

MEETING MINUTES

Alaska Health Care Commission Friday, February 27 – Saturday, February 28, 2009 Juneau, Alaska

Commission Members Present

Voting Members: Jay Butler, MD (Chair), C. Keith Campbell, Jeffrey Davis, Ryan Smith, Wayne Stevens, Lawrence Stinson, MD. [Absent/Excused: Valerie Davidson]

Non-Voting Members: Linda Hall, Representative Wes Keller, Senator Donny Olson

Commission Staff: Deborah Erickson

Others Present

Skip Gray (Gavel to Gavel technician), Lynda Barker (transcriptionist), Alice Rarig (note taker), Dennis McMillian and Duane Heyman (for presentations), William Hogan and Anna Kim (for welcome).

The following members of the general public observed at various times: Marie Darlin, Jim Pound, Rod Betit, Jeff Ramp.

Live audio stream of the meeting was carried by Gavel to Gavel.

Friday, February 27

The meeting convened at 10:30 a.m.

Welcome and Introductions

- The meeting convened at 10:30 a.m. Dr. Butler (Chair) welcomed the group and commented on the importance of and the challenges facing the new commission. Commissioner Hogan (DHSS) and Anna Kim (Governor Palin's Office) arrived and each welcomed and thanked the group.
- Members, other participants and observers introduced themselves.
- Reviewed agenda and meeting ground rules.
- Reviewed Administrative Order #246 establishing the commission

Handouts Provided:

- *Meeting Agenda*
- *Meeting Ground Rules*
- *Alaska Health Care Commission Members (Roster with short bios)*
- *Comparison of Health Commission Authorizing Language (table, draft dated 2-16-09)*
- *Administrative Order #246*
- *HB 25*
- *HB 75*

Alaska Health Care Reform Findings and Recommendations

Representatives of the two most recent groups to address the question of health care reform in Alaska made presentations on the process and outcomes from those efforts. It was noted that both groups' recommendations included that an ongoing health care reform policy board be formed.

Alaska Health Care Strategies Planning Council – Dennis McMillian, President, Foraker Group

The planning council was established under Administrative Order #232 in February 2007 by the Governor to identify short and long term strategies that would include a combination of public and private solutions for addressing the issues of health care access, cost and quality. There were 14 members, 13 of which represented various sectors of the health care industry. The council had a very short timeframe – met monthly for six months during summer/fall 2007. Council was directed to review existing studies in order to develop recommendations.

The council used a consensus process to vet facts gleaned from council member review of a large volume of available information on the issue of health care reform, the condition of Alaska's health care system, and the health of Alaskans. Mr. McMillian suggested this commission review the Consensus Facts list developed by the Council. Decisions were reached through consensus when possible, and through majority/minority determination when not.

The council identified issues of interest as: Access to health care, Quality of health care, Cost of health care, Prevention/public health, Provider recruitment/retention, Care for very young, Care for elders. Recommendations were developed around seven goals:

1. Health costs for all Alaskans will consistently be below the national average
2. Alaska will have a sustainable health care workforce
3. All Alaskan communities will have clean and safe water and wastewater systems
4. Quality health care will be accessible to all Alaskans to meet their health care needs
5. Personal responsibility and prevention in health care will be top priority
6. Develop and foster the statewide leadership for statewide health and health care policy
7. Increase the number of Alaskans covered by health insurance

Handouts Provided:

- *“Alaska Health Care Strategies Planning Council: Report to State Health Commission,” PowerPoint Presentation by Dennis McMillian, February 27, 2009.*
- *“Final Report: Summary and Recommendations,” Alaska Health Care Strategies Planning Council, December 23, 2007.*

Action Items/Follow-Up:

- *Find and provide a copy of the Alaska Health Care Strategies Planning Council's Consensus Facts list to the Commission.*

Alaska Health Care Roundtable – Duane Heyman, former AHCR Executive Director

Mr. Heyman first provided a brief background on Commonwealth North and the Alaska Health Care Roundtable. Commonwealth North is a non-partisan public policy forum created by former Governors Walter Hickel and William Egan. Commonwealth North identified health care as a priority issue in 2004, and spent a year studying primary health care. As a result of that study the Alaska Health Care

Roundtable, a coalition of business and health care stakeholders, was created and met for two years to continue the dialogue.

Principles of reform identified by the Roundtable included the need to: create healthier people; support individual responsibility; improve value for health care dollars; etc. (all reform principles are included in the "Principles" handout). Mr. Heyman reviewed guiding principles recommended for the commission's process, which included: the need to acknowledge this problem is complex and will take more than a few months to solve, the importance of getting all the best ideas out on the table for consideration and not just taking one path, the opportunity for learning from other states and national initiatives, the need for conducting sufficient Alaska research to evaluate policy alternatives, the importance of involving the right stakeholders (including those who will have to implement the reforms) in the decision making process, and working at both the federal and state levels (see the accompanying PowerPoint presentation handout for a detailed list of the guiding principles).

