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ALASKA HEALTH CARE COMMISSION
DENA'INA CIVIC & CONVENTION CENTER
600 W. 7TH AVENUE
ANCHORAGE, ALASKA
THURSDAY, JUNE 23, 2011
8:00 A.M.
VOLUME 1
PAGES 1 THROUGH 269

1 children, adults, and seniors with disabilities. I'm here
2 representing the Alaska Mental Health Trust.

3 COMMISSIONER LAUFER: I'm Noah Laufer, a family doc here in
4 Anchorage and representing primary care.

5 CHAIR HURLBURT: I'm Ward Hurlburt. I'm the Director of the
6 Division of Public and the State of Alaska Chief Medical
7 Officer for the Department of Health and Social Services, and
8 I'm the designated Chair for the Commission here.

9 Colonel Paul Friedrichs, who had to step out with a phone
10 call, is also here now. Dr. Friedrichs is the Commander of
11 the hospital at Elmendorf and is on the Commission
12 representing the Veterans Administration. So welcome back,
13 and if you would introduce yourself and then let's go through
14 the audience there and have everybody introduce themselves.

15 MS. FENAUGHTY: Andrea Fenaughty. I'm the Executive
16 (indiscernible - away from mic).

17 MR. SCANDLING: I'm Bruce Scandling. I'm a Program Officer
18 for the State Hospital and Nursing Home Association.

19 MS. SWEET: Randi Sweet with the United Way of Anchorage. I'm
20 the Director of the (indiscernible - away from mic).

21 UNIDENTIFIED FEMALE: I'm (indiscernible - away from mic).

22 MS. HEFFERN: I'm Sandra Heffern with Community Care
23 Coalition.

24 MR. LESMANN: Good morning, Mike Lesmann, Office of the
25 Governor.

1 UNIDENTIFIED MALE: Hi (indiscernible - away from mic).

2 MR. FOSTER: Mark Foster, consultant.

3 COMMISSIONER ERICKSON: This is Deb Erickson with the Alaska
4 Health Care Commission.

5 CHAIR HURLBURT: Rich?

6 MR. WOOTEN (ph): I'm Rich Wooten, and I'm the Admin Assistant
7 to the Alaska Health Care Commission.

8 CHAIR HURLBURT: And we don't have many of our presenters
9 here, except myself (indiscernible - recording interference),
10 but Rich very intentionally wore the yellow shirt today so we
11 can't miss him, and we have added something new to help keep
12 us on schedule for our speakers. So you can't miss the yellow
13 shirt, and Rich will have those because we really do have a
14 lot of really good stuff on the agenda here now for us, so
15 thank you, Rich.

16 COMMISSIONER ERICKSON: Is it okay to say that we specifically
17 brought the timecards for the surgeons who are going to be
18 presenters today?

19 CHAIR HURLBURT: Right. Are you ready, Deb?

20 COMMISSIONER ERICKSON: So you all have received an additional
21 tree with your notebooks. And so if you hadn't figured it out
22 yet, the first page in there goes in your front cover and
23 everything else had a sticky on it that showed what tab it
24 should go behind. And I want to make sure -- this may be a
25 little basic, but I want to make sure you realize that there

1 is a Table of Contents in the front of the notebook showing
2 the tabs and it really kind of aligns with the agenda.
3 I wanted to just go through for a few minutes the -- in your
4 front cover -- and folks in the audience, we have these on the
5 front table as well, the handout table. And for folks online
6 -- maybe I should just take a minute to mention too, for
7 everybody who is online this morning, almost all of the
8 handouts and more than what's even on the back table are
9 posted on the Commission's website right now along with most
10 of the PowerPoint presentations. Any of the PowerPoint
11 presentations we had received by noon or so yesterday -- which
12 isn't all of them, but most of them -- are on the website. So
13 for some of the presentations today, you'll be able to follow
14 along if you access those online.
15 But I wanted to take just a minute first actually to help kind
16 of provide -- make sure that there is context and we're
17 framing what we're doing today. In your front cover is this
18 four-page document titled "Alaska Health Care Commission
19 Strategy for Transforming Health and Health Care" and just to
20 review quickly the kind of path that we had laid out,
21 actually, with our original Commission of a process really for
22 moving through, developing a vision, making sure that we
23 understand the current condition of the system, and then
24 working on strategies both to build a strong foundation for
25 our transformed health system, and we had identified the three

1 elements of the foundation as the health information
2 infrastructure -- we changed it from health information
3 technology to infrastructure at our last meeting --
4 strengthening the workforce and providing leadership for
5 statewide health system improvement and then designing
6 policies to enhance the consumer's role, both innovating in
7 health care delivery to improve quality and accessibility and
8 affordability of health care, and then supporting strategies
9 for helping Alaskans to live healthy lifestyles, and then
10 measuring progress along the way.

11 So if you turn to the second page of that document -- and I'm
12 not going to go over the third and fourth pages. The third
13 and fourth pages are meant to capture what we've done so far
14 in summary outline form in terms of current recommendations.
15 All of our recommendations that we've made so far starting in
16 2009 are still current recommendations. And also just a
17 bullet about information that we've gathered so far.

