Transforming Health Care in Alaska

2011

PUBLIC COMMENT DRAFT: 2011 Findings & Recommendations
Written Comments due Friday, December 2, 2011

2010 – 2014
Strategic Plan
Update

Transforming Health Care in Alaska

2011 Report/2010-2014 Strategic Plan

Alaska Health Care Commission

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PUBLIC COMMENT DRAFT: 2011 Findings & Recommendations
Written Comments due Friday, December 2, 2011

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
ALASKA HEALTH CARE COMMISSION

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November 11, 2011

To: Alaska Health Care System Stakeholders

The Alaska Health Care Commission was established in 2010 under Alaska Statute 18.09.070 to foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state, including a strategy for improving the health of Alaskans. The commission is advisory in nature, and is charged with presenting annual recommendations to the Governor and Legislature by January 15 of each year.

The commission held public meetings during March, June, August and October of this year to learn about the current condition of Alaska's health care system and leading health concerns, and to discuss strategies and develop recommendations for improvement. A draft of the commission's 2011 findings and recommendations are presented here for public review and feedback. Also included for public feedback are the commission's planned areas of study for 2012. The commission will meet one last time this year on December 9 to consider public comment and finalize finding and recommendation statements for inclusion in their 2011 report.

Please submit comments in writing by Friday, December 2, 2011, to:

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Please contact me if you have any questions about the work of the commission.

Sincerely,

Deborah Erickson
Executive Director

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Part I: Introduction

A. 2010–2014 Strategic Plan Framework

The following graphic depicts the framework the commission is using to guide the process for improvement of Alaska's health care system, and includes updates on the status of each step in the process.

Describe the main characteristics of the ideal future health care system for Alaska; develop goals for health care system transformation; identify values of the transformed system. *Accomplished (2009). See Part I.B. of this report.*

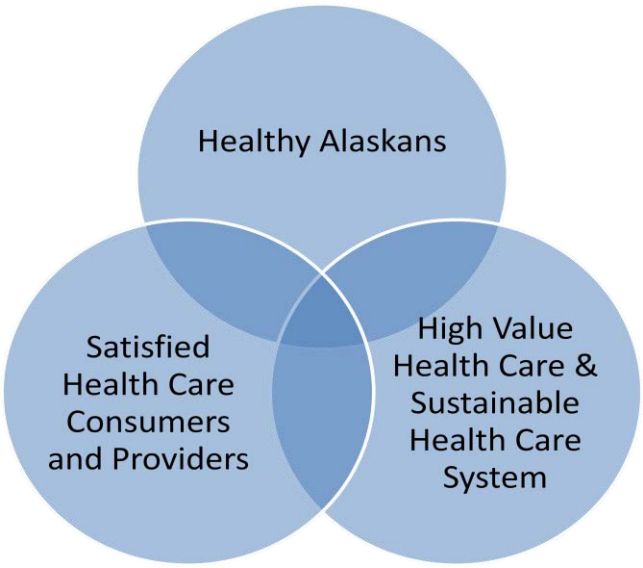
Accurately describe Alaska's health care challenges to understand why the current system is not achieving the vision. *Accomplished: System Description & Issue Identification (2009); Impact of Federal Reform (2010); Cost Analysis, Pricing & Reimbursement Comparisons, Long Term Care (2011); 2012-2014 TBD. See Part II of this report.*

Ensure the building blocks for a sound health care delivery system are in place to provide a strong foundation for transforming the current system. *Accomplished (2009): Recommendations for Workforce, Health IT, & Leadership. See Part III of this report*

Design the elements necessary to achieve the health care system vision. *Accomplished: Promoting Healthy Lifestyles, Patient-Centered Primary Care, and Medicare Access (2009); Evidence-Based Medicine (2010); Patient-Centered Primary Care (con't.), Price & Quality Transparency, Payment Reform, Trauma System, Obesity, Immunization, Behavioral Health (2011). See Part III of this report.*

Track implementation of recommendations, and establish an indicator set (including benchmarks and targets) for measuring progress of health care system improvement. *Updates on implementation of prior year recommendations included in annual reports. Indicators for measuring system improvement to be established in 2012.*

B. The Commission's Vision for Transformation of Alaska's Health Care System



Vision

Alaska's Health Care System:

- Produces improved health status
- Provides value for Alaskans' health care dollar
- Delivers consumer and provider satisfaction
- Is sustainable

The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center of their health experience and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at an affordable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system is one that is sustainable over time.

Health Care Goals

I. Improved Access
II. Contained Cost
III. Safe, High Quality Care
IV. Prevention-Based

The Commission is crafting strategies focused on attainment of the following four goals for a transformed health care system:

I. **Access:** Access to affordable health care coverage and to a viable and vital health care delivery system is improved.

II. **Cost:** The cost of health care is controlled so that the medical inflation rate in Alaska is below the national rate.

III. **Quality:** Alaskans can be assured that health care services they receive in Alaska meet the highest quality and safety standards.

IV. **Prevention:** A focus on preventive services, both clinical preventive services for individuals and community-based prevention policies, will support improved health status and control costs by reducing the burden of preventable disease and injury.

Values

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

The Commission applies the following values to guide planning and policy recommendation decisions for transformation of Alaska's health care system:

Sustainability: A redesigned health care system for Alaska must be sustainable in terms of: 1) government, private sector, and individual ability to financially support implementation over the long term; and, 2) health care provider ability to deliver quality care while maintaining a sound business operation.

Efficiency: A redesigned health care system for Alaska will minimize waste in clinical care and administrative processes.

Effectiveness: A redesigned health care system for Alaska will support practices best known to produce the best outcomes.

Individual Choice: A redesigned health care system for Alaska will provide information and options for Alaskans in terms of health care coverage and service providers.

Personal Engagement: A redesigned health care system for Alaska encourages and empowers Alaskans to exercise personal responsibility for healthy living and for obtaining and participating in their health care.

C. Core Transformation Strategy

The figure below depicts in graphic form the core strategies identified by the Commission for transforming Alaska's health care system to achieve their vision, and the relationship of those strategies to one another and to the planning process.