Handouts Provided:

- *"Sustainable Health Care in Alaska," PowerPoint Presentation by Duane Heyman, February 27, 2009.*
- *"Principles, Elements and Specific Steps," Alaska Health Care Roundtable recommendations, August 29, 2007.*
- *"Alaska Primary Health Care: Opportunities & Challenges", Commonwealth North, July 31, 2005.*

Commission Member Information Sharing & Discussion

Dr. Butler invited individual commission members to share position papers on health care reform from their own or other organizations or constituency groups, as well as other information resources. A summary list of all the documents distributed at the meeting, as well as other information resources referenced during discussion, is included at the bottom of this section.

Mr. Smith shared a publication on principles for health care reform produced by the Alaska State Hospital & Nursing Home Association (ASHNHA). This document came out of discussions held at the ASHNHA annual meeting last fall in Talkeetna. He reviewed ASHNHA's principles for guiding health care reform, which are to:

1. Continue to improve health care quality and efficiency
2. Establish health care accountability
3. Improve and expand health care coverage and access
4. Strengthen public and private health care programs

Mr. Smith also provided a copy of a summary report on a public opinion survey, commissioned by ASHNHA (survey conducted December 2007), to determine attitudes toward health care in Alaska and evaluate acceptance of various healthcare reform measures.

A conversation ensued related to the consumer survey regarding whether people know how to use online data. It was noted that early evaluations of online data systems on comparative health care quality measures demonstrate few (less than 5%) consumers utilize them; however 1) we might expect to see use increase as systems become more familiar and information improves, and 2) evaluations have demonstrated that, while consumers haven't fully embrace them yet, these systems have been effective at generating competition between and increasing quality of health care providers/services.

This discussion prompted a note that quality measures for hospitals, physicians, and other providers need to be developed “with” the providers, and not be “done to” them.

Another strain of this conversation related to use of online information for enhancing individual wellness and healthy lifestyles. The question of whether financial rewards are more effective than increased access to information for incentivizing individual behavior change was raised.

Another question regarding consideration of insurance mandates (employer and individual) came up. ASHNHA has explored the Massachusetts model, and that state’s experience could be followed as time goes on. A member warned that “the devil is in the details,” and that one of the commission’s principles should be to avoid unintended consequences (referencing the Washington experience from the 90’s where health care reform measures led to loss of nearly all private insurance companies in the state). The possibility of exploring the success that other mandates have had was suggested.

The issue of terminology, the need to be clear about definitions, was identified. For example, does everyone define “universal coverage” the same way? For some it implies a comprehensive government program, and for others simply a set of policies that would provide a public/private approach for expanding access to insurance. The importance of keeping our terminology straight and starting a glossary of definitions was stressed. Also the importance of using research and lessons learned from other policy efforts regarding the potential success of different strategies, e.g., do mandates work?, was identified.

The data on page 5 of the survey handout was referenced --- people want access to high quality services as close to home as possible, but willingness to pay more to expand access is pretty evenly divided (46% strongly or somewhat agree; 41% strongly or somewhat disagree). But then 83% think that setting up a sliding-scale co-pay system would be a good idea. A member mentioned attending two community forums under the state insurance planning grant initiative, at which public participants largely agreed they would be willing to contribute what they could for health insurance, but the amount consistently identified by the participants as affordable was \$100/month. The question of whether the general public really knows how much health care, and how much insurance premiums, actually cost was raised.

Dr. Stinson showed the group a volume of reference materials he is compiling and will review before sharing, and discussed efforts to gather additional input from other medical practitioner types, such as nurse practitioners and physicians assistants.

Mr. Campbell provided copies of a PowerPoint presentation on health care reform made at the Alaska Health Summit in December by JoAnn Lamphere from the national AARP office. The presentation provides examples of other state health care reform efforts. Mr. Campbell noted it would be nice to get copies of some of the other states’ proposals. Themes of these other efforts include coverage for low income adults and shared responsibility. Some aren’t necessarily working, but we could learn from their efforts, especially to prevent reinventing the wheel. Massachusetts, Iowa, and Oregon are states for which we could review work and outcomes to-date. We would still need to take into account the fact that Alaska is unique, one aspect being there is a lot of fragmentation and duplication of services in our system, e.g., multiple hospitals (private, non-profit, military, tribal) in one community, which drives up overall cost.

Another resource document Mr. Campbell referenced is the Alaska Health Care Data Book, which is available online.

Ms. Erickson asked a question regarding how the commission would like information shared, and what sort of vetting process they would like before having information forwarded to them. Mr. Davis recommended using a process similar to the Health Care Strategies Planning Council, with posting pertinent resources on a commission website. Dr. Butler asked if the group was interested in reviews of other state's experiences. The response was affirmative, with a note that the reviews need to be fair and balanced.

Mr. Stevens shared a number of issues that have come up in the course of Chamber of Commerce discussions on the topic of health care costs and reform efforts.

