 of us also trained in primary care before subspecializing, 2 are psychiatrists, with the balance in emergency medicine, Ob/Gyn, and anaesthesiology). Alaska has staffing shortfalls in many fields outside of primary care as well (including psychiatry, to name but one), and by discouraging physicians who might be considering those fields, I believe the net effect on recruiting qualified physicians to practice in the state will be a negative one. I am unaware of any proposals for the future of healthcare staffing that include a model of 100% primary care doctors, which will be the likely outcome of a roughly \$250,000 payback for non-primary care physicians (on top of already hefty educational debt).

I recommend doing away with the payback recommendations in C2c and E(a), and instead keep the payback requirements the way they are now. Additional restrictions will be counterproductive to expanding WWAMI program and the physician workforce in Alaska. Instead, focus on developing graduate medical educational opportunities in as many fields as possible.

Thank you for your time.

Sincerely,
Ryan McGhan, MD, MSPH, FCCP

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Erickson, Deborah L (HSS)

From: Sewell, Robert G (HSS)
Sent: Wednesday, December 16, 2009 10:11 AM
To: Erickson, Deborah L (HSS)
Cc: Carr, Patricia A (HSS); Millard, Mark A (HSS); Whistler, Bradley J (HSS)
Subject: P-0030 - Commission - feedback on indicators: please include - ORAL HEALTH

Morning Deb,

~ Wanted to say that you did an excellent job on your presentation, re: the HC Commission – at our recent ALPHA conference (12/8)
~ Very sharp, succinct, well-organized, and informative

Call for feedback

~ Also, I noticed that you (& the Commission) are calling for feedback on the report/document until Dec 28th, and I thus do have a suggestion

Include: Oral Health

~ Please include (at least) 2 or 3 measures of “**oral health**” and/or “**dental services**” – as regards our Alaska population overall, and possibly broken out by census area
~ There are several reasonable indices, and many of these are presented below, as to be found in either the AHCDB, or, the AOHP

Alaska Health Care Data Book (2007)

<http://hss.state.ak.us/dph/healthplanning/publications/healthcare/>

(for instance, click on the following link to thus look up (any) of the tables listed below, re: oral health:

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Alaska Oral Health Plan: 2008-2012

<http://www.hss.state.ak.us/DPH/wcfh/Oralhealth/docs/Oral-Health-Plan.pdf>

Let me know if you need help on this, or any related matter,
Best, Robert

Erickson, Deborah L (HSS)

From: Patrick Anderson [patrick@Chugachmiut.org]
Sent: Monday, December 14, 2009 6:08 PM
To: Erickson, Deborah L (HSS)
Subject: Alaska Health Care Commission Draft plan
Attachments: AlaskaHealthCareCommission.doc

Attached are comments I am submitting on the draft plan.

Patrick M. Anderson, Executive Director
Chugachmiut
1840 Bragaw St., Suite 110
Anchorage, Alaska 99508
(907) 334-0147

Written comments on:

Transforming Health Care in Alaska
2009 Report Draft: 2010-2014 Strategic Plan
Alaska Health Care Commission

I have 2 areas of comment on the draft plan.

1. I am truly amazed that not one member of the commission is aware of the tremendous value being created in hospital and health care systems in the United States through the implementation of the management system referred to as "Lean Healthcare." Here are a few examples with citations to Internet resources documenting the improvements.

The Clearview Cancer Center in Huntsville, Alabama, reduced their patient journey by 60 to 90 minutes. They anticipate another reduction in patient journey of 30 minutes once a central communications system was implemented. Patients are no longer kept into the evening to complete their treatment. Their patient load has increased by 45% in 2 years without an increase in staff, except for nurses. The reason—patients are living a lot longer and coming back for multiple treatments.

<http://www.lean.org/common/display/?o=805>

Sutter Health Care in Elk Grove, CA used a lean pre-design process that resulted in a facility requiring 40% less staffing, 30% less square footage, reduced energy consumption by 25% and reduced patient wait times by 50%.

<http://facilitymanagement.com/articles/design2-1207.html>

Virginia Mason has increased the amount of time its nurses spend with patients to 90%. They have a variety of other incredible improvements that are documented here. The quality of their patient care has climbed considerably.

https://www.virginiamason.org/home/workfiles/pdfdocs/press/vmps_fastfacts.pdf

Theda care reduced its in patient care costs by 25% before they quit counting. Their CEO projects that the United States could save \$400 million in Medicare costs if all hospitals achieved similar results.

http://www.usatoday.com/news/health/2009-09-09-saving-money-hospitals_N.htm

The Pittsburg Regional Healthcare Initiative reduced central line associated bloodstream infections by 68% during a 4 year period using lean healthcare techniques.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5440a2.htm>

I urge the Alaska Health Care Commission to reconsider it's discussion of quality to advocate for adoption of lean healthcare management models for Alaska, and for funding to provide the technical assistance that will be required to spread the management model.

