# Transforming Health Care in Alaska

# 2011

2011 Annual Report of the Alaska Health Care Commission

2010 – 2014
Strategic Plan
Update

# Transforming Health Care in Alaska

## 2011 Report/2010-2014 Strategic Plan Update

### Alaska Health Care Commission

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STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
ALASKA HEALTH CARE COMMISSION

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January 15, 2012

To: The Honorable Sean Parnell, Governor, State of Alaska
The Honorable Gary Stevens, President, Alaska State Senate
The Honorable Mike Chenault, Speaker of the Alaska House of Representatives

We are pleased to present the 2011 Annual Report of the Alaska Health Care Commission in accordance with AS 18.09.070. During this past year the Commission continued to identify solutions for improving health and health care while working to better understand current challenges. This report includes findings from new studies regarding the cost of health care in Alaska, and policy recommendations intended to guide state government down a path that supports transformation of our health care system so that it better meets the needs of patients, providers, and employers.

Alaska's health care delivery system is headed towards a financial cliff. If medical costs continue to grow at current trends the results will be catastrophic. At risk is financial access to care for individual Alaskans, affordability of health benefits for employers, sustainability of public programs that pay for health care and support vulnerable Alaskans, and the long term economic viability of our health care providers. The Commission's recommended approach to containing cost growth is to improve care, not cut it, by focusing on value – increasing the quality of care for each dollar spent – and also by increasing efforts to prevent avoidable health problems.

The Commission's 2011 recommendations include strategies for enhancing care at the front end by strengthening the role of primary care and arming clinicians with tools for coordinating care and managing chronic disease. They call for increased price and quality transparency to better inform consumers and clinicians. Also suggested is an approach to design of new payment structures that incentivize quality and positive health outcomes. A continued focus on prevention emphasizes the need to control obesity, increase immunization rates, and improve behavioral health status. These recommendations build on those presented in 2010 regarding the importance of evidence-based medicine in improving quality and controlling costs.

Thank you for this opportunity to present solutions for transforming Alaska's health care system so that it is sustainable and provides value, meets the needs of patients and providers, and focuses on health.

Sincerely,

Ward B. Hurlburt, MD, MPH
Chair, Alaska Health Care Commission
Chief Medical Officer & Public Health Director
Department of Health & Social Services

Deborah Erickson
Executive Director
Alaska Health Care Commission

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**Appendix A:** "Alaska's Health-Care Bill: $7.5 Billion and Climbing," Institute for Social & Economic Research with Mark A. Foster & Associates (under AHCC contract), August 2011

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**Appendix C:** Overview & Update of Federal Health Reform in Alaska, PowerPoint Presentation, December 2011

**Appendix D:** Voting Records and Summary of Public Comments

## *Acknowledgements*

The Commission benefited from the knowledge and experience of numerous experts from across the country as well as within Alaska who made presentations and participated on panels to help educate us on the various issues and potential solutions we studied this year. The Commission would like to acknowledge the gracious contributions of the following individuals and thank them for sharing their time and expertise.

**Health Care Costs and Sustainability**

- Becky Hultberg, Commissioner, Alaska Department of Administration
- William Streur, Commissioner, Alaska Department of Health & Social Services (DHSS)
- Mark Foster, MAFA and Associates
- Scott Goldsmith, Institute for Social & Economic Research
- Edward Jhu, Milliman, Inc.
- John Pickering, Milliman, Inc.

**Patient-Centric Primary Care**

- Harold Johnston, MD, Director, Alaska Family Medicine Residency Program
- Doug Eby, MD, MPH, Vice President of Medical Services, Southcentral Foundation
- James Shill, CEO, Tanana Valley Clinic
- Kevin Munson, CEO, Mat-Su Health Services, Inc.
- Robert Onders, MD, Kodiak Area Native Association
- T. Noah Laufer, MD, Medical Park Family Care
- Marilyn Kasmar, Executive Director, Alaska Primary Care Association
- Kim Poppe-Smart, Deputy Commissioner & State Medicaid Director, Alaska DHSS
- L. Allen Dobson, Jr., MD, President, Cabarrus Family Medicine, N. Carolina
- Margaret Mason, Manager, Clinical Programs Development, Blue Cross Blue Shield of Michigan
- Jean Malouin, MD, MPH, Associate Chair, Clinical Programs in Family Medicine, University of Michigan
- David Ford, President & CEO, CareOregon
- David Labby, MD, PhD, Medical Director, CareOregon

**Payment Reform**

- Harold Miller, Executive Director, Center for Healthcare Quality & Payment Reform; President & CEO, Network for Regional Healthcare Improvement; National Quality Forum; Carnegie Mellon University.
- Bruce Lamoureux, Senior Vice President/CEO, Providence Health & Services Alaska; Board Chair, Alaska State Hospital & Nursing Home Association
- Ryan Smith, CEO, Central Peninsula General Hospital
- Michael Banks, Acting CFO, Alaska Native Tribal Health Consortium
- Jeff Davis, President, Premera Blue Cross Blue Shield of Alaska
- T. Noah Laufer, MD, Medical Park Family Care