- There seem to be unrealistic expectations on the part of everyone with a stake in health care. Everyone – consumers, providers, insurance companies – has to be represented at the table and everyone will need to give a little bit to make this reform effort work. Follow-up on the comment made earlier related to consumers willing to pay \$100/month for health care --- a small business owner testified at a legislative hearing that her business could afford to pay \$100/month for health care premiums for employees, but the expectation was she could get the same coverage as state employees, which costs \$850/month. People's expectations don't match up to reality.
- There is a question regarding the proportion of health care costs that are spent on care in the first and last 6 months of life – no answers, just a question.
- There's a need to overcome the entitlement mentality and emphasize personal responsibility of consumers.
- Another issue relates to tort reform, and how fear on the part of providers regarding potential liability translates into unnecessary testing and technological fixes, driving up the overall cost of care.
- A central repository for electronic personal medical information that can be shared between providers could be a cost-effective way to achieve efficiencies and lower costs.
- The regulatory environment, such as HIPAA, makes it more expensive for the health care industry to do business.
- An access issue that could be addressed is the times clinics are open during the day – do they accommodate families with two working parents? Does lack of flexible clinic hours drive some people to emergency rooms who otherwise would go to a clinic if it was available outside regular business hours?
- Concern about mandates on business. Insurance benefits are necessary to attract quality employees, but costs need to be weighed against margin. Businesses operating on a slim margin could be driven out of business by a mandate that increases their costs just a little bit. The commission should think about the unintended consequences of recommended strategies.

Conversation followed regarding unrealistic understandings and expectations about access. It was noted that Alaska has safety nets in ACHIA [Alaska Comprehensive Health Insurance Association – the high risk insurance pool created by the legislature during the mid-90s], Medicaid, Medicare, Community Health Centers ("330" clinics), the tribal health system, etc., and that we need to identify our strengths and what we do have, not just gaps. There was also conversation about the need to educate people about actual costs of care; and also about how Alaskans like to think individualistically/independently and not acknowledge how their personal health affects others – another educational need.

Mr. Davis shared two documents from Premera: a one-pager listing Premera's public policy principles for health care reform, and the other a report from BlueCross/BlueShield Association (BC/BS) on recommendations for reform. He pointed out that between the last two groups in Alaska that met on health care reform (two presentations this morning), ASHNA (referencing information provided by Mr. Smith) and the Admin Order establishing the commission, there is a lot of agreement about general principles. He noted Premera serves 205,000 Alaskans. Premera's principles assert that all people should be able to obtain medical care and have a choice of coverage; the private market fosters innovation, choice and efficiency; government's role is to provide access to care for those who can't afford it, and to regulate the market; the problem of the rising cost of care must be addressed; and individuals, providers, and insurers all share responsibility and accountability. Recommendations from BC/BS include increasing research on effectiveness of medical care, refocusing incentives on outcomes, empowering consumers, promoting health and wellness, and fostering public/private solutions. Referenced page 43 of the BC/BS document - 56% who don't have insurance aren't eligible for public programs but can't afford private insurance, 25% are eligible for public programs but not enrolled, and 20% have high enough incomes that they could afford some out-of-pocket costs on their own. This is a broad, complicated picture – it's not just about health insurance – there are many discrete problems that need to be addressed. He also referred to a recent report by the Congressional Budget Office (CBO) on key issues for analyzing major insurance proposals, which is a good summary that provides explanations of mandates and other strategies.

Follow-up conversation addressed whether we've stigmatized public assistance for those who are eligible and won't apply, although providers in general are encouraging people to participate if they are eligible. ACHIA is available as the high risk pool for those with preexisting conditions, but few choose to participate because of the cost. Others just choose to not have insurance and go to the emergency room when they have a medical need.

There was a question about migration from private to public coverage, with a response that the CBO report addresses this issue, termed "crowd-out,"--- that it is proven people will drop private coverage when they become eligible for public coverage under an expansion, and we should be concerned about it (e.g., we will expect to see some low-income workers drop employer coverage for their kids and enroll in SCHIP if expansion proposals pass).

A question was asked about the BC/BS recommendation to "encourage research on what works." Do they have specific points of view on comparative effectiveness? Mr. Davis referenced page 7 of the report, noting that ineffective, redundant, inappropriate care is estimated to be 30% of health care spending, and 54% of acute care is based on evidence-based recommended treatment. Questioned whether we'd accept this type of performance from a cell phone company – what if our cell phones worked only 50% of the time? Premera and BC/BS believe that it is a legitimate role of government to identify what works, and help eliminate inefficiency in the system.

Another question was regarding private market versus government insurance. Mr. Davis noted that Medicare does not administer health benefits – that work is contracted to private carriers because innovation and efficiency is better in the private market. Private market solutions also allow more choice for the consumer. Government's role is to help the otherwise uninsurable. He questioned why we would dismantle the system (private insurance) that currently covers 83% of the population.