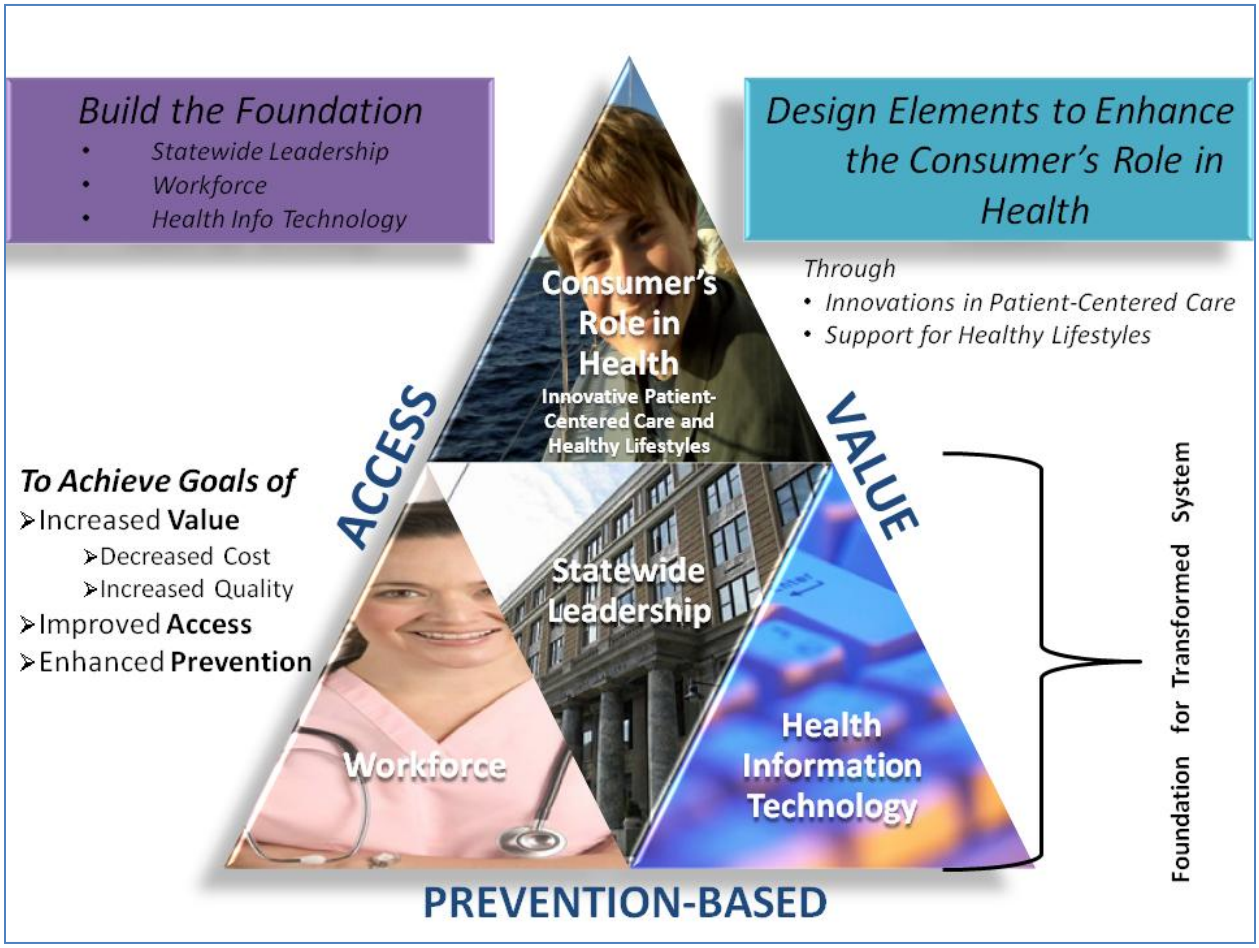


Figure 1: Alaska Health Care Commission's Core Strategy for Health Care System Transformation

Understanding and supporting the consumer's role in health care is the central focus of Commission's strategic approach to transformation of Alaska's health care system. Two aspects of the consumer's role are critical to addressing the goals of increased access, improved value (cost and quality), and a focus on prevention – 1) individual lifestyle choices and the impact those choices have on health outcomes and demand for health care services; and 2) the individual's central position in their health care experience. Support for healthy lifestyles and new innovations in patient-centered care are the pinnacle of the Commission's health care transformation strategy.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and an innovative patient-centered system depend. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. On-going study, planning, and policy development is necessary to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

D. Definitions of Health & Health Care

The commission adopted the following definitions as a tool for providing a common understanding for group discussion and for guiding planning efforts. These definitions are not meant to imply certain roles for government or health care providers.

Health & Healing

- Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health.

Physical	Fitness. Nutrition. Medical self-care. Control of substance abuse.
Emotional	Care for emotional crisis. Stress Management
Social	Communities. Families. Friends
Intellectual	Educational. Achievement. Career development
Spiritual	Love. Hope. Charity.

- An individual's health status is largely self-defined, encompassing a broader state of well-being beyond physical health and lack of disease or infirmity.

- Healing is restoration of wholeness and unity of body, mind and spirit. It involves curing when possible, but embraces more than cure. When illness is limited to disease and health care is limited to cure, the deeper dimensions of healing are missed.

Health Care

- Health Care means any care, treatment, service, or procedure to prevent disease, injury and other physical and mental impairment; and to maintain, diagnose, or otherwise affect an individual's physical or mental condition.

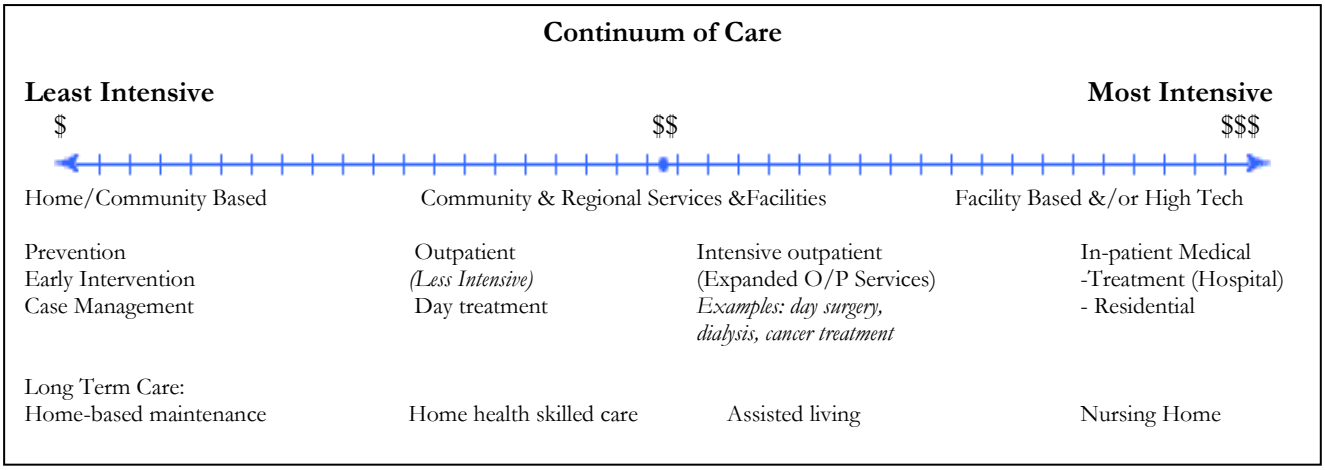
Health Care System

- A health care system is a collection of organizations, practitioners and allied workers, facilities and technologies, financing mechanisms, policies, and information that provide and support the provision of health care for a population.

- People in Alaska obtain health care through three different systems: the private sector, the military/VA, and the Alaska Tribal Health System.

Health Care Continuum

- The health care continuum is the full array of physical and behavioral health services, from prevention to treatment to rehabilitation and maintenance, required to support optimum health of a population.



Part II: Understanding Alaska's Health Care System Challenges

A. Summary of Prior Year Findings

Concerns regarding the current condition of Alaska's health care system described in detail in past years' reports include the following. Please see the Commission's 2009 and 2010 reports for more detailed findings and discussion.

- The high and rising cost of health care in Alaska is unsustainable.
- Health insurance coverage in Alaska is inadequate.
- Providers and patients experience logistical challenges in the delivery of and in accessing health care services.
- Fragmentation and duplication in Alaska's health care system creates inefficiencies.
- Alaska suffers from shortages and maldistribution of health care workers.
- Health status, health risk behaviors and changing demographics contribute to high utilization of health care services.
- Use of modern health information technology is taking hold in Alaska, but much remains to be done.
- Alaskan Medicare enrollees living in urban areas have trouble accessing primary care.

B. 2011 Study: Cost of Health Care in Alaska

The commission contracted for two studies this year to learn more about the cost of health care in Alaska. One was an economic analysis conducted by the Institute for Social & Economic Research (ISER)/MAFA on spending for health care services in Alaska, including estimates of total spending levels by payer and types of services. The other was an actuarial analysis conducted by Milliman, Inc., an international health care actuarial consulting firm, on health care pricing for hospital and physician services.

