ALASKA HEALTH CARE COMMISSION

DENA'INA CIVIC & CONVENTION CENTER

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P R O C E E D I N G S

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(On record)

CHAIR HURLBURT: I'd like to welcome everybody back to the Alaska Health Care Commission meeting. I'd like to welcome the public attendees and those of you joining us on the telephone. On the phone, we'll have it in the lecture mode which means you can hear what's going on, but it will be muted from our end as far you're concerned until we come to the public comment period and then we will invite comments from the members of the public.

We always start our meetings going around and having everybody introduce themselves. We'll start with the Commission Members and the public members that are here in the Dena'ina Center with us and then those of you who are on the phone. So maybe we'll start with Keith. If we could start with you and go around the table? Just introduce yourself and say what you are representing on the Commission.

COMMISSIONER CAMPBELL: Keith Campbell. I am holding a seat for the consumers on this group, and I live in Seward and been here quite a while. So I know where some of the bodies are buried, so watch out, you all.

CHAIR HURLBURT: Thank you.

COMMISSIONER HALL: Linda Hall. I'm the Director of the Division of Insurance, and I hold the seat for the Governor's

Office.

COMMISSIONER ENNIS: Emily Ennis. I'm representing Alaska Mental Health Trust. I'm from Fairbanks, and I'm Executive Director of Fairbanks Resource Agency.

COMMISSIONER STINSON: Larry Stinson, physician in Alaska for several years. We have practices in Anchorage, Fairbanks, and Wasilla, and I'm representing the physician point of view.

COMMISSIONER DAVIDSON: Good morning, (speaking in Native language), Valerie Davidson. I represent the Tribal Health System, and I work at the Alaska Native Tribal Health Consortium.

COMMISSIONER DAVIS: Jeff Davis, I guess ostensibly representing the health insurance industry, but hopefully representing all Alaskans. I'm President of Premera Blue Cross Blue Shield of Alaska. I live here in Anchorage.

CHAIR HURLBURT: I'm Ward Hurlburt, Director of Public Health Division, Chief Medical Officer with the State, and Designated Chair of the Commission.

COMMISSIONER ERICKSON: Good morning, I'm Deb Erickson, Director of the Alaska Health Care Commission.

COMMISSIONER MORGAN: Dave Morgan. I occupy the seat for Primary Care Association and providers.

COMMISSIONER LAUFER: I'm Noah Laufer, a primary doc here in Anchorage. I'm President of Medical Park Family Care. We're a private practice.

COMMISSIONER STEVENS: Good morning, Wayne Stevens, Alaska State Chamber of Commerce. I live in Juneau and presumably represent the business community.

CHAIR HURLBURT: And I don't think you folks in the audience need to come up to the microphone unless you want to, but just speak loudly so we can here you and the folks on the phone can. Chelsea, we'll start with you, please?

(Indiscernible - no microphones on)

COMMISSIONER ERICKSON: We're not going to be able to hear them since we put them on lecture mode, but we'll take role call when we go off lecture mode at 1 o'clock for the folks on the phone.

CHAIR HURLBURT: When we go off at 1 o'clock, the folks on the phone, whether you have any comments or questions, we'd at least like you to let us know, if you will, who has called in, so we can get that. I'd like to welcome everybody here to the meeting. I'll turn it over to Deb to review the agenda.

COMMISSIONER ERICKSON: First I wanted to mention, especially for everybody on the phone, that most of the presentations, if not all of the presentations -- actually I think we'll be missing a couple of them today, but most of the presentations that we'll be seeing as far as PowerPoint today are posted on the Health Care Commission's website on the page that's set up for the November 16th and 17th meetings. So if you're listening on the phone and want to follow along with a

presentation or at least attempt to, you should be able to access on the Commission's website. And some of the handouts are also posted on the website. And for those of you from the public who are in the room, there are hard copies of the presentations on the back table as well, if you want to pick those up. I think that's the main housekeeping item I wanted to mention. We'll make sure we mention a few other things when we go off lecture mode later this afternoon.

I'm going to go over a few slides right now, just to use a few slides to guide us through what our plans are going to be for the next couple days, day-and-a-half. And inserted in the front -- for the Commission members, inserted in the front of your notebooks is a document that I'm hoping will help guide us through our discussions throughout several sessions over the next day-and-a-half. It's the Meeting Discussion Guide. It's posted on the website too for folks who are on the phone, and there are copies of this. It's laid out in a PowerPoint presentation on the back table for folks in the room, but we'll just be using these slides periodically for our discussions throughout the course of the meeting.

So I'm going to use those just to help go over what our plans are, what we're hoping to accomplish here today and tomorrow.

One of the things that we're going to spend more time doing -- we got a start on it -- actually identified that we

really had a need to spend some more time with -- now that we're reconvened after a good nine or ten month break for our former Commission members and have grown and added some new members and actually have a statute that is very similar to our original Administrative Order but also does have some changes in the duty list and that sort of thing, that we needed to really spend some time making sure that we all are in agreement about what our purpose and our role and our scope is as we move forward. And so we're going to spend some time doing that the first thing this morning, a little more generally, about purpose. And then we'll get into more of the details again to touch base on whether our goals, we feel, are clear. I think we agreed that our Vision Statement was good at the last meeting. And also look at our strategic framework again and see if we need to make some revisions to that as we move forward.

But after we talk about our purpose this morning, one of the things that you all had requested at the end of our last meeting in October was an overview of key department of Health and Social Services' initiatives that are directly related to the role of the Commission and the priorities of the Commission. And so we're going to spend most of the morning hearing presentations and you all having an opportunity to ask questions of various folks from the Department and other department partners who will be talking about some of these

key initiatives.

We'll have a full hour break for lunch today and then have a one-hour period, up to a one-hour period for public comment. And then after that, we have just a few small business items of your first Financial Status Report and we'll revisit the Bylaws change that we heard for the first time at the meeting a month ago and just something, an informational piece I wanted to share with you on some of the media coverage the former Commission had and some of the media coverage we got after our last meeting a month ago. I thought you would just be interested to see that.

And then again we'll spend most of the rest of the afternoon in this regrouping or regrounding, I'm thinking of it, talking about, again, making sure that our planning process is understandable and that our goals are clear and that we're addressing any gaps or deficiencies you might have identified in what we had laid out so far as a general strategy for health system improvement in the State. And as part of that, I actually thought -- on your agenda, we have identified a time to talk some more about the studies that we're doing that are going to help us understand better what the problems in the system are. One of the Commission members asked at the last meeting that they wanted to make sure they understood what the problem is we're trying to solve, and it's an important part. If you look at how we've laid out our

planning process step-by-step is that we're kind of diagnosing Alaska's health care system accurately. If we don't really understand accurately or completely what the problems are, we're going to end up, potentially, off base in our solutions.

So we'll talk about where we're at with studies related to that and what more we need to do. So that should get us through the day, and then tomorrow morning, we're going to meet for just half the day. We'll adjourn by noon at the latest, and we will start with a discussion on the specific policy recommendation that you would like include 2010 report related to evidence-based medicine. I did not have anybody suggest any additional areas for recommendation in the interim since our last meeting, but we still can see if there is something that we want to talk about. I'll be a little bit concerned if it's an area where the group hasn't had a chance to do some study and learning together. But in addition to specific policy recommendations, we want to make sure that we have kind of the course laid out for next year. So that will be the second half of the morning, what specific strategies you want to be studying together and learning about together over the course of the next year to prepare for the 2011 policy recommendations.

And then we'll talk about next steps, some specifics about what's going to happen by what date over the course of the next month or two to get our 2010 report done and that

should be it. We'll do a short meeting evaluation again. So does anybody have any plans at all for -- or I'm sorry -- any questions about our plans for the next day-and-a-half? Very good. Hearing none, do you want to spend a minute going over meeting rules, Dr. Hurlburt?

CHAIR HURLBURT: Yeah, let's do that. And then give -- ask some folks who have come in, if they didn't introduce themselves, to do that. So let's do the meeting rules.

COMMISSIONER ERICKSON: And I actually don't have these, I believe, posted on the Web. We've gotten used to looking at them a lot, but I might start doing that. And they're not in the back of the room for the folks in the audience, but for members of the Commission, behind your agenda in your notebook on a pink sheet of paper are the meeting rules that we've used for the first year with the initial Commission. I've really made no changes to these. Since we've reconvened though, I made one small change, which was to note our new number of voting members and how many we need to call a quorum.

A few things I wanted to highlight and touch on though too, I think, one of the things that might feel a little different for some of the former members -- with the group getting a little bit bigger -- with a smaller group, it's easier to be able to enter into more of a conversation. We'll test this a little bit, but I actually sat more in the middle at the front table -- I usually would sit off to the side a

little bit -- because I want to make sure I'm able to see everybody and make sure that everyone is having an opportunity to fully engage in the conversation. So we might try being a little more formal than we've been in the past, in the interest of -- I'm looking at under the Participant Behavior section of the Meeting Ground Rules, that everyone is practicing active listening, that only person is talking at a time, that there aren't any interruptions or side conversations going on, and that differences will be respected.

I think one of the things that I heard over and over again from members of the Commission and other folks observing in our first year was we had folks at that point -- and we do still -- with really some very differing viewpoints on issues and on solutions, and it was always wonderful that we could have a conversation and folks felt safe in being able to share their different viewpoints and hear each other. So we hope to continue that tradition in making sure that differences will be respected, different ideas won't be discounted, everybody is being mindful about sharing the floor, not monopolizing conversation, not using jargon or acronyms, that sort of thing.

I actually spent less time at our first meeting last month going over participant behavior, more time going over the decision making process. So I'm going to skip that part

this time. Does anybody have any questions or comments or suggestions for our meeting rules?

CHAIR HURLBURT: Thank you, Deb. There have been a few folks who have come in in the audience, and at the start, we did ask everybody just to introduce themselves and say what you do. So Mike, maybe could we start with you, and just those of you didn't introduce yourself, if you could just do that?

MR. LESMAN (sp): Good morning, my name is Mike Lesman from the Office of the Governor (indiscernible - away from mic).

CHAIR HURLBURT: Tom?

TOM (LAST NAME UNKNOWN): (Indiscernible - away from mic)

(Indiscernible - away from mic)

CHAIR HURLBURT: Anybody else here? Thank you very much. Yes, please?

(Indiscernible - away from mic)

CHAIR HURLBURT: Great. Thank you, Jeff. Again welcome to everybody here, and we will go on to the discussion as Deb outlined there on the role and the scope of the Commission.

This was something that, as Deb noted, was discussed and there was consensus on quite a bit with the group last year, but we are expanded. We have new representation, and as Deb and I talked about this after our last meeting, we felt that we really are a new group now and that we should come back to

this and have this open discussion with all of the members of the Commission here. We talked it a little bit last time, looking at our charge. Hopefully Wes Keller will be coming in, but he was helpful in sharing the perspective of the Legislature as they established it and the Governor signed, establishing the Commission in its more permanent form there. But we'll look at that and look at the legislation authorizing the Commission and talk about that. So Deb, can I turn that back to you again now?

COMMISSIONER ERICKSON: Certainly. One thing I wanted to mention, first of all, I'm not expecting actually that either Representative Keller or Senator Olson are going to be able to join us at this meeting. Representative Keller is actually at a national health meeting right now down south, and Senator Olson had to be in Barrow. He's working with some search and rescue folks up there on a project. But I am expecting the rest of our -- the other couple members to come.

And one of the other things I wanted to mention too is that I'd hoped to have Minutes from our last meeting to you all actually in advance of this meeting, let alone right now. I just got the transcripts electronically over the weekend and in hard copy yesterday, and while we're still a little bit short-staffed, I'm needing to use the transcripts to finish Minutes. So I'll, hopefully, get those out to you in the next couple of weeks. And once we have a little more help, we can

be more timely about Minutes, but it's a real important point and I wanted to make sure that folks knew that. And just in case somebody wants to go back and really reference something that somebody said at the last meeting, we do have the transcripts here with us. So I wanted to make a point of that.

And one of the things I wanted to do in the introduction was actually give a special thank you to Chelsea Fisher (sp). She has just applied to some medical schools and is hoping to attend medical school and be a family practice physician sometime in the future, but Dr. Nighswander who -- I think also what we would need to if we want to improve our physician supply here is clone Dr. Nighswander because, for those of you who know him, he has just been a wonderful mentor for young people interested in entering the field of medicine and medical students, and if we just could have 15 or 20 of him and plant them around the State, I'm sure we would not have a physician supply problem. But Dr. Nighswander sent Chelsea to help me, suggested that she could spend some time volunteering for the Commission. And so she's been coming to the office for a few hours every week and has been a tremendous help, and she's going to be here with us at the meeting the next day-and-a-half, and I really, really appreciate her help. It's been really valuable, so I appreciate it. And so I wanted to give Chelsea a special thank you and make sure the Commission

knew.

One of the things that -- on to the discussion about our purpose, role, and scope -- and for Commission members, we're behind tab two of your notebook, a few things that I included.

As Dr. Hurlburt mentioned, we spent some time talking about this since the meeting. I actually had spent some time also talking with Commissioner Hogan about the Department's hopes and expectations for the Commission, and he had actually planned to join us this morning to spend some time in conversation about the Department's perspective on purpose of the Commission as well as giving an introductory overview of Department priorities, but we're in the middle of a transition in leadership at the Department right now and so decided that, since we're looking forward instead of looking back, his time could be better spent. So the Commissioner will not be joining us this morning, but I might share, at least, some of his reflections so we understand what some of the thinking behind the creation and support out of the Department has been. And Deputy Commissioner Streur can correct me if I'm wrong at any point, too. And then I want to just open it up for conversation.

Let's see if I wanted to make any other points about that. I think one of the other things I wanted to mention, our plan in the future will be to include -- in the front of our notebooks with our agenda and meeting rules is information

on the purpose and the scope, our statutory charge, and also our vision, goals, and values because one of the other requests that you all had made at the end of the last meeting is that we just spend a minute at the beginning of each meeting just using that as a touch point and reminding ourselves what we're about and so we will do that. We actually have just expanded that to this half-hour discussion this morning.

So what I've provided behind the tab two is -- the first handout should be a one-pager on the Vision and Values of the Alaska Health Care Commission, and this was actually -- you know, I was sorry that I had failed to share this as a one-pager, especially with the full goal statements laid out in sentence form, at the last meeting. I think too many things I'm taking for granted and just need to regroup periodically. But I wanted to mention for our new Commission members and remind the old Commission members we actually had worked on this together at the very first meeting of the Commission and then refined it over the course of the subsequent few months and approved it a few months after that. So this was actually a formalized document that the group had voted to approve in this form, and I do not mean to suggest at all that it cannot be changed, but that we had gone through a formal process to come up with this document.

One other thing I wanted to note too is that, I think, a

couple of you made the point a few times at our meeting last month that, especially when we started getting off on some of the specific issues I think, there was a concern that we might get either derailed or pulled off track or bogged down, that we just need to remember and remind ourselves what our vision and our goals and our purpose are periodically and stay focused on that to keep from getting pulled off track because there are so many issues, so many problems, and so many potential solutions that we could be looking at that it would be easy to get pulled off track and lose focus.

The other document -- I pulled just a one-pager out of our statute to lay out what our statute says is our Purpose Statement and list of duties. And then just so you can double-check to make sure that I'm not missing something important, I've included a copy of our statute behind that. So those are the three documents you have in your notebook.

The one-pager on our statutory charge is word-for-word exactly the way it's written in the statute, except for under our duties, point A, the Commission may hold public hearings, there were some rules about how we're going to hold public hearings that are laid out there. I didn't include those details. I didn't think it was important to our charge conversation.

So starting with the purpose statement and I'll talk a little bit about the conversations that I've had with Dr.

Hurlburt and the Commissioner and then we'll go from there and open it up for questions and discussions and see how you all want to move forward. And I'm just going to read the Purpose Statement as it's written, word-for-word, from our statute and this is Alaska Statute Title 18, Chapter 9, Section 10;

(Whereupon the Purpose Statement was read as follows:)

The purpose of the Commission is 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.

(Whereupon reading of the Purpose Statement was concluded)

I'm not going to read through the duties in detail, and for those of you who are on the phone, this document is available on the Web, and it's provided as a handout in the back of the room for folks in the room as well.

But just some thoughts now about role and scope. I think one of the things -- I pretty much grew up in public health in this state. I've worked in for the State Division of Public Health for 24 years, and in my experience, we've spent a lot of times in groups similar to this, but in my experience, we usually were working in a collaborate relationship with partners in more of a coalition and advocacy group role. And the way we've approached this Commission, more as a formalized

body responsible for studying and coming up with recommendations regarding specific policy solutions that could be made to the Governor and Legislature and thinking of it -- and I don't know if you're very familiar with how the Institute of Medicine process works when they convene formal committees, but what they'll do is bring together, you know, a group of experts. And one of the things that would be different is they will have meetings that aren't public, so folks in the group can feel free to speak their minds periodically and then hold public hearings in addition to that. We certainly aren't going to do that. But anyway I'm thinking of this group less like a coalition or a collaborative or advocacy group and more like a body of experts meant to study the problems and come up with thoughtful solutions about those and that we, at least initially, have been very focused on policy recommendations for the Governor and the Legislature and so that's one point we might discuss at some point, if we come up with recommendations for other sectors, how we'll frame those, if that's something we even want to do and how we'll frame those and use those.

One point I wanted to make too, particular to the coordination role because that's something that we went back and really wanted to make sure we understood from our Commissioner's perspective, since it had been included in the

Administrative Order that he had helped write and that had a been a question at the last Commission, but we never really fully addressed this, just because we didn't know if we were going to exist in the future or not, and that is the very first line of our duty statement, that the Commission shall serve as the state health planning and coordinating body. And what does it mean to be coordinator? And we were thinking in terms of just a wide spectrum, and we started, in our first year I think, at the far end, minimal coordination of just having a list of all of the groups, both formal bodies and then any professional organizations or other informal groups either that come together periodically to talk about issues related to the health care system and health care improvement.

So we have an inventory of all of those groups. We also have an inventory of all of the plans related to health and health care in any way. Statewide plans is what we try to focus on, but it's a pretty long list, and I'll make sure that we all -- actually I need to update that and add some. I think we've at least three or four major studies over the past year that I need to add to that list of plans and studies.

So we really just started with inventorying these two things, who is doing some work related to this and what documents have come out, as a starting point in our coordination role. But you know, we could go to the far extreme and take responsibility, potentially, for involving

ourselves in all of the work that any group is doing related to statewide health and health care system planning. And regardless of whether that would be a good idea or not, we don't have the resources to do that, and whether that was really intended or not. And so in the conversation -- again just to prompt some conversation with all of you -- that I had with Commissioner Hogan, the sense I got from him and confirmed afterwards is that, initially anyway, the idea would be that this group, since there is so many other groups interested and involved in working on health care planning, would be tracking those activities and that we would be mindful of any places where there are overlaps, and that we're doing as much as possible to align resources and work so we're not duplicating effort, and hopefully, not going off in completely different directions.

So tracking/identifying areas of similar focus and working to share resources and avoid duplication is, at this point, what leadership in the Department is thinking of in terms of a coordination role.

And then as far as scope, this might be a little bit -- get a little abstract. But first this is a question that was asked a few times with our first Body, are we working health care specifically or are we addressing health more broadly? And our statute is a little bit -- it almost uses the two interchangeably at points, but there does seem to be more of

a focus on health care. And then another question, if we narrow down what we think those are, do we need to define those?

And then again just one final point related to scope, are we flying at the 5,000 foot level or at the 50,000 foot level? And the Commissioner's response immediately to that question was, you have to fly at the 50,000 foot level and there will always be people trying to drag you down to the three foot level in trying to -- hoping that the Commission will align with specific issues and help support very specific solutions to very specific problems.

I think one other point I wanted to make, actually two related points. I've had a couple conversations with the State Assistant Attorney General who is responsible for and has been for over 20 years and is the guru in state regulations and reviewed the statute, specifically the Department's regulatory authority that's included in our statute, and she pointed out -- actually this wasn't the question; we were looking at something else, but she pointed out -- because the first thing she wanted to see was what our regulatory authority was -- that the Department has very broad authority to regulate the activity of the Commission, and the example she gave was that we could define any term in the statute that we wanted to for the purpose of what the Commission is going to be responsible for. And so if this

Body feels or future leadership of the Department feels they need to bring some clarity and/or direction to the role of the Commission, it's possible that we'll end up with specific definitions of health, health care, coordination, those sorts of things in regulation. Hopefully that won't be necessary, but it's a possibility and it's something that you all might decide that you want at some point. I wanted to mention that.

And finally the last thing I wanted to mention before I open this up for discussion was the Commissioner also made the point that he hopes and envisions that the Commission will operate at arms-length from the Department. The Commission is not meant to be -- it's housed in the Department of Health and Social Services, and the Department does have regulatory authority over the Body, but that he does hope that you all will feel as though you can operate as independently as possible and aren't just another agency within the Department of Health and Social Services or an arm or being used in some way to further some particular policies of the Department, that you really are -- the intention is that you are going to be operating independently, understanding that the leadership of the Commission is designated in statute as the Chief Medical Officer for the Department of Health and Social Services.

So with that, I am going to stop talking and maybe just start off with opening up to comments and discussion and then

we'll see if we need to frame some specific questions.

CHAIR HURLBURT: Particularly for the newer members of the Commission, really anybody, but I specifically any of the newer members to comment and either make comments or ask questions that Deb or I or others of us in the group here could respond to related to the scope of what we do, the role that we have here. Just kind of open that up. Sounds like you were startling clear, as usual, Deb.

How about from the perspective of those who have been around, which does not include me, from the beginning of the Commission as far as what Deb said and what you see with the history that we have and now being somewhat on a new path? Any disagreement with Deb's historical drawing of the -- so we're okay? Val?

COMMISSIONER DAVIDSON: Okay.

CHAIR HURLBURT: If you say we're okay, then we're okay. Well thank you very much, Deb. The rest of the morning.....

COMMISSIONER ERICKSON: Can I just ask a quick question?

CHAIR HURLBURT: Yeah (affirmative), please.

COMMISSIONER ERICKSON: Does a lack of comments or questions -- just specific to the ideas that were laid out about the role and the scope, I just am wondering -- I'm taking it by reading folks' faces around the room that folks understand and are in agreement with those ideas, but I don't want to make that assumption. So I just want to check if

anybody really disagrees with any of those ideas about what our role and our scope is, what level we're flying at, and kind of how we're operating in terms of a coordination role, whether you feel as though you should be more of a collaborative or a coalition, an advocacy body? Linda?

COMMISSIONER HALL: Since you're obviously looking for some feedback -- and it's difficult, having chaired meetings, to look at a whole group who go, hmmm, I think you did a really good job. We spent, I think some time last year. It was a little different group. It operated under an Administrative Order as opposed to a statute. So there are some things that are different, but I think you've captured, in my mind, what we felt our role was then. I think we have an expanded group with some additional interests represented, but I still think the general idea that you put forward here about our role and the scope -- although the last one really is a question, and I would comment on -- I think we have to be at the 50,000 foot level or we won't get anyplace because we've become mired in details. But I'm going to just express that I really agree and I think you've done a good job of a somewhat awkward definition of our role.

COMMISSIONER DAVIS: So if I may?

CHAIR HURLBURT: Yes.

COMMISSIONER DAVIS: Thank you. I agree with you, Commissioner Hall, that that was a very good overview. And

just commenting on the 50,000 feet, I agree there. And then looking at the health versus health care, it appears that, even with the statute, it's a mixed message. I'm just kind of looking through here. Twice, just the word health is used. And five times, the word health care is used. So perhaps the answer is that it's really both and that they're inextricably tied. I think that's what seems to be -- that was certainly something we wrestled with before, and this provides some clarity about that. Thank you.

COMMISSIONER MORGAN: Since you're looking for validation, I think, several of us that we were added to the Commission, it's not like we didn't attend a lot of the meetings of the old Commission. I think I missed one. I think you do the best job you can, take what you got, and move on. If we try to get into minutia, we would need sub-commissions. You know, we'd have 200 people in here trying to get this stuff done. So it's not through boredom that we're not saying anything. It's basically, hey, I don't know of any other way to do this, frankly. And if it makes everyone feel a little better, a lot of us that were added to the Commission did go to a lot of Commission meetings last year. I maybe missed one or two. So you know, carry on.

CHAIR HURLBURT: Anybody else? Thank you all very much who did provide that feedback. That was helpful. The rest of the morning, in response to the request from all of us, from

the group, from our last meeting, as Deb noted, we do want to talk about some departmental initiatives here and you see those in the agenda. We'll plan to take a break at a convenient time around 10 o'clock or so. We're going to have -- and I'll just kind of go through the list initially. We're going to talk about the Medicaid Task Force, which is another one of the groups that has been set up, has had one meeting so far. We'll talk about that, some of the quality initiatives that we have in Medicaid, a little bit about the Medicaid program.

This is something that's huge in our country. It's huge in our state. I think we've probably all seen the recent news items that -- probably with Texas taking the lead, but we have a dozen states that are talking about maybe we should just drop out of Medicaid because it is going to be so horrendous on our fiscal situation within the state, and we think we can do it better and cheaper, and particularly if we can get the federal subsidy for folks who didn't have the insurance. Now my guess would be none of that will come to pass. However we know that Arizona probably was, what, about ten years after anybody else in joining Medicaid. So it wasn't that Medicaid, right from the very beginning, was a monolithic entity, just to Medicare basically. Wherever you go you've got Medicare and it's pretty much the same. While there are a lot of very similar things in Medicaid, but basically if you've seen one

state Medicaid program, you've seen one state Medicaid program. And there are differences among the states, but almost all the states are feeling tremendous pressures there now and so I'm sure when Bill talks with us that will underlie a lot of what he talks about, and I think it is very appropriate and it is important that we talk about Medicaid.

Now we want to talk about the Health Information Technology, and Paul Cartland is here and will share what we're doing, what's going on as we speak today with some testing of systems between us here and the Feds, what the plans are for the near future. We've probably -- as a state, as our health care delivery sector, we're probably somewhat behind maybe the average of the country in adopting and embracing electronic medical records and some of the other health technology things. The federal sector has been engaged for a much longer time, whether it has been the military, the VA, Indian Health Services, Tribal Health programs, but outside of that in the private sector, we've probably been a little slower to embrace that, but the federal government is clearly pushing it. The federal government has decided that, through the embracing of electronic medical records and other Health Information Technology, that we can both enhance the quality of health care that's provided and use resources more efficiently. And so that's something that we're going to be continuing to hear more about and Paul will share with that.

Health Workforce Development. There's probably not a place in the country that doesn't feel that they don't need more providers, and we all read the papers where -- with the Patient Protection and Affordability Care Act, that, with extension of coverage to significant numbers of those who are uninsured as far as health insurance in this country, will only result in increased demand for services when folks are just struggling now. Again we see the news here in the State about access problems for folks when they reach 65 and go on to Medicare with access problems in our own state here. And so Health Workforce Development is something that we've talked about here in our state and other states have, and Delisa is going to share with us about some of the work that's been done on that.

And then the last two items, Andrea Fenaughty, who is our Deputy Director of our Chronic Disease Prevention and Health Promotion Section within the Division of the Department here, will talk to the ones about obesity prevention. You've heard me mention that as one of my real passions and real concerns, that as we continue to have more and more overweight Americans and more and more obese Americans that the prospects for the health status of Americans are staggeringly distressing. The CDC has estimated -- and again it's been in the news again recently because, I think, they keep trying to say, hey folks, wake up, listen, pay attention -- that we're going to see a

third of all Americans being diabetic as opposed to now the numbers are -- I guess I still use the 6%. Some of the reports are 10% of adults now. But the cost for that is huge. The morbidity is huge. The loss of kidney function and eye sight and so on and the financial costs are huge. And so I think the country -- and it's reflected in the First Lady, in Michelle Obama's adopting this as her cause as First Lady, recognizing that this is a big issue for us. And so Andrea is going to talk with us some about some of the efforts that we're engaging in related to that.

