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ALASKA HEALTH CARE COMMISSION

JANUARY 7, 2011

8:30 A.M.

3601 "C" STREET, SUITE 896

ANCHORAGE, ALASKA

P R O C E E D I N G S

1  
2 8:37:00

3 (On record)

4 CHAIR HURLBURT: We can probably go ahead and start. I  
5 think we have a quorum. Pat.....

6 (Pause - background discussion)

7 CHAIR HURLBURT: I think Pat Branco should be here  
8 shortly. He's expecting to come, and I saw Jeff Davis  
9 yesterday and I know he's expecting to be here so probably  
10 will be here shortly. I think our two Legislators will not be  
11 here. They're both recharging their batteries right now,  
12 getting ready for their marathon that starts here in a couple  
13 of weeks down in Juneau. So I think we'll probably wish them  
14 well as they get ready for that. I think everybody has  
15 received the agenda that we have here. Are there any comments  
16 or questions on the agenda that you have? As Deb indicated in  
17 that, we'll have some flexibility. Not really quite sure how  
18 long some of the scheduled sessions will run and we gave it  
19 our best guess, but we may rearrange it a little bit there,  
20 depending on how things move along. Deb, can you talk about  
21 the meeting rules? Val is not going to be here, but we did  
22 know that in advance.

23 COMMISSIONER ERICKSON: Yes. Right now, we do have a  
24 quorum. I just wanted to note that, and we are expecting Pat  
25 and Jeff to be here any minute and then we'll have ten of 11

1 voting members present. And our Legislators couldn't join us  
2 today. Senator Olson is in Barrow and Representative Keller  
3 is out of state at a conference. So we should just be missing  
4 one voting member today, who is also out of state.

5 What I'm going to do -- actually what I thought I would  
6 do is just take a minute to review what we're going to do  
7 today and then go over a couple of main points about the  
8 meeting rules. After our introductions this morning, we're  
9 going to spend up until the break working on the report. I've  
10 summarized, even more than the summary you received. I just  
11 kind of tried to pull out the main points from the public  
12 comments that we had received, and I want to review what I had  
13 identified as the main points. Rather than going through  
14 every single letter, even the summary of each letter that I  
15 prepared for you, go over the main points, see if you think  
16 I've left any main points out, and then I've organized those  
17 around the main questions that we want to answer, any of the  
18 comments specific to our 2010 recommendations, any of the  
19 comments specific to our plans for either what strategies  
20 we're going to study, what current issues we want to study in  
21 2011. And so I've organized them that way, and we'll take  
22 each of those questions together and see what other input you  
23 all have, what decisions you want to make about changes, and  
24 then we'll finalize that.

25 So the plan is to really finalize the work on the 2010

1 report this morning. The rest of the day, including the  
2 public hearing portion of the day, is going to be about  
3 getting our 2011 year started.

4 So we're starting with a couple of panel presentations on  
5 a couple of the issues that we had identified that we want to  
6 look into, strategies we want to continue studying in 2011.  
7 And then one of the members had asked at the last meeting that  
8 we do -- while we're not focused on the new federal health  
9 care law, we're not -- this Commission isn't charged with  
10 making recommendations it -- that we continue to get updates  
11 about what is going on in Alaska related to implementation of  
12 the new law.

13 So at the end of the day, as the Commission requested at  
14 the last meeting, we have some of the key lead officials in  
15 working on and responsible for anything related to  
16 requirements under the new law who are going to share with us.  
17 Two of the three are at the table with us right now.

18 One of the things I wanted to note just about logistics,  
19 for those who are joining us as visitors and observers, there  
20 is some light continental breakfast available. Everybody is  
21 welcome to that, as well as to the lunch. And for folks who  
22 are on the phone, you all are on lecture-mode for the whole  
23 day, except during the public hearing period from 12:30 to  
24 1:30.

25 One of the other things I wanted to note about the public

1 hearing session is that we have a guest from Washington D.C.  
2 Amanda Makki of Senator Murkowski's staff is joining us today,  
3 and we've asked if she could just, during the public hearing  
4 portion of the agenda, share with us a little bit about her  
5 perspectives from Washington D.C. and what's going on back in  
6 our Nation's capitol right now. So we're going to carve a  
7 little bit of time out during the public hearing to devote to  
8 a conversation with Amanda.

9 Other than that, one of the things I especially want to  
10 remind everybody, I wanted to point -- we'll see how this  
11 works. It seemed like we were all lost in a sea of  
12 microphones for the last couple of meetings and so we have  
13 fewer microphones and so you need to share your microphone  
14 with your friend next to you. Hopefully that will work, and  
15 if it doesn't, we'll go back to the full -- everybody with  
16 their own personal microphone, but we pay extra for each mic  
17 and I'm being real cheap, even though this isn't -- I was  
18 telling Sunny, our court reporter, this morning that I hope  
19 that somebody appreciated that folks we're being cheap --  
20 government officials would be cheap with money that's not  
21 theirs, which is why we're meeting in this room again. I know  
22 some of you don't think it's the most comfortable place to  
23 meet, but it's free and any of our other choices wouldn't be.

24 A reminder for all of you who are in the audience today,  
25 if you could please make sure you sign in on the sign-in sheet

1 in the back of the room, and if you're interested in  
2 testifying during the public hearing later today, there is a  
3 column for you to mark off next to your name if you're  
4 interested in testifying. It will just help us keep track of  
5 how many people to expect.

6 Related to the mics again, I wanted to make sure that you  
7 all remember that you not only turn your mic on when you're  
8 talking and off when you're not talking, you really need to  
9 keep your mouth as close to the mic as possible, and I think,  
10 it was especially difficult for folks on the phone to hear  
11 last time if people didn't have their mouths right up to the  
12 mic. So if you could try to remember that and then we'll try  
13 to remind you, and I need to be reminded periodically, too.  
14 Those are the main things.

15 Again if anybody in the room has cell phones, if you  
16 wouldn't mind putting them on vibrate, and I think we're  
17 probably good to go with that.

18 One of the other things that we're making a point of  
19 doing is just including the Commission statutory charge and  
20 the one-pager that I had put together at one point that quotes  
21 from our statute, our purpose and our duties. So we have that  
22 as a reminder as well in your packet.

23 One other thing for folks in the room, I have copies of  
24 the presentations for today in the back of the room. And for  
25 those of you who are on the phone, everything that's available

1 as a handout to folks in the room here is available on the  
2 Commission's website right now on the January 7, 2011 meeting  
3 page, and if you don't have the Commission's website handy, if  
4 you just Google Alaska Health Care Commission, that's probably  
5 the quickest and easiest way to get to that page.

6 I think that's about it. Dr. Hurlburt, when you do  
7 introductions, we're not going to -- the way we have the phone  
8 set up today, we're not going to be able to invite the folks  
9 on the phone to introduce themselves, but during the public  
10 hearing when they'll be off mute, we can invite them to do  
11 that at that point in time.

12 CHAIR HURLBURT: But we do want to include those who are  
13 all in the room, okay? Yeah, let's -- why don't we go ahead  
14 with the introductions now, and we'll go around the table for  
15 the Commissioners first and then turn to you folks here that  
16 we appreciate joining us today. Noah, if we could start with  
17 you, just say who you are and who you represent in a sentence  
18 or two about what passion brings you here.

19 COMMISSIONER LAUFER: Good morning, I'm Noah Laufer. I'm  
20 a family doc here in Anchorage in private practice. I've been  
21 here about ten years, second generation. I'm President of --  
22 or the current President of Medical Park Family Care. I'm  
23 here representing primary care physicians. Thank you.

24 COMMISSIONER STINSON: I'm Larry Stinson. I'm a  
25 physician in the state of Alaska. I went through the WWAMI

1 program. We have clinics all over the State, and I'm here  
2 representing the interests of the practitioners, but really  
3 the State.

4 COMMISSIONER MORGAN: Dave Morgan filling the seat for  
5 Primary Care Association and Community Health Centers.

6 COMMISSIONER ENNIS: Emily Ennis representing the Alaska  
7 Mental Health Trust and its four beneficiaries' boards. I'm  
8 also Executive Director of Fairbanks Resource Agency providing  
9 long-term care services and support to people with  
10 disabilities, having a workforce of about 400.

11 COMMISSIONER DAVIS: And I'm Jeff Davis and I'm the  
12 President of Premera Blue Cross Blue Shield of Alaska, and I'm  
13 representing, I guess ostensibly, the insurance industry, but  
14 more importantly, the people that use our services and the  
15 people who pay the bills, and my passion is to help create a  
16 sustainable health care system in Alaska.

17 COMMISSIONER CAMPBELL: I'm Keith Campbell. I hold the  
18 seat for consumers, representing consumers which is, I guess,  
19 everyone around this table and everyone in the State and will  
20 try to bring that perspective to deliberations. Thank you.

21 COMMISSIONER FRIEDRICHS: I'm Paul Friedrichs. I'm the  
22 Commander or CEO at the Air Force VA Hospital over at  
23 Elmendorf and represent the Veterans and federal  
24 beneficiaries.

25 COMMISSIONER HALL: I'm Linda Hall. I'm the Director of

1 the Division of Insurance with regulatory oversight of the  
2 insurance industry. So I'm a non-voting member of the  
3 Commission, representing the Executive branch of state  
4 government.

5 COMMISSIONER STEVENS: Wayne Stevens. I hold the seat  
6 designated for the Alaska State Chamber of Commerce and  
7 represent the business community who pays the bills.

8 COMMISSIONER ERICKSON: Deb Erickson, Director of the  
9 Health Care Commission.

10 CHAIR HURLBURT: I'm Ward Hurlburt. I'm the Chief  
11 Medical Officer of the Department of Health and Social  
12 Services and the Director of the Division of Public Health and  
13 the designated Chair for the Health Care Commission, and I  
14 will share my passion. I think that all of us in the room, as  
15 recognized by the really impressive group of participants we  
16 have in the audience as well as Commissioners, come with  
17 passion, knowing that we have a major challenge here in  
18 looking at health care in our country and our challenges in  
19 our state and that -- I think I said it once before, that it's  
20 very much cost-driven, that, in Alaska, we're spending 23% of  
21 our state's Gross Domestic Product on health care, at least,  
22 and continuing to go up, and it is forcing us to deal with it,  
23 but that because everybody in this room who does come with  
24 passion about that has commitment, has understanding, and  
25 knows that this is an industry that has unique moral and

1 ethical dimensions to it and that, if those of us who care  
2 passionately about it don't address that we have, sooner or  
3 later, others who don't have that level of understanding or  
4 passion that we do will not. So I see this as the opportunity  
5 that the Governor, that the Legislature has given us to  
6 address these issues, to wrestle with them, not to come up  
7 with perfect answers, but to look for areas that we can have  
8 reform to meet the needs of the citizens of our state and to  
9 do it compassionately and to do it well and to do it  
10 affordably.

11 I'd like to ask the folks in the audience now if you'll  
12 introduce yourselves and maybe have a special welcome to  
13 Senator Davis who has joined us here, if you could just -- you  
14 don't need to introduce yourself, but I guess since everybody  
15 else, if you could, Senator Davis, and then we'll go around  
16 the room? Thank you for coming.

17 MR. KEPACZ: I'm Fred Kepacz. I'm representing no one  
18 but myself, although I am employed by SouthCentral Foundation,  
19 and my passion, of course, is that health care -- our health  
20 care system is unbelievably screwed up, from my point of view,  
21 and it's got all the wrong incentives built into it, and I'm  
22 really just passionate about seeing reform where, in fact, we  
23 can spend the same amount of money and get much better  
24 results.

25 MR. TAYLOR: My name's Randy Taylor. I was in private

1 practice, family practice for about 35 years in Anchorage and  
2 am very interested.

3 MS. FISCHER: I'm Chelsea Fischer. I'm a current WWAMI  
4 applicant.

5 MR. BRITTEN: Good morning, my name is Eric Britten. I  
6 have a consulting firm here in Anchorage, and one of the areas  
7 in which I work is a patient-centered medical home, which is  
8 going to be a topic of discussion for you today. My passion  
9 is the patients at our medical home. As we look at emerging  
10 models of primary care, it's one that, I think, is beginning  
11 to gather a lot of steam and a lot of credibility, and it  
12 seems to be a model that will begin to answer, I think, some  
13 of those questions that all of us in this room are thinking  
14 about. So thank you for allowing me to join you.

15 MS. PRIEST: Good morning, my name is Robyn Priest. I'm  
16 representing the Alaska Peer Support Consortium. Yes, I've  
17 just moved here from another country, so learning about the  
18 health care system is interesting, to say the least. The  
19 passion for the Peer Support Consortium is to see the  
20 integration of primary health and behavioral health and look  
21 at utilizing peers coupled with the beneficiaries of the Trust  
22 into behavioral health systems and primary care systems to  
23 actually get better health care for all. If we can integrate  
24 it, it would be awesome.

25 MS. CULPEPPER: I'm Delisa Culpepper. I'm the Chief

1 Operating Officer for the Alaska Mental Health Trust  
2 Authority. The Trust is interested in all forms of health.  
3 Our beneficiaries are often vulnerable people who are high  
4 consumers of primary care and long-term care and behavioral  
5 health services. I'm very interested in what happens. I'm  
6 here to support Emily and do research and keep our  
7 beneficiaries and our boards informed.

8 MS. HEFFERN: I'm Sandra Heffern. I'm representing the  
9 Community Care Coalition. I'm primarily interested in helping  
10 to create a fully functional and sustainable long-term care  
11 system in Alaska.

12 MR. OBERMAYER: Tom Obermayer, staff to Senator Davis.

13 MR. MATTINGLY: Regan Mattingly with the Primary Care  
14 Association.

15 MS. KILEY: Deb Kiley, nurse practitioner.

16 MS. MERRIMAN: I'm Nancy Merriman of Denali Commission.  
17 The Commission has been interested in the provision and  
18 accessibility of primary care services across the State for  
19 about 11 to 12 years now, and we continue to be interested in  
20 some innovative ways to improve health care delivery and  
21 accessibility, especially to rural and underserved  
22 populations.

23 MR. LESMAN: Good morning, my name is Mike Lesman. I  
24 work for the Governor. I'm one of the Special Assistants, and  
25 Health and Social Services is one of the departments I work

1 with.

2 MS. HUGHES: Good morning, I'm Emily Hughes and I'm a  
3 pre-med student, and I just came here to learn about some  
4 things. Hopefully someday, I'll be practicing here.

5 MS. HUGHES: And I'm her mother, Shelley Hughes. Good  
6 morning, everyone, and I look forward to the day when the  
7 solutions that you offer are taken seriously and implemented  
8 in our state because we do need a sustainable system where all  
9 Alaskans have access to good health care, affordable health  
10 care.

11 MS. MAKKI: Hi, I'm Amanda Makki. For those of you in  
12 the room who don't know me, I am here for Washington  
13 representing Senator Lisa Murkowski. I've been her Health  
14 Care Assistant for about four years, and I've never been able  
15 to attend one of your events. So I'm very excited about this  
16 and I look forward to hearing from you all and seeing how this  
17 all happens because, usually, I'm on the phone. Thank you.

18 CHAIR HURLBURT: Again thank you all for being here.  
19 Deb, can we turn this back to you on the rules and the charge?

20 COMMISSIONER ERICKSON: Yes. I think we're actually  
21 ready to get started with the next part of our agenda,  
22 considering public comments that we received and having final  
23 review of the main points we want to include in this report  
24 before it is transmitted to the Governor and the Legislature a  
25 just a little over a week from now. If I'm not pushing the

1 button on Friday, it's due on Saturday and I'll be doing it on  
2 Saturday.

3 Everything that we need for this part of the discussion  
4 is in the right side of your packet, and I put together, again  
5 as in the last one or two times that we've met, a PowerPoint  
6 that will serve as kind of a meeting discussion guide for us.  
7 That's right behind the current, new draft of the report that  
8 you all have, everybody in the room, and on the website, there  
9 is a copy of the Meeting Discussion Guide available.

10 Behind the Meeting Discussion Guide is the table that  
11 summarizes the public comments received so far by the  
12 Commission in 2011 -- 2010, I'm sorry. And in addition, just  
13 as a reminder, you all received this a little over a week ago  
14 in the email. A few comments that came in a little bit late,  
15 late in the day on the last day they were due on the 30th, I  
16 emailed to you all on Sunday, but this is a complete packet of  
17 everything that was emailed in those two sets of attachments.  
18 So the table -- a separate table set up for the public comment  
19 period for the report starts on page two of the Public Comment  
20 table that you have and so listed in chronological order from  
21 the first one that we received during that period to the last  
22 at the end of page four. In that table, I just tried to  
23 capture the main points, kind of the category or categories  
24 that the person was commenting on, the name of the person and  
25 where they're from, and then a brief summary of those comments

1 and then the form that we received and the date, if it was an  
2 email or a letter or whatever it was. And then the full text,  
3 a copy of everything that we did receive, the email or letter,  
4 whichever it was, is attached on the back, so if you want to  
5 reference that. I'm hoping you all had a chance to review  
6 these in the past week. As I mentioned earlier, what I did --  
7 you know what? First, I'm just going to go over -- I'm going  
8 to go over first just an overview of the points that we're  
9 going to discuss today so this doesn't get, hopefully, too  
10 confusing.

11 So first as I mentioned earlier, we're going -- I tried  
12 to pull out what I thought were the main points from all of  
13 the comments that we received during the public comment period  
14 on the report, and I've organized those into general  
15 categories, and I thought I'd just go through what I thought  
16 were the main points, see if you all want to have a brief  
17 discussion about those, see if there was something that you  
18 identified in your review of the public comments that you  
19 think I left out as a main point, and we'll get that added in.  
20 And then what we'll do is shift to a discussion about those  
21 three main things we want to approve for our 2010 report  
22 today, and I've reorganized the public comments that we  
23 received around each of those three main points, and we'll add  
24 anything in, again, if you think that I left something out.  
25 But for each of those -- so we'll start with the 2010

1 recommendations at that point, and we'll look at the public  
2 comments specific to our 2010 recommendations, see if you want  
3 to make any changes based on those, if there are any other  
4 changes that you all would like to see made before we finalize  
5 the 2010 recommendations for the report, and actually would  
6 like to take a formal vote when we're done on those Finding  
7 and Recommendation statements. Then we'll move on to what we  
8 plan to study in 2011 in terms of current conditions, current  
9 issues in the system, look at the public comments received  
10 specific to those, see if there are any changes you want to  
11 make based on the public comments, any changes you all would  
12 like to see made, and then we'll do the same thing; we'll see  
13 if we can have a formal vote.

14           And one of the things I wanted to mention both about what  
15 we're going to study over the next 12 months and in terms of  
16 current problems in the system, as well as potential  
17 strategies, just because we're voting to identify those for  
18 this report doesn't mean we're locked in stone, that we're not  
19 going to have some flexibility over the course of the next 12  
20 months, but as I mentioned at our last meeting, what it's  
21 really doing is setting the agenda for how we're going to  
22 spend our time and our resources up front, and if we need to  
23 make some changes throughout the next 12 months, we can make  
24 some. You know, we'll be able to make some adjustments, but  
25 this is going to get us started and let folks know, as well as

1 give us a sense of direction, of where we're headed.

2           Then we'll look at future strategies, too. We had some  
3 suggestions for making sure we include those in the report and  
4 don't forget those and see if there is anything you want to  
5 add to that list. Each time we meet, I'm going to ask if  
6 there is anything you want to add to that list and also if  
7 there is anything you want to move to this year's list.

8           There were a couple comments received related to our  
9 process, and I thought we would just talk about that at the  
10 end of our discussion this morning.

11           And then at the very end of the day, the last point in  
12 terms of our discussion overview -- just I have some suggested  
13 timeframes for future meeting dates. I'm actually going to do  
14 a web survey with you all just to see what's going to work  
15 best for the majority of the group, but I wanted to get those  
16 out and see if you -- if there are any major conflicts that  
17 you know about, like Dr. Stinson pointed out to me earlier  
18 that, unless we meet in Fort Lauderdale during -- the initial  
19 dates that I identified for March were right at Anchorage's  
20 spring break, so those sorts of things, but we'll wrap up the  
21 meeting with talking about getting our calendars set for the  
22 coming year and what our plans are going to be now that we're  
23 going to be able to be stabilized, hopefully stabilized, over  
24 the course of the next year compared to these last couple  
25 years.

1           So does our plan for the discussion this morning make  
2 sense, and does anybody have any suggestions for doing  
3 anything a little different or better?

4           So hearing none, I'm going to move in -- just quickly,  
5 these are the major categories that I had identified that, I  
6 think, most of, if not all of the comments, fall within. We  
7 received quite a few comments about and all positive, I think,  
8 and supportive anyway in terms of the Medical Home Model, a  
9 number of workforce related issues and strategies, a few  
10 comments related to the cost of care analyses and strategies  
11 both, and payment reform strategies kind of related to that as  
12 well, a suggestion related to encouraging healthy lifestyles,  
13 a few comments related to the importance of encouraging  
14 patient responsibility, a comment related to our plans for  
15 developing indicators -- for finalizing our set of indicators  
16 for measuring health system improvement, and then a number of  
17 comments related to specific services and programs, a comment  
18 related to facility supply and distribution, and then, as I  
19 was just mentioning, a couple comments just related to our  
20 process. So those are the main categories that I identified.

21           So what I thought I would do next then, the main points  
22 that I pulled out for each of these categories I'm going to  
23 note here. So from your review of the public comments -- and  
24 if you have a question, I think I can remember. It's been a  
25 week now, but I think I can remember and point us to the

1 specific comment if you have a question about that. And again  
2 if you think I'm missing something really important that  
3 somebody identified, please let me know.

4 So again starting with Support for a Medical Home Model,  
5 we probably had four or five commenters speak supportively to  
6 the Medical Home Model, a couple, at least if not three,  
7 requesting or suggesting that we make a specific  
8 recommendation related to the pilot. Just a note about that.  
9 We have already made that recommendation in 2009. And I  
10 should probably make, at least for the audience and especially  
11 for all of us -- one of the things that hopefully is going to  
12 be more clear -- and I could -- will take any advice too, for  
13 making it even more clear. We intend that our  
14 recommendations, the recommendations of this Commission -- I  
15 think we talked about this last time too, but I just need to  
16 remind everybody. The recommendations of this Commission  
17 aren't meant to be an annual legislative policy agenda. It  
18 really is meant -- we're trying to put together a picture of  
19 and pull together the pieces of the puzzle that we think need  
20 to be in place for improving the system over time. And so our  
21 -- the recommendations that we make each year are meant to  
22 stand, and unfortunately, I didn't have a chance to put the  
23 description in the public comment draft. And next year if we  
24 have a normal year, we're going to have a full month for a  
25 public comment period with a full draft, but we weren't really

1 inviting comment on last year's recommendations at this point  
2 in time. I've described those in a little more detail and  
3 actually in the current draft of the report that you all  
4 received earlier this week and also provided a description of  
5 activities related to that recommendation that has moved those  
6 recommendations forward in some way. There is a description  
7 of those in the current draft of the report now.

8 So everything that's happened -- everything -- main  
9 things that have happened during 2010 related to moving our  
10 2009 recommendations forward are included in this report, as  
11 well as kind of introduction that our recommendations from  
12 2009 still stand as current recommendations until and unless  
13 we change them or delete them. So hopefully it'll be a little  
14 more clear to the public in the future that we're trying to  
15 build this picture over time and that we're not just coming up  
16 with an annual plan that's going to get thrown out and redone  
17 each year. Does that make sense?

18 So with that being said, we did have some specific  
19 recommendations related to recommending that a pilot -- that  
20 an Alaska pilot test -- that the Governor and the Legislature  
21 support pilot testing the Medical Home Model, and we did  
22 include that recommendation in 2009 already.

23 Is there anything else that you all wanted to note from  
24 your read of the public comments, specific to the public  
25 comments, not about Medical Homes in general, but specific to

1 the public comments, anything that you wanted to note from  
2 your review of the public comments specific to Medical Home  
3 Models?

4 COMMISSIONER FRIEDRICH: I would just comment that I  
5 think one of the public comments mentioned, the Gruma (ph)  
6 Corp article, and Mr. Britten and shared that with several of  
7 us, I believe, and I don't believe that we've included that in  
8 our references, but it may be a useful additional point to  
9 include because it does give a good overview. It highlights a  
10 review of the research that's been published so far and at  
11 least the initial indicators that suggests that there may be a  
12 return on investment for the Medical Home Model.

13 COMMISSIONER ERICKSON: Any other comments? Moving on to  
14 workforce, there were several related to workforce again, a  
15 specific to volunteer EMTs and making sure that we're not  
16 leaving them out of any assessment or planning work that we do  
17 related to workforce, a general comment, a couple of them  
18 supportive of family physicians, requests again that we  
19 include loan repayment and incentive programs as a recruitment  
20 tool as an important strategy. This is another one that was a  
21 specific recommendation of the Commission from 2009 that we  
22 would see as still standing. A suggestion that we make sure,  
23 again, any of our work related to workforce, that we recognize  
24 all and acknowledge and be supportive of all types of health  
25 aides, community health aides, behavioral health aides, dental

1 health aide therapists, I think are our three main types of  
2 health aides right now in the State. A recommendation that we  
3 look at studying the licensure process and how to streamline  
4 that and make it more efficient and more effective and  
5 comments related to the importance and the significance of  
6 nurses' and nurse practitioners' role in the health system, as  
7 well as in Medical Home Models, as well as in participating in  
8 the work of the Commission and the planning that we're doing.  
9 So anything that you all would like to particularly note about  
10 workforce? Keith?

11 COMMISSIONER CAMPBELL: I don't know if this -- I presume  
12 it's workforce, but there was a comment about EMTs,  
13 volunteerism, and things like that and how we go forward on  
14 that. Is that where we should be thinking about plugging into  
15 the workforce umbrella, those kinds of comments or at least  
16 acknowledge them?

17 COMMISSIONER ERICKSON: Did you see a comment related to  
18 volunteerism beyond the EMTs?

19 COMMISSIONER CAMPBELL: Well the EMTs that are -- yeah,  
20 you know.....

21 COMMISSIONER ERICKSON: Could you hold your mouth closer  
22 to the mic?

23 COMMISSIONER CAMPBELL: The fact was that there was a  
24 comment -- I can't lay my fingers on it -- about what we do to  
25 encourage these kinds of things in our local community so that

1 that nucleus of providing those kinds of services continue. I  
2 presume the comment was made because some communities are  
3 having a tough time stimulating this kind of a local  
4 workforce. I don't know.

5 CHAIR HURLBURT: Maybe just let me comment on that. I  
6 think the specific comment came from a couple of times that  
7 Dr. Kohler testified who works at Bassett and lives up in  
8 Delta and is involved with the state trauma system, the state  
9 EMS system. In a very American way, there is a movement among  
10 the EMT groups saying, shouldn't we professionalize more,  
11 should we maybe be more paid, less volunteer, should we have a  
12 board, should we have some of these things, reasonable  
13 suggestions that we need to look at. The pre-hospital system  
14 is probably as important here in Alaska as anywhere else,  
15 maybe more important than anywhere else, in the country  
16 because of the unique logistics that we have, and there are  
17 over 2,000 Certified EMTs in the State. They are a very  
18 passionate, very committed group of people that are a real  
19 resource for the State. This reflects that interest and that  
20 passion, and they are internally having that kind of  
21 discussion that I just eluded to now. So I think, you know,  
22 that Dr. Kohler is saying, don't forget us. We have this  
23 whole spectrum from pre-hospital care to Medical Homes,  
24 whatever that is, to hospitals to long-term care and so on.  
25 We probably need to decide where can we most effectively

1 impact, can we do it all, should we narrow that down, but I  
2 think that reflects this reminder to us from Dr. Kohler, hey,  
3 don't forget this very important part of our health care  
4 system in Alaska.

5 COMMISSIONER ERICKSON: Keith, would you like to put in -  
6 - were you suggesting that we make sure that we're looking at  
7 ways to encourage volunteerism a little more generally in the  
8 health care system? I could put that -- I could note that in  
9 a parking lot for us to come back to later, if you're.....

10 COMMISSIONER CAMPBELL: That's sufficient, just so we  
11 don't lose these kinds of things over time and we do, at some  
12 point, address these concerns and maybe try to.....

13 COMMISSIONER ERICKSON: Beyond.....

14 COMMISSIONER CAMPBELL: Because it is a valuable resource  
15 (indiscernible - simultaneous speaking).....

16 COMMISSIONER ERICKSON: But I just want to just make sure  
17 I'm clear. Beyond volunteer EMTs, just more generally?

18 COMMISSIONER CAMPBELL: Well I haven't given it all  
19 that.....

20 COMMISSIONER ERICKSON: Because we won't lose volunteer  
21 EMTs. We have them in our public comments, and I've.....

22 COMMISSIONER CAMPBELL: As long as we don't forget it,  
23 that's all I'm saying.

24 COMMISSIONER ERICKSON: We're not going to forget them.  
25 I just wanted to make sure you didn't want to go beyond pre-

1 hospital.

2 COMMISSIONER FRIEDRICH: Well can I -- as I listened to  
3 what you were saying and looked back at some of the comments  
4 both that we received and in other forums, there was a  
5 discussion at one point about whether Alaska wanted to pursue  
6 something similar to what Texas has with their, I think they  
7 call them, medical rangers. It's essentially an organized  
8 volunteer system in which the State recognizes volunteers,  
9 both proactively and very positively, those who do  
10 particularly remarkable or positive contributions, make  
11 positive contributions to the health of the State, and it  
12 gives them a pool that they can reach out to very quickly.  
13 That may be a long-term goal for us to look at. If we're  
14 talking about parking lots, I'd just offer that because, from  
15 my time in Texas, it was a very effective way of accomplishing  
16 some of the things that you had talked about.

17 COMMISSIONER ERICKSON: For those of you on the phone, I  
18 was just noting, for our parking lot on the flip chart, that  
19 we will look, over time, at strategies potentially for  
20 encouraging volunteerism and see if we learn maybe something  
21 from some other state models, like Texas, but we still will  
22 make sure that volunteer EMTs and the pre-hospital system stay  
23 on our list of specific issues and services and specific  
24 workforce issues. Sound good?

25 Other comments, is there anything that you think that you

1 pulled out of the public comments related to workforce as a  
2 main point that you think is missing from this bulleted list?

3 COMMISSIONER FRIEDRICHS: Well I'll dive in again here.  
4 There were a number of comments about the perception that  
5 there was a lack of discussion or insufficient discussion of  
6 mental health needs or behavioral health needs and those  
7 crossed.....

8 COMMISSIONER ERICKSON: That's in another section.

9 COMMISSIONER FRIEDRICHS: I know, but you asked about  
10 workforce and the one thing that we did address already here  
11 on page 27 was the Alaska psychiatry residency. What we did  
12 not include -- and I would offer I think this may be a time  
13 for the Commission to discuss, do we want to explicitly  
14 support the recommendation that Alex Van Haften (sp) shared  
15 with us that the State provide the delta in funding that they  
16 need to get the residency going. We had a previous  
17 recommendation that spoke, I think, more generically to it,  
18 but there's a delta in funding, if I remember correctly from  
19 my notes, of \$3.6 million that they need to open the  
20 psychiatry residency here.

21 COMMISSIONER ERICKSON: Can we table that until we get to  
22 the point where we're talking about recommendations? Right  
23 now in this point of the agenda, I just want to make sure that  
24 we're not leaving anything out of the public comment in terms  
25 of main points.

1 COMMISSIONER FRIEDRICHS: Okay.

2 COMMISSIONER ERICKSON: But that is, actually, a bigger  
3 question that we need to discuss is, how specific we're going  
4 to get in our recommendations? So if we're going to recommend  
5 at any point -- earlier, we were talking about how our  
6 recommendations will stand over time and not be an annual  
7 agenda, if, each year, we're going to go back and make some  
8 very specific recommendations that would be more like a  
9 legislative agenda for the coming year or if we're going to  
10 leave our policy agendas more general and allow other advocacy  
11 groups to take our recommendations and work them, but that's  
12 something for discussion when we get to the point where we're  
13 making decisions about our recommendations later. So don't  
14 let me forget; you won't.

15 COMMISSIONER FRIEDRICHS: Not to worry.

16 COMMISSIONER ERICKSON: Anything else related to public  
17 comments on workforce that's missing, you think?

18 Cost of care. One comment was, as we're looking at the  
19 cost -- spending in Alaska for health care services and  
20 pricing and reimbursement, that we also look at the cost of  
21 operating a practice in Alaska. We are including in our  
22 request for the contract with actuarials would be looking at  
23 pricing and reimbursement. You all had asked that we also  
24 include a second part of that to look specifically at the  
25 problem with Medicare and the differential between cost of

1 operating a practice and the reimbursement for Medicare. So  
2 specific to Medicare, we're planning on doing that already.  
3 And then another comment that we also look at tort reform as a  
4 strategy. The specific concern that was raised was about how  
5 defensive medicine might be driving the cost of health care.  
6 So was there anything else that you pulled out of the public  
7 comments related to cost?

8 COMMISSIONER FRIEDRICHS: So I met with some of our  
9 colleagues, physician colleagues here in the State, and it  
10 doesn't look like they submitted this, but one of the concerns  
11 or questions that was raised related to cost of practicing is  
12 the cost to the health care system of physician-owned or  
13 practice-owned ancillary services and that is a subset of the  
14 Medicare discussion, but there have been studies done  
15 elsewhere that looked at the differentials in cost in the  
16 utilization of ancillary services that were owned by practices  
17 versus referrals to those types of services when they were not  
18 owned by the practice, and the suggestion was made that there  
19 may be value in looking to see whether that is a problem or a  
20 concern or an opportunity here in Alaska as well.

21 As a surgeon, if I also owned the CAT scanner, and every  
22 one of my patients gets a CAT scan for their hernia or for  
23 their whatever, is that the same practice pattern that a  
24 surgeon who doesn't own a CAT scanner might do and is that the  
25 best utilization of health care resources? And I didn't see

1 that in the comments. I don't know if it was ever submitted.

2 COMMISSIONER ERICKSON: So what we'll do is we'll bring  
3 that in when we get to the point of talking about our plans  
4 for 2011 studies as a Commissioner's comment for what we might  
5 want to include. So I've made a note on my pad about that, so  
6 we won't forget. Any other major points from the public  
7 comments?

8 Moving on. Payment Reform Strategies. A recommendation  
9 that we streamline billing processes and just a caution, I  
10 think this was the commenter who referred to defensive  
11 medicine as an issue and requests that we look at tort reform,  
12 was just a caution about service bundling and a comment  
13 related to that, I think, that it's, in this particular  
14 person's perspective, not necessarily the fee for service  
15 system that's driving the costs and some concerns, but no  
16 specific concerns noted about service bundling. And for those  
17 of you who might not have read the report who are in the  
18 audience -- everyone around the table, of course, has read the  
19 draft report -- service bundling is on a list of strategies to  
20 consider in the coming year. Did any of you pull out anything  
21 from the public comments related to payment reform that's  
22 missing here or anything you want to elaborate on related to  
23 those two points?

24 I'm going to move on. Insurance Coverage. There was a  
25 suggestion that we look at -- that we study underinsurance in

1 the coming year. Was there anything else that you pulled out  
2 related to insurance specifically? There were some primary --  
3 one or two primary care access questions that were kind of  
4 related to insurance, but it wasn't a specific insurance  
5 question, so I didn't note those here. They were more related  
6 to primary care access.

7 Encouraging Healthy Lifestyles. The one specific comment  
8 was a recommendation that we consider recommending to the  
9 Governor that he launch a Governor's Challenge for living  
10 healthy lifestyles. I don't know if any of you are familiar  
11 with the campaign that Governor Huckabee of Arkansas had a few  
12 years ago. He was really a champion, and I think he, at the  
13 time, was the head of the National Governors Association as  
14 well and kind of made it a nationwide governors' initiative, as  
15 well as a real specific state initiative. So the commenter  
16 suggested something like what Governor Huckabee did, so that  
17 was that specific comment. Did you pull anything else out of  
18 the public comments related to what we might be considering  
19 related to healthy lifestyles? Keith?

20 COMMISSIONER CAMPBELL: I really think that, in  
21 individual communities around the State, there are things  
22 happening and it might be -- in order to reinforce this  
23 recommendation, if it goes forward, would be to have some sort  
24 of comments from these communities who are trying their  
25 wellness programs and things like that because I know it's

1 happening in several communities, and you could survey the  
2 whole system, but maybe the Municipal League or somebody has  
3 done some work or could find out for us or something like  
4 that.

5 COMMISSIONER ERICKSON: So survey community wellness  
6 initiatives is what you're suggesting. I'm putting that on  
7 our list for study discussion for a little bit later this  
8 morning. Other thoughts that these are prompting, in addition  
9 to other comments that you pulled out?

10 The next is Encourage Patient Responsibility. I  
11 don't.....

12 COMMISSIONER FRIEDRICHS: Now hold on just a second.

13 COMMISSIONER ERICKSON: You weren't fast enough.

14 COMMISSIONER FRIEDRICHS: Well I'm seldom accused of  
15 that, but I'm just trying to be polite and not interrupt. I  
16 was struck by the number of comments from health care  
17 providers about their frustration with the lack of personal  
18 responsibility for health, and we indirectly addressed that in  
19 one comment in the report, but there's not much more of a  
20 discussion beyond that in the report in which we say that  
21 health care, at least in every course or training program I've  
22 been through, is not a constitutional right, but it is the  
23 obligation of the government to provide whatever resources you  
24 need, regardless of what choices you make as an individual.  
25 And there was, I think, some very eloquent testimony to the

1 frustration about the focus on evidence-based medicine if you  
2 have a patient population who chooses to smoke and eat fast  
3 food. As one letter writer pointed out, if you have a patient  
4 who smokes, that is a choice. It is an addiction once you  
5 have made that choice, but we do not explicitly address  
6 patient responsibility, I think, beyond that first comment,  
7 and given the number of public comments that we received, I  
8 would recommend that we do include that for 2011 as another  
9 area for review of strategies around the United States in  
10 which patients have assumed responsibility or in which states  
11 have required patients to assume responsibility for their  
12 choices in health care because, I think, there is great  
13 validity in the criticism that we have focused almost  
14 exclusively on the health care system's responsibility, but  
15 there is very little in our report that speaks to the  
16 individual's responsibility.

17 COMMISSIONER DAVIS: Well said, but we had a great deal  
18 of discussion in 2009 that, unfortunately, you weren't a part  
19 of, but I agree completely that we have to look at both sides  
20 of the equation and it is, I believe, in the 2009  
21 recommendations and report, and hopefully, we can continue to  
22 look at it and emphasize it and move forward with some other  
23 recommendations in that area.

24 COMMISSIONER ERICKSON: It is one of our values as well,  
25 but what we might do is identify where there are some more

1 specific recommendations. One of the pending strategies on  
2 our pending list that is probably right now the one that's the  
3 most directly related to individual responsibility is the  
4 worksite wellness programs that would help engage, and it goes  
5 beyond worksite wellness. It's the health management programs  
6 that engage folks, but through the worksite and through their  
7 employee-based insurance is what it's intended to do.

8 So when we get to talking about our current and future  
9 strategies later this morning, I've made a note of that, so we  
10 can have a little more of a conversation at that point about  
11 patient responsibility and if there is some more specific  
12 recommendations that we want to put on the list either for  
13 2011 or pending for the future related to that.

14 COMMISSIONER FRIEDRICHS: And I guess it brings up a  
15 question just from a process standpoint because there was a  
16 Section 1(b), I think, somewhere in here, where we said follow  
17 up on 2009 report items. Is that language that -- I didn't  
18 see it in the version that's in our package here. I think it  
19 still says that that's pending. Are we going to add some more  
20 to that then?

21 COMMISSIONER ERICKSON: Which section specifically? I'm  
22 sorry.

23 COMMISSIONER FRIEDRICHS: Part 2(a), Summary of 2009  
24 Findings, Draft Under Development, page eight.

25 COMMISSIONER ERICKSON: Well that's -- yeah, that's just

1 the main points on the issues and the problems that were  
2 identified in 2009; yes.

3 COMMISSIONER FRIEDRICHS: And it's unfortunate that our  
4 legislative advisors aren't here, but is the intent, at some  
5 point, to go back and say we said this in 2009 and nothing  
6 really has happened, nothing has changed since then?

7 COMMISSIONER ERICKSON: That's more the Recommendations  
8 section, I think, not the Findings section. The Findings are  
9 going to be the main challenges and problems that were  
10 identified. But as far as our recommendations go, that's the  
11 section that's in here now that explains any progress or any  
12 developments related to each of those recommendations over the  
13 past year, and we'll work into our process a review of the  
14 standing recommendations from prior years in the future as  
15 well to see if we need to either refine those, if we're going  
16 to make them more specific, if we've identified additional  
17 information that we leads us to want to eliminate those  
18 recommendations for some reason. Does that help?

19 COMMISSIONER FRIEDRICHS: I will let you know at the end  
20 of the day.

21 COMMISSIONER ERICKSON: Anything else related to  
22 encouraging patient and personal responsibility?

23 Measures of Health System Improvement. One comment  
24 received related to that was that we, at least for the  
25 measures in our draft set of indicators that are related to

1 health status and health behaviors, frame those in a positive  
2 rather than negative way. So rather than saying 20% of  
3 Alaskans smoke, we would say 80% of Alaskans don't smoke. So  
4 that's the suggestion, which I really kind of liked but want  
5 to talk with our epidemiologists to see if there's some reason  
6 not to do that. Did anybody pull anything else out of the  
7 public comments related to the system measures?

8 CHAIR HURLBURT: More than 81%.

9 COMMISSIONER ERICKSON: I'm sorry. I knew you were going  
10 to correct me.

11 So this is a big section. Improvement of Specific  
12 Services and Programs. And again, there were comments related  
13 to looking at access to primary care as well as the comments  
14 that were specific to the Medical Home Model. One commenter -  
15 - actually the one comment that we received from somebody out  
16 of state was more specific. I generalized it to just general  
17 rehabilitation services, but somebody who is the head of an  
18 organization that, I think, certifies folks who work with --  
19 was it specific to the developmental disability population or  
20 at least provide rehabilitation counseling services wanted to  
21 make sure that in -- the comment was actually specific to the  
22 Affordable Care Act. This was probably a form letter that  
23 went out to any state commission anywhere that has health in  
24 the title is my assumption. The specific recommendation was  
25 that the State include in benefit design under the Affordable

1 Care Act rehabilitation counseling services. That was a very  
2 specific comment. I did just generalize it to include  
3 rehabilitation services under specific services that we  
4 received comments on. A number of comments about behavioral  
5 health and not forgetting behavioral health in our work. A  
6 specific comment about the importance of integration of  
7 behavioral health in primary care and vice versa. A similar  
8 comment about long-term care, not leaving those important  
9 services out. We did acknowledge that we are considering  
10 long-term care as a part of the continuum of care that we're  
11 planning for.

12 COMMISSIONER ENNIS: Deb -- this is Emily Ennis, online -  
13 - although we received just three comments regarding these two  
14 issues specifically, I did want to point out they were fairly  
15 strong comments and a strong concern that we had omitted long-  
16 term care and the integration of behavioral health. And I  
17 think, you know, long-term care perhaps was seen as being left  
18 out more significantly, and as Commissioner Streur pointed  
19 out, long-term care is definitely related not just to access  
20 and having availability of the options for our seniors and for  
21 people with disabilities, but it is a cost driver. It's  
22 expensive. It's growing. And so the need to really re-  
23 evaluate a more specific recommendation or need for study, you  
24 know, is based on that, that it's a bigger area than, say,  
25 trauma or pediatric specialties, which we did list it as

1 needing study along with those other things, but that long-  
2 term care really does have a significant impact potentially on  
3 our health care system and our future.