**Alaska's Top Population Health Challenges**

- Ward Hurlburt, MD, MPH, DHSS Chief Medical Officer and Public Health Director
- Melissa Stone, Director, DHSS Division of Behavioral Health

**Trauma System**

- Frank Sacco, MD, Alaska Trauma System Review Committee
- Dan Johnson, Director, Interior Region EMS Council
- Julie Rabeau, Alaska Trauma Program Manager, Division of Public Health, Alaska DHSS

**Long Term Care**

- Duane Mayes, DHSS Senior & Disabilities Services Director
- Millie Duncan, Administrator, Wildflower Court
- Dave Cote, Director, Division of Pioneer Homes, DHSS
- Denise Daniello, Executive Director, Alaska Commission on Aging
- Kay Branch, Elder/Rural Health Program Coordinator, Alaska Native Tribal Health Consortium
- Nancy Burke, Program Officer, Alaska Mental Health Trust Authority
- Sandra Heffern, Chair, Community Care Coalition
- Thea Agnew Bemben, Principal & Founding Partner, Agnew::Beck Consulting

**Health Information Infrastructure**

- Paul Cartland, State Health Information Technology Coordinator, DHSS
- Andrea Fenaughty, PhD, Deputy Chief, Section of Chronic Disease Prevention & Health Promotion, Division of Public Health, DHSS
- Joe McLaughlin, MD, State Epidemiologist & Chief of the Section of Epidemiology, Division of Public Health, DHSS.
- Jeannie Monk, Small & Rural Hospital Program Officer, Alaska State Hospital & Nursing Home Association.
- Denise Love, Executive Director, National Association of Health Data Organizations

**Health Workforce Development**

- Jan Harris, Vice Provost for Health Programs, University of Alaska
- Karen Perdue, President/CEO, Alaska State Hospital & Nursing Home Association
- Delisa Culpepper, Chief Operating Officer, Alaska Mental Health Trust Authority

**Affordable Care Act**

- William Streur, Commissioner, DHSS
- Linda Hall, Director, Division of Insurance, Alaska Department of Commerce, Community & Economic Development

Also, to the many Alaskans who took the time to testify before the Commission during public hearings, comment on the Commission's draft findings and recommendations, and attend Commission meetings, the Commission is grateful for your interest in improving the health of Alaskans and Alaska's health care system.

# Executive Summary

**Introduction**

The Alaska Health Care Commission was established by the Legislature in 2010 to advise the state on policies for improving health and health care for all Alaskans. Members are appointed by the Governor, and represent stakeholder groups specified in statute. The Commission originally convened during 2009 under Governor's Administrative Order #246.

The Commission's approach to improving Alaska's health care system began with identification of a vision of the ideal health care system for Alaska, plus goals and guiding values for the planning process. We are now in an ongoing cycle of learning about current challenges to better understand why the system is not attaining the vision, designing policies that will transform the system into one that embodies the vision, and evaluating progress. Information, findings and recommendations presented in each annual report build on prior year reports, which should be referenced together for a full picture of the Commission's learning and recommendations to date.

The ideal health care system envisioned for Alaska places individuals and their family at the center of their care experience and focuses on creating health, not simply treating illness and injury. The best system will also provide value for Alaskans' health care dollar – delivering safe 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 the final but essential element of this picture is that Alaska's health care system will be sustainable over time.

The Commission's core strategy for attaining the goals of improved access, affordable costs, high quality care, and increased prevention, is to strengthen the consumer's role in health and health care through innovations in patient-centered care and through support for healthy lifestyles. This core strategy rests on the foundation of a sound health care system - a sustainable workforce, a complete health information infrastructure, and statewide leadership. Values the Commission adopted to guide recommendations emphasize the importance of sustainability, the need to increase efficiency and effectiveness of care, and the significance of individual choice and personal engagement.

**Understanding Alaska's Health Care Challenges**

To better understand why Alaska's health care system is not achieving the vision, the Commission began in 2009 by describing how health care in Alaska is delivered and funded today (see Appendix A of the 2009 report). Challenges described in the 2009 report identified the extent to which:

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

In 2010 the Commission added to learning about Alaska's health care system challenges by compiling information on the newly passed federal health care reform law - reviewing and providing summaries of the law's provisions, and contracting with the Institute for Social & Economic Research for an analysis of the potential impact of the law in Alaska.