The purpose of these studies was to provide information regarding health care cost drivers in Alaska to inform future policy recommendations aimed at improving affordability and access to care. Hospital and physician services were the first two areas selected for actuarial study because they represent the highest proportion of spending for health care in Alaska at 31.5% and 28% (respectively), compared to 9% for prescriptions and equipment, 3% for nursing home and home health care services, 5.5% for dental services, 10% for administrative costs, and 13% for all other services. The commission plans to study pricing for skilled nursing facility care and prescription medication during the coming year.

The economic analysis conducted by ISER/MAFA identified trends in levels of spending, who is paying the bills and how cost shifting occurs between payers, the services Alaskans are buying, the numbers of Alaskans with health insurance, and the proportion of employers offering health care coverage to their employees. This study was published in August and is available on ISER's web site at: http://www.iser.uaa.alaska.edu/Publications/RevisedHealthcare.pdf

The actuarial analysis of physician payment rates conducted by Milliman compares health care prices for the top 25 utilized procedure codes for each of 18 physician specialties in Alaska with five other states: Washington, Oregon, Idaho, Wyoming, and North Dakota. The analysis includes a comparison of billed

and allowed charges for commercial payers, and fees for Medicare, Medicaid, Workers' Compensation, the Veteran's Health Administration, and TRICARE.

The hospital payment rate analysis compares payment levels in Alaska's non-federal facilities with non-federal facilities in the same five comparison states plus Hawaii. Hawaii was added at the request of the state hospital association because of logistical challenges similar to Alaska's, such as those associated with transportation costs, and because of the similarly high cost-of-living. This analysis was restricted to non-federal hospital facilities due to data limitations, and because federal facilities serve a defined beneficiary population, have unique federal funding streams, and operate under differing rules than non-federal facilities. Additionally, the commission's recommendations are primarily targeted at state government policy leaders and will have more limited influence on federal and tribal policies.

The hospital analysis includes 100% of the non-federal acute care facilities and 74% of licensed acute care beds in Alaska (federal tribal and military hospitals support 19% and 7% respectively of total licensed beds). The commission may choose to conduct a separate analysis of price and cost drivers for federal tribal and military hospital services at some point in the future if analysis of potential strategies related to cost of care and sustainability of the health care system require this additional information.

The commission's findings on the cost of health care described below are based on the ISER report and other studies published in peer review journals, as well as preliminary data from the Milliman reports. The Milliman reports will be published and available to the public by early December.

Findings

- **Health care spending in Alaska continues to increase faster than the rate of inflation, and consumes a growing share of Alaska's wealth.** Total spending for health care in Alaska reached $7.5 billion in 2010, a 40% increase from 2005. At current trends it is projected to double to more than $14 billion by 2020. Health spending in 2010 was roughly 50% of the value of oil produced at the wellhead that year. By comparison, this measure of health care spending against petroleum industry production (the major driver of Alaska's economy since statehood) was 6% in 1980, 16% in 1990, 33% in 2000, and is projected to reach between 72-74% by 2020.

- **Health care is becoming increasingly unaffordable for U.S. and Alaskan employers and families.**
    - The cost of health insurance premiums in the U.S. increased by 160% between 1999 and 2011, compared to an overall rate of inflation of 38% during that same period.
    - American workers' contributions to health insurance premiums increased 168% between 1999 and 2011, compared to a 50% increase in workers' earnings during that same period.
    - Since 1982 the Anchorage Consumer Price Index increased 95%, while the CPI for medical care in Anchorage over that time period increased 320%.
    - Alaska is number one in the nation for the cost of employee health benefits based on a newly released survey by United Benefits Advisors, which found that Alaska employers are paying an average of $11,926 per employee each year for health insurance – nearly twice as much as the least expensive state.
    - Fewer Alaskan employers are offering employee health benefits in 2010 than in 2003.
        - The percentage of large employers in Alaska (those with more than 50 employees) offering coverage dropped from 95% in 2003 to 93% in 2010.
        - The percentage of small employers offering coverage dropped from 35% to 30% during that same period.

- Alaskan employees' share in the cost of their insurance premiums increased from 11% to 14% for single coverage and from 17% to 22% for family coverage between 2003 and 2010.
- The average cost of a health care premium increased 51% for single coverage and 35% for family coverage between 2003 and 2010.
- The average annual premium cost for family coverage in Alaska was $14,230 in 2010.

- **Cost shifting occurs between commercial and public payers.** Cost per unit of service is significantly higher for commercial payers relative to provider operating costs and compared to the two largest public payers, Medicaid and Medicare. For example, commercial reimbursement rates are 110% higher than Medicare reimbursement for hospital services in Alaska. Also, as spending has increased over time for all payers in Alaska, it increased at a higher rate for individuals and private employers compared to government employers and public programs.
  - Because of the cost shifting that occurs through rate disparities, rate reductions by public payers may result in higher rates charged to commercial insurers and translate into higher premiums for individuals who purchase private insurance and for employers who provide employee health benefits.
  - While the major public payers appear to under-reimburse providers compared to private payers, they provide additional financial support for health care through other mechanisms. For example, Medicare subsidizes physician residency training, Medicare and Medicaid provide Disproportionate Share Hospital (DSH) payments to hospitals that see a high proportion of Medicare and Medicaid patients, and the federal government through the Indian Health Service and Alaska Tribal Health System has funded much of the development of the rural health infrastructure in Alaska.
  - The existence of public insurance programs helps spread health care system fixed costs among more payers and beneficiaries.

- **Commercial insurance premiums in Alaska are roughly 30% higher relative to five comparison states, which are higher than the national average. Commercial insurance premiums are primarily a factor of utilization and price for health care services.**

- **Alaska's health care utilization rates do not appear to be a major driver behind higher premium rates. Utilization of health care services in Alaska is roughly in line with comparison states, and is lower than the nationwide average.**
  - Alaska uses 13% fewer services than the nationwide average to treat a similar Medicare patient.
  - Alaskan Medicare enrollees have fewer hip replacement surgeries and roughly the same number knee and shoulder replacement surgeries (rate per 1,000 enrollees).
  - For the commercially covered population, inpatient bed days are higher overall in Alaska, but lower in urban Alaska than the comparison states. Emergency room visits are higher, outpatient visits are about the same, and medication prescriptions are lower.

- **Health care prices paid in Alaska are significantly higher than in comparison states.**
  - Reimbursement for physician services in Alaska is 60% higher than in comparison states for all payers based on a weighted average; and 70% higher for commercial (private insurance) payers.
  - The difference in reimbursement for physician services varies significantly depending on the specialty. For example, pediatricians in Alaska are reimbursed at rates 43% higher on

average than pediatricians in the comparison states, and cardiologists in Alaska are reimbursed at rates 83% higher than cardiologists in the comparison states.
    - Commercial reimbursement for private sector hospital services is 35% higher in Alaska than in the comparison states. Medicare fees paid for private sector hospital services are 36% higher in Alaska than in the comparison states.