18 But on page two, the 2011 priorities, and these are,
19 essentially, the agenda we set and identified in our 2010
20 report at the end of 2010 as part our public comment period.
21 These are the things we're going to study and consider in 2011
22 and so they're laid out here, linked to the different parts of
23 the process that we're working on. Understanding health care
24 cost drivers and variations and quality is something that we
25 identified that we wanted to do for accurately diagnosing

1 problems with the health care system and also understanding
2 population health status and disparities.

3 So we're going to, today, hear a little bit about where we're
4 at with each of those three things. Mark is going to give us
5 an updated -- we have almost final reports within a month or
6 so, both on the overall spending for health care in the state
7 analysis and also the Affordable Care Act economic analysis.

8 And then we, as of maybe not even a week ago -- it was last
9 Friday, I think, we had the final signatures on the contract
10 with Milliman for the price and quality, the price variation
11 study -- pricing variation study. You all have that in your
12 notebook. I actually -- you had a draft of it. We had a
13 draft when I sent the notebook out. But in your stack of
14 additional papers that you got this morning is the final
15 contract, final signed contract. And for folks who are online
16 or in the audience, there isn't a hard copy handout of that,
17 but it's posted on the website on our meeting handouts page
18 for today. And we will have -- and we're going to need to
19 make sure we're right on time on the agenda at that point.
20 We'll have the Lead Health Actuary, Consulting Actuary for
21 Milliman on our project tying in over teleconference this
22 morning just to give us an overview of the project and to
23 answer any questions you all might have.

24 And then, of course, we have Dr. Hurlburt putting his -- how
25 many -- I don't know how many hats you have at this point, at

1 least three or four, but he's going to take off his Chair hat
2 for a little bit this afternoon and put on his State Public
3 Health Director hat for a while and share with you, along with
4 Melissa Stone, who is the Director of the Division of
5 Behavioral Health, the update on population health status and
6 disparities, again all under this -- part of our goal to make
7 sure we understand the current condition of the health system
8 and health status of Alaskans.

9 We'll have a little bit of an update from me and from Paul
10 Cartland, the Department of Health and Social Services Health
11 Information Technology Coordinator, a little bit later this
12 morning, just an update on health information infrastructure,
13 and we'll spend more time at our next meeting in August
14 focused on that topic.

15 Strengthening the health workforce, we don't have anything
16 directly related specifically to workforce today, although it
17 certainly is, I think, a theme that comes out periodically in
18 our conversations and something that we'll be thinking about,
19 but the statewide coalition working on developing a strategy
20 plan plans to report to us in October when they have that
21 done, so that's when we'll be working on that piece.

22 Innovating to improve quality, affordability and access to
23 health care, we will spend all of our time tomorrow on
24 patient-centered medical home and that was a significant goal
25 was to learn more about what we could do to advance that model

1 in Alaska. We still have that as a standing recommendation
2 from 2009 that patient-centered medical home models should be
3 fostered in Alaska and that the Department should try pilot
4 testing them. So that's been on our books for a while, but
5 we're digging in a little deeper on that to see how we can
6 better support advancing that model and strengthening primary
7 care in the state.

8 We started learning, at our last meeting, about the long-term
9 care system and issues, and we will have a report. That group
10 plans to report to us -- they're working hard -- in October.

11 And then studying payment reform strategies, especially with
12 the focus on price and quality transparency, payment bundling,
13 and leveraging purchasing power is something that we'll study
14 at our next meeting as well. Won't be focused on that as much
15 this time.

16 So I wanted to just make sure again -- so if you're reviewing
17 page two of our strategies document, which is the 2011
18 priorities page, I just wanted to make sure that it's clear,
19 that you have you some context for what we're doing today and
20 tomorrow and understand our plans for the rest of the year, at
21 least in some general terms. Does anybody have questions
22 about what I just went over or comments, either one?

23 And so as far as our -- I, essentially, went over our agenda
24 for today, and you all have it in front of you. I did give
25 you a new copy of the agenda in that packet. We have a few

1 minor changes, but in terms of the timing for the sessions,
2 nothing has really changed. So if you had a chance to review
3 your agenda after you received your notebooks a week or so
4 ago, does anybody have any questions about the agenda?

5 As Dr. Hurlburt noticed, we have a pretty amazing array of
6 folks who are coming to speak and make presentations to us,
7 and I'm amazed at how gracious they've been with donating
8 their time. Why don't we go ahead and -- well, you know what?

9 I'm going to take a couple more minutes.

10 Just a reminder, you have your meeting rules behind tab one,
11 and we've reviewed those a number of times together before.
12 I'm not going to go over those today. Just a reminder to try
13 to keep your cell phones, at least on vibrate and to remember
14 to listen carefully to your colleagues on the Panel and to
15 make sure that you're sharing the floor. And we also have the
16 charge. Our Purpose and Duty Statements from the statute is
17 behind tab one, too. So that's in there.

18 Something else that I wanted to point out to you, just about
19 your notebook contents, a couple of things especially that I
20 wanted to highlight. I had mentioned you have the contract
21 from Milliman in the notebook. We don't have Mark's
22 presentation in hard copy for you this morning, but we'll get
23 that to you sometime in the next week or so. But I did
24 include just the Executive Summary from two reports from
25 Massachusetts that have come out just in the past two to four

1 weeks, just because, you know, they had caught my attention.

2 I've been looking at other bodies similar to ours in other
3 states and the sorts of work that they're doing and the
4 reports that they're producing, and the Maryland State Health
5 Commission is one body that's been studying health care cost
6 and pricing, but Massachusetts -- it's actually a state
7 agency.