Another question was asked regarding how to control the cost of care and address the unsustainability of growth – Means testing? Rationing? Taxation? Evidence-based medicine? Mr. Davis first indicated

the importance of separating out cost, funding, and financing, and the need to truly reduce cost, not just shift funding. We need to reduce the rate of growth as it compares to growth of GDP, so health care expenditures are growing at a slower rate. Then he discussed the importance of improving quality through evidence-based medicine, faster adoption of best practices, and reduction in errors --- the need to base practice on clinical studies that demonstrate what works, then provide incentives for consumers and providers who comply. We should pay providers for outcomes. This is not rationing – but paying for what works. He gave an example of a pilot project Premera has in Seattle with a large group practice for diabetes care where consumers are incentivized to participate with lower deductibles/co-pays, and providers are incentivized with pay for performance (based on improved outcomes).

Another question was asked about what drives choice on the part of consumers for deciding what coverage to buy – the balance between cost vs. perception of risk? Yes, but consumers need more information regarding costs and options, and ability to adapt packages of coverage to the needs of the group. For example, the Foraker Group has developed a pilot project with Premera that includes an element of personal responsibility through the inclusion of both a health savings account, and a health risk management program. There's a high deductible, but the employer contributes to the HSA and the employee has some of their own money in the game.

Another issue raised was the fact that a very small proportion of a covered group drives the majority of the cost. Mr. Davis pointed out that 80% of costs are from chronic disease and 50% of that is driven by lifestyle choices, but the people who are chronically ill today didn't become that way over night. And those who will be the chronically ill cost drivers of the future are "in training" today – we need to short circuit that.

Representative Keller was asked to share his perspective. He noted that he doesn't have a health care background, but has exposure to public policy making on health issues in the legislative arena for the past 10 years and can bring that to the table in support of getting this work accomplished. He emphasized that sustainability of our solution is going to be key, and the amount of public money that will be needed for the health care solution will be an important factor in its success. He thinks about recommendations for health care reform as being on either end of a scale, from self-directed, market driven on one end, to universal coverage on the other end. He could argue for either end of the scale, but in reality we're going to end up somewhere in the middle.

He identified the fact that the commission may have a bit of a credibility problem with the legislature, since members have a vested interest in the health care solution, so if the group makes recommendations that just move toward putting more public money into health care as the solution it may be viewed somewhat skeptically. One way to address this could be to limit the very first recommendations that come out of the commission to strategies that actually save public money, rather than cost more.

Mr. Davis responded that he was in agreement about needing to start small and "take one bite of the elephant at a time." One thing that may be doable and have a net savings is the Alaska eHealth Network (AKeHN)(noting both he and Dr. Butler are on the AKeHN Board of Directors), which is working to connect physician offices that have their own electronic medical records systems. Research has shown that if you can connect the systems, you can reduce costs by about 5% by eliminating duplication of medical services and improving quality.

Mr. Davis made another comment that Premera and BC/BS are actually supportive of a mandate. He explained that there are two concepts to universal coverage. Universal coverage can just mean everyone has insurance. Or it can mean a single-payer system where the government is the payer. Premera BC/BS believes everyone should have coverage, but it shouldn't be a single government payer. The private sector has a role, and government has a role with some populations.

Representative Keller made the suggestion that the commission could benefit by listening to some of the national groups working on health care reform that have values related to personal responsibility and consumer-driven ideas, such as Newt Gingrich's Center for Health Care Transformation.

Mr. Campbell suggested that we need to find the spot on the continuum between the two ends of the spectrum that could give us the efficiencies of a single-payer system, but still have the flexibility and other benefits of a market-driven system, noting that the single-payer system in Canada is very administratively efficient, but certainly limits choice. He also noted the need to find solutions to relieve providers from continuing to accumulate bad debt from individuals who can't afford their high deductibles.

Responding to the need for efficiencies, Rep. Keller referred to a recent presentation by a private company, U.S. Preventive Medicine, to a legislative committee. This firm contracts with businesses and governments to put preventive health plans in place in their organizations, and provides case management services as one service in those plans. Mr. Davis pointed out that state employee health coverage provided by Premera already includes a preventive element, including case management services for those with chronic disease.

Mr. Smith responded that he agrees with an incremental approach, and acknowledges the need to be clear about self-interest, but is not sure if cost savings can realistically be realized by the initial strategies the commission will recommend. He referred to the list of six strategies under duties of the commission's administrative order, and noted that the commission will need a lot of information and sophisticated expertise to accomplish its mission.

Rep. Keller responded that he believes the list of strategies is broad and therefore somewhat loose – that the commission has some flexibility to prioritize specific strategies for which they will develop recommendations, and can identify certain strategies on the list they may table for now.

Sen. Olson explained that, if the commission comes up with some well-thought-out ideas for recommendations, it will have credibility with the legislature, and he and Rep. Keller will be the liaisons for the commission for any legislative work that needs to be carried forward to implement commission recommendations.

Ms. Hall explained that as the executive branch representative to the group, she will be the liaison to the Governor's Office. She explained that she has been involved with numerous health insurance panels and task forces, and would like to see something more concrete come from the commission. She agrees with taking an incremental approach, noting that with a state of our size and the limitation on resources we won't be able to make a huge change right away. She explained that much of the private health insurance market is controlled by federal regulation, which will preempt some of the things we might want to do. Access is important, but the need to address the high cost of health care and the impact on the economy and business is a high priority (referred to Alaska having the highest worker compensation rates in the country).