- **Medical prices are driven by two components: 1) operating costs associated with delivering medical services, and 2) profit margins. Following are attributes of medical prices in Alaska's private health care sector:**
    - Operating costs for health care providers are higher in Alaska relative to the comparison states. There is insufficient data available to fully analyze and compare physician practice operating costs, but analysis of publicly available hospital cost reports found Alaska private sector hospital operating costs are 40% higher overall and nearly 80% higher for Alaska's private sector rural hospitals. Higher operating costs in Alaska for both hospitals and physician practices are driven by:
        - The cost of living, which is 15-20% higher in Alaska than in comparison states (overall, not accounting for rural/urban differences).
        - Medical salaries for health care workers, which are 2% - 10% higher in Alaska (excluding self-employed physicians).
        - Health benefit costs for hospital and physician practice employees, which in Alaska are higher than any other state in the nation.
        - 11% - 15% utilization of "travelling" temporary staff, who typically are paid at a higher rate and whose employment results in other inefficiencies in delivery of health care services;
        - Administrative burdens associated with government regulation and compliance with payer requirements, including documentation requirements, fraud and abuse audits, licensing and certification requirements, and employee background checks.
        - Drivers of higher operating costs in Alaska specific to private sector hospitals include:
            - RN staffing ratios, which are 28% higher than in comparison states.
            - Occupancy rates, which are lower at approximately 50% in Alaska relative to approximately 60% in comparison states.
    - Operating margins for Alaska's private sector hospitals are high, especially for Alaska's urban hospitals which make on average profits approximately three times higher than the average of the comparison states' hospitals and also the national average for all hospitals. The average profit margin for Alaska's private sector rural hospitals is slightly higher than the comparison states' average.
    - Physician discounts are low in Alaska relative to the comparison states, an indication that physicians in Alaska have more market power in Alaska relative to pricing.

- **Utilization for health care services in Alaska, while similar to the comparison states and low relative to the U.S. and other industrialized nations, is still a critically important factor to consider in containing cost growth and improving quality of care and health outcomes.** Utilization of health care resources is highly inefficient. The estimated level of wasted health care spending in the U.S. is between 30% and 50%, leaving significant room for improvement in the effectiveness and efficiency of health care delivery.

- **Market forces affecting pricing for health care services are impacted by state laws and regulations in Alaska.** There are state laws and regulations in place that influence the market in such a way as to drive prices higher for the consumer. For example, Milliman notes a state regulation requiring that claims be paid at the 80th percentile of charges by geographic area, limiting private payers' ability to negotiate rates and imposing a legal mandate to reimburse providers with more than 20% market share in a region for the full amount of billed charges regardless of the rate.

C. 2011 Study: Long Term Care in Alaska

Long term care encompasses a broad range of medical and support services for individuals requiring assistance over time with meeting skilled acute care needs and custodial support with activities of daily life. These services can be provided in the home, community settings such as senior centers, assisted living facilities, and nursing homes. Alaskans with long term care needs span all ages and include children with intellectual and developmental disabilities, people with spinal cord and traumatic brain injury, people with persistent and severe behavioral health conditions, and seniors suffering decreased mobility or cognitive functioning due to aging or those with severely disabling chronic disease.

Medicaid is the primary payer for long term care services and supports in the U.S. and in Alaska. To become eligible for Medicaid coverage long term care recipients must spend down most of their personal resources. Medicare pays for time limited nursing home stays that are transitional and rehabilitative in nature, and will also pay for limited home health services if there is registered nurse oversight and the services are therapeutic. Other sources of funding include out-of-pocket spending (which accounts for 18% of long term care spending nationally), and long term care insurance (though only 7.2% of Americans have or use private insurance to pay for long term care). Unpaid family members and friends provide the majority of long term care services.

Nearly 50,000 Alaskans benefit from state-administered long term care services in Alaska, with a total expenditure of $422 million annually. 78% of state-supported long term care spending provides for home and community-based care. 97% of state-supported recipients receive long term care services and supports in a non-institutional setting. Currently in Alaska only 38% of senior and disability service recipients in Medicaid programs are seniors over 65 years of age.

Alaska policy makers have worked for years to move away from institutional care to a more balanced system emphasizing home and community-based care. Alaska is one of very few states that do not maintain a state facility for the developmentally disabled, and the only state to have no intermediate care facility for individuals with mental retardation. There are currently 15 nursing facilities with 662 licensed nursing home beds. While the senior population has tripled over the last 20 years, the number of nursing home beds has decreased as programs have moved away from institution-based care.

The move away from institutional care led to a substantial increase in Medicaid spending for home and community-based services, which more than quadrupled over the past decade from approximately $58 million in 2000 to nearly $280 million in 2010. Alaska Department of Health & Social Services officials cite the growing cost of providing long term care services as one of the most critical issues facing the state's Medicaid program. The department projects Medicaid spending for all long term care services will increase by 240% over the next decade to $922 million in 2020.

The State of Alaska conducted numerous studies over the past decade to develop recommendations for the future of long term care in Alaska, but a strategic plan focused on finding the most appropriate, cost effective, affordable, sustainable approach to meeting the long term care needs of Alaskans does not exist. A new coalition of long term care stakeholders was formed during 2011 to help facilitate that planning. In the short time since this coalition convened they have reviewed and compiled recommendations from the most recent studies, gathered existing data on the current system, and also gathered future cost and demographic projections. The commission benefited from presentations by the coalition this year, commends them on their rapid progress, and looks forward to additional information and future recommendations from the coalition.

D. Issues Prioritized for Study in 2012

The commission intends to focus on the following areas to continue learning about the current condition of Alaska's health care system during 2012:

- **State legal and regulatory barriers:** Identify barriers to innovation in health care delivery, financing and reimbursement in Alaska that are specifically created by Alaska laws and regulations. Consult with Alaska health care providers, payers, purchasers and patients to gather their ideas.
- **Cost of Skilled Nursing Facility Care and Pharmaceuticals in Alaska:** Compare pricing and reimbursement levels across payer types for Skilled Nursing Facility and Pharmaceuticals to the comparison states, and identify drivers of cost differentials.
- **Federal Reform:** Continue to track Affordable Care Act implementation activities in Alaska

Tabled for Study in Future Years

- **Genetic advancements in medicine**: This is sure to have an effect and result in issues related to cost, access and quality, but there is not much the commission can do to address it right now.
- **Malpractice Reform**: Tort reform legislation was passed in Alaska in 2005. Future work could address how standards of care are defined in case law, and study models for alternatives to litigation.
- **Fraud & Abuse**: Numerous new programs to prevent and control fraud and abuse are being implemented under federal reform and the state is trying to align state fraud and abuse efforts with the new federal programs and requirements as much as possible to minimize disruption for providers. The commission will wait and see how these programs develop.
- **Alaska's Public Health System:** The Alaska State Constitution vests the legislature with the duty to "provide for the promotion and protection of public health" (Article 7, Section 4). The commission may devote future study to learn about the system in place to fulfill this duty, and identification of strengths and weaknesses of the current system.
- **"Hyperconsumerism":** System incentives caused by third-party payment systems lead patients to seek more care and not seek value: This issue has been addressed in part in the 2011 payment reform and transparency discussions, and will be addressed further during 2012 discussions on employee health benefit and plan design.
- **Alaska's Worker's Compensation Program:** It is not the commission's role to develop operational recommendations for specific state programs such as Workers' Comp and Medicaid; however, issues related to state programs and general policy recommendations affecting them emerge in the course of the commission's work. Issues related to this program were identified in part in the 2011 cost studies, and will be further identified and addressed during 2012 through the work on the Employer's role in health and health care.
- **Demographic changes:** Specifically, the effects of the Baby Boom generation population bubble on the health care system following its "pop" – how will our kids and grandkids support (or dismantle) the huge infrastructure that will be created to care for us?