And finally, the final one is Healthy People 2020. Nationally we are engaged in that process of adopting the Healthy Americans 2020. One of the -- the Commission members have all received the document that came from the Healthy Alaskans 2010. We don't have funding yet for a Healthy Alaskans 2020, but Commissioner Hogan stated we will figure out a way to do that. And I think those of us who will have the chance to be working with his successor will remind him of his predecessor's commitment as we have a new Commissioner there. That has been a useful document.

I learned yesterday that, on a national level, the intent had been to narrow down the list to make it more manageable in terms of numbers of goals and measurements, and not surprisingly as much of what our representatives in Washington do for us sometimes, the list is now 600 and some items, which

is probably not doable. So I guess I'm taking my prerogative to editorialize that we come up with a usable list of practical size in Alaska. But this is something that's gone on for a number of decades, and really seldom have we seen success in terms of meeting the goals, but there have been benchmarks developed now for having the benchmarks and something that we can measure ourselves against. And so sometimes even if you don't reach your goal, you still improve where you are.

Just to pick a topic, our young child, two-year immunization rate is a distressingly low 67% in our state. We're number 45 out of all the states. We should be about 90% with those kids. Alaska Native kids are about 90%. So in some ways, it's easier for the Tribal Health System because the population in the rural areas is somewhat more captive. It's harder to get away when the public health nurse comes or the community health aide comes after you, but the logistics are also much greater. But it shows what can be done, and the rest of the State needs to catch up with that and be there. But even if we don't get to that -- scientifically if we get to at least the 80% level, we've got what you call herd immunity. Well this is the kind of thing -- I think it's useful. It's an opportunity to say we're failing; we're not doing well. We need to do better. We need to do better consistently, and we can get a goal for where we ought to be

and target that. And it helps through the whole system. It helps the Legislature to say these are some goals that thoughtful people have set out, and shouldn't we be engaging in some effort to do those kinds of things. So Andrea is going to share with us on that.

I think there will be some time for discussion on each of those items there. As I say, Medicaid is probably the biggest thing to every state in this whole country now, and we have that first.

We're fortunate to have Bill Streur as Deputy Commissioner and leading our Medicaid program. Bill's had extensive background. Most of you know him better than I do. He developed and led a Medicaid Managed Care program in the Midwest. He spent a number of years with the (indiscernible - voice lowered) system on the provider side, worked with the medical management companies before he came over to the state here, and has been providing leadership here for our Medicaid program. So welcome, Bill, and let me turn it over to you.

COMMISSIONER DAVIDSON: Before we start, can we just ask that whoever is having that Windows issue, if you could put your phone on mute because that's really distracting? Thanks.

COMMISSIONER ERICKSON: I'm afraid -- since we're on lecture mode, I'm afraid that what might be happening is that's actually the phone system, not Windows. And we can check with the operator on a break to see if there is

something we can do about that, and I'll do that when we have a break. Otherwise just think about your kids playing in the background or something and try to block it out. That's what I do.

So Deputy Commissioner Streur, I will operate your slides for you, if you want to just give me a hand signal, yell, throw something?

COMMISSIONER STREUR: Yes, ma'am. Thank you all for allowing me to be here today. I'm going to try to be a bit brief because some of the stuff that is following is important stuff that you need to get today, and you may not get as much opportunity as you will with Medicaid and updates from me on Medicaid.

Ward has talked a bit about my history. I have 30-something years -- yes, I started very, very young -- working in Medicaid, and I still love it. I still love what I do. I still beat my head against the wall on a regular basis, but Medicaid has provided and continues to provide a lot of care to a lot of people who otherwise would not receive that care in the state of Alaska. And it's an important initiative. It's scary as heck right now, National Health Reform, with the states rattling their sabers about what they are or are not going to do. Ward and I exchange emails on a regular basis with information that we've picked up. But Medicaid is a service that we all need. Medicaid is an asset to the

community, but we need to figure out better ways to do it. And a little bit of what we're going to be focusing on today is just giving you a quick snapshot of Medicaid initiatives and how they relate to the Health Care Commission in the state of Alaska.

The Department's overarching, overriding theme is to help individuals and families create safe and healthy communities. What that looks like, how we do it probably almost changes daily. What you see, the snapshot that you see of it is an ever-changing, ever-following the needs of the people, and we hope we can continue to follow the needs of the people on that. Next slide, please, Deb.

The five priorities on which the Department has focused over the past couple of years -- I remember when we sat down to first do these in late 2007/early 2008 and tried to come up with an overview of where the hot buttons were for health care in the state of Alaska.

The five priorities are substance abuse; health and wellness, Ward's favorite subject; health care reform, my favorite subject; long-term care, something that is going to rear up and become much, much more prevalent in the state of Alaska in what we do; and vulnerable Alaskans. We all can relate to different vulnerable Alaskans throughout the State.

But the health care reform, I need to clarify that health care reform strategies focus on establishing and supporting

the Health Care Commission in starting Medicaid reform in the state of Alaska. So when we look at health care reform, it's not the Affordable Care Act as much as it is touching the people and residents of the state of Alaska and what the two entities do. Next slide, please.

I'm going to talk a little bit about Medicaid initiatives because I want to focus in on that, initiatives specifically related to the Health Care Commission's agenda. The Medicaid Task Force, in brackets there, you see cost containment. If I have a charge regarding the Medicaid Task Force, it's bend the curve. Figure out a better way to do what it is we're doing and that will be the focus, will continue to be the focus of the Medicaid Task Force as it moves forward. I feel it's necessary to move forward, regardless of, you know, what happens. The Commissioner may be gone. Others of us may be gone. Ward and I may be back on the street again. But the bottom line is, I don't think the state of Alaska can move forward without continuing the Medicaid Task Force to figure out how to do things smarter and better.

Quality Measurement and Reporting Initiatives, I know all of you have heard me say this before. I don't know if we're delivering the right care in the right place to the right people at the right time for the right amount of money. Yet we spend $1.2 billion a year regular as clockwork. That's pretty scary and it's something that we need to begin to focus

on. And Jeff may have some of the same challenges right now as he deals with the insurance industry. Linda sees it from her perspective, and I know that the providers in this group see it on a daily basis.

Quality Improvement Projects and Medical Home, figuring out a way to do things better. Elderly Care Management, as I've already said, is going to continue to project itself. And Health Information Technology, there are some of us sitting in this room that believe that this can be a very, very strong tool for us to move forward.

I will address the first four. Paul Cartland will provide you with the last overview on Information Technology. Next slide, please.

The Medicaid Task Force, I want to give you an overview of that and talk about how it relates to the Health Care Commission.

The Medicaid Task Force is a Joint Executive-Legislative Branch Task Force, four members each, DHSS, Senate, and House. This was requested by the Governor's office to address the growth in the Medicaid budget because that line of increased cost keeps getting steeper and steeper, and it's time to begin to address it before it ends up being more than the 800-pound gorilla in the state budget. It was convened on September 29, 2010, and if all goes well and some of us stick around to the end, we anticipate a report in March of 2011.

We will meet half a dozen times going forward, and we've already had to delay the November meeting because of the reorganization of the House and Senate after the election. Poor timing on our part to schedule it at that time, but we're hoping to continue to move forward and the December 1st meeting is still on the agenda.

The members of the Medicaid Task Force, I want to point this out to you because of the overlap that we have, the intentional overlap that we have between the Medicaid Task Force and the Health Care Commission.

Commissioner Hogan is gone, will be gone prior to the next meeting. I may or may not be here at the next meeting. Dr. Hurlburt may or may not be here at the next meeting. Assistant Commissioner Elgee may or may not be here at the next meeting, but Senator Olson, Senator Davis, Senator Hoffman, Senator Coghill, Representative Joule, Representative Keller, and Representative Herron have committed their time and efforts to be a part of this. Representative Hawker notified me on Friday that he will no longer be able to participate on the Committee, and we will be looking to the Governor's office for another representative to place on there.

The overlap is you see the members in bold. They also -- those members, Dr. Hurlburt, Senator Olson, and Representative Keller, also sit on this Body because of the interaction that

we have to have going forward and working together with each other. So that's important to point out.

The Medicaid Task Force is going to be focused on shorter term strategies, operational strategies -- in other words, getting in the weeds; that 5,000 foot level that you saw -- and 120,000 Alaskans, those Alaskans who are enrolled in Medicaid or CHIP. The Commission, I believe, is more focused on longer term strategies, systemic or system strategies, and 680,000 Alaskans, all Alaskans in the state of Alaska, living in the state of Alaska. Next slide, please.

Quality Measurement Initiatives, now we're going to run into a bunch of acronyms here, so bear with me. I have 20-some years in the military, and I swear that we have come up with more acronyms than the military has in the last couple years.

So anyway the first one is CHIP, Children's Health Insurance Program, Child Health Care Quality Measurement. Right now it's voluntary, CMS reporting in our CHIP FY2010 Annual Report. However -- and here is where you're going to start seeing more and more likenesses between Medicare and Medicaid. There are more and more similarities that are going to be coming down from the federal government to begin to make the two look more alike. CMS mandatory reporting by 2013. The use of HEDIS, the Healthcare Effectiveness Data and Information Set, and other accepted specifications. The next

one is the CAHPS, Consumer Assessment of Healthcare Providers and Systems. It's a health plan survey on parents' experience with their children's care. CMS, once again, mandatory reporting by 2013.

As Ward indicated, I managed a health plan. I founded and managed a health plan for some years prior to coming back to Alaska, and one of the things that we did was we had both the HEDIS and the CAHPS that we had to report to the State as a part of our contract with the State. And three of the five years that I managed that program, we were in the top five in the nation for reporting of those, and I know we had higher quality care as a result through our hand-in-hand relationship with our providers and our recipients. So I'm firm believer in this, and I think that it's going to be a part of our lives, whether we like it or not, going forward. Next slide, please, Deb.

Some of the Child Health Measures, and I'm not going to spend a lot of time on this, but the measures that we're looking at are low birth weight, C-section rates, chlamydia screening, well child exams, testing related to antibiotics, preventive dental and treatment, emergency department use, repeat emergency room visits by very young asthma patients -- you know, are we doing enough to take care of them? that is a strong indicator of that -- use of medications for children with Attention Deficit Hyperactivity, follow-up after

hospitalization for Myocardial Infarctions.

There is a total of 14 that we're going to be looking at. You see those ten there. The additional four are still to be selected. So it's kind of hold onto your hat; there's more coming.

There are 24 core measures identified by CMS, but we're going to just report on those 14 for the first year, eventually moving to the full 24 set, we anticipate, within three years. Next slide, please.

The CAHPS Survey is a survey of the parent's experience with child's care. It assesses the overall satisfaction with the health care system; the health plan, in this case, Medicaid; the personal doctor, so our providers in the room. You know, we'll have a report card done on you; and specialist care.

The intent is to summarize customer satisfaction, the ability to readily access care, the ability to access needed care, how well doctors communicate, and shared decision making.

You're going to see this not only showing up in children, but I think going forward, you're going to see it showing up in adults. You're going to see it in elder care programs. You're going to see it in just about all levels of health care that we provide. And once again the private health insurance plans have been doing this for some years, so it's not a whole

lot of new. Next slide, please, Deb.

Quality Improvement and Medical Home, I have no idea where this is going to go. In my heart-of-hearts, I believe that, you know, this is going to be our magic bullet, that we're going to avoid a lot of the other more ox-goring (ph) changes that are necessary, may be necessary to go forward by establishing good quality programs and medical home.

We have recently received a Child Health Quality Demonstration Grant Project to establish and evaluate a national quality system for children's health care provided through Medicaid and CHIP. They picked three contiguous states, Alaska, Oregon, and West Virginia, to participate in the pilot. I'm not really sure how we ended up together, but we did. And we submitted a T-CHIC grant, the Tri-State Children's Health Improvement Consortium grant, and have recently kicked it off. I believe we kicked it off in September and are moving forward on it. Next slide, please.

The grant was awarded March of 2010 to demonstrate the impact to the patient-centered care delivery model and health information technology on the quality of children's care. Alaska's allocation over a five-year period is $4.0 million, so it's not small potatoes. Half is dedicated to grants/contracts to practice sites to test quality measures and the effectiveness of patient-centered medical home. This couldn't have come at a more opportune time because I've been,

I think, putting my toe in the water for, what, about a year-and-a-half now, David, and trying to figure out how to get some momentum to move this forward, and this is our opportunity to move this forward. Next slide, please.

The Quality Improvement and Medical Home characteristics. It's funny because I looked at the PACE program and I looked at this, and I thought, my goodness, they're identical. We'll be talking about the PACE program here shortly, but it involves a personal physician and that, to me, is the core of it because it's an ongoing relationship between the recipient, the patient, and the physician. I'm dealing with some health care issues now and realize the importance of that and to have that communication, to have that hand-in-hand relationship between the two.

It's Physician-Directed Medical Practice. The physician-led team is responsible for the care. In my case, I may see the physician, I may see a physician's assistant, I may see a nurse, I may see a specialist, but the physician is driving everything that is occurring. It's a Whole Person Orientation. It's not just focusing on a presenting issue. It's about the wellness of the person, about the care of the person and their needs. The physician is responsible for all of it.

Care is coordinated and/or integrated across physicians, hospitals, home health agencies, nursing homes, and anything

else that you may imagine. The ideal medical home has dental care involved in there. It has behavioral health care involved in there and is focused on the person's overall health and wellness.

Quality and Safety: care planning, evidence-based medicine, clinical decision support, and performance measurement.

Enhanced Access: open scheduling, expanded hours, and new communication options. That's going to be a tough one for us up here because we tend to be pretty strict on the hours that we operate, and to avoid, for instance, emergency room visits out of the medical home visits, there needs to be those hours and the open scheduling available to the individual. So it's a, I think, smarter way to provide the care that's going to be necessary.

And payment, we can't go anywhere without payment that must appropriately recognize the added value to patients.

So what's in it for me is going back to the doctor. Next slide.

A waivered grant will be issued to the Community Health Center in Unalaska. That one is going to be the initial test. It's -- it was issued non-competitively. An additional one to three practice sites will be awarded a grant under a competitive RFP process that we hope to issue later this month. This year's grantees must be non-profit --

opportunities in the future years for for-profit sites. I'm kind of at a bias there because, I think, that we need to have and be able to have physicians' office practices to be able to participate in this to see, you know, if it can really work because putting it into a non-profit opportunity, such as a community health center, is one model, but physicians' offices are going to be the key to moving it forward.

Tribal and non-tribal providers are desired. I have an expectation that we will have both in the one to three practice sites, additional practices sites, and providers' EHRs will need to be certified by CMS. Next slide, please.

Elderly Care Management. Deb and I fought over these next couple of slides because I didn't want to say PACE; she did. So we kind of split it that way. I have Elderly Care Management; she has her PACE in there.

PACE is one option that we're going to talk about. I talked to you last year about it. It's a program of all-inclusive care for the elderly. It's a Medicare and Medicaid waiver program. It's a Medicaid waiver program only in the sense that states want to make it a Medicaid waiver program. It is developed as a Medicare waiver program. It's capitated; capitated managed care benefit for frail elderly. And I'm an ex-military guy and so I like to talk about calling in fire on our own hill, back to Vietnam days. It's scary program for providers to participate in because frail elderly, it's just a

couple of very complex cases. It can turn the capitation totally upside down. So it's going to need to be a carefully developed and carefully managed program.

Features. Comprehensive medical and social services. Interdisciplinary team approach. You see the similarities here, but this one is based in an adult day health center. So these folks are pretty much spending their days as a part of this thing, and it's supplemented by in-home and referral services. Next slide, please.

Current status of PACE development. Here's where I become a pessimist. I don't think in looking at the numbers that we have enough population to support a robust PACE program. I've talked about the capitation. Everything I read is that we need between 120 to 200 people participating in a single program. I'm not sure that we can even identify in the Anchorage area, in the Anchorage Bowl an adequate number of people to be able to do this on a daily basis. But that said, an elderly care management program needs to be a part of what we do going forward.

So we're going to pick up discussions with provider organizations. We're going to see if we have that minimum population and the ability to generate that minimum population. We're going to conduct an actuarial study and develop reimbursement methodology. I suspect that we'll do less of that than the Feds will do it. Once the State has

identified that they want to participate in a PACE program or we have a provider that wants to participate in a PACE program, we'll let the Feds do the actuarial study for the Medicare population and we will pick up that same capitation rate and same rates. We'll submit a State Plan Amendment to CMS. That's required for everything that we do. We'll contract for a pilot in tribal and non-tribal care systems, and we'll report out the results. Next slide. Thank you.

CHAIR HURLBURT: Thank you, Bill. I think we have some time for questions from the members of the Commission to Bill. Medicaid pays for more than 50% of all the babies born in our country, so it's a big deal. We're not quite there yet. I think.....

OPERATOR: Excuse me. People are not hearing you. Is there any way you can turn them up?

CHAIR HURLBURT: Let me try. Is that a little better, getting closer, operator?

OPERATOR: (Indiscernible - telephone static interference) low volume (indiscernible - telephone static interference).

CHAIR HURLBURT: How about that? Is that better?

OPERATOR: (Indiscernible - recording interference)

CHAIR HURLBURT: Thank you, operator. I'd like to know if there are any questions from the Commission members to Bill related to what he talked about, or since we have handcuffed

to him to seat, if you have other Medicaid-related questions? We'll take the opportunity. Why don't we take about five or six minutes to do that? Keith?

COMMISSIONER CAMPBELL: My question, Bill, is you talked about the low birth weight, all of your 24 measures. This assumes that, I presume, you're going to publicize the results of those measures and how the providers relate and all these sorts of things going forward?

COMMISSIONER STREUR: There will be reporting developed. Initially, I think it's going to be generalized. It's going to be, basically, our state measures. I'm not going to get into the report card area at the outset, if that's what part of your question.

COMMISSIONER CAMPBELL: That was my presumption.

CHAIR HURLBURT: Val, please?

COMMISSIONER DAVIDSON: I have a question. First of all, thank you for your testimony. It was great. I had a question maybe stepping aside from -- stepping back from these issues. I know that some of these things are coming about because of the Affordable Care Act implementation, et cetera, and I know that there are -- I'm not even sure how many grants that are available to states for implementation of certain provisions. And I guess my question is, how is Alaska, as a state, making decisions about which programs that we're applying for and which we are not and how does that play into sort of the

State's plan for how we move forward for ensuring that we improve access to care for our citizens?

COMMISSIONER STREUR: That's a far-ranging question. I'll address this as delicately as I can, as appropriately as I can, but ultimately, it's going to come down to new leadership of the Department. But we take each grant opportunity and we evaluate it with the group of our brain trust of individuals that focus on the Affordable Care Act and meet each month to address the issues around it. The grants that you see in my presentation are not related to the Affordable Care Act, but are related to the standard course of events. Once we have a recommendation out of the group -- what's the group called, Deb?

COMMISSIONER ERICKSON: The APIT.

COMMISSIONER STREUR: The APIT.

COMMISSIONER ERICKSON: It's Alaska -- it's PPACA for the Patient Protection and Affordable Care Act. Impact Team. And it's a department level leadership team, senior executives from three major departments that are affected by -- have programs affected by the Affordable Care Act, the Department of Health and Social Services, Department of Administration in their role as an employer and the provisions that impact employers, and the Division of Insurance related to changes in the insurance industry, the insurance market regulation. So leadership from those three departments have been meeting

periodically to share information about new requirements under the Affordable Care Act and funding opportunities under the Affordable Care Act and to have conversations about what the agencies' decisions about going forward should be.

COMMISSIONER STREUR: Once we have a recommendation out of the group, we put together a summary statement. And like with any grant that we submit, we run it through the Governor's office for review and with a recommendation to them to move forward.

COMMISSIONER DAVIDSON: Thank you. So I guess the other question I have is a follow-up. I recently attended the Tribal Technical Advisory Group to CMS meeting, and one of the things that we learned is that, in some instances where a state is unable to -- whether the requirements are determined to be too burdensome or for whatever reason the policy decisions are made that, if a state decides not to pursue a grant opportunity, it may have some authority to designate, as far as CMS is concerned, authority to someone else in the state to be able to accept funds or to apply for those kinds of funds in the State's stead. So for example, one of the examples that was specifically addressed was home and community-based waiver services that CMS was interested -- in parts of the country where there are very few home and community-based services in tribal communities, if a state passed on those opportunities -- money follows the person,

expanded opportunities, et cetera -- that there were opportunities for states to designate that authority to others in the state so that, for example, tribes or tribal organizations or other populations could seek designation from the state to be able to ensure that those populations had access to those resources.

COMMISSIONER STREUR: That has just been clarified to us all. I was just at the National Association of Medicaid Directors meeting and what came out of the TTAG -- assuming the meeting that you were at -- it was clarified to us by CMS that we had much more latitude than we'd previously had in that area. So yes, that's accurate.

CHAIR HURLBURT: Other questions? Dave?

COMMISSIONER MORGAN: This was very good. I thought your presentation at the Medicaid Task Force was really good, too. It's required reading for our executive staff in our organization.

This is a general question. Do you think the reimbursement process or concepts right now are mismatched -- this is a softball question -- to the concepts that you're recommending in trying to use market forces to direct organizations to do those programs? I mean, your reimbursement system is not exactly conducive or matches what has been up on the screen, right or wrong?

COMMISSIONER STREUR: As far as I'm concerned, you're

right, but I'm a managed care guy. So you know, fee for service reimbursement is not the way to encourage appropriate best levels of care, greatest return on dollar, greatest return on investment, but that's coming from a managed care guy. So I'm sure, as a provider with our physicians sitting here, that managed care and capitation are not particular areas they want to venture into.

CHAIR HURLBURT: Noah, please?

COMMISSIONER LAUFER: I don't want to be a rebel rouser, but I will be. When I -- just the glimpse, from the last meeting and reading the paper, of the amount of money spent in the name of public health, managed care, facilities that are operated, it is baffling to me. We see 50,000 people a year on less than $9.0 million. I mean, that's fee for service. I do -- we do regular polling of our patients about satisfaction. We do that already because we're in business. We want them to be happy. You know, we're doing this already.

And then just as an example, I look in the paper and the new Neighborhood Health Center is going to be a $28 million building. I mean, that's probably ten times what we spent on a building that's lasted us 40 years and seen us through millions of patient visits. It's really -- it's breathtaking to me. And then at the same time to say we're doing it more efficiently, it's just -- I know it's a different patient population, but it can't be that much more expensive. I think

even though this is a 50,000 foot view, the real answer is, okay, here is an interaction between a doctor and a physician or a provider and a physician; how many other people are making a living off of that? When I was a resident ten years ago in Seattle under primarily HMO care, it was 46 people. You can imagine that it's going to cost more than $100 to see that patient because 46 other people need to make a living.

I think a real task for this Commission would be to get an itemized set of identity-scrubbed, itemized bills for a year of care for people and look at where does the money go, where do the dollars go, how many people are supported by this because it's not surprising that it costs so much when so many people have their hands in the pie. That's enough.

COMMISSIONER STREUR: That's a good point. At the outset, I mentioned that we spend $1.2 billion for basically 120,000 people in the state of Alaska, $1,100 for every man, woman, and child enrolled in Medicaid per month just on health care. That doesn't include any of the administration or anything else. That's $1,100 per month. How would you like to pay that? You know, take your family of four; that's $4,400 per month.

COMMISSIONER STREUR: The flip side of that is, if I got $1,100 a month to care for Medicaid patients, they could come to my house, have my telephone number, you know. I mean, that's not what is seen at the end in a fee for service thing.

That's a lot of money; where did it go?

COMMISSIONER STREUR: You're exactly right. It's a lot of money and where does it go. If I thought I could get away with contracting a capitating physician for what I paid last year for services, I think I'd probably jump on it, if I thought I could get away with it. It's a tough sell.

CHAIR HURLBURT: Any other questions? David?

COMMISSIONER MORGAN: Do you think the 24 HEDIS measures or more will also give you some insight to exactly what's going on and the effect of the dollars that are going in when you start getting measures and benchmarks on your Medicaid? I think it was 24 HEDIS measures you planned to set up. That might answer some of those questions, in that looking at where we stand in comparison to other states and other demographics. Does that figure into your concept there?

COMMISSIONER STREUR: It has to figure into my concept. As I said, you know, right care, right place, right time, right people for the right amount of money, I have no idea. Anything I get is going to improve what we have, and we have to also partner much more with the provider community in what we do to figure out the smarter options because they know as well as I do. They know better than I do how we can move stuff forward. (Indiscernible - voice lowered) and we have to work more closely with the hospitals. So we have to work more closely with primary care physicians. We have to work more

closely with specialists. We're not doing that.

CHAIR HURLBURT: Anything else? Bill, thank you very much. We will ask you back because you're a big factor in the whole health care picture in the State, but thanks for your presentation and for open and sharing with us.

COMMISSIONER STREUR: As always, thank you for the opportunity.

CHAIR HURLBURT: Why don't we go ahead and take about a 15 minute break? We'll come back together about 10:27.

10:12:09

(Off record)

(On record)

10:27:00

(Due to a power failure of approximately eight minutes, the following is a representation of the portion of the testimony)

CHAIR HURLBURT: Gather back in. Next session scheduled is Health Information Exchange, Health Information Technology, Medical Record. Paul Cartland, State Health Information Technology Coordinator, works with Medicaid and Health and Social Services, leads the Department, Department head man here. A lot of knowledge.

MR. CARTLAND: Responsible for coordinating projects that go on in the State. Tall order. Don't own very many of them, but am supposed to somehow all come out to achieve goal. Goal

is improved health quality and lower cost. Wish there was another term than Health Information Technology. It is a means to the end, not the end itself. Next slide.

A lot going on regarding Health IT. Regional health centers. R.E.C. is to help providers. A lot going on regarding Health Technology development. University developing. Kicking off shortly. To focus on today, health information incentive and exchange.

Key Terminology. Health Information Technology is anything that is electronic that helps in the sharing or capture of health information. Exchange is strictly about the systems. If you think of paper of medical record, that's a paper version of medical record, rather than health record that spans more than one provider. Next slide.

EHR is a federal program, 100% federal funded to incent providers, aligned with improving quality and costs. Next slide.

In 2011, a provider or hospital that meets the qualifications, adopt, implement, or upgrade. Brand new certification that was stood up. First happened in September/October of this year. Next slide.

List of eligible professionals. Notice number of different types who are and aren't. Everyone who is in required types has to meet Medicaid patient volume to qualify. Percentages listed. About 2,500 providers that are in correct

provider types, but doesn't speak to Medicaid volume requirement. Important, in order to achieve.....

10:35:25

MR. CARTLAND: .....share the information. If the point is, when I go to the emergency room, the emergency room doc needs to be able to see all the information about me. If my doctor isn't participating, there is nothing there to see. So we need everybody to participate, all the providers, all the hospitals, all the labs, everybody, and we need all the patients in order to truly achieve the value that we hope to achieve using the Health Information Technology. So because this program only incents a certain subset of providers, we need to find ways to incent other providers to participate. Next slide, please.