8 Their Division of Health Care Finance and Policy actually has
9 a state statutory mandate to produce annual reports on health
10 care cost trends and had just again, in the past month,
11 released a report, one on health care pricing variations and
12 another one on overall health expenditures in the state. And
13 so since it was so aligned with the two cost projects we're
14 doing today, their price variation study is a little different
15 than ours because they weren't looking at pricing generally in
16 their state and comparing to other states, which is what we're
17 doing. They actually looked at pricing variation within the
18 state and actually named specific health care hospitals, not
19 individual providers, but they also were looking at the same
20 two categories that we're looking -- or three -- hospital
21 inpatient, hospital outpatient, and professional services in
22 their study.

23 So since -- I just thought you might be interested to see what
24 another state is doing with similar studies and maybe there is
25 something that we can learn along the way about improving in

1 the future if it's something we decide to do or if we have an
2 opportunity for making some tweaks and improvements along the
3 way. Yes, Paul?

4 COMMISSIONER FRIEDRICHS: Deb, thanks. And I just offer I
5 think that it's great to look at Massachusetts. I'm just back
6 last night from a meeting, and Massachusetts' model was held
7 up as one of the ones that we looked at very carefully. I was
8 surprised to hear that, for all of the information in the
9 media, at least according to the State Medical Association,
10 70% of the doctors in this state now are supporting and
11 actually in favor of the model they've moved towards. They've
12 walked through, you know, what happened to wait times, what
13 their payment amounts have done since they've implemented the
14 Romney Plan or whatever they want to call it there. Very
15 contentious, obviously, but very interesting to see a state
16 that's now several years into a different model of health care
17 delivery. The patients seem to like it. The providers, as a
18 whole, physicians and others seem to like it. The vast
19 majority of them, that is. They are bending their cost curve,
20 and they seem to be positively impacting some of their outcome
21 measures. So I was surprised that what I had heard -- again
22 this was one group's perspective on it, but it was actually
23 the physicians' group, which has not always been most amenable
24 to making changes like that. So that may be something for us
25 to dig into more, since they have one of the longer track

1 records in a different health care delivery.

2 COMMISSIONER ERICKSON: Do you want to say anything about what
3 the studies show?

4 CHAIR HURLBURT: Yeah. I think the documents that Deb put in
5 are just the Executive Summary, and there have been three
6 longer documents that have come out that are available online,
7 two in May and one in June, addressing that. I think,
8 somewhat cynically, the reason the physicians are happy is
9 that, particularly physicians, the amount of money going to
10 physicians has gone up substantially. ER utilization has gone
11 up substantially. So that, at least according to those
12 documents, their bending of the cost curve was the other way.
13 It's going up rather than down. So with that coming up from
14 the AMA meeting, it might be of interest to look at these
15 reviews. They were done by Mathematica or a lot of the data
16 came from Mathematica. So they contracted with an outside
17 organization there. But it is something clearly to watch, and
18 it is probably closest on state level to the experiment that
19 we have of the Affordability Care Act.

20 COMMISSIONER ERICKSON: One other thing I wanted to point out
21 in the notebook, I had wanted to explain it, but I didn't want
22 to overload you with information. So I chose not to in the
23 email to you, but in the back pocket, this document titled
24 "Transitioning to Accountable Care" really isn't meant to be
25 suggesting that we need to transition to developing

1 accountable care. It's not a judgment on that, one way or the
2 other.

3 The reason this is included in your packet and the reason it
4 was in your back pocket is that it's reading for our next
5 meeting and it is a really good primer on health care payment
6 strategies and payment reform. And Dr. Hurlburt was
7 threatening to make you all want to read a textbook on the
8 subject, if you don't read this 40-page paper, but that is why
9 it's included in your back pocket. It's just a little bit of
10 reading for future reference and because there's a really good
11 explanation about payment reform strategies.

12 And maybe this would be a good time now to talk about what's
13 going to happen tomorrow rather than waiting, and we won't
14 have time to talk about it first thing in the morning tomorrow
15 because, at 8 o'clock sharp, we will be broadcasting our
16 meeting as a webinar, starting right then, and we're
17 broadcasting Dr. Dobson's presentation.

18 So Dr. Dobson from North Carolina, you all have his bio in
19 your notebooks now, but a pretty impressive background. He's
20 a family medicine doc and has been a leader in family medicine
21 in his state for 30 years or more now, but has also had the
22 opportunity to serve as the Assistant Secretary for Health and
23 Medical Services for the state of North Carolina and as the
24 state's Medicaid Director and has also been the Director of a
25 family medicine residency program in North Carolina as well.

1 So anyway, he will be presenting to us on community care of
2 North Carolina tomorrow morning and will be here in person
3 with us, and we're going to be broadcasting that as a webinar.

4 So we're going to be a little more structured and on-script
5 for that in the morning, but then following that presentation,
6 we have a number of medical leaders and administrators from
7 practices around the state who are going to be sharing with us
8 who have been trying to watch the first two webinars that we
9 put on and will be sharing with us their experience with
10 starting to transition their practices to medical home models
11 tomorrow.