4 COMMISSIONER ERICKSON: Let's plan to talk about some  
5 specific changes or plans that we want to make for 2011 in  
6 just a few minutes when we get to that point, but thanks for  
7 emphasizing that there were very strong comments related to  
8 long-term care and behavioral health and not leaving them out.

9 Anything else? We did have a specific recommendation to  
10 look at the expansion of the Denali Kid Care Program. I put  
11 that on the list of services, specific services and programs  
12 here, and another recommendation related to streamlining and  
13 providing improved access for veterans, veterans health care.

14 Were there any other specific services or programs that  
15 you thought -- or categories of services that you pulled out  
16 of the public comments that I've left off this list? Yes,  
17 Emily?

18 COMMISSIONER ENNIS: One other question I saw in the  
19 comments was interesting, and it's the recommendation to  
20 define health care. And of course within that, we might be  
21 able to make sure our readers know that long-term care is a  
22 component of health care because, I think, the general  
23 layperson might not recognize that.

24 COMMISSIONER ERICKSON: I actually included that. Thanks  
25 for noting that. I mean, we had had that noted before in a

1 past meeting and so it's something I've kind of put on a  
2 parking lot anyway, but I included under process down below  
3 the definition suggestion. So anything else related to  
4 specific services?

5 Moving on. Facility Supply and Distribution was another  
6 suggestion that we not look just at workforce supply and  
7 distribution, but we also look at facility supply and  
8 distribution in the state.

9 And then to process again, there was a specific  
10 suggestion that we define health care and then there were some  
11 suggestions related to engaging stakeholders, that the  
12 Commission should do a better job of including nurses and  
13 nurse practitioners in our planning and deliberation process,  
14 that we do a better job of including the Mental Health Board  
15 and Advisory Board in alcoholism and drug abuse specifically,  
16 and then there was just a general comment, just generally, to  
17 make sure that we're engaging organizations in the process as  
18 we move forward.

19 Were there any other process comments that you noted?  
20 And then we are going to talk about each of these related to  
21 changes we want to make in this report and plans for next  
22 year.

23 How are we doing for time? When are we going to break?  
24 10:30. We've got an hour. Good.

25 So now specific to our 2010 recommendations, there were

1 two comments specific to evidence-based medicine, and I don't  
2 know that any of these were suggesting that we make specific  
3 changes to the findings. And what you all are really going to  
4 be voting on are our Finding Statements and our Recommendation  
5 Statements to approve the statements that are in the box. We  
6 did not have any specific requests to make any changes to  
7 those. I don't know that we even had any suggestions that we  
8 -- more general suggestions to changing those, but I did note  
9 that the two places -- the two commenters who had mentioned  
10 evidence-based medicine specifically were, more specifically,  
11 that we shouldn't just emphasize provide quality and evidence-  
12 based medicine, that we focus on patient responsibility as  
13 well. We just had that conversation, but that was one of the  
14 two comments we received specific to evidence-based medicine.  
15 And the other was related to -- you know, I had included kind  
16 of a -- not comprehensive but short laundry list of some  
17 existing programs. I think the commenter meant to speak  
18 specifically to those programs and that we be cautioned that,  
19 just because a program exists, doesn't mean that it has  
20 positive outcomes. And the purpose for, I think, other  
21 information that we learned from Dr. Hurlburt's and Dr.  
22 Cahana's presentations at the end of the last Commission's --  
23 former Commission's meeting that Dr. Cahana had presented to  
24 us, as well as other information presented in here, was meant  
25 to provide the background for why we think that there are

1 positive outcomes from emphasizing evidence-based medicine.  
2 Listing those programs was just meant to provide some examples  
3 of some programs that are in place and not to suggest that  
4 they be models, but also to show that there is growing  
5 interest and engagement in this area as well. So I don't know  
6 if any of you want to respond to either of those two comments,  
7 if you think we should make any changes to our Finding and  
8 Recommendation Statements or if you think I should just be a  
9 little more clear at that one point in the report that these  
10 programs are just some examples.

11 COMMISSIONER FRIEDRICHS: Can you just tell me, when you  
12 say the reports -- so I know what you're talking about, which  
13 page and item in the report are you referring to?

14 COMMISSIONER ERICKSON: You should have from your packet  
15 right now the January 4th draft, pages 31 through 34. And so  
16 the Finding Statements are at the top of page 31 and the  
17 Recommendation Statements at the end of page 34. We can take  
18 a couple minutes, if you all want to be reading those Finding  
19 and Recommendation Statements. Actually what we can do then  
20 is we don't need to discuss those specific comments, if you  
21 don't feel that's necessary, but if there are any changes you  
22 all want to propose now to -- let's start with the Finding  
23 Statements and I actually have them up on the screen. If any  
24 of you want to propose amendments, we can make the changes so  
25 you can see them before we actually vote to approve them and

1 then we'll move on to the Recommendation statements. And then  
2 remind me to go back to that earlier slide when we're done  
3 voting because there are some of those other specific  
4 recommendations that people had suggested we make related to  
5 Medical Home, pilot loan repayment, and Dr. Friedrichs'  
6 suggestion or question about the psych residency as well.  
7 We'll go back to that after we're done with evidence-based  
8 medicine in terms of recommendations that we want to make  
9 specifically in this 2010 report.

10 COMMISSIONER FRIEDRICHS: Were there changes in this  
11 section from the language that you had sent out the week  
12 before?

13 COMMISSIONER ERICKSON: No.

14 (Pause - reading document)

15 COMMISSIONER ERICKSON: I'm waiting to -- I see nobody is  
16 reading anymore, and as soon as nobody is reading, then we'll  
17 entertain a motion. It looks like folks are done reading, so  
18 we'll entertain a motion to adopt these Finding Statements for  
19 this year and then we can have a discussion.

20 COMMISSIONER FRIEDRICHS: Actually I would move that we  
21 modify these Findings.

22 COMMISSIONER ERICKSON: Actually I wonder -- we don't  
23 have -- we're missing our parliamentarian today, but what if  
24 we move to adopt these and then discuss amending them?

25 COMMISSIONER CAMPBELL: I'll move the adoption of the

1 recommendation.

2 COMMISSIONER STEVENS: Second.

3 COMMISSIONER ERICKSON: Discussion?

4 COMMISSIONER FRIEDRICH: So this is where I'm going to  
5 ask -- since we don't have a parliamentarian and you've got a  
6 vision for how you want to do this, I just want to understand  
7 the process. So getting back to this issue of personal  
8 responsibility and the impact that that has on evidence-based  
9 medicine and how we would apply evidence-based medicine here,  
10 the public comments that we received were mostly from health  
11 care providers saying, how do you balance non-compliant  
12 patients with an interest in evidence-based medicine in which  
13 we're going to evaluate how well the physician or the nurse  
14 practitioner or the psychiatrist cares for his or her  
15 aggregate patient population? We also had a good discussion a  
16 couple of meetings back about the challenges of finding a  
17 large enough population -- I think, Noah, you touched on that  
18 -- which we don't specifically address in these Findings,  
19 which will make it difficult to apply evidence-based medicine  
20 precepts to a small single provider practice or maybe two or  
21 three provider practice. At what point do you want to have  
22 that discussion?

23 COMMISSIONER ERICKSON: At what point do you want to have  
24 the discussion specific to improving patient engagement, was  
25 that your question?

1           COMMISSIONER FRIEDRICHS: Correct. I mean, I think where  
2 we are right now is we're talking about the Findings and  
3 whether they reflect both what we discussed and the public  
4 comments. The public comments specifically raised a concern  
5 about patient accountability, which we touch on in here but  
6 don't very.....

7           COMMISSIONER HURLBURT: I'd say one context, in order to  
8 accomplish our assigned task which is to come up with some  
9 recommendations for this year to the Governor, to the  
10 Legislature, is that we do need to look back on what we've  
11 done since the last recommendations went in a year ago. What  
12 recommendations do we come up with?

13           As Deb pointed out, the recommendations don't sunset 12  
14 months later or at any specific time. If conditions change,  
15 we might want to change the recommendation. If we say, oh  
16 gosh, if in 2009, we knew what we knew now, we would say it  
17 differently so we could say it differently. But I think that  
18 part of where we'll come out from today is looking toward 2011  
19 and what things do we want to get into and what agenda do we  
20 need to do, but part of our assignment today from a practical  
21 sense is, what recommendations can we come up with? Based on  
22 the discussion since the last recommendations a year ago, what  
23 did we have enough discussion on that we can recommend?

24           Part of our agenda is going to be, what are our  
25 priorities going to be for the coming year? So it's not to

1 totally discount what you said, but I think from a practical  
2 sense, we probably can't go back and rehash things and say, oh  
3 no, we should have been doing this for the last 12 months and  
4 redo it too much. So I think that's one context that we  
5 probably need to have about our discussion today. Yes, Wayne?

6 COMMISSIONER STEVENS: Would it be helpful to have those  
7 2009 recommendations in front of us? Are they accessible?

8 COMMISSIONER ERICKSON: They're in the report.

9 COMMISSIONER STEVENS: Okay. I guess what I was trying  
10 to get to is, is there a way to tie them together to respond  
11 to Paul's comments?

12 COMMISSIONER ERICKSON: I wanted to point something else  
13 out too that's specifically in our current Findings for 2010  
14 and also in the narrative description further down on page 31.  
15 In the narrative behind evidence-based medicine, we do discuss  
16 -- and maybe I didn't emphasize quite enough -- the importance  
17 of health care decision making being a shared responsibility  
18 between the patient and the physician or health care  
19 practitioner. And in Finding A.3.d, the last one, we tried to  
20 make that point, but maybe it's a little -- it's too implied.  
21 Involvement of health care providers and consumers -- and  
22 maybe consumers isn't the right word -- in decision making is  
23 essential to the successful application of evidence-based  
24 medicine to clinical practice and public and private payer  
25 policies. So this was meant to suggest that decision making

1 in health care is the consumer's or the patient's  
2 responsibility together with the provider's. So I think if  
3 you want to make a specific change to a Finding Statement  
4 right now, maybe you think we could improve this statement,  
5 but I would need then a specific recommendation.

6 COMMISSIONER FRIEDRICH: I guess I'm struggling to  
7 understand the process a little bit. When I've been on prior  
8 commissions or responded to or drafted reports for Congress at  
9 the federal level, if we've received public comments that were  
10 very specific highlighting what was perceived to be a gap,  
11 we've tried to address those in some way and close that gap,  
12 so that there is not a later criticism or perception that  
13 we.....

14 COMMISSIONER ERICKSON: And I think Dr. Hurlburt's  
15 suggestion was that we are going to address it in our 2011  
16 strategies that we're going to discuss after we discuss our  
17 specific recommendations for evidence-based medicine for this  
18 year. The other thing that we're going to do next in terms of  
19 process, making sure it's clear, right now, we're considering  
20 the Finding and Recommendation Statements specific to  
21 evidence-based medicine. What changes do you want made to the  
22 evidence-based medicine recommendations and findings? And  
23 we're going to approve those, but we are going to stop and  
24 revisit the question of, are there other recommendations, at  
25 this point, that you want to include in the 2010 report based

1 on public comment, other thoughts or feelings you all are  
2 having right now? So we are going to do that as well.

3 CHAIR HURLBURT: So very specifically, we would be  
4 looking at the boxes on pages 31 and 34.....

5 COMMISSIONER ERICKSON: Right now, we are just going to  
6 vote on.....

7 CHAIR HURLBURT: .....for the verbiage in there. Is that  
8 acceptable? Is that appropriate?

9 COMMISSIONER ERICKSON: And these are the Findings  
10 specific to evidence-based medicine and the learning that we  
11 did together around evidence-based medicine and specific to  
12 the recommendations related to evidence-based medicine. If  
13 there's something outside of evidence-based medicine that you  
14 want to recommend in the 2010 report outside of evidence-based  
15 medicine, we're going to consider that next. Linda and then  
16 Emily?

17 COMMISSIONER HALL: You made a comment, and I think it  
18 might help, in Finding A.3.d, change consumers to patients.  
19 Down in the verbiage, you talk about providers and patients,  
20 and I think if consumers were patients there, it would help  
21 that.

22 COMMISSIONER ERICKSON: I see heads nodding about that.  
23 Would you like to -- actually you can't because you're not a  
24 voting member. If you all would like to see the word consumer  
25 changed to patient, does somebody want to move that we amend

1 that statement?

2 COMMISSIONER FRIEDRICHS: So moved.

3 COMMISSIONER ERICKSON: So we have a motion to amend  
4 Finding A.3.d by changing the word consumer to the word  
5 patient. It's seconded by Laufer. Any discussion?

6 CHAIR HURLBURT: Any discussion? Emily?

7 COMMISSIONER ENNIS: Again just referencing long-term  
8 care and home and community-based services, often the word  
9 consumer is preferably used rather than patient, as noted for  
10 the record.

11 COMMISSIONER LAUFER: This is Noah Laufer. That's  
12 interesting, to me, because it's a term of semantics and why  
13 do you choose consumer versus patient. I can tell you, as a  
14 physician, the label patient is one of high esteem. It is not  
15 a derogatory term in any way, and it doesn't imply a different  
16 class of a person. I think they're more than consumers.  
17 They're human beings, and all of us are there. And this is  
18 one of these issues which is subtly offensive.

19 COMMISSIONER ERICKSON: Does it take away from the  
20 relationship between the patient and the provider to refer to  
21 them as consumers, do you think?

22 COMMISSIONER LAUFER: I think it does. They're not  
23 consumers, and I'm not just a provider. It's not a widget.

24 COMMISSIONER ENNIS: I can understand the perspective  
25 here. It's semantics. The term consumer has changed over the

1 years. We've used client. We've used a number of terms, but  
2 currently, the word consumer is accepted by both professionals  
3 and individuals who receive services outside of a clinical or  
4 institutional setting.

5 CHAIR HURLBURT: I think, since Noah introduced it, I'll  
6 pick up on it because I think it is germane to the discussion  
7 of providers and consumers.

8 I was sitting in on a hearing at the Washington State  
9 Legislature one time, when the representative of the  
10 Washington State Medical Association was there and saying,  
11 look, docs are just getting beaten up now by, you know,  
12 Congressman Starr, Congressman Waxman, and other people that  
13 are going after the docs, and we're really getting beaten up  
14 and now you're calling us providers, and we're physicians and  
15 that's an esteemed term. We've worked hard to get that.

16 So I was working with a payer organization at the time  
17 and I went back and I said, we're going to call them  
18 physicians and other providers because there is a spectrum.

19 And I think part of your point is that, maybe in a long-  
20 term care setting, patient connotes illness in a different  
21 way than it does to a physician, but I think that probably --  
22 and I would maybe ask my three physician colleagues that are  
23 here today as far as the provider term whether physicians have  
24 just given up, or whether it doesn't have the connotation that  
25 it did. But I think since we brought the issue up with those

1 who are receiving services, do we need to also bring it up  
2 with those who are giving the services? It's a little more of  
3 a challenge because provider connotes a hospital. It connotes  
4 a physician. It connotes a physical therapist or lots of  
5 other people. So I don't know, Noah or Larry or Paul, if you  
6 have any thoughts about that?

7 COMMISSIONER LAUFER: First, I need to congratulate  
8 myself for not taking us off on a tangent. I waited over an  
9 hour to say anything.

10 COMMISSIONER FRIEDRICHS: You're a better man than I.

11 COMMISSIONER LAUFER: Thank you, Paul. That was great.  
12 It just semantics, but it actually is the heart of the issue.  
13 You know, we talk about this being 50,000 feet, and it's not a  
14 50,000 foot issue. It's a down on-the-ground, person-to-  
15 person, people's lives issue, and you know, I don't think any  
16 real change can be made without recognizing that it's -- you  
17 know, providers are doing this as a calling. It's not a  
18 simple business. It's not capitalism, and patient is just  
19 part of everybody's life. We're all patients at some point.  
20 You know, sorry. It needs to be real. I don't want to be a  
21 rebel rouser and mess up the process or slow you down, but  
22 that's where it is.

23 The reason patient is now derogatory in some views is  
24 it's had enough time to become that way. There are many words  
25 like that that don't start out as derogatory words, but people

1 eventually say, hey, I don't want to be called retarded. That  
2 just means I'm slow, but on every grade school playground,  
3 that's not a nice thing to call someone. It wasn't initially  
4 and that's a problem. Anyway, sorry. Thank you, Dr.  
5 Hurlburt.

6 CHAIR HURLBURT: You have yet to be a rebel rouser, Noah.

7 COMMISSIONER ENNIS: And I wonder if consumer was chosen  
8 in this Finding because of the word provider, that they're a  
9 little more generic? And if, in fact, we change to patient,  
10 you know, should we change to physician, which I think then  
11 that perhaps narrows the description.

12 COMMISSIONER LAUFER: I'll be brief, but in my training,  
13 the patient -- the designation as patient means that that  
14 person in the relationship, their interest needs trump  
15 everyone else's. That's what it means. It doesn't -- it is  
16 not a derogatory term. It means whatever my needs are,  
17 whether I need to go to the bathroom or I'm tired or whatever,  
18 don't matter if they conflict with the patient's needs.  
19 That's what it means.

20 COMMISSIONER FRIEDRICHS: Larry, I don't see you jumping  
21 for the mic, so I'll follow Noah there. This was a heated  
22 discussion at the American Medical Association, and actually  
23 representatives from the American Nursing Association and  
24 several other health care groups were part of this discussion.

25 The term health care providers has, you know,

1 pejoratively been used to encompass all sorts of things and is  
2 not terribly popular. The consumer term though was the one  
3 that was most problematic across the different level of health  
4 care providers.

5 From a federal side, we have beneficiaries, people who  
6 are not consumers. They receive health care as an entitlement  
7 and so, you know, we've been largely moving towards that term  
8 of beneficiaries to delineate those who are entitled to care  
9 from those who are consuming or paying for care.

10 Wrapping this back around to the point that I originally  
11 made, the public comments that we received were very specific  
12 to the concern of patients in the context of evidence-based  
13 medicine. And so if we're going to incorporate -- and this is  
14 where I'm still struggling to understand the process that  
15 we're following, and I apologize for being the dim bulb on  
16 God's front porch here, but if we're going to incorporate the  
17 public comments which spoke to the importance of patients',  
18 not consumers', but patients' responsibility for engaging to  
19 their benefit in evidence-based health care delivery, then I  
20 would suggest the appropriate term is patients. I mean,  
21 that's what the public commenter spoke specifically to.

22 CHAIR HURLBURT: Would a term such as -- it expands it a  
23 little, but does it get at the issue that Emily raises -- and  
24 I'd ask you, Emily, to say patients or clients because those  
25 are both personalized terms, but it does indicate that we're

1 talking somewhat more broadly than individuals who are sick.

2 COMMISSIONER ENNIS: Well I think my earlier question  
3 about the definition of health care may help me understand  
4 this, and actually if I'm requesting that we clarify and  
5 include in the definition long-term care under health care,  
6 then perhaps the use of the term patient is appropriate rather  
7 than client, definitely.

8 CHAIR HURLBURT: Any other comments?

9 COMMISSIONER ENNIS: And I'm saying this because of the  
10 language and the terminology we're using in this report. I'm  
11 not necessarily changing my own personal bias about this, but  
12 I think for the semantics and language of this report, it  
13 would make sense.

14 CHAIR HURLBURT: Let me state it, and please correct me  
15 if I'm misunderstanding it. We have a motion and a second to  
16 adopt the material in the two boxes on pages 31 and 34. We  
17 don't? Oh, just 31. The Findings on page 31.

18 COMMISSIONER ERICKSON: The first thing we need to vote  
19 on is whether to make the amendment that was proposed most  
20 recently. Then we'll vote on the whole body of just the box  
21 on 31.

22 CHAIR HURLBURT: Right. That's where I was going. So  
23 what I'm hearing is a suggestion, which I'm suggesting maybe  
24 I'm hearing in terms of a motion, that we modify the wording  
25 there to change the word consumer to patient; is that a fair

1 statement of what you suggested, Emily? Wayne, did you have  
2 something? Yes, Keith, please?

3 COMMISSIONER CAMPBELL: I'd just call for the question on  
4 the amendment.

5 CHAIR HURLBURT: So there's a suggested -- now I'm not a  
6 Robert's Rules of Order guy, so I'll turn to you, Deb. But we  
7 have what I've said is a motion that was made. Do we need a  
8 second now on that?

9 COMMISSIONER ERICKSON: No. No. We already had the  
10 second. So what we're doing is voting on it. And just right  
11 before we vote on just the change of the word consumers to  
12 patients in Finding A.3.d -- and I've made that change so you  
13 can see how it will be worded now on the screen behind me. So  
14 it would now read, involvement of health care providers and  
15 patients in decision making is essential to the successful  
16 application of evidence-based medicine to clinical practice  
17 and public and private payer policies.

18 CHAIR HURLBURT: And this is not the vote to adopt the  
19 whole box?

20 COMMISSIONER ERICKSON: Correct.

21 CHAIR HURLBURT: This is dealing with the specific  
22 reference.....

23 COMMISSIONER ERICKSON: To change the word consumers to  
24 providers.

25 CHAIR HURLBURT: .....to the recipient of the services.

1 COMMISSIONER ERICKSON: I'm sorry, consumers to patients.  
2 All in favor?

3 MEMBERS IN UNISON: Aye.

4 COMMISSIONER ERICKSON: Any opposed? We have one  
5 opposed, and for the record, someone should -- I do need to  
6 maintain for the record a specific voting record. So when we  
7 take a formal vote and the record is -- this is in our statute  
8 -- note how each person voted. We didn't have to be this --  
9 we didn't have to be quite this formal in the past.

10 CHAIR HURLBURT: Is there anybody who wishes to be  
11 recorded as non-voting?

12 COMMISSIONER ERICKSON: Everybody else who is a voting  
13 member, you have no choice. Everybody else will be noted as  
14 voting in favor of this amendment. So any additional  
15 discussion on this, the four Finding Statements? Any  
16 additional Recommendations that you wish to make?

17 COMMISSIONER FRIEDRICH: So is the time then to move for  
18 an additional recommendation to address the public comments,  
19 that a mechanism does not currently exist to assess patients'  
20 compliance with medical recommendations?

21 COMMISSIONER ERICKSON: You're suggesting addition of a  
22 Finding Statement specifically related to evidence-based  
23 medicine?

24 COMMISSIONER FRIEDRICH: Yes.

25 COMMISSIONER ERICKSON: This would be the time to make

1 that, if you would like to add a new Finding in this body of  
2 Findings.

3 COMMISSIONER FRIEDRICHS: So we received several public  
4 comments, as we discussed, that we can assess how well nurse  
5 practitioners or physicians or hospitals do, but we don't have  
6 a mechanism to assess individual patients' engagement or  
7 accountability or participation in their health care. So if  
8 we're trying to capture the state of medicine as it exists  
9 today and given the comments that we received, that is an  
10 important balance that should be factored in as people  
11 consider evidence-based medicine. It is not solely an  
12 evaluation of the physician's or nurse practitioner's  
13 performance, but we don't have a way right now to assess the  
14 patient's participation in a particular health care model.

15 CHAIR HURLBURT: So am I correct that you were somewhat  
16 formal in your initial sentence, that the wording that you  
17 suggested there is wording you're proposing to add to the  
18 Findings of the Health Care Commission for the calendar year  
19 2010; is that correct?

20 COMMISSIONER FRIEDRICHS: Yes, sir.

21 CHAIR HURLBURT: Is there any discussion about that?

22 COMMISSIONER ERICKSON: We need a second. Do you want to  
23 read that again and I'll type it in?

24 COMMISSIONER FRIEDRICHS: Mechanisms do not  
25 currently.....

1 COMMISSIONER ERICKSON: Wait a second. I'm sorry. I'm  
2 sorry.

3 COMMISSIONER FRIEDRICHS: Mechanisms do not currently  
4 exist to assess patients' compliance with evidence-based  
5 medical recommendations.

6 CHAIR HURLBURT: So that's suggested as a modification, I  
7 guess. Do we need a second on that? Is there a second?

8 UNIDENTIFIED COMMISSIONER: Second for discussion.

9 CHAIR HURLBURT: Is there a discussion?

10 COMMISSIONER ERICKSON: Can you all read that on the  
11 screen behind you?

12 CHAIR HURLBURT: Keith?

13 COMMISSIONER CAMPBELL: I guess I'm struggling with how  
14 big a study this is going to take to establish this kind of  
15 thing to work it into, do we load up -- I'm just thinking out  
16 loud now. Do we load up the position with one more stat? Do  
17 you have to go through the medical record that this patient is  
18 compliant/this patient is not, and who gets those statistics  
19 and the mechanism? It's a sound idea. I just don't  
20 understand the mechanics, and I guess I fear the kickback or  
21 pushback from physicians and all practitioners in trying to  
22 come up with a stat that's meaningful in engaging the  
23 effectiveness of evidence-based medicine, but I'm just  
24 thinking out loud here.

25 CHAIR HURLBURT: Noah, did you have a comment?

1           COMMISSIONER LAUFER: There are a couple places where  
2 this is applicable. One would be the obvious things, like  
3 whether or not a prescription is filled and that data is  
4 available and it's dismal. The other one would be, you know,  
5 the model that gets held up all the time for evidence-based  
6 medicine and patient-centered medical homes, which is diabetes  
7 and a note can be made fairly easily if a person is compliant  
8 or not. I have to say the vast majority of medicine is far  
9 more ambiguous than that, and you know, the idea of even  
10 applying evidence isn't possible in most of those cases,  
11 particularly in primary care which is a specialty of  
12 ambiguity, but those are things that can be measured and I  
13 imagine that you do, in the VA system, measure all of those.

14           COMMISSIONER ERICKSON: Can I make a comment related to  
15 Noah's comment just now? This is a Finding Statement. We're  
16 finding this to be true, and what I'm hearing Dr. Laufer say  
17 is that it's not true that mechanisms don't exist or maybe are  
18 not mechanisms that aren't comprehensive to all compliance is  
19 what I think I hear you saying.

20           COMMISSIONER LAUFER: I think that's correct. There are  
21 measures, if we want to pretend this is a very simple system,  
22 that can be manipulated easily, but I agree with the statement  
23 in general.

24           COMMISSIONER ERICKSON: You agree that there are no  
25 mechanisms to currently assess patient compliance?

1           COMMISSIONER LAUFER: There are very few or they are  
2 inadequate.

3           CHAIR HURLBURT: I think there has been some interesting  
4 work done on this and very much like you just pointed out, and  
5 I think the issue, as Paul breaks it up, is an important one  
6 that we have. There have been studies, for example, looking  
7 at the Pitney Bowes systems or the John Deere for their  
8 employees, where they have looked at things like doing away  
9 with co-pays for medications for diabetic patients and they  
10 find they do have better compliance, or when you look at  
11 bringing in somebody in the physician's office to spend time  
12 or the physician spends time, or it's like the article in the  
13 paper this morning about Vernon Cakes (ph), the old-time doc,  
14 was doing a lot of things that we call Medical Home now, but  
15 he was spending time with his patients saying, you know, why  
16 did this problem happen or what do you do, how do you deal  
17 with that? So I think that's there. I think there are some  
18 areas where there is hard evidence of it. Most of it, as Noah  
19 points out, there is not. And I think that, because it really  
20 does impact on outcomes, that might be an appropriate area for  
21 discussion, but I guess I would push back a little bit and say  
22 I did not see that as a part of our discussion during the last  
23 calendar year. And therefore, my bias would be it was not a  
24 Finding from the last year, and therefore, not a part of our  
25 appropriations. So I would kind of argue that way. Paul?

1           COMMISSIONER FRIEDRICHS: And I would -- and my memory  
2 may not be all that it once was, but I thought that we did it  
3 and it was specifically in the context of when we measure the  
4 impact of an evidence-based program, diabetes for example, and  
5 we say that Dr. Friedrichs did not do a good job managing his  
6 diabetic population. We then had the discussion about small  
7 numbers and the difficulty of teasing out. If you've only got  
8 12 diabetics in your panel, can you come up with a  
9 statistically valid interpretation of how well Dr. Friedrichs  
10 managed those patients or Nurse Practitioner Friedrichs  
11 managed those patients? And it was in the context of that  
12 discussion that we also talked about, and what if those  
13 patients choose not to follow the recommendations? So that  
14 was my recollection of the discussion.

15           COMMISSIONER LAUFER: This is an interesting point.  
16 Again it's that 50,000 feet versus the ground. If you wanted  
17 a mechanism to measure patient compliance, what you would do  
18 is pay for performance. And the doctor and the patient who  
19 are on the ground will figure it out, and if it is possible  
20 for that patient to be dismissed, they will become an orphan  
21 without a physician because they will negatively affect the  
22 stats for that doctor, and you'll have a mechanism for  
23 measuring compliance, a very accurate one.

24           CHAIR HURLBURT: Jeff?

25           COMMISSIONER DAVIS: Thank you, Dr. Hurlburt. I'm

1 struggling with this discussion because, I think, we're mixing  
2 at least three things together, if not more, but all three of  
3 those things are related which is why we're mixing them.

4 Evidence-based medicine is one thing and that, to me from a  
5 layperson's standpoint, means there is evidence that in this  
6 situation this is the thing to do or these are the things to  
7 do and these are the things not to do and that's sort of --  
8 that's a physician-centered scientific exercise in  
9 consultation with the patient. That's one thing.

10 Then there is the whole question of, okay, now what  
11 happens because of that, because of the intervention, because  
12 you wrote a prescription or whatever? Now at that point, you  
13 know, the physician has very little control and the member has  
14 a great deal of control. Dr. Eby talked with us about this  
15 spectrum. You know, if you move from -- when Dr. Friedrichs  
16 has someone anesthetized on the table and doing a surgery, the  
17 patient has very little control and he has a lot of control.  
18 That's one thing, but now we're talking about and the comments  
19 were about, well what about the other things that are not in  
20 the physician's control, smoking, filling the prescription,  
21 taking it after you fill which is as abysmal as filling it.  
22 That is in the patient control, but to me, that's something  
23 different than evidence-based medicine. It's the next part of  
24 the progression to an outcome that is desired and intended by  
25 the evidence-based medicine. So I think that in the new

1 Finding, I would say limited mechanisms exist to assess.  
2 That's fine. It's based on the comments, and it is true, but  
3 I think then talking about patient or consumer or client  
4 responsibility or personal responsibility is a different  
5 discussion that we began in 2009 and we can continue in 2011.  
6 And I would just kind of separate those for this report and  
7 say this is dealing with evidence-based medicine, but we'll  
8 pick up the other side, the next part of the progression.

9 And then, you know, how you pay people to reward them for  
10 all of this, how you incent the patient and how you incent the  
11 provider and how you have all that lined up is yet a third  
12 discussion that we, I think, have identified as something we  
13 need to talk about, but those, all three, are related but  
14 separate, in my thinking.

15 COMMISSIONER ERICKSON: So are you offering a friendly  
16 amendment?

17 COMMISSIONER DAVIS: To A.3.e, I would, just based on  
18 what we know and the comments of Dr. Hurlburt and Dr. Laufer,  
19 that limited mechanisms exist, and I believe that is more  
20 accurate.

21 COMMISSIONER FRIEDRICHS: And I concur and accept that as  
22 a friendly amendment.

23 COMMISSIONER ERICKSON: Any other discussion on the  
24 proposed addition of the new Finding Statement? And I will  
25 read it. It's on the screen behind me, but we're adding an

1 additional Finding Statement. The proposal is to add this,  
2 limited mechanisms currently exist to assess patients'  
3 compliance with evidence-based medical recommendations.

4 COMMISSIONER FRIEDRICH: And again I think that Jeff  
5 made an absolutely crucial point going back to page 34 when we  
6 talk about our first recommendation involving provider payment  
7 methods. If indeed we're going to tell the Governor to use  
8 evidence-based medicine as a mechanism to determine payments,  
9 that's the second order part. There's the outcomes piece and  
10 the payment piece. If we're going to explicitly speak to  
11 evidence-based medicine as a driver for determining payment  
12 models, this is what, I believe, the public comments were  
13 referring to, that there is a shared responsibility.

14 CHAIR HURLBURT: Any other comments? I'm wondering.....

15 COMMISSIONER ERICKSON: Is somebody going to call for the  
16 question?

17 CHAIR HURLBURT: .....on the syntax on this sentence. If  
18 we said existing mechanisms to assess patients' compliance,  
19 blah-blah-blah, are limited.....

20 COMMISSIONER ERICKSON: Heads are nodding.

21 CHAIR HURLBURT: .....if that's the point that we're  
22 making, that the challenge that we have is that those  
23 mechanisms are limited in their effectiveness more than that  
24 there are some limited ones that exist, but the challenges are  
25 limited, does that ring true with anybody?

1           COMMISSIONER ERICKSON: So it would read, existing  
2 mechanisms to assess patients' compliance with evidence-based  
3 medical recommendations are limited.

4           CHAIR HURLBURT: I guess I'm offering it as an amendment  
5 to the amendment.

6           COMMISSIONER FRIEDRICH: I believe that would be a  
7 second order amendment that is in order, and I accept it as a  
8 friendly amendment.

9           CHAIR HURLBURT: Thank you, Paul.

10          COMMISSIONER ERICKSON: Call for the question?

11          CHAIR HURLBURT: Are we ready to vote on that? All those  
12 in favor of -- can we do that in one action -- maybe adding  
13 this Finding A.3.e as a Finding for the 2010 Health Care  
14 Commission, that we are adding this as it's worded on the  
15 screen there in front of you?

16          COMMISSIONER ERICKSON: I'll read it one more time,  
17 existing mechanisms to assess patients' compliance with  
18 evidence-based medical recommendations are limited.

19          CHAIR HURLBURT: Wayne?

20          COMMISSIONER STEVENS: It's time for us to vote on it.

21          CHAIR HURLBURT: All those in favor, raise your hand.  
22 All opposed, the same. I think it's unanimous, Deb.

23          COMMISSIONER ERICKSON: It's unanimous.

24          CHAIR HURLBURT: Thank you, all.

25          COMMISSIONER ERICKSON: Now we, I think, are ready to

1 vote unless there are any other suggested amendments to any of  
2 the now five Finding Statements. Any other changes? Why  
3 don't we just call for the question on that? We're  
4 circumventing a couple steps probably in our process, but this  
5 is good enough for government work.

6 CHAIR HURLBURT: Is there a motion to adopt the five  
7 Findings as.....

8 COMMISSIONER ERICKSON: As amended?

9 CHAIR HURLBURT: .....amended?

10 COMMISSIONER STEVENS: (Indiscernible - away from mic)

11 CHAIR HURLBURT: To accept it, okay. So we'll call for  
12 the question.

13 COMMISSIONER ERICKSON: Yeah, we just call.

14 COMMISSIONER STEVENS: (Indiscernible - away from mic)

15 CHAIR HURLBURT: All those in favor, raise your hand.  
16 Opposed, the same. It's unanimous. Thank you. Thanks,  
17 Wayne.

18 COMMISSIONER ERICKSON: Moving along then to our  
19 Recommendation Statement on page 34 in the draft in your  
20 packet. Emily?

21 COMMISSIONER ENNIS: I have another question about  
22 semantics or wording. Perhaps we can.....

23 COMMISSIONER ERICKSON: Is it specific to these  
24 recommendations?

25 COMMISSIONER ENNIS: It is.

1           COMMISSIONER ERICKSON: Why don't we -- I think we need a  
2 motion to adopt these Recommendation Statements first and then  
3 we'll discuss amending them.

4           CHAIR HURLBURT: Keith?

5           COMMISSIONER HURLBURT: I move to adopt.

6           COMMISSIONER ENNIS: Second.

7           CHAIR HURLBURT: Discussion? Emily, please?

8           COMMISSIONER ENNIS: Thank you. Again a question of  
9 wording. In looking at all three of these, A, B, and C, the  
10 Commission recommends that the Governor and Alaska Legislature  
11 encourage and support are the verbs used in the first one. In  
12 the second and third recommendation, the Commission recommends  
13 that the Governor require, and I'm questioning whether the  
14 word require is too strong or too directive to be used in  
15 relation to legislative activity and whether or not -- if  
16 there a reason for that, perhaps that could be discussed.  
17 Otherwise, is there a reason not to repeat encourage and  
18 support in B and C?

19           COMMISSIONER ERICKSON: There actually is a specific  
20 reason why this reads required rather than support. The first  
21 two -- and this came out of discussion. I can't remember who  
22 was available to participate in the discussions on our  
23 teleconferences. We had a couple of short teleconferences as  
24 we kind of refined these before we put them out to public  
25 comment, and there was concern expressed about public

1 programs, governmental programs imposing medical decisions on  
2 physicians and patients, providers and patients. I'm sorry.  
3 And so this was in response to that concern, that in the first  
4 two statements while we are supporting that these policies be  
5 considered, that in the third recommendation, we're saying, if  
6 these policies are considered, state government programs must  
7 involve patients and providers in the decision making process  
8 and a government program can't impose new policies related to  
9 guidance on, for example, how we're going -- if a particular  
10 service is going to be paid for or not without involving. So  
11 it was very intentional that the word required was used there  
12 and for that reason.

13 COMMISSIONER ENNIS: Thank you, Deb, and I support the  
14 involvement of providers and consumers when these decisions  
15 and activities are made. Perhaps it's number -- the second  
16 one, item B, that has more of a connotation of directive that  
17 I wanted to bring to the attention and just have an  
18 explanation for that.

19 COMMISSIONER FRIEDRICHS: Yes. I would offer the  
20 observation that, while I'm sure Alaska is much more efficient  
21 as a government than the federal government is, supporting or  
22 encouraging is a fairly unproductive activity at the federal  
23 level; requiring sometimes gets things done. And that's a  
24 personal observation, not speaking for the federal government.

25 COMMISSIONER ERICKSON: The second recommendation,

1 recommendation B, is specific to requiring the state programs  
2 involved in development and application of evidence-based  
3 medicine policies to coordinate together. So both the second  
4 and the third recommendation are directive and impose a duty  
5 on the state program. So the first one is that state programs  
6 -- for example if the State Medicaid program and also the  
7 State Employee Health Plans must coordinate together and  
8 create a consistent approach to developing these policies is  
9 what it's suggesting.

10 So the requirement is for these programs to work together  
11 to develop a consistent approach and not develop separate  
12 approaches to evidence-based medicine policy development.

13 CHAIR HURLBURT: Let me ask a question maybe because the  
14 issue that Emily raised raised a question in my mind. Is the  
15 context specifically in A.3.b the direction to the Governor  
16 for the state system with the State as a purchaser of health  
17 care services through Medicaid, Employees', Retirees',  
18 Workman's Comp, Corrections, whatever? It's not that the  
19 Governor directs and requires the private sector to do that.  
20 It's not Linda, for example, requiring that Jeff has to do  
21 this. Now Jeff, in his own enlightened self-interest, may be  
22 doing that with Premera, but we're not saying the State is  
23 saying you must do that; is that correct or is that -- it's  
24 just Emily's question raised that in my mind.

25 COMMISSIONER ERICKSON: Yeah, the Recommendations are

1 targeted to the Governor and the Legislature and they are  
2 specific to state government programs that.....

3 CHAIR HURLBURT: As a buyer of health care services.

4 COMMISSIONER ERICKSON: .....pay for health care  
5 services.

6 CHAIR HURLBURT: Does that make any difference in your  
7 comment, Emily?

8 COMMISSIONER ENNIS: (Indiscernible - away from mic)  
9 Sound didn't get on. Sorry. There's still a concern about  
10 the word require being a little, perhaps, too strong or too  
11 directive in terms of your previous comment that we weren't  
12 going to take that kind of direction with legislative  
13 suggestion or mandate.

14 COMMISSIONER ERICKSON: What we're recommending -- it's a  
15 recommendation to the Governor and the Legislature that they  
16 require government agencies to coordinate and to involve  
17 stakeholders, essentially.

18 COMMISSIONER ENNIS: And then conversely, would we not  
19 want to, perhaps, use the word require in the first one? I  
20 question the consistency and whether there was some reason for  
21 really emphasizing the second too, if these are  
22 recommendations. There was some concern expressed to me about  
23 the word require, that there could have some negative  
24 implications that the State may need to do this without all of  
25 the full information and research available to them, that we

1 don't have the evidence-based practice in place.

2 COMMISSIONER ERICKSON: Yeah, I think that's why the  
3 first recommendation is that the Governor and the Legislature  
4 encourage state government programs to engage in the  
5 application, but does not require that. But then the second  
6 two statements are, if state government programs do, they have  
7 an obligation to make sure they're working together to  
8 coordinate their approach to that and they have an obligation  
9 to engage stakeholders in the process. That's why the wording  
10 is.....

11 CHAIR HURLBURT: It's an analogy to maybe what, I think,  
12 they've been attempting to do, to some extent, in Wisconsin,  
13 where the State as a buyer, as a Medicaid buyer, for example,  
14 has reached out to hospitals, to physician groups, to others  
15 to say let us come together and let us work together and look  
16 at how we can make our dollars go and that's what's driving  
17 it, but basically saying let's do this collaboratively. And I  
18 think, you know, in the short tenure that Bill Streur has had  
19 as Commissioner here now, that Bill has been reaching out to  
20 ASHNHA, to disabled group advocates, to others, saying we've  
21 got to address this. We've got an imperative that we have to  
22 do it, but let's do it together. So I think that that may be  
23 what's driving it.

24 COMMISSIONER ERICKSON: Let me give one example, too.

25 After the conversation that we had on the teleconference

1 about the concerns that we might have, one example that I  
2 found in the literature was specific to a behavioral health  
3 situation and specific to our final recommendation here.  
4 There was an example -- and I'm not going to remember any of  
5 the details, but there was an example of, I think, relatively  
6 recent in just the past few years a government program. I  
7 don't know what or where, but a government program somewhere  
8 where government policymakers who do not have the sufficient  
9 medical expertise, read in the literature somewhere something  
10 about a particular drug to treat schizophrenia, and based on  
11 reading that article and not having the medical expertise to  
12 assess that literature correctly and to understand the  
13 situation, they imposed a public policy that -- I don't  
14 remember again exactly -- either that drug couldn't be used or  
15 it had to be used, one or the other. I think it had to be  
16 used. And so there were no psychiatrists involved in making  
17 that decision. The patient community wasn't involved in  
18 helping the policymakers to understand the implications of  
19 requiring a specific drug when that's not a good thing to do,  
20 I guess.

21 So there actually is a whole, now, national group that  
22 formed out of this behavioral health advocacy group that's  
23 specific to -- and my reading of it actually supports  
24 evidence-based medicine, but encourages that it be done right.  
25 And this is one of the things that that group was recommending

1 is that you need to make sure that the health care providers  
2 and the patients are engaged in these decisions because, if  
3 you just leave it to government bureaucrats, they might be  
4 very well-intentioned but read an article and say this is good  
5 idea and make a decision without knowing what they're doing.  
6 So that, again, emphasizes why it's required, but then why  
7 this recommendation is even in there in the first place, and  
8 another example in addition to engaging them in these  
9 decisions and helping to understand what cost controls we can  
10 put in place.