The incentive payments for those folks that are eligible, for providers, it's up to $63,750 over six years. That's a calculated amount that was in our legislation. It's intended to cover 85% of the implementation costs of a Certified Electronic Health Record. For eligible hospitals, it's $2.0 million plus a factor based on discharges. And so that's payable over three years. Once again, this is 100% federal ARRA money. The administration of this program is 90% funded by CMS, so 90% federal money. The requirements: they have to be eligible, they have to use certified technology, and they have to attest to meeting the criteria, the criteria that we

discussed. You know, they have to have spent some amount of money to prove that they really meant it, for lack of better words. So there's a payment requirement. There's the certified record that they have to provide evidence that they've adopted, implemented, or upgraded to. They have to attest to the patient volume. Next slide, please.

I talked a little bit about the administration being 90% federal/10% state. To keep costs down, we're going to do our best to use existing staff. We're going to leverage existing Medicaid business processes, so the existing enrollment process, payment, auditing, federal reporting, all of those things. The way it will work beginning in January of 2011, CMS will have a website where providers will go and register for either Medicare or Medicaid. If they choose Medicaid and they choose state of Alaska, they'll be redirected to a state EHR incentive site or a state level registry. The CMS site is the national level registry. We began our testing yesterday with the national level registry on our ability to receive the information on who has registered for the program, so that, when this becomes available in January, we'll be ready to stand up. Next slide, please.

The State Level Repository Solution. It's an online registration module. It will look very similar to the new provider enrollment portal that has been created for the Medicaid program. It'll allow the providers to enter the

information that's required, attach documents, and it will give us the reporting we need to report to the Feds on what we're doing. Next slide, please.

Before we can stand up the program in January, we had to submit what's called the State Medicaid Health Information Technology Plan, or SMHP to CMS. That was done in October. We're expecting approval of that yet this month. Assuming we get that approval, then we will stand up the state level registry in January 2011 and we expect the payments to begin in April of 2011. That's inline with what CMS is doing with the Medicare payments. Next slide, please.

Once again in year one, 2011, it's adopt, implement, or upgrade. In future years -- and you can do this in year one, the providers will have to meet Meaningful Use criteria. Remember this is about achieving improved quality. Well how will we know if we've achieved improved quality? We have to collect quality measures. So Meaningful Use is the method that we'll have to report on and see improved -- hopefully see improved quality. So there is a set of measures. So in out years, the providers will be able to input those quality measures, and hopefully within the not too distant future, we'll be able to collect those quality measures using the Health Information Exchange that we'll talk about here in a minute, so that providers won't have to input those manually. Next slide, please.

The other thing that I wanted to talk about is the Health Information Exchange Cooperative Agreement. In 2009, Senate Bill 133 was signed into law that said, Health Care Commissioner, thou shalt go out and create a Health Information Exchange.

The American Reinvestment and Recovery Act required the Governor to name a State Designated Entity and a Health Information Technology Coordinator in order to receive the ARRA funds relative to Health Information Exchange. The Governor designated Health and Social Services as the State Designated Entity and named me as the Health Information Technology Coordinator. And then we contracted through a competitive process with the Alaska e-Health Network to procure and manage the Health Information Exchange. Next slide, please.

Senate Bill 133 was signed, I believe, July of 2009. The ARRA bill passed or was signed into law sometime after that, actually. And the program started with a grant application to the Office of the National Coordinator for Health Information Technology in October of '09, went through some comment periods, some revisions. In March of 2010, they awarded a grant to us. There are three pieces to that grant. There's a planning portion and intrastate and an interstate set of funds. We're operating under the planning funds only. We have submitted our State Health Information Technology Plan.

It was based, in part, on the report of this Commission, looking at, you know, what our goals -- what we were trying to achieve. That was submitted last week. We hope for a quick turnaround, but they've got a lot of them to deal with.

The Alaska e-Health Network contract was awarded in April of this year. They immediately issued an RFP, went through a competitive bidding process, and they expect to award a contract for the Health Information Exchange vendor next month or sign the contract next month, with work to begin, essentially, immediately, hoping to have an operating pilot up in April of next year. That operating pilot will be four hospitals, I believe, four distinct electronic medical records, and hopefully supporting 400 providers. Next slide, please.

That's my office. That's my phone. If you have questions, I'm happy to answer.

CHAIR HURLBURT: Thank you, Paul. Let me start out with a question. We've got three or four minutes, I think, for questions now. Thank you for that presentation.

The threshold for participation on the part of a physician for Medicaid, the 63,000 Medicaid, is 30% of your patients being Medicaid. Bill Streur told us we have 120,000. That's about 17%/18% of the State's population. We know disproportionately Alaska Native citizens meet the criteria for Medicaid and enroll, and more than half of them, at least,

would go to the Tribal Health System facilities. Many go to private sector facilities. But you envision a significant number of physicians meeting that 30% criteria, but in terms of the number of enrollees in the State, in terms of, particularly, the number of non-Native enrollees in the State, you don't see that being an issue as far as not having many physicians to meet the 30% criteria?

MR. CARTLAND: I don't know that you can use the population as the basis because it's not a number of patients. It's visits and counters. So just because I'm only one -- if I was a Medicaid enrollee, if I'm only one person, I may see multiple doctors. You can't use that as the basis.

One of the biggest problems that I'm having is that I have to tell the Feds how much money I think I need for those payments. Yes, all of it. Give it to me now. Thank you. So we went out with a survey and tried to get a feel for how many providers thought they met the criteria. If we had an all payer database here in the state, then there would be a fairly simple task for me to go out and say here's how many Medicaid encounters because we could figure that out, and here is how many total encounters Dr. X has seen, and we'd know who qualifies and who doesn't, but we don't have that. So what we're doing is, we'll ask the providers to input the numerator and the denominator for that calculation for the Medicaid percentage, and at least in the first year, we're going to

take their word for it and then audit behind the payments.

CHAIR HURLBURT: Thank you. Noah, did you comment?

COMMISSIONER LAUFER: I could just say quickly, we already have an EMR. We meet all the criteria for Meaningful Use. It's been extremely painful. We won't meet the requirements for Medicaid; we will for Medicare. My wife's a pediatrician, and she'll easily meet the Medicaid requirements, so I imagine they'll go after it.

The other thing is a fairly simple question, maybe not. Is there enough evidence or is there evidence now that the implementation of EMRs improves care or reduces cost?

MR. CARTLAND: That's a huge question, and there has only recently begun to be put forward data on the real improvements, not that the data doesn't exist out there somewhere, but we haven't had the systems and the means to collect it and nobody's -- I don't necessarily ask the question, you know. So for so long, IT has been -- we're going to IT because IT is good. This is not that. This is trying to say, you know, let's show what we're doing. Let's show improved quality. And I imagine, if we don't see improved quality, the investment will go away.

CHAIR HURLBURT: Val, one more quick question and then we should move on.

COMMISSIONER DAVIDSON: So just looking at the criteria for Meaningful Use, you have to meet the minimum threshold for

Medicare and/or Medicaid, pick either one. And then the other is you have to be an eligible provider, and I'm guessing that Alaska is going to be under-represented in terms of incentive payments because, in the areas of the State where it's relatively easy to meet the Medicaid population, the challenge is that -- for example in rural Alaska, it will be relatively easy to meet that Medicaid criteria. The challenge is a lot of the eligible providers are community health aides, community health professionals, dental health aides, behavioral health aides, none of whom are considered eligible providers. I know we provided public comment as these regulations were being promulgated that, in some rural areas, a third or half the patient encounters are through a community health aide, community health professional, dental health aide, or behavioral health aide, and those folks won't receive any incentives for participation in this program. So perhaps it needs a legislative fix. I'm not sure what that whole process is, but just in terms of predicting, we sort of have this challenge of -- in communities where there are eligible providers and then we have communities that meet the Medicaid or Medicare threshold, and they don't necessarily align.

CHAIR HURLBURT: Thank you, Val. Yeah, Wayne, go ahead.

COMMISSIONER STEVENS: Just a couple quick questions on the technology. Is there a standardized system that all the different providers are going to use, you know, sort of the

VHS beta discussion? I mean if everyone in the room has the ability to do electronic health records but they don't communicate with each other, what good is the system?

And then the follow-up question to that is more on, you know, it's great to have this wonderful new technology, but sort of to what Valerie was saying, there are a lot of parts of our state who don't have the bandwidth or the broadband capabilities to move the volumes of information you're talking about. So we've got this wonderful idea, but we can only go this far down the trail with it and a whole bunch of people can't access it.

CHAIR HURLBURT: Thank you. I think we do need to move on. We can go into the lunch hour a little bit, but we'll have about maybe 25 minutes each, including questions, for the next three presentations. Paul, thank you very much for bringing that to us.

The next area that we want to look at is Health Workforce Development. Delisa Culpepper, who is the Chief Operating Officer with the Alaska Mental Health Trust, was a part of the group that looked at that. I think all the Commission members received the document that was prepared at the last meeting. I'm sure Delisa will refer to that, but I won't say anymore. Delisa, if you can please go ahead?

MS. CULPEPPER: Good morning. I brought one my partners with us, and we're going to go through two or three projects

that kind of lead to each other, some history, what's happened in the recent past, and what's going to go on in the future in some of the health workforce areas.

So I wanted to introduce Jan Harris. She's Vice Provost for Health Programs at the University of Alaska Anchorage, and she'll be talking with me about where we've gone.

I'm not going to spend a lot of time today talking about data, although I want you to know there is a lot of data around health workforce that Deborah can get for you, some links. There were studies out of the Department of Labor and Workforce Development. They recently did an entire issue of their economic trends on health and social service workforce last April, I think it was. It really looked at where we had been the last ten years, where they we're going in the next ten years. It is the number one growth field in the last ten years and predicted to be for the future ten years, and this is without health care reform. This is -- you know, health care reform brings a new dimension to it, but even without that, we're under-resourced in most of our areas of health and in the ability to train our own and do other things.

We also have information through a joint study that we have helped fund with the University of Alaska, a vacancy study, and we used that and we do it -- it's done every other year to look at where the vacancies are in health across the state and so those are also available to you. Just with our

limited time, I didn't want to go over the data itself today. But if you're interested in that, Deb can get you links to both of those sets of data and information.

I want to just say 30 seconds about the Alaska Mental Health Trust, an understanding for those of you that are not part of the state of Alaska system.

The Alaska Mental Health Trust is an independent public corporation of the state of Alaska, and I won't go into a long history of how the Trust was initiated. There are two parts of the Trust, the actual land and cash assets that were actually a part of the statehood negotiations and were to fund, quote, mental health programs and that's a pretty broad area, and we'll see in a minute what that covers. But then again in 1995 at the end of a ten-year court settlement brought on by a class action lawsuit in 1984 or '83, the State who had been -- and the Legislature -- the Trustees of the Trust were removed as Trustees by the court as no longer being trustworthy. They had made some decisions that, you know -- my boss, our CEO, tells this story. He was one of the lawyers in the class action lawsuit, and it's always funny when you have to say that the Legislature is no longer trustworthy. This is a legal thing.

They created the Alaska Mental Health Trust Authority, which are now the legal trustees of the Trust. There is a seven member Board of Trustees, independent of the Legislature

and the Governor. They do have to be appointed and approved by the Legislature but cannot be removed, except for cause. And they also are the only -- we're also the only corporation that can spend money without the Legislature's approval. The Legislature is not allowed to appropriate our funds. This is all part of not being trustworthy in the court's eye. So we had a very unique situation with the State, and we work, essentially, as a funder. We are a philanthropic organization that gives out grants to fund different things around what you'll see in a second is our beneficiary areas, and we also have a third element which is a separate budget bill in the Legislature called the Mental Health Budget Bill that has to do with any programs that serve our beneficiaries.

These are for people with mental illness, developmental disabilities, alcoholism problems, Alzheimer's disease, and brain injury. They are also considering expanding out to general substance abuse, which is allowed in statute and in the court settlement. So we're looking at it. So any program that serves people in a continuum from prevention through treatment are things that we could spend our money on and that we also advocate for to make sure that the State has a maintenance of effort in their programs. And we work a lot, from the Trust perspective, on system change and trying to make sure that there are good systems that serve our beneficiaries and create circumstances in which they can be as

successful as they could possibly be. And that takes us to our next area, which is why we work in workforce.

Fortunately, I work for an organization because I come from a public health background, also like Deb and others, that look at not just whether or not beneficiaries have treatment available but whether or not, in order to succeed, they have the rest of the right things in their lives, a system there which includes facilities and workforce and homes and laws and transportation, a lot of things in order to be successful in their lives. And some of our people can only be so independent and others could hope for some real recovery and a normal life and so we work in a big spectrum of things.

And workforce is one of what we call our focus areas, and we do these things long-term. Some of the others are disability justice because a lot of our people are in the court systems, inadvertently and/or on purpose, and we do housing. We do transportation. We work on a lot of different things that affect the lives of our beneficiaries, and a big part of what we do is advocate for system change, making sure all the salient systems are working together to make sure that the programs that serve our beneficiaries are going to help them be successful.

So workforce is a common one across all of our beneficiary groups, that none of them have enough of a trained workforce available for the providers. You can have all the

money to, you know, provide access and pay for a system, but if you don't have a facility in the right place, which, you know, we know across Alaska and in many places, that's true, or once you get the facilities -- because we learned that in the last ten years as we've built our new community health centers -- if you don't have a workforce to work in that, you're not opening. And that happens. So we've had to do a lot of careful planning and try to make sure that the workforce has the right training and is in the right place.

And back in 2004, we began kind of a journey of working together in a partnership with DHSS, the University, and the Trust to really look at this in a more coordinated way. They had a big summit down in Girdwood, came up with some things they thought we could do. And then the University, after that, came to us. Karen Perdue, when she was working as Associate Vice President for Health, came to the Trust and gave us kind of a package that was called Behavioral Health Initiative Project, BHIP, and it started us out in a journey of looking at expanding our academic programs to meet the need in behavioral health and developmental disabilities and senior direct care service areas that really did expand. We ended up committing, at one point, $1.1 million a year between the University, DHSS, and the Trust for several years, and we're still putting money into it and that worked so well in talking together, really studying the bigger problem. We began to see

though that we needed more than just academic programs, that they were not the only answer to our program. We needed also to look at training, recruitment, and retention, training of the current workforce on job training for jobs that didn't have degrees and certification and other things, and we had that kind of a spectrum.

So in 2008, we went back to the Trustees, actually in '07 and started in '08, and said we really want another focus area just in workforce. They agreed that it was important, and we began to plan additional strategies around training in recruitment and retention issues.

One of the things that we wanted to do to keep this going and to keep a focus is you always know staff are important. Deb will be -- you know, it's very important. You can't keep the Commission business going if you don't have staff that can do your research and help you follow up and do things. We knew that on the workforce thing, too. Karen and Bill Hogan and myself, who had been partners since 2004 in this workforce development area, none of us the time to really follow up on a day-to-day basis. So Karen came up with this idea about a position that we would all share that would look at workforce, since we all were in that business, and we did get OMB for the first time to approve a position that is jointly funded by all three of our organizations, and she has been working for us for three years. It really works nicely, and we keep a focus.

She would have been here with us today, but she's out of state, but she has become our expert in health workforce. But it's the only way to get things done, to have a coordinator and somebody who watches what's happening and helps us, becomes an expert in that area.

Some of the other things I'm just going to go through really quickly. This is something we had to put together for our Trustees at our last meeting, some of the accomplishments in the last three years. Again we are working towards system change and capacity building. We needed a lot of curriculum built. Some of our things that started out in the BHIP was a Ph.D. in psychology, the first Ph.D. at the University of Alaska. It turns though, once you get your Ph.D., you have to actually do an internship. So then we had to plan and start an internship that goes for two years. It took three years of planning. It's actually started just this summer. It's working it's way to accreditation, and I think this will really provide some workforce on a more stable basis for us long-term with psychologists. These psychologists are trained in community and rural psychology, so we think they'll be very useful to the system. We were very specific about that in wanting to train them to work in the public system.

We also have been working on such things as core competencies. We looked across training and realized people have to know what it is that everybody needs to be trained in

and then you have to have an entity that's responsible for training. And one of the things that we did early on in our focus area was create something called the Trust Training Cooperative, which I don't know why we named it that, but it just came out that. But some central place that could be a repository of what kind of training is going on, who is doing it, helping people that do it well share it with it others, helping them make it distance delivery. A lot of small organizations don't have that capacity and need some help with their everyday training, and other entities are big enough they have their own training coordinators. So this was a way to have some organization that helped them all put that together and so they're working on that. They took the core competencies. They're working with some contractors and running curriculum for that, and they'll make that distance delivery also and continuing to bring together then all the entities that do do training outside the academic system and coordinate, so we're not stumbling over each other, and yet we maximize all of our opportunities and make as much as we can distance delivery.

Other things we've worked on, we've worked a lot in loan repayment. We did establish our own program, and then two years ago, we teamed up and matched the funds for the State to get federal funds from the National Health Services Corps State Loan Repayment Program where we've just given out all

those funds. We're hoping to get some new ones next spring. We'll see how that works. We did fund maybe 30-some professionals to work underserved areas, doctors, psychiatrists, dentists, nurses, counselors, a whole broad range of people that get loan repayment for a commitment for two years' service.

We have been working in one of the big things that last years that was in your original recommendations two years ago; it's looking at some of the other workforce areas. Psychiatric residency was one of them. The Trust funded a study on the feasibility of having a psychiatric residency program in Alaska, and a year into that study, it was concluded that it is feasible. The University of Washington School of Medicine, School of Psychiatry said they would work with us if we got the funding to assure that, once we got it going it going, we could keep it going. And that was the only way we thought -- because there was a real shortage of psychiatrists in Alaska and we're having more and more trouble recruiting new ones up here, getting them -- and while everything doesn't need to be done by a psychiatrist, there are still things in the behavioral health field that require someone at the top for the most severely mentally ill people that can do treatment planning and prescriptions and other things. So we're looking at the residency program. We actually are taking it to the Legislature this year. We have

a good combination of funding of public and private, many of the hospitals and other behavioral health organizations that are committed to working with us to make this happen. So you'll be seeing that come forward.

We have worked on Children's Mental Health Certification. One of the things we've worked on is something called Bring the Kids Home which I won't go into, but it was a lot about making sure that we could keep our kids up here in the behavioral health system without sending them to residential programs Outside. But when we tried to do that, we found out that a lot of our professionals said we're not trained in working with children and youth. And so we ended up working with the University and others to provide a curriculum for certification for professionals in children's mental health. So those are the kind of things we've been doing. There is a whole list of those other types of things that we've worked on to get new curriculum, new certifications. We've done a lot in recruitment in media campaign. I'm hoping some of you have seen some of our ads trying to interest people in working some of the fields that we do on TV and radio, and some I'll pass around that are about life experience counts, looking at trying to go to alternative workers to seniors who may want to work part-time or mothers, youth, and other people to let them know that they could get into these fields.

All of this led to knowing that we need to still work on

broader health issues. And so about three years ago, Karen Perdue and I went to the Alaska Workforce Investment Board and encouraged them, yet again, to work on Health Workforce Plan because, under the Department of Labor and Workforce Development, the AWIB works on those issues, and we were successful in getting them to let a group work on that. And I'm going to let Jan talk about what they did and where they're at, and if you could just pull out your little thing while she's getting the microphone, she's going to be referring to the broader plan that now we've morphed into.

MS. HARRIS: And if you don't have your copy along, there is some behind Deb that she could pass out more hard copies. You had it at your last meeting, so we brought extra. You can just go to the first slide.

So as Delisa mentioned, we had begun -- the Alaska Health Workforce Coalition started meeting in the summer of 2009 as a result of all of the activity that had gone on before. There were many people working on health workforce, and we just tried -- it was very ad hoc sort of group that began and just tried to pull people together that we knew were working on that area and had an interest. There were many entities that came to the table. The Steering Committee, which is a smaller group than the overall coalition, includes industry, government, and education partners. And then there's a broader coalition, at this point, of about 30 interested

partners that we're hoping to expand over the next year or so as we continue this work.

The Steering Committee partners provide coordination and financial and in-kind support to the effort, a lot of staff time, a lot of hands-on work on this project. Go ahead to the next slide.

We're dealing -- when we look at health workforce, we're dealing with all of the realities and challenges that exist in health care, including that it is a growth industry.

We have changing demographics, so we don't only have an aging population generally, but we have an aging workforce with many retirements pending over the next decade.

Technology advances are a particular challenge for workforce development because, as you get a piece of new equipment, all of a sudden, you need a new kind of technician. And so it's a very constantly changing and evolving situation.

We're dealing with very complex systems, as Delisa mentioned, the wide range from on-the-job training to doctoral level and post-doctoral education. So we really have to look at the whole spectrum. High cost is, obviously, something you will be talking about a lot. We have access issues around the country, but in Alaska particularly for rural populations as well as uninsured or Medicare populations -- have critical needs.

So we're focused on workforce shortages, which is one of

the realities of health care. We've made great progress in this area, but the needs are ever-evolving and ever-increasing. And so we're always running to catch up.

Shortages is not just a numbers game. It's also a distribution. It's a matter of skill sets that have to be evolved to meet changing times. And besides teaching technical skills to our students, we also need to help them understand how health works and various approaches, like things like medical homes, areas like evidence-based practice, quality improvement, a whole array of other things that need to be brought to that student's education besides just their technical skills. So it's challenging and a lot of fun.

So our planning process, the approach has been intentionally industry led, data driven, and widely participative. I tend to say that as wildly participative and that was kind of it, too.

These are sort of the steps that we went through in the process, starting in the summer of 2009. We developed a laundry list of health occupations. They're kind of all over the place. You'll find them -- I always have to look at this -- on page 24 of the plan, so you might want to sort of turn to that because I'll also refer to a couple of areas there.

We went through the process of discussing in a number of forums that happened in the fall and early winter of 2009, including the Hospital Association at a Workforce Summit.

There was a Behavioral Health Workforce Summit. The Public Health Association met, and we had discussions with people at all of those and then proceeded to do some specific surveys, one of the Tribal Health Directors, another that captured a few members of the Medical Group Management Association to get their input as well. And we need to always continue trying to broaden that participation.

So you'll notice in the plan itself that, at the beginning, there is some general strategies, the first portion of the plan, that could really apply to most any industry. We're just looking at them from a health care perspective. And then in the latter half, starting on about page 25, I believe, we have occupation-specific prioritization and strategies for the occupations that were selected. I believe it's on page 23 you see the initial list of occupations that were chosen to start with, and this is really just a start. There were 15 occupational groups, about 26 occupations that were targeted in this particular initial plan and the strategies related to them.

All of that was documented in this document. The Workforce Investment Board approved it in May of 2010. We received a small HRSA Primary Care Workforce Planning Grant this fall for about $150,000 through the Workforce Investment Board that will help us carry forward into the coming year. Let me hit the last slide there.

So next steps revolving around the plan itself. We're taking a hard look at those 15 priority occupational areas, digging in deeper into those. We'll select the highest priority occupations and strategies to work on for the next few years and do action planning around them. There are hundreds of strategies in this plan, so our group is going to really try to focus in.

We're formalizing the relationship between the contributing partners on the Steering Committee with an MOA, and we have a couple of grant-specific activities. We have to expand the Steering Committee by two members to meet the requirements of the grant and also to finalize and implement the work plan for the grant, so that's kind of -- we were going to do this anyway. It's very nice to have a little grant funding to help us. And then there are a few related activities.

One is the data enhancement project. If you look at, I think, pages 42 to 43, there is a foldout in here that's kind of frightening. Page 43 folds out. This was the initial data set that we used to do the work of picking out the occupations, and it accumulates data from a number of different sources. As Delisa mentioned, we work with Department of Labor data, with the Vacancy Study data, and we try to put it all together. We had a giant poster-size one of these that we used at the forums to talk about, and we'll be

updating all of that data and then also looking at how -- what other sorts of data we want to be able to develop as a coalition to really be able to project better into the future. We need to prepare for implementing our plans and also develop strategies around advocacy for getting the funding that we will need to move some of these forward. And we'll be looking at strategies that other states and other entities have used, including some of the industries here in the State that have put together coalitions to move workforce efforts forward, and we'll be looking at those and figuring out how to do a sustainable coalition. That's it.

CHAIR HURLBURT: Thank you, Jan. Thank you, Delisa, very much. Maybe one question? What's that?

COMMISSIONER ERICKSON: (Indiscernible - away from mic)

CHAIR HURLBURT: Depends on.....

COMMISSIONER ERICKSON: (Indiscernible - away from mic)

CHAIR HURLBURT: Yeah. I think if we wanted to stay with the 25 minutes per presentations, that will take us ten minutes into lunch if we do that, but if there are some questions? Yeah, David?

COMMISSIONER MORGAN: I'm looking at your document. My one question is, what are the two -- this is a general question, so it should be -- or three incentives or things you do to try to -- when I'm looking at this foldout sheet of all of what's needed versus what we have, is there two or three

main top incentives or things you're doing to try to fill them? I know that's very general because you've got, what, a couple of hundred, but what are the three biggies?

MS. HARRIS: I would say at this point -- and I should let Delisa also chime in on this -- but definitely looking at things like loan repayment, employment incentives, training and education as a major one, and then it gets down into many other approaches, but I would -- do you want to add any others?

MS. CULPEPPER: I'd say, whenever you're working in workforce, you've got to have some short-term strategies and some longer term. The grow-your-own can take a while and that doesn't help us on the ground right now. And so we have come up with things like loan repayment and other -- not just loan repayment but other incentives, sometimes bonuses and other things that are tied. Some people are more mature workers and don't need loan repayment but might come if there was a housing stipend, depending on some of the rural areas where housing and other things are really expensive, travel stipends, just cash incentives, something to give people a way to compete, and it's getting harder to compete as other states also have all these same problems. But you always have to have short-term ones. How do we get the people now? And then for our state which is young and still needs to build our system capacity in training and in academic things to grow our

own, we need to start doing that now, like we're doing with the residencies and the internships and we did successfully with the nursing program and other things in the last ten years. It just takes longer, but it's a tough one to -- but I will tell you that a lot of the hospitals and the other things, especially in nursing and PT and some of the other under-resourced areas, they're paying a lot for *locum tenens* all over the State and it costs a lot of money to pay that. And so we need to work with the industry to see, you know, how could we use that money differently and provide a more quality service because quality goes out the window sometimes slightly, and especially in mental health when you have *locum tenens* and people coming and going every month. They can't reestablish a relationship with people, and for our voluble population for trust, our people take a while to decide if they want to trust you and come in and let you do anything, and they are a population that needs to be in primary care more often, as you heard. They often have more physical health problems that they are not able to control that become very costly to the Medicaid and other systems.

CHAIR HURLBURT: Any other questions? Yes, Keith?

COMMISSIONER CAMPBELL: One. In your incentive programs, we had some initial discussions about incentives a year or so ago and some of them went in the report. But with your experience, do you have a fairly short list and rank according

to what seemed to be the most effective incentives?

MS. CULPEPPER: That was our short list, loan repayment and other types of cash incentives right now, housing and cash incentives. Those three things, depending on what is the most important and where the organization is situated, what's going to happen with them, but those are the most ready things that people are going to be able to do, along with just basic salaries.

You know it gets more expensive out in rural areas to pay people, and it's easier to get somebody to come to Anchorage, but in some specific fields, not even then. And we can't get psychiatrists, for instance, in Fairbanks and that's not exactly a rural area. So there aren't a whole lot of other things, and most of the other states have caught on to do all the same things we have.