Dr. Butler shared his perspective on health care reform, viewing it as based on four pillars – Cost, Quality, Access, and Prevention. Referring to cost, he noted that 16% of the nation’s GDP goes to health care today with a projected increase to 20% by 2018 if we don’t change course. Regarding quality, quality combined with cost equals value, but there’s also a safety issue, and the Institute of Medicine estimates 90,000 deaths per year in this country are due to medical errors. Access includes two components – insurance coverage and health care workforce availability/accessibility. He referred to conversation with colleague in Massachusetts who noted their reform effort as covering more people with health insurance, but having problems finding health care providers. Prevention is the fourth pillar, which ties back to cost. He explained he’s been working on getting at specifics of what we are spending in the state Medicaid program as a result of obesity, and in 2008 we were up to \$45 million on treatment of type 2 diabetes. It amazes him that 42% of the kids on Medicaid who have diabetes have type 2 disease, which was very rare when he trained as a physician and now it’s nearly half of these diabetic kids, and this disease type is almost exclusively related to obesity.

Dr. Butler also commented that we can learn from other states and countries, but there won’t be another model out there that will fit Alaska perfectly. What we do in Alaska will have to be appropriate for Alaska and will have to represent all Alaskans, not just those around the table.

Mr. Stevens asked a question about type 2 diabetes in kids, and whether that’s related to lack of physical education today in schools. Dr. Butler responded that recent research (published in Journal of Pediatrics) concludes that PE alone doesn’t solve the problem, but PE in the context of health education including a nutritional education component makes a difference in the prevalence of obesity in the student population. Dr. Butler mentioned working with Commissioner LeDoux of the Alaska Department of Education & Early Development recently (noting an interest on the part of the education system right now on improving the health of students) on integrating health education and improving school meals.

Sen. Olson mentioned the commission should consider learning more about Canada’s approach to caring for the elderly and kids, the most vulnerable populations, and also about the efficiencies in their system.

Dr. Butler wrapped up this discussion with a note that Val Davidson, the tribal health system representative to the commission, couldn’t participate in this meeting as she had a prior commitment in WA D.C., but will have an opportunity to share information and perspectives at the next meeting.

Summary of Information Resources Shared

Handouts Provided:

- *“Alaska Department of Health & Social Services 2009 Priorities,” DHSS, June 23, 2008 (Dr. Butler)*
- *“Guiding Principles for Health Care Reform 2009,” Alaska State Hospital & Nursing Home Association (Mr. Smith)*
- *“Key Findings from Cromer Group Public Opinion Survey,” Alaska State Hospital & Nursing Home Association, February 27, 2009 (Mr. Smith)*
- *“Making Health Care Reform in Alaska a Reality,” AARP presentation by JoAnn Lamphere to Alaska Health Summit, December 2, 2008 (Mr. Campbell)*
- *“Public Policy Principles,” Premera, February 2008 (Mr. Davis)*

- *“The Pathway to Covering America: Ensuring Quality, Value and Access,” BlueCross BlueShield Association, 2008 (Mr. Davis)*

Other Resources Referenced:

- Center for Health Care Transformation, www.healthtransformation.net (Rep. Keller)
- Alaska Health Strategies Planning Council: Resources Web Site, <http://www.hss.state.ak.us/hspc/resources.htm> (Mr. Davis)
- “Key Issues in Analyzing Major Health Insurance Proposals,” December 2008, Congressional Budget Office (<http://www.cbo.gov/doc.cfm?index=9924>) (Mr. Davis)
- *Alaska Health Care Data Book*, 2007, Division of Public Health, DHSS, <http://www.hss.state.ak.us/dph/Healthplanning/publications/healthcare/default.htm>

Action Items/Follow-Up:

- *Start a glossary of terms.*
- *Check with the staff who managed the Health Care Strategies Planning Council web site on their process for reviewing and posting information resources to the web for the Council’s use, to adapt and adopt for the commission; and will set up an information resource sharing page on the commission’s web site.*
- *Begin compiling existing reviews of other states’ recent attempts at health care reform.*

Administrative & Procedural Business

Bylaws

A first partial draft of bylaws was provided in the meeting notebook. Commission members were questioned as to how they wanted to move forward with development of their bylaws – active involvement in drafting with a subcommittee? The group indicated they prefer staff complete the draft and circulate via e-mail for feedback. A suggestion was made that the bylaws be kept as simple as possible so work isn’t constrained - necessary details should otherwise be included in work plans instead.

Duties of the Chair should include facilitator and adjudicator. Agenda’s should be drafted by Executive Director and Chair, with member input up front and feedback on drafts.

Meeting frequency should be noted as quarterly with option for calling special meetings. We should note that meetings may be held via teleconference. The group noted wanting to have their next meeting earlier than 3 months from now, to keep up momentum, and to be able to hear from Val Davidson. The suggestion that we meet monthly at first was made. The group agreed to set meeting frequency once the work plan is more clear. The most immediate work plan activity should be making sure the commission is established in legislation, for credibility and to ensure viability of work and recommendations. The scope and complexity of the work needed on health care reform is too broad and complex for an ad hoc group to address in one year.