12 We'll hear, for just a few minutes, from three leaders working
13 on some sort of statewide initiative related to patient-
14 centered medical homes: the Primary Care Association, a
15 representative from the tribal health system, and then also
16 the Primary Care Association talking about just very briefly -
17 - mostly to make sure that you are aware there is kind of more
18 of a statewide effort going on from these three different
19 organizations' perspective to advance this model, and so it
20 will just give you a chance to hear a little bit about their
21 vision and ask them some questions.

22 And then we'll wrap up with, hopefully, enough time to have a
23 good conversation amongst this group about what you see as
24 kind of the next level, again, beyond our first and current
25 standing recommendation that patient-centered medical home

1 models are good and we need to advance and foster them here
2 and pilot test them to what are some of the considerations
3 that we need to be keeping in mind, what are some of the key
4 findings that you think you all have taken from the webinar
5 series and from what we will have heard that morning, and then
6 if you're ready to start drafting some recommendations, we
7 will be ready to do those, work on those.

8 Again in terms of process, anything we draft, in terms of
9 Findings and Recommendations, eventually will go into a draft
10 report that will be circulating for public comment during the
11 month of November.

12 Does anybody have any questions or comments about our plans
13 for the next day-and-a-half?

14 CHAIR HURLBURT: I want to just share a few thoughts and
15 perspectives as we get started and also give a chance -- maybe
16 start first with the Commission members who came since we went
17 around the table. I did introduce you, Paul, but please
18 introduce yourself, also just who are representing here on the
19 Commission. So Paul and the other four folks, if you could go
20 ahead?

21 COMMISSIONER FRIEDRICHS: Thank you, sir. I apologize for
22 stepping out to take that call. I'm Paul Friedrichs,
23 currently the Commander of the Air Force VA Hospital here in
24 Anchorage, and I am here representing the federal,
25 particularly, the Veterans' health care system.

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CHAIR HURLBURT: Val?

COMMISSIONER DAVIDSON: Good morning, my name is (speaking in Native tongue) Valerie Davidson. I work at the Alaska Native Tribal Health Consortium, and I represent tribal health.

CHAIR HURLBURT: Jeff?

COMMISSIONER DAVIS: Good morning, I'm Jeff Davis. I'm the President of Premera Blue Cross Blue Shield of Alaska. I guess I'm here representing insurers but also all Alaskans.

CHAIR HURLBURT: Linda?

COMMISSIONER HALL: I'm Linda Hall. I'm the Director of the Division of Insurance. I'm not exactly sure what that represents. Actually, I am the representative of the Governor's office on this particular Commission.

CHAIR HURLBURT: Thank you, Linda. Representative Keller will be here tomorrow with us. He was sorry to miss today because he's out of town, but he'll be here tomorrow. Senator Olson is not going to be able to be here with us this time and sends his regrets doing that. I wonder if we could just pick up the folks in the audience. Then we won't do this again as others come in, but Tom, I'm going to pick on you first because Tom - and often, Tom and Senator Davis have been here very regularly, very interested in the Commission. So Tom, if you could just introduce yourself? If anybody didn't introduce yourselves before, just introduce who you are and who you represent. Thank you.

1 (Audience Introductions Indiscernible - away from mic)
2 (Audience members present: Tom Obermeyer, Amanda Ryder, Tom
3 Chard, and Joan Bantz)

4 CHAIR HURLBURT: Did we get everybody? Thank you very much,
5 and again, welcome and welcome to everybody online.

6 As we meet this week again, today and tomorrow, I think we
7 want to keep an end point in line. We do -- we have been
8 chartered now and established by the Legislature to go, at
9 least for several years, but I think we also need to keep the
10 perspective of why is there a Health Care Commission, what was
11 in Governor's Palin mind when she first established this
12 Commission, what was in Governor Parnell's mind, what was in
13 the Legislature's mind as they chartered and established the
14 Commission?

15 And I would share maybe a personal caution that I feel that
16 probably everything we're going to talk about is important,
17 but we also have to be careful not to become too broad and too
18 inclusive. Then we don't come down to anything.

19 There is a little kind of one-minute manager type book, a book
20 called *Amazing Fans*, and this book -- basically, the tenet of
21 the book was it's not good enough -- and I've used in health
22 delivery settings a number of times. It's not good enough to
23 have satisfied customers. You need to have raving fans. You
24 need to have raving fans about what you do, and a part of that
25 is deciding what is your core business, which is you can't be

1 all things to all people.

2 So I'll pick on something that actually is really near and
3 dear to my heart, something that I really enjoyed being
4 involved in as a clinician. This has to do with our trauma
5 system, and Frank Sacco will be here and others with
6 presentations, and this is critical. We know this is
7 important. The biggest killer for Alaskans ages one through
8 44 is unintentional injury, so it's an important area. It
9 goes from the pre-hospital area through the hospital kinds of
10 service. We'll hear more about what's happening in Alaska,
11 learn more about that today.

12 One of the things that I did as a surgeon here in Alaska was,
13 jointly with George Longenbaugh (ph) who was a surgeon in
14 private practice in Sitka at the time, we started -- even
15 before the ATLS program, we started an ATLS-like program. And
16 then when the American College of Surgeons bought that program
17 from the University of Nebraska, we adopted that here because
18 we really needed it and it was really important, but I'm
19 concerned some that, if we focus too much on this, that may be
20 going afield of what is it that was really in the mind of the
21 members of the Legislature and of the two Governors, really,
22 in establishing this Commission.