I wish that people felt more adventurous and wanted to come to Alaska. We still get a few people like that that want that experience and want to come and things, but what's happening -- and I saw this -- I was on the National Health Services Corps Advisory Council for three years, and I saw this across the nation that many of our professionals, especially doctors and nurses and psychiatrists and dentists, are married and have families by the time they're out of school. So they not only have to decide whether or not they want to be adventurous, but they also have to decide can they

find a place for their families to live, can their spouse find a job, are there schools for their kids. It becomes a much more complicated issue that just, you know, thinking we can lure them with just money. They have to think about their families and what is happening and so it's much harder to get them to go to rural, or you know, what they consider out of the country.

CHAIR HURLBURT: Noah?

COMMISSIONER LAUFER: Along those lines, I think you're heading in the right direction. Particularly with doctors, it's important to consider this decision to become a primary care doctor is a crux decision in your life. The federal government provides only one set of post-graduate now. You can't change your mind, and it's interesting to me. I'm 45, and when I interview younger docs, they almost never ask me about money. They want to know, am I going to enjoy practicing? And additional restrictions make that harder and that's what chases people out of primary care. We always interview their partners because there is no point in hiring someone who is enthusiastic and their partner doesn't want to live in Alaska. So you know and the incentives, even if they were huge, can't compare to the difference in pay gradients between primary care and a specialist. You can make it up in a month, you know, the biggest incentive the State could provide. So that's the real issue, you know. If you're going

to be asked to be captain of the ship as a primary care doctor, are you captain? Do you get to own the ship? Do you get to decide where it goes, what weather it's going to sail in, you know, what cargo you're going to carry, or are you just going to be held responsible and told to fill out paperwork and sign?

MS. CULPEPPER: And I think that that's really true. I heard recently at a couple national meetings that one of the things that's luring primary care docs is the medical home model. They are attracted to that. It gives them more control. It gives them more a sense of, you know, really treating the whole patient and being the patient-centered thing. But the other things always count, and I think that, you know, it never hurts to have some loan repayment, but that won't overcome somebody. The whole idea of the National Health Services Corps is not just to get somebody to go somewhere and stay two years. It's hoping that, once they get them there, they will stay there, but that won't happen if, like you said, their spouse -- or there's no opportunities for their spouse or their children or other things. So it is a whole package of things that you have to have. And eventually like you say, we have to have a system -- and hopefully the medical home model will begin to address that -- that will compensate primary care docs fairly and also allow them control, unlike managed care that continued to take decisions

away from them on how they could practice. So we're hoping that the future is going to be a little different.

CHAIR HURLBURT: Anything else? Thank you all very much. The next two presentations, Dr. Andrea Fenaughty who is our Deputy Director of our Section on Chronic Disease Prevention & Health Promotion. We're going to talk about obesity in Alaska and then about Healthy Alaskans 2020. So Andrea?

MS. FENAUGHTY: Hi, good morning and thanks for this opportunity to talk to you a little bit about burden status of obesity in Alaska and then a little bit also about our new efforts that we're taking on. And I apologize in advance; I didn't realize I would not be driving so I'm going to flip these through Deb.

So just an overview to really touch on why we care. I assume a lot of you know this, but I have to, at least, start there and then just update on our new initiatives.

So as far as the burden, why we invest in preventing chronic disease? Chronic illness is the leading cause of death and disability in the U.S., seven of ten deaths nationally. It's a little lower than that in Alaska.

If we look at the leading causes of death -- this is 2008 data right up at the top -- cancer and heart disease are one and two. We have unintentional injuries next which is a little unusual compared to the U.S., but then chronic lower respiratory disease, stroke, diabetes, Alzheimer's, all

indicated in red.

Another way of putting this -- this is a global initiative called 3-Four-50. It's very easy to remember. Three risk factors -- that's tobacco use, poor diet, and inactivity -- contribute to the four chronic diseases, heart disease, diabetes, lung disease, and many cancers, which are responsible for 50% of the deaths worldwide.

If we look behind the causes of death to what are called the actual causes, the things that lead to those, you see here on the left a number of factors. And if you just kind of keep flipping through these, this is the actual number of deaths in 2000, estimated to be nationally due to each of these causes. And right up at the top, you see poor diet and inactivity and tobacco really swamping the rest of the field.

The bottom line economically -- nationally we see about three-quarters of the $2.2 trillion spent in total health care attributable to chronic disease. We have some estimates for what those costs are in Alaska: $600 million -- and these are annual costs -- for heart disease and stroke and that's just hospitalization alone; $419 million for direct and indirect cost of diabetes; close to $500 million for direct medical care related to tobacco use as well as the lost productivity just from the tobacco-related deaths; and a similar amount, $477 million direct medical costs alone for obesity. We know there is a lot of other costs that are not included,

absenteeism, presenteeism. That final bullet, we've estimated just $9 to $10 million just for state of Alaska employees alone related to obesity.

So if we look at what the current data looks like in terms of those risk factors in Alaska, this is looking at adults and if you just page right through these, about 22% smoke, no one is eating enough fruits and vegetables, about 21% are completely inactive, 28% are obese, and the final, we have about two-thirds of adults are either overweight or obese.

This just shows the trend just looking in that overweight and obese in Alaska adults, from just about half to two-thirds between 1991 and 2009.

We switch gears and look at high school students. This is statewide. We see not too different numbers; 16% of high school students smoke. We see 83% are not eating their fruits and veggies. We see 58% are not meeting the recommended physical activity -- that's 60 minutes every day, 12% are obese, and we have 26% are overweight or obese. So already in adolescence, we have almost 30% of kids overweight or obese.

This just shows some data just looking at Anchorage School District. We worked with them to analyze their data over about a year. So this is actually measured height and weight to get the weight status. When we started looking, we started off at 30% were overweight or obese. That climbed

right up until the 2002/2003 school year to be 38%, a little bit of good news. At that point, it seems like it stabilized and it's been about level at 38%/36% through the last school year.

As far as looking at what we're doing currently for obesity prevention, I have to start always with what we've done with tobacco. There are a number of differences between these two battles, if you will, but they're both around changing behaviors and they're very difficult to do in a sustained way at a population level. So what you're looking, the yellow line, is adult smoking prevalence. If you look over about 18 years, you'll see that it did come down from 27% to 22%. And then superimposed are just a number of different things that happened, some policies, whether around tax increases for cigarettes or around smoke-free air, a number of fundings, so infusion of cash at different places. You'll also see, importantly, that high school smoking dropped way before adult smoking dropped, but the point really is probably all these things had to happen together over a pretty long period of time to see the decreases we've seen in tobacco, and I think we'll have at least that much of a battle ahead for obesity prevention.

So another way to summarize what worked for tobacco -- and this is in Alaska as well as nationally -- price, exposure, and image. Price, increasing the price of tobacco;

there is a lot of studies to show that that definitely affects, especially, young people's purchasing of cigarettes. Limiting exposure. Kids should not be able to access tobacco that easily, and we've made a lot of progress there. Reducing secondhand exposure. If you choose not to smoke, you shouldn't have to be exposed to smoke. Changing the image, really targeting those ads that target kids. We should -- you know, putting a lot of limits on that, as well as clearly communicating the harms. You all know that the recent changes in what are on the cigarette labels is taking place now.

Sort of the parallel for obesity in those same three categories, there is the increasing of unhealthy food versus the decrease in the cost of healthy food, and different locations are taking this on. As far as exposure, let's just have healthy food more accessible, have that out there and maybe have not as much exposure to the unhealthy food in terms of vending machines and such. And as far as image, all those cartoon ads and placements on Saturday mornings for all the sugar cereals and the sodas, we can really do a lot to reduce that.

I want to just focus on one really quickly, the decreasing access to junk food. We have some recent data that looks like we're maybe making some headway in that front. This is not consumption, but it's availability. So whether -- in secondary schools all these different categories of foods

are available, and if you see just the eight years between 2002 and 2010, we've cut in half the availability of chocolate candy, other candy, and salty snacks in Alaska's secondary schools and this is quite an accomplishment.

And this is looking just over the last four years in the availability of soda or fruit drinks -- and that is not fruit juice -- as well as some reduction as well in sports drinks. So we are starting to make some headway.

The new efforts that we have in obesity prevention, this is just an overview. The first is Alaskans Taking on Childhood Obesity or ATCO. This was something spearheaded by Dr. Hurlburt. The second I'm going to touch on briefly PE Standards. Then we have the Food Policy Council. And then finally the Funding for the Obesity Prevention and Control Program.

So Alaskans Taking on Childhood Obesity, this is an interagency task force. It's a small, but I think, really great group of folks here, Commissioners from Health and Social Services as well as education. We have Superintendent Carol Comeau, Dr. Jay Butler from ANTHC, Joseph Reeves from Alaska Association of School Boards, Dr. Hurlburt, and Kerre Fisher from Public Health, as well as Senator Dyson.

This is a Steering Committee. Kind of below this is a working group of the worker bees who meet more frequently, but the charge was really to develop and promote a list of

priorities that target childhood obesity in the state of Alaska with some specific steps that we can take and move forward, focused primarily in the school age. And we want to make sure that those -- whatever recommendations we came up with aligned with the existing plan, so we're not ending up with five different plans going different directions. One of the first things we did was establish an MOA, which had never been done before between the two Departments.

One of the priorities that we came up with to promote was, really, to provide grants and some technical assistance around helping schools get more physical activity in the day, not just PE, but physical activity before school, after school, extracurricular programs.

And this is just to show that this does align with the evidence. One of the CDC evidence-based strategies is to increase opportunities for extracurricular physical activity, and there's also some evidence around locating schools in easy walking distance within neighborhoods. Of course, we're not necessarily talking about building a whole bunch of new schools, but working on that access to schools in terms of biking or walking to school.

Another priority that ATCO came up with was to establish a -- I think Delisa mentioned the power of having a dedicated staff who wakes up and breathes and everyday their job is a certain focused activity. Have a PE specialist, which we

currently don't have, who can provide technical assistance and resources around the State on implementing quality PE. PE has come a long way since dodge ball, and there's a lot of benefits to what's called quality PE. And so we believe having a PE specialist would do a lot towards moving that forward.

Again this aligns -- CDC's recommendation is to require PE in schools. We know there is a lot of pushback from schools just in terms of very real logistics of having enough facilities in every school, having enough PE teachers in every school. So we're taking more of the encourage and support PE through this PE Specialist position and promoting PE standards.

What the PE Standards are, we worked on these with folks from the Division having input, as well as Education and Early Development developing a set of -- they are voluntary, but it's certainly a place to start. Board of Ed adopted this set of standards, and there is a number of aspects to them. They really create maximum participation. As I say, it's not dodge ball where, you know, the five excellent stars are out there doing PE. You're really trying to encourage everyone to have lifelong physical activity, which is really what's going to affect obesity. It incorporates cultural diversity, respect, and safety, and there are a clear set of standards that can be measured. We all know what gets measured gets done, and so if

you don't have those standards, it's pretty hard to know if you're making it. And again the overall bottom line is to create healthy kids who become healthy adults.

Then we have something called the Food Policy Council, and this is a group who see themselves as an information resource on the food system in Alaska. They are charged with identifying and proposing policy and environmental changes to improve that system, and that's all the way from production and processing through security and safety of the food system. It's 140 members from across government and private agencies.

I have to say I've been involved in a number of groups, and sometimes you're just, like, beating the bushes to get people to join you. We had people calling us, saying I'm not on this group; I want to be on this group. It cuts across so many areas. People are really excited about it.

These are five committees. They're covering everything from education to traditional and cultural foods. So I think a lot of exciting policy changes will come out of this group.

And finally, funding. Just to remind you, poor diet and physical inactivity are really neck-and-neck with tobacco in terms of the impact we see in death as well as in costs.

These again are the direct medical care costs that we saw earlier. However if you look at funding for OPCP prevention and control the State, it's really the David and Goliath picture. Because of the Master Settlement Agreement, we have

been able to fund tobacco prevention efforts in the State very well. We had more of a challenge with obesity prevention, so we were very pleased this last session.

We finally did get, as of this State fiscal year, $375,000 of GF in the base for Obesity Prevention and Control. This just allows us to do things in more of a sustainable manner. That's it. Is there any questions?

CHAIR HURLBURT: Yeah. Would you like to pause for questions? You're doing really well. We've got almost another half hour, Andrea. So any questions for Andrea? Yes, Wayne?

COMMISSIONER STEVENS: The physical education piece makes a lot of sense, but we have in our communities and in our state foisted more and more things upon the school system but not given them or asked them to stay another hour in the day or another week in the year. So you've still got the same 180 days, and you're just trying to cram more and more stuff in that used to get done in the home, health education, sex education, brush your teeth, balance your checkbook stuff that used to get done at home that now gets foisted on the school.

So maybe the question is, as a part of adding physical education into the school system, do we need to also hold a conversation about an extra hour in the day? And you addressed a couple of three other issues, latchkey kids, daycare issues, productivity in the workforce as mom/dad start

to worry about is Johnny going to get on the bus, is grandma going to be there when he gets off the bus, et cetera, et cetera. So maybe in the grand scheme, rather than focusing on the little piece of physical education you focus on, should we start talking about another hour in the day of the school day? And then you start to accomplish some of these other things and you get some ancillary benefit from that one extra hour every day and then take those little son-of-a-guns out and just run them ragged for an hour. They won't have time to get in trouble until mom and dad get home.

MS. FENAUGHTY: I don't know if I'm really am going to have an answer to that.

COMMISSIONER STEVENS: That was more editorial comment.

MS. FENAUGHTY: I appreciate that, and I think it's an important discussion to involve lots and lots of partners in because, obviously, it does extend into the community, extends into the schools, it extends into, you know, working parents and how that all would be affected, but yeah, it's a good question.

CHAIR HURLBURT: Maybe I could just add to that because, leaving aside the question do we add an hour a day or not, when we think back when you were young and even when I was young, we had PE in the schools and we were falling behind as a country in reading, writing, and arithmetic. And so that came out to try to address that national challenge, but there

is very credible evidence now that kids do better in so-called academic subjects if they have the PE, if they're active, if they have formal PE, if they're active during recess. So that's not to, in any way, argue against whether or not we need to, as a nation, extend the hours of the days in school, but more to say, I think, that the data suggests that whatever time we have in school, if we incorporate these times of good vigorous physical activity, the reading and writing and arithmetic are going to come out better also. Yes, Keith?

COMMISSIONER CAMPBELL: I'd like to go back to your smoking campaign because it's been really pretty well-funded in the State and we're one of the few states that didn't rip off the funds to any great degree. But in small towns -- I'm particularly impressed with the Chilkoot Charlie's owner and those ads because they're effective. But in small towns, the blood tends to flow in the streets when you talk about taking smoking out of the bars and things like that, and I wonder from a policy standpoint if maybe we can go out on a limb and recognize that the Legislature just make it flat statewide, so you don't have all these local political battles that get really very personal. It's hard in a town like Anchorage, but it's almost impossible in some of these other communities. And I just wonder if it's a time that we, as a Commission, just talk about some of these kinds of recommendations because that is one of the most effective. And if it works for

smoking, then it will tend to drift down into some of the other things we're talking about here in your presentation, I think. It's just a question I'm asking.

MS. FENAUGHTY: Yeah. I mean, the idea of a statewide Clean Indoor Air has been discussed. ATCA, not to be confused with ATCO, is the Alaska Tobacco Control Alliance, and they have been discussing for a while when is the right time. And I believe they're considering starting to move forward with those discussions. Obviously lots of things have to happen to move that forward, but for the reasons that you just said, it's one thing to do it in Anchorage or in Juneau, but it's quite a battle in some of these other places, and to have just -- a good -- if it's a good one, to have it go statewide. We don't want it to be not as effective or a weaker policy than already exists other places.

OPERATOR: Please excuse me. This is the Conference Operator. I do apologize for the interruption, but we have some reports from folks online that they're having a hard time hearing the conference. Is it possible you could adjust the volume on the speaker phone or stay as close as possible to the microphone?

CHAIR HURLBURT: Thank you, Operator. Any other questions or comments on this? Yes, David?

COMMISSIONER MORGAN: This is not so much a question. What I was looking for is I serve on the Municipality -- I

chair the Anchorage Municipality Health and Human Services Commission, which is coordinating an obesity plan for the Municipality. We have a plan. We have a subcommittee. We even have someone on the group that's the food group you were talking about. This is the first time I've heard what you just said, and I've been there two years. Could you come to that Municipal Commission and talk to that group? They're trying to coordinate all the programs in the City, the Municipality, like ski trails and vending machines and the whole deal, but I have not heard what I just heard in the last half hour. Could you come and do the same thing again there?

MS. FENAUGHTY: Absolutely.

CHAIR HURLBURT: You made her day. Why don't we go ahead with the Healthy Alaskans 2020? And then we'll probably have a few minutes for questions, and if there are others related to this talk, we could bring them up then again. Andrea?

MS. FENAUGHTY: Great.

COMMISSIONER ERICKSON: Excuse me. Could I just make a quick comment for the Commission members so that they have a little more context and are thinking about this as Andrea is making this part of the presentation?

The reason I had asked Andrea to give you all a quick overview on the Healthy People initiatives and Healthy Alaskans is specifically in response to the discussion at the last meeting about one aspect of our health care cost problem

being driven by how healthy we are, our health status, and the fact that, as part of our study over the next year, you all would like to learn more about health status, health trends, health disparities, that sort of thing. And the first thing I thought of was Healthy People/Healthy Alaskans as one mechanism and one place where we could go, potentially, for getting that picture of all of that data.

So we'll have this conversation later this afternoon, but one of the things maybe you could keep in mind when you're hearing from Andrea is if you think that Healthy People/Healthy Alaskans is going to answer that question for you or if we need to do something more or different. Thank you.

MS. FENAUGHTY: Ready to start? So thank you again. Here I am to talk about the Healthy People initiative, which is the national initiative as well as Healthy Alaskans, which is just what I said.

So to start off talking about the Healthy People initiative, really, it's seen as a way of focusing the efforts as well as giving us a mechanism to evaluate how we are doing, so I'll talk a little bit more about that.

I stole these slides from the Healthy People folks. So how they define the Healthy People initiative is the national agenda that communicates a vision and a mission, overarching goals, and is supported by topic areas and specific objectives

for improving the population's health.

Down along the bottom, you'll see the different initiatives over the years, Healthy People starting in the '90s and then Healthy People 2010, and then the most recent 2020.

The key features of this. First of all, it creates a strategic framework or an umbrella for uniting many different health promotion and disease prevention issues.

The second is the data piece, that it requires tracking of data-driven outcomes in order to monitor progress, and to really focus that action to make changes.

Third, it engages a network of a really broad variety of stakeholders at all different levels, which is very powerful. It also guides a national research agenda on public health, and it establishes accountability for public health service grants to all tie back to those objectives.

Just again to focus in on that part though about creating a strategic framework, you know, people often ask, well why really do you need to this? Every individual program, they have their metrics. They have their objectives, and they'll meet them and what's the really the benefit of having some big effort like this tying them together. And just visually, I like this because it shows that's really -- these different arrows going off in all different directions, whereas the power of aligning those on the right and focusing on a single

goal is really impressive.

This shows the evolution of a Healthy People effort over time. Across the top, you see the different goals. We went from just having two just pretty basic goals to adding a focus on reducing health disparities to, more recently, eliminating health disparities, and now in 2020, we've got four goals. That also adds the social and physical environment piece, as well as across the lifespan issues. You'll see the number of topic areas have increased from 15 to 42, and as I think was mentioned earlier, the actual number of objectives has gone from 226 to almost 600, and I will say the actual number of indicators to measure those is about 1,200. There was a lot of discussion about limiting that and everyone thought that was great, as long as you don't touch my specific objective. So that was the problem that they came up against.

This is just a quick snapshot. Obviously it's still in development, but Healthy People 2020 is going online. They want to have a lot of different much more interactive usable elements this time around than a couple of giant volumes that sit on everybody's shelf. Mine lifts up my computer monitor, actually.

So a couple more elements. Again it's web-based and interactive. There is going to be a lot more focus this time around on the evidence-based strategies that we need to do to actually change some of these outcomes. It's going to be

dynamic. We won't have to maybe wait ten years when we decide maybe we didn't have the right priority or maybe we have a new measure that we want to throw in there or there's a new strategy that there's evidence for. December 2010 is what they're calling their soft launch, I think, because they really want to have something happen by 2010. Spring of 2011, they're going to roll out their leading health indicators. They will have a smaller subset of leading health indicators. And then it will be 2012, really, before the full implementation comes off that they're calling Version 2.0.

So jumping to Alaska, this is already -- the Healthy Alaskans 2010 has been held up. There was an earlier version I wasn't able to get a snapshot of, but it was -- I think it was a slightly more compact process. It was much more focused within the Department, whereas for Healthy Alaskans 2010 -- we have Vanna White over here to hold it up for you. For 2010, it was -- there was a lot more stakeholder involvement for that process. So what you're seeing right up here on the screen is Volume 1 on the left, which was the book of the indicators and the targets, and then Volume 2 on the right was the stories about what communities are doing.

COMMISSIONER ERICKSON: I just wanted to note for the Commission members you have the 2010 book in the back of your notebooks.

MS. FENAUGHTY: So just a little bit in terms of what it

took to pull off Healthy Alaskans 2010, and Deb can, please, jump in since she was involved in this and it was before I came on. There were several FTE who worked on this process. It took about 18 months, I believe, from start to finish. As I said, there was very broad stakeholder involvement. There was a partnership council, and they broke up into separate little workgroups for all the topic areas and that's how it was developed. In terms of the products again, you saw the hard copy of Volumes 1 and 2 as well as an Executive Summary.

And I want to say the Volume 2, if you aren't familiar with it, people really responded to that. Sometimes, I don't know, a story says more than a whole bunch of facts and figures, and so those were stories from the communities themselves of efforts that they had initiated in, you know, their words what had happened through that process and what was changing because of it. So it was very powerful.

This is just a snapshot of what the topic areas for 2010 were. You'll see the headings sort of lined up vertically, Health Promotion, Health Protection, and then Preventative Services and Access to Health Care. It runs the gambit from all the risk factors you see on the left and then a lot of conditions on the right, as well as access to quality health care and all the way through public health infrastructure. So those were all the topic areas that it was divided into.

So as we started, at least, trying to envision what

Healthy Alaskans 2020 might look like if we decided to do that, we decided to collect some data and find out what people thought about the Healthy Alaskans 2010 and this is what we heard. They found it very useful for planning. To have a target really helps you know where to go and try to design a way of getting there. The objectives were useful for securing grant funds. That often came in handy. It coordinated efforts across a number of stakeholders and that people really liked the accountability. You know, we said we're going to get this to this level and let's see if we can get there. We also heard there were way too many objectives. So even with 2010, people said there's just too many; you can't possibly track all those, as well as please do another one. Please have there be a 2020. We find it valuable.

And oh by the way, how did we do on 2010? The unit that was together at the time that put out 2010 is no longer around, so it was really not clear and there were not necessarily resources set aside in a concerted way to monitor what had happened. We know that nationally, I think, about just under 20% of the objectives were met for Healthy People, but they found that about half of the objectives were going in the right direction. There was improvement made, if those were not made. So how many of Alaska's were met? Well we don't know right now.

Of course individual programs and individual efforts do

monitor their own data. This is just an example of something that Alice Rarig pulled together for the Rural Health Conference earlier this year, a scorecard of the leading health indicators. And so the data exists. One can pull together pieces of it, and this is just an example of that.

So as far as Healthy Alaskans 2020, as I referred to earlier, there was a Division planning group that met over a period of months and said this is important, we should do this, and here's how we think it should go forward. There do need to be dedicated staff. We need a coordinator for sure. We want to put this on the Web, so we need someone who knows how to do that. It's about data, so we need someone who understands a little bit about data. We want to have a process that involves broad partnership and stakeholder input, but we don't want to create just a bunch of static books. We want it to be interactive and updateable and really usable. We also thought that we should have a little bit more in there about strategies, just as the national effort is doing, so that people have more tools in terms of bending the trend. And yes, let's have a smaller set of objectives, if at all possible.

And I'm just jumping over a little bit to talk about just a couple of ways of maybe making sure that we do keep honest and set up a system that can help us report out on how we're doing. This is just an example of something called IBIS.

It's an indicator-based information system, public health, and a number of states are using it. We've been slowly developing our own capacity. This is New Mexico's version. But it's just a way of making -- getting the data out there in a much more usable way for the public to use, for policymakers to use, as well as for ourselves to track our own efforts. And this just shows one screen shot, so you can see you can really track where you are versus the country over the period of time. And that's all I've got. Have you got questions?

CHAIR HURLBURT: Keith?

COMMISSIONER CAMPBELL: Your last database there, is that a commercial (indiscernible - voice lowered) one or you have take it and adapt to each state?

MS. FENAUGHTY: It's free. It's been developed by the State of Utah, and when they initially developed it as part of the Community Assessment Initiative, they were given some money by CDC to actually fly around and help people install it and the technical systems together to use it. So we use took advantage of that. Unfortunately, they're funding was cut and they were no longer able to give that technical assistance. So we're getting closer and closer to doing this. It's really the matter of really dedicated staff time to take the bigger steps instead of the baby steps. We've been working on it for a couple of years.

COMMISSIONER CAMPBELL: So you're not reinventing the

wheel?

MS. FENAUGHTY: No.

COMMISSIONER CAMPBELL: Thank you.

CHAIR HURLBURT: Any other questions or comments? Any questions or comments that I cutoff on the first presentation that Andrea had? Thank you very much. We're at our lunchtime. I understand the lunch is supposed to come in here. They may be not quite as timely bringing lunch in as they were with taking breakfast out, but we'll.....

COMMISSIONER ERICKSON: We'll check on lunch. Lunch is available, and everyone who has joined us from the public is welcome to join us for lunch. And we have a full hour for lunch, so we'll reconvene at 1 o'clock and would ask that the Commissioners be back at the table maybe a few minutes early, since we're planning on starting the public comment period right at one. And for folks in the audience if you didn't have a chance to sign in, please do so. And if you could just indicate, there is a place to checkmark on the sign-in sheet if you're interested in testifying at 1 o'clock, that would be helpful. And for folks on the phone who are going to want to testify, we'll just make sure we open up the phone lines and give you an opportunity periodically. You do not have to have pre-registered or signed up in advance. Thank you.

CHAIR HURLBURT: Thank you, Deb.

12:03:11

(Off record)

(On record)

1:05:54

CHAIR HURLBURT: If we can convene, this is the public comment period. I think Deb has, it looks like, a lengthy, or that's just the attendance?

COMMISSIONER ERICKSON: This is just the attendance list.

CHAIR HURLBURT: We'll start with the some of the folks here in the room and then we'll go to folks on the phone. We have until 2 o'clock set aside for public comment.

COMMISSIONER ERICKSON: We have four people signed up.

CHAIR HURLBURT: We have four folks signed up for public comment. If those in the room, if you can come up to the table and the microphone there, just push the button, and as you've heard me being reminded, speak loudly and speak close to the microphone if you can do that. Shelley Hughes, if you -- we have you signed up here. If you'd be willing to come up first? Thank you.