The ethics section of the draft bylaws was referenced is based on the state Ethics Act. It was noted that the Ethics Brochure for Commissions was included with the commissioners’ appointment letter from the governor, was e-mailed to them by Ms. Erickson, and is also included in the meeting notebook. The

assistant attorney general for ethics will make a presentation on compliance at the next commission meeting.

The travel compensation section of the bylaws was reviewed, and more information was requested on the actual compensation rates.

Role of Committee re: Pending Legislation

The group discussed potential drawbacks to taking positions on legislation, such as loss of credibility by politicizing the work of the commission, alienating constituents of bills the commission might oppose, complexity of managing work on bills for which commission members' employers or constituents may take a differing position from the commission, placing the commission in a reactive rather than proactive mode, resources required for analyzing bills, and making the commission a target for lobbyists. The group agreed that a more positive approach will be to develop their own policy statements on recommendations they want to see advanced, and will possibly draft their own legislation at times for either governor or friendly legislator sponsorship.

Executive Director Duties; Decision to Employ

Commissioners recommended leaving the Executive Director's duties out of the bylaws, and instead directed that a draft job description be developed and circulated via e-mail for feedback and for review and approval at subsequent meeting. Bylaws should just note that the E.D. serves at the pleasure of and works for the commission. Roles of the E.D. were discussed; those identified included: keep process/group moving forward, communication, information management, supporting facilitation of meetings and process, research to identify pertinent/relevant information sources, and manage day-to-day business functions (including financial arrangements).

Ms. Erickson distributed her resume and summarized her background working two decades in public health in Alaska, the last six years as deputy director for the Division of Public Health, and involvement in many health policy planning groups working together similar to the commission.

Formal Decision:

Mr. Davis made a motion that the commission employ Ms. Erickson in the position as Executive Director. Rep. Keller seconded. All voted unanimously in favor of the motion.

Public Participation and Communication

The web site for the commission is already up. There is a listserv in development. In the interest of public communication and transparency, this meeting today is being documented by a transcriptionist, and there is a live audio stream provided by Gavel to Gavel. A suggestion was made that a simple one page communication plan be drafted. Dr. Butler mentioned that the Public Information Office of DHSS is available to help with press releases, at those times we want to communicate something to the public through the press. Regarding the question of public participation/input, the commission might include time on each future agenda for public comment, or the commission could wait until they have draft products, and invite public comment. Additional options include public hearings, community forums, town hall meetings and surveys. Public input opportunities will be included on the communication plan draft for commission consideration.

Handouts Provided:

- *Draft Bylaws of the Alaska Health Care Commission (02-22-09 draft)*
- *Ethics Brochure for Members of Boards and Commissions (AS 39.52), State of Alaska, June 2007*
- *Travel Memorandum of Agreement form for Non-Employees, DHSS*
- *Personal Vehicle Use Reimbursement Log form, State of Alaska, January 1, 2009*

Action Items/Follow-Up:

- *Draft a complete set of bylaws for commission review, revision and approval.*
- *Draft a job description for the executive director for commission review, revision and approval.*
- *Provide more detailed information regarding travel reimbursement and per diem to commission members.*
- *Draft a communication plan for commission review, revision and approval.*

The Commission recessed for the day at 5:00 p.m.

Saturday, February 28

The commission reconvened at 7:07 a.m.

Began with discussion of planning process for the year, and planning process and agenda for the day in light of how the Commission wishes to proceed with the planning over the coming months.

Vision & Values for Alaska's Health Care System and Approach to Designing the Solution

Ms. Erickson provided a rough draft planning elements and timeframe proposal. The group felt it was premature to develop a comprehensive state health plan, and noted that the charge is to “*foster* development of a statewide plan.” Health information technology (HIT) was given as one example of an area the group might identify as a high priority and develop recommendations in the shorter term, prior to developing a full, comprehensive plan. It was noted the federal stimulus package might drive health care issues/strategies that may need to be addressed in the short term by the commission, and because HIT is included in the stimulus package, it might be prioritized to move more quickly.

Discussion followed about defining the scope of the commission's charge within the context of the six strategies identified in the administrative order. The six strategies were taken from the goals adopted by the Health Care Strategies Planning Council (HCSPC). The six goals are very broad in scope. And the other part of the charge refers to the commission as the state health planning and coordinating body. The question was asked regarding what other organizations are already involved in this role, and what is the function of the commission related to them?

One commissioner suggested the group start with the HCSPC goals and the more detailed list of strategies listed under each one, and use a consensus voting or negotiated rulemaking process to prioritize those. Discussion continued regarding whether to use an inductive vs. deductive approach --- should the group start with a preexisting list, “dissect” and prioritize from there? Or work from their own vision and expertise to identify those issues the group agrees is important, and determine how they fit within the six goals?

The need to be innovative and not limit learning and identification of issues, priorities and recommendations to the six areas identified by the previous group was expressed. On the other hand, the need to hit all six for a balanced approach was emphasized. The need to consider what has changed in the past 18 months since the HCSPC report came out was also noted.