In 2011 the Commission focused on studying health care spending trends, pricing and cost drivers. The Commission also learned about Alaska's long term care system and the status of statewide planning to meet long term care needs, Alaska's trauma system and implementation of a plan to improve it, and the status of the Affordable Care Act. Highlights from this year's cost and pricing studies include:

- **Health care cost increases in Alaska continue to outpace inflation.**
  - Health care spending in Alaska reached $7.5 billion in 2010, a 40% increase over 2005. State government's portion of this bill was close to $2 billion.
  - At current trends health care spending is expected to double to more than $14 billion by 2020. By comparison the wellhead value of oil produced in Alaska in 2010 was $16.4 billion and is projected to be $18.6 billion in 2020.
  - Since 1982 the Anchorage Consumer Price Index increased 95%, while prices for medical care in Anchorage over that time period increased 320%.

- **Health care is increasingly unaffordable for our employers, families.**
  - At $11,926 per employee, Alaska has the highest average annual cost for employee health benefits in the nation - twice what employers in the lowest cost state pay.
  - Fewer Alaskan employers are offering employee health benefits, dropping from 35% to 30% of small employers between 2003 and 2010.
  - The average cost of health care premiums in Alaska increased 51% for single coverage and 35% for family coverage between 2003 and 2010. The average annual commercial health insurance premium for family coverage in 2010 was $14,230.
  - Despite the fact that Alaskans utilize roughly the same amount of care, health insurance premiums are about 30% higher here than in comparison states.

- **Health care prices paid in Alaska are much higher than in comparison states** (Washington, Oregon, Idaho, Wyoming, North Dakota, (and also Hawaii for hospital comparisons only)).
  - Different payers (Medicare, Medicaid, Workers' Compensation, commercial health insurers, TRICARE, and the Veterans Health Administration) pay different prices for the same service.
  - The average reimbursement for physician services in Alaska is 60% higher than in comparison states for all payers – 69% higher for commercial health insurers.
  - The difference in reimbursement for physician services varies depending on specialty, for example Alaskan pediatricians are paid 43% more, while cardiologists are paid 83% more.
  - Commercial health insurance reimbursement for private sector hospital services is 37% higher than in comparison states; Medicare pays our private sector hospitals 36% more.
  - Alaska's higher medical prices are due in part to higher operating costs for providers resulting from a higher cost of living, more costly employee benefits, transportation and shipping costs, fuel prices, and workforce shortages.
  - Higher prices are also due to high physician pricing power compared to other states, and a high average operating profit margin for the private hospital sector.
  - Low Medicare payment rates create upward pressure on prices for other payers.

During 2012 the Commission plans to learn about pricing for pharmaceuticals, the behavioral health care system, and the impact of Alaska's malpractice reform law passed in 2005.

## Alaska Health Care System Transformation Strategies

During 2009 the Commission developed general recommendations regarding the importance of patient-centric primary care and support for healthy lifestyles, and more detailed recommendations for promoting the use of health information technology, providing statewide health leadership, strengthening the health workforce, and improving access to primary care for Medicare enrollees. During 2010 the Commission added to these strategies with recommendations for employing evidence-based medicine to improve the quality of health care and contain cost growth.

This year the Commission identified findings and developed recommendations regarding:

- Patient-Centric Primary Care: Compiling lessons learned from a variety of patient-centered medical home programs from other states that are demonstrating success at improving patient care and outcomes and controlling costs, the Commission recommends the State of Alaska support a patient-centered medical home program and include the attributes they identified as common to successful programs.
- Price & Quality Transparency: Identifying the importance of price and quality transparency for empowering consumers and providers with information required for improving value in the health care system, the Commission provides recommended first steps toward improving and developing needed data systems to support this strategy.
- Payment Reform: Finding that changes in the way we pay for health care can improve quality and decrease costs without imposing price controls or rationing care, the Commission recommends the State of Alaska align state programs that purchase health care and utilize payment policies for improving value.
- Alaska's Trauma System: The Commission recommends the State of Alaska support a strong trauma system, defining the necessary elements for the system and emphasizing the need to continue implementation of a 2008 improvement plan.
- Population-based Prevention Priorities: The Commission identifies obesity, low immunization rates, and significant behavioral health challenges as the top health concerns in Alaska's population, and recommends the State of Alaska support efforts to address these problems.

Following is a general summary of the Commission's recommended solutions for improving health and health care in Alaska to-date:

**Ensure the best available evidence is used for decision-making.** Support clinicians and patients to make clinical decisions based on high grade medical evidence regarding effectiveness and efficiency of testing and treatment options. Apply evidence-based principles in the design of health insurance plans.

**Enhance the quality and efficiency of care on the front-end.** Strengthen the role of primary care providers, and give patients and their clinicians better tools for making health care decisions. Improve coordination of care for patients with multiple providers, and care management for patients with chronic health conditions. Improve Alaska's trauma system.

**Increase price and quality transparency.** Provide Alaskans with information on how much their health care costs and how outcomes compare so they can become informed consumers and make informed choices. Provide clinicians, payers and policy makers with information needed to make informed health care decisions.

**Pay for value.** Design new payment structures that incentivize quality, efficiency and effectiveness. Support multi-payer payment reform initiatives to improve purchasing power for the consumer and minimize the burden on health care providers.