23 So I think that that should be some background of what we talk
24 about. We can't be all things to all people. We do sweep a
25 lot of things into health in our country here, but we want to

1 be able to have a practical impact on how can we address areas
2 of affordability, accessibility for care, for quality, and
3 clearly, a part of the charter was the prevention, the keeping
4 people healthy kinds of things. That's part of what I'll talk
5 about today and part of what we'll hear about on the
6 behavioral health side, but I think that's an important
7 perspective for us to keep in mind that we can defeat our
8 purpose by becoming too broad.

9 I want to talk a little bit about a book. Now three of you
10 have gotten this book, and what -- as Deb and I talked --
11 Deb's got a couple other copies here. I said, if anybody will
12 commit to read it, the Commission is buying it for you, and
13 three folks have gotten it now.

14 Some of you have heard of John Wennberg. Some of you haven't.
15 He's a well-known guy. I -- at Noah's suggestion, one of the
16 things that I did was to meet with the Board of Directors of
17 Alaska Physicians and Surgeons. I also did that with ASTHMA
18 and also with the ASHNHA group, but basically talking about
19 our contract that we now have with Milliman and some of the
20 things that we're looking at, why we're doing it, what we're
21 doing, and so on.

22 And so when I was meeting with the Alaska Physicians and
23 Surgeons Board, George Rhyneer and several of the others there
24 said, Ward, have you heard about this John Wennberg and have
25 you heard about this book? Well, I had heard about John

1 Wennberg, but I had not heard about this book called *Tracking*
2 *Medicine*. It came out last year.

3 John Wennberg was a doc who, back in the -- about 1974,
4 started looking in Vermont, in a small state, small population
5 -- looking at differential rates of various kinds of services,
6 for example, tonsillectomy and adenoidectomy and
7 (indiscernible - voice lowered). And he found in this small
8 state with a small population that there were differences in
9 the incidences of that, and it might depend on, did you have
10 an otolaryngologist in the town? Or what was the
11 philosophical bent of the school health physician who was
12 there? And you could see, when that changed, that some of
13 those rates of therapy changed. The physiology and anatomy of
14 the kids didn't change, but the context and the philosophy of
15 the providers changed.

16 Well, he started that in Vermont, founded an institute at
17 Dartmouth in New Hampshire, has done a lot of work nationally
18 on that. So a lot of what's in this book is the fascinating
19 analysis of the differences in rates for hysterectomies in
20 women, of (indiscernible - voice lowered), of a whole long
21 list of things in various areas and that's there and that's
22 what you're mostly familiar with. Others have written some
23 about it now. We've talked in the past about that, last June.

24 I think a year ago now maybe, (indiscernible - recording
25 interference) article in *The New Yorker* magazine that got a

1 lot of attention, looking at McGowan, Texas and El Paso. Big
2 differences in the rates. So that's a part of it that's in
3 there.

4 Tom Niswander and I have been friends and colleagues for a
5 long time, I don't know, at least 35 years, and I said to Tom
6 -- Tom, I said, I've known you for 35 years. I have never
7 said to you, Tom, you have to read this book. I said, Tom,
8 you've got to read this book. So I strongly recommend it.
9 The other thing that, I guess, I somewhat intellectually knew
10 but that really came home to me in reading this book and it's
11 the second reason -- it's not a real quick read, but it's not
12 a huge, long book. The other thing that came home to me was
13 the difference that it makes by the context of medical
14 practice today where the role of the physician or the nurse
15 practitioner or others has really expanded to be an educator
16 of the patient as well as the care provider. So that, in my
17 early days in practice, almost universally, the patients
18 delegated the decision making to me. Should these major
19 things be done to them, taking out their colon, taking out
20 their gallbladder, amputating their arm, major, major
21 decisions, and that was basically delegated. Well maybe
22 partly due to trial attorneys, maybe partly due to television
23 probably, but also, I think basically for some.....

24 COMMISSIONER LAUFER: The Internet.

25 CHAIR HURLBURT: The Internet, absolutely. For some very good

1 reasons, that has changed, and the best medical practice now
2 comes about where there is a partnering between the provider
3 and the patient. Now sometimes, you have an unconscious
4 patient that came in from an automobile accident and they've
5 got a chest filling up with blood. You're not going to have
6 time to run through blood in the thorax 101 before you do
7 something, but by and large, that's what's there.

8 It's the -- that message came through, to me, that that is
9 important, and it impacts on decision-making. For example, to
10 pick on Paul's specialty of urology there where one of the
11 very common procedures that is done is a TURP, a transurethral
12 resection of the prostate, for men who are having obstructed
13 urethras, having difficulty voiding, getting up multiple times
14 at night, and if you have yours -- like a roto-rotor procedure
15 -- if you kind of clean out, so that you can void, can urinate
16 more easily again, you don't have to get up five or six times
17 a night. You might have to get up zero or one, and it
18 improves your quality of life, but you also may become
19 incontinent of urine, and there's a risk for that. Or you may
20 become impotent and lose your ability to have sexual
21 intercourse. These are things that Paul would counsel his
22 patients on in talking about such a surgery. There are
23 benefits, and there are risks and that's a trade-off.
24 Well, one of the examples in this book was interesting. They
25 took group health of Puget Sound, and they took -- and where

1 you have the differences in the rates of various procedures,
2 including TURPs, a transurethral resection of the prostate,
3 across the country, they tended to be pretty low, now for
4 various kinds of reasons, and I think my bias is mostly good
5 reasons there. But when they developed a program of
6 interactive videos with men for whom this TURP surgery was a
7 potential thing to do to address some really lifestyle,
8 quality of life compromising issues that they had, they found
9 that their rate of the surgeries, when the patient became
10 actively in that, dropped even farther.