A comment was made that Strategy 3b (in Admin Order), related to safe water and waste water, didn't seem to fit as well into a health care plan. The HCSPC wanted to make sure environmental issues continued to be addressed, but it prompts the question now regarding whether this is a “Health Commission”, or a “Health Care Commission”.

Preference was expressed for getting a handle on a few things we can do something about – two or three immediate and doable projects – and if and when the commission becomes permanent it can take a more comprehensive approach. It was also noted that we need to understand what's going on with the new Obama administration's plans for health care reform, as well as the stimulus package. The

commission needs to be flexible – there might be new opportunities that didn't exist when the HCSPC met.

The group decided to spend the rest of the morning brainstorming issues and needs, prioritizing those, and identifying next steps related to the highest priority issues. Ms. Erickson suggested she prepare a first rough draft of a vision and values statement based on yesterday's discussion to share with the group for discussion at a later time.

A member noted that the discussion about process was good for relationship building – getting to know one another and how to work together.

Action Items/Follow-Up:

- *Begin a rough draft vision and values statements based on the group discussions that occur during this meeting.*

Handouts Provided:

- *Proposed Planning Elements and Timeframe Table (02-27-09 draft)*
- *Alaska State Health Plans and Special Reports, DHSS/Health Planning and Systems Development, February 24, 2009*
- *Health Care Resources web page from Health Care Strategies Planning Council site: <http://www.hss.state.ak.us/hspc/resources.htm>*
- *“Alaska’s \$5 Billion Health Care Bill – Who’s Paying?” UA Research Summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.*

Priorities Discussion

Issues and potential solutions that came up during the brainstorming session included:

- **Cost** – medical liability drives up cost - need for tort reform; how does supply and demand influence cost?; relationship of consumer decision making about utilization of health care and also healthy lifestyle behaviors to cost.
- **Workforce** – one aspect of access
- **Health Information Technology** – Strategy for cost savings through efficiencies; an issue for medical providers is communication between systems – compatibility of systems - coordination/standardization is required; what are the opportunities through the economic stimulus package?
- **Consumer’s Role** – personal accountability encompasses healthy behaviors (50% of health determinants are lifestyle choices), consumer utilization of health care services and insurance programs, and patient compliance with medical instructions; consumers need to be better informed; commission needs more information on how to incentivize health --- money (e.g., “PFD for BMI” – extra health dividend rewarded for healthy behaviors included in PFD)? Other rewards? Tax disincentives? Marketing?; Consider potential uses of newer communication technologies to reach (educate/inform) consumers
- **Fragmentation and Duplication in the health care delivery system** – funding silos fragment population and duplicate health care infrastructure in some communities and increases cost
- **Regulatory Environment** – HIPAA, CON, other regulations drive costs and limit efficiencies; also stymies innovation.

- **Fraud** – drives up cost; pros and cons to Medicare/Medicaid audits – creates more cost for providers and health care delivery system – is it worth it? Or can the problem be addressed more efficiently/effectively.
- **Quality** – includes safety and effectiveness of care
- **Access** – includes workforce, also facilities, hours of service, availability of clinic appointments; ER used in communities where there isn't easy access to clinics; Medicare access problem – providers not accepting Medicare patients; designation of underserved areas by federal government increases access to federal resources for health care

From the issues and potential solutions brainstorming session, the group identified 5 priorities, and at least one next-step action item for each:

- **The Role of the consumer in Health Care**
 - Compile info on incentivizing wellness
- **Access to Primary Care for Medicare Patients**
 - Compile info on the two Medicare clinic pilot projects/models being planned for Anchorage (one 330-clinic; one private physician practice model)
 - Compile info on 330 clinics in Alaska – where they are and how they're funded (note that there is \$2 B in the stimulus package for 330 clinics)
- **Workforce Shortage/Distribution**
 - Compile information on Loan Repayment/Scholarship Programs
 - Medical education – compile information on WWAMI seat increase; compile information on post-graduate medical education (residency programs for internal medicine, pediatrics, and psychiatry)
- **Health Information Technology**
 - Compile information on the Alaska eHealth Network – general info on status and next steps; economic stimulus package opportunity; pending legislation
- **Establish Commission in Statute**
 - Bill to be drafted by Commission (needed as policy statement and to facilitate the process, since the commission cannot take a position on the two pending bills currently before the legislator)
 - Subcommittee formed to outline the bill for full commission consideration:
 - Subcommittee members: Dr. Butler, Dr. Stinson, Mr. Campbell, Rep. Keller, Jim (staff assigned by Rep. Keller)
 - Use Admin Order 246 as a starting point
 - Must be a single-issue bill (no other issues beyond establishment of commission to be addressed in bill)
 - Jim will prepare first draft for subcommittee consideration within 3 days
 - Deb will schedule subcommittee teleconference for mid-week next week

Formal Decision:

Form a subcommittee of the commission to draft legislation to establish the Alaska Health Care Commission in statute (moved by Mr. Davis, seconded by Mr. Stevens, unanimous consent); and pattern the draft legislation to establish the Alaska Health Care Commission on Administrative Order #246 (moved by Mr. Davis, seconded by Mr. Smith, unanimous consent).