**Build the foundation of a strong health care system.** Ensure there is an appropriate and sustainable supply and distribution of health care workers. Create the information infrastructure required for maintaining and sharing electronic health information and for conducting health care analytics to support improved clinical decisions, personal health choices, and public health.

**Focus on prevention.** Create the conditions that support Alaskans to exercise personal responsibility for living healthy lifestyles. High priorities include reducing obesity rates, increasing immunization rates, and improving behavioral health status.

Additional strategies the Commission will study and consider for future recommendations during 2012 include:

- Reduction in government regulations that hamper innovation and increase costs.
- Enhancement of the employer's role in improving quality and controlling cost of health care through the design of employee health benefits, and in improving the health of their employees through worksite wellness programs.
- Improvement of patient choice in end-of-life health care decision making.
- The use of technology and telecommunications to facilitate access to health care services.

# Part I: Introduction

## A. Purpose of this Report

The purpose of this report is to convey the 2011 findings and recommendations of the Alaska Health Care Commission to Governor Parnell and the Alaska Legislature as required under Alaska Statute 18.09.070. This report builds on the work of the original Alaska Health Care Commission (created by Governor Palin under Administrative Order #246) which in their 2009 Report presented a 5-year strategic planning framework as a "roadmap" for strengthening Alaska's health care delivery system. The 2009 report was described as a "living" plan meant to evolve each year as problems regarding health care quality, cost and access are studied, potential solutions are analyzed, and implemented strategies are evaluated. This latest report documents the continuation of that process.

Findings and recommendations by the Commission included in past reports are still current, but are not repeated in this report. Please see the Commission's 2009 Annual Report for the:

- Overview of current challenges in Alaska's health care system
- Findings & Recommendations on:
    - Patient-Centric Primary Care
    - Healthy Lifestyles
    - Statewide Leadership
    - Workforce
    - Health Information Technology
    - Medicare Access
- Detailed description of Alaska's health care system (separate report included as Appendix A)

Please see the Commission's 2010 Annual Report for the:

- Findings & Recommendations on Evidence-based Medicine
- Affordable Care Act Overview and Projected Impact in Alaska

Included in this Annual Report for 2011, are:

- Part I: An introduction including background on the Commission; a summary of the Commission's 2011 activities; a description of the Commission's strategic planning framework; the Commission's vision, goals, guiding values, and core strategy; and key definitions.
- Part II: Information on certain aspects of the current health care system, particularly challenges related to the rising cost of health care, and an overview of the long term care system in Alaska. 2012 plans for continued study of health care system challenges are also included.
- Part III: The Commission's 2011 recommendations for transformation of Alaska's health care system, and strategies that will be considered in 2012;
- Appendices: Copies of studies conducted for the Commission this year on health care spending and cost trends (by the Institute for Social & Economic Research), and on payment levels and cost drivers for hospital and physician services (by Milliman, Inc.); an overview and update on the implementation of the Affordable Care Act in Alaska (in chart pack format); and additional information by and about the Commission.

## B. Background on the Commission

The Alaska Health Care Commission was first established by Governor Palin on December 4, 2008 under Administrative Order #246. Original Commission members were appointed on January 27, 2009 and the Commission met throughout 2009, producing a report on their findings and recommendations in January 2010. The Commission created under A.O. #246 terminated with the production of that report.

The current Alaska Health Care Commission was established in state statute (AS 18.09.010) during 2010 with the passage of Senate Bill (SB) 172 to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. SB 172 was passed by the Alaska Legislature on April 17, 2010 and signed into law by Governor Parnell on June 21, 2010. Members were appointed in September and the new body convened for the first time in October, 2010.

Duties of the Commission prescribed by AS 18.09.070:

I. Serve as the state health planning and coordinating body;
II. Provide recommendations for and foster the development of a:
    1. Comprehensive statewide health care policy;
    2. Strategy for improving the health of Alaskans that
        i. Encourages personal responsibility for disease prevention, healthy living and acquisition of health insurance;
        ii. Reduces health care costs;
        iii. Eliminates known health risks, including unsafe water and wastewater systems;
        iv. Develops a sustainable health care workforce;
        v. Improves access to quality health care; and,
        vi. Increases the number of insurance options for health care services.
III. Submit a report to the Governor and the Legislature by January 15 of each year regarding the Commission's recommendations and activities.