MS. HUGHES: I'd be delighted to come up. Hi, I'm Shelley Hughes with the Alaska Primary Care Association. And just for those of you who aren't familiar with us, we are a membership organization, and my work is to be somewhat of a legislative watchdog and monitor things and also be a liaison and available to be a resource to government officials and to you folks. We do receive a federal grant to provide technical

assistance to the community health centers in the State. There are 25 organizations running 142 clinics, urban, rural, tribal, non-tribal, and these are non-profit with community buildings. And so I just wanted to let you know that little bit of background. (Indiscernible - recording interference) providers around the State, and I do look out for all, including the for-profit, the non-profit, and the tribal. So (indiscernible - recording interference) to you as you make your recommendations to the Governor and Legislature in January that you just always bear in mind the importance and the foundation of primary care to all of this work because it is absolutely essential that we have a strong primary care system, a stronger one than we presently have if we are going to improve health outcomes, number one, which I know is near and dear to your hearts but also to sustain the costs. And (indiscernible - recording interference) a city, a region, a state, a country, wherever there is a strong -- the stronger the primary care system the lower the cost and the healthier the people. And so as you do your work, I'd just encourage you in that way. (Indiscernible - recording interference) remove barriers and (indiscernible - recording interference) and I think in removing barriers (indiscernible - recording interference) encourage you, you might to consider (indiscernible - recording interference) providers around the state is it would be very helpful if the licensing process

were more efficient, that there is sometimes a hold up, and I know it gets tricky because (indiscernible - recording interference) different health care professional types only meet quarterly. I think for the most part, (indiscernible - recording interference) and different department than Health and Social Services, and so it's a little bit different. But efficient licensing is very important because sometimes there can be six months or even a year lag and so that's something that could be tweaked and worked on and could really improve access and help in the long run. Another area the different boards, professional boards, have to deal with is the scope of practice of the various provider types, and it's very important that they all work to their potential, that their scopes be expanded and so I would encourage that and that those barriers be removed.

I'll also mention the need for a state-controlled as opposed to federal-controlled incentive program. That was touched on a little bit this morning. It has been shown -- there have been extensive studies. I worked with a workgroup to put together a recommendation and then eventually became the bill that came very close to passing. It was SB139, and (indiscernible - recording interference) around the table that would know (indiscernible - recording interference) recruitment and retention is. And like you heard this morning with the Workforce Development, we can only produce, you know,

a certain number of people here in our state. And (indiscernible - recording interference) people through, we've got to be able to get people right away, and it's been proven -- and actually the incentive program that was housed in that bill that we hoped would be in a bill this future legislative session would actually make us competitive with other states and it's important. You know, it's a considerable (indiscernible - recording interference) focus on primary care but not solely. In primary care, we have the hospitals at the table too with this because they are, for instance in Juneau -- and I don't know the current status, but I know in the spring there was no cardiologists in Juneau, for example. So it's not just primary care. There are some other needs, but this would really help our state, and we hear stories constantly where we're losing candidates to other states. And it's important that we have one that we can control because the federal programs may not allow the placements that we may need. They may not include all the different professional types that we need in certain places. So it's really important that we have one that we can craft to work for us. So I'd just encourage you (indiscernible - recording interference) that recommendation was included -- when former Governor Palin had her Strategies Planning Council, that recommendation was in that January 2008 report. It was in the January 2009 report that this Commission did. So I encourage

you to include that again in this -- I'm sorry; I'm off a year, '09, '10, and now please '11 -- include '11 if you would.

One thing I'll quickly finish up is investment in the primary care infrastructure. We do have an existing system through the health centers, and I would like to mention, Dr. Laufer, in regard that (indiscernible - recording interference) health center, and I know you know that it's a challenging population, but the health centers also provide dental care and behavioral health care. So those costs are more in (indiscernible - recording interference) physicians and PAs, et cetera, that come in and work with the health centers. They typically (indiscernible - recording interference) and they'll be there for a season of their practice life and then realize they have to put the kids through college and so, you know, then they'll work elsewhere. So (indiscernible - recording interference) centers have areas (indiscernible - recording interference) efficient and productive, but they're really (indiscernible - recording interference). And yes, the federal government is providing some infrastructure money for the (indiscernible - recording interference), but I think you'll see if you look at the (indiscernible - recording interference) they do have to do a lot and they really stretch their dollars. So I just (indiscernible - recording interference) recommendation for

state support here. Primary care, whether it be for-profit, non-profit, tribal, et cetera, I think it's really important and something that you should all consider recommending, and with that, I will conclude. Thank you.

CHAIR HURLBURT: Great. Thank you very much, Shelley. We appreciate that. Any questions from the Commission for Shelley?

COMMISSIONER BRANCO: Yes. Thank you very much for those comments, and perhaps you can point us in right direction if you have the information. Do we have data on the health centers for those patients who received care, what their health care utilization and the cost of their health care utilization is relative to the patients who do not have a primary care home like that?

CHAIR HURLBURT: Either Shelley or Dave, do either of you know?

MS. HUGHES: We have -- we definitely have national data, but we have some state -- they have reporting requirements that the health centers have to do in order to receive the federal grants that they do to help subsidize the uninsured/uncompensated care. And so there is some level of data. It could be improved. And Dave has something he can hand you there that has a little bit of information.

COMMISSIONER MORGAN: It has a real nice graphs and stuff in it. It has how much goes in and where it goes and how many

people are taken care of and then the breakdown of services nationally, and I think there's even a little state data. But I'm sure the Primary Care Association could pull another -- some stuff together, right?

MS. HUGHES: Yes. And we (indiscernible - recording interference) national data that patients who were seen at health centers on a regular basis as their medical home will save the system up to 40% and it's because they're staying -- you know, they're getting that care, things are getting nipped in the bud and controlled, chronic disease. It's keeping them out of the ER, shortening hospitalizations, et cetera. I don't have that data at the state level.

COMMISSIONER BRANCO: And I guess I would offer that to the Commission. As we look at prioritizing which initiatives are going to have the greatest return on investment, it would be helpful if we have that data available through some venue to know and to be able to show what the return on investment has been here in Alaska. I absolutely agree with you about some of the existing data. Coming from Louisiana you know, there has been a clear return on investment in community clinics in the post-Katrina New Orleans era, for example, but if we can demonstrate that that may be helpful to augment your point about the need for primary care investment.

The second question, if I may, the medical home model has gotten a lot of attention from the Institute of Medicine and

the American Academy of Family Practitioners and ACP and others. When we move it out at the federal level, that's been a substantial investment of staff, very expensive investment. In the VA for example, you have about a 1,200 patient panel maximum with a doc, a nurse, and two assistants working with them. And then for every three panels, you have a social worker and a pharmacist and they aggregate staff along that line. Is the position of your organization that the State should fund a similar level of support for private practice primary care physicians?

MS. HUGHES: We do think that (indiscernible - recording interference) and so we have a capital request for $35,000 per organization, which isn't a lot, but it's to help to get them going, to get something off the ground and implemented. And we also know -- as the numbers you mentioned in a lot of villages, we realize it's going to take cooperation where you might have to share some of those providers and so we are looking at that and we're also -- I don't believe you were this morning. Deputy Commissioner Streur mentioned a medical home project, and the health center in Unalaska will be part of that as a demo projects, and some other health centers might be participating in that also. But yes, up front, it does cost a lot to get up-to-speed and meet the criteria.

CHAIR HURLBURT: Thank you very much, Shelley. The next one on the list is Woolsey Lindt (sp). Maybe if you could

just come up and introduce yourself, Mr. Lindt?

MR. LINDT: My name is Woolsey Lindt. I'm 71 years old. I'm retired and I'm only on Medicare insurance. I'm new to Anchorage. I've only been here ten months, and I've spent 20 years in Juneau where I did not have a problem using a Medicare card.

The Medicare crisis in Anchorage was well-documented for those of you who do not have Medicare cards. It was well-documented in a recent newspaper article by the *Anchorage Daily News*. It was a front page article, and there is lady named Donna who called 63 primary care doctors looking for just one who would be willing to accept a new patient on Medicare. Ten months ago when I moved to Anchorage, I ran into the same problem, but the newspaper article gives you a hard copy documentation of it, of the human side of the story.

I'm testifying because, in two meetings of this Commission, I've witnessed a forest of provisions from the new Medicare reform law, but there has been an omission of one tree in that forest of provisions and that tree has Alaska's name on it. The tree was introduced by Senator Mark Begich, and in the handouts that you have, the title of the Press Release is "Legislators Offer Medicare Solution."

This legislation is a companion to the federal provision that was introduced, that one tree with Alaska's name on it, and that tree allows -- that provision allows the State to put

in money to, essentially but not technically, complement and supplement primary care payments to doctors. It pays off Anchorage doctors and that's what I am interested in seeing done.

On the second page of the handout at the bottom, it says -- is a part of a letter from an Alaskan representative who wrote a bill to be a companion to the federal law for a State House of Representatives bill, and he considers the new federal legislation underlined at the bottom of the second page and I'll read that. That gives us the importance of the relationship between the federal and state government;

(Whereupon a portion of handout titled "Legislators Offer Medicare Solution" was read as follows:)

Senator Begich succeeded at gaining support for a provision that was added to the recent federal health care legislation. The amendment he offered provides that a state may establish a "grant" that directs payments to medical providers in areas of a state where there is a medical care shortage. The inclusion of this amendment overcomes federal agency arguments that states may not provide funds to doctors to enable them to treat Medicare patients.

(Whereupon reading of a portion of handout titled "Legislators Offer Medicare Solution" was concluded)

MR. LINDT: So that's the thing, that's the very

important part;

(Whereupon a portion of handout titled "Legislators Offer Medicare Solution" was read as follows:)

Any grant program, however, will likely have to be worded to benefit seniors, not just seniors who utilize Medicare. And it must implemented by an agency other than DHHS.

(Whereupon reading of a portion of handout titled "Legislators Offer Medicare Solution" was concluded)

MR. LINDT: That's us. That's the State Department of Health and Human Services. Excuse me, that is not us. That is the federal equivalent to us. That's the U.S. Department of Health and Human Services. We are the State Department of Health and Social Services. And I think that part of the reason I have seen this omission on the Commission's part is because the federal law does not permit DHHS from being part of the implementation agency, and the DHSS has DHSS as part of it. So we have been cut out.

This morning when you said that you wanted to fly at 50,000 feet rather than three feet, that sort of took the winds out of my sail because I had a specific three foot bill as the second page of the handout, but it's instructive to see what this Legislator has done to try to get state money flowing to the Medicare recipient, to the Medicare doctor.

Notice that the Act is entitled a program in the

Department of Commerce, Community, and Economic Development. That's not HHSS. But if you look on the last page on line 15, you see;

(Whereupon a portion of handout titled "Legislators Offer Medicare Solution" was read as follows:)

To the extent permitted by law, the department may enter into agreements with and shall consult with the Department of Health and Social Services in implementing this section.

(Whereupon reading of a portion of handout titled "Legislators Offer Medicare Solution" was concluded)

MR. LINDT: So in the front door apparently, it has to be a different agency than HHSS. But in the back door, it is your agency, the Department of Health and Social Services. And I think that's what's been the problem of causing the omission, and all I'm here to do is to ask your recommendation to the Governor and to the Legislature for the new possibility to -- made possible by the health care reform law that allows the State to compensate physicians and payoff Anchorage doctors, and I urge you to use your sophisticated techniques to get that legislative action done. I don't know what techniques should be used. All I am at the level is writing my Legislator a letter.

CHAIR HURLBURT: Thank you very much, Mr. Lindt. Is there a question on that? If not, we appreciate that.

MR. LINDT: Thank you very much for your time.

CHAIR HURLBURT: You're welcome. We have a couple of more folks here and then I'm not sure how many on the phone. So if we can target five or six minutes or so on that, we may be all right. The next person that we have signed up is Kay Branch from ANTHC. Kay?

MS. BRANCH: Good afternoon, my name is Kay Branch. I'm with the Alaska Native Tribal Health Consortium, and I want to talk about -- bring up long-term care and that aspect of health and health care. I do, actually, long-term care planning for the Consortium, and I've worked with Alaska Native elders for the past 15 or so years.

And so one of the things that ANTHC is working on is we've done a feasability analysis for a nursing home, a tribal nursing home, within the Municipality of Anchorage. And as we were doing that feasibility study, we were also looking at what are the trends that are happening, and I think, you know, the fact that Alaska has the fastest growing senior population in the country is one issue and that in the Southcentral Region of Alaska that population is growing really rapidly, over 60%. And our Alaska Native population is also growing quite rapidly, the elders of that population. And when we did our feasability study, we looked not only at the need for long-term care facilities, but (indiscernible - recording interference) nursing home beds are maybe, I think what, eight

in Juneau and two in Homer since the 1980s. And other than that, it has remained stagnant. So we looked at the need for long-term facilities care as well as for home and community-based care because what we do hear from our elders and the families is that the people would rather be in their own homes and communities.

What's actually happening is that, in the past five years, the home and community-based services in many areas of the State have declined and we're hoping to be able to build that back up again. But for now you know, we do see a large decline. I've just been, in the past couple of days, working on summaries of the Medicare expenditures, long-term care expenditures for the last five years, and I can see the real decline in those costs for personal care and home and community-based services, particularly in the rural areas, and that startled me. Also I've done this fall (indiscernible - recording interference) here in Anchorage that are in an assisted living home or a nursing home, either on the Medicaid (indiscernible - recording interference) or perhaps general relief. Perhaps they would not be eligible for Medicaid long-term care services, but there 314 people that I've identified from the sources that I have. I know there is others out there. And (indiscernible - recording interference) only 57 were from the Southcentral Region. The rest are from the rural areas because there aren't services available. And so

(indiscernible - recording interference) looked at from both perspectives, both the home and community-based and the facility, and how can we meet those needs? (Indiscernible - recording interference) other part in the planning is (indiscernible - recording interference) 314 nursing home beds and Providence has plans to decrease the number of beds at Providence Extended Care when they do the rebuilding of their old facility by 90 beds. And there is concern that there would be kind of a lack of those services here in Anchorage for people who need them.

So (indiscernible - recording interference) that long-term care is an important thing to have the table when we look at the whole health care realm. And (indiscernible - recording services) we mean all of the services, not just nursing homes and not just elders but also younger people with disabling conditions. And there are quite a few of them that are here in Anchorage and receiving care (indiscernible - recording interference) throughout Alaska.

(Indiscernible - recording interference) your decision making process is that, you know (indiscernible - recording interference) tribal health organization to tribal health beneficiaries that the Medicaid (indiscernible - recording interference). The Medicaid would be entirely from the federal government and so we see that as a (indiscernible - recording interference) to be able to expand services without

affecting the General Fund Medicaid budget. So I do have a handout that I will distribute, and if you have any questions? Thank you so much for the opportunity.

CHAIR HURLBURT: Thank you, Kay. Are there any questions for Kay? Thank you very much. The last person in the room before we go to the phone is Kitty Farnham, who has signed up, with the Matanuska Health Foundation currently.

MS. FARNHAM: Good afternoon. Grateful to be here. Yes, I am Kitty Farnham. I'm actually with Catalyst Consulting, but I'm here on behalf of Elizabeth Ripley, the Executive Director of the MatSu Health Foundation, who simply couldn't make it today.

I'm here to talk about something -- the end goal we all share is quality health and health outcomes for Alaskans, but sometimes the means to the end are related to systems where we can maybe collaborate. And some of the earlier comments related to having the right data available and accessible where we can determine the best strategies is at the heart of my comments.

The MatSu Health Foundation is leading some efforts with their partners in the Valley and the State of Alaska to develop a Health Status Report, and through that, to promote the use of health data to better drive health improvements in the communities.

MatSu has learned that the Alaska Department of Health

and Social Services has plans and is making progress towards what may be a sustainable interactive online source of health data. Such a system would benefit the MatSu, the State, and communities all across Alaska. In fact, I believe Andrea Fenaughty may have some of those tools in her presentation about Alaska 2020 and they have made some good progress, but what we're looking at is how to really see that idea to its fruition.

The conversations between the MatSu, the State, and other parties interested in better access to community level health information have been very productive. As a result, a public/private coalition is beginning to be considered to advance these efforts. Historically, a significant amount of time and effort has been required to collect, gather, disseminate, and use one-time snapshots of health data for a specific community report. In recent years for example, health assessments have been done for Anchorage, Fairbanks, North Star Borough, Kenai Peninsula Borough, Kodiak, Seward, and Valdez, and probably others. This approach is inefficient, costly, the reports are quickly out-of-date and have to be manually redone when the information is sought again.

Alternatively, best practices in other states and nations show that a core level of data dissemination tools and associated infrastructure are most effectively produced at a

statewide level, not using a different approach in every community which doesn't offer any standardization or comparability. However this again is not an effort to produce data for data's sake. The vision is, again, for community partners at a local level to engage in local actions that improve their health and the social and environmental conditions that also affect health outcomes. Such action is always best when grounded in timely and relevant health information. The data is also needed to demonstrate measurable results over time and strategies that work.

So these comments are offered to the Health Care Commission because the goal, better access to the use of existing health data, may also support the mission and goals of the Commission. Whether we're trying to reduce the prevalence of obesity, to use data to drive improvements across Alaska, Healthy Alaska 2020, engaging action at all levels, turning the vast amounts of data that are available into accessible information and information leading to knowledge and knowledge leading to actionable strategies has many potential benefits for many partners.

So finally the MatSu Foundation and this emerging public/private coalition will continue to explore cost-effective strategies and associated benefits. The group includes the State, the Municipality of Anchorage, United Way Agencies, and other potential funders. We would welcome an

opportunity to provide the Health Care Commission at a future date with information regarding the current status and alternatives, costs, and potential benefits to such a public/private partnership. Thank you for your time. Thank you for your efforts to improve health in Alaska.

CHAIR HURLBURT: Thank you, Kitty. Are there any questions for Ms. Farnham?

MS. FARNHAM: I'll leave a copy of my notes as well.

CHAIR HURLBURT: Thank you very much. Next we'll turn to anybody on the phone who would like to make a comment. If you do, if you could identify yourself by your name? And if you are representing any organization, just if you share that with us, too? Are there any on the phone who have comments?

DR. KOEHLER: This is Dr. Koehler from Fort Wainwright, Fairbanks area.

CHAIR HURLBURT: Yes, please go ahead, Dr. Kohler.

DR. KOHLER: My name is Dr. Danita Koehler. For the record, I'm a member of the Alaska Council on Emergency Medical Services. I reside at Mile Post 1379, Alaska Highway, Dry Creek, Alaska, 99737.

Commissioner, Commission members, and the distinguished guests, thank you for this opportunity. The opinions expressed are my own. I would like to identify an important gap in Workforce Development, which impacts every Alaskan.

Para hospital medical emergency personnel, more commonly

known as emergency medical technicians and paramedics are an emerging workforce. These professionals are state-certified to the Alaska Office of Emergency Medical Services or licensed by the Alaska State Medical Board. Their mission is to provide care and transport of Alaskans to a medical treatment facility when an emergency arises. (Indiscernible - phone interference) activate the 911 system for a medical emergency, your life or that of your loved one depends on one of these health care providers.

In review of the 2007 Alaska Health Workforce Vacancy Study, EMTs rank as one of the highest health care occupation vacancies at 26% comparable to the vacancy rate for psychiatrists. I'm not aware of an action plan to help fill this gap, which I believe is actually much wider and is at a critical pivot point needing your Commission's time and effort to close.

Pre-hospital medicine is no longer a sideshow or an afterthought when discussing evidence-based outcomes or access to care. More often than not, you will dial 911 to get help and an EMT or paramedic will respond. This workforce needs to be accounted for in the Commission's planning, including the critical workforce shortage in pre-hospital emergency services, which needs the inclusion in the Commission's 2011 Strategic Action Plan. Thank you for this opportunity to testify.

CHAIR HURLBURT: Thank you very much, Dr. Koehler. Are there any questions from anybody on the Commission for Dr. Koehler? Pat?

COMMISSIONER BRANCO: I just have a simple comment to make. I know Dr. Koehler from her time in Ketchikan. This is Pat Branco. Dr. Koehler has been a powerful advocate for pre-hospital care for over a decade now, and she spent a lot of her own time on development of these EMTs and paramedics. So she is speaking directly from the heart, but also in support of the patient.

CHAIR HURLBURT: Thank you, Pat. Any other comments? Again thank you very much, Dr. Koehler. Are there any others on the phone who have comments? We have one other individual here in the room and we'll go to her and then again invite anybody on the phone, if you do have any comments. Leslie Shalcross (sp) with the Alaska Dietetic Association. Leslie, please?

MS. SHALCROSS: My name is Leslie Shalcross and thank you for giving me a moment to speak. I'll be very brief. I've got a very short but passionate request and that is that registered dieticians and the Alaska Dietetic Association be included in planning and implementation of health care systems in Alaska.

I'm a registered dietician and president of the Alaska Dietetic Association, an affiliate of the American Dietetic

Association, and I represent over 100 registered dieticians who live and work in the state of Alaska. Our members work in many different areas, but are all considered nutrition experts nutrition experts and our training includes, at a minimum, four to six years of college education in chemistry, biochemistry, anatomy, physiology, and statistics. We're also prepared to do individual counseling and implement community programs and strategies that support individual behavior change.

Diet, nutrition, and physical activity are modifiable and cost-effective factors for the promotion and maintenance of good physical and mental health.

The interventions can impact on all of our chronic diseases and in many of our acute diseases, coronary heart disease, stroke, cancer, and Type II diabetes, all big problems for our communities, as we know.

Registered dieticians must be included in health care promotion and disease prevention activities and workgroups as we are the only professionals specifically prepared to deliver these important preventive services in the community and in clinical settings.

So I, along with 134 members of the Alaska Dietetic Association, will urge the Alaska Health Care Commission to include registered dieticians in all aspects of health care transformation. We can effectively provide preventative

services to reduce the impacts of obesity and other chronic diseases that we're now facing. Thank you.

CHAIR HURLBURT: Thank you. Pat?

COMMISSIONER BRANCO: Just a quick question. What's the workforce status of our registered dieticians in Alaska? Do we have a shortage?

MS. SHALCROSS: I would say we have a shortage, but I also would say there is currently a shortage of opportunities for dieticians to be employed and to work to contribute to preventing health care problems. I've been -- this is funny, and I'll just add I've been involved with nutrition for 40 years. My earliest thought was to be a physician, and my thought after I was about 18 was I wanted to prevent health care problems and that is why I'm a dietician. But I have not seen dieticians included in health care, either providing services or in the planning of services to the level that could have the impact which it can truly have. Thanks.

CHAIR HURLBURT: Thank you. Any other questions? Thank you very much, Ms. Shalcross. Anybody on the phone? Last call. Thank you very much. We'll move on next to our business discussion, and we'll have that and then we'll take a short break. Deb?

COMMISSIONER ERICKSON: If you all could turn behind tab four in your notebooks, really just, I think, two relatively quick business items and a quick informational piece.

First is a 1st Trimester Financial Status Report for the Commission and there isn't necessarily a whole lot of information in this document yet, but I mostly wanted to put something together and give you a sense of how -- once we start having quarterly meetings, I'll report to you on how we're doing, but it does show how much we have spent from the State accounting system through the first trimester, through October, against our budget for the State fiscal year, how much we have obligated in terms of contracts underway that we know we will -- we have the amount of money defined so far. These contracts aren't quite in place yet, and I'll talk about that a little bit later this afternoon, the two agreements with the Institute for Social and Economic Research that we talked about at the last meeting. And I pretty much just balanced it out for the year. I'm assuming, at this point, that we are going to have enough ideas for consultants and special study work that we're going to not have any problem spending our money this year.

One of the things I did, I did include the budget that you all approved at the last meeting, the next page behind that. I realized, as I was putting the Financial Status Report together, that I had failed to note our different funding sources on the budget and wanted to make sure I did that. So this document is amended to reflect that we actually are funded primarily with State General Funds, but late in the

process going through the Legislature, we were asked by the Legislature, the Department was, to try to reduce the amount of General Fund spending, and Department of Health and Social Services came up with a plan to allow charging against some Medicaid matching funds. So we actually have federal dollars contributing from the Medicaid program to our work, and it shows that breakdown there.

I mostly just wanted to see if you have any questions about how I'm displaying the information here on Financial Status and any suggestions for improvement for when it starts getting more meaningful when we get a little further down the road in spending money here. Yes, Keith?

COMMISSIONER CAMPBELL: The mother sitting next to me said this sounded like a pregnancy ongoing.

COMMISSIONER ERICKSON: Any other questions or comments? We'll do quarterly instead of trimester reports after this for sure. Hearing no questions, moving right along.

You all had presented to you at the last meeting in October a suggested Bylaws change and folks seemed to be in agreement and ready to vote on it then, but we recognized we had a procedural issue. We needed to wait a month from the first official introduction of the Bylaws amendment before we could actually approve it. But if you would turn to page five in the Bylaws document, just as a reminder, we're updating the notice of how many voting members we have and how many voting

members need to be present in order to establish a quorum. Previously, we had to have four of seven voting members. And now with our four new voting members, we need to have six of 11 voting members. So we've just made that change under Item A there, and we've added a new subsection B under Parliamentary Authority, Article VII that no person may substitute for a voting member and that proxy voting is not permitted. So I would entertain a motion now related to this amendment. Yes, Wayne?

COMMISSIONER STEVENS: Mr. Chairman, I'd move approval of the amended Bylaws as presented by staff.

COMMISSIONER CAMPBELL: Second.

CHAIR HURLBURT: Any discussion? It's been moved and seconded that the Bylaws of the Health Care Commission be amended to change the number for a quorum to be present and to clarify that proxy voting is not permitted. All those in favor, raise your right hand. Opposed the same. It's carried. Thank you very much.

COMMISSIONER ERICKSON: Moving on to the informational point, I thought you all would be interested in seeing the couple of media pieces that came out following the last meeting of our group, and I also included a couple of articles from the ADN and another piece that had been included as part of a newspaper insert in all of the rural papers in the State last May on the Commission's report. Again not to point out

anything in particular related to these, except to point out that there is media interest in the work of the Commission and there has been consistently over the past year-and-a-half or so.

One other point I wanted to make about is that I had actually developed a communication plan that included a media component for the last Commission and we ended up not implementing it because we developed it when we thought we might get money and then we didn't get money, which actually I was very tickled about this rural newspaper insert and getting the article in there because it was a specific request that we try to work with the rural papers and rural media. Actually I also had a number of phone calls from rural radio stations and was interviewed online by a couple of them, too. So even though we made no attempt to get the information out to these folks, it happened anyway. So I was really thrilled to see that we ended up being able to get some information out to rural Alaska.

I didn't include a copy of that communication here. I figured that's something we can maybe pick up with the New Year when we start again in 2011 at this point, but when we do start that at the beginning of that first full year, we'll revisit that communication plan, see what you all think about it, and actually implement it now that we have some money to implement it. So again more of an informational piece. Does

anybody have any questions or comments?

Well we're doing well. It's very early, but should we take a short break now and then reconvene and see how the conversations the rest of the afternoon go?

CHAIR HURLBURT: Does that sound good to everybody? Let's take a 15-minute break, come back together at ten minutes after two, and we'll get into the next item on the agenda then.

1:54:23

(Off record)

(On record)

2:13:15

CHAIR HURLBURT: Let's come back together, please. The next area that we want to get into is Health Care System Diagnosis: What is the Problem that we're trying to solve? We want to talk about the current plans for studying the Alaska Health Care System, identify and prioritize some additional studies as needed. And a lot of this is a follow-on to our discussion. At the last meeting, we did some brainstorming, talking about options, talked about some names to get some expertise in some of these areas. That's what we want to do next, and I think that's in your slides here, Deb.

COMMISSIONER ERICKSON: First of all, why don't you turn behind tab five? We'll reference some of these documents as we go along, but that's the tab we're behind right now. And

we probably should note for the record too that Colonel Friedrichs joined us at noon today. I don't think we mentioned that earlier, but for his benefit, we started off this morning using this handout that's in the front pocket of your notebooks again, and as a reminder for everybody else, as a guide for the discussions throughout this day-and-a-half.

So we spent a little bit of time at our meeting in October talking about what more the Commission needs to learn to make sure that they understand problems in the health care system in Alaska well enough to come up with some good solutions and strategies. And the question was posed at one point, what is the problem we're trying to solve? We just need to make sure we understand the problem we're trying to solve and what are the different aspects of that problem.