11 CHAIR HURLBURT: Paul?

12 COMMISSIONER FRIEDRICHS: Deb, I think that's a great  
13 example. I'll tell you again, from the federal level and  
14 especially through the American Medical Association, across  
15 the United States, you can find instances where unilateral  
16 actions were taken in the absence of a collaborative approach  
17 that wound up having very undesired and unintended second  
18 order effects, and I think the language is very appropriate  
19 and you're right. We did talk about this on the  
20 teleconference. I would support leaving it as written right  
21 now.

22 COMMISSIONER ERICKSON: Heads are nodding.

23 COMMISSIONER ENNIS: Thank you. I appreciate this  
24 discussion. I didn't want to get into too much of  
25 wordsmithing here, but I did need to understand that a little

1 more fully, so thank you.

2 CHAIR HURLBURT: Do you want to leave your comments as a  
3 proposal to amend the wording or not?

4 COMMISSIONER ENNIS: No.

5 CHAIR HURLBURT: That was just discussion; okay.

6 COMMISSIONER ENNIS: I wanted to raise the question to  
7 see if anyone else had a concern, particularly the physicians,  
8 regarding the word require versus encourage and support.

9 CHAIR HURLBURT: Any other comment before we vote? Paul?

10 COMMISSIONER FRIEDRICHS: Mr. Chair, if you'll help me?  
11 So if I'm going to propose a follow on Recommendation that  
12 will link to the Finding that we added previously, is this the  
13 time to do that or when?

14 CHAIR HURLBURT: Please. Yeah.

15 COMMISSIONER FRIEDRICHS: So I would suggest that we  
16 amend our Recommendations to include Recommendation A.3.d,  
17 state health care programs will seek to incorporate data on  
18 patient compliance in developing new provider payment methods.

19 COMMISSIONER ERICKSON: I'm sorry. Is that specific to  
20 evidence-based medicine or is this a strategy to consider in  
21 2011?

22 COMMISSIONER FRIEDRICHS: I will seek your help in  
23 wordsmithing that, to the extent that we meet the needs of the  
24 Commission. I mean, we're speaking -- this is section is in  
25 toto referencing evidence-based medicine. And again, I'm not

1 sure how best you want to wordsmith that, but as I read  
2 through the public comments, this was that recurrent theme  
3 from the providers and physicians in particular that sense  
4 that the Commission report focused heavily on physician  
5 responsibility to do the right thing, to be cost-conscious.  
6 Where there is data that also speaks to patient responsibility  
7 and patient acceptance of that responsibility, that should  
8 factor into decisions. And I think this directly ties, sir,  
9 back to the discussion that we had. And I have to apologize.  
10 Maybe my colleagues can help me that were at the ASHNHA  
11 meeting because it may have been at ASHNHA and not here. So  
12 if it wasn't here, please correct me. But we had a very good  
13 discussion about the opportunity in Alaska to be innovative,  
14 to not blindly adopt what everybody else is doing in the Lower  
15 48 just because that's what everybody else is doing, but  
16 because we are building a health care system that has not  
17 existed for 200 years, we can do things differently here. And  
18 one of the things that has not happened well in many levels of  
19 the health care industry is to include the patient decision in  
20 an evaluation of how effective evidence-based medicine is.

21 COMMISSIONER ERICKSON: Can you read that again one more  
22 time, Paul, please?

23 COMMISSIONER FRIEDRICHS: State health care programs will  
24 seek to incorporate data on patient compliance in developing  
25 new provider payment methods.

1 CHAIR HURLBURT: Any other comments on that?

2 COMMISSIONER ERICKSON: Do you want it just specific to  
3 provider payment methods or to also include benefit design?

4 COMMISSIONER FRIEDRICH: Thank you. That's a wonderful  
5 point, and I would include benefit design. Thank you.

6 COMMISSIONER ERICKSON: Yes?

7 COMMISSIONER LAUFER: I'd just like to really support  
8 that, in primary care, we're very used to lots of  
9 encouragement and support, which I would call hot air, and no  
10 payment for the majority of the things that we do. And in my  
11 experience, particularly in training in Seattle in an HMO  
12 environment, evidence-based medicine, while it's a double-  
13 edged sword, only one edge was used and it was only used to  
14 deny payment or deny care. If it were used to reimburse  
15 doctors, it'll happen. Thanks, Paul.

16 COMMISSIONER ERICKSON: That was a second.

17 COMMISSIONER FRIEDRICH: And you notice they separated  
18 us for this meeting.

19 CHAIR HURLBURT: So we have a second to the motion.

20 COMMISSIONER ERICKSON: And I'll read it and we can call  
21 for the question.

22 CHAIR HURLBURT: And this is the motion to amend the  
23 wording.

24 COMMISSIONER ERICKSON: Well this is the motion to amend  
25 our set of Recommendations by adding a new Recommendation that

1 will read, state health care programs will seek to incorporate  
2 data on patient compliance in developing new provider payment  
3 methods and benefit design.

4 CHAIR HURLBURT: All in favor, raise your hand. Opposed,  
5 the same. It's unanimous.

6 COMMISSIONER ERICKSON: It's unanimous.

7 CHAIR HURLBURT: So now, are we ready to vote on adopting  
8 the Recommendations?

9 COMMISSIONER MORGAN: I move that we adopt the  
10 Recommendations.

11 CHAIR HURLBURT: Thank you.

12 COMMISSIONER STEVENS: Second.

13 CHAIR HURLBURT: Thank you, Wayne. Any discussion? All  
14 in favor, raise your hand. Opposed, the same. Again  
15 unanimous. Thank you.

16 COMMISSIONER ERICKSON: Now we need a time check. We're  
17 way behind schedule. What we need to do is we were supposed  
18 to have a break at 10:30. It's 10:37 now. I propose we try  
19 to take a very short break and try to reconvene at 10:45 if at  
20 all possible. We have a group of folks here to share some  
21 information with you all on the community health data, and I'm  
22 suggesting that we -- in the past -- I need to check our logs  
23 to see if folks have signed in. In the past, we've used a lot  
24 less of our public comment period that we have allotted. So  
25 if we don't have a whole lot of people signed up to testify,

1 we can continue our discussion and vote on our 2010 report  
2 during the time allotted for the public hearing. I think I'm  
3 going to suggest beyond that, but I'll check with the Chair  
4 because we can't shorten lunch anymore. It's already half-an-  
5 hour and maybe we'll just limit it to 15 minutes and have a  
6 working lunch.

7 The other thing that we might do is try to shorten the  
8 time at the end of the day devoted to the Affordable Care Act  
9 discussion. The three members of the Administration who are  
10 here to present can very quickly go over some main points, and  
11 I've included documents that have been made public by those  
12 organizations so far in the packet.

13 CHAIR HURLBURT: So what are you suggesting for the 10:45  
14 panel, Deb?

15 COMMISSIONER ERICKSON: I'm suggesting that we try to  
16 reconvene at 10:45, acknowledging that we'll be a few minutes  
17 late.

18 CHAIR HURLBURT: And as far as the panel?

19 COMMISSIONER ERICKSON: With the panel. With the panel.

20 CHAIR HURLBURT: Oh, to reconvene with the panel?

21 COMMISSIONER ERICKSON: Yeah. We've had people show up  
22 just for this time period just to present, so I think we need  
23 to move on with that panel and work to get our 2010 discussion  
24 finished for the report throughout the day today.

25 CHAIR HURLBURT: We'll break.

1 10:39:10

2 (Off record)

3 (On record)

4 10:48:08

5 CHAIR HURLBURT: We're at 10:45. Not much of a break,  
6 but we knew that. I wonder if we could get back together  
7 again, please. I'd like to just remind all of the public  
8 attendees here, if you could sign in on the sign up sheet, and  
9 if anybody wants to testify, if you could sign up there, so  
10 that we know going into the session after lunch how many folks  
11 we have.

12 (Pause - background discussion)

13 CHAIR HURLBURT: I think we're almost all back here  
14 together. Thanks. Sorry for the short break, but it's your  
15 own fault.

16 Before we get started on this next session, I think it's  
17 probably not a first. I think maybe Jay Butler came and  
18 visited one time, but I'd like to acknowledge Ryan Smith who  
19 put a lot of effort and work and was such a positive  
20 contributing member of this Commission for about the first  
21 year-and-a-half that we were in existence and really  
22 appreciate your coming today. Ryan was a representative of  
23 ASHNHA as one of Pat Branco's predecessors as the Chair, the  
24 President of the ASHNHA group. So thank you for being here.  
25 We look forward to anything you may have to say, maybe give

1 you a special invitation during the public comment period, if  
2 you'd like to share your perspective as one who was around  
3 from the beginning, but welcome and thank you, Ryan.

4 This next panel that we have, we want to talk about the  
5 consumers' role in prevention, healthy lifestyles, and some  
6 about the online community-based health data system.

7 We have three presenters here for that. The first two  
8 presentations will be more informal and then Andrea's will be  
9 a more formal presentation with overheads.

10 Elizabeth Ripley, who is the Executive Director of the  
11 MatSu Health Foundation and who has been a regular  
12 participation with this group, coming to a number of our  
13 sessions, is here.

14 Next will be Michele Brown, who is the Executive Director  
15 with United Way. Michele, likewise, has been here.

16 And then Andrea Fenaughty, who is the Deputy Director of  
17 our section on Chronic Disease Prevention & Health Promotion  
18 and who is probably Miss Smoking Cessation, Miss Obesity  
19 Prevention, Miss Lots of Titles. Since I have been here, I've  
20 learned what an asset Andrea is to the State and to me in my  
21 job and so Andrea will be having the last presentation here.

22 But Elizabeth, if we can start with yours, and welcome  
23 again. Thank you for coming. Please go ahead.

24 MS. RIPLEY: Dr. Hurlburt, Commissioners, thank you for  
25 this opportunity today. My name is Elizabeth Ripley. I'm the

1 Executive Director of the MatSu Health Foundation, and the  
2 MatSu Health Foundation is a 501(c)(3) that shares ownership  
3 in the MatSu Regional Medical Center, and we use the revenues  
4 that we earn from that relationship to invest back into our  
5 community to raise health status to the tune of about \$4.3  
6 million in grants annually at this point, given our current  
7 investment strategy.

8 I have been involved in health planning work in MatSu for  
9 almost 20 years, and I've worked with stakeholders across this  
10 vast borough, which is the size of West Virginia, with the  
11 State's fastest growing population to try to raise health  
12 status of MatSu residents. And during that entire time in  
13 more conversations than I care to recall, we have lamented our  
14 challenges with accessing valid and reliable data, borough  
15 level data, and I'm not talking about zip code level or a  
16 census-designated place, but actually just borough level data.

17 The State's fastest growing region is, quite often,  
18 lumped in with Anchorage, and we're not only lumped in with  
19 Anchorage on the data dissemination end, but we are lumped in  
20 with Anchorage on the data collection end. For instance, the  
21 Center for Disease Control's Behavioral Risk Factor  
22 Surveillance System requires that each state gather at least  
23 2,500 surveys annually, and the state of Alaska collects those  
24 2,500 surveys based on 500 from five regions across the State.  
25 And by combining Anchorage and MatSu into one region, 54% of

1 the State's population is measured by only 20% of the data  
2 collected for BRFSS.

3 The State lumps 150 MatSu respondents in with 350  
4 Anchorage respondents to report on health behaviors. MatSu is  
5 currently 12% of the State's population and growing rapidly,  
6 yet it is represented by only 6% of the State's BRFSS  
7 sampling. This creates high margin of error rates for MatSu  
8 on select indicators. For instance, in the Robert Wood  
9 Johnson Foundation's County Health Rankings Report which came  
10 out last year and is due out again shortly, which pulled from  
11 the BRFSS, some of the indicator margin of error rates for  
12 MatSu were as high as 80%. Now we certainly can't rely on or  
13 allocate resources based on such data.

14 The state of Alaska also collects a great deal of data,  
15 and much of this is not accessible to community-based efforts,  
16 such as ours. Either we cannot access it at all or it is only  
17 provided in the aggregate form or it lacks context and  
18 analysis. We recognize that there are huge data collection  
19 efforts by numerous state agencies and departments, but even  
20 within the state, the different departments do not uniformly  
21 share the data, trend the data, and analyze across issues.

22 That said, I do want to be clear that I've had nothing  
23 but great responsiveness from the public health officials and  
24 data gurus and epidemiology and chronic disease prevention and  
25 health promotion departments over the years. They work hard

1 to help us to provide what data they can and also customize  
2 individual reports when time allows. They are doing this work  
3 for community-based organizations, such as ours, and they're  
4 doing it for legislators and their staff and other bureaucrats  
5 on a need-by-need basis because there is no uniform, common  
6 system accessible to the public.

7 This need-by-need basis data production is not cost-  
8 effective, and it will not help the State or local communities  
9 to make broad changes to systems to improve public health. We  
10 need a better system to maximize the use of the data the State  
11 is collecting. This system, this data needs to be accessible  
12 and usable for all branches of state government and also by  
13 local communities to understand where we need to work, where  
14 we need to allocate our resources, to track improvements, make  
15 strategy adjustments, and even celebrate successes.

16 They say that most politics are local. The same is true  
17 for health. At the American Public Health Association's  
18 annual meeting this past October in Denver, in numerous  
19 sessions, covering every topic from chronic disease rates to  
20 obesity rates to heart disease mortality, they analyzed ER  
21 admission data in many different parts of the country and  
22 asked the question, why is this particular zip code healthier  
23 than this one? Why is this zip code in Tennessee right next  
24 to another zip code in Tennessee, why is one healthier than  
25 the other?

1 More and more often, public health officials, private and  
2 public funders, like the MatSu Health Foundation, and  
3 community-based stakeholders are turning to place-based  
4 environmental strategies to create health communities. We  
5 need to understand where the health disparities and the health  
6 deficits are in Palmer, in Wasilla, in Talkeetna, in Sutton,  
7 and how they are changing and trending due to our rapid  
8 population growth.

9 We need to address the access issues, the lifestyle  
10 changes, and the environmental improvements that need to take  
11 place to help raise health status. We need to understand  
12 better the huge behavioral health needs presenting at the  
13 MatSu Regional Medical Center emergency department and design  
14 a system to prevent the ER admissions in the first place. We  
15 need to better allocate resources to address the problems and  
16 create a healthier MatSu.

17 The MatSu Health Foundation is committed to making  
18 measurable improvements in our population's health,  
19 improvements driven by data. So we have financed the Alaska  
20 Healthy Kids Survey of MatSu seventh, ninth, and eleventh  
21 graders for our local Substance Abuse Prevention Coalition.  
22 We're taking the lead in a new community needs assessment. We  
23 commissioned a regional plan for the delivery of senior  
24 services in MatSu because we have one of the fastest growing  
25 senior populations in the country. And this year, we're

1 commissioning a separate sample of 500 MatSu residents for the  
2 BRFSS. It's obvious why the MatSu Health Foundation and MatSu  
3 stakeholders are interested in valid and reliable MatSu data,  
4 and in the spirit of action, we have initiated this step, but  
5 shouldn't the State also have some keen interest in the  
6 fastest growing region of the State?

7 This region has been the fastest growing for four  
8 decades. We ask that you look carefully at the state budget  
9 for 2012 and into the future and build an equitable mechanism  
10 for data collection into this budget, and we encourage you to  
11 look at creating additional regions for BRFSS sampling.

12 You need to know that the MatSu Health Foundation is also  
13 committed to partnering with the State where possible to  
14 address this data collection and dissemination issue.

15 We have been very impressed with the IBIS-PH platform  
16 that you will see demo'd here today. The State has already  
17 invested in this platform, but has not allocated sufficient  
18 resources to see it through. This system will potentially  
19 eliminate the need for so much individualized data requests  
20 and reports within the state because it houses and integrates  
21 the data and makes the data available to state employees,  
22 legislators and their staff, and community stakeholders trying  
23 to understand and improve the health of their communities.

24 If we can improve this system, it's a win for MatSu.  
25 It's a win for the communities that you represent. It's a win

1 for Alaska.

2 Accessible, meaningful data at the community level is a  
3 key driver in helping Alaska meet Healthy People 2020 targets,  
4 in reducing Medicaid costs, in eliminating costly hospital  
5 admissions that are preventable, in managing chronic diseases  
6 in a way that keep people working, and building quality of  
7 life in our state. Thank you for this time this morning.

8 CHAIR HURLBURT: I think we'll have want to have any  
9 questions and any discussions -- we can probably come back to  
10 it at the end, but maybe if there are any comments or  
11 questions now for Elizabeth from anybody? Yes, David?

12 COMMISSIONER MORGAN: This probably is a simple question  
13 and I just missed it. How does the data that's collected,  
14 evidently not just from surveys but from other activities, how  
15 does all the data get into the system? Is that done by the  
16 organizations or by Medicaid or by the public health section  
17 of the state? How does that work?

18 MS. RIPLEY: Well I think that's one of the issues.  
19 Right now, you have individual departments in the state  
20 collecting the data, and the data is not even necessarily  
21 shared with other departments. There is actually -- you know,  
22 there are agreements and user issues and cleaning the data and  
23 all these other issues that complicate it on the ethical side,  
24 but there is no data repository, so to speak, that exists  
25 where that can be. But who does it? Somebody has to take the

1 leadership role in that, a leadership role in making sure all  
2 the departments do put the data in and are committed to that.

3 COMMISSIONER MORGAN: I never ask a question, unless I  
4 already know the answer. Yeah. I just wanted to make sure  
5 that that's what it is because, in my background of  
6 interacting with the State, it does seem like it's fractured  
7 and not centralized and not easily accessed. So basically  
8 what you're proposing is to correct all that with the system,  
9 is that -- have I got it?

10 MS. RIPLEY: Definitely. It takes leadership to make  
11 sure that all the departments follow through and then it takes  
12 resources to be able to build it out.

13 CHAIR HURLBURT: Larry?

14 COMMISSIONER STINSON: Elizabeth, previously -- this is a  
15 little bit off topic, but we had talked about Medicare clinics  
16 in Alaska, how important that was to serve that population. I  
17 know that you have started a trial Medicare clinic out at the  
18 MatSu. How is that working out?

19 MS. RIPLEY: It's full. It's working out very, very  
20 well, and they do plan to recruit additional providers to that  
21 practice and maintain it, but they're already -- their  
22 schedule is full and they are taking Medicare patients as they  
23 can, but right now I believe, they only have one physician  
24 provider and they're working on recruiting additional  
25 physician providers to that practice.

1 COMMISSIONER STINSON: But it is self-sustaining, it's  
2 self-supporting?

3 MS. RIPLEY: No. No. The hospital is planning on taking  
4 a loss, a budgeted loss.

5 CHAIR HURLBURT: Yes, Paul?

6 COMMISSIONER FRIEDRICHS: So I usually ask questions  
7 because I don't know the answers and that's the way I go  
8 through life, unfortunately, is not knowing the answers.

9 We heard a presentation, and I apologize because I don't  
10 remember if it was the same system to which you were  
11 referring, but when we were meeting at the -- I think it was  
12 the Dena'ina Center, one of the offsite meetings or other  
13 locations, we had a very nice presentation about a data  
14 repository which was used in New Mexico. Does anyone recall  
15 if that's the same system to which you are referring? And I  
16 apologize if you addressed that when I came in late.

17 MS. RIPLEY: No, I think you had a very brief reference  
18 to it, and this morning, you're going to get sort of the full  
19 demo.

20 COMMISSIONER FRIEDRICHS: And then the follow on question  
21 to that, which I don't recall again being addressed clearly at  
22 the last presentation is, what would be the cost for the State  
23 to implement a similar system? Has anyone seen data on that  
24 or have I just forgotten it from the last presentation?

25 CHAIR HURLBURT: Andrea?

1 MS. FENAUGHTY: Hi, I can address that. It would be  
2 variable relative to the extent to which we implemented it,  
3 but we could get a very good start for probably around  
4 \$200,000.

5 COMMISSIONER FRIEDRICHS: And then the last question --  
6 and really, Mr. Chair, this is directed to you and to the  
7 Commission members is, we just spent a fair amount of time  
8 discussing our recommendations to the State, specific to  
9 evidence-based medicine. In the absence of such a data  
10 system, what evidence will we base our decisions on?

11 CHAIR HURLBURT: Well, I think what I'm hearing, we're  
12 addressing the health care part and the health care  
13 intervention part, but probably a more generic question that,  
14 you know, we all could draw the map of Alaska stretching east  
15 to west and north to south as far as the Lower 48 is concerned  
16 and we would not think about just one set of data.

17 The other reality is that we have the number of people in  
18 the whole state that the people in a lot of the country would  
19 call a middle-sized city and so we have to balance those. And  
20 so we've got the historic breakdowns that we've had on data  
21 that we break out into a northern region and a Wade Hampton.  
22 People say, what's that? You know, Southwest Alaska, the  
23 Fairbanks area, Anchorage, MatSu, Southeast Alaska, and there  
24 are differences in climate that impact on a lot of things, on  
25 work opportunities, on health, on a number of things there,

1 differences in geography and the populations there. And as  
2 Elizabeth is pointing out, MatSu, which has also always been  
3 kind of the tail tacked onto Anchorage of Anchorage/MatSu, has  
4 been for a long time now the fastest growing part of the  
5 state. And so you know, what are the implications of this?

6 We're talking about health care, but maybe -- I would  
7 assume -- and I live in Anchorage and not MatSu, but I would  
8 assume that there is push for other kinds of data, employment  
9 data or whatnot, to recognize the reality of what's happened.  
10 So I guess I would turn the question or maybe change it a  
11 little to just ask for a comment from Elizabeth on that.

12 If we do make a part of our recommendation that -- maybe  
13 in the 2011 recommendations or whatever to the State that we  
14 really look at expanding from five to six or redoing or  
15 whatever the suggestion is, the number of geographic areas in  
16 the state, so what, which I think is what you're asking maybe,  
17 Paul, a little, what is the impact, specifically narrowing  
18 back down to health? Are the implications for what you're  
19 going to do about it what the implications are of how you  
20 address the problems in MatSu going to be significantly  
21 different than they are in Anchorage where you have a  
22 population that ethnically is similar, economically is  
23 probably somewhat similar but a much more disbursed lifestyle?  
24 There are some differences there. Resource availability is  
25 somewhat different, so I'd just ask for maybe a comment on the

1 so what, that if we do break it out and we get a sixth area or  
2 however it's going to be, how it's going to impact what we can  
3 do to address issues and challenges.

4 MS. RIPLEY: I think it's pretty significant. I mean,  
5 our population is very different demographically. We're much  
6 more homogenous in many ways. We're 85% Caucasian, 7% to 8%  
7 Alaska Native, and you know when you look at the -- and I'll  
8 just give a few simple examples, but you know when we look at,  
9 say tobacco, from the research we've done, we know the highest  
10 rate of chew is in Palmer. It's going to make how we respond  
11 -- and why is tobacco chew being used more in Palmer? I mean,  
12 I think we have to literally get down to that level. What's  
13 the culture in Palmer that is making chew more accessible to  
14 the kids there and more acceptable and why is the rate higher  
15 there?

16 So I mean, I think that -- and when I talk about  
17 environmental strategies, what are the things in our  
18 communities that are actually creating health by their very  
19 constructs. And then, of course, access. Access is going to  
20 be markedly different in MatSu than in Anchorage because we  
21 have -- certainly in the core area, we have pretty decent  
22 access to primary care and specialty care, but outside the  
23 core area -- and again we're talking about an area the size of  
24 the state of West Virginia and a population density that's  
25 about 3.1 persons per square mile, you're talking about

1 completely different access in the outlying areas.

2 On my way in, I was listening to your conversation and  
3 you talked about the emergency medical system. I mean, that  
4 EMS system is critical in MatSu in terms of access, pre-acute  
5 care. It's absolutely critical. And so we design that system  
6 to meet the needs of that outlying area is going to be, I  
7 think, markedly different from what you're going to see in  
8 Anchorage. So I think the response on the health determinant  
9 side all the way to the health access side is going to be  
10 different in MatSu.

11 The important point is, if we have the data, we're going  
12 to take ownership in responding and helping our community to  
13 be healthier.

14 CHAIR HURLBURT: Yes, Paul? Thank you, Elizabeth.

15 COMMISSIONER FRIEDRICHS: So thank you, ma'am, and thank  
16 you, Mr. Chair. Let me put my cards on the table. We said  
17 just before we took the break that we were going to conclude  
18 our discussion at a later time on 2010 Recommendations. I  
19 will look for the Chair's advice on how best to do this,  
20 whether it needs to be a motion to reconsider recommendations  
21 or if you had planned to entertain new recommendations, but  
22 since we had already discussed this issue of data collection  
23 at a previous meeting, it's clearly germane to our 2010  
24 recommendations and also germane to the discussion of  
25 evidence-based medicine. It's difficult to imagine how you

1 can provide evidence-based medicine in the absence evidence  
2 and that evidence is going to be the data to which, I believe,  
3 Elizabeth is referring right now. And the State has an  
4 opportunity, and I'd be happy to discuss that further,  
5 whatever point you deem appropriate today to act on that and  
6 help us move forward with these other recommendations that  
7 we're making. So I'll defer to you, sir, on when you would  
8 like to have that discussion, but it does tie directly to our  
9 2010 Recommendation.

10 CHAIR HURLBURT: And I think we do plan to fit in the  
11 discussion on that. I guess my comment reflected my biases  
12 that it would be appropriate to look at as a part of our  
13 discussion for the coming year, but I think that's open to the  
14 group as to whether or not we want to modify what we had for  
15 the last year's discussions on that, and obviously, another  
16 year would mean another year's loss as far as the value of any  
17 impetus by the Health Care Commission recommending to the  
18 Governor, to the Legislature that we look at how we divide up  
19 the data from the State.

20 COMMISSIONER FRIEDRICHS: And if I may just add, again  
21 from a federal perspective, we began working on this in the  
22 late 1980s and early 1990s. We are not yet at a point where  
23 we can reliably provide all of the data that we need, even for  
24 diabetes management in real time fashion. This is a non-  
25 trivial undertaking. The longer that the State delays

1 tackling this and laying out the parameters in which you're  
2 going to do that the more difficulty, I believe, the State  
3 will experience in actually implementing evidence-based  
4 medicine or the Medical Home Model that we've also discussed  
5 here.

6 CHAIR HURLBURT: Right. Thank you. I think we probably  
7 need to go on to Michele Brown to have your presentation now.  
8 Thank you.

9 MS. BROWN: Thank you. Also Diane Ingle who is the  
10 Director of the City's Department of Health and Human Services  
11 couldn't be here, but I do have a written statement from her,  
12 if I could just pass that around.

13 So Dr. Hurlburt and Commissioners, thank you for having  
14 me. I'm Michele Brown with the United Way of Anchorage

15 First, I want to thank you for your service. I  
16 appreciate what you're doing for all the citizens in this  
17 state and for hearing today from us to talk about the value of  
18 having a reliable Community Health Data Indicator system. I'd  
19 like to share, if I may, one brief example with you of the  
20 power of how data has been used to help Anchorage see some  
21 improvement, and I think it will tie together some of the  
22 themes you've heard today. Two years back, my organization  
23 was looking at commemorating our 50th anniversary. So we  
24 started planning for the next 50 and realized, somewhat to our  
25 chagrin, that, you know, we're working on some of the same

1 issues that we were working on 50 years ago. And as hard as  
2 we were all working, as much money has been spent, as much  
3 heart and passion that had been invested, some of the same  
4 issues were still troubling us in the same way.

5 So we realized we really needed to take some stock,  
6 really understand our community and then also take stock of  
7 ourselves and our role in how we're addressing these community  
8 issues. That taking stock became known as the Anchorage  
9 Community Assessment Project. It was co-chaired by United  
10 Way, Providence, and the Municipality, and we had dozens of  
11 partners and extensive input, and the assessment offered a  
12 comprehensive view of our quality of life, tracking 231  
13 indicators in multiple areas, one of which was health, and I  
14 brought an Executive Summary as well as some of the first  
15 pages of the report so you can see actually the list of  
16 indicators. It's all available online, if you want to follow  
17 up on it.

18 It is mostly a compilation of secondary research, much of  
19 which is from state sources, but I have to tell you it was  
20 pretty difficult to cull those out and to synchronize them.  
21 There is primary research that came from telephone and face-  
22 to-face surveys to give us some sense of how people are  
23 experiencing quality of life. The data snapshot that was  
24 assembled is important, but the real benefit to having that  
25 indicator set is that it jump-started a critical conversation

1 in the community about, are we satisfied with this? Is this  
2 what we want to have for our community or do we want to see  
3 change? And it's also helped us keep momentum up because  
4 we're tracking trends now. We've now completed three cycles  
5 of this assessment, and we made a strong commitment when we  
6 started this. The assessment and data is not an end in and of  
7 itself. It provides us the information, but it's up to us to  
8 take action and do something with that data. So our plan of  
9 how to do that is the slide you have up there, and it's really  
10 a four-part cycle.

11 First is information. It helped us set some very clear  
12 community goals, and it was based on a sound collective  
13 understanding of where the community stood on several key  
14 indicators.

15 Secondly, it took us to the point of true collaboration,  
16 not just sharing, but really taking unified action and  
17 integrating our strategies with common reporting of  
18 performance outcome measures that tie to the overall  
19 population level change we wanted to see.

20 Third, it drove, in part, more coordinated, more  
21 leveraged, and even occasionally blended resources, and I know  
22 that's, you know, a pretty hard goal for many of us to think  
23 about.

24 And then the last quadrant is it led us to continually  
25 track the trends, monitor progress, verify measurable results,

1 and recalibrate as needed. And all parts of this cycle have  
2 to be worked to make change. Lots of us have been involved in  
3 one quadrant or another, but it really is important that we  
4 keep working the whole cycle. And how that played out in  
5 Anchorage, the first assessment captured for us that we had a  
6 -- 40% of our kids were not graduating on time, so a pretty  
7 huge number and that wasn't new news, but this showed a  
8 spotlight on it and it also showed us what kids we were losing  
9 and why because we had a lot of community data about what was  
10 happening to our kids. And although much of that data was  
11 also known, it was the first time it came out in one place and  
12 put all the puzzle pieces together, and it was not a pretty  
13 picture. But what it did was it led more than 40  
14 organizations across multi-sectors to come together and put a  
15 line in the sand and say, we're no longer talking about this  
16 grant and that grant or this program or that program or this  
17 service or that service. We are not successful until we turn  
18 around that graduation rate. It doesn't matter all these  
19 other pieces. We have got to turn that around.

20 And so in this chart over here, you can see what that  
21 enabled us to do was we set a clear goal and the means to  
22 track it. We set -- we developed a community plan with common  
23 use outcomes that will move that graduation line. We re-  
24 purposed as necessary, and we blended resources, and we are  
25 continually tracking.

1           The result in four years is we have seen almost a 10%  
2 increase in graduation rates, and it's not because, you know,  
3 of some new phenomenal idea. It really is more than blending  
4 and tracking and really making sure that there is -- as you  
5 were saying, that, if we think something is best practice, we  
6 need to verify that, in fact, it's leading to the result we  
7 want.

8           Another interesting fact is, when we began this work, we  
9 inventoried the data collection work that was going on among  
10 these 40-some partners and we were stunned to see how much  
11 money was going into that, and it was disproportionate to  
12 program expenditures or the value that we are getting out of  
13 it. So when we could come together and agree on a common  
14 effort, like the Community Assessment Data Indicator Set, we  
15 were able right then and there to free up a lot more funds for  
16 substantive program work, which included anything from one-on-  
17 one use services to some of the environmental public policy  
18 things that have been talked about earlier.

19           Similar work is underway in Anchorage now on decreasing  
20 family homelessness and access to health care, but I've got to  
21 tell you the health area has been the toughest for us to work  
22 on, and the two major reasons are the lack of accessible  
23 consistent data and the real willingness to cross silos and  
24 share strategies and resources.

25           I was struck in the draft report and strategic plan that

1 you all had prepared of your statement of, basically faced  
2 with an extraordinarily complex system that has developed  
3 piecemeal over decades with players of radically different  
4 perspectives, your solution was to start with a vision of  
5 improved health for Alaskans and that health status, I think -  
6 - you know, starting from that point is really, really crucial  
7 and then designing back to how you're going to get there. The  
8 foundation though to build to that vision must build on  
9 consistent data that we can all unite around. You also set  
10 goals for access, contained costs, safety and prevention. The  
11 foundation to build to those goals has got to rest on, again,  
12 consistent data, tracking, and performance outcomes that we  
13 all commit to that we believe will turn those curves around,  
14 those status outcomes we want to see.

15 And also the report recognized that communities play an  
16 important role in creating the local environments that can  
17 encourage or discourage healthy lifestyles. The foundation  
18 for that is, as I think Elizabeth was just pointing out, we  
19 can't create the right community conditions together that are  
20 going to contribute to better outcomes, unless we have  
21 consistent data tracking and collection.

22 So in short, we've just got to have this kind of  
23 consistent, accessible data to make meaningful progress on  
24 health outcomes.

25 We think that the State is in the best position to

1 provide what you had called in the report this critical  
2 resource for community health planning and that resource is,  
3 of course as you say in there, timely and relevant data that  
4 we can all align around. But I want to tell you, the State  
5 doesn't have to do this alone. Many of us are already working  
6 in this area. A public/private partnership is ripe for the  
7 picking. There are many who are willing to step up and help  
8 the State in this, and we do it in partnership and then we'll  
9 be able to plan better in our communities, if we started from  
10 that point in partnership. We just need, I think, to make all  
11 of us the commitment to outcome-based work and the commitment  
12 to building that foundation around consistent, accessible,  
13 reliable data.

14 So thank you very much for listening, and again, thank  
15 you for all you're doing.

16 CHAIR HURLBURT: Thank you, Michele. Any comments or  
17 questions for Michele? Paul, please?

18 COMMISSIONER FRIEDRICHS: So your construct of a  
19 public/private partnership is interesting. \$200,000 is a  
20 remarkably optimistic figure for executing a statewide data  
21 repository and collection mechanism, and I don't mean that in  
22 any way to sound critical or pejorative, just personal  
23 experience in working these programs. They wind up being  
24 quite challenging to execute. Could you expand a little more  
25 on what you envision in a public/private partnership, and

1 especially specifics on numbers and timelines would be helpful  
2 to understand what you're referring to?

3 MS. BROWN: I'm thinking of, if we build on a lot of the  
4 efforts that have already been started on data collection and  
5 we come together in a summit and really design what would be  
6 the framework for the key indicators that we would need to be  
7 tracking consistently throughout the state, we could match  
8 state money with, say, private philanthropic dollars, or you  
9 know frankly lots of times, we have seen these things -- if  
10 everybody put on the table what they're currently spending for  
11 that now, pooled it together, you could probably build a  
12 system for half of what everybody is currently throwing into  
13 this subject anyway. So it's really a question of that  
14 blending resources and agreeing up front of what the structure  
15 will be, but you know, we would try to develop -- build --  
16 raise the money to match what the State put in through private  
17 sources. I don't want to speak for you, but.....

18 MS. RIPLEY: I think I said that in my presentation.

19 CHAIR HURLBURT: Jeff?

20 COMMISSIONER DAVIS: Thank you. Thank you, Elizabeth and  
21 Michele. That's great. I think that -- well two comments, a  
22 comment and a question. The question first. I think that  
23 we're in danger here of mixing two things up. I think what  
24 you're talking about is population health-based data, and I  
25 think, Paul, what you were talking about was clinical data,

1 and those are -- you know, they're related again, but they're  
2 very separate things, and the clinical data is a much more  
3 monstrous project than the population-based data that I think  
4 what I'm hearing the two of you talk about. So am I correct?  
5 I see your heads nodding. And they're related, and you know,  
6 there is health data in the population data, but we're not  
7 talking about what happened in a physician's office visit,  
8 which is -- when we talk about evidence-based medicine, that's  
9 what we're referring to, but it's a very different thing and  
10 there are different initiatives going on around that in the  
11 health IT area that, of course, are way more expensive than  
12 \$200,000. Am I on the right track?

13 MS. RIPLEY: That's different, but there are -- for  
14 instance, you already collect the ASHNHA, the Alaska State  
15 Hospital Nursing Home Association, inpatient reports, and now  
16 they're collecting ER data, and from the chronic disease  
17 standpoint, that data is not publicly accessible.

18 COMMISSIONER DAVIS: No, but again, you're looking at  
19 population-based data. What was the rate of ER use per 1,000  
20 in this spot? So that's a very different thing, and I'm just  
21 -- I would say I agree with you that, you know, that famous  
22 health statistician Yogi Berra said, if you don't know where  
23 you're going, you're liable to end up someplace else, and if  
24 you don't know where you're starting, you don't know where you  
25 need to go. So I just thank you for your comments and they're

1 very valuable.

2 COMMISSIONER FRIEDRICH: Well I was going to use the  
3 same Yogi Berra quote because we always use that when we talk  
4 about data, especially. And Jeff, I don't completely agree  
5 with you that there are two different things because we spent,  
6 at least in my organization, ten years operating under that  
7 premise that there are two different things. We spent a lot  
8 of money developing very elaborate parallel systems, only to  
9 discover that, ultimately, what we needed was a single system  
10 and what we needed to design towards was a single system that  
11 would provide both. And again if you know where you're going,  
12 which is a single data repository from which you can get both  
13 population based and individual data, you can begin with that  
14 end state in mind. Having nothing, getting just population-  
15 based data is a step forward. If you step in a progressive  
16 fashion where your end state is a robust data repository from  
17 which you can get both evidence-based patient level data for a  
18 clinician to use as well as population-based data for various  
19 enterprises to use, it usually will lead you in a slightly  
20 different direction than if you start to do just one or the  
21 other. So I would encourage the Commission and I would  
22 welcome comments from both of you on that, but our experience  
23 has been that, if you try to do those as separate endeavors,  
24 you will spend a great deal of money building redundant  
25 systems, and ultimately, you'll wind up having to bring them

1 together into one point.

2 CHAIR HURLBURT: Noah?

3 COMMISSIONER LAUFER: I don't want to belabor this, but I  
4 think a lot of the problem actually is in the things that she  
5 wants to measure. A lot of the statistics used to show what a  
6 miserable system is are not the results of medical care. They  
7 are cultural failures because we do not have a social  
8 contract. You know, one comes to mind right away because I  
9 think anecdotes are helpful.

10 Several times in my training, I experienced racing down  
11 to labor and delivery. I'm going to deliver a baby for a  
12 woman who showed up in the ER term, in labor, a mess, who has  
13 had no prenatal care at all. It's usually not a question of  
14 access because, in most places, you would qualify for care.  
15 They just don't have care. This is a baby born, you know, on  
16 whatever, crack or meth. Several times, I saw moms leave the  
17 hospital after the baby is born. This is a child that will  
18 require millions of dollars of neonatal intensive care. She  
19 knows she can't care for them, and it's a huge mess for all of  
20 us. This is a social failure and not a failure of the medical  
21 system. The kid will receive the best care ever has existed  
22 in the history of medical care in the world and may survive,  
23 but those are the things we need to measure. And the longer I  
24 practice family medicine, the more I realize the failures are  
25 in very simple things, like is it safe to walk in Anchorage in

1 the winter time? Is there somewhere where I can get  
2 affordable food? You know, very, very basic things, and those  
3 need to be measured.

4 CHAIR HURLBURT: Jeff?

5 COMMISSIONER DAVIS: Thank you. I think we have really  
6 more a difference of point of view than a disagreement in what  
7 needs to be done because I agree 100% with what Noah said.  
8 When we go back to Michele's example of high school dropout  
9 rate, that's an example of this. And what we would know if we  
10 study history, most of the things that have given us an  
11 advance in lifespan weren't about what happened in the  
12 doctor's office. They were about food and exercise, and you  
13 know, those -- clean water -- clearly, clean water, one of  
14 those things. So I think what I'm hearing is it is a point of  
15 view and that a lot of things that we can do that affect  
16 health overall come from this population data that says, whoa,  
17 why are kids chewing tobacco in Palmer? You know, what can we  
18 do about that? And but there are -- it all does tie together,  
19 but I see them as two separate things and would like to, I  
20 think, see, if it really is a \$200,000, which I was, like wow,  
21 let's do it tomorrow, then let's do that while we're spending  
22 the millions of dollars on the HIT work and then, if we bring  
23 them together later, great. Thank you.

24 CHAIR HURLBURT: On last comment, Noah?

25 COMMISSIONER LAUFER: Our job, I think, is to think out

1 of the box to some degree because we really need to and there  
2 are so many examples like that. I mean, I am an athletic  
3 adult because I grew up in Anchorage and because I had great  
4 access to after-school sports programs, and I cross-country  
5 ski raced and ran, and I carried that through into my  
6 adulthood, and there's a whole community of people who do  
7 that. Those programs are gone, and the children are obese. I  
8 saw a 15-year old Friday, who is 280 pounds and he's diabetic  
9 with a fatty liver. You know, chances are he will die in his  
10 early 40s or late 50s, unless things change. It's not a  
11 medical failure. I can put them on all the medicines and  
12 insulin and all that. It's a social community failure.

13 CHAIR HURLBURT: On Monday -- before we go on to Andrea -  
14 - I'm presenting to the ALPHA Summit, and my compulsion is to  
15 talk about obesity and overweight. In one of the cartoons --  
16 this is totally irrelevant, but one of the cartoons -- that my  
17 assistant who is putting the PowerPoint together for me -- is  
18 an obese Spiderman not being able to do his rescue, but it's  
19 pervasive that we have that.

20 COMMISSIONER LAUFER: Obese is a derogatory term now.  
21 You have to think of some other.

22 CHAIR HURLBURT: Okay. Andrea, if we can go on to you  
23 now, please?

24 MS. FENAUGHTY: Sure. Thank you very much. Good  
25 morning. Thank you, Dr. Hurlburt and Commissioners, for

1 inviting me back again. I'm Andrea Fenaughty. I'm the Deputy  
2 Section Chief for Chronic Disease Prevention & Health  
3 Promotion and also the Chronic Disease Epidemiologist, and I  
4 certainly appreciate taking the hit as being someone who  
5 provides data from the State and am in complete agreement with  
6 our previous speakers, just so you all know. I think we all  
7 have the same vision in mind.

8 I have Dr. Charles Utermohle's name up here as well.  
9 He's not here, but he's certainly contributed more than anyone  
10 else to the work that we've done so far.

11 So just really quickly, I'm going to keep you guys on  
12 your schedule. As an overview, I'm going to hit just very  
13 briefly on the role of local data in health improvement, since  
14 you've heard quite a lot about that already, a really brief  
15 overview on what's already available, what we do to get data  
16 out both statewide and locally, then addressing what the gaps  
17 and limitations are and then sort of vision for how we think  
18 we can get there.

19 So value of local health data, it's a tool. No one is  
20 looking at data for data's sake. It's a tool for reaching our  
21 health improvement goals by helping you set those priorities.  
22 What is the most important thing for us to take on and what  
23 are the resources we have to make that happen?

24 One of the little -- I think this is similar to something  
25 Michele said. One of the quotes I found was, it's the spark

1 plug for those local health improvement efforts. And again,  
2 IOM coming out in favor of this type of approach. A different  
3 graphic for the right brain people here, just really showing  
4 this constant cycle of assessing where you are, figuring out  
5 how you find your priorities, developing those programs,  
6 implementing them, and evaluating them, and local data is  
7 important at every single one of these places. You already  
8 saw this graphic.