Commission members are appointed by the Governor, with the exception of the two legislative representatives who are appointed by their respective bodies. Short biographies for each of the Commission members are provided on the Commission's web site. The members of the Commission are:

- **Ward Hurlburt, MD, MPH:** Designated Chair; Chief Medical Officer for the Alaska Department of Health & Social Services; Anchorage.
- **Patrick Branco:** Representing the Alaska State Hospital & Nursing Home Association; Chief Executive Officer of Ketchikan General Hospital; Ketchikan.
- **Keith Campbell:** Representing consumers; retired hospital administrator and former AARP Chair; Seward.
- **Valerie Davidson:** Representing Alaska tribal health care providers; Senior Director of Legal and Inter-Governmental Affairs for the Alaska Native Tribal Health Consortium; Anchorage.
- **Jeffrey Davis:** Representing Alaska's health insurance industry; President of Premera Blue Cross Blue Shield of Alaska; Anchorage.
- **Emily Ennis:** Representing the Alaska Mental Health Trust Authority; Executive Director of Fairbanks Resource Agency; Fairbanks.
- **Col. Paul Friedrichs, MD:** Representing the U.S. Department of Veterans Affairs health care system; Commander of the Air Force/Veterans' Affairs Joint Venture Hospital at Elmendorf; Anchorage.

- **T. Noah Laufer, MD:** Representing primary care physicians; family medicine physician and president of Medical Park Family Care; Anchorage.
- **David Morgan:** Representing community health centers; Reimbursement Director for the Southcentral Foundation; Anchorage.
- **Allen Hippler:** Representing the Alaska State Chamber of Commerce; Chief Financial Officer for Faulkner Walsh Constructors; Anchorage.
- **Lawrence Stinson, MD:** Representing Alaska health care providers; anesthesiologist and co-owner of Advanced Pain Centers of Alaska; Anchorage.

**Ex-Officio** (non-voting members)

- **Linda Hall:** Representing the Governor's Office; Director, Division of Insurance; Anchorage.
- **Representative Wes Keller:** Representing the Alaska House of Representatives; Wasilla.
- **Senator Donny Olson:** Representing the Alaska Senate; Golovin.

## C. Summary of 2011 Activities

**Meetings and public hearings:** During 2011 the Commission held six face-to-face meetings, all but one in Anchorage: January 7 (the last meeting of the 2010 Commission to incorporate changes based on public comment, finalize and approve the 2010 report); March 31-April 1 (Juneau); June 23-24; August 25-26; October 11-12; and December 9. All of these meetings were open to the public, and teleconferenced for members of the public unable to attend but interested in listening or providing testimony. The general format of each of the four quarterly two-day meetings included presentations by experts on the various topics studied, followed by a panel of Alaskan providers offering their perspective. Public hearings were also held during each of the four quarterly meetings. The Commission's voting record from these meetings and a summary of public comments received are included in Appendix D.

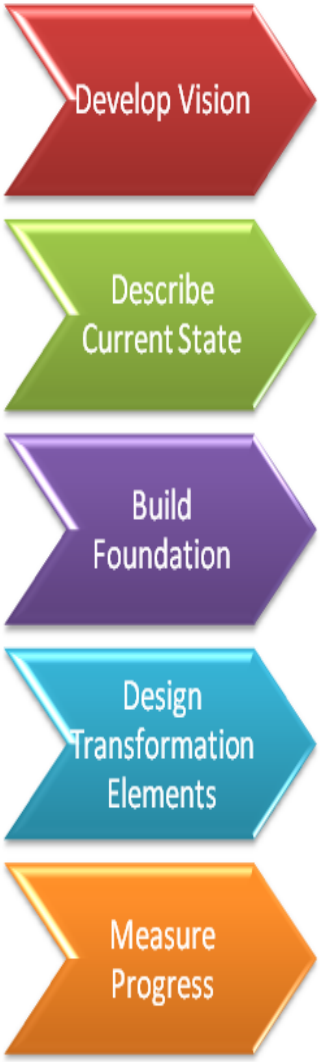
**Administration:** The Commission developed with guidance from the State's ethics attorney a Financial Disclosure form as required under AS 18.09.060. A copy of the Commission's meeting rules, by-laws, SFY 2012 budget, and ethics handbook are available on the Commission's website (see website address below). Copies of Commission members' 2011 Financial Disclosure forms are available from the Commission office on request.

**Communication and coordination:** The Commission updated and maintained a website for posting information regarding their meetings as well as reference documents related to their priority focus areas (http://hss.state.ak.us/healthcommission/). The listserv established to maintain communication with system stakeholders and members of the public interested in receiving periodic updates was also enhanced, and by the end of 2011 there were over 600 subscribers. The Commission also maintained an inventory of boards, committees, coalitions, and other organizations in Alaska involved in health planning in some way, as well as a list of health reports and plans (also available on the website).

**2011 Products:** The Commission's primary product for this year is this annual report. In addition, the Commission contracted with consultants to conduct two studies during 2011. The Institute for Social & Economic Research and Mark Foster and Associates conducted an economic analysis of health care spending in Alaska for the Commission; and Milliman, Inc, an international health care actuarial firm, compared payment levels for hospital and physician services in Alaska to a number of other states. The Commission also held a three-part webinar series on successful patient-centered medical home programs in other states, and also a webinar on payment reform. The four reports resulting from the two consultant studies and recordings of the webinars are available on the Commission's website.