So one of the other things that you all had received -- and I had provided some copies on the back table for folks -- and it's actually tab six, if you want to reference it at some point, but the Commission members received a summary from the discussion part of our meeting a couple of weeks ago with some questions posed in it. And so this is actually question five from that handout, but I thought it would be helpful to have the conversation about what we need to understand more and what the problems are before we go on to revisit our strategic framework. I flipped that on the agenda kind of at the last minute.

So this was question five in that handout, are there other areas for the future the Commission should consider to help better understand and describe Alaska's health care system? How would we prioritize these? So for those of you completed that or had a chance to, at least, think about it and have notes to yourself about that, you can pull that up.

I wanted to review where we're at right now with some of the studies that we are starting to get underway, and one of those is the impact of the federal health reform law. If you'll remember at the end of our last meeting, we talked about putting a contract in place with the Institute for Social and Economic Research to kind of do a review and finalization of work that Mark Foster has been doing in terms of just kind of a high level impact assessment, economic impact of the federal reform law in Alaska. Just as much as anything as an informational piece for the Commission, moving forward, understanding as that law is getting implemented how it might be changing the environment that we're hoping to effect here. So that's more of a background piece.

And then the Health Care Spending and Cost Drivers, we had a copy of the report that ISER had done, and I think, it was published March 2006, but it was using 2005 data looking at cost by major payer category, expenditures. When we talk about cost, we're talking about expenditures, not cost of providing the service, but health care expenditures in

Alaska's health care system. And you all had directed that it would be helpful to update that, but there needed to more of an analysis and a focus on the cost drivers, what's driving those costs. And so I've been talking with them about that and have a proposal, a new proposal, from them. We had a preliminary proposal in your notebook last month. So we have a new proposal from them, and they are also proposing to look at not just what the cost drivers are but what the tradeoffs are, what the impact would be. If we were to be successful in turning the curve in escalating health care costs, will that somehow negatively impact our welfare in some ways?

So if you want to take a minute to take a look at that, we actually have the contracts underway, but it's not so far down the process that we couldn't make some amendments. And we'll be working with Mark regularly as he works on these projects.

And then third, you all had directed me to start working on a contract with a health care actuarial firm to look into questions about health care pricing and reimbursement practices in the State and that's something that we've started in the State Procurement System. Another document, the second piece of paper that you have behind tab four is a copy of a form that we have to fill out when we want to start a contract. It's called "Authority to Seek Professional Services." There's a description of the purpose there. It's

the beginning of and a summary of what the scope of work for this contract would be and so I've provided that for you all to see if you want to make any suggestions for improvement or have any questions about that. It's just a short couple paragraphs that you could be looking at. It's the "Authority to Seek Professional Services" form and that is it, Colonel Friedrichs. It's behind tab five. It should be the second piece of paper behind tab five.

And then there were three other potential areas of study that were brought up, and actually I think in that homework document that I had sent out to all of you, I was still keeping them lumped together as two different -- or as the same issue and I ended up breaking them out into two separate issues. And one, the question about how healthy are Alaskans, what's our health status, what are the disparities, what are the trends in health and health conditions? And the second part of the question, which I realized was, really I think, a completely separate question is, are we utilizing our Alaskans -- do they have access to the right kind of care at the right place at the right time, essentially? And some examples were given. You know, are people showing up in emergency rooms because they don't have access to a primary care provider on the weekends or in the evenings when they're out of work, I think, was one of the examples that was given. So I broke that out into two separate issues, two different studies,

potentially.

And then the third area on workforce and I think the question was posed, what would be the cost of success? And so I'm characterizing it or thinking of it, at least right now, as a Workforce Development Cost Benefit Analysis, but I think I'm going to need some more help with that and we'll talk about that in a minute.

One of the things that helped me think about these studies a little bit, I came across -- first of all in our 2009 report -- I mean, this was something that the Commission had really focused on in their first and expressed concerns about was the cost of health care in Alaska overall and not just price specifically, but we did, at one point, kind of break out two aspects of costs as the price and utilization. Again cost being total expenditures for health care. And so when we were having the conversations about costs in the first year and we've actually, I think, included this equation in our report, we were trying to think of those two different aspects but didn't have time to dig in and study either one in that first year, especially with no financial resource to support it.

And following the conversation we had at the meeting in October, just this past month, I came across this Health Care Cost Equation that helped me think about, you know, the different components that actually make-up the utilization

side of that equation. So it's helping me. I don't know if this is going to help you. It's helping me to frame these different studies that we're talking about doing. And so it takes the utilization part and it breaks it down even further into number of conditions, number of episodes of care per condition, number of services by service type per episode of care, and the number of processes per service, and then price being price-per-process.

So then looking at the number of conditions part of that equation, to what extent is health status driving utilization and therefore overall cost? And then lumping these other parts together, the service delivery piece together, and the question that Deputy Commissioner Streur raised this morning that I had written down before this morning, just because he walks the halls in the Commissioner's office in Health and Social Services asking this question all the time. For him specifically, are Alaskan Medicaid patients getting the right care at the right time in the right place -- and he had finished before -- also at the right price? And then, is care delivered as efficiently and effectively and as safely as possible?

So that's how I'm thinking of this other part of this equation and translating it, again at the right price, into these -- the different ideas for studies that we've broken out seem, to me, to align very well, potentially, with all of the

components of the Health Care Cost Equation. That first one, the big picture analysis of how much money we're spending, who is spending it, at a high level cut. I'm sure we'll get spending by categories of service at a very high level -- how much is being spent on hospital care, for example -- and then what the cost drivers are, and then breaking it down beyond that into the more detailed information that we're hoping to get on health care pricing and reimbursement in the State, and then the health status and health care service utilization pieces. So does that -- it helped me. I don't know if that helps you at all, if it makes sense. Does anybody have any questions or comments or response?

CHAIR HURLBURT: I would say, I think, that understanding this and understanding the pieces and looking at the pieces and numbers of pieces and cost-per-piece and all is important, but from a payer's standpoint whether it's a Medicaid program or a health insurance plan or society generally in what you're paying for care, you're really interested in the aggregate and so there are companies, like Ingenix, that look into episode treatment groups where you want to know what does it cost for an episode of care, what does it cost for a colorectal carcinoma for the total universe of care, pre-op, evaluation, surgery, post-op care for the hospital and the physicians, say, at Providence or at Regional or at Elmendorf. You want to look at that in terms of what the pricing is. So it's good

to understand the pieces, but you're also looking at the lumping.

Something that Shelley eluded to when she talked, and we've talked about it more here, that again a payer, whether it's the State or a health plan or looking at the aggregate at society, you don't want to see waste. And certainly if people need the care of a neurosurgeon, you want them to get to a neurosurgeon and you want them to get that care, but you want to make sure that it's necessary. It's pretty well-recognized, as Shelley pointed out, around the world -- and last I knew United States is part of the world -- that a payer, if they're an enlightened payer -- no and obviously there could be an exception that you're worried, but you're never going to use about somebody using primary care too much because, clearly, there's a payoff. That's music to Noah's ears there, but you know it because you walk it everyday. So I think that the pieces are important, but we also want to keep in mind we're talking about the aggregate and the aggregate could mean what are the total costs for X procedure or X disease to society and then it helps to know it makes up the cost. But also looking at the cost of care of the various kinds of things, some things are really desirable and there is evidence that shows that you ought to be spending more. If we had more primary care visits, we would have less costs for secondary and tertiary care. That's been shown over-and-over

again. So I think that maybe is just a little amplification, not a disagreement with what you're saying. The pieces are important, but we want to keep the aggregate in mind also. Any other comments?

COMMISSIONER FRIEDRICHS: Well I think you make an interesting point, and I'll juxtapose that with the recent study that looked at the highest billing physicians in the Medicare system. If I recall correctly, they were all primary care docs who were doing incredible studies. You know, every patient of theirs had a sleep study, an EMG, and you know, a series of things that were done. So they were phenomenal over-utilizers of the system. So I would qualify or ask that we qualify what you're saying in that it's got to be good primary care medicine. It's got to be appropriate primary care medicine as we go through this. That's a part of the entire system, but it's also one that's very ripe for abuse, as the federal system is discovering right now without adequate oversight.

CHAIR HURLBURT: Yeah. I think that there, clearly, is fraud and abuse, and those in the health care business have more responsibility to not accept that than we have sometimes done in the past and those are examples of gross abuse there, but that is the exception. That is what grabs the headline, and I think my comments were more when you look at the aggregate, where most physicians and I'd say probably,

particularly, most primary care physicians have a very real community orientation and sense of responsibility for their communities and that's an asset to be maximized. But yeah, I think that we also shouldn't be so naive as to not recognize that there is so much money that there -- if (indiscernible - voice lowered) goes to rob a bank, there's so much money that people that want to engage in fraud and abuse are going to go to health care because there's so much money there now. Keith?

COMMISSIONER CAMPBELL: A point of clarification. I'd like to go back to the study on -- the actuarial study, just for my own edification. You're talking about the top 25 most commonly used codes and then you go through a whole list of specialties. I presume that 25 is for each of those specialties, not the aggregate of the whole thing?

COMMISSIONER ERICKSON: Correct.

COMMISSIONER CAMPBELL: All right. Thank you.

CHAIR HURLBURT: Val?

COMMISSIONER DAVIDSON: So I guess I'm struggling with, what do we do with the information once we have it and where do we go from here?

So one of the things that I really appreciated about Andrea's presentations this morning is, I think, it's one of the few times that I've seen somebody present data in a way that's actually usable and gave the information that says,

okay, here's information, here's what the data says, without us having to ask so what, so that means, the implications for Alaska are, et cetera, et cetera. And so I'm assuming that the deliverables for all of these folks who are going to be doing this work are going to be tasked with giving us some more than just data but sort of what are the implications of their findings. And I just want to -- maybe that goes without saying, but I just want to make sure that that's what they're being asked to deliver.

CHAIR HURLBURT: Linda?

COMMISSIONER HALL: Along those same lines, my reaction was to kind of the same. We're going to talk about spending and pricing. Are we going to have any outcomes that go with that, kind of on the same line that Val's talking about?

When I first saw studies about the cost of health care in this country and became aware of that, it kind of coincided with me being in this position that I'm in. But you looked at comparable costs of providing coverage, health care coverage in various countries around the world, and it talked about outcomes. And I'm not sure how you measure outcomes, but what we spent did not seem to get us any better outcomes. So if we talk about spending and what we spend and how it's priced -- and utilization was my topic, actually -- how do we fit in what we get for that, I mean, what outcomes do we get? Do we get better outcomes, that same kind of issue?

CHAIR HURLBURT: I think maybe to take a stab at that -- and Deb can try it -- both, Val, what you said and Linda. On that I think, probably what Andrea talking about is related to health and that's what the end point for all of it is, but that was fairly specific and easy to understand.

I think one of the issues that we've looked at is the cost of health care, and I know, Val, you've said, well, we need to talk about quality, we need to talk about what we're getting for it. But where we're spending at least 23%, according to Mark's figures, of our Gross Domestic Product on health care in Alaska, we're getting a lot. And when we hear physicians say, I can't make it on what Medicare pays, even though we know it's 29% more than it is Outside, and we, well, why? It doesn't initially compute. So I think some of the data that we want to get is to try to help us understand why do we pay so much more, both in terms of dollars and in terms of our state's domestic product for health care, than anybody else pays, and why, what happens that makes it so a physician says I can't make it on this. It's just -- you know, I'll some of it for charity, for my community, a sense of responsibility, but the payment isn't enough. So I think part of it is getting an understanding of that.

COMMISSIONER DAVIDSON: So can I just respond? I guess the piece that I'm struggling with is I'm trying to figure out how to win this particular battle without solving the whole

global problem of world peace. And so I'm a little worried that -- and maybe I'm the only one who is missing something, but if you look at page four under tab six, some of these questions, the health conditions and health costs of service, we talked about last time. Like we keeping talking about the rising cost of Medicaid and where we're spending so much money, et cetera, but you know, what are the leading causes of death? Where are we spending our money, et cetera, et cetera, et cetera? So I get those, and these questions I understand, but I'm having trouble translating this to some of those. I think it's the green one up there, but I thought I heard in the discussion more world peace kinds of things than sort of drilling down to deal with our particular thing. And I guess what I want to make sure of is that we have resources available to actually fix a finite problem and not necessarily being -- and I'll just say this and I'm sorry, but I'll just say it. I don't want us to be the latest favorite piggy bank for private consultants who have yet another opportunity to fund some study of how we're going to fund the health care, how we're going to solve the health care problem in Alaska because we have lots. I mean, I don't know about the rest of you, but I have boxes and boxes in my office of studies, national studies, state studies, and I've only been doing health care for 12 years, but there are boxes, literally boxes. And in those 12 years, not a lot has changed. And I

just want to make sure that we're trying to solve a tangible fixed problem and not dealing with world peace, necessarily.

CHAIR HURLBURT: Just a point of clarification, do you consider dealing with the aggregate cost of medical care to be world peace because there are unmet needs, but there are huge resources going into that? I think we would want to see that the resources go where they're most effective, but part of that is dealing with the aggregate, isn't it?

COMMISSIONER DAVIDSON: I guess I wasn't thinking about just this in particular, but we keep coming back to costs. And the last time I brought up this issue up before was, what is the system that we're trying to design? What is it that we want our health care system to look like, one? Two, what finances do we need to be able -- how are we going to finance it? And then three, with the resources that we have available, where should we prioritize our spending? And it just feels like we keep coming back to this. It feels like we're not looking at what is it we'd like it to look like, what's sort of our grand vision for the future, and instead, here's where we are now, here's what it costs, and we're going to spend lots of time talking about costs without necessarily a link to where is it that we want to go. And maybe that's only my short-sighted perception, but that's just what it feels like to me.

CHAIR HURLBURT: Noah?

COMMISSIONER LAUFER: This is a classic dilemma and that's actually why I wanted to come here as sort of the philosophical thing. What's a unit of health care? You know, what in the hell is that? Excuse me, but -- and what are we -- like we looked at the leading causes of death. I mean, death is not avoidable. You could die of something else, but you're going to die. And then, to me, the question is, how do you have a nice longevity, high life expectancy, and a high quality of life during that? And that's very different from spending millions and millions of dollars on everything.

The second issue with cost is, you know, I'm sensitive about being in private practice, but what's included in costs because included in my costs is the facility, the cost of my training and the loans I'm still paying back, my retirement, my own health benefits, the health benefits for 80 employees at 32 cents on the dollar. Those need to be included in the calculation with a large institution with lavish facilities, federal retirement and health care, you know really if you're going to look at the overall costs. And I would argue -- I'm not a libertarian, but we're very efficient. We can't afford not to be.

COMMISSIONER STINSON: Looking at the Authority to Seek Professional Services, there's just a couple of other things that come to mind as I was looking at it. If you think of a pie, we're talking about one slice of the pie. The equipment

that people use up here is more. I've already had different vendors tell me that. The pharmaceuticals are often more. The hospital charges, I don't know how they compare to the Lower 48, but if it follows everything else, it's probably more. So when you're focusing -- now I agree this should be studied, but this is just one piece of a larger pie. And I think you get an incomplete picture if you're just going to be looking at that.

COMMISSIONER DAVIS: So we have Val who doesn't want to study too much and Larry wants to see the whole picture, so what do we do with that? Val, just sort of in the way I'm viewing this is that you definitely need to know what your destination is. You know as famous health care philosopher Yogi Barra said, if you don't know where you're going, you're liable to end up someplace else, but you also need to know where you're starting. And I really don't think without this work we know where we're starting. And so to see the bridge between -- the gap between the two, we need to understand where we are, and I just would encourage us to continue down this road and to add to the picture as time goes on. And once we understand where we are, then I think a vision of what's possible and where we can go will emerge and be more clear to the Commission.

CHAIR HURLBURT: Yeah, Larry?

COMMISSIONER STINSON: You know what might be interesting

as somebody who could answer some of the questions I just brought, actually Jeff with Blue Cross Blue Shield of Washington and Alaska. I'm sure some of those questions you already know.

CHAIR HURLBURT: Commissioner Hall?

COMMISSIONER HALL: Yeah, I'd know the answers to some of them too and have done some of that kind of research between -- with, really, just talking about private insurers, not the breadth that we're talking about in this, but to look at Ingenix which you mentioned and the private insurance marketplace and doing 15 CPT codes, what does it look like, what does cost in Seattle, and what does it cost in Anchorage, and I was appalled when I got some of the results for that, but it didn't give me -- maybe it told me where we were in a little microcosm of the health care world, but as Val said, it really didn't tell me why. I still don't know why.

CHAIR HURLBURT: Yeah and that's what Larry was trying to point out, and I think that would be the hope that we would get some of those answers of the why because, I think, we're all left with why. Paul?

COMMISSIONER FRIEDRICHS: So you know, part of what we try to do in the federal system is to look at what we're spending and what we're getting, and if I may, I believe that's getting back to Val's point a little bit there. If we're spending more in Alaska for any 25 CPTs that we want to

dig back into, that's a useful data point.

The second piece, which I think was embedded in some of what Deb had was, so what are we getting for that? And I'd shared with Deb some of the data that we looked at for the Federal Healthcare Task Force, which shows that we're getting a very high suicide rate, we're getting a very high obesity rate, we're getting a very high hospitalization utilization rate, we're getting very poor outcomes across the board. And you can go through, you know, numerous data banks -- and they're all available on the Web right now -- and break that out for Alaska and show that we're spending a lot of money to get poor outcomes for our patients.

CHAIR HURLBURT: And at somewhat low primary care?

COMMISSIONER FRIEDRICHS: Well and so, you know, when I go back to what we were tasked to look at, which is recommendations for and foster the development of a statewide plan to address quality, access, and availability of health care for all citizens of the State, I would offer that any research that we do should have that as part of the product from the researchers that, as they look at this, if indeed they can tell us where we are today, that's great.

The second part of the analysis should be, what would change or what should change to improve quality access and availability of services? That's the "so what" part of each of these studies. That's what we spend a lot of time looking

at, as I suspect Linda does in her job. If I'm going to go out and spend $38 million in Anchorage, I've got to explain what I spent that money and what I'm getting for it. And I get a lot of people asking me that question because that's how much I spend in the community in here, in addition to the $120-some odd million that we spend in the hospital.

CHAIR HURLBURT: But if you take -- say take Milliman doing the cost analysis and the components of it, why? What's driving the cost? They can do that analysis. They've done it in other states. They can show you what they find for Alaska. They can tell you where we are different than other states, but I don't know that a contractor, like that, would be as good as we would be here to say what can we do to change it because there are uniquenesses. And those of us are here -- you know, maybe it's that they're being pig-headed, but I think that we're probably the better ones to say what can we do different. We can have them point out what other people are doing different that may end up with different results, but it's kind of like evidence-based medicine. Whether it's policies or whether it's the individual clinical encounter, when you come to the end, there is still room and you still need some judgment. And we, in Alaska, are probably the better ones, don't you think, to exercise some of that judgment.

COMMISSIONER FRIEDRICHS: Well I'm absolutely convinced

that there is nobody in the United States that understands what happens here who hasn't lived here. I have that discussion everyday with people back in D.C. and they just don't get it, more often than not. Having said that though if we're structuring contracts which go to UAA or someone here in Alaska, I think -- I would offer that there is value in asking those who live here and who are doing this research for us to provide their input. I mean, Mr. Foster was very impressive in some of the research and analysis that he presented about health care reform. UAA's institute has done some great work for us.

I will freely confess that, if you're looking for me to help connect the dots between what we're spending and how to improve quality access and availability, I'm going to be able to provide a small bit of information on that, but I don't spend my life looking at that. I'm not expert consultant. And I think if we're going to pay somebody to do this research, we should both get the here's where we are, and then also if you want to improve quality access or availability, here's options that are available. And then we look at that and say this option costs $10 billion, probably not going to do it. This option gets us whatever and costs $200 million; that's a good one to recommend in the next report to the Legislature. I guess that's how I'm looking at it.

CHAIR HURLBURT: Thank you. Pat?

COMMISSIONER BRANCO: I want to hit on the topic of pricing, and as a key component of determining costs, one of crippling things I found here a decade ago when I got here was asking a neighbor hospital, what are your charges for, X, Y, Z, and I got my hands slapped seriously. To my knowledge, there is not a third-party system in determining prices, and I'm a child of the gas wars where a bit of open, honest competition really helped keep the costs lower. I'd be a real strong advocate for finding a vehicle in which we can identify prices across the continuum of health care here in this state and whether it's state-sponsored, so it's a safe vehicle so we don't hit anti-trust issues or price fixing issues. I understand those concerns, but really trying to find a determination of what are the prices we're charging and how can we cooperatively get those lower.

CHAIR HURLBURT: Yeah. And we will be getting to that probably, but that -- we have the transparency of pricing as being something that we feel is a function because, I think, you hit the nail on the head. We are a third-party. We're a neutral third-party and that can be a very useful role for the Commission to play. I think that's exactly right. Yes, Emily?

COMMISSIONER ENNIS: Will the information we obtain here help with transparency? Is it going to give the detail that we would like to see? And then secondly you know, I'm

interested what are the health disparities, what is the health status of Alaskans, and is there any tie-in with this information to that information, is there any relation to how much we're paying for certain chronic and acute illnesses and the health status of Alaskans, will we get anything from that that helps us with that information?

CHAIR HURLBURT: I think that the transparency can help. Now it's not a slam dunk. There was a recent article published that the state of Oregon has tried to engage in making hospital charges transparent for a number of common conditions, like a coronary artery bypass procedure, and they've done that for three years. The article basically was pointing out that there was still a very wide disparity among hospitals there, particularly in the Portland area, and it really had not impacted where business was going very much. So it's not a slam dunk, but it is something that's just been used around the country quite a bit. I think it is a tool. It is a step. As long as so much of medical care is paid for by a third-party, by Medicaid, by Medicare, by an insurance company, by whatever, some of your normal economic drivers are not place that they are when you go to buy a car, but it has been used. It has been felt to be helpful. So I don't know. We can't say it's a slam dunk, but think that it could and it should help to do that.

The other thing related that a number of states are doing

-- and we mentioned last time -- is they are publishing outcomes, data, quality data of what are your outcomes, what is your death rate for people with heart bypass surgery. Again it's not always acted on, but states, like Pennsylvania, like New York, have done that. Despite that when ex-President Bill Clinton had his heart surgery, he went to the hospital with a poor track record, and of course, he did fine. So it's the, you know, individual physician that he knew and he did that, so again not a slam dunk. But a number of other states have been doing that and we haven't here, and I think it is a role that we can play to try to help assure greater visibility. Yes, Wayne?

COMMISSIONER STEVENS: As we're talking pricing and getting back to Noah's question, what does a unit of health care cost, I got to thinking about the other end of the equation and the expectations of patients around the State that, where an x-ray used to be sufficient, now we have to have an MRI or a CAT scan. And so hospitals around the State are buying more and more advanced equipment for more and more expensive dollars, and in a major metropolitan area, you might have one piece of equipment that would serve hundreds of thousands of people. Yet in this state, we have expensive pieces of equipment serving 30,000 people or 13,000 people. And so there is a ratio of price of equipment, population, and utilization that, I think, somehow ought to enter into the

equation, and I'm not suggesting that we only have a CAT scan in one place. I'm just saying, if you're going to understand what drives the cost, also understand your utilization rates and the cost of the piece of equipment and its location and number of potential users of that equipment. And I think that would very quickly start to point out, you know, we have very expensive pieces of equipment in small population bases and so you're getting a piece of equipment that, in a major metropolitan area of a million people, has a very different cost-per-unit of use than in a community of 13,000 people. I don't know how you put that into an equation.

CHAIR HURLBURT: That's true. And then the universe radiates out from wherever any of us are sitting. So if you live in Emmonak, you really think the Mayo Clinic ought to be in Emmonak and that's just human nature and that's okay. That's the way God made us, that we're that way. But I think we do need to -- it's why, you know, a certificate of need, particularly as a Hospital Administrator, is going to be a very controversial thing, but do we need all the CAT scans that we have? And we know we're creating, what, 37,000 cancers a year now because of the heavy use of CAT scans around the country. And your employer, your know -- you've been around and you've got a strong back and you're very oriented toward costs, but if you get a new piece of equipment and you're not using it, Peace Health is going to say, Pat,

why did you spend all this money for that, where is our return on this investment, and you have to justify it that way. So that's a part of the system, and I think again, it's an area where we can be an impartial, neutral, third-party, provide some information, some transparency, and support the people with the white hats that are trying to do white. Yeah, Wayne?

COMMISSIONER STEVENS: And I guess, you know, part of that is an understanding by the users that your community chose to have this piece of equipment and you, as consumers, benefit from that piece of equipment in your community, but because of these ratios, your cost-per-use is exponentially higher than anybody else's in a situation. So I mean I think, part of it is helping people understand cost. And back to a comment made earlier that if people just go to the doctor and somebody else pays for it, you're not near as in tune with that as when you go to buy the car. So I think there is some benefit there in sharing very clearly what the costs are to the consumers that use product equipment.

COMMISSIONER FRIEDRICHS: So if I could clarify, are we anticipating that this Commission will get to the point where we'll say that we're spending X amount of money on something for which there is no evidence that there is benefit?

CHAIR HURLBURT: My personal response, I don't know that we would collectively have the expertise to do that. I would see what we could contribute would be to promote, promulgate,

foster the use of evidence and evidence-based policy making, evidence-based clinical decision making. I don't see us as coming up with a series of algorithms of, that's the way you should do urology, or Noah should do family medicine, or Larry could do pain management. So I don't think that's our expertise or our charge, and I think it would be a formula for failure. But to foster the concepts of the use of evidence in determining what's Medicaid going to pay for, what's Workman's Comp going to pay for, what's the State employment system going to pay for, or what's Premera going to pay for, I think fostering that concept we could do the -- fostering the concept of you in your decision making, and obviously, you feel you do it now. But I think we, in medicine, can do it better, that we do use high-grade evidence, understand grades of evidence, and in your clinical practice, Noah's, Larry's day-to-day clinical practice, that, yes, it is used more than we do.

COMMISSIONER FRIEDRICHS: So you know again I think Val's original point was a great one, the so what question with all the data that we collect. And Deb, you shared excellent articles on evidence-based medicine. As I shared with you, I had previously been looking at this IOM report that had come out that highlighted the gap between evidence and what we spend money on and how that gap is actually growing over time, that we are spending more and more money on things for which

there is no evidence that there is value to the patient or to society, but we continue to pay for those services. If our charge is to look at quality, access, and availability of health care, is our going in assumption then that, whether or not there is evidence for the health care, we should provide access and availability to it, or as a Commission, is our charge that we are going to provide access and availability to evidence-based health care because that's not what the Legislature asked us to do? And I want to make sure I understand what it is we're trying to accomplish. Is this how we do we get more people access to more health care, that whatever it is they want is quality health, or is this how do we give access and availability to evidence-based health care?

CHAIR HURLBURT: Let me take a stab at that and see how it works. I agree that that was not the explicit charge to us, but I think both from the Governor's office and from the Legislature, the reason we're here is because of cost, because of what we're spending. We will have an annual report that goes to both the Legislature and to the Governor's office, and I would see that, a part of that, as being the opportunity to educate and to say it's not that we just want to provide access willy-nilly for anything anybody might want, but that we do want to assure access for all Alaskans for the services that they need and that will benefit them, and a part of that definition are services that are supported by the evidence.