9 Just a few specific examples of how local data is  
10 important to celebrate successes. For example, there's a  
11 number of communities across the whole country as well as here  
12 in Alaska that are working on clean indoor air, smoke-free  
13 workplaces, and because they've collected data that look at  
14 hospitalization and mortality from MI, they've been able to  
15 show dramatic, immediate effects and to really celebrate those  
16 successes because it's difficult work to make that happen and  
17 then other regions can learn from those successes as well.

18 Learning from neighboring regions, kind of the flip side  
19 of what I just mentioned. We have been able, sometimes, to  
20 provide that regional data. We've done so for tobacco,  
21 regionally showing across a number of tobacco-related  
22 indicators, and some communities have seen that their rates,  
23 for example, of smoking among pregnant women is 40% compared  
24 to a lot of the other regions. They may have had an inkling  
25 that that was going on, but seeing how they compare to their

1 neighbors really helped them focus, redouble their efforts in  
2 that area, and make some changes.

3 Driving the discussion of health as a community priority,  
4 I think this is something that Michele mentioned. Every  
5 community has competing priorities, economic development, is  
6 it safety, is it education. When you have those numbers and  
7 they're staring you right in the face, it really helps elevate  
8 health as part of that priority.

9 And then again, helping prioritize among many health  
10 goals. Is obesity, in fact, the big thing that we need to  
11 conquer or it is smoking for now or is it diabetes?

12 Building community partnerships, again that's been  
13 alluded to a couple times, and there is a number of health  
14 improvement efforts already underway, for example, with the  
15 MAPP system, and collecting local data is an important part of  
16 that.

17 So just as an overview statewide of what we already  
18 collect and then disseminate, behavioral risk factor data,  
19 this would be the BRFSS some of you have heard mention of, so  
20 looking at whether it's obesity rates, smoking rates, injury,  
21 mammogram screening, all self-report from adults in Alaska as  
22 well as from high school students with the YRBS. Alaska  
23 Bureau of Vital Stats, of course, we're looking at mortality  
24 and births. The *Alaska Health Care Data Book* came out in 2007  
25 with a number of indicators. The Division puts out something

1 called the Health Status Indicators Report, which is a nice  
2 compact -- I think it's about 35 of what we have decided are  
3 the most important health status indicators in the Division  
4 and put out very brief information showing trends and what the  
5 limitations are of those data each year. *Alaska Maternal*  
6 *Child and Health Data Book* put out data focused on that  
7 particular content area. The *Alaska Scorecard*, coming out of  
8 the Comprehensive Mental Health Plan. *Epidemiology Bulletins*  
9 are coming out all the time on different topics and then  
10 various periodic program-specific reports that come out.

11 At the community-level, again the *Alaska Health Care Data*  
12 *Book* was able to do some regional breakouts, which was very  
13 useful. We do, as we can, one-off reports. We did provide  
14 information to the Muni effort, looking at health status  
15 indicators as well as to Kenai, Fairbanks, as we have the time  
16 and resources to do that.

17 As I said, we have put out regional tobacco fact sheets.  
18 One time, we were able to do that. Hopefully we could do  
19 more, as well as Health Care Directories. But what you'll  
20 see, there is no system in place to meet these ongoing local  
21 needs.

22 Just to kind of show you, so you're familiar with what  
23 some of these reports are that we put out, this is the BRFSS  
24 Annual Report. It's available online, and it talks about the  
25 indicator, shows you the trend. This, for example, is heavy

1 drinking. It shows Alaska relative to the U.S. so you can see  
2 how we're doing and talks a little bit about special  
3 populations that might be affected more than others.

4 This is what YRBS comes out with a number of graphs  
5 online as well as a book when we're able to do that.

6 This is what our Division Health Status Indicators Report  
7 looks like. Again this is the 35 indicators across public  
8 health. Again it shows you the trend of Alaska versus U.S.  
9 It also shows the Healthy Alaskans 2010 target, so you can see  
10 how you're doing relative to that.

11 This is the *Health Care Data Book* that many of you may be  
12 familiar with and just other -- including the *Alaska Maternal*  
13 *Child Health Data*, and Vital Stats does a really good job of  
14 presenting their data by the census area and borough levels.  
15 Again Healthy Alaskans 2010.

16 And this is the *Alaska Scorecard*, which is kind of nice  
17 and shows the little thumbs-up/thumbs-down as far as briefly  
18 getting a sense of where we're going with each of those  
19 indicators.

20 So the gaps and limitations you've heard probably  
21 already, the main one is resource constraints limit how often  
22 we can update all these different reports, as well as the  
23 websites. Communities want local data. You've heard that  
24 several times, and we just don't, really at this point, have  
25 the resources available to make for every region or for every

1 census area those same data available.

2 There is an issue of small numbers, and no system is  
3 going to fix that. There are some communities in Alaska that  
4 you can never look at one year of data with any reliability  
5 and that's just a fact.

6 Mapping options. Everyone likes maps. It's a great way  
7 to get a sense of what the data looks like in a meaningful  
8 way. We don't really have that up-to-speed as much as we  
9 would like right now. And again there is no system to meet  
10 those recurring needs.

11 So what is our vision? I mentioned it last time I was  
12 speaking with you, and you've heard it mentioned already.  
13 We're looking for something web-based, which immediately means  
14 it will be accessible to everybody who has access to the  
15 Internet, and also is a system. It's a system. It's not one  
16 analyst responding to reports and doing them as they are able.

17 The specific one that we're looking at is called IBIS,  
18 Indicator-Based Information System for Public Health. It was  
19 developed out of Utah over a number of years and now many  
20 states use the same system.

21 This is just a screen shot, but I'm going to hopefully be  
22 able to jump over to live and give you a little demo of what  
23 it looks like. Hopefully you can see this well enough to get  
24 a sense of it.

25 So first off, this is their portal. Alaska's version

1 would have our look and feel. The main pieces of it are what  
2 here is called the Indicator Reports and the Dataset Queries.

3 The Indicator Reports are probably what nine out of ten  
4 users would be interested in. This is a set of static  
5 reports. They've been generated already. They're created and  
6 then just updated annually as the data are updated, and it's  
7 about a page. It shows you the trend. It shows you how, in  
8 this case, Utah is doing relative to the United States. It  
9 gives a little context to what that indicator is, why is  
10 obesity important, why is health care access important, what  
11 does that mean, and then gives you links to other data, and we  
12 can walk through a few here.

13 If we look through the alphabetical listing, this goes on  
14 for hundreds and hundreds of indicators. Again this is Utah.  
15 They've been doing this for a long time, but as you can see,  
16 everything from birth defects, birth rates, cholesterol.  
17 You've got risk factors. You've got deaths. You've got  
18 cervical cancer incidents, any number of indicators. And so  
19 simply -- let's say we're interested on health care costs,  
20 annual rate of increase, click on that and there it is. This  
21 shows you how Utah compares with the U.S., compares with the  
22 region over time. Up at the top, it's telling you a little  
23 bit about why is that important and then it tells you the  
24 definition, how it's measured. That's it. Very simple. Very  
25 easy to use. So if somebody knew they wanted to look at this

1 indicator, they could find it pretty quickly. If they didn't  
2 know that's what they wanted, they'd probably need a little  
3 more help. So you can go into this more topically organized  
4 way to find the system. At the very top, they've got it  
5 broken out by -- if you're interested in underlying  
6 demographic context, you'd open that up and see what all the  
7 options are. If you're interested in health care services and  
8 systems, then you've got access to care and a bunch of  
9 indicators under each one of these. If you're interested in  
10 risk factors, you've got environmental and lifestyle. Let's  
11 say we want lifestyle. That's where I tend to go. And let's  
12 just take a look at overweight or obese, and there we go,  
13 percentage of adults who are overweight or obese by year, Utah  
14 versus U.S. Both are going up.

15 And then you can see on many of the indicators, you also  
16 have not just this which is overall, but you can break it down  
17 by year, age, and sex, and look, by local health district. So  
18 you can get local data right there. And this shows how each  
19 of the local health districts in Utah look.

20 Another nice feature is right up here, Related  
21 Indicators. It just kind of gives you hints as to other  
22 things that might be related to this that you want to pull up  
23 too, so let's look at Health Care System Factors that might be  
24 related to overweight/obesity. Maybe cost is a barrier, and  
25 one button, and then you've got more information. So I find

1 it pretty easy to use and pretty extensive.

2 And as I said in answer to your earlier question, what  
3 we're looking at is starting out with the behavioral risk  
4 factor data, which is really what's currently housed in my  
5 section, and that's a really good place to start, but it can  
6 expand, as they have, to include any number of different kinds  
7 of indicators.

8 The second piece here, which is really more for people  
9 who maybe want to say, yeah, but I want to see just women over  
10 40 and I just want to see in this period of time or maybe I  
11 want to compare these to regions. Then you want to do a  
12 little more specialized -- you actually run a query to your  
13 specifications and it runs right then. You're analyzing the  
14 data right then. So let's say we're interested -- again let's  
15 go down to health surveys. Let's go to the BRFSS just because  
16 I'm most familiar with that. It gives you a couple options  
17 here, sort of a default which is the quick. Let's go ahead  
18 and do that. And let's say we want access to health care, and  
19 I'm interested in, Unable to Get Needed Care Due to Costs.  
20 Let's see what -- the very first thing that pops up because  
21 I'm running this data right now is I have to say, I am not  
22 going to use this data inappropriately, and this is how we do  
23 this, and I read through that and I say I'm not going to make  
24 this data available. I'm doing it for good purposes. And  
25 then it lets you make your selections. There's a default to

1 all of these. The default is just the current year, so let's  
2 stick with that. Let's say we wanted to look -- I don't know.  
3 Maybe I'm interested in young adults. Let's look at both men  
4 and women, all demographic characteristics. You can cross it  
5 here, this step five, by other indicators. So let's say I  
6 wanted to look by smoking status or non-smokers; I could do  
7 that. I want to look at let's say all health districts. And  
8 I just submit and it's running. See, I mean, that wasn't too  
9 bad. And here I have, Unable to Get Care, so it shows for all  
10 of the years, and this is just -- if you look at the top,  
11 sorry -- 18 to 34.

12 Now if I want to look at a map, I go back up to Dataset  
13 Queries. See down at the bottom, Utah Map Dataset Selection,  
14 and I can look at the same kinds of information, graphically  
15 displayed. So let's just grab mortality, age-adjusted rates,  
16 and then I get to pick the same kinds of information. Let's  
17 see, cause of death, I'll pick acute bronchitis, and I want to  
18 see a map. Let's see what this gives us.

19 Here we have a map that fast. So again this is Utah.  
20 Now it shows a lot in red because it's insufficient data  
21 because I'm looking at just one year. So now I know all I  
22 have to do is go back and include more years, and it'll rerun  
23 with multiple years, but the point is you can see you'd be  
24 able to compare -- we would have -- we could break out regions  
25 however we wanted to define them. We could do borough and

1 census area levels. We could do regions defined by the BRFSS  
2 regions or labor market regions, but it's pretty powerful, and  
3 the more you look at it, it raises another question. Well you  
4 know, what's this related to? And it's pretty easy to cross  
5 back and then link it to the other variables that you have in  
6 the system.

7 So just to recap the benefits, it's sort of "one stop  
8 shopping." Once you get all the systems in that you do want,  
9 it's really appropriate to the breadth of public health, which  
10 is really nice for a guiding program. It's efficient. Once  
11 the system gets set up, it costs no more for 10,000 people to  
12 be doing this than for one. Whereas right now, every single  
13 person who emails my analyst to have them run something that  
14 means Elizabeth is not getting her analysis done, which  
15 doesn't make her happy.

16 So it puts data in the hands of more users, and it  
17 presents data in multiple ways. Some people are the visual  
18 people. Some people like to read it. Some people want those  
19 tables. All of those are available, which is very nice. It's  
20 Freeware. Utah made this available for free, and they're part  
21 of a community of practice across the country that supports  
22 other states reusing this, so there is a lot of benefits to  
23 that as well. And the bottom line is making local data more  
24 easily accessible.

25 Investment so far, we have a server. We've got the main

1 analysis software. Our analysts have gone through the  
2 training. We've had IBIS Utah people up a number of years ago  
3 working on this. We've put a lot of staff time in around the  
4 edges as they've been available. This doesn't fall under any  
5 of our normal work.

6 So we feel like what it would take to support moving this  
7 forward, we need a little bit more personnel time. We need a  
8 full-time Charles who has been the main driver of this for  
9 years to really be able to focus on this, and he can't right  
10 now. We'd need a little more of that consultation from the  
11 Utah folks to help us get things more current, since it was a  
12 number of years ago that we started, a little more additional  
13 software and hardware, and of course, we'd have to coordinate  
14 with our own IT and network people.

15 And just really quick, I wanted to show you this is what  
16 New Mexico looks like, so it's a different look and feel but  
17 the same basic pieces. Lois Haggart (sp) who was at Utah when  
18 this was developed moved to New Mexico. Within six months,  
19 they had the system up and running to some level. So it's  
20 definitely doable. This just shows you another screen shot of  
21 that.

22 This is actually says Alaska, not Utah. So this is just  
23 an example. If we were to do some regional maps, you would  
24 tie that in with the indicator system as well. And there is  
25 MatSu.

1           So thank you very much. There is my information and  
2 Charles', who knows way more about this than I do, and I just  
3 appreciate your time.

4           CHAIR HURLBURT: Wayne?

5           COMMISSIONER STEVENS: Great presentation. I fully  
6 support the concept, but a caveat to think about as you're  
7 doing this is, how do you define those geographic regions? I  
8 mean, to Elizabeth's question, MatSu is a tail to Anchorage.  
9 Kodiak, in the Department of Labor, is a part of the Gulf  
10 Coast, which includes Cordova, Kenai Peninsula. The  
11 Department of Commerce has a different set of geography. They  
12 have 12 economic development regions. Obviously, you have a  
13 different set of geography. So when you talk about community  
14 and developing, one of the early things that I would encourage  
15 to look at is a uniformity of geographic descriptions so that  
16 the community can say I am a part of this region, however it's  
17 defined, and it applies across-the-board to every set of data  
18 that we collect as a state because, right now, it's mind-  
19 numbing when you try to get data about a region or a community  
20 because sometimes it's in the Gulf Coast, sometimes it's in  
21 Southwest, sometimes it's in something else. So if there's a  
22 way to encourage the conversation about geography early on, so  
23 that our ultimate goal would be standardization of the  
24 geographic description across multiple departments because  
25 there's a wealth of data out there, beyond just want you guys

1 are collecting and using that, I think, could be hugely  
2 beneficial to communities and organizations as they make  
3 decisions about their future.

4 CHAIR HURLBURT: Are there constituencies that would be  
5 opposed to that, do you know, Wayne?

6 COMMISSIONER STEVENS: Opposed? Those that have to  
7 unravel it would probably have nightmares about how you would  
8 do it, but I mean if you approach it from this perspective, it  
9 benefits all of us. It's that where do we stop in time and  
10 say we all agree now that, for the purposes of this  
11 discussion, your community is a part of this geographic  
12 economic model, health care model, labor department model, so  
13 that your data is consistent across-the-board, and I'm sure,  
14 somewhere out there, there are people who would be opposed to  
15 that, depending on how those lines of definition are drawn.

16 CHAIR HURLBURT: Noah, did you have something?

17 COMMISSIONER LAUFER: I just want to be a quick pain,  
18 devil's advocate. It depends who is using the data, too. I  
19 mean, very useful, if you're pleading for more federal funds  
20 or state funds or more interests, but I'll tell, if I were,  
21 say, a manager from Japan thinking of where to open a Toyota  
22 plant, I might look through there and say, God you know, we're  
23 obligated with all these new laws to all this health care and  
24 it's huge overhead and expense. I think New Mexico is out.  
25 It's public, right?

1 CHAIR HURLBURT: Paul?

2 COMMISSIONER FRIEDRICH: I think going back to the  
3 discussion we had earlier, Jeff is correct that we're more in  
4 agreement than not, but the point that Wayne raises, really  
5 foot stomps the need to define where you're trying to go  
6 because, ultimately, what, I believe, you're describing there,  
7 Wayne, is not so much that we would all agree that Cordova is  
8 in this region or in that region, but to take it to the  
9 desired end state, where any user can define what he or she is  
10 looking for and that's part of what that IBIS system describes  
11 there. I mean if they want to say all coastal villages with a  
12 population less than 2,500 will be grouped together and then  
13 all inland villages or interior villages with a population  
14 less than 2,500, that's kind of the desired end state. And so  
15 with each of these, that's the point that I'm trying to make  
16 is that we should hopefully have a vision for the State of a  
17 very configurable by the user, data repository and what that  
18 would require then is a common way in which you enter the data  
19 and then the user can define how they want to parse the data.

20 COMMISSIONER MORGAN: I can only relate an experience I  
21 had last year where five entities, five health organizations  
22 across the state were trying to come with six quantitative  
23 measures, whether it was HEDIS or how many visits. It was  
24 basically for EPSTAT to come up with some standardized  
25 statistics. It's a year later. We're still trying to work

1 out what are going to be the six standards that we're going to  
2 pick. We couldn't even -- it was -- at one point, we  
3 compromised. It was three HEDIS standards and three other  
4 types of standards, basically community health center  
5 standards from their UDS reports. But it's still being  
6 wrangled around.

7 The issue of geographic locations or how you break down  
8 the data is one thing, but what are you collecting? And in  
9 order to have a rational system, I'm assuming the system has  
10 standard data elements you pull, but you get -- it's like  
11 accountants. You get five of these entities in a room, and  
12 you're going to have six different opinions as to what we want  
13 to collect of data or even the type of data. So I mean,  
14 there's challenges. Evidently in New Mexico and these other  
15 states, they were able to do what I couldn't get done with six  
16 people, six entities on six standards of coming up with what  
17 those are.

18 CHAIR HURLBURT: Andrea?

19 MS. FENAUGHTY: Yeah. I think the beauty of this -- if  
20 you were doing a printed publication, you'd be limited and  
21 you'd have to come up with what are the six. They have  
22 hundreds and hundreds of indicators, and I didn't go through  
23 all of them, but the limits are the buy-in of the person who  
24 owns the data. If somebody says, I've collected data and I  
25 know how much -- some measure of program activity across the

1 state, they can add that on there and then it's up to the user  
2 if they want to look at that or not. And in terms of the  
3 different geographic boundaries, we can put in census area  
4 borough. We can overlay that with BRFSS region, with market  
5 labor region. It's really driven by how the data is  
6 collected, and as long as they're in there, they'll show up in  
7 whatever way the user defines.

8 CHAIR HURLBURT: Yes, Linda?

9 COMMISSIONER HALL: Much of the data that I see collected  
10 on health care cost in the private insurance world is done by  
11 something called a Geo Zip and it's used to accumulate --  
12 that's a geographical zip code. I spent a day-and-a-half  
13 listening to a presentation on these, but it's accumulating  
14 data from various payers, and the thing that doesn't make it  
15 mesh with what you're talking about is that it's then  
16 combined. You used an example, and I'll use one using some of  
17 the same areas. In terms of usual and customary is really  
18 what we're dealing with in this particular model, it combines  
19 Kodiak with Southeast as an example, and it's based on  
20 commonality of charges in general areas. It divides the State  
21 into, I think, four areas, but there is no logical reason that  
22 you would combine Kodiak with Southeast, but in this Geo Zip  
23 arrangement, it used not only in health insurance; it's also  
24 used in the Worker's Compensation world when they come up with  
25 medical fee schedules. So you're dealing with these Geo Zips.

1 So you've got information that many people would like to see  
2 included in this kind of information, but it's aggregated so  
3 differently that I don't know how it would ever fit. Does  
4 that make, what I'm saying, other than it's bizarre?

5 MS. FENAUGHTY: It sounds bizarre and I'm not familiar  
6 with that, but again, it would be up to the people who create  
7 that data, if there was some other way to notate where those  
8 regions were. I mean, we know where Kodiak is, so maybe we  
9 could -- you know what I'm saying?

10 COMMISSIONER HALL: (Indiscernible - away from mic)

11 MS. FENAUGHTY: Yeah.

12 CHAIR HURLBURT: So we're in a time of no budget  
13 increases, basically, which feels very tight to us, just  
14 better than 47 other states since we're not taking big cuts,  
15 but are we hearing a request that the Health Care Commission  
16 recommend a \$200,000 expense to refine our ability to report  
17 on health-related parameters and to break that out more  
18 meaningfully. Is that what the intent was for this?

19 COMMISSIONER MORGAN: There has to be a cost of all these  
20 different systems now. Somebody is paying for that stuff  
21 inside the State. You know, you have at least five or six of  
22 these systems, I think. The real question is, if you take six  
23 systems and they're merged or put together, is there is, you  
24 know, \$200,000 to do this and you're spending \$8 to do all the  
25 others or whatever it is, does anybody really know what the

1 real cost of doing all the different systems is right now?

2 MS. FENAUGHTY: Yeah. I don't -- I mean, it seems like  
3 that's find out-able. I can speak to what we invest and we  
4 meaning our section because we have the BRFSS, we're over the  
5 YRBS, and the Cancer Registry, and those are certain pieces  
6 and I guess your question is, by combining, is there savings  
7 in other systems? I don't know directly that someone in  
8 Bureau of Vital Stats is going to save money by doing  
9 something for our system, but I think the bottom line is, if  
10 we make this investment, there's so much more use and so much  
11 more value added to the data that we're already collecting  
12 that it hardly -- I mean, it seems like a no-brainer.

13 COMMISSIONER FRIEDRICHS: David, I can offer the federal,  
14 or at least, the Air Force and the VA experience with that,  
15 that, over time, the answer is yes, if you do it correctly.  
16 And what that means is you have to set that end state that,  
17 ultimately, the goal is that all state agencies will use a  
18 common means of storing or recording data so that you can do  
19 these very configurable data collections.

20 What you had mentioned earlier about, are we going to  
21 look at HEDIS measures or ORYX measures, that's a second part.  
22 I think Jeff articulated it very clearly. There is a  
23 continuum piece. The first part is agreeing that we're all  
24 going to use LOINK (ph) or we're all going to use a particular  
25 way to capture the data and then we decide how we're going to

1 extract it and turn it into information that we can act on,  
2 and ultimately then, you want to be able to drive that data  
3 back down to Noah's level where he can I say, I want to look  
4 at the patients in my geographic area for whom I billed care  
5 and see how well I'm taking care of them. I mean, that's one  
6 user population that a good repository would serve, but you  
7 have to agree up front on how you're going to collect the data  
8 to ultimately get to that point and that was the point I was  
9 poorly articulating earlier.

10 Having said all of that, I want to reiterate the attempt  
11 to make a motion, and again, I'll ask if this is the right  
12 time to do that. Absolutely this is a first step for the  
13 Health Care Commission to put a marker on the table that, if  
14 the State wants to improve health, they have to invest in the  
15 data to be able to determine where to focus evidence-based  
16 efforts.

17 CHAIR HURLBURT: The calendar is such that, if there is  
18 going to be a recommendation developed through the normal  
19 budgetary process to spend additional resources -- and I'd  
20 have to reiterate, we're in a posture that there are no  
21 increases available. We're a hold your own budget which is  
22 better than 47 other states, but there are not increases  
23 there. But if there were to be recommendations for that  
24 through the normal process of the development of the  
25 Governor's budget going to the Legislature, what we're talking

1 about now is the Fiscal 2013 budget starting in July of 2012,  
2 that we're there and that gets kind of back to the point you  
3 were making before. You don't get to where you're going until  
4 you start, and you don't start until you start. But I think  
5 we have to think about that that's a practical reality, but  
6 also are we taking on the basis of this discussion? Are we  
7 saying, yes, one, we accept this assessment that we heard from  
8 the three presenters today, that the data that is available  
9 through the State and from the State is inadequate to making  
10 local, regional, statewide needs? And two, do we think that  
11 this IBIS system which, you know, Charles and Andrea have been  
12 talking about for a long time -- it's not a flash-in-the-pan,  
13 but it's the first time this group has heard about that system  
14 -- are we saying that, based on what Andrea told us today this  
15 is what we think the State should do?

16 COMMISSIONER FRIEDRICHS: Just a point of clarification.  
17 I thought this was the system on which we were briefed at our  
18 two meetings back.

19 COMMISSIONER ERICKSON: It was mentioned. It was  
20 mentioned in a presentation and that's why we -- well we have  
21 multiple process questions here going on at once. So maybe I  
22 will back up. One of the questions is, why are we hearing  
23 about this right now today? And I've flashed up -- we haven't  
24 actually used this presentation yet. I've run it by the  
25 Commission members a couple times and tested it on another

1 public group, trying to put into pictures our lists of our  
2 different strategies and all the different things we're  
3 studying and how it's relating to our goals and to our  
4 foundation and how it's playing out over time. And so I'm  
5 going to use this to try to help -- I'm going to use these  
6 diagrams to try to help with our process discussion, where  
7 we're at right now.

8 We heard about -- first of all just related to our 2010  
9 report and our 2010 recommendations, our plan was to be done  
10 with approving of the 2010 plan before we had this  
11 presentation right now, and we just didn't get there. And  
12 this is one of the strategies that you all identified that you  
13 wanted to add to your strategies list because of the public  
14 comments you heard on Elizabeth's behalf that Kitty Farnham  
15 made during the public comment period at your last meeting,  
16 and it followed on a related presentation that Dr. Fenaughty  
17 had given where you heard reference to this same system.

18 So I'm just reminding you all of your conversation a  
19 month ago. It peaked your interest enough that you wanted it  
20 on your 2011 list, and what it was was understanding how an  
21 online community health information system could better  
22 support the work that folks in our state, like Elizabeth and  
23 Michele, are doing to improve community conditions that  
24 support improved population health, and it was a strategy  
25 related to our prevention goal.

1           So that's why you're hearing about it now is I thought we  
2 could get through our 2010 report finalization a little more  
3 quickly and would have time to start on hearing about our 2011  
4 strategies that we want to consider for our 2011 report. But  
5 now we have multiple issues that started coming up this  
6 morning, including how and when we make recommendations and  
7 how specific they get, if there is a very specific need or  
8 very specific project.

9           The psychiatric residency was the example that came up  
10 this morning. It's related to a general policy. Are we  
11 making general policy recommendations and being proactive in  
12 identifying what we think are important policy recommendations  
13 and/or are we responding to specific needs and endorsing  
14 specific strategies? That's one policy question.

15           As we start the New Year, we're going to have make a  
16 decision, and these first two years of the Commission were  
17 very unusual for lots of reasons. In both years, this one  
18 really just being a quarter, we had some learning together and  
19 then developed our recommendations and finalized them, just as  
20 we were wrapping up our report.

21           As we start a New Year -- and we're going to have a full  
22 year and staff and resources, and we'll be hearing  
23 presentations on our strategies throughout the year -- will we  
24 stop and make recommendations each time? The last two go-  
25 arounds with the Commission, we did not do that. We waited

1 until the end of our year to develop recommendations. I don't  
2 think it's going to make sense for this, but I also think we  
3 might want to wait until the next meeting to actually  
4 formulate recommendations on issues we may have heard before.

5 Another process and timing question related to Dr.  
6 Hurlburt's comment, if we're going to be very specific, we  
7 want a new increment in the budget at some point. Or are we  
8 making -- then the State's going to have to wait until 2013,  
9 if we're going to get that specific. If we make a general  
10 recommendation related to policy, then that's something we're  
11 expecting the Governor to direct the Commissioners, his  
12 Cabinet to work together on to make happen, whether we wait  
13 two years for the Legislature to appropriate the money or not.  
14 Those are all things that, I think, we ought to be thinking  
15 about over the lunch, the ten minutes we're going to have.

16 CHAIR HURLBURT: I think the latter is -- in my bias,  
17 it's a bottomless pit. If we get into the specific.....

18 COMMISSIONER ERICKSON: To responding to specific project  
19 requests?

20 CHAIR HURLBURT: Yeah.

21 COMMISSIONER ERICKSON: But that doesn't mean the  
22 Commission can't still recommend that online community health  
23 information systems should be developed. The distinction is,  
24 are we making a policy recommendation that an online community  
25 health system should be developed or are we saying, do you

1 want to make a recommendation that the Legislature appropriate  
2 and the Governor approve \$200,000 for the section of Chronic  
3 Disease in a particular fiscal year to support IBIS  
4 specifically? That's the distinction, I think, that I'm  
5 making in my mind between, are we responding to specific  
6 projects that get proposed to us or are formulating a general  
7 policy recommendation?

8 COMMISSIONER FRIEDRICHS: Deb, take a breath for just a  
9 second.

10 COMMISSIONER ERICKSON: I think we should break for lunch  
11 because we have to start our public comment period in 20  
12 minutes.

13 COMMISSIONER FRIEDRICHS: So we've heard your input on  
14 what you think the Legislature intended. We have two members,  
15 current or former, of the Legislature here who perhaps could  
16 share with us their understanding of what the Legislature  
17 intended to guide us in this.

18 I will tell you, you know, my personal input, having been  
19 on a variety of Commissions and other groups, is most  
20 organizations are looking for specific rather than general  
21 observations, especially when it comes to budgetary matters.

22 Now I'll remind the Commission that I will recuse myself  
23 from votes on specific budgetary matters because of my federal  
24 position here, but having said that, I personally have never  
25 been involved on a commission or a group in which the group to

1 which we were reporting was not looking for as specific as  
2 possible recommendations for a way ahead. There is a wealth  
3 of general information out there. There is very little  
4 specific recommendations to a population or a group, and I  
5 thought that was the intent. But my request to the Chair  
6 would be, if you concur and my fellow members concur, that we  
7 ask those members of the Legislature who are here to help us  
8 understand their intent.

9 CHAIR HURLBURT: I think we probably better break for  
10 lunch.

11 COMMISSIONER FRIEDRICHS: Then I would formally make that  
12 motion and ask that we reconsider it after lunch.

13 CHAIR HURLBURT: I think it's not an unreasonable  
14 suggestion, but to keep the meeting going, I think we need to  
15 break for lunch.

16 COMMISSIONER ERICKSON: One more thing. I want to  
17 request that the Commission members get your lunch first,  
18 before the rest of the public starts getting their lunch and  
19 try to come back to the table as quickly as possible so we can  
20 start the public comment period.

21 12:13:08

22 (Off record)

23 (On record)

24 12:35:11

25 CHAIR HURLBURT: I think we'll get started here in just a

1 minute. We'll wait. Deb will be coming back in. We have  
2 just two people here, the public participants in the room, who  
3 have signed up. Three? Okay. We have three folks here in  
4 the room who have signed up to comment. Our guideline has  
5 been probably five minutes max or so for the comments. And  
6 then we'll see if there is anybody on the phone. Are the  
7 phones on now? We don't need to turn them on, but.....

8 UNIDENTIFIED MALE: I've just got to plug it in, so they  
9 can talk on it.

10 CHAIR HURLBURT: So if anybody is listening on the phone  
11 that wants to comment, after we have the three folks here in  
12 the room comment, then we'll open it up for anybody on the  
13 phone. Then Amanda, after that, we'll turn to you there. And  
14 then the other thing we want to do in order follow through on  
15 Paul's suggestion, Senator Bettye Davis had to leave, but she  
16 and Tom both talked with Deb, and I think, she's going to  
17 relay her perspective on Paul's comments there.

18 So that will be the order that we'll do it and then, I  
19 think, we'll probably still pick up some time and we can go  
20 back and pick up some of the things that we missed this  
21 morning. So I guess I don't have the list of who is here to  
22 comment now.

23 COMMISSIONER ERICKSON: I do.

24 CHAIR HURLBURT: You do? So, do you want to go ahead?

25 COMMISSIONER ERICKSON: Yeah. We had two people who

1 signed up.

2 CHAIR HURLBURT: Three now.

3 COMMISSIONER ERICKSON: Oh, three people? Well I have --  
4 okay. So Shelley Hughes, Robyn Priest, and Sandra Heffern are  
5 the three people signed up to testify in the room and Ryan  
6 Smith. So we have four folks signed up in the room right now,  
7 and I don't know who we might have on the phone.

8 CHAIR HURLBURT: And while you were coming in, I kind of  
9 went through what the order was going to be on this. So I  
10 think, Robyn, why don't we start with you?

11 COMMISSIONER ERICKSON: Robyn and then Sandra.

12 CHAIR HURLBURT: Okay.

13 COMMISSIONER ERICKSON: That's Robyn.

14 CHAIR HURLBURT: Yes. Go ahead.

15 MS. PRIEST: Hi, I'm Robyn Priest from the Alaska Peer  
16 Support Consortium. We're a 501(c)(3) not-for-profit funded  
17 by the Trust in SAMHSA. Currently what we're doing is doing a  
18 whole lot of work around peer support with beneficiary groups.  
19 In (indiscernible - voice lowered) peer support, what we're  
20 talking about is people with those particular health issues  
21 supporting each other or family members supporting each other.

22 One of the things that I wanted to briefly tell you what  
23 we do and then talk about peer support in the context of what  
24 you've been talking about this morning is that we have a  
25 mission to develop, grow, and nurture peer support around

1 Alaska. And so part of our SAMHSA grant is getting out and  
2 talking to people about peer support and we're involved in the  
3 development of the Behavioral Health Manual and putting a  
4 piece in there on developing peer support networks out and  
5 around Alaska because we feel, given the workforce shortage,  
6 given the rurality -- that's an odd word -- of Alaska, that  
7 peer support, having people who have experienced those issues  
8 supporting each other will be something that can be put into  
9 any community, any village in the State.

10 Part of what we do is educating people about peer support  
11 and its benefits. We do or are doing workforce development  
12 for people. We get people who are doing peer support together  
13 a couple of times a year. We run conferences to educate peers  
14 and families about different issues, and you know, try and  
15 increase what's happening out there and get it happening more.

16 Predominantly, we've worked with mental health and  
17 substance abuse organizations, but we're now starting to look  
18 at traumatic brain injury, developmental disability, and  
19 Alzheimer's and dementia populations as well.

20 What I did want to say is that there is some really good  
21 research, particularly coming out of Georgia, peer specialist  
22 model in mental health, and they're looking at training peers  
23 in whole health and not just supporting people around their  
24 mental health issues. And some of the research coming out of  
25 that is really supporting where people with mental health

1 issues are actually going to see physicians doing things that  
2 will make them healthier because, currently, the statistics  
3 are showing that people with mental health issues are dying 25  
4 years younger than the general population. So getting whole  
5 health into peer support is changing the way that people with  
6 mental health issues are actually going and getting some of  
7 their physical needs met.

8 I also wanted to talk about, in terms of peer support  
9 with the military and veterans population, around Post-  
10 Traumatic Stress Order, there's some really good stuff  
11 happening there, and I think it's really important that we  
12 look at how we further develop that in this state as well.

13 One of the things that I heard people talking about this  
14 morning was diabetes and non-compliant, which is -- non-  
15 compliant is not a term that a person with a mental health  
16 issue likes, but I'll use it for the sake of this. One of --  
17 a new study that's just come out -- and I didn't bring the  
18 studies with me, so I have them if people want them -- is  
19 saying that peers -- so people with diabetes working with  
20 other people with diabetes is showing a much higher compliance  
21 rate, and I got that study in December, so it's a fairly  
22 recent one.

23 So I mean, you know, we all know that there is cancer  
24 support groups out there, so I'm just saying let's start  
25 looking at peer support in a whole range of different places.

1 Some of the places -- obviously I'm not traditionally from  
2 Alaska. Some of the things where I've seen peers work really  
3 well are in emergency rooms, particularly for mental health  
4 and alcohol and drug addiction. People are coming in really  
5 distressed. It takes time to get seen in an emergency room or  
6 it takes time to see a crisis mental health worker or someone.  
7 Peers coming in and working with people -- and some people are  
8 actually leaving the emergency rooms without having to be seen  
9 and are okay and getting back on with their lives. So it's  
10 not trying to take the place of anyone. It's trying to say  
11 that, in combination with the medical field, I think -- and  
12 this is my (indiscernible - voice lowered) of putting it --  
13 you get a better bang for your bucks if you do a combination  
14 of that.

15 Also with the issue of workforce shortage, I don't think  
16 we'll ever have enough doctors or nurses or social workers or  
17 psychologists. I mean, everywhere in the world has exactly  
18 the same issue. And I guess the peers are an untapped  
19 workforce that we actually haven't necessarily done a good job  
20 of tapping into in particular places. And Alaska hasn't  
21 utilized a lot of peer workers and just starting to kind of  
22 pick that up a bit more. So it's an untapped market that  
23 working in conjunction, you know, in collaboration with other  
24 people can do some really good stuff.

25 I just wanted to quickly look at any other comments. So

1 I guess what I wanted to say is, when you're thinking about  
2 workforce, when you're thinking about the kind of things that  
3 you look at in the future, peer support should be one of the  
4 things that's sitting there because there's a whole lot of us  
5 sitting at this table that have a whole range of different  
6 issues that, if we're working with someone that has those same  
7 issues, you know, we can say, hey, this worked for me. It  
8 might not work for you, but here's a thing. And sometimes,  
9 you know as a person with a mental health issue, I don't  
10 listen to the doctor, but I'll listen to my peer. And so some  
11 of the reasons I'm still compliant is because I speak to my  
12 peers about what I'm like when I'm not.

13 So you know, that's, I guess, all I wanted to say really  
14 quickly and thank you for the opportunity. I had no idea what  
15 this would be like.

16 CHAIR HURLBURT: Thank you very much, Robyn. We  
17 appreciate your coming and appreciate your comments. Any  
18 quick questions?

19 COMMISSIONER STINSON: Are those pamphlets right there?

20 MS. PRIEST: Yeah. I'll throw them out.

21 COMMISSIONER STINSON: I would like a few because I see  
22 patient clientele that could benefit from that.

23 MS. PRIEST: I've got some here, but I've got some more  
24 I'll leave on the back table, if you want some more.

25 CHAIR HURLBURT: Thank you, Robyn. Sandra?

1 MS. HEFFERN: Dr. Hurlburt, Commissioners, and DHSS  
2 staff, thank you for the opportunity for being able to provide  
3 public comment today.

4 My name is Sandra Heffern and I'm representing the  
5 Community Care Coalition. It's a coalition of trade  
6 associations that work with elders, individuals with  
7 behavioral health issues, developmental disabilities, and  
8 physical disabilities. My comments today are my own and do  
9 not necessarily reflect those of the representative  
10 associations.

11 First, I want to thank the Commission for the work you've  
12 done to date. I agree that further definition of who or what  
13 is the health care system needs to occur. I represent the  
14 long-term care industry. I appreciate that the Health Care  
15 Commission has mentioned long-term care in their planning  
16 documents, but I'm concern that perhaps long-term care as a  
17 component of the health care system may spread the work of  
18 this Commission too thin.

19 I fully support additional learning in long-term that  
20 will lead to a fully functional, comprehensive long-term care  
21 system. I don't know if this should be a standalone or if  
22 this should be part of the work of this Commission. What I  
23 would appreciate is further discussion by the Commission  
24 members of that particular issue.

25 Second, as an observer of the process, I have some

1 concerns that it appears the very valuable work of the  
2 Commission may be perpetuating the piecemeal approach to  
3 health care system design. For example, the Commission  
4 members heard presentation on evidence-based medicine. You  
5 had some high level discussion and then came out with a  
6 recommendation that would affect policy decisions, which will  
7 ultimately begin to shape the health care system. To me, it  
8 seemed premature. I would suggest that the Commission needs  
9 to further define goals and objectives for the health care  
10 system before making policy decisions that could have far-  
11 reaching implications.

12 Finally, I fully support behavioral health as a critical  
13 component of the primary care system. I have been witness to  
14 well-meaning primary care staff attempting to provide  
15 behavioral health services. This is a disservice to the  
16 primary care staff, as well as to the consumer or patient.

17 A coordinated approach to treatment of the whole  
18 individual by individuals trained in the specific discipline  
19 is a great way to go. I applaud the efforts of the Commission  
20 in engaging in further learning and development of specific  
21 strategies in this area. Thank you.

22 CHAIR HURLBURT: Thank you, Sandra. Any comments or  
23 questions for Sandra? Thank you very much.

24 COMMISSIONER FRIEDRICH: Ma'am, before you leave, you  
25 used the term at the end of your comments about specific

1 strategies. Could you help me understand what level of  
2 specificity do you think would be helpful to the Governor and  
3 to the Legislature?

4 MS. HEFFERN: You know in listening to your conversations  
5 earlier, I agree that there does need to be specific  
6 recommendations that are made to the Legislature. My concern  
7 for the -- I'll try to be politically correct, but I'm not  
8 going to do it anyway, so that's my caveat. My concern for  
9 the 2010 report is that there wasn't enough time for the  
10 people sitting around this table to be making specific  
11 recommendations yet. I think that, when your 2011 report  
12 comes out, you'll have the opportunity to have thought  
13 through, done your research, and then be able to make specific  
14 recommendations.

15 Personally, I think your recommendations need to be very  
16 specific because, otherwise, nothing is going to get done.  
17 The recommendations need to be actionable. They have to be  
18 observable, measurable, describable in order to, again, have  
19 something actually occur.

20 My concern about the 2010 report is, again, you had two  
21 meetings for this year and now you're making a recommendation  
22 that could have far-reaching effects, and I'm not convinced  
23 that everybody around this table truly knows what those might  
24 be. Thank you.

25 CHAIR HURLBURT: Thank you. Any other comments?

1 Shelley?

2 MS. HUGHES: Good afternoon, everyone. Shelley Hughes,  
3 Alaska Primary Care Association, and I was a latecomer signing  
4 up to testify because it was right before lunch that I started  
5 thinking about something and it was regarding, just as the  
6 previous testifier, about how specific to get. And before I  
7 go on, I just want to ask -- can I ask Deb a quick question,  
8 Dr. Hurlburt? Did you only have two meetings in this fall?  
9 Were there no meetings January through June?

10 COMMISSIONER ERICKSON: There were no meetings January  
11 until mid-October. Yeah. The 2009 Commission ended with the  
12 production of the report. Under the Administrative Order, it  
13 terminated which was this time last year. The Commission  
14 didn't get reappointed until mid-September and had our first  
15 meeting in mid-October, but we were continuing the work of the  
16 Commission. We did have a series of presentations on  
17 evidence-based medicine at the end of the January 2010  
18 meeting.

19 MS. HUGHES: Yes. And I was aware that some of you were  
20 from the previous year. I do think -- I just want to tell you  
21 my experience walking in and speaking with legislators in  
22 their offices a lot the last number of years. And when  
23 Governor Palin had her Strategy Planning Council, they did a  
24 report. And then the report, the 2009 report that some of you  
25 were involved with, what I experienced when I would go in with

1 that and take it in there, they would not be aware that it  
2 existed and this would be people on the Health and Social  
3 Services committees. This could even be Chairs. Or if they  
4 kind of vaguely knew it existed, they hadn't read it. And  
5 then when you start pointing things out, things were somewhat  
6 general and they didn't take it very seriously.

7 My recommendation, if we really want to transform the  
8 system and get the outcomes that I know everyone around this  
9 table wants, I really do think you're going to have to think  
10 about getting more specific, and it may even take during the  
11 course of a legislative session and then coming back and  
12 looking at some bills that are on the table.