## D. 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.*

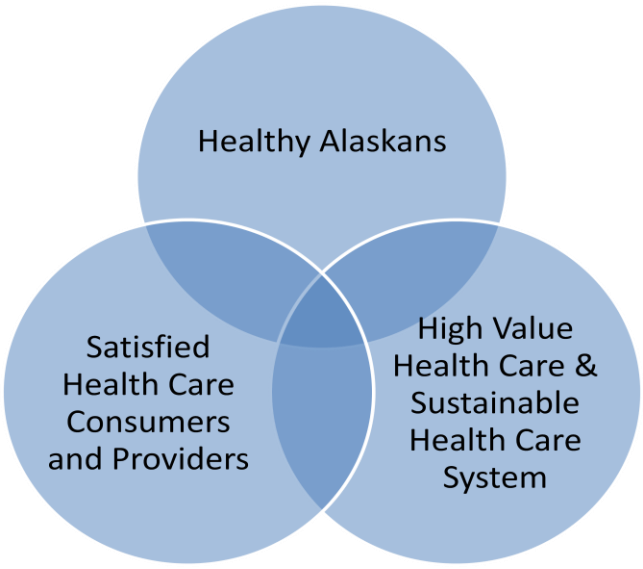
Accurately describe Alaska's health care challenges to understand why the current system is not achieving the vision. *Accomplished: System Description & Issue Identification (2009); Impact of Federal Reform (2010); Cost Analysis, Pricing & Reimbursement Comparisons, Long Term Care (2011); 2012-2014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

## E. 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:** Improve access to affordable health care coverage and to a viable and vital health care delivery system.

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

**III.** **Quality:** Health care services provided in Alaska meet the highest quality and safety standards.

**IV.** **Prevention:** Focus on preventive services, both clinical preventive services for individuals and community-based prevention policies, to 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. Individual investment is a vital part of a robust health care system.