2. I urge the Alaska Health Care Commission to examine the Adverse Childhood Experiences Study conducted by Kaiser Permanente in California in partnership with the Centers for Disease Control, and models used to counteract the behavioral patterns adopted by adults who have ACE's. The health consequences of ACE's are major, and need to be addressed by methods other than traditional medicine.

http://www.cestudy.org/files/Gold_into_Lead-_Germany1-02_c_Graphs.pdf

ACE's are common, and difficult to overcome. They contribute to many high-risk behaviors due to the early trauma and its effect on areas of the brain that handle mood, stress response, bonding, memory and how the body stores fat.

Patients with high ACE's scores have higher rates of smoking, alcoholism, depression, anxiety, promiscuity, financial difficulties and sexually transmitted diseases.

http://naturalmedicine.suite101.com/article.cfm/childhood_trauma_and_adult_illness

Working with patients with high ACE's scores will require more behavioral interventions, but Washington State and Oklahoma have programs to address children and adults with high ACE's scores.

<http://www.fpc.wa.gov/publications.html>

http://www.oica.org/facts_and_publications/index.html#Adverse_Childhood_Experience_Issue_Briefs

Cognitive behavioral therapy and dialectical behavioral therapy are apparently 2 possible methods for addressing ACE's issues.

Thank you for reading and if you have any additional questions, please feel free to contact me.

Patrick M. Anderson
Executive Director
Chugachmiut, Inc.
patrick@chugachmiut.org
(907) 748-3261

Erickson, Deborah L (HSS)

From: Julia Heinz [juliah@searhc.org]
Sent: Thursday, December 10, 2009 9:53 AM
To: Erickson, Deborah L (HSS)
Subject: Re: trauma

Many Thanks, Deborah. I am comforted by your reply!
Julia

Erickson, Deborah L (HSS) wrote:

> Hello Dr. Heinz,
> The Commission has not reviewed the ACS trauma system assessment and
> consultation report. They spent their first year designing a general
> strategy and planning approach to health care reform for Alaska, and
> developed some initial recommendations addressing broader system
> issues (e.g., health care workforce, health information technology).
> The only more specific issue they delved into this year was the
> problem with access to primary care for Medicare beneficiaries.
>
> However, our original Commission Chair, Dr. Jay Butler, spearheaded
> the trauma system review (in his role as Chief Medical Officer for AK
> DHSS) and developed an implementation plan for the recommendations in
> that report right before he left in June. And our current Commission
> Chair, Dr. Ward Hurlburt (the new Chief Medical Officer for AK DHSS
> and Division of Public Health Director), has already been working on
> this, participates in the Trauma System Review Committee meetings, and
> has identified trauma system improvement as one of his top public
> health priorities for the coming year. He just created a new position
> to serve as the Trauma System Coordinator, and is recruiting for that
> position right now. That person's first job once they're hired will
> be to develop a strategic plan for trauma system improvement.
>
> Also, the Commission has compiled an inventory of recent health system
> plans and assessments, and also a list of all the various planning
> committees involved in addressing some aspect of Alaska's health care
> system, and the Trauma System Assessment is on the inventory of plans
> and reports, and the Trauma System Review Committee is on the list of
> planning committees. So they are at least aware of its existence. My
> guess is Dr. Hurlburt and the department will make significant
> progress on implementation over the next couple years, especially with
> the creation of the new Trauma System Coordinator position.
>
> I will share your question with the Commission as part of the public
> comment review too, so they will know there is interest in this issue
> on the part of the public.
>
> Thank you for your inquiry,
> Deb
>
> -----Original Message-----
> From: Julia Heinz [mailto:juliah@searhc.org]
> Sent: Tuesday, December 08, 2009 11:13 AM
> To: Erickson, Deborah L (HSS)
> Subject: health care commission
>

Erickson, Deborah L (HSS)

From: Julia Heinz [juliah@searhc.org]
Sent: Tuesday, December 08, 2009 11:13 AM
To: Erickson, Deborah L (HSS)
Subject: health care commission

Hi Ms Erickson,

I am a family practitioner in Haines Alaska and am curious if the commission ever reviewed the college of surgeons report on emergency care in Alaska. Thanks, Julia Heinz MD

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Erickson, Deborah L (HSS)

From: Thomas J. Hendrix [tjh@mtaonline.net]
Sent: Monday, December 07, 2009 5:29 PM
To: Erickson, Deborah L (HSS)
Subject: public comment

Hello:

Thank you for the opportunity to comment. As a member of the original Health Care Strategic Planning Council I am quite familiar with the issues before the commission. I was surprised and disappointed that there is not a single nurse on the commission. In fact, there should be a registered nurse on the commission. There are more registered nurses involved in the delivery of care in the state of Alaska than any other single profession and the numbers are not even close. They are by far the majority.

Regards, Tom

Thomas J. Hendrix, PhD, RN
Health Policy/Health Economics
Assistant Professor
School of Nursing
University of Alaska
tjh@mtaonline.net