13 It's like thinking about going on a trip, but you never  
14 go on the trip. You're just looking at the maps. You're  
15 looking at pictures of the destination. You're examining your  
16 budget. Meanwhile, there are planes being scheduled and  
17 planes taking off and people getting on those planes that are  
18 getting there, and we're not getting there. So I really think  
19 it's something that, if it's -- some of these goals having to  
20 do with prevention, having to do with the Medical Home Model,  
21 these different things, there are some real actionable kind of  
22 things that are happening during the session.

23 And also from my perspective when I go into a policymaker  
24 and I bring -- I have brought the reports these groups have  
25 done, the Strategy Council, and I said, you know, looking --

1 they're saying there's a challenge with workforce, and one of  
2 the things they're suggesting is loan repayment and incentive,  
3 but it's not -- if you would actually come forward -- and I  
4 know there is some hesitation about endorsing a specific bill,  
5 but unless you get that specific, it doesn't get their  
6 attention. And your recommendations go to both the Governor  
7 and the Legislature, and I tell you the Legislature really  
8 likes to know the Governor is onboard with something. And the  
9 report has come out using that workforce as an example because  
10 there have been general recommendations that the State  
11 consider some kind of loan repayment or incentive, for  
12 example, but the Governor is going to have to come out and say  
13 I support this bill, and I think the Governor is more apt to  
14 do that if he hears that first from you all.

15 There is such a wealth of knowledge and information and  
16 good conversation coming out of here, and you all are  
17 investing a lot of time, and yet when it comes down to what  
18 the policymaker is going to see or not see is whether  
19 something specific that you're going to recommend, you know,  
20 this bill number or this very clear item. And so I'd just  
21 encourage you. I -- you know even looking at the report  
22 that's going out that you worked on earlier this morning, if  
23 there is any way to refine something more specifically, I  
24 encourage you to do that. I encourage you to consider, during  
25 the course of the legislative session through the middle of

1 April that you maybe have -- I hate to add anything to  
2 Deborah's plate, but whether you should have somebody kind of  
3 making you aware of something that might be lining up with  
4 even the 2009 report. I mean, you're not -- everything in  
5 these older reports you all are saying you still support.  
6 Well there may not have been any action taken, and I tell you  
7 there wasn't. But perhaps there will be a bill and you all  
8 can get behind it to move some of your solutions forward  
9 because you've got some good solutions out there. So I just  
10 wanted to give you that perspective and encourage you in that  
11 way.

12 CHAIR HURLBURT: Thank you, Shelley. Any comments for  
13 Shelley? Ryan, can we turn to you?

14 MR. SMITH: Dr. Hurlburt and Commission members, thank  
15 you for this opportunity for public comment. I came here  
16 today to check up on my replacement, Pat Morenko, and let him  
17 know he's failing. And so -- but presenting here, I guess I  
18 want to let you know that I do not represent the ASHNHA  
19 organization with my comments today, as some of them may not  
20 be appreciated by my peers.

21 When we're asked kind of as a CEO of these health care  
22 organizations, you know, what keeps us up at night, I'd say  
23 recently it's three things. One is the potential repeal of  
24 the Health Reform Act, which I don't support. The second one  
25 is the recently enacted Mandatory Nurse Overtime Law, which I

1 would support the repeal of. And the third thing really is we  
2 had a consultant come and speak to our Board of Directors  
3 about the fact that, with the reimbursement systems in the  
4 state of Alaska, we are riding a horse that's going to die and  
5 we may have to eat it, and I thought it was a pretty good  
6 analogy of where we stand in terms of, for instance, our  
7 facility generating net revenue per adjusted admission in the  
8 \$17,000 to \$18,000 range and my peers in the Lower 48 have the  
9 same net revenue per adjusted admission between \$7,000 and  
10 \$8,000. And so we're generously rewarded for the work that we  
11 do, in my opinion. Again not all of my peers would agree with  
12 me relative to that fact.

13 And the thing, I guess, that I have the most guilt about  
14 and the thing that makes me the biggest hypocrite when it  
15 comes to talking about this is that we're really incentivized  
16 as providers in the state of Alaska to provide the most  
17 inefficient and the highest charged care that we possibly can  
18 because we're reimbursed, you know, like hospitals in the  
19 Lower 48 were 20 years ago as cost-based facilities for both  
20 our Medicare and Medicaid. However at the same time, we've  
21 not been presented any alternatives on how we're going to get  
22 reimbursed, so we work to maximize those systems. And so we  
23 completely generate volume and not value necessarily for the  
24 services that we provide. We try to provide value, but we're  
25 really incentivized to provide volume and that's what we do,

1 and I think we do that well.

2 And so I was very encouraged to see that the work of this  
3 Commission has provided for this health care price and  
4 reimbursement study. I think it's probably the most  
5 meaningful piece of this document, or at least the one that  
6 I'm focusing on. There's lots of meaningful pieces in here,  
7 but if the vision really is to create a sustainable health  
8 care system, which I would say that the way we're currently  
9 reimbursed is not sustainable. And if our values are for  
10 sustainable, efficient, and effective care and the goals are  
11 containing costs, we have to produce some data in order to get  
12 to that point.

13 And one of the things that has been very discouraging to  
14 me, when I was on a commission and since, is I think there has  
15 been some real -- I don't want to call it dishonest, but not  
16 meaningful dialogue related to reimbursements for the biggest  
17 chunk of the Medicaid budget, which is what I would think  
18 would be hospitals, nursing homes, and physicians.

19 And one of the things that I could offer to the  
20 Commission is that I started working at Central Peninsula  
21 Hospital about five years ago, and since that point in time,  
22 we've tried to create an integrated model where, when I got  
23 there, we really didn't employ any physicians and now we  
24 employ about 30 physicians. We employ family practice  
25 physicians, internal medicine physicians through our hospitals

1 program, all of our emergency room physicians, our  
2 anesthesiologists, a psychiatrist, a pediatrician, an  
3 orthopedic surgeon, a pain management specialist, a general  
4 surgeon, a neurologist, an OB/GYN.

5 And the thing that I can offer that maybe the Association  
6 wouldn't offer or independent, you know, physicians might not  
7 offer is actual production and income generated by these  
8 employed physicians and for our hospital providers, for our  
9 nursing home, for the hospital, and I know that some of those  
10 things are laid out in this study that's in this report and  
11 you might not be able to get to all the information you want  
12 to get to through that report. And so if there is ways we can  
13 help enhance that, we're willing to work with whoever you  
14 select as the provider in doing that to help maybe provide  
15 some more meaningful data relative to payer (indiscernible -  
16 voice lowered) production and the income that's generated as a  
17 result of that, at least for the physicians that we employ as  
18 a provider. And so I think it's important to get to honest  
19 dialogue about what all those things are because, if we don't,  
20 you know, nobody wants to eat a horse, right? So we don't  
21 want to get to that point.

22 We want to work to create some more meaningful  
23 reimbursement mechanisms for us as providers going forward  
24 because we're going in a completely different direction than  
25 our peers in the Lower 48 are going and there is a judgment

1 day somewhere for that, and I think we understand that. So  
2 thank you for the opportunity.

3 CHAIR HURLBURT: Thank you. Are there some comments?  
4 Noah?

5 COMMISSIONER LAUFER: I completely agree that there needs  
6 to be more openness and transparency, and I would even go so  
7 far as to say something very, very rude. We should have  
8 identity-scrubbed, itemized bills from large hospitalizations  
9 in the newspaper, and I can tell you there would be a crisis  
10 just because of this revelation because people, when they go  
11 bankrupt, when they see their bills and medical expenses --  
12 primarily hospitalizations are the leading cause -- it's a  
13 crisis for them. It's an embarrassment for me as a primary  
14 care doctor what goes on, and they are called doctor bills,  
15 but they're often not doctor bills. I saw one -- you know, I  
16 don't even want to go into it, but astoundingly huge numbers  
17 for ridiculous things.

18 I can tell you, from me, I had my appendix removed five  
19 years ago at the cheaper hospital. The surgeon did not charge  
20 me as a personal courtesy. It was \$18,000. I saw a nurse  
21 once after the OR. I shared a room. I was given a urinal. I  
22 was charged for Flagyl, which is pennies, \$800. I called and  
23 contested it, and they said, oh sure, and took it off my bill.

24 When you make systematic errors that benefit you, they're  
25 not errors, and this should be talked about openly. It's not

1 a 50,000 foot issue. It's a right on-the-ground itemized  
2 exactly -- why did the tissue paper cost that much? You know,  
3 that needs to happen. I don't see it happening, you know, and  
4 it needs to be honest because, you know, one of --  
5 Providence's Administrators love to say, well we only charge  
6 105% of, you know, the national average. Baloney. It's a  
7 glittering city over there that Alaskans paid for.

8 MR. SMITH: Yeah. I think we're faced with very perverse  
9 incentives that lead to these things happening, and without  
10 honest dialogue and putting those things out there, we'll  
11 never be able to fix them.

12 COMMISSIONER LAUFER: If that's the mission of an  
13 institution is to optimize income, that's great. A wonderful  
14 job has been done. You're right; the incentives need to  
15 change.

16 CHAIR HURLBURT: Jeff?

17 COMMISSIONER DAVIS: Thank you, Ryan, for your comments.  
18 Appreciate it. Good to see you. And if there is a way to  
19 take Ryan up on his generous offer to provide some data to the  
20 people who end up doing the studies, I think that would be  
21 well worth our while and I appreciate that. Thank you.

22 CHAIR HURLBURT: Yes, Larry?

23 COMMISSIONER STINSON: That was exactly what my question  
24 was going to be because it sounds like maybe a unique  
25 opportunity in Alaska. Who gets the data? How do we compile

1 it? What do we do with it? I mean, where would that go? I  
2 have no answers. I'm just asking the question. It sounds  
3 like a good opportunity.

4 CHAIR HURLBURT: Any other comments? Yes, Keith?

5 COMMISSIONER CAMPBELL: We're looking at a very brave  
6 man.

7 MR. SMITH: And potentially not employed for much longer  
8 either.

9 COMMISSIONER MORGAN: Well, I think the first place to  
10 start is, I think, all the hospitals file Medicare cost  
11 reports of some type. Those are on file in Baltimore. I  
12 would think that Medicaid could get that. That ties back --  
13 I'm sorry. That does tie back to their general ledger. It  
14 does have their costs and their units. There are some things  
15 that aren't exactly matched, but it would be a good beginning  
16 for the hospitals here. And by the way, have you ever tasted  
17 horse?

18 MR. SMITH: No, I haven't.

19 COMMISSIONER MORGAN: I have.

20 MR. SMITH: Is it good?

21 COMMISSIONER MORGAN: It's not that bad. Not that bad.

22 CHAIR HURLBURT: Paul?

23 COMMISSIONER FRIEDRICHS: Well I will second David's  
24 comment. Having had horse in China, it is not that bad,  
25 especially with lots of sauce on it. Having had my appendix

1 out in Budapest in a hospital in which you had to bring --  
2 your family had to bring food to you, my bill was not \$18,000,  
3 but I shared a room with ten people and it's a very different  
4 experience than how we do it here, which brings me back to  
5 Jeff's point and then to Ryan's point.

6 Jeff has very eloquently reminded me on more than one  
7 occasion about the concept of a continuum, and your comments  
8 are always so helpful, Jeff, in helping me kind of focus what  
9 I'm trying to say.

10 Ryan, what you are speaking about is the same discussion  
11 that's happening on the federal side right now which is, how  
12 do we change the discussion? And I would challenge my fellow  
13 Commission members here, just as someone said a moment ago,  
14 Noah or someone, that we can completely rethink this. We  
15 talked about doing the study that you referred to at our last  
16 meeting and getting that data and walking backwards from our  
17 end state. If our end state is quality health care which is  
18 reasonably affordable to the State -- given the discussion  
19 that you led us through, Mr. Chairman, at our last meeting on  
20 costs being one of the primary focuses here -- then I think  
21 what Ryan is proposing is absolutely crucial for us. And  
22 later in the meeting, I think, if I understand where we're  
23 going, that we're going to talk about the focus for 2011, I  
24 would respectfully ask that we invite Ryan back while we do  
25 have that discussion of the report that we've requested and

1 that he share his data prior to that meeting with the person  
2 generating that report, so that they can consolidate that and  
3 bring a more thorough analysis back to us.

4 CHAIR HURLBURT: We probably better move on, but Ryan,  
5 one, you just emphasized why I said such nice things about you  
6 when I introduced you as being here because you were so  
7 valuable to the Commission, and we really appreciate your  
8 coming back.

9 Maybe just to try to respond a little bit to the question  
10 that Larry raised and related to the comments that you and  
11 Noah had, I think that, as we do talk about one of the tasks -  
12 - and as you know, we talked about it when you were on the  
13 Commission, one of the things that we see the role for the  
14 Commission to play, as Noah suggested, is to provide  
15 transparency in some of these areas. And so as far as who  
16 would pick it up in Larry's question, I think that is the part  
17 of the role that we have and that we will be working on as the  
18 Commission.

19 And as I said, I think you weren't in here, but when I  
20 kind of had my introduction this morning, I commented, which I  
21 can never avoid doing on the cost issues, but how I had been  
22 so gratified that my new boss who was also not here this  
23 morning when I made the comments, but that he has been  
24 reaching out to ASHNHA, to other groups and just asking for  
25 what you said. And as my eyes were sweeping the room when you

1 made your comments, I saw that you interrupted his lunch a  
2 little bit and he looked up to pick up on what you were  
3 saying. So I think that, as far as Larry's question, is this  
4 going to drop or are we going to pick up on it, I think you  
5 bet. You bet we will. The Commission will. And I suspect my  
6 boss and others here will too, because we need to do it  
7 collaboratively. We need to work together on it. We need to  
8 come together because it's all too important, and if we all  
9 don't do it, it'll be done worse. We won't be perfect, but  
10 we'll do it as good as anybody can. So thank you so much for  
11 your comments.

12 MR. SMITH: Thank you.

13 CHAIR HURLBURT: Anybody on the telephone now? We'll  
14 flip the switch.

15 MR. BRANCO: Yes. Hi, Dr. Hurlburt. This is Pat Branco.  
16 I wanted to let you know that I had joined the meeting by  
17 phone, following my morning episodes, and to thank Ryan for  
18 his comments as well. I agree with much of the things he  
19 said, and I think we are on a good pathway to try to find  
20 reasonable and equitable solutions to the broken system.

21 CHAIR HURLBURT: Thank you, Pat. Any other comments from  
22 anybody on the phone?

23 MS. BURKHART: This is Kate Burkhart from the Alaska  
24 Mental Health Board and Advisory Board on Alcoholism and Drug  
25 Abuse.

1 CHAIR HURLBURT: Yes, Kate. Please go ahead.

2 MS. BURKHART: Thank you. The Alaska Mental Health Board  
3 and Advisory Board on Alcoholism and Drug Abuse appreciates  
4 the opportunity to, again, provide public comment and to  
5 support the Alaska Health Care Commission's statutory charge.

6 The Commission's 2010 Report and Recommendations to the  
7 Governor and Legislature was made available for written public  
8 comment in draft form for a two-week period from December 14th  
9 through the 30th. To meet that deadline, a decision was made  
10 to only allow public comment in written form during those two  
11 weeks. We appreciate having that opportunity and that the  
12 Commissioners have our comment and have undertaken it for  
13 consideration.

14 We understand that the public comment period for the 2010  
15 report to the Governor and Legislature has concluded the  
16 Commission has approved its report and that today's public  
17 comment period will not be considered for the 2010 report on  
18 how to improve the health care system in Alaska.

19 We have already registered our concern that the Health  
20 Care Commission's work to date has not substantively included  
21 behavioral health as a part of health care. Not considering  
22 behavioral health as a fundamental part of health is a  
23 mistake. Not only does it ignore the health needs of over  
24 50,000 Alaskans, but it ignores the programs and providers of  
25 services that you've heard about already today from

1 organizations, like the Peer Support Consortium and the  
2 organizations in the (indiscernible - telephone interference)  
3 represented.

4 Addressing the person's whole health will help improve  
5 patient compliance, reduce repeat visits, cut costs, and  
6 improve quality. There are evidence-based practices on  
7 integrating behavioral health care and primary care that can  
8 inform planning and system improvement. In fact, there are  
9 evidence-based practices on integrating behavioral health care  
10 and primary care that are being effectively implemented in  
11 Alaska right now. For example, the Impact Model of combining  
12 depression and diabetes care in a primary care setting is  
13 being used with great success in Anchorage.

14 The Screening, Brief Intervention, Referral and Treatment  
15 model for addressing substance use and substance abuse in a  
16 primary care setting is also being effectively implemented by  
17 tribal health providers and others.

18 As we've already registered this concern about the  
19 inadequacy of attention to behavioral health, we would like to  
20 briefly comment today on our concern about the process by  
21 which the Commission is developing recommendations.

22 Recognizing that new Commissioners joined late in the  
23 year last year and that the Commission has only met twice  
24 before having to prepare the 2010 report, we are concerned  
25 that stakeholder groups affected by the recommendations of

1 this Body have not been adequately engaged and that the  
2 necessary discussions and development of the recommendations  
3 has not occurred.

4 In the absence of these discussions, it appears we have  
5 limited opportunity for input in overall recommendations. We  
6 strongly encourage that this important process not be rushed,  
7 especially given the comments heard today about the need for  
8 specificity in making recommendations.

9 In adopting specific recommendations, the Commissioners  
10 need to be able to have the time to decide how those  
11 recommendations will be implemented, what the consequences are  
12 to the recipients of services and the providers of services,  
13 and to look long-range at the overall impact on Alaska's  
14 health care system. In order to do that, the Commissioners  
15 have to be able to have time to engage with stakeholders.

16 Thank you for the opportunity to share these thoughts and  
17 concerns with the Commission.

18 CHAIR HURLBURT: Thank you very much, Kate. Any comments  
19 or questions on that? Thank you, Kate. Anybody else on the  
20 phone who would like to make a comment? Next we want to move  
21 to the award for the person who came the farthest for the  
22 meeting here, and unfortunately, all we had was lunch, but you  
23 got that. But Amanda, we really appreciate your coming.

24 Amanda is going to have some comments. I'm not sure what  
25 they are, but a couple of things we've asked for is to share

1 the perspective that she has coming from Washington, where  
2 there is a lot of discussion, a lot of things going on related  
3 to health care and health care changes and policy and so on,  
4 but there may be a number of other areas.

5 As Amanda mentioned, she's been with Senator Murkowski  
6 for four years now and is her health person there and so is  
7 very interested in what we're doing and what's going on in the  
8 State as well as what is going on nationally, so welcome and  
9 thank you.

10 MS. MAKKI: Thank you. I guess I'll kind of start off,  
11 it was obviously an interesting week in Washington. It was  
12 the incoming class, the 112th Congress, and for us in the  
13 office, it was particularly nice. We had a swearing-in for a  
14 Senator Murkowski, and you know, all that goes with it, but it  
15 was really the incoming class that ran on a very conservative  
16 ticket that came in with the mandate to repeal the Health Care  
17 Bill. And it's kind of symbolic that we have this vote next  
18 Wednesday in the House on repealing the Health Care Bill. I  
19 think it's probably going to be HR1, the first bill, and again  
20 largely, it's symbolic because we know this isn't going to  
21 come up in the Senate. The Majority Leader has already  
22 indicated that he is not going to bring this up. Even if  
23 there was a chance that, for some reason, he did, there is the  
24 President, who has the veto pen.

25 So this is largely symbolic. It's going to happen in the

1 House, and it's going to happen next Wednesday. They've  
2 already kind of set the procedures in motion.

3 Now in the House as opposed to the Senate, you have to go  
4 to the Rules Committee to offer any amendments. In other  
5 words, the majority gets to control everything in the House  
6 and so they can set which amendments can come up. So I think  
7 what you'll probably see is a series of amendments offered by  
8 the Democrats, and the Republicans will or won't accept them  
9 to come to the floor.

10 Now in the Senate, it's different. The Senate -- any  
11 Senator -- any one United States Senator can bring an  
12 amendment to the floor. Any one United States Senator can  
13 hold a bill from moving.

14 So I think you're going to see amendments that are  
15 offered largely in the vein of, you know, requiring members of  
16 Congress to say that they would not accept their own health  
17 care benefits that they get. I think the Democrats are trying  
18 to term that as you're getting government-sponsored health  
19 care; why won't you allow other people to get the same  
20 government benefits that you get? I would argue that they're  
21 very different because it's employer-based coverage rather  
22 than, you know, Medicaid which is going to be expanded under  
23 the Health Care Law, but I think you're going to see a series  
24 of amendments in that vein.

25 The Democrats have been really employed by the CBO's

1 score that came out with what the repeal of the Health Care  
2 Bill would mean to the deficit, and the number that's being  
3 floated around is \$200 billion, but the actual number is \$145  
4 billion that the CBO says will be added to the deficit if the  
5 Health Care Bill is repealed.

6 The Republicans, of course, have their own talking points  
7 on that. I think one of the strongest talking points that  
8 they are going to argue is there were a lot of assumptions in  
9 the CBO's projections, and one of those assumptions is that  
10 Medicare is going to be cut by \$529 billion. That was in the  
11 original assumption of the Health Care Bill, and I think a lot  
12 of people would argue those cuts may never happen. So if  
13 you're assuming that, that assumption is not accurate to these  
14 numbers.

15 So I think you're going to hear the Republicans have  
16 their own talking points on that, but certainly the Democrats  
17 have been empowered by the CBO's score in saying, well you  
18 know, you guys also ran on the platform of not increasing the  
19 deficit, so you're increasing the deficit by offering this up  
20 for a vote.

21 I think you're going to see a lot more ads. I know the  
22 political season was supposed to be over, but I think it's  
23 just starting. I think you're going to see a lot of ads from  
24 senior groups, college, college age kids who now can stay on  
25 their parents' plan up until age 26, the children who get to

1 stay on -- or get to have health insurance coverage without  
2 pre-existing conditions being a part of that. So I think  
3 you're going to see a lot of very heartfelt emotional  
4 commercials and advertisements. Sorry about that, but it's  
5 going to be a very emotional draw to this and to keep House  
6 members from voting on this repeal bill.

7 Another thing that we saw this week was Secretary  
8 Sebelius sending out some interesting letters. The Health and  
9 Human Services Secretary sent a letter to the new House  
10 Appropriations Chairman, Harold Rogers of Kentucky, saying  
11 that they're moving the Office of Consumers Information and  
12 Insurance Oversight created under the Health Care Law, they're  
13 moving that from Health and Human Services to CMS. I think  
14 it's interesting that they're doing that, you know.

15 The explanation that the Secretary has given is that,  
16 well, CMS has the expertise to handle this kind of detailed  
17 level of oversight that's necessary. I think a lot of people  
18 will tell you that the more likely reason she is sending this  
19 to the House Appropriator, Chairman of the House  
20 Appropriations Committee is because the Republicans have  
21 talked about de-funding the Health Care Law, and a lot of that  
22 would be with HHS. What's interesting about that is that, if  
23 you tried to de-fund CMS, the Centers for Medicare and  
24 Medicaid Services, you're going to hear a lot of people say  
25 they're trying to cut Medicare. They're going to cut seniors.

1 They're trying to cut seniors' health care. So again, a lot  
2 of this is posturing and making sure that, you know, boxing in  
3 where they can, and I think this is good strategy to -- if you  
4 move it to CMS, it's going to be hard for the Republicans to  
5 want to, you know, cut from that.

6 Another letter that Secretary Sebelius, along with  
7 Secretary Geithner, the Secretary of Treasury, and Hilda  
8 Solis, the Secretary of Labor, sent this week was basically  
9 laying out the consequences of repealing the Health Care Law,  
10 its impact on the deficit, and its impact on jobs and the  
11 economy. So I think there is a lot of lobbying. I mean, this  
12 is what we would call internal government lobbying to stop the  
13 Republicans from doing what is really inevitable. I mean,  
14 they campaigned on this. It's going to happen, that they're  
15 going to bring this up.

16 I think that there is going to be, again, a lot of  
17 talking points that are going to be generated. I think you  
18 can expect very lightning speed talking points coming out of  
19 the Democratic campaign committees and the Senatorial  
20 committees basically responding to what the Republicans are  
21 trying to do with the Health Care Law.

22 So it's interesting because, really, the focus of this  
23 Congress is on this Health Care Law. It's very interesting  
24 that this is really taken on a life of its own. I mean, it's  
25 become the biggest news. I mean, we had major changes, major

1 shifts in the White House and personnel. It almost paled in  
2 comparison to what really has been a lot of news and a lot of  
3 focus on repealing the Health Care Law.

4 I think that the focus for Alaska is really, where does  
5 this leave the State and what happens with the Health Care Law  
6 and its impact on the State? I thought it was interesting --  
7 there was a political article this week. Deb was in it, and  
8 it was interesting to see that Alaska's one of the states to  
9 focus on. See what happens. What is this state going to do?  
10 So much of this is, what does the State end up doing because  
11 the federal platform has been laid out and certainly the  
12 regulations will take years to develop, but this all has to be  
13 implemented on the state level. And so what the states decide  
14 to do is very critical to what happens, and ultimately, there  
15 is obviously the Supreme Court -- or there is a federal court  
16 case that Alaska has joined with 20 other states in Florida  
17 and that is something that has also become very political  
18 because of the judges who were saying yes, this could be  
19 unconstitutional, and the judges that are saying no, this  
20 isn't unconstitutional, and it's very much politically  
21 divided. And so you know, they've been raising hay about that  
22 as well.

23 So I think there is -- you know, the court case is going  
24 to take a while, but in the interim, the states are going to  
25 be doing what they are doing and the Administration is going

1 to continue to lobby the states. And I think that there is  
2 going to be a full court press on -- with the Administration  
3 on the states to get them to start implementing these things.  
4 And once implementation happens -- and this was one of the  
5 things -- a friend of mine who is Democrat was saying, once  
6 things go into place, there isn't any looking back. I mean,  
7 there is going to be so much buy-in that is going to have  
8 already happened and so many constituents who are already  
9 going to be affected by this or impacted or benefitted by this  
10 that it's really going to be hard to move away from this.

11 So I think that the states are really going to be  
12 critical to what ultimately happens with the Health Care Law.

13 I think for the Senate -- I focused a lot on the House  
14 because, when you're in the Majority -- I worked in the House  
15 for some time, and when you're in the House and you're in the  
16 Majority, you can control everything and the other side,  
17 basically, has no power. They have no voice. But in the  
18 Senate, it's very different, and the Senate is still  
19 controlled by Democrats, but there are some key Democrats who  
20 are coming up for reelection in 2012 and they are in key, what  
21 we would consider, battleground states and they are going to  
22 be making sure they protect themselves and their political  
23 futures. And so I think you're going to see Senators, like  
24 Claire McCaskill of Missouri, Senator Nelson, Benjamin Nelson  
25 of Nebraska, who are going to be key people to watch and see

1 what they do to, in particular, reform the individual mandate.

2 The individual mandate is really -- has become the  
3 biggest problem with this bill, and Howard Dean, the former  
4 DCC Head, this week said, there's no reason to have the  
5 individual mandate because it's only a boon to the insurance  
6 industry; that's all it is. We never needed this; it'll  
7 probably be scrapped. So I think it will be interesting to  
8 see how this all plays out because, I think, a lot of people,  
9 including myself, view this as the individual mandate is the  
10 key that holds this entire thing together, and if that's not  
11 there, if they try and unravel that, I don't know ultimately  
12 what happens, but it's interesting to see that there is  
13 bipartisan support for that. So ultimately, what does that  
14 mean for the bill? I don't think it bodes well for the bill,  
15 if the individual mandate is no longer there.

16 So that's kind of a wrap-up of what happened in  
17 Washington. It was a lot that happened this week. So if  
18 there any questions, I'd be happy to answer them.

19 CHAIR HURLBURT: Any questions? David?

20 COMMISSIONER MORGAN: What I was watching this morning on  
21 MSNBC, doesn't the House also have regulatory review, i.e.  
22 those committees in the House, you're right, their  
23 implementing -- as I remember, about 1,600 regulations will  
24 have to be written and implemented on the state level, but the  
25 House has committees that review and can call witnesses and

1 actually can pass laws or reviews on those regulations. So  
2 the strategy I heard this morning was Congressman Rogers who,  
3 by the way, lives four doors down from my dad in Lexington,  
4 has 200 staffers whose sole job, part-time job is to make sure  
5 that every regulation is reviewed and goes through committee.  
6 That could slow it up also, correct?

7 MS. MAKKI: Yeah. I mean certainly, they can exercise  
8 many different procedural maneuvers, and I can't even speak to  
9 all of them, but slowing things down -- you know, I think the  
10 ultimate goal is, well if we, you know, de-fund something,  
11 then that makes it that much more difficult for implementation  
12 of whatever, you know, particular provision that might be.

13 And one of the other things with taking this Oversight  
14 Commission to CMS versus HHS is that there is, again, this  
15 movement that we do need to cut the government, you know, cut  
16 different programs, cut different bureaucracies, cut different  
17 agencies, and that's something that they've talked about very  
18 openly and candidly that that's something that we have to do.  
19 We have to cut from the different departments to save money.  
20 And so that would be, you know, really a no-brainer that they  
21 would start cutting from the different agencies, and I think  
22 that would happen very quickly. So I think Congressman Rogers  
23 and Congressman Darrell Issa of California are going to be  
24 extremely, extremely busy -- busybodies and you're going to  
25 hear their name a lot because they're going to be doing some

1 pretty controversial things in this new Congress.

2 CHAIR HURLBURT: Yeah. Alaska was on the NPR news this  
3 morning that I listened to, again maybe a follow-up to the  
4 interview with Deb, but basically quoting Alaskan Governor  
5 Parnell as being a leader in -- depending on how you look at  
6 it -- stonewalling as far as implementing the regulations  
7 because, as you were saying what Secretary Sebelius and others  
8 are doing, I think they are trying to push the states into a  
9 spot that, if you're challenging the constitutionality of some  
10 of the aspects of the law, you can be put in an embarrassing  
11 position. And you know, you may or may not agree with  
12 Governor Parnell's position on the law, but I think hearing  
13 that news item this morning illustrates that it's totally  
14 consistent with the belief of our Governor and our Attorney  
15 General that the law won't stand up to a constitutional  
16 challenge. And if you believe that, then you really do need  
17 to be pretty cautious about implementing some of the things  
18 that may be good, in and of themselves, that are in the bill,  
19 but it's interesting that Alaska doesn't often make the news  
20 as a national leader in that way. It was on the news this  
21 morning.

22 MS. MAKKI: Yeah. It sounds like they followed up right  
23 from the *Politico* article because -- I didn't hear the NPR  
24 news. I got in late last night, so I was sleeping. But it  
25 was almost a surprise, to me, to read the way that they

1 emphasized how Alaska was stonewalling, and I just thought,  
2 wow, that's interesting because there are 20 other states too  
3 that are involved in this lawsuit, and they really made a  
4 point to say that, you know, Governor Parnell and the State is  
5 really trying to prevent things from being implemented.

6 CHAIR HURLBURT: Any other questions or comments? Yes,  
7 Noah?

8 COMMISSIONER LAUFER: Can I just ask -- it's a somewhat  
9 abstract question, but I don't understand how Washington. I  
10 was just reading Bowles' and Simpson's recommendations, you  
11 know Alan Simpson, and I'm thinking, did they -- is there  
12 really a capacity there to inflict pain, if it's necessary?  
13 You know because there seems to be, like, the give-it-away  
14 camp and then the don't-pay-for-it camp, but there isn't a  
15 let's-do-things-rational camp, as far as I can tell. Do we  
16 have the capacity as a country, does the mechanism work to  
17 actually say we're going to do it right, even if I don't get  
18 reelected? Is that possible? I'm hopeful that it is.

19 MS. MAKKI: Gosh, I don't know how to answer that. You  
20 know, are there members that want to do things right? It's  
21 just so interesting because it always seems like everyone  
22 wants to protect their own hide, you know. And when you see  
23 someone, like Claire McCaskill, who was on TV -- I remember  
24 because I was here in Alaska for the entire month of August  
25 2009 with the Senator doing these Health Care Town Hall

1 Debates, and so it was kind of nice because every morning I'd  
2 get to watch. You know starting at 4:00 a.m. or 5:00 a.m.,  
3 I'd start watching all the different town hall debates that  
4 were going on throughout the country. So they'd start kind of  
5 on the East Coast and then move, you know, towards the West  
6 Coast, and I'd get to see the questions that they were  
7 answering and how the members were responding, and Claire  
8 McCaskill was very much defending this and saying how great it  
9 is and everything like that. Well gee, what a difference two  
10 years makes because now she realizes that, well I said that  
11 two years ago, but this isn't popular. People in Missouri  
12 just -- they had a referendum and they -- I think it was that  
13 the State 70% voted against any kind of any individual  
14 mandate. And then you have Roy Blunt, the former House  
15 member, you know, very popularly elected with a healthy  
16 margin, and here she is coming right up against that in 2012.  
17 Well all of a sudden now, the individual mandate is so bad.  
18 Well the individual mandate was the glue that brought this  
19 bill together.

20 So it's interesting because, in response to your  
21 question, I can only answer it in seeing what I've seen play  
22 out, you know. Ben Nelson didn't have to support the bill.  
23 He did, you know. One could argue he was the 60th vote  
24 because there were only 60. But now all of a sudden, the  
25 provision is not good. It's not good any longer, you know.

1 No. I guess if I had to answer your question with a yes or no  
2 answer, I would say people are going to protect their own  
3 political hide. They're not going to do what's right. That's  
4 just based on what I see, based on these people that I watch,  
5 people that I heard them on the Senate floor because I watched  
6 this debate very closely, and you would see them going down to  
7 the floor talking about how great this bill is, but all of a  
8 sudden now, it's not great.

9 COMMISSIONER LAUFER: Thank you.

10 CHAIR HURLBURT: Anything else? Thank you, Amanda, very  
11 much. Thanks for coming and thanks for sharing with us.  
12 Interesting times. Deb, can we come back now to our earlier  
13 agenda?

14 COMMISSIONER ERICKSON: Yes. We're moving on with  
15 learning more about what's going on today in terms of Medical  
16 Home Model adoption in the state, and we have a number of  
17 different folks to present to us today to come up to the  
18 table. And I think, to the folks who are on the panel, that  
19 we're not structuring this as a formal panel presentation so  
20 much as maybe just a series of presentations. And we have  
21 with us today Marilyn Kasmar, who is the Executive Director of  
22 the Alaska Primary Care Association, and she is going to share  
23 some information about what the Association is doing to  
24 support the adoption of Medical Home Model in community health  
25 centers across the state. Dr. Harold Johnston, the Director

1 of the Family Medicine Residency Program, is going to share  
2 with us some information about why they chose to convert the  
3 family medicine center at Providence to the Medical Home Model  
4 and how that's gone so far. And then Dr. Laufer is going to  
5 share with us his perspectives on how the Medical Home Model  
6 works in his private practice. And then we have Dr. Alice  
7 Rarig who is going to participate over the phone today from  
8 Juneau who is going to share some information on a new pilot  
9 program that the State Department of Health and Social  
10 Services is launching with some federal money to pilot test  
11 Medical Home Model specifically, a project funded by HRSA with  
12 CHIPRA funds, Children's Health Insurance Program  
13 Reauthorization Act, that's specific to kids and improving  
14 care for kids, but I believe that grant RFP was scheduled to  
15 close today. The proposals were due today. And so Dr. Rarig  
16 is going to talk to us a little bit about that pilot project  
17 for Medical Homes. And then Commissioner Streur is going to  
18 wrap up, just make a few comments related to Medicaid's role  
19 and the state government's role -- potential roles rather in  
20 supporting Medical Home Models.

21 So actually if our panelists would like to come to the  
22 table we already have -- Dr. Laufer -- how about Harold and  
23 Marilyn, would you want to just come up together, so we don't  
24 have to juggle too much? And then Dr. Laufer, you can maybe  
25 just -- when it's time for you to comment, you can just do

1 that from your seat. This is good.

2 CHAIR HURLBURT: Why don't we go ahead and start?  
3 Marilyn, you want to start? We'll just go down the group.

4 MS. KASMAR: I'm Marilyn Kasmar. I'm the Executive  
5 Director of the Alaska Primary Care Association. I know many  
6 of you and it's nice to see you today, and I would like to  
7 talk with you about the health care home model and as it's  
8 regarding the community health centers in the State. And  
9 Deborah asked us to talk about how we're supporting the  
10 evolution of the health care home model for the community  
11 health centers here, and I'm making the assumption that you're  
12 familiar with the model and the basic principles of the model  
13 and that. Good. All right.

14 Well the Primary Care Association is a membership  
15 organization. We serve Alaska's community health centers and  
16 other safety net providers. We provide technical assistance  
17 and training and advocacy, research, and other kinds of  
18 membership services. A large portion of our membership is the  
19 community health centers, although it's not exclusively our  
20 membership. And as you know, there are 2,500 organizations,  
21 142 sites around the State. They're serving over 86,000  
22 people and providing over 388,000 visits a year. We're  
23 expecting more new access points to be funded this year as the  
24 result of additional funding for the community health center  
25 program at the national level and that funding is supporting

1 new development and also expansion of existing sites and  
2 services.

3 In April of 2010, we began our exploration of the Medical  
4 Home Model for the health centers in Alaska and took a deep  
5 look at the NCQA Patient-Centered Medical Home process. We  
6 brought folks from the Primary Care Development Corporation,  
7 which is a non-profit that educates on the model and provides  
8 technical assistance and implementation -- brought those folks  
9 to the State to present on the model and start talking with  
10 our health centers about, you know, how to get started with  
11 implementing.

12 We quickly realized, as we started to go through the  
13 structure of the model, that, as it was structured with NCQA  
14 which, at the time, was being widely followed in the Lower 48,  
15 it was the basis for the first nationwide Patient-Centered  
16 Health Care Home pilot, but it doesn't fit every type of  
17 practice and every type of clinic. And we found that the  
18 greatest issues with the NCQA model would be faced by our  
19 rural and frontier CHCs.

20 At the time, NCQA was the only organization offering any  
21 kind of recognition and that has since changed or will be  
22 changing.

23 Health centers here typically fall into one of three  
24 categories: frontier, which means that there are fewer than  
25 six people per square mile living in the area; urban or

1 urbanized areas, which we only actually have one in the state  
2 of Alaska and that's Anchorage; that's a nucleus of 50,000 or  
3 more people. So we only have one site that fits in that  
4 category and that would be the Anchorage Neighborhood Health  
5 Center, and everything else is rural.

6 So some of the issues that we found that would affect  
7 most of the people that would be trying to implement this NCQA  
8 model were the lack of infrastructure at all levels in rural  
9 and frontier areas. You know in some areas, it's better than  
10 others, as you know. But many areas experience significant  
11 communications issues with their phone and Internet and other  
12 kinds of technology infrastructure and then a lack of  
13 abilities to support that infrastructure.

14 The cost of the Electronic Medical Records for small  
15 organizations and frontier clinics could be a big barrier.  
16 Meaningful use and other IT standards -- the use of Health  
17 Information Technology and implementing Meaningful Use and the  
18 Patient-Centered Health Care Home would be problematic as a  
19 result of that.

20 The isolation of the remote communities in geographic  
21 distance leads to difficulties in referring for some clinics  
22 and coordinating care, particularly for the tribal non-  
23 beneficiaries. So referring the non-bene from a rural part of  
24 the State into the more urban parts or larger towns can be  
25 problematic. There isn't really a good system for doing that.

1 And then of course, the travel logistics and expense and  
2 weather issues that happen.

3 There is a lack of access to specialty care in rural  
4 areas, a lack of lab and x-ray support facilities, and lab and  
5 x-rays that are sent for consultation can sometimes take a  
6 while to get there.

7 The pharmacy structure is different, and the standards in  
8 the Patient-Centered Health Care Home it would be difficult to  
9 meet with the way the pharmacy services are structured in some  
10 rural communities.

11 The small populations mean that there are low volume  
12 practice issues. Productivity, of course, isn't going to be  
13 as high as it would be expected to be in an urban area or in  
14 this model, and the use of the Patient Health Team -- because  
15 the teams are small, it would be difficult to meet that  
16 standard, too. And the low practice also creates some issues  
17 when it comes to retention. People start to feel like they're  
18 losing their skills when they're not seeing a lot of volume  
19 and that can cause some problems as well. As you know, there  
20 is a health care workforce crisis in this state as well and  
21 that's one of the complicating issues.

22 The extensive use of non-physician providers in Alaska,  
23 community health aides and nurse practitioners and PAs, don't  
24 fit well with the urban model of the Patient-Centered Health  
25 Care Home. And the training issues can be challenging in

1 terms of getting staff training, training for staff. It's  
2 expensive to send people to training and it takes them out of  
3 the community where they need to be providing services.

4 So since we realized pretty immediately that the NCQA  
5 model wasn't going to work for us, we started looking at other  
6 options and so what we're really focusing on at this point in  
7 time -- and there is some support for doing this at the  
8 national level -- the health centers should be seeing some  
9 support for the implementation of the Patient-Centered Health  
10 Care Home from the Bureau of Primary Health Care, which is  
11 really encouraging that the health centers so this and so  
12 they're providing some funding, small amounts but a little bit  
13 to help them get started with it. They've also provided the  
14 PCA with a little bit of funding, enough to staff a position  
15 to focus on helping to research models and implement --  
16 demonstrate and implement a new model.

17 So what we're looking at is we'd like to design a pilot  
18 project that would -- design a model that would fit well for  
19 rural and frontier practices and clinics here in Alaska and  
20 actually nationally. We don't think this is being done  
21 elsewhere at this point in time and so that's what we'd like  
22 to do, and we'd like to engage the Commission and the  
23 Department and all the appropriate partners and stakeholders  
24 that it would take to actually pull that off.

25 We've looked at a lot of the pilots that are happening

1 around the country. We've looked at NCQA. We've looked at  
2 the TransforMED Qualis pilots, the YRAC (ph) pilots, the Iowa  
3 Care Pilot, and the Oregon Pilot, and we think that the best  
4 fit to look at as a practice, best practice for us to follow  
5 would be the Oregon model. And so we have developed a  
6 preliminary of how we would develop and integrated approach to  
7 do that, and we would be looking at for-profit and non-profit  
8 primary care practices, urban, rural, and frontier primary  
9 care clinics. We'd be working with the Department on the  
10 policy issues. We'd also want to be working with the payers  
11 and other stakeholders, such as policy groups and  
12 policymakers.

13 Our plan would include creating formal relationships with  
14 these organizations, managing the model development process,  
15 collaborating with the partners and stakeholders to develop  
16 the final draft, convening the working groups which would  
17 include a design committee and a project implementation  
18 committee, and in the model developing of the definition, the  
19 guiding principles, the standards, the quality measures, and  
20 then the plan for training, fund-raising, implementation, the  
21 reimbursement model's development, data collection, and the  
22 evaluation.

23 I think that's about my ten minutes and that's it, in a  
24 nutshell. So if you have any questions, I'll be happy to  
25 entertain those later.

1 CHAIR HURLBURT: Keith, did you have.....

2 COMMISSIONER CAMPBELL: Just one. What is your time  
3 table on the duration for your developing and implementing and  
4 evaluating the program?