## F. 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.

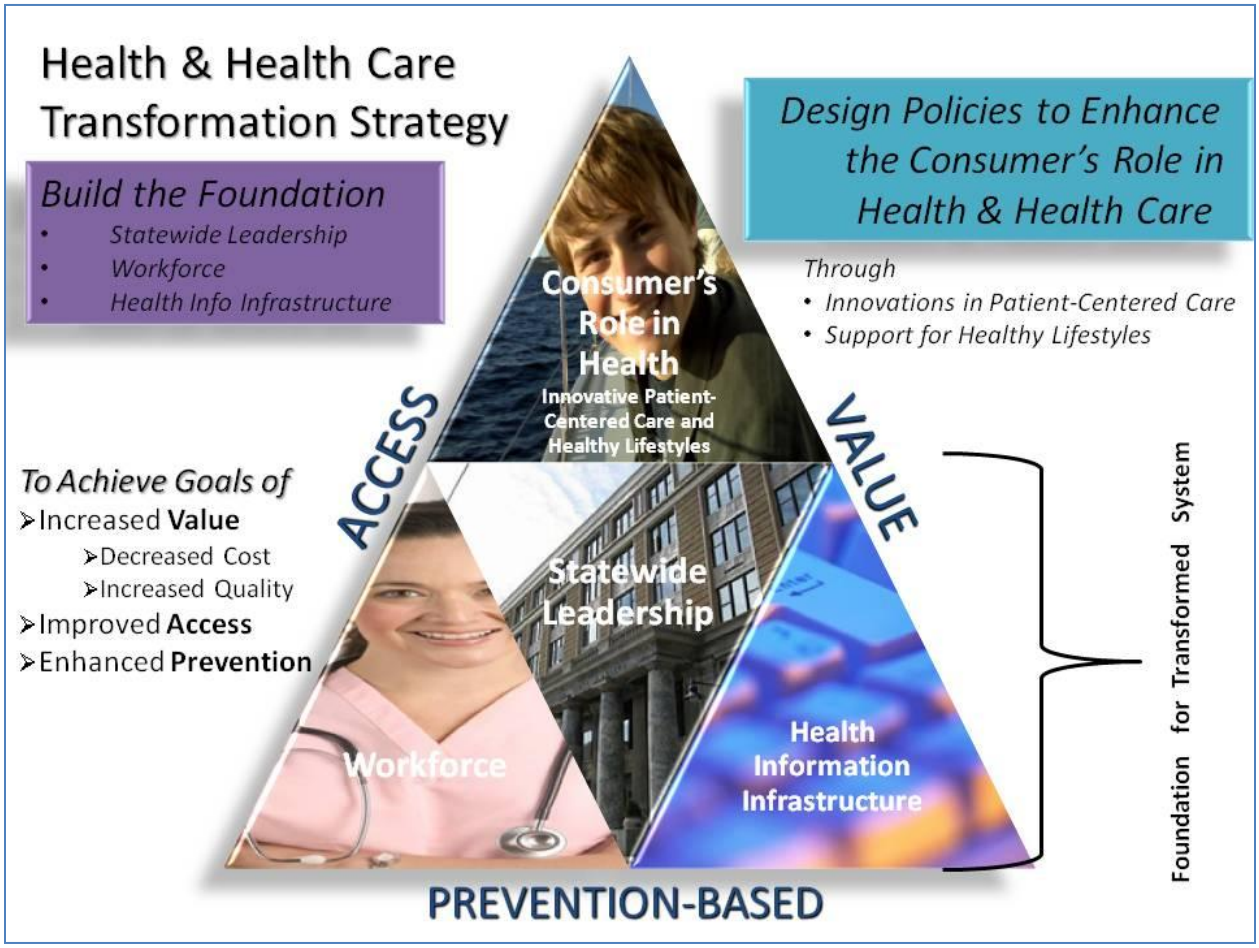



**Figure 1: Alaska Health Care Commission's Core Strategy for Health Care System Transformation**

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. Ongoing study, planning, and policy development is necessary to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

## G. 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.

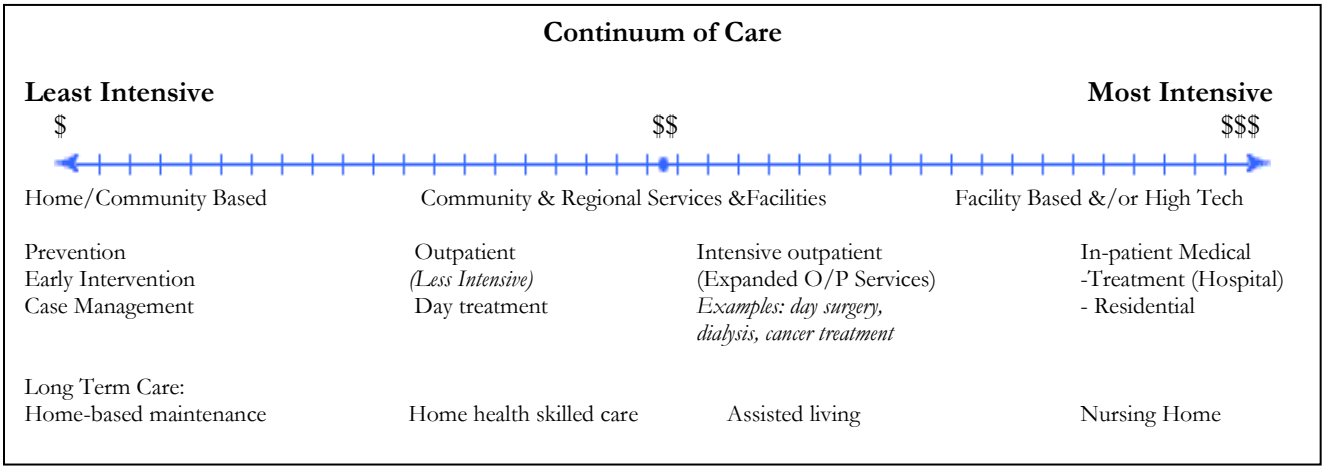
## Health Care System

- 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.




## Public Health

- Public health is what society does collectively to assure the conditions for people to be healthy. The two main characteristics of public health are 1) it is concerned with prevention rather than cure, and 2) it is concerned with population-level rather than individual-level health concerns.

- Public health protects and improves communities by preventing epidemics and the spread of disease; promoting healthy lifestyles for children and families; protecting against hazards in homes, worksites, communities and the environment; and preparing for and responding to emergencies.

# 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 certain health care workers.
- Health status, health risk behaviors and changing demographics influence 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 a financial 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 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 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, published in August, is included as Appendix A of this report and is available on the Commission's website at:
http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm.

The financial analysis of physician payment rates conducted by Milliman, Inc. compares health care prices for the top 25 utilized procedure codes for each of 17 physician specialties in Alaska with five other states: Washington, Oregon, Idaho, Wyoming, and North Dakota. This 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 report on physician payment rates also includes a comparison of the average reimbursement level for durable medical equipment (DME) overall and by payer.

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 it has logistical challenges somewhat 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 reimbursement levels and cost drivers for federal tribal and military hospital services at some point in the future if analysis of potential strategies related to affordability, cost of care and sustainability of the health care system require this additional information.

The analyses of hospital and physician payment rates and cost drivers are presented in three reports from Milliman, Inc. and are included in Appendix B of this report (available on the commission's website at: http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm). Note that these reports are systems-level analyses and are not intended to be utilized as an evaluation of individual facilities or physician practices. Statistics for individual facilities vary widely within the systems-level averages presented, and conclusions should not be drawn about specific facilities from these data without review of each individual facility's financial and cost reports.