It's not our role to say what that is specifically, but to provide that education that, with the State as a payer, with the State as a policy setter, with the State as an insurance regulator, whatever, all the roles that the State plays, that they can have a role and opportunity to weigh in on ensuring that the services are provided are quality, which is defined in significant measure by being supported by the evidence. That's the way I'd respond to that. Jeff?

COMMISSIONER DAVIS: So with your permission, I'd like to tell a story that may bring us back from war and peace and/or world peace, which is even greater than war and peace, and really, I think, speaks to what Emily read about transparency. A lot of what we're charged to do we don't have the power to do. I mean, it's not in our wheelhouse, as people might (indiscernible - voice lowered) not sure what that means, but it's not in our wheelhouse. So others have to understand the situation before they'll be willing to take action on it. And so I think a lot of this has to do with transparency. I mean, some of us may or may not understand what we're going to get factually from this study, but outside this room, I think very few people will understand what we're asking to be revealed and we're asking for it as a neutral third-party with no dog in this fight. And I think that has great power to then inform decision makers who will potentially be taking action based on what we're recommending. We're asking the Governor

to do things, and he needs to know why that is, so I think this is a really important.

So here's the story because, I think, transparency is so important and so lacking, and I'll clean it up and leave the names out of this to protect the innocent and the guilty. But air ambulance, near and dear to my heart, there are several carriers in this state and in certain locales, and there is one carrier who consistently charges three times what the others do. And we became aware that, in one locale, there had recently been three transports on the high cost carrier. We looked at the cost, $157,255 per transport versus $52,000 on the other carrier, so $105,000, in my view, wasted for the same service. And as soon as we saw that, I called up the facility and I knew some people there, and I said, whoa you know, this has got to stop. They had no idea. They had no idea that there was this difference in cost. And so I flew there, and we sat down, and we went through it, and I guarantee you that's going to change in terms of their referral pattern, but they had no idea. And that situation has existed for a significant amount of time. How many other times in this 23% or 30% or whatever it is of our GDP in this state we're spending on things where we have situations like that? Until we can start to peel it back and understand it, we're not going to be able to deal with that.

So I'm not focused on world peace. If I could just stop

that from happening, okay -- there's another instance with another provider. We haven't solved it yet. It's $900,000 a year, same situation. And so -- but it's just one example of where I hope we will find ourselves informed by the work that's going to be done, and there'll be many more questions raised than there will be answered. Thank you.

CHAIR HURLBURT: It's funny he should bring up the transportation thing because I was going to ask Dr. Friedrichs in his Milliman study out there -- I think you mentioned the cost of transportation at the previous meeting. Are you rolling those into unit pricing in this study by Milliman because we have astronomical costs for transportation in this state?

COMMISSIONER FRIEDRICHS: Actually we're not rolling them into the cost as part of a particular disease type because the reason that people are transported varies so much. So we've looked at separately how much we're spending on transportation and we have that information, but the Milliman study is looking more at what we're spending for a particular specialty or a disease type. It's going through a more traditional.....

COMMISSIONER CAMPBELL: A unit price per specialty or diagnosis?

COMMISSIONER FRIEDRICHS: Correct.

COMMISSIONER CAMPBELL: I do think that we ought to think about that as one element of this background of the total part

of health care, if we're going to get our arms around it, because that is a large dollar amount and it ought to be allocated somewhere. I'm not an economist enough to where or an actuary, but it ought to be allocated somewhere in this whole equation because it tends to get forgotten, I'm sure.

CHAIR HURLBURT: Paul? Val?

COMMISSIONER BRANCO: I just was going to comment, you know I think, that that's an excellent point. And part of what we did is to move more aggressively in the telemedicine. We have what are called the turtles now that we're able to document the transports that didn't happen within the federal system because we had the ability to monitor our congestive heart failure patient, someone who is on Coumadin who we actually check their INR remotely, rather than bringing them back when they have a head bleed. And so those are the sorts of things within the federal system, or at least within the DOD and VA and Alaska Tribal Health Consortium, that we've begun to do to mitigate the cost of transports. Again that's an investment that we made up front in technology, which is now allowing us to save money on the back end on transport.

CHAIR HURLBURT: Val?

COMMISSIONER DAVIDSON: I was just going to ask the question, so then based upon this conversation, the moral of the story is?

COMMISSIONER ERICKSON: Based on this conversation, the

moral of the story is -- this is where I think we're at and what I've heard, so I'll try to summarize it and then you guys can correct me.

One of the things I heard and I actually didn't write this down -- hold off on responding for a few minutes and we can go back to each of these main points.

One of the things, I think, I heard at the very beginning is that we maybe need to define further our Vision Statement to maybe get into a little more detail of describing what the ideal health care delivery system for Alaska looks like. So that's one of the things, I think, I heard.

Sorry. I wanted to make sure I wrote that down. Then I think another thing that I thought I heard was that I need to make sure I include in the solicitation for these contracts and in the scope of work for these contracts looking at different aspects of the health care cost equation, ask the consultants to make sure that they are providing us with some analysis and information, not just data, and that they are also, to the extent that they are able, tying the information that they glean from this data to outcomes, including outcomes as an aspect of that analysis, what we're getting for price on one hand or for certain utilization, if it's the utilization study, for example.

I've also added to the pricing study that we're not just looking at individual providers but hospital, pharmaceutical

pricing, medical transport, use of different types of equipment, so adding that to the scope of work.

And then for each of these studies if the consultants and analysts can also provide some recommendations from their perspective of what they think we might consider for potential solutions for correcting issues related to quality, access, affordability, availability.

And specific to health status, if we're able to make a link between the health problems that are identified and cost of services and utilization of services.

And then there was a discussion about the utilization rates, kind of economies of scale, but I think it was really getting to a transparency point of making sure that the public and consumers of health care understand what they're getting for the dollars that are spent and why pricing might vary.

So that's what I think I heard. I took this as direction to me to make sure I'm including certain things in the contracts. And then we can get back to the question about whether we want to do some additional visioning about the ideal health system, too. So do you think I -- did I understand the flow of that conversation? Is there anything you want to correct?

COMMISSIONER LAUFER: I think that sounds great. It's -- the 50,000 foot analogy is great. It's just that it's probably 75% overcast below us. We can't see anything and

perhaps there's a hurricane coming as well. Do we have a way to change midstream if the hurricane blows by?

CHAIR HURLBURT: I was going to call you on, Dave, anyway because you -- so you raised your hand. Please?

COMMISSIONER MORGAN: I guess I have one point and then one thing that we might want to think about, especially focusing on Medicaid.

I think the first question is -- I'll never forget my fifth year in economics. Professor Morrison came in. He was studied at the Chicago School and helped with the Nobel Prize, and the question was demand and supply. Easy question. So everybody went up to the board. They did it that way. You had to go up the board and write your equations, and everybody wrote all these elaborate equations. And since I was a fourth year student, I wasn't allowed to even go to the board. So he came out and he went around the six guys in the seminar and he just drew X's through them, X'd them out and said wrong, wrong, wrong, wrong. And then he went off and he said my analysis is basically based on the economics of two different types of weddings.

The first one is, if you have an open cash bar, you will have a lot of booze go out. If you have a cash bar where you've got to pay for the booze, a lot less booze will go out. That's the first theorem of a Master's level economics.

The second thing is, I think when you fundamentally get

through all this, you will prove Dr. Morrison right, the transparency and who is paying. The more that people pay for things or are responsible for things the less they'll use it and be prudent. It's just an axiom. We're all economists in here, and we all know it down deep. We just need some math to validate that.

The other thing is what we have found, especially looking at our -- or looking at Medicaid patients and other type patients, is -- and I don't know if there's any way of even putting this in a study, but between 8% and 12% of your empaneled patients usually use about 50% of what's going on. And I think maybe they'll figure out and they'll look at what they're using and why and see if there is -- you know, that's another utilization question away from even the issue of price or cost; 8% to 12% of an empaneled group is using 50% of your resources. And I guess the question would be, why?

CHAIR HURLBURT: And I would say, in my experience, you're being generous, that it's less than eight or 12. That is a small proportion. But isn't that a kind of a management issue, which may be beyond us? That's the group that you do complex case management on. You know, you may assign them to a nurse or to somebody who can oversee that care and can help coordinate it for that individual. So that's a management issue on the part of the payer because it's always the case, that a very small percent of your patients consume a huge part

of your resources.

COMMISSIONER MORGAN: Thank you. That's the other -- I think that's one of the other issues is looking at, in Medicaid especially, how we manage those patients, whether it's on the state level or who the state has a contract with and understanding why they're using it and using targeted case management or case management or the John Hopkins Intervention Case, whatever it is to look at that because one way to increase accessibility and reduce costs is maybe we've got some people not only buying transport at five times the going rate we may have people going to the ER room 14 times a year, where maybe we can get them to three or four. But that may be too low, below the (indiscernible - voice lowered). I don't know, but I just throw that out there. I don't know if we want to add it or not. I just think that is, especially on the Medicaid issue, something we might discuss and throw away at the end of this meeting.

COMMISSIONER FRIEDRICHS: I think that's a great point and that goes back to the discussion last time about health care utilization. Dartmouth has done wonderful population-based studies that suggest that, for X hundred thousand people, you can expect to have this many admissions for a cavage (ph) and this many admissions for an endarterectomy, and you can use that to predict both what your population should do and also what sort of resources, typically, you

require. I've not seen that sort of an analysis done that says that, for a population in Alaska of this size, we would expect to have this many admissions and we actually have that many because that's a different way to look at health care utilization and that's a great point that you raise.

To answer your question about how we look at that, and I think to validate to your point, Ward, certainly within both the DOD and the VA system, we look very carefully at that at the macro level and drill down, and you're right. That's the individual provider, but this gets back to then the transparency piece because we do drill it down to the provider to say, gee, Dr. Friedrichs, how come your patients get admitted to the hospital three times more often than Dr. Laufer's or Dr. Morgan's patients do? And we go back and we do something about that. That is something at the federal level, at the institution level, we're able to do from a transparency standpoint. Are you advocating for something similar to that in which we would.....

COMMISSIONER MORGAN: No. I'm just proposing the question. In any way I can gum the works, I take any and all opportunity. No, I'm not going -- I don't know. I'm just sort of thinking out loud, since we're writing stuff on -- and by the way, you have great handwriting, I have to say. But it just seems like I'd throw it out to see if it's of enough interest to include in any of this or not. I don't mean for

all -- everybody in Alaska. I'm talking about Medicaid. That may be a little narrow, but I kept hearing this morning for two or three hours $1.4 billion, you know. I mean, it seems to be a big interest, a big problem, and you know, I would rather us have more than enough ideas and then we can always get rid of a few and maybe this might be one we can't do.

CHAIR HURLBURT: Yeah. As I say, that may be getting into management, but I think the issue of a small portion of your population consuming a large part of the resource is partly just because they're the folks that are getting the short stick and maybe getting sicker. But there is usually more too that, and there is opportunity to intervene intensively there.

But to amplify a little on what Paul said from Dartmouth, there certainly aren't differential rates and we can look in the aggregate, and we are like a city with 700,000 people here in the state. We can look at the State. But we also know that Wenburg's data and Gwandi's article in the *New Yorker*, what, a year-and-a-half ago now show that cities closer together than Anchorage and Fairbanks, there is a huge difference in rates of hysterectomies, in rates of back surgery, in rates of a number of kinds of interventions that make no sense, other than if they're economically driven on what's happening, whether it's in a little state like New Hampshire or in Texas. The *New Yorker* article was about

Texas. Wenburg's stuff started in New Hampshire and then spread around. Noah, did you have something, please?

COMMISSIONER LAUFER: I'm afraid I'm feeling very cynical now, but you know, these questions have been sort of asked and looked at before and that's probably why PECK (ph) is going to lose 80 beds. They'll be full. API went from 260 beds or something like that to 80. Too expensive to care for these people. Brain injury patients are very expensive, you know.

And then the other thing is this idea of measuring of an individual doctor's capacity based on outcomes; that is very sticky. The good cardiothoracic surgeons see the sickest patients, typically, and have the worst outcomes. It varies by all kinds of things. I'm thinking about sort of class. If I go to a party with my wife who graduated from Yale and I lit a cigarette, people would fall over. There were would be an intervention. I'm serious. It's a class issue. If I go to a party with people I went to high school with, you know, a six-pack of beers pretty reasonable at night, a working guy, and a cigarette. You know, it's a different thing. And so it depends on who your patients are. And this is stealing -- this type of idea is stealing the fundamental captaincy of the ship from the doctor who is there to care for you, and if you happen to be difficult or have problems, you get more attention. If the doc or facility is penalized for caring for the hardest people, you know, he'll be a jerk and chase them

off. I don't know. I mean, you're already penalized because you're providing a much care-intensive care to somebody for the same price, but you know to actually be told you're a bad doctor because, you know -- anyway I digress.....

CHAIR HURLBURT: When you're looking at more aggregate numbers, I think you can control for severity level. And I think that that's not inappropriate to do. I think what you're saying, speaking of physicians as individuals, that when, say, a payer tries to provide information to individual physicians of maybe costs of care, maybe outcomes of care, maybe rates of some desirable outcome or some desirable procedure being done, that almost always the initial response will kind of be, well, you don't understand. My patients are different. My patients are sicker. And that's almost always going to be there because, I think, we all really try to do a good job. But if you can provide data -- physicians are scientists too. You know, we're artists, but we're scientists. And I think physicians generally most of the time, at least by the second or third thought after maybe some initial you don't understand, my patients are sicker, that physicians tend to react constructively and then they say, well, why and look at it. And they will look at themselves, I think. So I don't know. Maybe -- I think what you say is true, and you have to look at things in the aggregate sometimes, but I think can you adjust for that kind of thing,

but that can help improve quality.

COMMISSIONER LAUFER: I agree with you completely on that. Doctors will respond and will respond quickly, especially if you're told this is how you're going to be measured. But the idea has to be to provide an environment in which not just doctors, doctors and nurses and dieticians and everybody involved in health care can do more than the minimum requirement because everybody there wants to do that and will leave in frustration if they can't, you know, and to preserve this environment where medical care can be a calling.

I mentioned this when I came in, but Friday on my desk, there was a chart note from an emergency room doc about a patient of mine who is in his 60s and has three daughters, driving down the highway 80 miles an hour with a plan to kill himself, and he didn't. And in the note, it says that he saw -- excuse me -- my face and decided to seek appropriate care because I had told him that's not a unit of health care. There is not a price on it. It costs more that he didn't kill himself, but there are three girls whose dad didn't die of suicide. It's bigger than this, and it's not economics. It isn't even close to free market economics. It's a bigger issue. And my worry is that sort of abstractions and recommendations are going to kill this. It's already being killed. And if the professionalism leaves medical care, we haven't seen anything yet as far as escalation of cost, fraud,

and abuse, and the deterioration of the system.

CHAIR HURLBURT: Val?

COMMISSIONER DAVIDSON: Thank you. So we were -- even though we're not to have sidebars -- I think the conversation was really about not necessarily cost, but what the value is. So for example, we're spending so much time talking about the rising costs of Medicaid, the rising costs of health care, et cetera, et cetera, and then every time we want to talk about what the costs are, we always talk about the most vulnerable population. We want to know what those costs are for Medicaid patients, not for everybody, which is -- you know, I got a problem with that because we are 700,000 people in Alaska and it's the totality of our health care system that's driving the cost. It's not the Medicaid patients. It's everybody. It's everybody who elects cosmetic surgery or whatever it is that they need, just absolutely have to have. It's what the people value.

So I guess one, I want us to pay a little more attention to the value of health care and what is it that we're getting for what we're spending, not necessarily what the cost is because cost is just one piece.

There was a lot of conversation that we had at the last meeting and there was a lot of public testimony about what does Alaska as a state get from these expenditures for Medicaid. How many kids are attending school because they

have health care coverage and access to health care that they wouldn't otherwise have? It's what's the value to the State?

The other piece is there is a lot of conversation and the latest big hip thing in health care reform is transparency. Everything is going to be solved because we have transparency. Well that isn't necessarily true. We have a whole lot of transparency on car pricing. The price of cars have not dropped. The price of cars continues to rise. People are very aware of what the price of cars and what goes into those costs, and there's all kinds of transparencies. The price of cars has remained relatively stable or has increased, but the demand for what people value has improved. So for example, we now have cars that can park for you. We have cars that can tell you how to get lost faster or how to get found faster. We have cars that are built more so that you can survive a car crash, so that you can drive at, you know, 100 miles an hour and be less likely to get injured. So the question isn't necessarily -- I think we shouldn't kid ourselves that transparency alone is the answer. It is one component of how we get where we need to be, but it's really a question of value. What is it that we're paying for and what is it that we're getting out of it? And I just think we should be careful of it because we keep talking about costs. And I think what we're really meaning, if you look at our conversations, is what's the value to the State.

COMMISSIONER FRIEDRICHS: Val, another extraordinary point, and I guess I'd go back to the comment that you made, Ward, about how we can change behavior if we make things transparent. You were exactly right. I read that Oregon study actually within the last month or so and transparency, as it turns out, hasn't changed behavior. We all believe it should, that people would consciously choose not to drive up their premiums and would go to a hospital that charges less, but they don't, at least they haven't thus far.

Similarly, there have been a number of studies now that have looked at the value of the guidelines that we publish, and I've been a huge proponent of guidelines at every hospital at which I've worked for years. And yet if you send a guideline out, it turns out, even if you report which physicians are using it, which physicians are actually following all the steps along the way, that hasn't changed behavior all that much either, as much as we'd like to believe that it should and that people would comply with the guidelines. So this is a cultural change. It's very difficult to implement and transparency is a piece of it, but it's not yet had the desired effect in a number of areas.

And there was an excellent study also out of the United Kingdom where they looked at transparency in which they set a goal of, I think, 70% of physicians participating in a particular aspect of their system. And because they aligned

their remuneration to do that, what they wound up having was 90% of physicians participating in that aspect of their system but absolutely no change in the outcome to the patient, which suggested that the participation was more of a documentation issue than a real value to the patient. These are the conundrums that we look at along the way and that's why, I think, the aggregate look is so important, you know.

And the point that Noah has raised previously about the individual patient, Don Berwick just had an article that, I think I sent to you, Deb, also in an email yesterday that pointed out the real challenge in taking this below the aggregate level, that, most particularly, primary care docs don't see enough patients to have a meaningful analysis of the impact on their practice. You know, they don't have enough diabetics in their population or enough over 65 patients in their population to have a statistically significant change that we can extract to say that your panel is more complex and that explains why your outcomes are different than my panel, which is less complex. So what he was advocating for was a real caution in how we put this data out there, at least that's the way I read the article that, you know, we need to be very careful when we talk about transparency that we don't turn it into the spear for an individual doc, but that we keep this at a level where we say what we know, which is often only at the aggregate level, not at the individual level.

The last point that I would make, if I could, is to re-emphasize -- Val, I think you know, multiple people are saying the same thing that you just said. The charge was to look at quality, access, and availability, and I guess you can summarize that and should summarize that as value. Cost isn't actually in our charge, but that's -- well and this is the conundrum I keep coming back to, and I asked that question at the last meeting as well. And you're right. I mean, several people said, no, cost is part of it. That's the part that I'm still struggling with because, if we want to look at quality, access, and availability, if we want to look at value, that's a very different discussion than looking at just cost. Those are not the same things, and I still need help understanding, is our goal, much like the Medicare or the Medicaid Council or Committee that's meeting right now and looking at the cost Medicaid, to identify where to save money, or is our goal, as laid out in the first paragraph of the enabling legislation, quality, access, and availability? I'm not smart enough to connect those dots right now.

COMMISSIONER DAVIS: So I'm sorry; I didn't mean to react like that, but you cannot measure value without knowing what you're spending. You cannot. Value is what you get for what you pay. Paying three times more for an air transport on a non-certified carrier versus a third on a certified carrier is not value. And if you don't know the price, the people who

were making those decisions were -- they thought they were making value-based decisions and they had reasons for it. It wasn't just random, but once price was brought into the discussion, then they understand value and that what they thought they were getting wasn't worth what was being paid. So you can't get to value without knowing price, as an economist or any other, you know, view of this. And I would just submit that you can't get to access without understanding why is it that we're spending twice as much per person, per month for similar populations as people who live in Washington. And why is it that Medicaid is spending four times as much? And so you've got to understand where you are and what that is before you can even start to talk about value because, are we spending it on things that make sense? Great; then that's value. If we're spending it on things that don't make sense, like triple for an air transport, that's not great. So that's where, to me, cost is -- this isn't about cost, but you can't get to solutions without understanding the cost. And so it's just fundamental to us being able to take any meaningful action. That's my view. Thank you.

CHAIR HURLBURT: And from the establishing legislation;

(Whereupon a portion of the AS 18.09.070 was read as follows:)

Duties of the Commission.

(2) A strategy for improving the health of all residents

of the state that;

(A) encourages personal responsibility...

(B) reduces health care costs...

(Whereupon reading of a portion of the AS 18.09.070 was concluded)

CHAIR HURLBURT: And then it lists various ways through that, but I think it's pretty explicit that it's in the law. And in talking with some of the members of the Legislature and asking them this question, they said absolutely.

COMMISSIONER ERICKSON: Pat and then Paul and then Emily and then I would like to try to wrap this up with some summarization. I don't think we're disagreeing, but I think folks are pushing back on use of terminology and actually meaning the same thing. Pat first.

COMMISSIONER BRANCO: So at the risk of repeating, I just want to emphasize Jeff's point. These are overlapping equations. The value equation is really simple; value equals quality divided by cost. We define quality broadly by access and utilization and all of the other factors. So I think Val's point of what we're really aiming is, how do we determine value and really start to nail that down into what we're going to do as a purposeful outcome?

CHAIR HURLBURT: Emily?

COMMISSIONER ENNIS: I believe we have a very complex charge here in the statute. I believe value also is related

to patient satisfaction, the outcomes they hope to achieve, perhaps also related to the evidence-based models of practice. But I am concerned that, if we don't look at cost, we won't be able to improve access and availability, unless we really want to increase the percentage of the GPI. And so as complex as cost seems to me, me and my business have dealt very little with the price of the health care cost that you're talking about. I do understand why we need to look at it.

CHAIR HURLBURT: Paul? Keith? Val? Anybody else? Pat?

COMMISSIONER DAVIS: Mr. Chair, if I could submit another pithy phrase here, when the horse is dead, dismount. So perhaps we've beaten this one to death.

CHAIR HURLBURT: (Indiscernible - no mic)

COMMISSIONER DAVIDSON: (Indiscernible - no mic)

COMMISSIONER ERICKSON: So we did start wandering a bit into strategies, and we're going to talk about potential strategies to study more tomorrow, but this was a real good lead-in for the conversation that we'll have next. But just to wrap this one up -- and actually I'm going to jump ahead just a little bit before I go back and wrap things up because one of the things -- I'm going to jump -- well look at our pyramid, our Health Care Transformation Pyramid, and partly because we only had three sides and not four for our four goals but also because in identifying potential strategies we found -- and I'm going to jump ahead even further to the

potential strategies that we had laid out in our 2009 report. Looking at potential strategies for addressing cost or quality was impossible. Any of the strategies that were designed to address one of those aspects of value automatically addresses another one. It really became impossible to separate and put a group of strategies into a cost control category and separate an additional set of strategies into just value and quality category. And so we did combine, at one point, the cost and quality considerations into a single value goal, and we don't want to lose the focus on the cost. I think the reason that you're hearing the word cost so much, I think -- I believe that what some of you might be feeling is that the focus on the issue of cost and concerns about cost means that we're going to focus on strategies just to cut costs and leave some of these really important consideration aside. I believe the reason you're hearing the concerns about cost come out so much is there really is a sense of urgency in our department right now. I mean, you can't walk down the halls and not feel it with -- we heard at the last meeting that we're anticipating our Medicaid costs to be $300 million higher, 25% higher than what had been projected for this current fiscal year, and understanding the impact on state government budgets overall as well as other department programs of that kind of cost escalation, and being concerned about what that's going to do to access, hearing about -- I mean, I've never heard

another state raise the concern. I wouldn't have even thought it was a possibility that a state would consider eliminating their Medicaid program, never even used to think about it as an optional program, and the day I saw -- just a couple of weeks ago -- the survey that was circulated to all Medicaid State Directors across the country asking if they're considering eliminating their Medicaid program -- and then, you know, the fear about what that would do to our health care delivery system and to access for our most vulnerable patients in this state.

So I think the reason you're hearing the emphasis on concerns about costs are because of that, but I think we also understand and agree from our learning the first year that we can't separate cost and quality in our conversations and in thinking about what potential solutions might be.

So I just wanted to make that point before I go back and try to make sure -- I feel as though I have some direction from all of you as far as our next steps.

So right now these are still the six ideas I have for studies, and I won't summarize again the points that I thought I was hearing from all of you, but I mentioned earlier that I needed to make sure that I'm including some important aspects --so what we're asking the consultants to do in all of these -- the scope of work for all of these contracts. And so you understand, I'm moving forward with those top three right now.

So if you need to stop me, now is the time to do it, or if you need any additional direction or clarification beyond what I have written on the flip charts on the walls at this point. But we have RSAs in process with University of Alaska. RSA stands for Reimbursable Service Agreement. It's just a contract between state government agencies and state of Alaska system is what that means. Yes, Keith?

COMMISSIONER CAMPBELL: In the negotiations for these studies, what do you anticipate the expanding scope of dollars because we did give you some direction, I think three items to add to that?

COMMISSIONER ERICKSON: I'm going to talk to them, to the University, about these first two, and the first one, again, being the impact of federal health reform. I wasn't necessarily going to bring in anything additional to that, and that's just more informational big picture impact of that particular legislation. But the health care costs in Alaska, I definitely want to -- will go back and talk with them about that. My sense from them is that we were going to get that already from the conversations I've had with them, but I will be real clear that we're hoping to get that. So the price already went up once, based on some stuff that I added after our last conversation. So it might, but I don't think -- if it does, it won't be significant.

For the impact to the federal law, I'm expecting to the

final report in January. And then for the health care cost analysis, big picture cost analysis, I'm expecting to get the final report in March. And I'm hoping to start the competitive solicitation process for the health care pricing study in December and have that contract in place by January and don't have a sense for about how long that would take. Some of you probably have more experience in how long that might take, but I'm hoping that we would have that by June. Six months sounds reasonable?

So I want to ask questions about these other three that I haven't started yet, but before I do that, now is the time to stop me on any of these first three and to provide any additional direction and clarification, if you want me to continue moving forward.

I got one thumbs up. This is a "speak now or forever hold your peace" if you don't like what we're doing. I've got two thumbs up and some nodding heads.

COMMISSIONER MORGAN: Are you saying in addition to what we talked about as far as addressing access, availability, and quality, or are you saying that we will not address access, availability, and quality with any of these projects?

COMMISSIONER ERICKSON: No. What I'm going to do is work with ISER and the two contracts that were further down the road on getting in place to address the issues that were raised today regarding what we want to make sure was included

in the scope of work, so to the extent that they're able to help us understand the outcomes associated with the cost, the cost of health care in Alaska, and also -- I'm just scanning now; I have too many pieces of paper on the wall -- if they're able to help with identifying any links between outcomes and costs in this specific study, and then asking them if they can also provide some suggested solutions and that each study should include what we should change. So this is the point that you're getting at.

So that was the other point that I had mentioned earlier, what could or should change to improve quality, accessibility, and availability? So that's specifically what I'm going to back and ask them, but specific just to the health care cost analysis, big picture cost of health care in Alaska. But then we'll make sure that, as we drill down into the detail that will go into the RFP for the Health Care Pricing Study, we'll make sure that those aspects are included as well.