5 MS. KASMAR: Well one of the things that we need to do is  
6 additional fund-raising in order to support those activities.  
7 It's a fairly expensive endeavor. I've got some guidelines  
8 from the PCMH -- or from the Primary Care Development  
9 Corporation that talks about, you know, what the project needs  
10 to include. We'd like to do it, you know, immediately and  
11 with the resources that we do have. We have pulled together -  
12 - we have committed some staff time. We have committed some  
13 contractor funds to engage a contractor to help with the  
14 preliminary development. We are making use of national  
15 resources to help provide some early training for the health  
16 centers and get them started thinking about and a lot of them  
17 are, but in terms of designing this model, we would like to  
18 get started on it within the next few months.

19 CHAIR HURLBURT: We probably should go on. Maybe just  
20 one quick question, Paul.

21 COMMISSIONER FRIEDRICHS: So what specifically are you  
22 asking the Health Care Commission to support at this point,  
23 and is there a dollar figure? When you said that more  
24 resources were needed, what are you envisioning would be  
25 required to do this right?

1 MS. KASMAR: In looking at other models that have been  
2 developed around the country and the funding resources that  
3 have been required to it -- so say for a primary care  
4 association in Idaho to work with a set of -- I believe that  
5 their project has five organizations that they're working with  
6 in terms of the practices and clinics, and I believe their  
7 grant is somewhere in the neighborhood of half-a-million  
8 dollars from compiled sources. Half-a-million, yeah, but  
9 depending on the project size and that kind of thing, they  
10 differ. And you had a first part to your question?

11 COMMISSIONER FRIEDRICHS: So the first part of the  
12 question, is there something specifically that the Health Care  
13 Commission -- that you're looking to the Health Care  
14 Commission to do or support?

15 MS. KASMAR: Well the Commission has already indicated  
16 support for fostering the development of a model. So we want  
17 to make sure that, as we move forward, we continue to have the  
18 full support in that manner and then also to participate in  
19 the development as being one of the partners and then also to  
20 support our request for funding to other entities, such as the  
21 state foundations, those kinds of things. We understand the  
22 Commission, itself, does not have the financial resources.

23 CHAIR HURLBURT: Yeah. We've asked each of our  
24 presenters to try to limit to about ten minutes, and then  
25 hopefully at the end, we'll have a little time for discussion.

1 We are going to need to end this session on time because we've  
2 still got some business to pick up from this morning in  
3 response to Paul's question earlier today about specificity  
4 that we do have a response to. So Harold, maybe if we can  
5 turn it over to you now, please?

6 DR. JOHNSTON: You bet. Thank you. It's a real pleasure  
7 to be here. Thanks for inviting me. Hard to follow Marilyn.  
8 I can't imagine the challenges of trying to do this thing that  
9 we're struggling with here in Anchorage out in 140 community  
10 health centers around the State, but I'll help you if I can.

11 MS. KASMAR: It'll be fun.

12 DR. JOHNSTON: Our program is the Family Medicine Center,  
13 which is the training site for the Family Medicine Residency.  
14 It's a primary care clinic in midtown Anchorage, and we have a  
15 total of almost 50 doctors that work there, including the  
16 faculty and residents. We have 35 residents in the program  
17 right now, and we see somewhere in the neighborhood of 30,000  
18 patients a year. About a third are Medicare, about a third  
19 are Medicaid, and about 15% are uninsured on a sliding fee  
20 scale. We consider ourselves to be one of the safety net  
21 providers in the Anchorage community.

22 We started on the pathway to make ourselves a Patient-  
23 Centered Medical Home several years ago. Actually the vision  
24 of something like this is five or six years old in our place,  
25 and it stems from the need to be able to provide a different

1 kind of medical care nowadays than what is the traditional  
2 model of medical care.

3 I view the traditional model of medical care and primary  
4 care as being the doctor opens an office and provides services  
5 to the patients that come through the door of the office to  
6 whatever extent he or she is able to, based upon the patients'  
7 needs. That model of care worked pretty well when most of the  
8 problems were fairly acute problems and there wasn't a huge  
9 amount of technology or interventions that were very effective  
10 for the other kinds of problems that happened. However  
11 nowadays, the diseases that are affecting people are more in  
12 the line of chronic disease and much less in the line of acute  
13 disease.

14 Managing chronic disease is a much different type of  
15 activity than managing acute disease, and as our patient  
16 volume has switched to an elderly population and a population  
17 that's troubled by things like asthma, arthritis, diabetes,  
18 hypertension, more and more of these chronic illnesses, we  
19 have to adapt.

20 Sometime in the last decade, and I can't be more precise  
21 than that, an article was published that looked at the typical  
22 schedule that a family physician sees in their office and  
23 applied to that schedule the recommended health maintenance  
24 advice and screening tests that would be required and how much  
25 time it would take to apply those tests to that population.

1 It turns out there is, like, six or seven hours a day of time  
2 just to do the health maintenance and that's for people that  
3 don't have a disease. If you add in the types of diseases  
4 that are in the typical family physician's schedule and add  
5 the time it takes to do all the disease management  
6 recommendations that go with those, it's another ten hours.  
7 So the average day for the average family physician would  
8 consist of 17 hours of health maintenance and disease  
9 management before you even begin to address the reason that  
10 the patient showed up with their current complaint.  
11 Obviously, that is a ludicrous number to try and attempt to  
12 address in any kind of a regular practice.

13 So in order to be able to make a practice successful,  
14 you've got to reconfigure how you do that and that's where the  
15 Patient-Centered Medical Home comes in. The concept that we  
16 have arrived at after trying to work with this for a long time  
17 of the Patient-Centered Medical Home is that you move the care  
18 out of the office, move the care out to the patients in the  
19 community, do a lot of outreach and management through  
20 protocols, standardization, group education efforts, all that  
21 sort of thing, and try to reduce the amount of time that the  
22 physician spends one-on-one with each patient. It's the only  
23 way you can manage all of that chronic disease management and  
24 health maintenance.

25 In the old model, the physicians spent a lot of their

1 time doing things like trying to remember if this patient is  
2 due for a mammogram or not. That is not effective use of a  
3 physician's time. So you automate those kinds of things and  
4 try to involve other staff, people who are non-physicians in  
5 that kind of care.

6 So that was our vision, and a few years ago, we realized  
7 that, in order to do that effectively, you have to have a  
8 pretty sophisticated Electronic Medical Record. It can't be  
9 done with a paper chart system. So we embarked on changing to  
10 an EMR, which we did and wound up with an unfortunate choice  
11 that was a little difficult to use. So we've just switched to  
12 a new EMR, which we're enjoying quite a bit. We started it in  
13 October, and we are just now sort of getting off of the  
14 steepest part of the learning curve. So that has been an  
15 important change for us.

16 We started reading the NCQA guidelines for patients that  
17 are in Medical Home, and we used the national organization  
18 called TransforMed, which helps you change your client to a  
19 Patient-Centered Medical Home as a guideline, and realized  
20 that there are some things about the NCQA standards that are  
21 maybe not an exact fit with our vision, but on the other hand,  
22 they bring certain benefits with them. First of all, they get  
23 you an accreditation stamp, which is actually a good thing to  
24 have, and then there may be some funding that goes along with  
25 it. At least at one point, we thought there would be and so

1 we decided to apply for that. We just submitted our  
2 application for a Level I NCQA certification, and we're  
3 expecting by the end of this year to apply for a Level III,  
4 which is the highest level that you can get to.

5 What have been our biggest challenges? Probably the  
6 number one challenge been culture change. Having the vision  
7 of a new kind of practice is great, but turning that into a  
8 palpable reality that everyone in the office actually expects  
9 to work within is something else, and it takes a lot of time  
10 to do that. It takes a lot of staff meetings and visioning  
11 and process change and training and all that stuff.

12 So we have converted our schedule to what we call and  
13 advanced access schedule. That's very difficult in a  
14 residency program where the residents are only in the office  
15 part of the week, but we manage to do that okay. So that was  
16 one small slice. We transformed some of our patient service  
17 activities. That was a small slice. The next thing we're  
18 going to do is try to start working on this team-based care.

19 The thing that I'm most concerned about in turning into a  
20 Patient-Centered Medical Home is the affordability of the  
21 practice. Several things happen when you're a Patient-  
22 Centered Medical Home. One is your doctors are now not doing  
23 trivial stuff; they're doing significant stuff, and the things  
24 that they do take more time. So in the typical PCMH, the  
25 physician spends more time with each patient and therefore

1 sees fewer patients per half-day. Most of the patient care is  
2 happening through staff members and other people, case  
3 managers, nurses, medical assistants, front desk people, who  
4 are doing outreach to the patients or managing them without  
5 the physician involvement.

6 So your physician productivity will go down as measured  
7 in terms of the number of patient visits, but your costs will  
8 go up because you're going to have to hire case managers and  
9 other support staff to carry on this extended outreach  
10 program, plus you have to pay for the Electronic Medical  
11 Record.

12 The interesting thing about the Patient-Centered Medical  
13 Home -- and this has been supported by a number of  
14 experiences, as well as some published data -- is that, if you  
15 manage your patients in the PCMH method, you cut down on  
16 costs, overall costs. Hospitalizations, emergency room  
17 visits, urgent care visits, surgeries, and the other  
18 complications of uncontrolled disease are improved  
19 dramatically. In fact, they're improved so much that the cost  
20 of the Patient-Centered Medical Home is more than covered by  
21 the reduction in higher cost utilization. The problem is the  
22 cost of the PCMH is experienced by the primary care clinic,  
23 while the savings are experienced by the insurers or the state  
24 or some other entity.

25 So how are we going to be able to afford a Patient-

1 Centered Medical Home when reimbursements for primary care are  
2 the lowest reimbursements in the medical profession and we're  
3 expecting to increase the costs rather than reduce the costs?

4 It has to happen through some kind of payment reform, and  
5 we, at the Family Medicine Center, are fortunate to be  
6 supported by the big institution of Providence as sort of an  
7 experimental change, but this is not going to be a viable  
8 model for us in the long-term or for anyone else, unless there  
9 is a payment reform system. So the savings have to be shared  
10 across multiple groups that experience them.

11 One other point I wanted to make is that we're a training  
12 center. Our goal is to produce the next generation of family  
13 physicians for Alaska. We've been doing a good job of that, I  
14 believe, but as the Patient-Centered Medical Home becomes the  
15 new style of practice, we want our doctors to be able to go  
16 out and join practices that don't have doctors experiencing  
17 the PCMH and bring to them the knowledge about how to manage  
18 this and how to develop it and how it should operate. And so  
19 we feel it's good for us to be a leader in this area, if  
20 possible, because we're hoping that we'll be able to spread  
21 this across the state.

22 And with that, I think I'll stop my comments and thank  
23 you for your attention.

24 CHAIR HURLBURT: Thank you very much. I think we'll hold  
25 any comments until later. I saw Noah applauding some of the

1 things you said, and as Deb and I talked about planning this  
2 session, we wanted to make sure we asked Noah to talk with us  
3 because, I think, some of the concepts that you were talking  
4 about and you talked about, Marilyn, of the Medical Home that  
5 Noah has been involved in putting in practice, even before he  
6 probably heard the term, and doing it without a subsidy for  
7 somebody. So we've been very interested, and Noah, I'll turn  
8 it over to you.

9 COMMISSIONER LAUFER: I'm going to introduce myself  
10 again. I'm Noah Laufer. I'm a primary care doc in private  
11 practice. We have several of your graduates now, I think four  
12 of them, who are working with us, despite being told that  
13 private practice is bad.

14 In any case, I'm at Medical Park Family Care. Dr. Randy  
15 Taylor is actually here. He did 30 years there. I'm  
16 delighted to see that he's here. It's hard to get people to  
17 come out and support us when they're busy making a living.

18 We see 50,000 patients a year. This year, more than  
19 that. Twelve doctors. We are a same-day clinic. You can  
20 walk in and see your doctor, your doctor of decades. We have  
21 everything onsite that you could afford as a primary care  
22 facility. And I think we have already achieved many of the  
23 goals of a Medical Home.

24 The Patient-Centered Medical Home definition is changing  
25 to some degree. I agree with the transition from acute to

1 chronic and preventative care, and this is the most difficult  
2 thing that we are facing, the most difficult challenge,  
3 largely because there is not adequate reimbursement for it.

4 I was just -- you know, I don't do this kind of thing  
5 professionally, so I had to do some soul-searching and  
6 thinking about this and we actually have done this as an  
7 institution, you know, reviewing values and mission statements  
8 and all that stuff and experience, which is extremely painful,  
9 but we have done it. And when you look at the mission  
10 initially of the clinic, it was prompt, thorough, and  
11 concerned and that's wonderful and still applies, but applies  
12 primarily to the acute care issue.

13 Our latest mission, which changed recently from To Make a  
14 Positive Difference in Every Patient's Life is To Be  
15 Recognized As a Premier Medical Home in Alaska. We already do  
16 it. We are not subsidized. We don't anticipate getting any  
17 grants, and frankly, even accreditation. It doesn't really  
18 matter, to me, currently whether we're accredited or not. It  
19 matters to me whether my patients feel it. We do extensive,  
20 extensive patient satisfaction surveys, hundreds a month, to  
21 know that. We are dependent over 70% on word-to -- word to  
22 person-to-person referrals, word-of-mouth referrals, and I  
23 think it reflects it positively. We have a very large  
24 population of what are called unique patients. These are  
25 patients who identify us as their primary care doctor and have

1 for years and often many, many generations now. It's amazing.

2 So I was asked to say, you know, why we chose to  
3 implement this. We actually did, and it's because it's  
4 flattering to see that what is important about primary care is  
5 finally being recognized. It's not new. The Medical Home  
6 concept dates to the '60s, and frankly, far earlier than that.  
7 All good doctors have been holistic, even if they're, you  
8 know, intensely specialized. The ones that are good are  
9 holistic in their approach.

10 We decided to adopt a Medical Home because we want to do  
11 what we do well even better, and we recognize that there are  
12 weaknesses with paper charts, you know, when your focus is on  
13 the acute issue, but the person hasn't had their diabetes  
14 adequately followed, and we think we can do a better job at  
15 that, and the only way to do is to measure it. We adopted an  
16 Electronic Medical Records system at great expense and severe  
17 pain. I'm not sure if that's why Randy left, but it might be.  
18 I'm talking about several hundred thousand dollars, every  
19 doctor there an hour or more late every evening, and we did  
20 this of our own accord, and I fear that maybe we're going to  
21 have to do it with another system, like you guys experienced,  
22 which would really be horrible. And the cost of it is  
23 overwhelming. Just the transition from an ICD-9 to the ICD-10  
24 code, the estimate we just got was \$300,000 for the practice.  
25 This is a lot of money, and we have to absorb that.

1           So anyway, I think a lot of the -- I don't want to -- I  
2 could on about this for a long time, but the benefits of a  
3 Medical Home, right, are actually quite elusive, and it's not  
4 clear that this is going to be reproduceable in a corporate  
5 system for sure, and the majority of practices are shifting  
6 now from physician-owned to hospital-owned practices. They  
7 are based on -- the primary premise of the Medical Home is a  
8 long-term personal relationship with a physician. That's been  
9 part of it since the beginning, and that's not what everybody  
10 is talking about and it's really not applicable to a residency  
11 program where the docs are there for a brief period of time or  
12 to a program where the docs are so unhappy that they leave  
13 quickly. You know, we have the opposite problem. The guys  
14 are here for 30 years, leave, and want to come back. We have  
15 longevity, and the docs say, you know, I am Medical Park.  
16 That means they plan to be there their entire professional  
17 career. That's where the benefit of a Medical Home comes from  
18 is in that long-term personal relationship. I believe in  
19 making it anecdotal, and I think we should with our  
20 representatives because it's real.

21           A good example of this is very, very simple; it's a chest  
22 x-ray. I see a patient who has bronchitis. They don't need a  
23 chest x-ray, based my on exam. They want a chest x-ray. I  
24 tell them, you don't need a chest x-ray, and there is  
25 legitimacy in what I say because I can say, as you know, I'm

1 an owner here and I'd make more money if we did a chest x-ray,  
2 but I don't think you need one. I'm not doing this because  
3 I'm shilling for an HMO or anything like that. I'm doing it  
4 because it's not in your interest to have a test that involves  
5 radiation and expense. I can do that because I own it. It's  
6 mine to give away. It's not, if I work for a large hospital.  
7 I can also do it because we have immediate same-day access.  
8 You can come back this afternoon or tomorrow or next Monday.  
9 Don't worry about making an appointment and paying for it.  
10 Come and talk to my nurse, who you also know well because  
11 she's been my nurse for ten years and loves working there, and  
12 we'll do it -- we'll just do the x-ray, if you need it, but  
13 you don't need it now. It looks like I'm giving away income,  
14 but I'm not because it's a long-term, personal relationship  
15 with the patient who knows that I'm acting in their best  
16 interest and that's worth a lot to me and to the practice.

17 This elusive benefit is not going to be there, if the  
18 relationship is not an-adult-to-an-adult, and it isn't if you  
19 work for somebody else or if there is some utilization review  
20 person who says, boy, you're not seeing enough people fast  
21 enough or you're not ordering enough x-rays or you're ordering  
22 too much or they don't meet the qualifications. It won't work  
23 and that's the real problem is we have this incredibly complex  
24 system with too many fingers in the pie, and the relationship,  
25 which should be a one-on-one relationship is deteriorated.

1       Anyway, on-and-on.

2               We have made progress, in that we've adopted this. We're  
3 doing a lot of important things, like involving patients,  
4 patient access through the telephone, through the Internet,  
5 through our nurses. We're to look at quality. We're looking  
6 a lot at the management of chronic disease, particularly  
7 diabetes. It's the lowest of the hanging fruit. We are  
8 meeting outside of the clinic regularly with specialists from  
9 the community for education that is not involving of, you  
10 know, other interested parties, like pharmaceutical companies.  
11 We cater it ourselves, these kinds of things. We're trying,  
12 and we are very actively soliciting new docs who come from  
13 programs, like yours, not to work for us but to be partners  
14 with us and help us to meet the future, and we ramp them up as  
15 fast as possible to -- you know, there isn't an us and them.  
16 It's you, and we don't know what to do. What should we do?  
17 And it's been very interesting. They're eager, and I'd like  
18 to think we're getting the pick of the crop every time and  
19 that's our goal.

20               Some of the frustrations -- and I'm being, you know, too  
21 abstract because there are too many specific things, but some  
22 of the problems with it -- well the first is that there is a  
23 distrust among patients of this kind of thing because it  
24 smells a little of an HMO, and it's not that that's entirely a  
25 failure or a bad way to do things, but people don't like to

1 think their doctor is acting in a way other than in their best  
2 interest. That's very, very important, and it's been  
3 undermined to some degree. Obviously, the EMR has created  
4 great grief, and one of the docs said he misses his ex-wife  
5 the other day. So you know, you can imagine. It's not a lot  
6 of fun, but we're learning how to do it.

7 Another thing is that family medicine is, in a way, the  
8 specialty of ambiguity and it's the specialty of not being  
9 specialized, which translates financially into the specialty  
10 of all the things which are not well-reimbursed because, if  
11 you're well-reimbursed, somebody else is really good at that  
12 and will do what they can to make sure that they're the only  
13 person qualified to do it with things like accreditation. And  
14 the things we deal with don't fit into categories. They're  
15 not allorhythmic in nature. They're very personal in nature,  
16 and it's hard to sort of justify them, and the fear of having  
17 the quality of your care measured is difficult. It's easy  
18 with models like diabetes because, you know, it's not rocket  
19 science. You have a checklist and are the things on the  
20 checklist done, and it hasn't been done in nine months and  
21 you're supposed to do it in six. It's much harder with other  
22 things.

23 I'll be a little graphic. I saw someone recently. She  
24 is 66. She comes in. She wants a pap smear. It's not really  
25 indicated. She's never had an abnormal. She's had one

1 actually within a year, which was normal. She's on Medicare,  
2 and they reimburse, I think, \$46 now which is well under the  
3 cost, but in a way, that's not an issue because she's a long-  
4 term patient and I want to help her. So you know, should she  
5 get one? I'd be dinged if I'm being watched if I do one.  
6 Well you know, she was on Facebook and she found some stuff  
7 from her husband that implied maybe that he wasn't as faithful  
8 as she thought and she's not stupid. She went and looked and  
9 the viruses that cause cervical cancer are transmitted  
10 sexually, and she wants a therapeutic pap smear to reassure  
11 herself. She hasn't confronted her husband. These are  
12 ambiguous situations. The right thing to do is to do the pap  
13 smear for her and just hope to God that it's normal, which I  
14 did. But if somebody is looking at me and did I do the right  
15 thing, there is no algorithm for that. That does not fit into  
16 evidence-based medicine. There is nothing there. That's  
17 caring, and I was taught this many times, you know, the secret  
18 of caring is caring and that doesn't happen in algorithms. It  
19 doesn't happen when the bottom line is shareholder whatever,  
20 and it is at risk of being lost. I'm already doing it at a  
21 loss because \$46 is not enough to cover my expenses, but to do  
22 it at a loss and then be told by a bureaucrat that I am  
23 practicing medicine wrong is doubly insulting.

24       There is going to be tremendous resistance to this, and a  
25 lot is at stake. A lot is made out of this idea that 10% of

1 the patients cause 65% of the cost and that is an issue that  
2 needs to be addressed, but that also implies that 90% of the  
3 people are 35% costs and these are people who suffer equally  
4 when they're sick and they deserve good care, and I'll be  
5 class-biased, but they also include the people who pay for  
6 everything in general. And are we going to throw out a system  
7 that works very, very well for 50,000 people or patient visits  
8 a year for a possibility that something else might work  
9 better. I think these are really big questions, and the  
10 implications of what we decide are profound. I'll stop  
11 talking because I could go.

12 CHAIR HURLBURT: Great. Thank you very much. We do need  
13 to move on. I should say thank you, Dr. Katz (ph) -- I mean,  
14 Dr. Laufer. And I think you were probably inspirational to a  
15 young woman sitting in the back row here today with us. So  
16 thank you very much. Alice, are you on and we can turn to you  
17 next, please? Alice Rarig, Dr. Alice Rarig calling in from  
18 Juneau who is with our planning section there and has had long  
19 involvement. Alice, go ahead.

20 DR. RARIG: All right. Thank you very much. Are you  
21 able to hear me all right?

22 CHAIR HURLBURT: Just fine.

23 DR. RARIG: Oh, good. All right. I am Alice Rarig.  
24 I've been with the Department for 14 years now, and I am  
25 currently a planner for -- in Health Planning and Systems

1 Development, I manage the Planning Team and that includes  
2 being the State lead person for the Alaska Project referred to  
3 as the Tri-State Children's Health Improvement Consortium,  
4 which is going to be working on Medical Home demonstration  
5 projects with grantees and contractors over the next four-and-  
6 a-half years. It is a CMS-funded grant. I just wanted to  
7 clarify that. It's for the -- we seem to have some noise  
8 here. I'm sorry about that.

9 Our partner states, I think you may have heard this  
10 before, are Oregon and West Virginia. We all seem to have  
11 agreed on an acceptance of a Medical Home Model which is a  
12 little different from the NCQA and from the American Academy  
13 of Pediatrics Model.

14 I think you've heard both Marilyn Kasmar and Dr. Johnston  
15 mention that the NCQA model doesn't fit Alaska perfectly well,  
16 and it's partly because the NCQA explanation of what a Medical  
17 Home is is much more physician-centric, shall we say, does not  
18 as much acknowledge the arrangements for care and the  
19 decentralized care that we often provide in Alaska. The  
20 community health centers and the family residency program and  
21 the private pediatric and family practices are all our natural  
22 stakeholders, and yet we have had little contact with anyone  
23 for the last six months, simply because we're engaged in this  
24 procurement process which means that we can't be giving  
25 information to some but not all providers and that has put a

1 crimp on our communications to date, but we very much hope to  
2 have a lot more material online and to begin to hold some  
3 statewide meetings in March, by which time we should have  
4 selected our grantees.

5 I was very interested in hearing both Drs. Johnston and  
6 Laufer talk about their experience because we will certainly  
7 be wanting to talk to them and consider what we might do  
8 through this project, which is focused on children and  
9 improvement of children's care. So we'll be very interested  
10 in understanding what their lessons learned are and in how  
11 they have been using their Electronic Health Record  
12 information and their patient surveys to better monitor what  
13 is working and what isn't and how patients are finding the  
14 service and how they can improve the family-centeredness and  
15 acceptability and comprehensiveness of service.

16 I believe that you have seen the seven core competencies  
17 that we've built into our expectations of what our  
18 demonstrations will cover. I'll just name the big categories,  
19 and I can certainly go into them a little bit more, if you  
20 wish me to, but patient access is one, ensuring that there is  
21 a Medical Home relationship and that patients do have access  
22 to a personal provider or a care team, and of course, we  
23 envision this in Alaska as potentially being spread over quite  
24 a distance. But having points of contact and access through  
25 multiple channels is something that we see as important.

1 I think I'll mention, at this point, we do expect our  
2 grantees may come up with a variety of models for  
3 accomplishing each of these goals, and some of them may be,  
4 like the family medicine residency, already in the process of  
5 getting NCQA or some other certification.

6 The second area is accountable and quality improvement  
7 using population approaches to care, focusing on tracking  
8 health status of their members and managing care in  
9 conjunction with that.

10 Third is the patient and family-centeredness, making sure  
11 that there is an educational dimension. You've certainly  
12 heard that from all of those in the provision of health  
13 services realm as one of the aspects that they're certainly  
14 focusing on, ensuring that there is patient and family  
15 participation, and allowing patients and families to help  
16 evaluate the performance of the practice.

17 Fourth is continuous culturally effective care. We  
18 wanted to get the concept of culturally appropriate and  
19 effective services, and in that, we include geographic  
20 continuity and addressing any language barriers and being sure  
21 that information is available to all types of patients.

22 The fifth area is coordinated and clinically managed  
23 care, and this is where we emphasize clinically managed but  
24 not physician-directed, shall we say. Both Dr. Johnston and  
25 Dr. Laufer -- well especially Dr. Johnston talked about the

1 necessity to redistribute the tasks that might have fallen on  
2 the family physicians previously, but now are seen as,  
3 especially with best practices and models, establishing  
4 additional care coordination duties and clinical care  
5 management strategies and group educational strategies that  
6 the physician doesn't have to be involved in, as long as there  
7 are other qualified professionals.

8 Sixth is team-based comprehensive care. Seventh is cost  
9 control and alternative payment options and that topic has  
10 been brought up, and I'm sure, is of great interest to the  
11 Health Care Commission. One of the states, especially the  
12 Medicaid program's key interests in these demonstration  
13 projects is to be sure that the documentation of services  
14 allows us to look inside the black box of encounter rates, for  
15 example. We are hoping that the use of Electronic Health  
16 Records and the Health Information Exchange, which allows  
17 those records to be -- to have some of the information from  
18 medical records pooled for analysis might enable to see what  
19 is getting done in the Medical Home Models that is different  
20 from other settings and that will help the State make the  
21 decisions and determinations about how much is enough to  
22 sustain the model that is considered desirable.

23 As has been pointed out by the providers, it certainly  
24 appears that the cost savings are across the whole health care  
25 system and they do tend to be higher for those with special

1 needs, children with special needs, and adults with chronic  
2 problems. So that the more successful you are in managing  
3 those, the more you save the system of dollars and resources  
4 and you hope that the more satisfied patients and families are  
5 and the more comfortable they are in participating in their  
6 own care and improving their health.

7 Two important dimensions of our demonstrations will be  
8 the use of quality measures and the use of Health Information  
9 Technology, as I've mentioned, the Electronic Health Record  
10 and the Health Information Exchange.

11 The Quality Measures Work is a piece that CMS has asked  
12 for. They want to know if the 24 core quality measures that  
13 they've proposed be used to see how they work, if they work  
14 well. Alaska has (indiscernible - phone interference) to  
15 report on 14 of the 24 this year, based on all Medicaid kids,  
16 not just on the kids who might be in the practices that will  
17 be funded through this project. So the State Medicaid program  
18 is already making every effort to utilize those quality  
19 measures. The other ten, besides those 14 that were based on  
20 claims, data, and vital statistics data, really require  
21 medical record information, either chart review or something  
22 that could come out of Electronic Health Records systems.  
23 It's that piece of work that will be part of the effort over  
24 the next four-and-a-half years with the demonstration project.

25 So I think I've pretty much covered the basics about this

1 program. We hope we'll have three or -- well we hope we'll  
2 have four or five grantees by March and be able to start to  
3 have a conference in March or April that will really hone in  
4 on what are we thinking, is it the Medical Home Model or are  
5 the models that we want to -- that we will be working on. And  
6 then we'll certainly want to engage those who are already  
7 doing it in one way or another and get their advice and  
8 assistance and maybe work with them.

9 We hope also that we'll be able -- once we get our not-  
10 for-profit grantees organized, we hope we'll be able to set up  
11 a training program that might in state. It sounds as though  
12 maybe we ought to plan to do it, and at this (indiscernible -  
13 voice lowered) fashion. We would certainly be collaborating  
14 with folks, like the Primary Care Association and the  
15 Pediatric Society in state, to arrange for something like  
16 that.

17 I think that this grant project could provide the  
18 incentive payments to have clinics and providers participate  
19 in such training. That's something we have to develop in  
20 conjunction with those of you who are stakeholders and others  
21 out there in the world, and we very much look forward to  
22 seeing that take shape in the next six months to a year.

23 In exchange for providing some funding to convene  
24 interested parties or distribute -- do distributed distance  
25 learning on this model and the lessons that we'll be learning

1 and that others have been learning, in exchange for that,  
2 we'll hope to get, you know, some reporting back on how the  
3 model is evolving in various practices across the state.

4 So if there are any questions, I'll be glad to take them  
5 when you're ready.

6 CHAIR HURLBURT: Thank you, Alice. Alice, I think we're  
7 going to wait. We're going to try to wrap this up by quarter  
8 of. We have one more presentation now, but I think we'll have  
9 a little time left for questions at the end. The next is  
10 Commissioner Streur who is going to talk about the potential  
11 that we have through our Medicaid program, as far as  
12 supporting the Patient-Centered Medical Home. And  
13 Commissioner Streur, I wonder maybe if you could just come up  
14 here. Then everybody else can just stay around the table, and  
15 you can be Pat Branco.

16 COMMISSIONER STREUR: And I was all prepared to talk from  
17 the back of the room. As I sat here listening today, I came  
18 in the room thinking Medical Home is the only to go; it's the  
19 only way to go. As Dr. Hurlburt and I have been encountering  
20 recently, it's been a daily challenge dealing with the future  
21 of health care in Alaska and the many concerns that we have  
22 around costs. We've talked with Jeff Davis. We've talked  
23 with physicians. We've talked -- and I focus in on Medicaid.  
24 I grew up working Medicaid, and I have to constantly focus on  
25 balance. How do I get the benefit of this great and new

1 enterprise -- which by the way, I was speaking with a friend  
2 of mine the other night, a physician friend of mine who is  
3 older than I am even, and he remarked to me -- we were talking  
4 about Medical Home, and he says, think about it. He says,  
5 it's how you grew up in health care. You know, it just kind  
6 of struck me that, you know, now we're talking about all the  
7 sophistication of Patient-Centered Medical Home and all the  
8 changes related to that.

9 But to come back to the subject, it's a balance of, how  
10 do I move forward a concept that I believe in, that I believe  
11 is the only answer for health care? How do I get that pyramid  
12 that we've flipped outside down back to the way it's supposed  
13 to, where primary care is driving health care, and yet how do  
14 I afford it?

15 Every dollar that I look at bringing to our legislators  
16 and our governor going forward has to have more than a  
17 perceived value. It has to have a tangible value. And so I  
18 sit here listening today and I'm thinking, holy wah (ph), how  
19 do I get there? What is the way to do this? How do we move  
20 it forward? And I think that's the biggest challenge that the  
21 State has. Do I believe in it? Yes. Do I want to do it?  
22 Yes. I hope there is a pot of gold out there somewhere though  
23 that we can find to help us get there. I see the Denali  
24 Commission sitting here. I see the Trust sitting here. I see  
25 -- I think of others, but they're in the federal government.

1 I mean if they believe in this, you know, they're willing to  
2 step up and help us get there.

3 Listening to Noah talk, the reading that I've doing is  
4 very evident that physicians like it. When it's there and  
5 it's practiced, they stay. There is some sort of fulfillment.  
6 I guess it's circling around and being able to see the product  
7 of what you do. It's not somebody coming in -- some nameless  
8 person coming into your office, seeing them for five minutes,  
9 and walking out. And I know it's important, to me, to be able  
10 to see the same physician visit-after-visit-after-visit.

11 So what is the State going to do? I don't know. I know  
12 that I believe that this is the direction that we have to move  
13 in. I know that we need to enlist the support of our allies  
14 in this, the Primary Care Association, our physicians, and  
15 that's why I've been out meeting with docs and hospitals and  
16 people that lead the direction of this state, and we need to  
17 find a better way to do it. And I don't have the solution  
18 right now. I'm hoping the Legislature and the Medicaid task  
19 force that we put in place will be able to give us some  
20 leverage on this. I'm hoping to be able to convince people  
21 that do hold the purse strings for this state that there a  
22 value in doing, at least, some pilots, putting our toe in the  
23 water on, but right now, I don't have a crystal ball clear  
24 enough. Facing the budget issues that we're facing with  
25 Medicaid, it's a little scary.

1 CHAIR HURLBURT: Thank you very much, Commissioner.  
2 Let's open up. We've got about 15 minutes more, if we need  
3 that, for any comments or questions on any of the  
4 presentations here or related to the concept of the Patient-  
5 Centered Medical Home. Noah?

6 COMMISSIONER LAUFER: Obviously I'm an idealist, I guess.  
7 This is sort of a repetition of the same thing, and I said  
8 this, I forget, once before, but there is actually -- there is  
9 a lot of hope here, to me. I'd love to hear from somebody who  
10 is really expert in dealing with complex systems because  
11 that's really what we need, and I suspect that the answer is  
12 in reducing the linkages between people and not increasing  
13 them. We don't need extra layers of anything. The reason I  
14 believe that is not just, you know, doctors.

15 The reason I went into primary care, actually, is that I  
16 watched doctors that I knew, like Dr. Taylor and my dad and a  
17 lot of these guys, really enjoy what they do, really  
18 profoundly enjoy what they do. And so despite all advice not  
19 to do it from academia, I did it because I actually knew that  
20 you could. And this isn't just true of doctors. It's true of  
21 almost all health professionals. If you get out of the way  
22 and leave them alone, they will kill themselves. So go 120%  
23 to do what should be done. If you subjugate them and penalize  
24 them, they won't. They'll become like anybody else, you know,  
25 looking at the clock. It's 4:49, and you know sorry, I'm not

1 opening the door. We close at 5:00. My watch says 5:00.  
2 Click. And you know, I think there is an answer there. It's  
3 not that health care professionals in America aren't as good  
4 as elsewhere in the world. It's that we're bound by all this  
5 ridiculous, absurd, multiple layers of law, regulation, and  
6 frankly, parasitism, you know, all these other entities that  
7 make a living off of it. And if it is allowed to happen  
8 naturally, it will happen and the answer is there. If you  
9 tell us, you know, what we want from you as a family care doc  
10 is excellent preventive care and excellent chronic care, we'll  
11 do it. We'll learn how to do it. It's an easier thing to put  
12 your heart into and go behind.

13 This is really corny, but when I was trying to think  
14 about this, like you know, why in the world would I do this, I  
15 opened up my yearbook from medical school and there's a quote  
16 there from William Carlos Williams who wrote this in 1957,  
17 prior to any Medical Home note mention, in his essay called  
18 *The Practice*, and he won the Nobel Prize. But if I can, I'll  
19 read it, if I have my glasses. I'm getting old. I'll make it  
20 real quick.

21 Anyway, he said, it's the humdrum day-in/day-out everyday  
22 work that is the real satisfaction of the practice of  
23 medicine, the million-and-a-half patients a man has seen on  
24 his daily visits over a 40-year period of weekdays and Sundays  
25 that make up his life.

1 I've never had a money practice. It would have been  
2 impossible for me, but the actual calling on people at all  
3 times and under all conditions, the coming to grips with the  
4 intimate conditions of their lives, when they were being born,  
5 when they were dying, watching them die, watching them get  
6 well when they were ill has always absorbed me. To me, that's  
7 what it's about. I wasn't thinking about a commission when I  
8 put it on my, you know, page in the book, but that is what  
9 it's about and it's also the answer to the problem.

10 You know, we're doing this private practice without, you  
11 know, money or grants or anything. It's dependent on the  
12 satisfaction of our patients. We can't afford a lot of the  
13 things that are in the medical home. We tried. We had a  
14 diabetic educator that couldn't -- it was actually a PA which  
15 she couldn't support herself. I'd love to have a psychologist  
16 and pharmacist and a case manager, which I had when I was a  
17 resident, but there's no pay for that. I would like, actually  
18 for romantic reasons, to do nursing home visits and house  
19 calls or group meetings with diabetics so that they could work  
20 together to, you know, learn how to cook things that taste  
21 good and lose weight. It is not reimbursed. It's not paid  
22 for; hence, it does not happen. But if, you know, we were  
23 allowed to -- sometimes I think it would be great if the whole  
24 thing collapsed and people were trying to pay me in chickens  
25 again. It would be a lot simpler, you know. You don't look

1 busy, doc. I've got 100 bucks; can you help me? Sure.  
2 Absolutely. Come on in. I'm sitting here or standing here.  
3 The problem is not the health care providers, and further ways  
4 to squeeze the thumb are not going to help it. It's  
5 eliminating the bullshit in between.

6 CHAIR HURLBURT: Thank you, Noah. Other questions or  
7 comments? Paul?

8 COMMISSIONER FRIEDRICHS: How did you know I was going  
9 to.....

10 CHAIR HURLBURT: You're hand was itching.

11 COMMISSIONER FRIEDRICHS: So I'll go back to the article  
12 by Gruenbock and Grundy (ph), and I'll share this with  
13 everybody electronically after the meeting, but it's an  
14 interesting one to go through because it breaks down a number  
15 of the studies that have been done so far on this. And what's  
16 fascinating is, as you go through the article, you see, for  
17 the majority of them, return on investment was not quantified  
18 and that tracks very well with, I think, the comments a number  
19 of our speakers have made here that return on investment or  
20 the financial aspect of this is profoundly difficult to  
21 quantify.

22 For those organizations that have been doing this for a  
23 while -- and I'll use our own experience on the federal side  
24 with this -- we're finding much the same as what was described  
25 here. The savings are not in primary care. The cost is in

1 primary care. There's a tremendous investment required to do  
2 this. The savings are on the in-patient side and on the  
3 specialty side and on the emergency visit side. I say all of  
4 this, number one, to encourage my federal Commissioners to  
5 read this so that, as we do make decisions on what we'll  
6 capture in the 2011 report, we have some data that we can base  
7 our decisions on, but then I would pose the question to the  
8 Commission, so what? We've heard now an hour's worth of  
9 discussion about this. Where are we going to go as a  
10 Commission with this? What is the intent with the 2011  
11 report?

12 My recommendation would be that, unlike what we did this  
13 year where we waited until the end of the year and recognized  
14 this year was a little different because of the condensed  
15 timeline, we make an effort as we talk about these different  
16 subjects to take away some specific findings and  
17 recommendations at the time we have the discussion rather than  
18 delaying or waiting many months later to come back and try and  
19 remember what the presentations left us with, what thoughts we  
20 had or conclusions we arrived at. And along those veins, I  
21 would recommend that we try and come up with some findings  
22 today that, at least, we can begin to mark some things down,  
23 recommendations and findings, that we can then revise over the  
24 course of the year.

25 CHAIR HURLBURT: Did you have a comment, Dave?

1 COMMISSIONER MORGAN: No.

2 CHAIR HURLBURT: Noah?

3 COMMISSIONER LAUFER: Can I just say -- Paul, along those  
4 comments and the earlier ones, if we're going to do that, I'd  
5 like to, in regard to primary care, ban the use of encourage  
6 and support. It has to be something with a little more --  
7 like because we get a lot of encouragement and support, but we  
8 don't get paid.

9 CHAIR HURLBURT: So Paul's comment, essentially, is that  
10 we don't have many deadlines, but we do have a deadline of  
11 having the recommendations each year to the Governor, to the  
12 Legislature about this time of year. So we know that's  
13 coming. We know that, 12 months from now, we're going to have  
14 that deadline. So you're suggesting that we be cognizant of  
15 that as we go along that, as we get into issues, we get into  
16 them from the perspective of developing recommendations which  
17 may be a strawman to some extent, but then we can work on  
18 them, massage them, perfect them over the year so that, when  
19 we come to next December's meeting probably as to finalizing  
20 the recommendations for 2011, we won't feel like we felt  
21 today, that we were in a rush and that we haven't had enough  
22 time to consider that. Is that a fair comment?

23 COMMISSIONER FRIEDRICHS: I'll say it more bluntly. For  
24 someone who has had too much scotch and too little oxygen when  
25 flying, I don't remember what I talked about 12 months ago.

1 So come next December, I can guarantee I will not remember the  
2 great points that were made this afternoon. If we're going to  
3 come up with recommendations, if we can at least capture some  
4 of those now, that will help my enfeebled brain to recall the  
5 context and the reason of why we came up with what we came up  
6 with when we revisit this in December.

7 CHAIR HURLBURT: Yes, Harold?

8 DR. JOHNSTON: I think that's a really good suggestion,  
9 and I'm prepared to offer some ideas, if you're interested in  
10 some thoughts because I've been struggling with this for a  
11 long time and thinking about it for a long time. What would  
12 make it work? And I go back to some basic information that we  
13 know from a lot of studies that have been done over a long  
14 period of time, and that is that primary care is the low cost,  
15 high quality solution to the health care system. That's been  
16 demonstrated in the United States through the Medicare  
17 program. It's been demonstrated in individual practices.  
18 It's been demonstrated internationally. The literature is  
19 very, very consistent on this point. It really is not  
20 disputable. If you have a health care system that's based on  
21 primary care, the correct pyramid, as you said, Commissioner,  
22 the costs go down and the quality goes up, along with the  
23 satisfaction of the patients. We don't have that kind of a  
24 health care system in Alaska. Our health care system in  
25 Alaska is based upon the same model that's prevalent all over

1 the United States, which is why the United States has the  
2 highest cost health care system in the world. And the  
3 incentives are all against primary care.

4 So as I listen to conversations about this, what I keep  
5 hearing is the Patient-Centered Medical Home doesn't have a  
6 return on investment. There is a downstream -- there is an  
7 immediate cost and we don't know about the downstream value.  
8 We have to have it proven to us that, indeed if you make a  
9 Patient-Centered Medical Home, you're going to save money in  
10 the other end. It's been proven several times in different  
11 settings, but everybody wants it to be proven again for their  
12 setting before they're willing to make the investment to make  
13 it happen. It's just not going to happen naturally. It's  
14 going to have to be supported. There are different ways you  
15 can support it, but probably the best way is, at least the  
16 pilot way that Medicare tried was to have, you know, a per  
17 member/per month management fee that's added to the regular  
18 service fee, if you are indeed providing the Patient-Centered  
19 Medical Home services.

20 I think that we are not going to convince decision makers  
21 to just jump whole hog into having Medicaid start paying for  
22 Patient-Centered Medical Homes, plus there are not a lot of  
23 Patient-Centered Medical Homes in Alaska ready to receive the  
24 payment, but it would be smart to do a pilot program and  
25 include in the pilot program an analysis of the downstream

1 cost savings.