## Findings

- **Health care spending in Alaska continues to increase faster than the rate of inflation.**
  - 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.
  - By comparison, the wellhead value of oil produced in Alaska was $16.4 billion in 2010, and is projected to be $18.6 billion in 2020.
  - Also by comparison, total wages earned by Alaskan employees was $15.4 billion in 2010.

- **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 relative to comparison states based on financial analysis of the private health care system. 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 69% 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 37% 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) operating 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 38% higher overall and 86% higher for Alaska's private sector rural hospitals. Higher operating costs in Alaska for hospitals and physician practices are driven by:
        - The cost of living, which is 20-30% higher in Alaska than in comparison states (overall, not accounting for rural/urban differences).
        - Medical salaries for health care workers, which are 0% - 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 the private sector hospital system include:
            - RN staffing ratios, which average 29% higher than comparison states.
            - Occupancy rates, which on average are lower at 49.9% in Alaska relative to 58.1% in comparison states.
    - In 2010 the average all-payer operating margin for Alaska's private sector hospital system was 13.4% compared with the average of comparison states' hospital systems of 5.7%. Operating margins for individual Alaska facilities vary widely within these averages, ranging from -9.2% to 29.4%. For Medicare patients, the operating margin is 2.6 percentage points less than the comparison state average, at -11.5% in Alaska compared to -8.9% in the comparison states, causing upward pressure on commercial premiums in order to offset hospital losses.
    - Physician discounts are low in Alaska relative to the comparison states, an indication that physicians in Alaska have more market power 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.
    - Lower physician discounts in Alaska can be at least partly explained by the relative lack of competition among providers, particularly for specialty care. In many areas, including Anchorage, there are a limited number of providers in any given specialty (sometimes only one provider group). As a result, physicians can largely dictate the fees they are paid by commercial payers.
    - Relative provider leverage may be further exacerbated by Alaska's regulation requiring usual and customary charge payment to be at least equal to the 80$^{th}$ percentile of charges by geographic area. Since many providers have over 20% of their market share, this implies that those providers can ensure that their charges are below the 80$^{th}$ percentile and therefore, receive payment for their full billed charges.
    - A separate state law requires payers to reimburse non-contracted providers directly instead of through the patient, removing incentives typically used by payers to encourage providers to join their networks.

- **The average payment for durable medical equipment (DME) in Alaska is 21% higher for all payers relative to the average comparison state payment level.** DME consists of non-pharmaceutical items ordered by a provider for a patient. By payer, the average reimbursement for DME is:
    - 23% higher for commercial payers in Alaska relative to the average across commercial payers in the comparison states
    - The same in Alaska for Medicare and TRICARE as the comparison states' Medicare and TRICARE average
    - 180% higher for the VA in Alaska relative to the average VA payment across the comparison states
    - 55% higher for the Alaska Medicaid program relative to the average Medicaid program payment across the comparison states (excluding N. Dakota)
    - 98% higher for the Alaska Workers' Compensation program relative to the average of N. Dakota and Washington states' Workers' Comp payment level (Idaho, Oregon and Wyoming not available)

## 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 Pharmaceuticals in Alaska:** Compare pricing and reimbursement levels across payer types for pharmaceuticals to the comparison states, and identify drivers of cost differentials.
- **Behavioral Health Care:** Learn about the behavioral health care system in Alaska.
- **Malpractice Reform:** Tort reform legislation was passed in Alaska in 2005. Identify whether the new law had an impact on malpractice insurance rates for providers.
- **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. 2011 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.

## 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.

**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 study the need for and feasibility of an All-Payers Claims Database.

## 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.

## 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 include key stakeholders, and 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.

**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.

**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.

**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 (140 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.

**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 appropriate to the patient population.
  - Assure coordination between primary care and higher level behavioral health services.
  - 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 to facilitate integration of primary physical health care services with behavioral health care 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

# Appendix A

## "Alaska's Health-Care Bill: $7.5 Billion and Climbing,"

**Institute for Social & Economic Research, University of Alaska**
**with Mark A. Foster & Associates**

**August 2011**

Study Conducted under Contract for the Commission during 2011

Available on the Commission's 2011 Report webpage at:
http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm

# Appendix B

## Hospital & Physician Payment Studies by Milliman, Inc.

Studies Conducted under Contract for the Commission during 2011

1. **Physician Payment Rates in Alaska and Comparison States, November 29, 2011**

2. **Facility Payment Rates in Alaska and Comparison States, November 21, 2011**

3. **Drivers of Health Care Costs in Alaska and Comparison States, November 29, 2011**

Available on the Commission's 2011 Report webpage at:
http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm

# Appendix C

## Overview & Update
## Federal Health Care Reform
## (ChartPack)

Available on the Commission's 2011 Report webpage at:
http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm

# Appendix D

## Voting Records

## Summary of Public Comments

Available on the Commission's 2011 Report webpage at:
http://www.hss.state.ak.us/healthcommission/2011commissionreport.htm