Now we're being pretty informal in not taking formal votes on some of these decisions, and if at some point you all would feel more comfortable with us taking formal votes, we'll do that.

So then on to the next three areas of potential study. For Health Status in Alaska, I had included in your packet -- again the reason I asked Dr. Fenaughty to make a presentation on Healthy Alaskans is that I wanted you to just understand in

general what that initiative is all about. And again it was the first thing I thought of when I heard at the last meeting that you all wanted to have more information on health status in Alaska, that this is the one place, but it happens once every ten years where current information gets compiled.

I also included in your notebooks -- and again we're still behind tab five. So behind those two contractual documents, there is a document called Alaska Scorecard and this is a data summary that the Department produces on an annual basis. It is specific to key issues impacting the Mental Health Trust Beneficiaries, but I don't believe any of this data -- I didn't actually study it carefully -- is specific to that population. It's just these are indicators that are important related to understanding issues for this beneficiary population. I provided this -- you have the summary Scorecard which is just four-pager and then you have the more detailed. It's probably 40 pages providing more drill down information on each of these indicators.

And then behind that, the 40-page Scorecard, is Health Status Indicators, Alaska Health Status Indicators produced by the Alaska Division of Public Health. This is the most recent annual report. It was published last December, and they've already started working on this December's will include 2009 data. This is a set of key indicators from Healthy Alaskans 2010 that the Division of Public Health makes a point of

tracking. And so out of the 300 or so indicators in here, in the Healthy Alaskans 2010 document, there are 25 or so that the Division of Public Health specifically tracks. The reason I included these two documents -- and I checked with a few Division Directors and also with our Commissioner -- as far as any of us are aware these are the only two documents that are produced on an annual basis that provide a summary of just a few key indicators of health status of Alaskans. And so I wanted you to see that. Those are two examples of documents that are produced on an annual basis. And I wanted you to understand the potential of what we could have -- what we do have available, but it's now very outdated data, in Healthy Alaskans 2010 and the potential of what we could have in a Healthy Alaskans 2010 if the Department were to do that, and then didn't even realize that the Division was in the process of considering or thinking about or at least pushing for this online data system that could make this data of the Department even more readily available for other purposes as well, even for coalitions maybe meeting at the community level to assess their community health and come up with local strategies for improving their communities' health, how that could benefit them.

So it wasn't meant to be a commercial for that, but it's something probably we should consider in other strategies. But I wanted you to have a sense of what we do have now for

health status. And so my question for you is, have you thought through or do you have a good sense in your mind of what you feel you need for information about the health of Alaskans? Is just having these summary reports enough or do you have other questions that we could ask the Department of Health and Social Services to answer? Or do we need to do something more? Do you want to commission a special study to answer some more specific questions about health status in Alaska? Wayne?

COMMISSIONER STEVENS: What is the cost of doing this Healthy Alaskans study? And the reason I ask is, is the information here gathered in 2005 substantially different than the ten years of '98 to 2008, and what value do we get from doing another one? I mean, is there a trend that shows things are changing dramatically one way or the other that would provide extra value of paying for this study at this moment? Are we going to get some additional information that's going to provide us an aha moment? I mean I guess you know, I heard it would be really nice to do this again.....

3:51:23

(Due to a power failure of approximately four minutes, this portion of testimony is not available)

3:55:23

CHAIR HURLBURT: .....and they're not bad. And the Feds are pushing that. I see that as one of the good things in the

health care reform legislation, that we'll get pushed to do that, but I think we're going to want to look at that every year. Anybody else? Yes, Wayne?

COMMISSIONER STEVENS: I still didn't hear a cost of this Healthy Alaskans. Ballpark, anybody have any idea?

COMMISSIONER ERICKSON: It actually could vary pretty significantly. The first -- one of the things that maybe didn't come across as clearly and wasn't as an important a point specific to just wanting the data, but there is a process involved in just deciding what indicators to include in each of these areas. For most of them, different coalitions were created in both the Healthy Alaskans 2000 and Healthy Alaskans 2010 processes. And they worked to not only identify an agreed upon set of indicators that they thought were the most important for understanding that particular health issue or area of focus that they were looking at, but they also worked together to identify some strategies for moving forward and making improvement in each of those areas. So there is also kind of a health improvement planning process that goes along with this, so understanding that it's not just data compilation is important.

Healthy Alaskans 2000 was a minimal effort compared to 2010, and there basically was just a commitment made on the part of our Commissioner at the time at the Department of Health and Social Services to assign a health planner for a

year and to direct all of the different programs that are involved with the various focus areas to participate in the process. And so costs probably came down to, as far as what the Department was shelling out, maybe $100,000, plus however much it cost to produce the report.

This broader effort took two or three years, lots of people involved, a few on payroll, but they were all funded by the Robert Wood Johnson Foundation under another initiative and that's too long of a story, but probably more like $500,000 compared to $100,000. It was just a lot more people spent a lot more time and there is a lot more data in here, and probably either one; you're just getting a little different product but for a very different price, but that's at least a ballpark.

And I don't think I was suggesting that the Commission would want to fund entirely, but might want to make some -- might want to contribute to part of the data collection aspect. I was just trying to come up with ideas of what you might want next and you maybe don't want any of these. I was just trying prime the pump a little bit. And if you think you've learned enough about Healthy Alaskans at some point and you want to learn a little bit more and make a recommendation to the Department related to it, that's another question. But I'm not sure if you want me to look at contracting with a consultant to look specifically at health status, if there's

enough from what we have here for you to do some -- develop some understanding, if you want me to identify some other additional factors, indicators that you want me to look at, pull data together for you? Val?

COMMISSIONER DAVIDSON: I'm trying to figure out what you're talking about. I'm sorry. I'm constantly confused and perhaps I'm the only one. But I want to make sure that, when you ask the question and you're answering, we're talking about the same thing when we say Healthy Alaskans. Are we talking about what would it take to produce a Healthy Alaskans 2020, including volume one and volume two or just a part of it, or are you talking about a different report?

COMMISSIONER ERICKSON: The other report I'm waving around is Healthy Alaskans 2000.

COMMISSIONER DAVIDSON: So was your question, how much would it cost to produce Healthy Alaskans 2020? Okay.

COMMISSIONER ERICKSON: And I don't think that's quite been quantified, but I was just giving the range of two different processes that, I would imagine, could between $100,000 and $500,000.

CHAIR HURLBURT: I think there's a lot of interest within the Department on doing this and perception that it is of value to set benchmarks, so the commitment is there. As I say, Bill Hogan said we'll do it; we'll figure it out. And I say, we'll try to hang that on his successor. But I think

that the reality is, is that there is no way we're going to come close to a $500,000 product, that it'll be the $100,000 product, and the $100,000 will be in-kind. It'll be, you know, some modest printing costs, but taking existing staff, saying you figure it out and the duties that you have, like in the Planning Office there in Juneau with Pat Carr and Alice Rarig, probably some help from Kathy O'Laylick (sp) in Chronic Disease and Andrea where they're very interested. So I think my prediction is we'll figure it out, but this will be the model. It'll be the $100,000 model with the cash expense being largely for printing, I would say; would you agree?

COMMISSIONER ERICKSON: Yeah. And maybe I need to back up. I maybe was asking the wrong question or I needed to ask another question first.

The first question, the main question is, would having this book updated -- assume you don't have to pay for it -- going to give you the information you want on health status in Alaska, or do you want something different?

UNIDENTIFIED COMMISSIONER: Ten years from now?

COMMISSIONER ERICKSON: No, you wouldn't have it have ten years from now. If the Department started the process now and didn't do quite so involved of a process as this, you would have that information within, hopefully, a year if they started it soon.

COMMISSIONER FRIEDRICHS: So from the standpoint -- again

just as an observation from the federal agency standpoint, we collect this data in real-time. We display it in real-time. We use it for planning purposes in real-time. And I guess I would ask you to consider a slightly different option, which someone had touched on previously, and that's, rather than doing a report every five or ten years, we move towards a stated-funded data repository which displays this information so that anybody can look at it. The Mental Health Trust can look at it for what they need. We can look at it or the son of this Commission can look at it or daughter of this Commission. Whoever has an interest in health care outcomes would have access to it. That's really, I think, where the IOM is trying to drive organizations and where many states have gone already, rather than doing the individual reports. The challenge with the individual reports is you've got to remember where you put the book. You've got to flip through and find whatever you're looking for, and they are almost out-of-date as soon as they're published. A real-time data repository where folks can input their data and anybody can use it is a much more long-lived and valuable contribution.

CHAIR HURLBURT: And a lot of that -- Deb, I'd have to ask you again, but a lot of that exists now. They are regular periodic reports coming out of the Bureau of Vital Statistics. That would be mortality data based on X condition. There is data that comes out regularly from epidemiology folks. It

talks about incidence rates for various conditions. There is data that comes out of the Chronic Disease and Health Promotion related, say, to the Cancer Registry. We have the Trauma Registry. We have a number of reports that do regularly come out. And maybe what you're suggesting is.....

COMMISSIONER ERICKSON: How about some examples?

CHAIR HURLBURT: Yeah, okay. I don't know, Deb. Like I said.....

COMMISSIONER FRIEDRICHS: Right, but that's point my right there. That's exactly my point right there, if we want to shape health care outcomes, if part of what we're driving towards is improving quality, access, and availability of health care and we want to influence someone who is in private practice, federal practice, wherever, that won't do it. Where it does work -- and I was here for that. The New Mexico approach is a great one. There are several states that have done that, where it is on the Web. Anybody who cares can go and readily find that because it's right there. Virginia does a nice job, if remember correctly, also with that, where it's readily available. And so you can have the nurse practitioner or dietician or whoever cares enough about an issue go the website, find the data that he or she is interested in to support what their looking at, and then make changes at the individual level. This gets back to, I think, some of the things that we've been talking about here.

COMMISSIONER ERICKSON: Wayne?

COMMISSIONER STEVENS: And I think that's the essence of where, I think, we ought to be going because to spend whatever it took for this one a year or two from now isn't going to help us in our deliberations for the next year-and-a-half or two. And what we need is information in the next quarter or the six months that will help us make really good decisions. We've got a lot of data. There's a tremendous amount of data there. Maybe what we do instead of report is take some of the funds -- and we've only got a budget of $500,000. Now in my pocketbook, that's a lot of money, but in this arena, that's not a lot of money and it doesn't take very long to squander $300,000 or $400,000 grants and we're out of money. And so maybe what we do is look at gathering the data we already have available to us, epidemiology, vital statistics, and start pulling them all into one repository on the website where people can start to access it. We can start to encourage people to use the information readily available, and then as time goes on and these other groups and entities are creating their annual report, they can start migrating it into electronic process and become far more timely and far more cost-effective.

COMMISSIONER BRANCO: And just to demonstrate that Jeff isn't the only one with pithy old sayings, necessity may be the mother invention, but scientific curiosity is going to be

the path to solutions. And having some of this data in a single source that the question, the "what if" question or I wonder why this is occurring, will put the scientific minds to work.

COMMISSIONER ERICKSON: Yes, Paul?

COMMISSIONER FRIEDRICHS: So the question that we may not have talked about yet is value. And when you asked, what is the other question we need to answer, again I'm not smart to go through this binder and all of those reports and be able to intuit where to spend the next $10,000 or $10 million to have the greatest impact on value or on quality, access, and availability. If I were going to pay for a contractor, that's the question that I would ask them. With everything that we know about health care today, with all the data that we have about what's good or bad in Alaska, highest injury rate, highest suicide rate, highest STD rate, where would we spend the next dollar, $10 million, whatever it is, to have the greatest impact on quality, access, and availability?

I think that's the charge to us, and if they come back with a menu that says you can spend, you know, $100 million and have perinatal care provided for every pregnant woman up to the best standard and you'll save this many children and you'll save that many lives along the way, or you can spend $10 million on obesity by putting only these foods into the schools, that's where we then can make some prioritization

decisions and say, wow you know, that'd be wonderful if we had $100 million, but let's go with the -- let's recommend the $10 million solution right now. And when I said before that the enabling legislation didn't mention costs, I'm going back to that initial paragraph that's in there. I mean, I'm taking that as the overarching goal is quality, access, and availability, and there's a lot of subsets behind all of that there. This is where I think a good contractor can help us by going through that data, someone who understands health care better, certainly, than I do. I know how to run a hospital, but I do not know where to spend the next dollar in Alaska to improve quality, access, and availability.

CHAIR HURLBURT: That's a pretty tough question to answer.

COMMISSIONER FRIEDRICHS: So I'm not as dumb as I think I am.

CHAIR HURLBURT: And you know, that's the Holy Grail maybe, to some extent, but it's not an inappropriate question but I don't know that we have the resources to get somebody to do that. But because it is the Holy Grail, are you suggesting that Alaska could be a laboratory and that Deb could explore us partnering with Robert Wood Johnson or with somebody else who has far deeper pockets than we do and asking that question, come help us answer it? And yeah, we want to know the answer for Alaska, but that's the answer for everybody.

COMMISSIONER FRIEDRICHS: Now wearing my federal liaison hat that can't speak to how you all appropriate or distribute Alaskan money there, yes.

COMMISSIONER ERICKSON: So what I'm hearing is that we don't need to spend any money on studying health status. The Commission does not right now specifically. But I have put as a placeholder in our parking lot, recommend areas for potential recommendation, that you all might want to recommend that an online data systems that's interactive and keeps information up-to-date and readily available just to the general public, let alone to health planners and policymakers, so that's on our parking lot for recommendations. So we're not going to spend money specifically on health status, but might make this recommendation related to it.

I'm trying to understand if we can get at questions about health service utilization, if we need a special consultant to do that, if we are looking for a consultant to help us define our solutions for increasing accessibility and availability and quality, if this could just be a component of that or if we don't need to look at service utilization specifically, if we're going to ask that broader question.

I'm thinking tangibly about what scope of work I'm going to write next and maybe I just need to go away and come back with a recommendation for you, unless you think we need a specific study, if somebody feels we need a specific study on

health care service utilization in the State?

COMMISSIONER DAVIDSON: Well I guess I'm wondering if we need to spend all our money today. So for example, we may get some information back or maybe while it's happening and as we move forward we may have an urgent need for more information, and we should have the flexibility to be able to go out and get it quickly.

COMMISSIONER ERICKSON: I'm seeing some nodding heads and a thumbs-up; does that sound good? And in the meantime, I'll explore relationships with foundations and look at what other states are doing to answer this question specifically. Emily?

COMMISSIONER ENNIS: Is there any information available right now, perhaps not current but fairly recent, about this data?

COMMISSIONER ERICKSON: The health status data?

COMMISSIONER ENNIS: No, the health care services utilization.

COMMISSIONER ERICKSON: Off the top of my head, I would think we could ask the State Medicaid Agency. It would be specific to Medicaid again, but it's the one place we could go.

COMMISSIONER ENNIS: And secondly, what would be included in this? I'm thinking that, if it gives us a baseline of use of services, it's something against what we could measure increased access or increased availability. I don't know. Is

that the data that would provide that base for comparison?

COMMISSIONER ERICKSON: What I was imagining is that we would use national averages as, at least, a starting point for comparison. I think what I'm hearing is that we should hold off on this one for now, and in the meantime, I'll look for another consultant who can help us with some health policy strategy suggestions. Noah?

COMMISSIONER LAUFER: I don't want to harp on this too much, but I think we all understand that the State has a lot of problems. People are sicker than they should be. We pay a lot more. But there are a lot of issues there, like the State Department of Epidemiology website. I go to it and it's very interesting to me, but because it's aggregate, it's sort of not applicable to me or my patients because it's the whole state. The data is skewed terribly by other parts of the state, other populations and all that.

I'd like to know specifically, what are we buying and how much are we paying for it? You know, this revelation about the cost of the Medivac flight, to me, that's huge because that means every other data set -- every other person in that data set, that data is greatly skewed by $150,000. So if I look at that and it says, boy, to take care of a patient with CHF, we sure do a bad job, I feel better because I don't order Medivacs. And it shouldn't -- you know what I mean? I actually think -- I really do think it would be useful to get

an itemized bill or a set of them from patients and we just look at, boy, why could it cost a million dollars to care for this person this year? I know that that's not -- it's really anecdotal, but it's still helpful for shock value, do you know what I mean, if nothing else because that's really the question. Why are we paying so much and what are we getting? And we already know things are bad. They were -- it's very unlikely that, from the 2010 report to 2011, it's suddenly going to get better.

COMMISSIONER FRIEDRICHS: I thought that was purpose of the second and third studies that we had talked about on the prior side, the cost, pricing piece, and the health care costs or what it costs for services that are provided.

COMMISSIONER ERICKSON: The health care costs, that's probably not a good title for it. It's Health Care Expenditures in Alaska. It will be a pretty high level aggregate view. It won't get at the level that Noah is suggesting. Health pricing, I'm not sure how aggregated -- if the data that we'll be getting will be so aggregated that we're not going to get at Noah's question, and if we need the utilization to get at Noah's study, is that what you were suggesting?

COMMISSIONER LAUFER: It just seems like the opportunities for cost saving are actually specific and may be specific to a category or a specific disease state or a region

of the state. It's hard to say. I mean, it's so outrageous. When I ask people to get itemized costs or bills from the hospital and go through them and check them or get an accountant or a lawyer and go through them, it's not unusual for them to contest it and get $40,000 back. I mean, where else in your life would there be an error of $40,000 that just, boy, we didn't see that on your home mortgage. Sorry. Here's a check. I mean, it's huge amounts of money and it is all in the details.

COMMISSIONER ERICKSON: Well what if we go with the suggestion that we start with what we have now, health care expenditures big picture in Alaska and health care pricing and see how much information that gets us? And maybe even in the course of working with the consultants on those two pieces, we can try to get more specific in the questions and get some advice from them on how we answer these other more detailed questions about utilization. Does that make sense? Folks are nodding their heads.

The last question, as far as our study plans go, is related it workforce. And in the interest -- unless we have some clear help right now or you want to come back in the morning with some more specific suggestions -- I went back, and since I didn't have the transcript yet just to put together this meeting summary, I listened to the recording of our meeting several times. You all sounded very intelligent.

I listened to it over and over and over again. But the question was still broad enough in my mind I couldn't get at a more specific scope of work to even start to draft it.

And I was just talking to Jan Harris over the lunch break and suggested to her that I'd really like to sit down with her and some of the folks on the Workforce Coalition to see where they're going next with this strategic planning process for workforce in terms of how they're going to prioritize those -- how many did Jan say -- the different actions items? There were 1,000 different action items in the current plan. So getting down to the strategic part of that, what is the most important thing to do first and next, and what they want to do to study more to get the answer to that question to see if we can maybe align and add value to their process in trying to help answer this question. Unless you all have -- want to push me to do something more specific now or want to clarify that a little bit now, my suggestion is I just go back and work with Jan and other folks who did all this good work on the Workforce Plan that I'm pointing to right now. I'm seeing nodding heads for that, too. Anybody want to provide additional clarification or give additional work direction to me?

COMMISSIONER FRIEDRICHS: This is coming up at the meeting on Thursday that I'm attending and the meeting on Friday. It's going to be at ASHNA and also at the Federal

Health Care Partnership. Part of what we've struggled with from the federal side is, where do we support Alaska? You know if it costs $50,000 a year per medical student, how many of those medical students graduate and come back to Alaska? If it costs $100,000 for loan repayment for a doc, how many of those docs stay there? What's the return on investment for the different options that are out there?

COMMISSIONER ERICKSON: I had heard the question that was asked by this group at the last meeting when we were discussing this particular project specific to physicians and I didn't mean to ignore it, but I did. Actually I did mean to ignore it -- I'll be honest -- just because it was specific to physicians and I thought it was put out just as an example. If you want me to study the question about physicians specifically, we could do that.

The reason the Commission focused on physician workforce issues in the first year was because we had very, very limited resources and time and the Physician Supply Task Force, whatever the name of that group was, that study had just recently been done and come out. And so it was something tangible that we could get a hold of that we had data from that we could look at to a real specific problem that we thought was real important, but we had a lot of pushback from the community generally and some criticism, due to the fact that we looked just as physician supply and not at other

health care workforce issues.

So that being said, understanding that I just took this suggestion at the last meeting about cost benefits specific to a couple of specific strategies for physician recruitment and retention, if you want me to investigate a cost benefit study for physician recruitment and retention, I will do that.

COMMISSIONER DAVIDSON: I think there's a lot happening already with physicians. I mean, I see that happening all over the place. There's reports, and people are very invested in that process. What we don't see though are looking at what I'll call alternative provider types, whether they are community health aides or behavioral health aides or dental health aides or dental health aide therapists that are models that are working in many parts of our state.

And one of the challenges we have is, are we really marketing those opportunities to show that we're making progress or not? I think in some cases, we're not. For example, Ward, you mentioned earlier today the fact that the immunization rates in the tribal health system are so high. It isn't because of the physician predominantly. It's because of the community health aides and the community health practitioners. And if we didn't change their scope of practice to allow them to be able to do those immunizations and EPSDT exams, then we would not have been able to achieve those levels. So I think looking at how we deliver health

care should be beyond just the traditional provider types of how we go about doing that.

COMMISSIONER FRIEDRICHS: Yeah. I absolutely agree and was not in any way suggesting we only look at physicians, but I do think, if our charge remains quality, access, and availability from a workforce standpoint, where do you spend your next dollar? Where do you get the biggest return on investment? What have we gotten? And the community health aide programs are wonderful. We know that we couldn't get physicians to go work in Selawik or any number of villages out there and so the health aides have provided access.

The challenge is going to be how many do we need. You know if we spend -- if the Legislature will spend $10 million, they can get blah for that. You know, that's the sort of analysis that, I think, we could bring forward to say, for this amount of money based on what's happened thus far in Alaska, you can get this and we would recommend you do so. That's a very specific, concrete, tangible, actionable recommendation from this Commission that would help drive this forward. Val, you're exactly right. There is a ton of stuff that's out there. Our frustration -- we've looked at it from the federal side -- is a lot of it is sort of motherhood and apple pie. There should be more, and everybody from every discipline says there should be more and here are 18 ways to get more. Well which one of those 18 ways is the least

expensive but gives the greatest return? That's value and that's the part that I've not seen, and we've actually asked the specific question with the residencies, with the nursing school, the dental hygiene program. That's really what we're driving at.

COMMISSIONER ERICKSON: And I think that's what I want to ask the Workforce Coalition that's been meeting for a few years and that's produced this plan now and that has the federal dollars to develop a strategic plan to implement this, is if that's what they're planning on doing next and if we can work with them to add value to each other's work. And if not, if they're not planning on doing that, then we'll come back and revisit this question and see if we can get a good scope of work formulated and figure out how much it might cost and the right type of consultant to work with. Yes, Larry?

COMMISSIONER STINSON: Ultimately what Paul just said is exactly what the Legislature is going to want to hear because, ultimately, we're going to be talking to the Governor and the Legislature, and if we're speaking in general specifics, yeah, we need more health care, but if you can say you spend $10 million and you can get so many health aides, so many nurse practitioners, so many PAs, so many physicians, that's what they're going to really want to hear.

COMMISSIONER ERICKSON: Any other thoughts on the workforce question? I have marching orders. I will follow

them. Thank you. And I'm afraid we're out of time and aren't going to get to our next question. I was worried that we weren't going to have enough work to do tomorrow and that we would end early. Now after this great conversation this afternoon, I'm worried that, if we add this afternoon's remaining agenda item, we'll be here until midnight tomorrow. But we'll just take a stab at it. If you all could remember that homework assignment is behind tab six now, the one that you got a couple weeks ago but you have an extra copy of it behind tab six. And what we're going to be doing next is just revisiting -- hopefully very quickly; we'll try to go through it quickly first thing tomorrow morning -- questions one and two to make sure that the planning process is clear. I think we're pretty close with in answering your questions. The goal statements are clear enough.

Paul, I think you were the only one who missed it. First thing this morning, I apologized for, at our first meeting last month, I actually hadn't included -- I just had the bullet -- the one or two words about what our goals are, but we had approved a full sentence for each of those. I thought maybe that would help clarify it. That's in the front of your book behind tab two, if you want to take a look at that. And also the question about whether the indicators -- not whether we have the right list of indicators yet -- I'll think we'll work on those in 2011, but whether having that list of the

kind of four key indicators for each of those four goal areas also helps clarify what our goal statements mean.

And then suggested changes for Health Care Transformation Strategy. Look at your meeting guide handout. There is one suggestion. It's not necessarily the best suggestion, so I hate to even suggest it without a conversation, but something to think about. A couple of changes to that pyramid appear on slide 26.

I think some of the big questions, if you look at the questions I've posed there, should we expand our focus beyond primary care and work on improving care across the continuum of care, or do we still need to maintain, make sure we don't lose the focus on the importance of building primary care and somehow keep that in there, but still make sure that we're addressing the full continuum of care? And I've just asked questions about different ways we might break it out to prompt some thoughts. Do we break out the consumer's role completely separately and identify some other issues that came up today with transparency to enhance the consumer's role?

And another question on statewide leadership, I just wondered if we should re-frame that to indicate that we're really focusing on the policy environment and thinking of these three base pieces as the foundation of transformation of the health care system as making sure that we have adequate workforce, strong workforce, good Health Information

Technology systems in place, and a sound policy environment for supporting then all of the transformation work that the health care system will drive. So that's just something that you can be sleeping on that we can talk about first thing tomorrow morning.

And then I'm hoping you all will have thought a bit about specific language you might want to propose for recommendations related to evidence-based medicine that we would include in the 2010 report. And then we'll wrap up with the review of the list of potential strategies. Again if you look at that handout in the front of your notebook, I've highlighted in orange the suggestions that I did get from folks who responded. In green are the areas that we're already moving forward and making recommendations, and we'll do more work in the coming year, I'm imagining, around fostering primary care innovation and evidence-based medicine. But one person suggested, in addition to those, leveraging state purchasing power, bundling payment systems, and increasing cost and quality transparency and had prioritized those one, two, three. So those are those numbers.

And then at the very top of the page, Access to Care in orange again, there was just a recommendation that we work on strategies related to Access to Care.

So that is what we will discuss tomorrow, and I thank you all for your thoughtful discussion today. This has been

really helpful for me.

CHAIR HURLBURT: Let me ask you first, Deb, and then turn it to the group depending on what you say, are you concerned enough about our ability to get through the agenda tomorrow that we should consider moving up the start from 8:30 to 8:00?

COMMISSIONER ERICKSON: No, but that's very selfish thought because I have to drive in from Girdwood.

CHAIR HURLBURT: Because I think you've got the best judgment. If you're in no -- I don't think anybody else is going to argue with you.

COMMISSIONER ERICKSON: We got lots of thumbs-up on that one. So our start time tomorrow will be 8:30. If I get in early, we can go to breakfast. Any final questions or comments before we recess for the day?

CHAIR HURLBURT: Can we leave our materials here?

COMMISSIONER ERICKSON: That's a good question.

CHAIR HURLBURT: You wouldn't?

COMMISSIONER ERICKSON: I would recommend not, but I don't -- we have a different technician. Chris is gone. But are you all going -- will IMIG leave all of the sound system set up over night? The setup is going to be the same, and they'll probably, I assume, have the doors locked to protect the sound system equipment. So I guess I wouldn't leave my purse and my laptop here probably, but you're probably okay. Actually you're not allowed to leave your notebook here

because you're supposed to take it home and do homework tonight. Any other questions or comments? Any final word from the Chair before we recess for the evening?

CHAIR HURLBURT: I think we're adjourned. Thank you all.

4:31:58

(Off record)

SESSION RECESSED