2 At Providence, where we are doing our Patient-Centered  
3 Medical Home, we are going to be able to analyze our  
4 downstream costs or our patient experiences in the long run.  
5 Providence is not tremendously excited about the idea that all  
6 the doctors would become Patient-Centered Medical Homes  
7 because they live on more hospital admissions, and if we wind  
8 up saving admissions, it actually is hurting them rather than  
9 helping them, but they also are very interested in seeing the  
10 value of the model. So they're supporting us, anyway, to  
11 become a Patient-Centered Medical Home and helping us with the  
12 data analysis of our patients. Do they get in the hospital or  
13 not? But there are lots of other places those patients go.  
14 They go to specialists. They go to other hospitals. They go  
15 to imaging centers. So Providence will not be able to capture  
16 all the cost data on the outcome of the management of those  
17 patients. It takes an insurance company or a payer to be able  
18 to track all that and analyze it and then feed it back in  
19 terms of whether or not it's been successful.

20 CHAIR HURLBURT: David?

21 COMMISSIONER MORGAN: I'm not going to go into specifics  
22 because there's no time here, but there is a system that has  
23 primary care and tracks the downstream costs. It's tribal.

24 I know of one certified Level III NCQA that's been  
25 operating for about eight months. I think that -- I think it

1 will follow the literature that you've looked at. The real  
2 question is to sit down and to publish and to get that  
3 information out. I'm really not supposed to talk about tribal  
4 stuff, but that's the -- they're supposed to -- the one member  
5 that's not here that represents tribal organizations is  
6 supposed to do that, but let me say that the tribal system  
7 from an academic and a general way of saying it is, at least,  
8 we are base primary care. We are able to track since we  
9 empanel. We know our downstream costs, as Dr. Eby has come  
10 before this Commission and talked about.

11 So there is a model with a significant number of patients  
12 that could provide that information and has been in operation  
13 and is certified. I believe -- and maybe the Commissioner can  
14 elaborate on it and that'll be all I'll really say -- that, I  
15 believe under the legislation effective now, that, with a plan  
16 amendment, they can negotiate a management fee with a  
17 certified II or III NCQA that's recognized, if they can  
18 provide those benchmarks and to show those savings. I may be  
19 wrong on that, but.....

20 CHAIR HURLBURT: Let me say something about ROI issues  
21 and what you said, what Noah said, what Harold said a little  
22 bit there. And I spent about half as much time in the payer  
23 world as I spent in the clinical world, so I had a fair amount  
24 of experience there. And I think that, when you're speaking  
25 probably from a Providence system -- and I'm not being

1 critical of Providence -- when you look at the ROI, that you  
2 do have the dilemma that you talk about because Providence  
3 does well financially. They support their mission. They  
4 support their profitability by more high tech stuff, by more  
5 procedures, by more of all of this. But when you look more  
6 globally from a payer's perspective -- and I think I can  
7 probably comfortably speak for Commissioner Streur and  
8 Medicaid and Commissioner Davis on the private insurance side  
9 -- that you're payers are going to look globally at that, and  
10 they are concerned and they do see value in the ROI from the  
11 primary care home model.

12         And in 15 years on the payers' side where we looked at  
13 utilization, when we were concerned about utilization, kinds  
14 of data and numbers of visits and numbers of diagnostic  
15 imaging procedures and one thing and another, what are the  
16 things that, if anybody made the comment, it showed that you  
17 were a neophyte or not very astute if you were concerned about  
18 too many primary care visits because, I think, any payer  
19 recognizes that you don't want to hold down on primary care  
20 visits, that obviously it can be abused. You can have  
21 somebody that comes in to see you every week for a URI or  
22 something that just drives your costs. But overall when you  
23 look on a systemwide basis, I think that payers recognize that  
24 relationship with the primary care provider, as reflected in  
25 the visits, consistent with what we're talking about now in

1 the concepts of the Medical Home does provide both higher  
2 quality appropriate care and saves you money. So then, how do  
3 we compensate for it? And you mentioned that, and I think  
4 that's an issue. And I've said before that one of the  
5 elephants in the room that we have to deal with is, is it  
6 reasonable, is it valid, or who is going to take on the issue  
7 that, if you're a neurosurgeon, you're going to make \$2  
8 million year, and if you're a family medicine physician, you  
9 may make \$180,000 a year, and is that a sustainable model? Is  
10 it an ethically right model? But I think that's a part of it  
11 and that is not easy, obviously, to deal with, but that's a  
12 part of the whole picture of compensation. But I think, as  
13 far as the ROI, there are more people out there that  
14 understand what you're saying, more allies in that area that  
15 look at it globally, that, yes, it's the right thing to do.  
16 Yes, it's quality care, but it's also financially the prudent  
17 thing to do. Yes, Harold?

18 DR. JOHNSTON: Yeah, thanks for making that comment. You  
19 know, one of the problems that we have with the primary care  
20 system in America today and in Alaska is the shortage of  
21 primary care physicians, and interest in family medicine is  
22 down.

23 As a person who is recruiting family medicine residents  
24 all the time, I'm very concerned about the number and quality  
25 of people that are going into family medicine out of medical

1 schools today. If you talk to them, it's a financial issue to  
2 a large degree, and that is, they come out of medical school  
3 with \$200,000 worth of student loan debt, and if they become a  
4 radiologist, they're going to make \$400,000, \$500,000, or  
5 \$600,000 a year. If they become a family physician, they're  
6 going to make \$150,000 or \$180,000 a year. We live in a  
7 capitalistic system, and one of the biggest incentives to  
8 change behavior is to provide funds.

9 I don't think you need to start taking money away from  
10 specialists in order to make this happen though because we've  
11 already shown that the value added by primary care is already  
12 being lost elsewhere in the system through over-utilization of  
13 hospitalization, emergency room visits and procedures, and if  
14 you use primary care, that stuff gets cut down, if you do it  
15 well, like Noah is doing it, if you do it in a Patient-  
16 Centered Medical Home Model. So the idea is, you can increase  
17 the compensation of family physicians, incentivize more people  
18 to go into family practice by taking a little bit of that  
19 money out of the savings that will happen when the primary  
20 care Medical Home actually starts cutting down utilization.

21 And so apart from considering the pay of specialists or  
22 any other medical professionals, you have the resources there.  
23 It's the reallocation of them, and it's going to actually  
24 cause a reduction in the total cost of care at the same time  
25 it would increase the compensation to family physicians.

1 CHAIR HURLBURT: Thank you. I think Noah was asking a  
2 question of the Commissioner. I don't know if you -- I mean,  
3 not Noah. David. I don't know if you had a response on that.  
4 I think Paul has something, and Jeff did. So maybe -- I don't  
5 know, Commissioner, if you had any response to Dave or Paul  
6 and then we probably better end it.

7 COMMISSIONER STREUR: As David is so adept at doing, he  
8 set me up again. It is available. We could do a state plan  
9 amendment that will allow us to pay, basically, a head tax,  
10 sort of like we used to do with some of the capitation models  
11 and things like that, but this pays for the Patient-Centered  
12 Medical Home component of it. In other states, it's not a lot  
13 of money. And you know, we have to figure out a fair and  
14 equitable amount to do it, but I mean, that's the easy part.  
15 It's coming up with \$5 million to develop systems, coming up  
16 with a million dollars to develop systems, paying for NCQA  
17 accreditation that, frankly, I'm perplexed at the value of  
18 that, but it's the way it's being done. So we can do that.  
19 And I'll just be brief. It's entirely within the realm of  
20 what we can do.

21 CHAIR HURLBURT: Paul, the last word?

22 COMMISSIONER FRIEDRICHS: So thank you and I think, Mr.  
23 Chairman, you made the point very eloquently and I was happy  
24 to play the fool at our last meeting to walk down that path  
25 with you of, what is our driver? Our driver is cost. You

1 made that very clear as you read from our Commission there --  
2 or our charter rather. And as we come back to cost being the  
3 primary driver here, I would offer several things.

4 One would be a motion that we include a finding that the  
5 evidence supports that the Medical Home model has a return on  
6 investment of 1.5 to 2-to-1. That's what the published data  
7 supports right now. I would recommend we could go ahead and  
8 capture that and that we include that in our future reports,  
9 so that, as we talk about what we are going to recommend,  
10 there is a rationale behind that.

11 What I've not heard this afternoon are specific  
12 recommendations of how we would leverage that return on  
13 investment to actually implement or incentivize the  
14 implementation of the Medical Home Model and so I would  
15 challenge our speakers from the panel today to come back to  
16 our next meeting with specific recommendations for the Health  
17 Care Commission to consider, based on the assumption that this  
18 is, indeed, going to result in a net savings to the health  
19 care industry here in Alaska.

20 I don't believe any of us have the expertise. Noah has  
21 the great expertise as a primary care physician running a  
22 private practice. Many of have expertise in our individual  
23 areas, but we're not going to cross-cut well enough to be able  
24 to craft the specific how-to part of this, and I would  
25 challenge our speakers to come back with those recommendations

1 at our next meeting and then let us consider them and decide  
2 which we will include in our report.

3 CHAIR HURLBURT: Thank you. I think we have the request  
4 -- maybe we could hold the motion until we're back more in a  
5 business mode and thank the speakers. Thank you, Alice, for  
6 being on. We do have a request, and the other option on the  
7 request would be maybe to forward what you have on that to Deb  
8 and then we can kind of see what format we want to have it in  
9 next time, but I think sharing with Deb the information on the  
10 ROI, on the payback that Paul refers to as far as the Medical  
11 Home. I think that's a real consistency with the Commission  
12 since it's beginning has been an understanding, support, and  
13 advocacy for the value of primary care as it's articulated in  
14 the Medical Home, and I think that's going to be an important  
15 part of advocacy, I suspect, as long as the Commission goes  
16 on, as we modify this model of health care that we have in  
17 Alaska and in our country today. Yes, David?

18 COMMISSIONER MORGAN: Two minutes. We all can see that  
19 there are going to be different modalities of the Patient Home  
20 Model. Not every format, every concept -- just like  
21 accountability organizations, they're going to be different.  
22 They're going to meet the need to meet the objective, as we  
23 used to say in the Army, you know. You mold the terrain and  
24 the battlefield to meet your objective. But it would seem  
25 that, especially physician practices, community health

1 centers, primary care, organizations like this who are not  
2 necessarily cash rich that are, you know -- have few -- not  
3 200 days of cash or have a lot of capital to go on this, that  
4 the State, either through Medicaid or other formats, might  
5 look at some small demonstration grants or capital requests  
6 with the proviso that they report back and give them  
7 information on that savings or even put in benchmarks or use  
8 some case management concepts, but link it to showing that  
9 they've met those objectives, have met those quality levels,  
10 whatever is designed and those benchmarks, not just give you a  
11 bunch of money and hopefully it all works out. But there  
12 could be a way of working that out. They don't necessarily  
13 have to be extremely big grants, you know. That's what's been  
14 going around in my mind for the last eight or nine months.

15 Accountability organizations in the design at NCQA are  
16 designed physician offices, group practices, clinics, primary  
17 care centers, and then larger systems, like tribal systems or  
18 HMOs. So that may not be worth much, but I'd just like to  
19 throw that -- as we say in Kentucky, I like to throw a little  
20 barley out there and see if any horses eat it and think about  
21 it and maybe the Commission might make some non-specific  
22 program recommendations, but just concept recommendations to  
23 throw a little money in there, as long as there is utility  
24 proof and -- see, he's happy with that. He likes that  
25 because, you know, if he invests a dollar and gets five

1 dollars back, it's, you know, nirvana, right? That's the  
2 whole idea here, I think.

3 CHAIR HURLBURT: Just a second. Jeff has a comment, but  
4 I'm going to take a Chair's prerogative and say we're not  
5 going to have a break. So if folks need to get up and want to  
6 get a cup of coffee or go to the bathroom or whatever, slip  
7 out and do that, but I think that we didn't save any time on  
8 this section and it's because it is so important. And if  
9 we're going to get back and pick up what we didn't get done  
10 this morning, I think we probably need to do that. So Jeff,  
11 if we could turn it over to you?

12 COMMISSIONER DAVIS: Recognizing that I'm standing  
13 between you and the bathroom, a couple things. From my  
14 perspective, the conversation about ROI is, for sure, true,  
15 that there is ROI. It is also true that it doesn't  
16 (indiscernible - voice lowered) to the people who made the  
17 investment to make it happen. And if you don't figure out how  
18 to crack that nut, this thing is not going to bloom. There  
19 are a lot of demonstration -- not demonstration, but there are  
20 pilots that are being done where carriers are working with  
21 specific medical groups to say, okay, how can we do this? Can  
22 we look and see, you know, what happens down the road? And if  
23 you, in fact, reduce trend or reduce utilization, then it  
24 comes back to you on top of what you were already paid. If  
25 the Commission is interested at some point, maybe we can bring

1 some people who have experience with those and can talk about  
2 what's being done. I know we are, in Washington, doing pilots  
3 with a number of medical groups for that very reason, so thank  
4 you for that.

5 CHAIR HURLBURT: Thank you. Noah, did you have a  
6 comment?

7 COMMISSIONER LAUFER: I guess too many. I'm not a  
8 libertarian or a Tea Party member, and I'm interested in this,  
9 what Jeff is talking about, but I think, you know, it's fairly  
10 obvious. If you do the work, then you should be the one who  
11 gets paid for it, not somebody else. And all the offers we  
12 get are, you know, we're going to give you a whole bunch of  
13 risks and we'll give you a little bit of the benefit and that  
14 isn't going to fly.

15 I definitely don't want to sort of spread dissension  
16 among the ranks because, I think, the primary care people will  
17 agree with one another. But comparing, like, our system to  
18 the Native system, it's simply not fair. I mean, they can  
19 say, you know, look at all these wonderful outcomes we have,  
20 and I'm going look at that \$100 million building you have and  
21 that new four-story garage and the guaranteed pension and  
22 health benefits of your docs when they retire and the  
23 protection from liability and the loan repayment, you know.

24 I live in a completely differently world. We are, you  
25 know, capitalists, shoestring, dependent on the satisfaction

1 of our patients. We've operated for 40 years out of a  
2 building that might be worth \$4 million, and the roof leaks.  
3 I still am paying my loans off. I don't have a pension for  
4 retirement, and I don't have health benefits. Those are  
5 extremely expensive things that I would consider incredible  
6 luxuries, and they're not counted in the bottom line and that  
7 needs to be part of it. I would think that, if you can free  
8 it up and allow it to happen, you know, organically -- I guess  
9 not entirely in a libertarian way, but you know, let the  
10 person receiving the service and the person giving it be the  
11 primary financial interaction as well. It'll fix itself, you  
12 know.

13 As it stands now, I can't negotiate in a lot of things  
14 because of, you know, laws about Medicare. You know, you  
15 can't afford your co-pay? Tough. You know if I don't charge  
16 you, that's fraud. If I give it to somebody else for free,  
17 that's fraud. You know, it's -- I guess I'm a libertarian in  
18 this thing. Anyway, sorry.

19 CHAIR HURLBURT: Thank you.

20 COMMISSIONER FRIEDRICHS: So who was that, Gordon  
21 LaRouche or whatever his name was? Lyndon LaRouche, that's  
22 it. Yeah. So we've eaten horses. We've thrown barley in  
23 front of horses. We've done a variety of things with horses  
24 at this meeting. What are we going to do with the primary  
25 care Medical Home Model?

1           COMMISSIONER ERICKSON: We are going to move on in just a  
2 second, but I have tried to capture at least what, for now,  
3 I'm calling Draft Preliminary Findings, Recommendations, and  
4 Next Steps on the screen behind me. And so just really one or  
5 two minutes here for draft, preliminary, new Findings that  
6 we're going to add to our existing Findings in our 2009  
7 report. Savings resulting from the primary care Patient-  
8 Centered Medical Home Models do not accrue to the primary care  
9 practice that incurs the additional cost of implementing it.  
10 I do not want to wordsmith this. I want you to just tell me  
11 if I captured the main point. And also, evidence demonstrates  
12 that the ROI from the model is one-and-a-half to two-to-one.

13           And then draft preliminary recommendations, the one that  
14 I heard and at least understood is that we need to analyze the  
15 health outcomes and ROI of the models that we demonstrate, the  
16 pilots that we have in Alaska.

17           And then for next steps, request that we ask these same  
18 presenters to come back to our next meeting with some more  
19 specific recommendations for the Commission's recommendations  
20 and that we also investigate any existing pilot demonstrations  
21 between payers, including the private insurance companies,  
22 between payers and primary care practices that are working on  
23 shared savings. Again that's not worded very elegantly, but  
24 you get the main point, I think.

25           Do you think that I captured, for the most part -- and

1 this is in addition to our standing recommendation related to  
2 this, that we've already recommended that pilots be done and  
3 that reimbursement methodologies be looked at.

4 COMMISSIONER FRIEDRICH: If I may put down one more  
5 marker that I think I heard us talking about or heard many of  
6 the speakers talk about is that we recommend a capital budget  
7 item in the amount of whatever that amount is going to be to  
8 build the necessary infrastructure to deploy the Medical Home  
9 Model in Alaska. That's really going to be the action piece  
10 of this.

11 COMMISSIONER ERICKSON: So now the follow-up to our  
12 conversation immediately before lunch, and I have at least one  
13 of my two witnesses to this conversation. I will try to be  
14 brief, but in our past meetings, during our 2009 meetings, we  
15 had very active involvement from our two legislative members,  
16 Senator Olson and Representative Keller, plus I think the  
17 group also recognized that we encouraged that we were looking  
18 at being proactive, not reactive and making more general, not  
19 very specific policy recommendations.

20 Speaking with Senator Davis on the break right at lunch,  
21 she was very firm and said, it is not the role of this  
22 Commission to make specific recommendations on legislation and  
23 funding to the legislature. She was very clear and very firm  
24 about that, and her aide is here and Elizabeth was standing  
25 with me, and I think we asked a couple of clarifying questions

1 and it was pretty clear.

2           So understanding that -- I mean, we are trying to strike  
3 the right balance between being relevant, being specific  
4 enough and clear enough that we're relevant in our  
5 recommendations, but if -- we're not going to cross the line  
6 between making very specific recommendations and then  
7 hopefully -- I understand and appreciate the concern that was  
8 expressed during our public comments that, if we're not real  
9 specific, the legislators aren't going to pay any attention.  
10 I'm hoping that, with our ongoing and evolving reports -- and  
11 I'm not going to go into more details about how I'm  
12 envisioning that process playing out, but that, as we're  
13 accruing examples of what is happening related to our specific  
14 recommendations and keeping that posted online as well as  
15 updating our annual reports and including maybe some  
16 recommended action steps, like we did in our 2009 report -- we  
17 haven't done in this report -- that aren't part of our formal  
18 recommendations, that that might help bridge the gap and  
19 strike the right balance. But for now, especially with that  
20 feedback from Senator Davis, I would suggest -- and the fact  
21 that we are way over time, if for no other reason than we're  
22 out of time, and maybe we can get even some more formal  
23 direction. I also have some other suggestions about process  
24 for the future, so we can get clarification and not have to  
25 keep swirling around this.

1 CHAIR HURLBURT: And I think what Deb said would be  
2 consistent with my conversations with members of the  
3 Legislature, several of whom claim some paternity for this  
4 group, for the Commission, that that's their desire, their  
5 expectation. They're very concerned about the various issues  
6 and the charges, notably the costs, but they're not looking  
7 for us to get down at too low a level with specific  
8 recommendations. So that would be confirmatory.

9 COMMISSIONER LAUFER: Are we looking for innovative  
10 suggestions as to how to make our little, tiny population of a  
11 state, you know, work?

12 CHAIR HURLBURT: I think so.

13 COMMISSIONER LAUFER: We're just not asking them to spend  
14 money?

15 COMMISSIONER ERICKSON: No. It wasn't that we're not  
16 allowed to ask for money. It's just that our recommendation  
17 shouldn't be on a specific project basis.

18 So just for example in the conversation we had just had  
19 right before lunch, it's the difference between recommending  
20 that we need community-based data -- and I'm not going to get  
21 into the details, but we need a data system to support  
22 community health improvement action in order to improve  
23 population health -- again I'm not going to wordsmith that --  
24 as opposed to a recommendation that would say the Legislature  
25 should appropriate \$200,000 and the Governor should approve it

1 that to this particular program for this particular data  
2 system. That's the distinction.

3 CHAIR HURLBURT: To go back to what you have here on the  
4 second point, I'm a little uncomfortable with that. I would  
5 like to believe that I'm very convinceable of that, and I  
6 don't know if it's the article that you have with you, Paul,  
7 about that, but before getting to the specificity of an ROI  
8 one-and-a-half or two, I would be more comfortable just saying  
9 that it's positive at this point. And as we referred earlier,  
10 maybe then come back to that. You said you would share that  
11 article with us.

12 COMMISSIONER FRIEDRICHS: Yeah, I'll send it out tonight,  
13 with thanks to Mr. Britten actually who, I think, is still  
14 here for actually doing a great deal of the legwork to track  
15 some of this information down to get us beyond the -- we think  
16 it's good to -- there's data that shows that it actually makes  
17 a difference.

18 CHAIR HURLBURT: Deb, I think we have to give priority to  
19 what we need to do to wrap up the report and the  
20 recommendations over the panel on the Affordable Care Act.

21 COMMISSIONER ERICKSON: Yep, with thanks to our  
22 panelists. You know, my greatest concern was over the Finding  
23 and Recommendation Statements, and at this point, we're not --  
24 we could have had a whole other conversation about whether  
25 we're adding some recommendations that aren't specific to the

1 ones that were public noticed, and especially with the  
2 comments that we had about that not being long and involved  
3 enough, I would suggest that we're not going to add any  
4 recommendations related to other issue areas that haven't been  
5 public noticed in some way to our 2010 report.

6 So in the interest of time, as much as anything, I'm  
7 going to suggest we're just going to skip over that and go  
8 straight to plans for 2011 analyses. We did have, in public  
9 comment, some very specific additions to what we might  
10 analyze.....

11 COMMISSIONER FRIEDRICHS: Mr. Chair, I object. There was  
12 a motion on the table which has been dismissed by the  
13 Executive member, non-voting member of the Commission there.  
14 I'd like for a vote on my motion.

15 CHAIR HURLBURT: Could you restate your motion, Paul,  
16 please?

17 COMMISSIONER FRIEDRICHS: It was the motion this morning  
18 that we address the issue of the finding -- let me find it  
19 again here. We had talked at our last meeting and at this  
20 meeting about the difficulty in finding data.....

21 COMMISSIONER ERICKSON: I can't hear you, Paul. I'm  
22 sorry.

23 COMMISSIONER FRIEDRICHS: Of having readily available  
24 data in order to determine the efficacy of evidence-based  
25 medicine, and I had proposed a finding assessing the outcomes

1 of health care interventions as challenging, due to  
2 limitations, collecting, and sharing data among patients,  
3 clinicians, payers, and government agencies, and we had opted  
4 to table that at the time that I proposed it. I've not  
5 withdrawn that proposal, so I would respectfully request that  
6 we either act on that, vote it down, but that we not just move  
7 on. Thank you.

8 COMMISSIONER ERICKSON: Do we have a second to that  
9 motion?

10 COMMISSIONER STEVENS: Did we have a second to it this  
11 morning?

12 COMMISSIONER ERICKSON: We did not.

13 COMMISSIONER STEVENS: For the purposes of discussion, I  
14 would second.

15 CHAIR HURLBURT: Do you want to type it, so we can see it  
16 up there?

17 COMMISSIONER ERICKSON: Yep.

18 CHAIR HURLBURT: Maybe Paul, if you could read it slowly  
19 again?

20 COMMISSIONER FRIEDRICHS: Assessing the outcomes.....

21 COMMISSIONER ERICKSON: For some reason, I'm not hearing  
22 you. I don't know why you're -- oh, we have too many mics on.  
23 That's why.

24 COMMISSIONER FRIEDRICHS: Assessing the outcomes of  
25 health care interventions is challenging due to limitations on

1 collecting and sharing data among patients, clinicians,  
2 payers, and government agencies. Patients, clinicians -- Deb,  
3 your mic is on. I think that's what's -- payers, and  
4 government agencies. And again this directly relates back to  
5 the presentation at our last meeting about the need for the  
6 IBIS system and the presentation that we heard here today.

7 (Pause)

8 COMMISSIONER FRIEDRICH: And I'd like to speak to that.

9 CHAIR HURLBURT: Please?

10 COMMISSIONER FRIEDRICH: So.....

11 COMMISSIONER ERICKSON: I'm sorry. I have a process  
12 concern again. If we're talking about adding this to our  
13 evidence-based medicine set of Findings, we already approved  
14 that set of Findings. So is this a finding you want to put on  
15 our preliminary draft list for 2011?

16 COMMISSIONER FRIEDRICH: Well Deb, I have to admit.  
17 I've never participated using a process like we've used here  
18 today. I had asked for a motion to reconsider, if that was  
19 appropriate. What we had agreed to was that we were going to  
20 come back to this later today, and since today is just about  
21 over, whatever mechanism or words I need to say, but we had  
22 agreed we were going to come back to it, so I'm asking that we  
23 come back to it.

24 CHAIR HURLBURT: Let's talk about it and have you do what  
25 you were going to do to explain it. And then I think we'll

1 need to come back to, well, what do we mean by this, where  
2 does it go, what's the intent, but maybe if you could explain  
3 it some, Paul?

4 COMMISSIONER FRIEDRICH: Sure. So the intent of this,  
5 as we talked about at the last meeting and at this meeting,  
6 is, if we're going to champion evidence-based medicine as the  
7 key part of our report, we have Findings and Recommendations  
8 specific to evidence-based medicine. What we're struggling  
9 with and what we've heard from multiple speakers at our  
10 sessions here is the lack of evidence on which to make  
11 decisions at the population level.

12 So my recommendation or motion to the Commission is that  
13 we include that as a finding under the heading of evidence-  
14 based medicine, with a specific recommendation to follow that  
15 the State pursue the most advantageous way to make that data  
16 readily available to these different groups. That again gets  
17 us started on this path towards whether it's building a new  
18 system, paying for a new system, not going to solve that  
19 today, but it starts the discussion that we began to have this  
20 morning, and which as you, I think, very much articulately  
21 said than I did, you don't start down that path until you  
22 start down that path. It's clearly a part of evidence-based  
23 medicine is being able to look at the impact of what we do, at  
24 least at the population level.

25 CHAIR HURLBURT: So that the State would make what

1 available to whom? As of to whom, I mean, do you mean the  
2 State as a payer for care or do you mean all payers to the  
3 State? Do you mean payers and clinicians and other providers?  
4 And as far as what's being made available, is it the  
5 compendium of literature dealing with evidence-based medicine,  
6 the interpretation of medical articles, the medical articles  
7 themselves, or population-based outcomes data? I just -- I'm  
8 not -- I don't have a real clear picture.

9 COMMISSIONER FRIEDRICH: So my personal recommendation  
10 would be that the State would make the IBIS, the I-B-I-S, or a  
11 similar database available. How we get there is up to the  
12 Legislature and the Governor to determine, but that, at least,  
13 is population level data which we've heard multiple speakers  
14 say would be helpful to determine how to improve the health of  
15 population, to improve the access of our population, all of  
16 the things that we are chartered to do. If we can begin that  
17 discussion and capture that in our recommendations this year,  
18 we're that much farther down the road in moving. But again  
19 I'm a little perplexed by the process because what I'm trying  
20 to get us to is saying the IBIS methodology is good or  
21 something similar to that is good, having data is crucial for  
22 evidence-based care, and we endorse that and recommend that we  
23 move forward on that.

24 CHAIR HURLBURT: So what you're suggesting then to bring  
25 it down in simplistic terms is that Elizabeth's plea for, can

1 we get population data for our market, for MatSu specifically  
2 there, but as an example -- but can we get population-based  
3 data for that and that the State needs to do a better job? I  
4 think, consistent with what Senator Davis said, I would feel  
5 it's probably inappropriate for us to say it should be the  
6 IBIS system. Personally where I sit, I think it's a good  
7 system. So in my role as Division Director, I support that.  
8 So I'm not opposed to the IBIS system, but as far as what the  
9 Commission does, we're identifying the need that was reported  
10 to us by the panel, by Elizabeth specifically for better, more  
11 complete population-based data, which implies more of a  
12 breakdown, a different breakdown than what we've had of the  
13 kind of data that a state public health system would normally  
14 provide. Does that sound reasonable?

15 COMMISSIONER FRIEDRICHS: That absolutely does, and  
16 however we need to say that within the constraints of the  
17 system we're operating under, I don't care. I just think  
18 we've heard the testimony. We've talked about it. We did  
19 that last year, prior to completing our FY10 report or  
20 calendar year '10 report, whatever it is. And this is an  
21 opportunity to capture both that Finding and that  
22 Recommendation. I agree with you; I'm not asking that we  
23 stipulate one particular provider, but I do think we can go on  
24 record as saying that we should do this as part of our focus  
25 on evidence-based medicine.

1           COMMISSIONER ERICKSON: And I have a concern that goes  
2 back to Jeff's comment earlier. I don't think that the system  
3 that was described to get at community health information for  
4 the purpose of improving population health fits within our  
5 definition of evidence-based medicine. I think what we're  
6 talking about is a more general principle that we need good  
7 data to support decisions, whether it's about individual  
8 medical decisions or whether it's about population health  
9 improvement. But then there is a difference between applying  
10 that in medical and clinical decisions, which is what our  
11 evidence-based medicine definition is about, as opposed to  
12 making population-based policies decisions which -- and they  
13 fit -- and the reason why this distinction -- one of the  
14 reasons why this distinction is really important to me is I  
15 need to make it fit in our model, and I'm the one who is going  
16 to have be able to describe it. And that's why I had brought  
17 up this diagram, the one that's on the screen right now  
18 earlier, is having an information system that's going to  
19 support community health improvement decisions for meeting one  
20 of our overall goals related to prevention is different from  
21 our value improvement strategy that's targeted at improving  
22 clinical decision making using evidence-based medicine  
23 principles. And then looking at our definition in our draft  
24 2010 report on evidence-based, we actually include two or  
25 three takes at these, but this is one specifically taken from

1 the medical dictionary that's italicized is about evidence-  
2 based medicine in the practice of medicine.

3 So I guess I have a concern with making the community  
4 health information system and population health improvement  
5 findings and recommendations in our evidence-based medicine  
6 findings and recommendations. So I don't know, Jeff, if I was  
7 understanding you correctly, and I'm having the same problem  
8 that you were having in this conversation?

9 COMMISSIONER DAVIS: I believe you are understanding me  
10 correctly. I do see them as two separate important things,  
11 and I don't see it really as a good fit in this particular  
12 category, but I do think it's something that we, at some other  
13 place in time.....

14 COMMISSIONER ERICKSON: I mean, could we do.....

15 COMMISSIONER DAVIS: .....need to address.

16 COMMISSIONER ERICKSON: Excuse me. Could we do what we  
17 did with primary care just now and come up with a couple  
18 really quick draft Preliminary Finding and Recommendation  
19 Statements related to community health data systems?

20 COMMISSIONER FRIEDRICHS: That works for me, as long as  
21 we're capturing these things and moving forward. The  
22 connection that I'm making again -- and this may be second or  
23 third order South Louisiana public school confusion -- is we  
24 talk about evidence-based medicine being between a nurse  
25 practitioner and a patient or a PA and a patient or whatever.

1 We're not to go into the exam room and see what Noah did with  
2 my wife or what Noah did with my son every time that he sees  
3 them. We're going to look at, in aggregate, what's happening  
4 in the population, and as a state, we're going to say, wow,  
5 something interesting is happening in MatSu and drive back  
6 down and say, wow, look; they all employed the same evidence-  
7 based algorithm for managing obesity and they turned the curve  
8 on obesity there.

9 What I'm driving at with this finding and this  
10 recommendation right now is having the mechanism to see the  
11 impact of evidence-based medicine. So that's the linkage  
12 that, in the ideal, you'd like to have a system which allows  
13 Noah to see what's happening just with his population and  
14 you'd like to have the system that was described to us today  
15 to see, in aggregate, how populations are doing, so you can  
16 drill back down and see the outcomes of those evidence-based  
17 measures and which ones are working and which ones are not.  
18 That's the connection that I think actually can be made  
19 somewhat plausibly and get this on the record for 2010.

20 CHAIR HURLBURT: Well you know, there would be some  
21 things that you might want to know, for example, to pick  
22 MatSu. We'll keep picking on MatSu, as we have been. To  
23 reflect the quality of medical care, you might want to know  
24 what percentage of their diabetic populations have an  
25 eyeground examination every year. But maybe what they're

1 looking at, the population-based things that the foundation is  
2 more concerned with potentially -- and Elizabeth's not here to  
3 speak to it now -- is not so much the quality of the clinical  
4 care, which would be what the frequency of your diabetic  
5 eyeground examinations are or how often your hemoglobin A1C is  
6 6.5 or less or whatever you're looking at. Not so much that  
7 is, what is the overweight and obesity rate among adolescent  
8 kids or adults? What's the smoking rate? What are some of  
9 these other kinds of things? And I think those kinds of data  
10 are, according to our Constitution in this state, a public  
11 health responsibility, therefore a state responsibility and  
12 that kind of information we should be getting out to them. I  
13 don't know that the State has the ability at this point to  
14 look at what's the rate of eyeground examinations in the  
15 diabetics in Noah's practice or on a geographic basis.

16 Now if you have an Electronic Medical Records system,  
17 like, you know if the Providence system gets a lot of their  
18 docs enrolled in EPIC (ph) and they're using it and they get  
19 an aggregate number of people in there, they can really look  
20 and say, oh, this is horrible. We've got to make an emphasis  
21 of this, or no, let's put this in the *Daily News* because we're  
22 doing so good on this and get people to come.

23 So are those really two things as I'm trying to make them  
24 or not in your mind?

25 COMMISSIONER FRIEDRICHS: The simplistic answer is, I'm

1 not sure I completely follow what you're saying, so I  
2 apologize for that. What I'm trying to drive us towards is,  
3 if we say that evidence-based medicine is our focus for 2010,  
4 assessing the efficacy and effectiveness of evidence-based  
5 medicine requires data. And you can pick any disease, and  
6 it's going to have a different data set. You can pick and  
7 community, and it will have a different set of data in which  
8 you're interested. But if evidence-based medicine is our  
9 focus for 2010 and we have heard multiple people say that the  
10 data is not available to assess many things related to health,  
11 we have an opportunity to respond to the public testimony  
12 we've heard by validating the need for the data as a finding  
13 and indicating it is not readily available right now and as a  
14 recommendation that the data become available, to the extent  
15 that that can be done.

16 COMMISSIONER ERICKSON: Can I make a suggestion? Well  
17 Jeff, did you.....

18 CHAIR HURLBURT: Go ahead, Jeff.

19 COMMISSIONER DAVIS: So I can't blame it -- well I can  
20 blame it on airplanes, too. A million miles on Alaska  
21 Airlines, and I don't drink scotch, but anyway. So I think  
22 I'm starting to hear what you're saying in a little different  
23 perspective which is, okay, we're going to do this micro  
24 thing, evidence-based medicine, but we really want to -- and  
25 there is certain science around that, but as a part of that,

1 you want to measure at a macro level what the overall impact  
2 on the population is because we've employed these evidence-  
3 based medicine techniques and that's the link you're making  
4 that says it belongs in this section. Am I getting it?

5 COMMISSIONER FRIEDRICHS: Yes. This is an enterprise  
6 level or a strategic look at the tactical employment of  
7 evidence-based medicine.

8 COMMISSIONER DAVIS: Then I would agree with you that it  
9 makes sense to include it.

10 CHAIR HURLBURT: I'm still struggling to understand it.  
11 So what kinds of data would you expect the State to supply to  
12 the MatSu Foundation for them to use?

13 COMMISSIONER FRIEDRICHS: Given that the easiest things  
14 to achieve are the incremental improvements, the short answer  
15 is the IBIS-like data sets that are already available, that  
16 the State already owns, but which, as we've heard from many  
17 speakers, are difficult to access and that may be a very  
18 achievable recommendation for us to make. Again if the  
19 stipulation is we can't specify the how part, I'm struggling a  
20 little bit then with how to phrase the recommendation, but  
21 there is data which the State owns today which would help  
22 communities, help health care organizations and communities  
23 decide which evidence-based practice on which to focus their  
24 efforts. If I'm in Selawik and I know that I happen to have a  
25 whole lot of people with obesity, then I may choose to apply

1 algorithms focusing on obesity rather than on something that's  
2 not as prevalent in my community. The State can help  
3 communities make that decision by sharing the data that the  
4 State already possesses.

5 CHAIR HURLBURT: So if you're providing public health  
6 type data, I see that. And I guess I think of evidence-based  
7 more in relation to clinical care, both in the policy and  
8 payer setting and in the individual physician-patient  
9 encounter setting. But if you're providing that data -- and a  
10 part of that public health data would be, like, the self-  
11 reported obesity or overweight rate. So if you take Noah's  
12 patients and you report that success, meaning i.e. a lower  
13 rate of obesity or overweight, the patients will certainly  
14 reflect how diligent Noah is in counseling his patients and  
15 parents about eating and lifestyle habits, but it also  
16 reflects how well the Anchorage School District does in  
17 getting sugar, sweet, and beverages out of the schools and how  
18 well they do as far as having physical activity during the  
19 school days and PE classes or during recess periods and how  
20 well the City does in building trails to do the kinds of  
21 things Noah described when he was young and available. So it  
22 reflects a lot of things, some of which may have more impact  
23 than the individual clinician have on those things. But  
24 they're basic public health kinds of data that you're saying  
25 the State should make available, and I'm totally onboard with

1 that, just a little slow getting there.

2 COMMISSIONER LAUFER: I think what they were asking was  
3 not for the State to collect data but to provide the data they  
4 had and then provide a repository for everybody else's data  
5 and that make a lot of sense, to me. If the goal is better  
6 health, then it's awesome. Evidence-based medicine is  
7 awesome. The medical, you know, Patient-Centered Home is  
8 awesome, et cetera. If the goal is to shift the risk to  
9 primary care doctors and make more money or spend less money,  
10 which is the same as making more money, then I don't trust it.  
11 And there are some fundamental things. It may well be that  
12 having a society where people live to be 80 or 90 years old is  
13 really expensive.

14 CHAIR HURLBURT: Yes, Keith?

15 COMMISSIONER CAMPBELL: Do we now go back and open up the  
16 motion we did this morning to add this under the category or  
17 what's the process here?

18 CHAIR HURLBURT: Well if we're wanting to change the  
19 report, to modify the report, to add to it, I wonder if the  
20 appropriate thing is to make a new box. This is not related  
21 to the 4.a, b, c that we looked at it, but it's a different  
22 category of the State providing -- making data available in  
23 usable format, in usable chunks. Is that.....

24 COMMISSIONER FRIEDRICH: Yeah, and I want to be clear.  
25 This is not something the federal government or I personally

1 have a huge vested interest in. We have had speakers that  
2 have spoken to it. We're trying to capture the 2010 reports.  
3 I think from the standpoint of the Commission, it also helps  
4 to address some of the feedback that we heard that people's  
5 input may not have been captured. This was something that, I  
6 think, we all agreed on when we heard it, and it does directly  
7 relate to assessing the impact of evidence-based medicine,  
8 which we did choose to include.

9 CHAIR HURLBURT: Yeah, is that doable?

10 COMMISSIONER ERICKSON: Anything is doable. One of my  
11 concerns, again to the point of some of the comments that,  
12 even with putting out draft Finding and Recommendation  
13 Statements, that some folks didn't feel as though there was  
14 enough stakeholder engagement and enough time for public  
15 comment. If we create a new category and a new set of  
16 Findings and Recommendations for our 2010 report right now and  
17 approve it and put it in our 2010 report, we will have allowed  
18 -- we had -- recognizing that this Finding and Recommendation  
19 is -- and this is something that I've advocated for for 20  
20 years and have wanted and have dreamed about having someday  
21 for the 23 years that I worked in the State Division of Public  
22 Health and that it's mom and apple pie. I can't imagine  
23 anybody having a concern about it on one hand.

24 On the other hand, it is outside of our process and what  
25 I imagined we would be doing is just making sure that we're

1 capturing ideas for our 2011 report. But one of the process  
2 things that we've mentioned a couple times today is that we --  
3 and that we started with the primary care -- could capture  
4 some preliminary draft findings for 2011 and maybe start  
5 working towards -- since we're going to have a more stable and  
6 full year and staff this time, that we could maybe put  
7 together some white papers on these issues that we're  
8 considering throughout the year with our preliminary draft  
9 Findings and Recommendations and not wait until we're  
10 developing the report at the end of the year this time.  
11 Emily?

12 COMMISSIONER ENNIS: I perhaps am not familiar with the  
13 process, but we did receive public comment and felt that some  
14 of that is valid and we have made some minor changes. We've  
15 added at least one statement to the Findings already that  
16 we've approved to be included in the 2010 report. What would  
17 be the process if we had plenty of time? Would we revise this  
18 report and put it out one more time? You know, we have public  
19 comment. We're considering that as we're finalizing the  
20 report and so that may mean we'll make some changes or add  
21 some items, I'm assuming, as we're doing today. It's not  
22 perhaps substantial, but we are making some edits. Would this  
23 not fall under that umbrella or do you think what we're  
24 recommending here is too significant a departure or addition  
25 to what's been discussed?

1           COMMISSIONER ERICKSON: Well this -- we -- first of all  
2 just to remind folks, under the statute, we have an annual  
3 report. Even though we didn't convene until October of our  
4 year, we have an annual report due to the Governor and the  
5 Legislature on January 15th, a week from tomorrow. We invited  
6 public comment on the draft Findings and Recommendations. We  
7 considered the public comments that we received during our  
8 public comment period, as we finalized this morning and voted  
9 to approve the Findings and Recommendations. Then we heard a  
10 presentation on a strategy that we're considering for 2011  
11 after that, and now we're considering going back and changing  
12 our 2010 Findings and Recommendations, based on the  
13 presentation that we had on the 2011 strategy.

14           COMMISSIONER FRIEDRICHS: Point of order. Just as a  
15 clarification, I made this recommendation prior to us closing,  
16 and I was asked to hold it. So I disagree with the timeline  
17 there a little bit.

18           COMMISSIONER ERICKSON: Was the recommendation prior to  
19 the community health system presentation?

20           COMMISSIONER FRIEDRICHS: Yep.

21           COMMISSIONER ERICKSON: Well that's maybe what's  
22 confusing things because maybe your recommendation, at that  
23 point, wasn't specific to the community health system.

24           COMMISSIONER FRIEDRICHS: Deb, I'm baffled here. I've  
25 been trying all day to accomplish the same thing, and we keep

1 shifting around on how we're going to do that. There's a  
2 motion on the table right now. I respectfully request that we  
3 vote on it. The options are that we vote on including in this  
4 report or we don't. If we don't, then we can include it in  
5 next year's report, but I think that's where we are from a  
6 parliamentary procedure standpoint right now.

7 CHAIR HURLBURT: Yes, Larry?

8 COMMISSIONER STINSON: Back in 2009, we talked about data  
9 collection frequently. We just didn't know what the best  
10 mechanism was to go about this. This is something that has  
11 been discussed time-and-time again, and this was, in essence,  
12 the holy grail because you cannot make good decisions with  
13 money, with value, whatever without information, without data.  
14 That's what you have to base it on. If you're going to put  
15 resources to something, you want to know where the resources  
16 will do the most good and the most efficiently. And I'm not  
17 quite sure about the process either, but I don't see why we  
18 should hesitate in collecting data. I don't find anything  
19 inherently troubling in that.