Part III: Alaska Health Care System Transformation Strategies

A. Health Care System Foundation

Health Workforce

The workers who provide patient care and support all other aspects of health and health care delivery are a foundational resource for the health system. Shortages of workers in certain health occupations can increase health care costs and limit access to care. The commission initially made a series of recommendations related to the health workforce during 2009. Since that time the commission has tracked the work of the Alaska Health Workforce Coalition, a public-private partnership of leading health industry, government, academic and training organizations formed in 2010 to address Alaska's health workforce needs.

In the short time since their formation the Alaska Health Workforce Coalition has made significant progress, leveraged through an impressive partnering effort and pooling of resources rarely seen between public and private sectors. The coalition identified a series of goals and strategies for strengthening the workforce and published the Alaska Health Workforce Plan in 2010, and during 2011 developed an "Action Agenda" to focus efforts on specific high-priority occupational and system improvement issues. The commission applauds the efforts of the coalition, and will continue tracking their work over the coming year. Of particular importance to the commission are the coalition's systemic change initiatives focused on improving workforce data to support needs-based planning and resource allocation, and on government policy barriers to and supports for workforce development.

Summary of current health workforce recommendations made by the commission in prior years:

- Make health workforce development a priority, and support coordinated planning
- Strengthen the pipeline of future health care workers
- Support workforce innovation and adaptation as care models evolve
- Increase the supply of primary care physicians
    - Support educational loan repayment and financial incentives for recruitment
    - Expand WWAMI Alaska medical school seats as resources allow
    - Support primary care residency program development & operation
        - Continue support for family medicine residency
        - Support development of pediatric and psychiatric residencies
        - Support planning for primary care internal medicine residency

Health Information Infrastructure

The health information infrastructure is the combination of all the people, data, policies and procedures, financial resources, facilities and technology which supports the creation, use, storage, protection and transmission of health information. Health information is required to support:

- Public health surveillance and epidemiologic studies
- Coordination and management of patient care by clinicians
- Performance management and quality improvement efforts of providers
- Decision-making by commercial payers, government policy makers, and community leaders
- Fraud and abuse prevention and control
- Consumer/patient decision-making regarding
    - Lifestyle choices
    - Purchase of health care services
    - Medical testing and treatment
    - Self-management of health conditions

Summary of current health information infrastructure recommendations made by the commission in prior years:

- Support health information technology (electronic health records, health information exchange, and telemedicine) adoption and utilization
- Ensure health information technology is utilized to protect the public's health
- Ensure data available through the health information exchange is used to improve health care
- Ensure privacy and security of health information
- Facilitate broadband telecommunications service access
- Improve reimbursement for telemedicine-delivered services

B. 2012 Commission Recommendations

1. Patient-Centric Primary Care

Findings

- Strong primary care systems are foundational to a high performing health care system. Improving access to primary care that is patient-centric and enhancing the role of primary care providers in the coordination and management of care improves health and lowers the per capita cost of health care.

- Improved evidenced-based care management, especially of patients with complex health conditions experiencing high needs and high costs, can reduce health care costs while improving patient care and outcomes.

- A renewed emphasis on the value of primary care and new models of primary care practice are borne out of a convergence in the progression of medicine and changes in patient needs.
  - The vast increase in medical knowledge over the past several decades has led to more complexity in the management of medical information and also increased specialization of medical practitioners.
  - Improvements in the prevention and control of infectious disease and injury have been accompanied by a higher prevalence of chronic disease in the population, which has led to a shift in patient care needs from acute episodic care to chronic care management.

- Changes in medicine and patient needs necessitate a stronger role for primary care providers in supporting patients with the navigation of medical information, coordination of care between specialists, and management of chronic health conditions. Primary care practitioners who have fully assumed these expanded responsibilities have demonstrated cost savings for the overall health care system and improved health status of their patients; however, traditional fee-for-service payment models do not adequately recognize the new functions and do not adequately compensate primary care providers for the additional work involved.

- Patient-centered primary care requires:
  - a continuous healing relationship between the clinical team and the patient; ensuring patients and their families have the information, skills and tools necessary to maintain and manage their health, and that they are treated in a way that is respectful, engaging and empowering.

  - a holistic approach to patient care that views the patient as a whole person, acknowledging and understanding behavioral as well as physical health needs, and integrating primary care for behavioral and physical conditions in a common clinical setting.

  - an active partnership between the primary care provider, community health and social service providers, and governmental public health agencies to effectively coordinate and manage the care of patients with complex health conditions and to support primary prevention for healthy patients.

- Innovative approaches to strengthening primary care and making it more patient-centric have been implemented and are being tested in many other states, by the Veteran's Administration and the Department of Defense, and here at home within the Alaska Tribal Health System. A number of these innovative programs are demonstrating that it is possible to improve care for patients, improve health outcomes for the patient population, and reduce health care costs for the payers. Some are beginning to move forward with multi-payer initiatives to drive further transformation of their health care systems. The design of pilot programs under development in Alaska can be informed by lessons learned from the experience of these early innovators, such as:
    - Community Care of North Carolina (CCNC), whose demonstrated cost savings and improvement in patient outcomes include:
        - Annual growth in Medicaid expenditures fell from a high of 11.5% in 2002 to 2.5% in 2010;
        - Total Medicaid savings of $1.5 billion between 2006 and 2010;
        - Scores in the top 10% in the nation on key quality measures related to care for diabetes, asthma, and heart disease.
        - Comparison of Medicaid Aged, Blind and Disabled members enrolled in CCNC to members not enrolled in the program demonstrated between 2007 and 2010:
            - Better access to care - 95.9% of enrollees use health care system compared to 86.5% of unenrolled population.
            - Average spending for inpatient hospital services decreased 6%, compared to a 25% increase for the unenrolled population.
            - Potentially preventable inpatient admissions declined by 12.5%, while increasing by 25.9% for the unenrolled.
    - Blue Cross Blue Shield of Michigan, which administers the largest patient-centered medical home (PCMH) program in the country with 2,500 physicians in 700 PCMH-designated practices, demonstrated in 2010 that PCMH practices had a
        - 7% lower rate of pediatric emergency room visits;
        - 25.5% lower rate of adult inpatient admissions among patients with manageable chronic conditions; and
        - 7.4% lower rate of adult high-tech radiology usage.
    - CareOregon, a non-profit Medicaid managed care plan in Oregon which piloted their Primary Care Renewal (PCR) program in 2007 and has been expanding it since. Results from the pilot test include a:
        - 7.6% increase in proportion of diabetic patients with blood sugar under control, and of hypertensive patients with blood pressure under control
        - Threefold increase in proportion of patients screened for depression
        - 9% decrease in average cost for dual eligible members (plan members enrolled in both Medicaid and Medicare) treated at a PCR site, compared to a 1.2% increase for those treated in non-PCR sites.
    - The Veterans Health Administration launched a three year plan in April 2010 to transition more than 900 primary care clinics across the country to patient-centered medical homes, investing more than $227 million to hire additional clinical staff, institute a nationwide training program, and develop regional learning collaboratives. In one year a sample clinic increased access to same-day appointments for veterans who previously had to wait as long as 3 months, reduced inappropriate emergency department visits from 52% to 12%, and improved blood sugar scores in 33% of patients with poorly controlled diabetes.
    - Within the Department of Defense all three service branches are moving towards a medical home model of care in their military treatment facilities and is collaborating with TRICARE

Management and the VA. The DOD and VA are working together on development of guidelines for evidence-based practices critical to the functioning of a medical home, and also on design of quality metrics and process evaluations.