11 Now when you have the concern that we all have and we have to
12 have of the cost of health care, that's a positive good, as
13 long as you're not doing something that's truly harming. But
14 if an informed patient says, I hate getting up four or five or
15 six times at night, but I also don't want to dribble. I also
16 don't want to be able to not have sexual relations. With that
17 informed decision partnered between the physician and the
18 patient, the decision-making is good, and generally, the
19 decision was one where an informed patient made the decision
20 in a way that resulted in less cost to the whole system.

21 So I think I had never really -- even though I intellectually
22 knew, I hadn't assimilated that in my own mind as much as I
23 had. So I would really urge folks to let us get this for you
24 and to read it. It's very good. It's very well written.

25 John Wennberg is still active. He's still around. He's a bit

1 of an icon now because he has been around for quite a while,
2 but has been one of the real pioneers in looking at what
3 happens with this now. So I wanted to recommend that to you
4 there.

5 Deb, did you have anything further you wanted to say? We're
6 going to share this a little bit on this (indiscernible -
7 voice trailed off).

8 COMMISSIONER ERICKSON: You know what? I'm going to save some
9 additional comments for a little bit later when I have time
10 during the Commission business section on the agenda.

11 Usually, that only takes a few minutes.

12 I was going to share with you all some of my experience with
13 the conversations I've been having with folks across the
14 country to try to get these webinars put together and the
15 Institute for Health Care Improvement meeting that I was very
16 privileged to be invited to just this past couple weeks ago.

17 So I have some things to share with you related to what I'm
18 hearing and experiencing in terms of the value and importance
19 in both empowering clinicians in our system, the providers in
20 the system, as well as really activating patients in their own
21 care. So I'll save those comments for later.

22 One of the things I forgot to mention this morning was we were
23 going to be a little more flexible with the time and maybe
24 start Mark's presentation a little bit later to give you all
25 enough time to have a couple minutes each to share some

1 thoughts, too. So if you're looking at your watches, we'll
2 probably be closer to nine or a little after nine before
3 Mark's presentation will start.

4 CHAIR HURLBURT: Who would like to start? Kind of your
5 thoughts at this point, aspirations at this point, cautions at
6 this point? Val? Thank you.

7 COMMISSIONER DAVIDSON: I guess I'm just ready to get into it.

8 CHAIR HURLBURT: Thank you. Go ahead. Oh, to get into the
9 agenda. Okay. So yeah, any opening comments from anybody?

10 COMMISSIONER MORGAN: I would say I did get the book last
11 week, and I read it over the weekend.

12 CHAIR HURLBURT: Wow.

13 COMMISSIONER MORGAN: And I even made some notes. I find it
14 was the most rational way of measuring what we're trying to
15 come up with ideas to measure and that was reduced to 150
16 pages, instead of reams of paper. So I would hardly recommend
17 doing it. I have to apologize. I was late this morning. We
18 had a little glitch in our -- and Val, I appreciate this --
19 cost report that we had to fix this morning at 6 o'clock in
20 the morning. Until you've had one of those phone calls from
21 Lee Olson at 6 o'clock in the morning, it's quite an
22 experience -- which we fixed. But I would say get the book.

23 If nothing else, go through the chapters that interest you
24 because it's almost like self-contained sections. So if
25 you're into stats or into, even, suggestions for reform or

1 concepts or how to measure, you don't necessarily have to read
2 the whole book. You can go to that. It's very
3 departmentalized in groupings of chapters.

4 CHAIR HURLBURT: Yeah, it is. Although I'd say there is
5 probably only one chapter I felt like was kind of a waste of
6 time, and most of it, I thought, was quite good, but you can
7 pick and choose, and it doesn't have to be read in order. His
8 conclusions on some of the things -- if I had the same
9 conclusions he had, I wouldn't be in my job. He tends to
10 think Hillary care was pretty good. He tends to think Obama
11 care is probably an answer. And my own bias is that the logic
12 doesn't lead me to the same place it leads him, but it is very
13 scholarly done. It is very well done. I think any of us in
14 the business really would benefit by reading the book.

15 COMMISSIONER ERICKSON: And I do have two extra copies up
16 here. We sold one. Do you want it? No?

17 COMMISSIONER DAVIS: Has anybody, but me, tried to download it
18 on your Kindle because I had the title wrong and it failed?