20 CHAIR HURLBURT: I think that I would agree, that the  
21 data is a desirable thing, as Deb said in her 25 years -- and  
22 I just gave her a 25 year pin yesterday -- that this has been  
23 something that she's working toward, and I think the Division  
24 and the Department will work toward that. As far as budgetary  
25 implications, the realities are that the opportunity for the

1 Department to submit for additional budget will be next summer  
2 to come for the following fiscal year, which will start a year  
3 from July. So we're talking 18 months out. And it takes some  
4 time.

5 In the meantime, as Elizabeth said, the Division does *ad*  
6 *hoc* things, to the extent that we can, to get information  
7 there. So I think you're right. Nobody is disagreeing with  
8 the intent of what Paul is suggesting, but maybe what I'm  
9 hearing now with Paul's last comment was that the request that  
10 a member of the Commission has made a motion. It's been  
11 seconded by Wayne, and basically, it's a motion then, do we  
12 open this process back up for the draft report that was sent  
13 out for a period of public comment and consideration for  
14 opportunity for input, do we open that back up to modify it or  
15 do we not open that up? And if we open it up to modify it,  
16 it's with the specific issue of data that Paul is suggesting,  
17 that, I think, nobody is saying the idea is bad on that, but  
18 should we open it up or not. Is that a reasonable comment?

19 So any more discussion on that? Yes, David? Sorry.

20 COMMISSIONER MORGAN: Well I thought I -- in my normal --  
21 I'm back in the normal mode, you know. So I'll try to confuse  
22 it as much as I can now.

23 Why couldn't we -- there is nothing that says the  
24 Commission can't have other communications, other than the  
25 final report, is my understanding. So why couldn't we go with

1 the current report without making -- opening up and changing  
2 it, but sending another communication, like a little -- with a  
3 white paper and a cover letter voted on by the Commission to  
4 the effect of dealing with this information? I mean, send  
5 this report, and that way, we'll meet our deadline and not put  
6 anymore strain on poor Deb and then have a separate  
7 communication that follows up with the full weight and measure  
8 of the Commission. Does that just confuse things?

9 CHAIR HURLBURT: Or does that impact on the credibility  
10 of what we're doing to have things dribble in over a period of  
11 time? And I don't know. I'm raising this question.

12 COMMISSIONER MORGAN: I constantly have people  
13 questioning my credibility, so I'm used to it.

14 CHAIR HURLBURT: Do you have any comment on what I said,  
15 Deb?

16 COMMISSIONER ERICKSON: I'm sorry. I don't remember what  
17 you said.

18 CHAIR HURLBURT: That, if we followed David's suggestion  
19 and submit our report as it's been done, but why not send  
20 something else, can we really have suggestions dribbling in,  
21 to use my words -- that's kind of a pejorative word -- to the  
22 Governor and to the Legislature?

23 COMMISSIONER ERICKSON: I think dribbling would be fine.  
24 I think there's no reason why we can't develop white papers  
25 with recommendations and findings during the year. We didn't

1 do that because we didn't have a year this past year. The  
2 year before, you didn't have staff. I don't think there is  
3 any reason why we could not develop white papers with Findings  
4 and Recommendations that have been officially approved  
5 throughout the year and then those would be compiled in the  
6 final annual report at the end of the year.

7 COMMISSIONER MORGAN: What I'm talking about is a couple  
8 of weeks, and the word dribble is not good.

9 COMMISSIONER FRIEDRICH: (Indiscernible - simultaneous  
10 speaking) urologist.....

11 COMMISSIONER MORGAN: Yeah, so I can understand. But I  
12 think we shouldn't make a habit of it, and it should -- this  
13 is an extraordinary -- and we should say that in the letter.  
14 You know, we only three months. We pulled it together as  
15 quick as we could. This came up. We're communicating this a  
16 few weeks later, but it's so important we need to do it. And  
17 that way, we meet that deadline without everybody staying up  
18 all night, a couple of nights getting the reports ready, and  
19 make the communications and just -- I mean, I'm not suggesting  
20 we make a habit of it, but we're in -- this is an  
21 extraordinary time, and I think this is a middle ground, a  
22 third way to get to maneuver through this situation. I just  
23 throw it out as one way to maybe make everybody mad, you know.  
24 I've got to do that once a year anyway.

25 CHAIR HURLBURT: Keith and then maybe we could go to a

1 vote?

2 COMMISSIONER CAMPBELL: Let's clean this up by taking a  
3 vote. I call for the question and then we'll act on whatever  
4 happens on this vote.

5 CHAIR HURLBURT: Everybody clear what we're voting on?  
6 The vote is a motion to add this wording to the report that's  
7 been developed.

8 COMMISSIONER ERICKSON: As a new Finding, I'll read it.  
9 So this would be a new evidence-based medicine Finding;  
10 assessing the outcomes of health care interventions is  
11 challenging due to limitations on collecting and sharing data  
12 among patients, clinicians, payers, and government agencies.

13 CHAIR HURLBURT: So I suspect it may not be a unanimous  
14 vote on this one. So maybe when you raise your hands, we'll  
15 have to leave it up long enough just to collect the names, if  
16 we need to do that. So the motion is to add the wording that  
17 Deb just read, to add that as a new Finding in a new box in  
18 the 2010 Recommendation documentation going to the Governor  
19 and the Legislature. All those in favor, raise your hand.  
20 All those opposed. So.....

21 COMMISSIONER ERICKSON: Are you the only one?

22 CHAIR HURLBURT: Yeah. Yeah, that was easy.

23 (Pause - no mics on)

24 CHAIR HURLBURT: Now as a corollary to that then, do we  
25 need to have a recommended action? Keith?

1           COMMISSIONER CAMPBELL: Yes. I move that we -- how do I  
2 want to word this -- amend our previous motion adopting the  
3 2010 plan to include this new Finding.

4           COMMISSIONER FRIEDRICHS: I think we just did.

5           COMMISSIONER CAMPBELL: Well but this wraps it all in one  
6 big box, in my mind.

7           CHAIR HURLBURT: So that's a second, Wayne, or do you  
8 have a comment?

9           COMMISSIONER STEVENS: (Indiscernible - away from mic)  
10 Did we, this morning, take action to adopt the report as  
11 amended? I thought we were just still working on Findings,  
12 and we, you know, kind of did all the motions to adopt the  
13 Findings and the Recommendations, but I don't know that we  
14 actually took a motion to adopt the final report as amended.  
15 So I believe -- did we or didn't we?

16           COMMISSIONER FRIEDRICHS: No, you're correct. We didn't.

17           COMMISSIONER STEVENS: So we did not adopt the report as  
18 amended. So we still have the report on the table in front of  
19 us, still subject to amendment, which we have just done. So  
20 the next step would be to, presumably, put the Recommendation  
21 to go with the Finding, which is one last amendment. And then  
22 we would adopt the report in its entirety, as amended.  
23 Yes/no?

24           CHAIR HURLBURT: Emily?

25           COMMISSIONER ENNIS: I agree, although I would hope to

1 have a short amount of time for discussion for some possible  
2 additional amendment or amendments under the Recommendation  
3 for Study, and I just wanted to ask for that opportunity.

4 COMMISSIONER CAMPBELL: My motion, therefore, is moot.

5 COMMISSIONER ERICKSON: Can we make a -- I just want to  
6 check in on time and process. We probably should acknowledge  
7 -- at this point, take a break from this discussion for a  
8 minute to acknowledge that we're not going to have a  
9 discussion on the Affordable Care Act, a presentation by our  
10 Executives who are here to share. There are heads nodding  
11 around the table, and with apologies to the folks who might  
12 have been here who were particularly interested in that.

13 For the Commission members, I just want to point out,  
14 since we're cancelling that discussion, that, in the very back  
15 of your packets on the left hand side of your folder, there is  
16 a current copy of the three probably most significant relevant  
17 documents right now, except for anything maybe related to  
18 insurance, Linda. But there are three documents that were  
19 updated as recently as yesterday that list all of the funding  
20 opportunities that have become available to date under the  
21 Affordable Care Act. It's broken up by state government  
22 agency-specific funding opportunities and then following that  
23 available to other organizations, non-profits, community  
24 groups, universities, and the status of application or not and  
25 grant or contract awards or not of each of those.

1           There is also, at the very end of that list, a list of  
2 funding opportunities that we anticipate will become available  
3 in 2011, and those are posted on the State Department of  
4 Health and Social Services' website on the Affordable Care  
5 Act, for the folks in the audience and members of the public  
6 listening in who might be interested in seeing that.

7           There also is a Table of Affordable Care Act Provisions  
8 that the various state agencies are tracking and analyzing  
9 with some information whether they've been identified as being  
10 mandatory or optional for state implementation and effective  
11 dates. So that is also in your packet.

12           And then there is a table that provides an analysis to  
13 date of -- by the State Department of Health and Social  
14 Services of the Medicaid provisions specifically.

15           So those are the three documents that you all have in  
16 your packets, and again, they're posted on the website and  
17 they've been updated recently. So I just wanted to point that  
18 out, since we're tabling that discussion for a later meeting.

19           And so I am going to go then to our January Meeting  
20 Discussion Guide, and it's possible that, on the screen, the  
21 slide numbers have changed from the handout that you have, but  
22 on the screen -- and now I've lost my handout. Thank you.  
23 This is an old one.

24           COMMISSIONER DAVIS: Mr. Chairman?

25           CHAIR HURLBURT: Yes?

1           COMMISSIONER DAVIS: Before we move, I believe a number  
2 of the Commission members were expecting that there would be  
3 another amendment offered, there would be a Recommendation  
4 that would be tied to the Finding that we just accepted.

5           COMMISSIONER ERICKSON: So we'll consider that, and then  
6 to Emily's request, we will go back to the analyses and  
7 strategies that we're going to study next year. And so we'll  
8 start with, after that, slide 11.

9           COMMISSIONER STEVENS: Mr. Chair? I would -- following  
10 along with Commissioner Davis' recommendation, I recommend the  
11 State of Alaska, Department of Health and Social Services  
12 implement a web-based data dissemination system.

13           COMMISSIONER FRIEDRICHS: Second.

14           COMMISSIONER ERICKSON: If you could set it down, I will  
15 type it.

16           CHAIR HURLBURT: For public health type data? What you  
17 suggested is a little open-ended.

18           COMMISSIONER STEVENS: I took it right off of your slide  
19 for public health. I mean basically, it's the information  
20 that's there in a web-based system. If we want to add to  
21 that, I just took it right straight off of the slide that was  
22 there. It doesn't speak to systems. It doesn't speak to  
23 dollars. It's just a general recommendation, so I think it  
24 meets the intent of what (indiscernible - simultaneous  
25 speaking).

1 COMMISSIONER ERICKSON: And your recommendation was  
2 targeted at the Department of Health and Social Services, is  
3 that right, the way you worded it? I'm sorry.

4 COMMISSIONER STEVENS: I recommend the State of Alaska,  
5 Department of Health and Social Services implement a web-based  
6 data dissemination system for public health information, or  
7 whatever, the stuff.

8 CHAIR HURLBURT: So there's a motion. Is there a second?

9 COMMISSIONER FRIEDRICHS: Second.

10 CHAIR HURLBURT: Is there a discussion? We'll take a  
11 vote. All those in favor, raise your right hand. Opposed,  
12 the same. It's unanimous.

13 COMMISSIONER ERICKSON: I'm sorry. Paul seconded; is  
14 that correct?

15 CHAIR HURLBURT: Yes.

16 COMMISSIONER ERICKSON: And it was unanimous, correct?

17 CHAIR HURLBURT: Yeah.

18 COMMISSIONER ERICKSON: Got it. So I think we are on  
19 slide 11 in your handout.

20 COMMISSIONER FRIEDRICHS: And then just from a process  
21 standpoint, so we'll come back to Emily's point and approve  
22 the final report at a later point this afternoon?

23 COMMISSIONER ERICKSON: We are back to slide 11 of our  
24 Discussion Guide considering plans for studies in 2011, and  
25 we'll move through slides 11, 12 -- I'm sorry. Actually we

1 should be on slide 10. What did I do?

2 CHAIR HURLBURT: But we'll move through that to get  
3 through the report, and then before adopting, we'll have the  
4 chance for a discussion or suggestions for amending it.

5 COMMISSIONER ERICKSON: So if you're looking at -- on  
6 yours, it's slide 10 and slide 11. On the screen, it's 11 and  
7 12. Slide 11 for you lists the three studies that we had  
8 already approved and that are included in the report for 2011.

9 Going back a slide to your slide 10, these were the very  
10 specific recommendations that we received in written public  
11 comments that we should study the cost of operating a  
12 practice, that we should study the percent of Alaskans who  
13 don't have access to primary care, we should study the percent  
14 of Alaskans who are underinsured, and we should study the  
15 percent of Alaskans who are insured but do not utilize  
16 services.

17 So those are just public comments. So we'll open up for  
18 discussion now your consideration of these public comments.  
19 Just because they're offered doesn't mean you have to  
20 incorporate them, and just because those are the only things  
21 that are suggested doesn't mean you can't offer additional or  
22 different ideas for what we have listed here.

23 So I'm on your handout, slide 11. These are the three  
24 that we were moving forward on to date for 2011: the Cost  
25 Analysis, which is actually the analysis of health care

1 spending and cost drivers; the Health Care Pricing &  
2 Reimbursement Study; and the population Health Status  
3 Assessment.

4 I guess the first question is, do we want to make any  
5 changes? Actually we can't, I mean, make a change, at this  
6 point, to the Cost Analysis. We had already discussed and  
7 approved that, and we have a contractual agreement in place  
8 with ISER right now. The contracting process is moving  
9 forward. It's not too late to amend our plans for the Health  
10 Care Pricing & Reimbursement Study that includes both the  
11 actuarial -- the comparison of billing and allowed charges.  
12 There are more details in the draft report, as well as a more  
13 specific analysis of reimbursement versus cost of providing  
14 Medicare services.

15 So if you want to make any changes to these two specific  
16 studies, if not, we can move on to suggestions for additional  
17 studies you would like to consider, including for 2011.

18 CHAIR HURLBURT: Any changes to these as written? Moving  
19 on to additional studies then. Any comment on that? Emily?

20 COMMISSIONER ENNIS: Yes. Thank you. I'd like to  
21 address the comments we received, both during the public  
22 comment period and what we heard today relative to the  
23 apparent omission or perhaps less emphasis on long-term care  
24 issues, the need for a long-term care systems plan, and  
25 behavioral health needs as they impact not just access but

1 cost and access. And I would suggest that we -- rather than  
2 simply listing behavioral health and long-term care on the  
3 very last page, 39, as one of the recommendations for future  
4 study, to address the availability of these specific services,  
5 that we actually break those out and list it as an item D, you  
6 know. On page 35, we begin Strategies Under Consideration for  
7 Study.

8 COMMISSIONER ERICKSON: Actually these aren't for studies  
9 of the current system. These are strategies to consider.

10 COMMISSIONER ENNIS: I'm sorry. Strategies, but one --  
11 okay.

12 COMMISSIONER ERICKSON: So we're going to talk about  
13 strategies that we want to consider next.

14 COMMISSIONER ENNIS: All right. I'm in the wrong place  
15 then. We'll wait. I'm sorry.

16 CHAIR HURLBURT: Well these specifically would be for  
17 studies then, additional studies to do.

18 COMMISSIONER ENNIS: Well I think maybe I'll back up  
19 then. I'll tell you what I'm considering or recommending and  
20 then you can tell me where it needs to go. I apologize if I'm  
21 on the wrong place.

22 I feel that we need to have additional study that will  
23 provide the Commission opportunity to understand additional  
24 information and have additional education about long-term care  
25 issues and the need for a long-term care plan. We need, I

1 believe, further emphasis on that. So wherever we put it, my  
2 recommendation is for additional study of the long-term care  
3 system.

4 CHAIR HURLBURT: Could I maybe ask for clarification for  
5 me? Go ahead, Deb.

6 COMMISSIONER ERICKSON: Can I make a suggestion?  
7 Studying the long-term care system is way, I think, too open-  
8 ended, but I think what I heard you say -- you said something,  
9 Emily, that I think -- and it was actually something that we  
10 heard from one of our folks in the room who made the public  
11 comment earlier, that it's not necessarily the role of this  
12 Commission or this Commission might not have the time and  
13 resources and the expertise to get into the details of  
14 studying and making specific recommendations about long-term  
15 care, but you just, Emily, suggested that we consider the need  
16 for a long-term care plan. And maybe what we could do as part  
17 of our strategies specific to -- this will help me. If it's  
18 not helping you, I'm going to our pictures again. If we're  
19 looking at access and addressing specific services and  
20 delivery methods, if we look at our long-term care box there,  
21 what we might do is add it where you were suggesting on page  
22 39 that it gets moved up, that we more specifically -- that we  
23 specify as a strategy related to access development of a state  
24 long-term care plan and that doesn't mean that the Commission  
25 will develop the state long-term care plan, but that, as a

1 strategy, the Commission will consider recommending that the  
2 State develop a long-term plan. When we get to the point of  
3 studying that as a strategy, we'll potentially get more  
4 specific and have background information about that. Does  
5 that get at what you want to include?

6 COMMISSIONER ENNIS: Let me read what I drafted as a  
7 statement because, I think, I'm suggesting something even a  
8 little before that.

9 During 2011, the Commission will engage in additional  
10 learning to identify specific strategies for advancing a long-  
11 term care system in Alaska. That may mean recommending --  
12 giving this to someone else to do, as perhaps suggested today,  
13 but the Commission to understand the issues surrounding long-  
14 term care and the need for a plan is what I'm recommending.

15 CHAIR HURLBURT: So might it be helpful, taking the model  
16 that we used today and we've used in other meetings, to plan,  
17 like, for our next meeting to have an hour to an hour-and-a-  
18 half to have a panel with three or four people, with Sandra or  
19 with others there, to educate the Commission about long-term  
20 care issues as the next step that we would take to get at what  
21 you're suggesting? Should this be a part of our purview or  
22 should we say that this is so big, this is so different that  
23 we should be clear that it's not, or should we embark on some  
24 formal study? Would that be an appropriate next step for our  
25 next meeting to do that?

1           COMMISSIONER ENNIS: Absolutely. I think that would be  
2 an excellent idea, as a place to start.

3           CHAIR HURLBURT: Yes, Larry?

4           COMMISSIONER STINSON: You know, I would fully support  
5 that because I'm sure Noah's got the same thing. I've got so  
6 many patients that, when they get older, they basically rid  
7 themselves of all assets, fall onto Medicaid, and then go into  
8 long-term care and that's very expensive for the State.  
9 There's got to be other options than that. I bet Commissioner  
10 Streur would be interested in hearing other options, too.

11          CHAIR HURLBURT: Yes, Noah?

12          COMMISSIONER ERICKSON: I think it fits better in our  
13 process to include it as a strategy, an access strategy, and  
14 it'll just be general. We won't have a specific strategy  
15 related to long-term care.

16          CHAIR HURLBURT: Noah?

17          COMMISSIONER LAUFER: The system has evolved to rid to  
18 you of all your assets. That's the point. That's how you  
19 build glittering buildings.

20          CHAIR HURLBURT: Yes, Emily?

21          COMMISSIONER ENNIS: I just wanted to clarify with Deb,  
22 access is only one piece of the problem for long-term care.  
23 If we feel that we can get -- that's not going to narrow our  
24 focus too much, then I would say, for the purpose of  
25 discussion and this report, that would be adequate, but part

1 of this education process is to understand how long-term care  
2 impacts much more than just access for people. It involves  
3 cost, and it involves studying the value and certainly the  
4 variety of options as it relates to all three and value, cost  
5 quality, access, and prevention. So you know, it's just  
6 bigger than access is my concern. So if, in fact, we put it  
7 there, I don't want to lose the other components that we need  
8 to look at.

9 COMMISSIONER ERICKSON: You just changed my mind. How's  
10 that? Am I allowed to change my mind?

11 CHAIR HURLBURT: Paul?

12 COMMISSIONER ERICKSON: That's a good thing.

13 COMMISSIONER FRIEDRICHS: Yeah. So if I understand  
14 correctly what you're saying and I agree with you because we  
15 certainly struggle with that on the federal side, I believe  
16 what I'm hearing is you're asking for a study of what would  
17 improve both the efficiency and effectiveness and access to  
18 long-term care in Alaska because, if we go after a study, that  
19 gives us data on which we can then have this discussion.

20 COMMISSIONER ERICKSON: Yeah, I think -- can I -- I mean,  
21 I want to make sure I understood what Emily was saying again,  
22 too. I think what Emily was suggesting was not that we  
23 commission a study. I mean, there have been lots of studies  
24 done. What I heard Emily just say is that the Commission  
25 needs to learn more about what's going with long-term care and

1 then Dr. Hurlburt suggested we bring some presenters who have  
2 been involved in conducting those studies to the table.

3 COMMISSIONER FRIEDRICHS: (Indiscernible - away from mic)  
4 What I think I'm hearing is we want to understand the problem,  
5 we want to understand what solutions are out there before  
6 making recommendations?

7 COMMISSIONER ENNIS: Correct. We want to be educated.  
8 We want to have a fuller grasp of the issues. Perhaps one of  
9 the recommendations that will come from the panel or other  
10 education will be a study. We've had -- I believe the Alaska  
11 Commission (indiscernible - voice lowered) gave me the number,  
12 18 studies that have been conducted over the last 15 or so  
13 years about long-term care, but the most recent was 2008. So  
14 we have some fairly current information, but perhaps after we  
15 hear further information and up-to-date information, there may  
16 be a need for another study, but I would think that my feeling  
17 is it's premature right now to recommend that.

18 COMMISSIONER ERICKSON: So what I've captured on the  
19 slide here, I've added a fourth bullet on our 2011 analyses  
20 for long-term care. The Commission will learn more about the  
21 issues around long-term care through presentations on studies  
22 conducted to date, and so that will be our starting point for  
23 this.

24 COMMISSIONER ENNIS: I think that's a piece of the  
25 education. We need to have the studies conducted to date.

1 There may be some other information the panel could provide to  
2 us.

3 COMMISSIONER ERICKSON: Through studies conducted to date  
4 and other information available. The distinction I want to  
5 make too is whether the Commission is going to invest money in  
6 hiring a consultant and that's why I'm trying to be real  
7 specific here. So I understand what you're asking me to do.  
8 You're asking me to bring folks to the table who are the  
9 experts in Alaska and to share with us findings to date,  
10 information gained to date.

11 CHAIR HURLBURT: I'm not hearing a suggestion for a  
12 consultant at this point. It's educating us on the issues.  
13 And just from a practical procedural thing perhaps, Emily, you  
14 and Deb and I could have a conference call sometime to talk  
15 about who should we have here, who would be the best folks to  
16 come in, and you might be thinking about that and we can do  
17 that sometime in the near future and set that up.

18 COMMISSIONER ENNIS: That sounds good. Thank you.

19 CHAIR HURLBURT: Linda?

20 COMMISSIONER HALL: I would urge you not to limit it to  
21 studies because that's old, and there are a couple things that  
22 -- one, there is a public-private partnership that Alaska has  
23 never explored with funding and et cetera. There also is a  
24 long-term care provision as part of PPACA. So I don't think  
25 we want to limit ourselves to studies, I guess is what I'm

1 saying. Education. But I think we need to make sure we're  
2 including current options because the PPACA long-term care  
3 option changes the Medicaid spend down stuff. So we need to  
4 look at the most current options, as opposed maybe to some of  
5 the former studies.

6 CHAIR HURLBURT: Yes, I agree. Yes, Emily?

7 COMMISSIONER ENNIS: If the discussion about long-term  
8 care is completed, I would like, for the record, just to also  
9 address the public comment about the lack of -- or emphasis on  
10 the behavioral health discussion that we've had in the last  
11 two meetings, specifically the impact on primary care. And  
12 I'm not so sure we need to have an additional amendment, such  
13 as we've just described here for behavioral health review and  
14 education because I do believe some of that will come out as  
15 we look at primary care innovation, but I did want to bring it  
16 up and to ask if the Commission felt that we needed to also  
17 restate that as a separate -- for separate emphasis. So it's  
18 a question of whether or not we should or whether we'll feel  
19 comfortable that we will get to it under primary care.

20 CHAIR HURLBURT: One of the things that they -- and I  
21 don't know if an impact bears on it or not -- there are lots  
22 of definitions for what primary care is, and in some states,  
23 that includes OB/GYNs. The definition of primary care that  
24 the Commission came up with, it's previous iteration, was  
25 family medicine, what's called primary care internal medicine,

1 primary care pediatrics, and psychiatry. And psychiatry  
2 meaning not.....

3 COMMISSIONER ERICKSON: Can I clarify? I just want to  
4 clarify that's our definition of primary care physician.

5 CHAIR HURLBURT: Physicians, yeah. That's what I was  
6 going to say, that not to say it's just so physician-centric,  
7 but that those kinds of services reflected by those kinds of  
8 physicians was arrived at by the vote and by this group, as  
9 that's what comprised primary care. So I'm not sure if that -  
10 - that still may not give adequate emphasis to it from what  
11 you're suggesting, but it was recognized that that's a part of  
12 the dominant need here in Alaska.

13 COMMISSIONER FRIEDRICHS: May I offer, for consideration  
14 -- and I'm not even going to hazard the correct parliamentary  
15 way to do with our current processes, so I'll defer to the  
16 Chair for guidance.

17 On page 35, Section A.2, Consumer's Role in Value,  
18 Primary Care Innovations, we have a very nice discussion about  
19 primary care in there. We don't specifically mention mental  
20 health, and I suspect that would be an easy editorial addition  
21 to make in that area to explicitly state that we're including  
22 mental health in our definition of primary care. And then in  
23 the last paragraph, during 2011, the Commission will engage in  
24 additional learning to identify more specific strategies for  
25 advancing Patient-Centered Primary Care Medical Home Model in

1 Alaska and improving access to behavioral health or mental  
2 health or something along those lines. I mean, we certainly  
3 did hear testimony about it. We certainly considered it. I  
4 don't think there was any deliberate decision to denigrate it  
5 or to minimize it. We just said.....

6 COMMISSIONER ERICKSON: I think it was more that it was  
7 assumed that it's part of it.....

8 COMMISSIONER FRIEDRICHS: Correct.

9 COMMISSIONER ERICKSON: .....and it's described more  
10 thoroughly in our 2009 report as being part of it and that's  
11 why it was assumed, but we should not assume that, and I think  
12 that's an excellent suggestion and I just made a note to add  
13 to that short, narrative discussion related to primary care  
14 innovation that we do include it.

15 The other thing that we were going to talk about after  
16 talking about strategies was process. And so the other thing  
17 that we won't do in our 2010 report, but I will not that we're  
18 going to do during 2011 and we'll add it to our meeting  
19 agendas, is developing and approving a definition of -- and I  
20 would suggest more -- I think the specific recommendation was  
21 to define health care, and I think that will help, if we're  
22 more clear. I mean, we discuss it in our 2009 report, but if  
23 we have a specific definition that we've approved as a group  
24 and folks can see that we're including behavioral health and  
25 behavioral health issues -- and what we might do, in addition

1 to defining health care, is also define health care system and  
2 health care continuum, so that we have a whole set of  
3 definitions that we all have agreed on and we can see how  
4 behavioral health, long-term care, and some of these other  
5 issues that folks are afraid we might be leaving out, and some  
6 of us might -- are just assuming that's a part and aren't  
7 stating it because of that. We can include that as a process  
8 piece for 2011. It's not necessarily either a study or a  
9 strategy, but it's just part of our process. Emily?

10 COMMISSIONER ENNIS: And to get to that -- and thank you,  
11 Paul. I think that's a good section to add a reference to  
12 behavioral health under A.2, Primary Care Innovation.

13 What may actually help and get to that definition, or at  
14 least partway here in this report, is, in the second paragraph  
15 perhaps after that first sentence, a comment such as, one of  
16 the critical elements of a Medical Home Model is behavioral  
17 health, a statement like that that really clarifies that we  
18 are including and we are reminding people that behavioral  
19 health is a part of this.

20 COMMISSIONER ERICKSON: That's a helpful specific  
21 suggestion. And so while we're on this point too, does  
22 everybody agree that we should just -- that we want to define  
23 some of these terms in 2011? And it will be time that we'll  
24 spend on one of our agendas or two. Noah?

25 COMMISSIONER LAUFER: This is something that I struggle

1 with a lot, but I would love to hear not from professionals  
2 what health care is but from -- what do you want to call them,  
3 consumers or patients, but what people think about health care  
4 because, I think, that's really where we're failing. You  
5 know, you can get no health care until you have some  
6 catastrophic event. Then a million dollars is spent in your  
7 name for the last two weeks of your unconsciousness and that's  
8 a huge failure of the system. So I don't know. You have an  
9 open public forum; what is health care and what do you want?

10 It's very interesting. There was a woman in Eugene,  
11 Oregon who was a trust funder and a primary care doc, and she  
12 floated this questionnaire to the community; what do you want  
13 from a community health center? And it's unbelievable. I  
14 want to hug my physician in the morning in an organic herbal  
15 garden. She has to know me by name. She has to be  
16 contributing to the health of the environment. You know, I  
17 mean, really amazing stuff. I can't do that, but that's what  
18 we should really be asking, what's health care in everybody's  
19 mind.

20 CHAIR HURLBURT: We did have the one gentleman here at  
21 the last meeting that addressed his concerns and perceptions;  
22 yeah.

23 COMMISSIONER FRIEDRICHS: I've taken a note for the  
24 federal services to begin work on an herbal garden for our  
25 system, too. Don't go there, please. We smoke all kinds of

1 things, unfortunately.

2 COMMISSIONER ERICKSON: Does anyone have anything else to  
3 add for our 2011 learning together? Maybe that's better than  
4 analyses.

5 COMMISSIONER FRIEDRICHS: If I may, along the same lines  
6 that Emily raised, there are an enormous amount of meetings  
7 happening right now on building a trauma system, and I  
8 suspect, by the time we finish our report for next year, we  
9 will have a way ahead for a trauma system in Alaska. I offer  
10 that to the Commission as an opportunity for learning. We can  
11 participate and learn some of what's going on right now or  
12 that can happen independently. There are a variety of groups  
13 that are meeting on that, but I would offer that to the group,  
14 since we identified that as one of our other areas for study  
15 and would happy to partner with you on bringing in some of the  
16 folks who are working on that.

17 COMMISSIONER ERICKSON: I see one head nodding.

18 CHAIR HURLBURT: Is that a generic enough issue that we  
19 want to bring it on? It's certainly something that I'm very  
20 engaged in and have a lot of concern about, based on my own  
21 professional background, you know, and I mean, discussions  
22 related to the pre-hospital phase, a hospital phase, and I'm  
23 feeling kind of optimistic, like you are right now, that we  
24 may be seeing some breakthroughs in that, but is that a  
25 generic enough issue to bring to the Commission?

1           COMMISSIONER FRIEDRICHS: Well again depending on how we  
2 -- what data we choose to drive our decisions, given that it's  
3 the leading cause of death among several large subsets of our  
4 population, one could argue that, by virtue of the fact that  
5 it's a leading killer, it's a primary driver. We certainly  
6 saw public comment from the Brain Trust about their  
7 disappointment that we didn't address it this year. So we  
8 have had public comment on it as well.

9           From the federal system, I will tell you that there is an  
10 opportunity to partner, if we choose to move forward and do  
11 so. I don't know how long that opportunity will exist. So  
12 taking advantageous of those.....

13          CHAIR HURLBURT: As long as you're here anyway.

14          COMMISSIONER FRIEDRICHS: Well again, you know, being  
15 totally candid, that may be true. Strike while the iron is  
16 hot sometimes is not a bad strategy.

17          COMMISSIONER NOAH: It seems like this will rest on  
18 whether or not insurance is mandatory. If everyone is  
19 insured, trauma would be a great business, and there'll be  
20 four trauma centers in Anchorage.

21          COMMISSIONER FRIEDRICHS: I think that leads into --  
22 again that validates why it'd be fruitful to learn more about  
23 what the options are and where the Health Care Commission may  
24 choose to recommend that the Governor and the Legislature go  
25 with this.

1           COMMISSIONER STEVENS: Just speaking in favor of that,  
2 Representative Coghill has a great interest in trauma and so I  
3 know the Legislature has been holding some discussions and  
4 kind of tiptoeing their way through how to build a statewide  
5 trauma system and so there is some interest, and I think it  
6 would certainly fit under the auspices of this August body's  
7 discussion agenda.

8           CHAIR HURLBURT: I'm concerned that we're going too far  
9 astray, but it is something that I have a lot of interest in.  
10 I just got permission from Dick Mandsager this week to say  
11 that, probably by the end of this year, Providence will be  
12 certified as a Level II trauma center, which would be  
13 wonderful. He told me that I could talk about it now.

14           COMMISSIONER FRIEDRICHS: And I will tell you that, you  
15 know, we are also -- and this is exactly the reason that I  
16 would offer that the Commission should think about this. We  
17 are also pursuing that certification. What is happening right  
18 now is a lot of individual efforts without a statewide  
19 strategy. There is an opportunity to craft some state level  
20 vision, if you will, and I'm bouncing back-and-forth also  
21 potentially as a member of the trauma commission. But there  
22 is an opportunity for us to capture this under our rubric of  
23 access, of which there is not great access to trauma care  
24 quality, which is not well-defined for the leading killer of  
25 Alaskans under the age of 40. I mean, all of those are

1 rationale that, I think, would bring it within the purview of  
2 our Commission, but timeliness is the biggest reason to talk  
3 about it right now.

4 COMMISSIONER ERICKSON: Anything else related to 2011?  
5 And now I think I'm going to change the analysis term to  
6 learning term and that will include analyses that we do, but  
7 leaves other learning opportunities for us. Anything else you  
8 want to learn about during 2011? Going once.

9 We're moving on to comments related to our 2011  
10 strategies, and let's see -- 2011 strategies. I want to just  
11 look at those real quickly with you. 2011 strategies are on  
12 your handout, slide 14, the strategies that we are planning to  
13 consider in 2011. This is more learning and potential  
14 recommendation development. Online community health data  
15 systems related to the Consumer's Role, Prevention and Healthy  
16 Lifestyles. Primary Care Innovation, Increase Price & Quality  
17 Transparency, Bundled Payment Systems, Leverage State  
18 Purchasing Power. Insurance Regulation/Deregulation and  
19 finalizing our indicator set for measuring Health System  
20 Improvement over time, and continuing work on Workforce  
21 Development.

22 So that's what we identified in our report as our  
23 preliminary set of strategies to consider. Going back to the  
24 comments related to these, we have a suggestion and I've just  
25 gone back a couple slides, probably to slide 12, a suggestion

1 that we consider tort reform, streamline billing processes, a  
2 concern about payment bundling, that we look at streamlining  
3 licensure processes, that we include volunteer EMTs in our  
4 workforce and do a better job of acknowledging nurses. The  
5 Governor's Challenge for a health lifestyle would be a new  
6 strategy. Something more specific to patient responsibility  
7 and then we have the list of services that we should consider,  
8 looking at veterans' care and streamlining that. We had  
9 specific recommendations about streamlining and improving  
10 access for veterans' care. Expansion of Denali Kid Care.  
11 Long-term care we perhaps are addressing by learning more  
12 about that. We've already added that to the learning. And  
13 integration with behavioral health and primary care. We  
14 already have the Primary Care Medical Home Model on here. And  
15 then Facility Supply & Distribution.

16 So based on the public comment and any other ideas that  
17 you all have that you might want to make sure we're  
18 considering as potential future strategy -- and if you want to  
19 -- the next slide, slide 15, lists all of our pending  
20 strategies for the future study too, if you want to look ahead  
21 to that and see if there's anything there that needs to move  
22 to 2011.

23 COMMISSIONER FRIEDRICHS: We had touched on the issue --  
24 I think it was at our first meeting we touched on the issue of  
25 streamlining the licensure process. We talked about that, and

1 I can't remember the exact context, but it did come up. I  
2 know that, Ward, you and I have talked it as long ago as last  
3 January when we were talking about some issues from the  
4 federal level. I'm sure how best to tackle that in the  
5 construct of the Commission. That really almost falls under,  
6 you know as you have it listed here, a workforce issue, but  
7 that's almost a go do it. Is there a way that -- do we have  
8 to wait for our report to say that the Commission agrees that  
9 the State could do a better job at processing licenses or  
10 streamlining the licensure process?

11 COMMISSIONER STEVENS: A recent conversation with the  
12 Director of the Division of Licensing, Mr. Habeger, indicated  
13 that they had gotten the message and were working diligently  
14 to address the concerns that had been raised, and they  
15 recognize there's a lot of stuff that they're tackling there  
16 in that Division, but it's, I believe, high on their agenda  
17 already. So I don't know that a lot of time spent here is  
18 going to produce much more than we've got already.

19 COMMISSIONER STINSON: I talked to them too because I was  
20 on the State Medical Board before I was on the Health Care  
21 Commission, and they've got the message, and they have a new  
22 Director now, and I believe it is going to get a higher  
23 priority.

24 COMMISSIONER FRIEDRICHS: Would it be appropriate maybe  
25 to ask them to come to one of our later meetings in the year,

1 just to put the marker on the table that we'd like to hear  
2 from them in November of what they've done and then decide  
3 whether to put it in our report?

4 (Pause - no mics on)

5 CHAIR HURLBURT: Is there a consensus that the  
6 Commissioners would like to have a report this fall? We can  
7 set that up, if you would like.

8 COMMISSIONER FRIEDRICH: I raise it only because it came  
9 up in the public comment period. I certainly am not  
10 advocating for a great deal of effort on this. If everyone  
11 believes it's addressed, that's great.

12 CHAIR HURLBURT: Okay.

13 COMMISSIONER FRIEDRICH: Mr. Commissioner, I move that  
14 we adopt the report as amended.

15 COMMISSIONER STEVENS: Second.

16 CHAIR HURLBURT: Any discussion? Question: all those in  
17 favor of adopting the report as amended today, raise your  
18 hand. Opposed, the same. It's unanimous.

19 COMMISSIONER ERICKSON: It's not quite out. We've got a  
20 couple things that we're going to do just in the last couple  
21 minutes here. I just want to make a note for you all. I'm  
22 going to use -- it might be a couple weeks, but I'm going to  
23 use a web-based survey tool to try to identify some dates that  
24 will work for us for this year and get our dates set. Looking  
25 probably -- I was starting to look a little harder at the

1 first week in March, not the second week in March that's noted  
2 on your second-to-last slide, but these are just some general,  
3 tentative dates, give or take a couple weeks. I'll send out  
4 some options for those and have you all vote and pick the  
5 dates that we're going to have the most voting members at.  
6 And then the year after that, we'll still be on a little bit  
7 funny schedule this year, since we went into the New Year.

8 One more thing as we wrap up, we need to acknowledge and  
9 maybe invite some final comments from Commissioner Stevens who  
10 just recently moved on from the Alaska State Chamber of  
11 Commerce and is going to be leaving the Commission now,  
12 resigning from the Commission as a result.

13 CHAIR HURLBURT: Will you share some comments, Wayne,  
14 please?

15 COMMISSIONER STEVENS: I have ended my employment with  
16 the State Chamber, effective December 31st. The seat that I  
17 hold is designated for the Alaska State Chamber and so it will  
18 be up to them to recommend a name to the Governor for the  
19 position. I had informed the Chair and staff a couple months  
20 ago at our November meeting, I guess, that I would be ending  
21 my tenure, and we agreed that I would stay through this  
22 meeting to kind of put a ribbon at a nice, easy break point  
23 for the process, but I wanted to say thank you to Dr. Hurlburt  
24 and Deb for the tremendous amount of work that they put  
25 forward and to each and every one of you for the tremendous

1 amount of time and energy you've spent working for an improved  
2 health care system in the state of Alaska.

3 It's, I think, important that we remember that, in  
4 amongst all of these discussions, it's the business community  
5 that ultimately is paying the bills, and each of you that are  
6 business people are paying the bills. And when you hear the  
7 numbers, the staggering numbers and the rate of increases in  
8 the costs related to health care, we're going to bring this  
9 country to its knees if we don't figure out some better way to  
10 deliver health care to our citizens. And I don't know that I  
11 have a clear idea what that might be, but certainly this kind  
12 of discussion and this kind of process, I think, leads us a  
13 long way to finding those answers.

14 And I think the most important thing is shining a bright  
15 light on the transparency, the issues of pricing, where those  
16 costs go and engaging the consumers, the patients, whoever  
17 they are in knowing exactly what a process or procedure costs  
18 so that, when they go in and say I don't feel well and I want  
19 X because I saw it on TV last night, you go, sure, but here's  
20 what the cost is. And you know, we talk about personal  
21 responsibility and personal engagement in the things that make  
22 you well, but we also need to have people understand what the  
23 costs of things are. I mean, when you go into a grocery  
24 store, you don't just sweep through and load your cart up and  
25 then go, oh my goodness, I didn't know because everything's

1 got consumer -- the grocer is required to put a price right up  
2 front so you know what it is. So you have a choice of buying  
3 the ten-dollar-a-pound steak or the two-dollar-a-pound steak.  
4 And I think we need to do the same kinds of things for health  
5 care.

6 People have to understand that they're responsible and  
7 they have a burden to help pay for it because, whether they're  
8 paying for it through contributions at work for insurance,  
9 they're paying for it through contributions in their tax  
10 structure, I mean, everybody every week, when they get a  
11 paycheck, pays 4.5% for Medicare. Part of it comes from the  
12 employer. Part of it comes from the employee, but they're not  
13 making that connection. And as those taxes go up, they grouse  
14 about their taxes, but they don't understand that there's a  
15 connection between the tax they pay the service they receive,  
16 and I think engaging in those conversations will help come to  
17 -- bring us to the point where we have resolution to access,  
18 costs, and all of those things.

19 So again thank you for the opportunity to serve and  
20 appreciate the time that I've gotten to spend with each and  
21 every one of you. It's been a learning experience for me, and  
22 hopefully, I'll see you somewhere down the trail in another  
23 role or capacity. Thank you for the work.

24 CHAIR HURLBURT: Well we very much appreciate all that  
25 you've done, and in many ways, it's been above and beyond what

1 the rest of us have done because it's been farther from your  
2 home and the logistics of having you come up, and your  
3 dedication and your commitment and your consistency has been  
4 good, and your wisdom has been helpful. And I think we  
5 recognize, at least I do and some of the others of us know, in  
6 your job with the Chamber, you've done some very good things  
7 working with small business to help make healthcare more  
8 available there. So you've walked the talk in your work, as  
9 well as here.

10 And I would say if the Chair had the liberty of having a  
11 Chair's award for the comments for the meeting, I would give  
12 it to you for what you just said because, I think, we have to  
13 keep that in mind. That's the reality that we need to deal  
14 with and we need to address it in constructive, positive way.  
15 So thank you very much, Wayne, and we wish you very well in  
16 whatever the next chapter is for you.

17 Anything else that we need to do before we adjourn? Well  
18 I guess we are adjourned. Thank you all very much.

19 4:34:45

20 (Off record)

21 **SESSION RECESSED**

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