- There is currently active interest and engagement in the development of patient-centered primary care models in Alaska on the part of health care payers and primary care providers.
    - The Alaska Medicaid Task Force, convened Sept 2010 – April 2011 to identify cost containment strategies, recommended that the state's Medicaid program pilot test patient-centered medical home. DHSS plans to contract with a consultant during SFY 2012 to assist with the design of the pilot program.
    - The Alaska Primary Care Association received a $400,000 capital grant from the state legislature this year to assist community health centers with transition to a medical home model.
    - The Alaska Native Tribal Health Consortium is supporting a collaborative of clinicians throughout the tribal health system in an Improving Patient Care initiative that includes testing and learning from patient-centered medical home projects.
    - Two primary care clinics in Alaska currently hold NCQA (National Committee for Quality Assurance) recognition as Patient Centered Medical Homes – the Southcentral Foundation (SCF) Primary Care Center (Level 3), and the Providence Family Medicine Center/Alaska Family Medicine Residency Program (Level 1).
    - Numerous private sector primary care clinics are actively working on implementing various aspects of the PCMH model, such as opening up schedules for same-day appointments, establishing or upgrading electronic medical records systems, and creating web-based patient information portals. The commission specifically learned about the efforts of the Tanana Valley Clinic in Fairbanks and Medical Park Family Care in Anchorage.
    - The state Department of Health & Social Services is participating in a multi-state collaborative ("TCHIC") funded by CMS to test quality measurement and health information technology applications to improve care for children in Medicaid. DHSS created a medical home pilot program under this initiative this year and awarded pilot-site grants to Central Peninsula Community Health Center (Kenai/Soldotna), Iliuliuk Family & Health Services (Unalaska), and SCF (Anchorage).
    - A number of clinics are working to integrate primary care and behavioral health services. Two organizations, Alaska Island Community Services (Wrangell) and SCF (Anchorage) received federal demonstration grants this year to introduce primary care services within behavioral health clinic settings.

Draft Recommendations

1. The Alaska Health Care Commission recommends the State of Alaska recognize the value of a strong patient-centered primary care system by supporting appropriate reimbursement for primary care services.

2. The Alaska Health Care Commission recommends the State of Alaska support state policies that promote the central tenet of patient-centered primary care – that it is a model of care based on a continuous healing relationship between the clinical team and the patient.

3. The Alaska Health Care Commission recommends the State of Alaska and other entities planning a patient-centered primary care transformation initiative incorporate the following strategies

the Commission found to be common to start-up of successful programs studied as models. These successful models started with:

a) Financial investment by the initiating payer organization (whether public or private).
b) Strong medical leadership and management involved in planning and development.
c) A collaborative partnership between the payers and clinical providers.
d) A vision concerned with improving patient care, followed by identification of principles, definitions, criteria for participation, and tools and measures.
e) A focus on local (i.e., practice-level) flexibility and empowerment.
f) A phased approach to implementation.
g) A tiered approach to managing patient populations.

4. The Alaska Health Care Commission recommends the State of Alaska and other entities implementing a patient-centered primary care transformation initiative include the following attributes the Commission found to be common to successful programs studied as models:
   a) **Resources** provided to primary care practices to support improved access and care coordination capabilities.
   b) **New tools and skill development opportunities** provided to primary care practices to support culture and practice transformation.
   c) **Shared learning environments** for clinical teams to support development of emergent knowledge through practice and dissemination of new knowledge.
   d) **Timely data** provided to primary care practices to support patient population management and clinical quality improvement, including centralized analytical and reporting capability and capacity.
   e) **Infrastructure support** for medical guidance, including a medical director for clinical management and improvement, case managers, pharmacists, and behavioral health clinicians.
   f) **A system of review** that includes both implementation monitoring by initiative partners and evaluation of initiative outcomes by an independent third-party.

5. The Alaska Health Care Commission recommends the State of Alaska support a patient-centered medical home (PCMH) initiative, recognizing:
   a) Front-end investment will be required for implementation, and it may take two to three years before a return on investment will be realized;
   b) Collaboration between State programs that pay for health care, other health care payers and the primary care clinicians who will be responsible for implementing this model is essential to success; and,
   c) Patient-centered primary care development is not the magic bullet for health care reform, but is an essential element in transforming Alaska's health care system so that it better serves patients, better supports providers, and delivers better value.

2. Price & Quality Transparency

Findings

- There currently is insufficient data and information to support consumerism in Alaska's health care market. Empowering consumers and health care providers with access to information on the cost and quality of care is an important strategy for improving value in Alaska's health care system.

- Some patients lack incentives to seek value in their health care decisions. Normal supply-and-demand price mechanisms do not always work when consumers are insulated from the cost of a good or service, which is one effect of the third-party payer health insurance system. Consumers who share directly in the out-of-pocket cost of their health care purchases are more likely to make decisions based on value (price and quality).

- State government and other payers require high quality health data sources and health analytics capacity to provide the information needed to guide payment reform and health care delivery improvement policies.

- Alaska's Hospital Discharge Database is an important source of health care data, and is a good example of collaboration between a health care provider group and the State to make health care data more transparent. However, this data set is currently incomplete due to lack of full participation by all of Alaska's hospitals. It is also insufficient for supporting full cost and quality transparency in that it represents care provided only by acute care hospitals.

- A number of states have implemented or are in the process of planning for All-Payers Claims Databases (APCDs) to complement data from their Hospital Discharge Data and Medicaid Management Information Systems. APCDs are large-scale databases that systematically collect and aggregate medical, dental and pharmacy claims data from public and private payers, and are valuable sources of information about outpatient services and health care payments for those states that have implemented them. They also minimize the burden on health care providers as the aggregated data from payers is an efficient alternative to collecting data directly from individual providers.

Draft Recommendations

1. The Alaska Health Care Commission recommends the State of Alaska encourage full participation in the Hospital Discharge Database by Alaska's hospitals.

2. The Alaska Health Care Commission recommends the State of Alaska develop an All-Payers Claims Database for Alaska.

3. Payment Reform – Paying for Value, Rather than Volume

Findings

- Current fee-for-service and third-party payment structures reward delivery of high numbers of costly services; compel health care to be technology driven, volume-driven, fragmented, and expensive; and are a disincentive to innovations that improve health outcomes and the efficiency and effectiveness of health care services.

- There are options to health care cost containment strategies that do not rely on across-the-board rate reductions, price controls and rationing. These alternative approaches attempt to maximize value by moving away from payment for individual services to payment structures that reimburse providers for high quality care and improved health outcomes.

- Improving value in health care requires the following four mutually supportive components:
  1. **Consumer Empowerment**
     a. Educational materials and tools
     b. Engagement strategies that recognize the consumer as a partner/owner in their care
  2. **Price and Quality Reporting & Measurement**
     a. Measurement and analytics system design
     b. Reporting on quality, cost and experience of care
  3. **Value-Driven Health Care Delivery**, which empowers the patient and focuses first on keeping the patient healthy, minimizing the need for hospital care when health is compromised, and ensuring efficient successful outcomes when care is required.
     a. Design and delivery of care grounded in evidence-based medicine principles
     b. Technical assistance to providers
     c. Provider organization coordination
  4. **Value-Driven Payment Systems and Benefit Designs**.
     a. Payment system design
     b. Benefit design grounded in evidenced-based medicine principles
     c. Engagement of Purchasers
     d. Alignment of multiple payers

- Successful payment reform initiatives require systems that can support:
  - Capabilities to **manage financial risk** for payers and providers
    - Data and analytics for monitoring utilization and quality
    - Actuarial expertise for financial risk analyses
  - Capabilities to **manage health** for patients, providers, payers
    - Methods for targeting high risk patients
    - Capability to track, coordinate and follow-up on patient care
    - Patient education and self-management support
  - **Alignment of organizational structures** among providers
    - Trust relationships between physicians and hospitals
    - Significant regulatory barriers exist
    - Neutral, trusted facilitator may be required
  - **Alignment of payment policies** among payers
    - Multi-payer approaches to avoid further fragmentation of payment systems

- 26 cents of every health care dollar spent in Alaska are public funds administered either directly or indirectly by the State of Alaska, including state and federal Medicaid funds and spending for state employee and retiree health benefit s, correctional system inmates' care, workers' compensation, and other state health care programs. State government holds significant purchasing power that could be utilized to leverage improvement in Alaska's health care system.