19 So.....

20 COMMISSIONER ERICKSON: What's a Kindle?

21 COMMISSIONER DAVIS: Maybe Noah can tell me on my iPad.

22 COMMISSIONER ERICKSON: If Noah doesn't want it, Emily wanted
23 it.

24 CHAIR HURLBURT: Any other comments from anybody? Keith?

25 COMMISSIONER CAMPBELL: I guess I could start out with, as an

1 observer of medical staff operations for 30-odd years, I could
2 be pretty cynical, if I really wanted to be, about how groups
3 of physicians (indiscernible - voice lowered) in small
4 communities, rural communities particularly, in my experience,
5 and you know, everybody tends to rub shoulders very closely
6 and one thing led to another in the old vernacular of don't be
7 the first nor the last to adopt something in medicine, and
8 I've heard the comments, particularly when Medicare and
9 Medicaid came in -- this is way, way back in ancient history.
10 You'd get these snide comments from medical staff aides, well,
11 doc, why did you take those tonsils out? The doc says, well,
12 for 100 bucks. You know, things like this, and you didn't
13 know what was true lots of times because there was no great
14 exchange of medical criteria, other than, lots of times, you
15 got to be 70 years old and your tonsils came out, things like
16 that, and I think we're well past those issues now. Or why
17 are you prescribing this antibiotic or something like that?
18 Well, my stockbroker called. This sort of thing, and I hope
19 that we can get beyond those kind of taints that have happened
20 in the history of medicine.

21 CHAIR HURLBURT: Yeah. I think a lot of it is still with us
22 today. There was a study reported in an article in the
23 *Washington Post* over the weekend. Then it was picked up by
24 the *New York Times* and *USA Today*, I think, and others on the
25 use of the CT scans of the chest, focusing on having them done

1 with and without contrast, and they just looked at chest CTs,
2 but my experience is it impacts on all CTs. But they pointed
3 out how -- they pointed out one academic center where about 8%
4 were being done, both with and without. In other places, it
5 was, like, 90%. My own experience on the payer's side was
6 that a radiologist would very sincerely say well, I've seen it
7 help, so he instructs his technologist to always get it with
8 and without when you'd get a CT scan. Even when you had a
9 sophisticated order like, say, a pediatric neurologist
10 ordering a study just with, they would still override that,
11 and we were in a position of refusing to pay for it, and
12 talking with -- I'm thinking of one particularly large, very
13 good radiology group saying, you know, we think the evidence
14 will support this. We talked to orthopedists and others
15 saying that we don't want to be wrong. We don't want to do
16 the wrong thing. Give us your evidence, and they did and
17 finally changed their practice, at least for us, on that. But
18 I think it's like what Keith is saying. I think we still do
19 have some of that. Sometimes it gets in the press, but there
20 is, I think, great opportunity to continue to use the
21 principles of evidence-based medicine, both in coverage
22 decisions and in clinical decisions. Noah, did you have
23 something?

24 COMMISSIONER LAUFER: I'm Noah Laufer, a primary care doc. I
25 think some of the things that you say are correct. I'm not as

1 cynical about it. There's a new idealism in docs that, to me,
2 is kind of shocking. All of my new docs refuse to talk to,
3 sign, look at, eat food provided by any drug reps. They have
4 been -- meanwhile, I take samples from them because I
5 appreciate giving them to me, but that culture has changed
6 dramatically.

7 The other thing is, in trying to measure and institutionalize
8 what is right and wrong in medicine, I don't see that as ever
9 being possible. That's the first lecture in school. Half of
10 what you learn is going to be proven to be false; we don't
11 know which half. It's heavily cultural, so that, while this
12 idea of evidence-based medicine is very appealing, many, many
13 -- the majority of things that are done in medicine are
14 determined by culture. Where did you train? What seems to be
15 the right thing to do? You know, how are you paid or not
16 paid? What's approved or not? And this changes.

17 When I graduated, if you had a post-menopausal woman not on
18 hormone replacement therapy, you were a bad doctor. If you do
19 now, you're a bad doctor. The physiology of women hasn't
20 changed, but I mean, you were punished either way, and this
21 changes. And if it's institutionalized, particularly by a
22 payer, it's going to slow the progress of medicine to a halt.

23 So it's true. It does vary place-to-place. It varies
24 institution-to-institution, doctor-to-doctor, patient-to-
25 patient, but it's a living organic thing. I don't know if you

1 can really put a stamp on it. Better education would be
2 great, but you know, that's not something you can do with a
3 stick. It's a carrot type thing.

4 CHAIR HURLBURT: But what you're saying reflects that we are
5 seeing the evidence-based concepts imprinted in the DNA of
6 physicians.

7 COMMISSIONER LAUFER: The evidence-based concepts absolutely
8 are, and part of that is, you know, I can look at -- I use
9 UpToDate a lot. I look at it with patients all the time. I
10 can look at things like the Cochrane database, but it's a bit
11 cumbersome. I can get, you know, U.S. Preventative Services
12 Task Force data right away. I see it as biased, even though
13 they say it's not. But I can do that and patients do that,
14 and it's super helpful, but it is continually changing. Right
15 now, Vitamin D is a huge fad. It's a ridiculously overpriced
16 test. It's in the \$150 range. Everybody wants it. They want
17 it rechecked. You know, there are national experts on the
18 radio talking about how you can't take enough, and it's -- I
19 mean, anybody who looks at it from any sort of distance
20 realizes this is kind of silly, you know, but it's a consumer-
21 driven demand, so you know.

22 CHAIR HURLBURT: Amen. Anything else? Yes, Jeff?

23 COMMISSIONER DAVIS: So I know Val's concerned to get to the
24 agenda, and notwithstanding, it is worthwhile saying a couple
25 of things. We have a really difficult task in front of us,

1 and I'm a quick study. So after only 30 years in the
2 business, I've realized that we are in trouble. You know, we
3 are seriously in trouble.