Wrap-Up

Meeting Evaluation

The group appreciated the following about this meeting:

- Ended on time both days
- Informality
- Size of group appropriate
- Openness/Sharing
- Comfort in sharing opinions – “Safe” – respectful group
- Legislative Involvement
- “Pushiness” of Executive Director - kept group on task
- Bagels

The group noted the following improvements could be made for the next meeting:

- No 7:00 a.m. starts!
- Send out meeting materials in advance

Next Meeting

Need to meet Fridays and Saturdays to accommodate members’ busy schedules.

Next meeting will be in Anchorage.

Potential dates identified for next meeting:

- April 24-25
- May 1-2

The commission meeting adjourned at 11:00 a.m.

FLIP CHARTS

Some headers added by Deb following the meeting

ISSUES

Cost

- Influenced by both supply of and demand for health care services
- Interrelated with the Consumer's Role

Workforce

Consumer's Role

- Personal accountability
 - Patient compliance
 - Healthy behaviors
- Consumers Need to be part of the solution
- Consumers Need to be better informed
- How do we incentivize health?
 - Money?
 - Other rewards?
 - Tax? (disincentive)
 - Marketing

Fragmentation and Duplication of Systems/Services

Regulatory Environment

- Drives cost
- Limits Innovation

Fraud

- Relates to cost
- Pros & Cons to Medicare/Medicaid audits
 - Creates more cost for providers/system

Quality

Access

- Appropriate level of care available when/where needed
 - E.g., after hours primary care clinics for non-emergent consumers who may go to emergency room otherwise
- Workforce (adequate supply of providers)
- Physical access
- Medicare Providers

POTENTIAL SOLUTIONS

Health Information Technology (EHR/HIE)

- Coordination/Standardization required
- What are the Economic Stimulus Package opportunities?

Health Care Workforce

- Medically Underserved Areas need to be designated
- Loan repayment and other incentives

Health Dividend to incentivize healthy behaviors – “PFD for BMI”

Incentivize Providers to work on wellness with patients

How do we use newer communication technologies to reach (educate/inform) consumers

- E.g., cell phones/text messages, Internet

SHORT TERM STRATEGIES – with immediate next-step action items

Role of Consumer in Health Care

- *Deb will compile info on incentivizing wellness

Access to Primary Care for Medicare Patients

- *Deb will compile info on the two “Medicare Clinic” models being planned for Anchorage
 - One 330-clinic (federally funded health center) model
 - One Private physician practice model
- *Deb will compile info on 330 clinics in Alaska – where they are and how they’re funded
 - Noted that there is \$2 B in the Economic Stimulus Package for 330 clinics

Workforce Shortage/Distribution

- Loan Repayment/Scholarship Programs
 - * Deb will compile information on Loan Repayment/Scholarship Programs
- Medical Education
 - “Where you Train is Where you Stay”
 - * Deb will compile information on WWAMI seat increase
 - * Deb will compile information on Post-Graduate Medical Education (Residency Programs)
 - Internal Medicine, Pediatrics, Psychiatry
 - Dr. Stinson will send Deb info on residency program development

Fraud

- Tabled for now – no immediate next steps

Health Information Technology

- * Deb will compile information from the Alaska eHealth Network
 - General info on status/next steps/needs
 - What’s happening with the Economic Stimulus Package?
 - Is there legislation proposed or drafted in the Alaska Legislature?

Establish Commission in Statute

- Bill to be drafted from Commission and proposed as H HSS Committee bill
- Special Committee formed to outline the bill
 - Committee Members: Jay, Keith, Larry, Jim (assigned by Wes)
 - Use Admin Order 246 as a starting point
 - Must be a single- issue bill (no other issues beyond Commission addressed in bill)
 - Describe what the important components of the Commission are
 - *Jim will prepare a first draft for Committee consideration (will take him 2-3 days)
 - *Deb will schedule Committee teleconference for mid-week next week

PROCESS GUIDELINES

- Definitions Required
- Understand Unintended Consequences of Potential Solutions
- Listen to Consumers
- Initial Short-Term Strategies should not cost state GF

VALUES (for guiding policy decisions)

Sustainability

EXPECTATIONS of EXECUTIVE DIRECTOR

- Don't be shy
- Keep process/group moving forward
- Communication
- Information Management
- Support facilitation of meetings and process
- Research – Identification of information resources

PARKING LOT

Role/Scope:

State health planning and coordinating body

“Health Care Solutions for Alaska”

Better Care – Less Cost

Why is per capita care cost higher in Alaska?

- What are our assumptions? And are they correct?

MEETING EVALUATION

What we liked about this meeting

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- Informality
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- Comfort in sharing opinions – “Safe” – respectful group
- Legislative Involvement
- “Pushiness” of Executive Director - kept group on task
- Bagels

What can be improved for next meeting

- No 7:00 a.m. starts!
- Send out meeting materials in advance