Draft Recommendations

1. The Alaska Health Care Commission recommends the State of Alaska utilize payment policies for improving the value of health care spending – for driving improved quality, efficiency and outcomes for each health care dollar spent in Alaska – recognizing that:
    a. Local payment reform solutions are required for Alaska's health care markets
    b. Payment reform may not result in immediate cost savings, but efforts must begin immediately
    c. Payment reform is not the magic bullet for health care reform, but is one essential element in transforming Alaska's health care system so that it better serves patients, and delivers better value for payers and purchasers.

2. The Alaska Health Care Commission recommends the State of Alaska take a phased approach to payment reform, revising payment structures to support primary care transformation as a first step in utilizing payment policies for improving value in Alaska's health care system.

3. The Alaska Health Care Commission recommends the State of Alaska develop health data collection and analysis capacity as a tool for quality improvement and payment reform. Data collection, analysis and use decisions should involve clinicians, payers, and patients.

4. The Alaska Health Care Commission recommends the State of Alaska support efforts by state officials responsible for purchasing health care services with public funds to collaborate on the development of common purchasing policies. These collaborative efforts should be used as leverage to drive improved quality, effectiveness, efficiency and cost of care in Alaska's health care system. These efforts should endeavor to engage commercial payers and federal health care programs in alignment of payment policies in a multi-payer approach to minimize the burden on health care providers.

4. Alaska's Trauma System

Findings

- Injury is the leading cause of death for Alaskans who are one to 44 years of age. Roughly 400 to 500 Alaskans die each year as the result of an injury. Approximately 5,000 Alaskans are admitted to a hospital each year due to an injury, over 1,000 of who are left with a permanent disability.

- A trauma system that provides rapid, effective, and efficient response and treatment is critical to reducing death and disability due to injury. An improved trauma system improves overall care for any health condition that is time critical, such as heart attack and stroke, not just trauma.

- The Alaska Department of Health & Social Services made trauma system improvement a priority three years ago with the commission of a study by the American College of Surgeons Committee on Trauma. Subsequently the Division of Public Health began implementing the ACS recommendations for strengthening Alaska's trauma system by establishing a Trauma System Coordinator position to support development of a trauma system strategic plan, and reorganizing to consolidate the Emergency Medical Services Program with the Emergency and Disaster Preparedness Program. More recently the Division has invested in improving the Alaska Trauma Registry to ensure sound data is available for informing prevention and system improvement efforts.

- The Alaska Legislature made a commitment to strengthening Alaska's trauma system, passing a bill during the 2010 legislative session establishing the Uncompensated Trauma Care Fund to incentivize hospitals to meet trauma center standards.

- Alaska's health care community has made commitments to strengthening Alaska's trauma system. The Alaska Native Medical Center has demonstrated leadership in trauma care in Alaska for many years and is currently the only Level II designated trauma center in the state, the highest level any hospital in Alaska can attain. Four of Alaska's rural hospitals are designated Level IV trauma centers. An additional nine hospitals are actively working towards attainment of trauma center designation. However, Alaska remains the only state in the nation without a Level II or higher designated trauma center serving the general population.

Draft Recommendations

- The Alaska Health Care Commission recommends the State of Alaska support a strong trauma system for Alaska that:
    - Is comprehensive and coordinated, including:
        - Public health system capacity for
            - studying the burden of injury in the local population
            - designing and implementing injury prevention programs
            - supporting the development and exercise of local and statewide emergency preparedness and response plans

        - Emergency medical service capacity for effective pre-hospital care for triage, stabilization and coordination of safe transportation of critically injured patients
        - Trauma center care for treatment of critically injured patients
        - Rehabilitation services for optimizing recovery from injuries
        - Disability services to support life management for individuals left with a permanent disability due to an injury
    - Is integrated, aligning existing resources to efficiently and effectively achieve improved patient outcomes.
    - Is designed to meet the unique requirements of the population served.
    - Provides evidence-based medical care to achieve the best possible outcomes for the patient.
    - Provides seamless transition for the patient between the different phases of care.

- The Alaska Health Care Commission recommends the State of Alaska support continued implementation of the recommendations contained in the 2008 consultation report by the American College of Surgeons Committee on Trauma, including achievement and maintenance of certification of trauma center status of Alaskan hospitals.

5. Obesity in Alaska

Findings

- The growing prevalence of overweight and obese Alaskans is the most significant public health challenge facing Alaska today. This largely avoidable condition affects Alaskans of all ages, from all regions, across all levels of education and income, and of all racial and ethnic backgrounds. The dramatic increase in overweight and obesity prevalence that occurred over the past 18 years will have lasting financial and health impacts on Alaskan families, communities, businesses, and the health care system for decades to come.

- Overweight and obesity cause 365,000 premature deaths a year in the U.S.

- Medical spending in the U.S. directly related to overweight and obesity was estimated at $147 billion annually in 2008, and $477 million in Alaska.

- As many as 40% of Alaska's children are overweight or obese.

- The generation of Americans born in the last decade may be the first generation of Americans who do not live as long as their parents, since our country began, due to the medical complications of overweight and obesity. A child born today has a 34-38% chance of developing diabetes in his or her lifetime.

Draft Recommendations

- The Alaska Health Care Commission recommends the State of Alaska implement evidence-based programs to address the growing rate of Alaskans who are overweight or obese. First efforts should focus on nutrition and physical activity for children and young people and raise public awareness of the health risks associated with being overweight and obese.

6. Immunization against Vaccine-Preventable Disease

Findings

- Until the mid-20th century infectious diseases were a leading cause of illness, disability and death in Alaska. Few effective treatment and preventive measures existed. Since that time there has been a dramatic decline in the burden of infectious disease in the population due to significant achievements in control measures, especially for those diseases for which vaccines have been developed.

- During the 20th century the success of biomedical science in development of vaccines combined with the success of the public health system in immunizing the population led to the eradication of smallpox from the worldwide population and the elimination of polio from the U.S. population. Furthermore, immunizations have resulted in substantial declines in other diseases that had previously been a common cause of serious illness and death among children, such as measles, mumps, rubella, diphtheria, tetanus, pertussis, and bacterial meningitis.

- Despite remarkable progress in vaccine development and use, there are a number of challenges in maintaining sufficient immunization levels to protect the population.
    - Vaccination schedules have become increasingly complex. U.S. children require 19 doses of vaccine by age 35 months to be protected against 11 childhood diseases.
    - The success of immunization policies in controlling once-dreaded diseases has led to complacency among some subsets of the population toward vaccines.
    - Insufficient and erroneous information about vaccine safety and effectiveness creates confusion among parents, who must recognize immunizations as an important tool in protecting their children's health and actively seek them.
    - Health care providers must be kept informed of the latest developments and recommendations.
    - Vaccine supplies and financing must be made more secure.
    - Researchers must address increasingly more complex questions about safety, efficacy, indications, contraindications, and delivery.
    - Information technology must be used to support timely vaccination.
    - Adolescents and adults must be targeted for vaccine-preventable diseases that affect their age groups, such as influenza and pneumonia.

- Alaska's childhood immunization rate has declined in recent years to nearly the lowest in the nation. Alaska's rate of immunization completion for children ages 19 months to 35 months was just 56.6% in 2009, compared to the national average of 70.5%, ranking Alaska 49th among the 50 states and leaving Alaska's children vulnerable to preventable diseases that can result in serious complications, preventable hospitalizations, and in some cases death.

- The Alaska Division of Public Health, Department of Health & Social Services, maintained a "universal vaccine program" (providing all recommended childhood and adult vaccines to public and private health care providers in the state) for over three decades. The vaccine program was supported almost entirely with federal funding from two different sources, one of which is reducing its annual allocation to Alaska by $3.6 million in a phased 3-year reduction starting in FFY 11.

- As a result of the loss of funding the state discontinued provision of all adult vaccine and of human papillomavirus and meningococcal vaccines for children in FFY 11, and will no longer provide the following childhood vaccines for children who are not eligible for the Vaccines for Children Program ("VFC"; a program for children who are American Indian/Alaska Native, on Medicaid, or uninsured) beginning in FFY 12: influenza, pneumococcal conjugate, and rotavirus.
- Elimination of the universal vaccine program is expected to have the following consequences:
  - Reduction in the number of small private medical practices that provide vaccine to their patients due to the complexities of maintaining separate vaccine supplies (per VFC administrative requirements), and the cost of up-front purchase of expensive vaccine;
  - Reduced immunization coverage leading to increased risk of vaccine-preventable diseases such as measles, mumps, pertussis, chicken pox and hepatitis A; and,
  - Inability to maintain a stockpile of vaccine to support timely response to outbreaks of vaccine-preventable disease.

Draft Recommendations

- The Alaska Health Care Commission recommends the State of Alaska ensure the state's immunization program is adequately funded and supported, and that health care providers give priority to improving immunization rates in order to protect Alaskans from serious preventable diseases and their complications.

7. Population-Based Prevention & Behavioral Health

Findings

- Behavioral health is essential to whole health. Almost one-quarter of all adult stays in U.S. community hospitals involve mental or substance use disorders. 83% of people diagnosed with serious mental illness are overweight or obese. The life span of a person with SMI is 27 years shorter than the average life span.

- Alaskans experience high rates of violence. According to the 2010 Alaska Victimization Study, 47.6% of adult women in Alaska experienced intimate partner violence in their lifetime. 37% experienced sexual violence, and 27% experienced alcohol or drug involved sexual assault.

- Adverse childhood experiences, such as recurrent and severe physical or emotional abuse, sexual abuse, or growing up in a household with an alcoholic or drug user, a member in prison, a mentally ill member, a mother treated violently, or both biological parents absent, are a significant determinant of health and well-being well into adulthood, correlating to poor health indicators such as obesity and depression.

- Binge alcohol use in Alaska is among the highest in the nation. 8% of all adults in Alaska, 20% of adults ages 18-25, and 25% of students in grades 10, 11, and 12 use marijuana.

- Alcohol use is suspected or proven in nearly 25% of all hospitalizations for injury.

- In 2009 the age-adjusted suicide rate for all Alaskans was 20.2/100,000 (1140 lives lost). The suicide rate among Alaska Native people is two times that of non-Native.

- Routine screening for substance abuse, depression, and a history of adverse childhood events using evidence-based tools is an important strategy for reducing the prevalence of health conditions related to these problems.

- Integration of primary care for both behavioral and physical conditions in a common clinical setting is an essential feature of patient-centered primary care.

Draft Recommendations

- The Alaska Health Care Commission recommends the State of Alaska support efforts to foster development of patient centered primary care models in Alaska that:
  - Integrate behavioral health services with primary physical health care services in common settings
  - Include screening for the patient population using evidence-based tools to screen for
    - A history of adverse childhood events
    - Substance abuse
    - Depression

- The Alaska Health Care Commission recommends the State of Alaska develop with input from health care providers new payment methodologies for state-supported behavioral health services.

C. Strategies under Consideration for Study in 2012

- **Design policies to enhance the consumer's role in health and health care - A) Innovate to improve quality, affordability and access to care:**
  - **Legal barriers and cost drivers:** Identify policies to address cost drivers and state legal barriers identified through 2011 cost and pricing studies and 2012 legal barriers analysis.
  - **Employer's Role in Health & Health Care – Employee Health Benefit and Plan Design:** Identify the roles Alaska's employers play in their employees' health and access to health care, and study innovative approaches employers in Alaska and across the country are utilizing to improve the quality, affordability and access to health care for their employees.
  - **End-of-Life Care:** Learn how improving quality of services and patient choice in health care decisions at the end of life can improve the patient's and patient's family's experience and contain costs.
  - **Use of Technology to Facilitate Access to Care:** Determine the characteristics of a legitimate electronic patient visit, and identify impediments to use of telecommunications technology to improve access, including reimbursement, liability, licensure (including cross-state licensure), technological, etc. Study the Veteran's Health Administration experience with telemedicine.
  - **Transparency - All-Payers Claims Database:** Conduct a needs assessment and feasibility study for establishment of an All-Payers Claims Database for Alaska
  - **Track Developments in Alaska Related to Previous Recommendations:**
    - Value-Based Purchasing (Payment Reform and Price & Quality Transparency)
    - Patient-Centered Primary Care
    - Evidence-Based Medicine

- **Design policies to enhance the consumer's role in health and health care - B) Support Healthy Lifestyles**
  - **Employer's Role in Health & Health Care – Worksite Wellness:**
    Identify the roles Alaska's employers play in their employees' health and access to health care, and study innovative approaches employers in Alaska and across the country are utilizing to create cultures of wellness and promote the health and safety of their employees.
  - **Track Developments in Alaska Related to Previous Recommendations:**
    - Obesity
    - Immunizations
    - Behavioral Health

- **Build the foundation of a strong, stable health system**
  - **Statewide Leadership:**
    - Identify indicators for measuring statewide health care delivery system improvement
  - **Health Workforce Development**
    - Track developments in Alaska related to previous recommendations
  - **Health Information Infrastructure**
    - Track developments in Alaska related to previous recommendations

Strategies Tabled for Future Years' Agendas

- **Strategies to support innovations in patient-centric care**
  - **Health Benefit & Plan Designs that support patient engagement in seeking value:** This strategy will be addressed in large part during 2012 work on the employer's role in health and health care.
  - **Care coordination and management for patients with multiple chronic conditions:** Will track new Medicaid program initiatives in this area for now.
  - **Patient-Provider shared decision-making support tools:** Work during 2012 on employer efforts to craft innovative health plans focused in part on improving and supporting employee health and engagement in health care will inform future direction for this strategy.
  - **Process/Quality Improvement:** The commission may elect to study provider efforts to improve quality and design more efficient processes sometime in the future.

- **Strategies to support healthy lifestyles**
  - **Rural sanitation:** A very important community health issue, but the commission might not be able to add value to the current efforts underway in Alaska.
  - **Fluoridation:** Local decisions regarding this important public health issue should be based on high quality research and evidence. The commission may chose to investigate the status of this strategy and changes in community policies at some point in the future.

- **Health Workforce Development**
  - **Workforce issues related to supporting the Patient-Centered Medical Home:**:
    - Sufficient supply of the appropriate workers needed to support the care team
    - Appropriate training and other workforce issues to support the roles of the care team members