4 When I was in graduate school, we were looking at Dr.
5 Wennberg's work and so it's not new news. But you know, when
6 you see USA Today's headline two weeks ago that, you know,
7 what was it, \$62 trillion worth of debt, if you really look at
8 Medicare/Medicaid obligations on into the future, if you look
9 at where -- the fact that health care in Alaska today for an
10 employer who is buying coverage is 65% more expensive per
11 member per month in Alaska than it is in Washington -- and you
12 know, when you think about Paul's comments that he shared with
13 us down in Juneau about the DOD making decisions about where
14 they were going to base people based on the cost of health
15 care here, when you think about the decline in the oil
16 production and what that means for revenues and a continuing
17 increase in Medicaid expense for the State and what's going to
18 happen when we expand eligibility, when you think about all
19 those things, you know, this is not news to anybody, but this
20 is not going to work. It's just not sustainable. And the
21 only way we're going to make a dent in it -- and I'm not a big
22 bang we're-going-to-solve-it-all-at-once kind of guy, but the
23 only way we're going to make a dent is just to keep at it, and
24 that's the responsibility, I believe, of all of us around this
25 table and many in the audience is just to keep everyday doing

1 what we can so we chip away at it because we don't have
2 another choice, except to give up and that's not the right
3 choice for any of us to make.

4 So I don't have the answers. I don't think there is one
5 answer. I think there are lots of answers. I think we're all
6 responsible for it as individuals, consumers of health care,
7 as physicians, as whatever kind of providers, advocates, as
8 insurers, we all have a role to play in this, and I believe we
9 are all called to do our very best every single day to make a
10 dent, and if we don't, then shame on us. And if we do, I
11 think we can make a difference.

12 So I shared with you the story of my wife giving me a verbal
13 berating in the parking lot about -- with respect to health
14 care reform and my responsibility as, you know, someone who
15 has been placed in a position of leadership, and I think that
16 is exactly the same advice we all need as well.

17 And I will read the book as soon as I can download it. Thank
18 you.

19 CHAIR HURLBURT: Linda?

20 COMMISSIONER HALL: I am one of the three who took the book,
21 and I've read the index, but I made a commitment to read it,
22 and I'm really much more likely to after listening to this
23 discussion today, although I had intended to.

24 I'd like to follow up a little bit on part of what Jeff said.

25 Part of what I see -- and I see the cost of health care

1 probably from a different perspective.
2 One of my areas of responsibility and oversight is the rates
3 that are charged for health insurance and the rates that are
4 charged for worker's compensation. Health care is the major
5 driver of both. In our state -- and I'm going to talk about
6 worker's compensation, you know, just a little bit because
7 it's the same cost driver. Seventy-five percent of the cost
8 of our work comp system is medical. The national average is
9 about 58%, and I put my name on a rate increase, or you know,
10 not a big enough decrease, whatever it is. These costs are
11 impacting all Alaskans, businesses. I get calls about the
12 health insurance premiums. We can't afford this. How can you
13 do this? How can the state of Alaska approve this?

14 So I would just kind of echo what Jeff was saying. And
15 Valerie, we do need to move on. But we have to find a couple
16 things, in my mind, that we can focus on. As you said
17 earlier, Ward, if we try to do everything we can't do, we
18 won't do anything. And to me, we need -- whatever they are,
19 we need a couple priorities that we can focus on, make
20 recommendations and efforts to see that something happens
21 because I agree. We can't -- doing nothing is really not an
22 option. So thank you.

23 CHAIR HURLBURT: Thank you, Linda. Anything else? Mark, I
24 think we're ready for you and right on, smack on when Deb
25 said, 9 o'clock.

1 Mark has some slides for us. I think everybody knows Mark
2 Foster who has been with us now and presenting regularly and
3 doing some very helpful and fascinating analyses, and if you
4 look at tab two, there's material in there from Mark.

5 MR. FOSTER: I think we're in warm up mode, but let's go ahead
6 and get started, rather than wait for the technology, so we
7 can keep on schedule.

8 Most of the presentation I have for you today will touch
9 briefly on some of the material you have previously seen
10 talking about costs, and we'll get to a few of those slides.
11 And then, I'd say, the second half really talks about what do
12 we know about various initiatives to try and get at higher
13 value for what we are buying and how they rank relative to
14 each other. Which ones really are the higher value
15 initiatives to chase down? What kind of incremental benefits
16 do we think we can get from them when we sort of look at the
17 bigger policy initiatives that are frequently discussed, so
18 you can get a sense of the relative magnitude?

19 And I think I have a few observations to make about sometimes
20 we hear there is 30% waste in the health care system or
21 thereabouts. I think that's primarily based on some cross-
22 country analyses about overhead and pricing. And when you
23 really peel that back, you'll see that estimate goes from 30
24 to maybe 10%. And then when you get the actuarials on it and
25 really work it hard, then you'll see that number get down to

1 two and three percent in terms of what we think we can
2 achieve, depending on the timeframe, and perhaps more
3 importantly, what system are you applying that particular
4 initiative to and what are its particular challenges? So I
5 think that's some of the stuff we'll be talking about today,
6 and I think we're almost ready.

7 (Pause)

8 MR. FOSTER: This is stuff from the prior presentations that
9 will be part of the report. We'll call this fine print,
10 describing some of the methodology and the funding. A little
11 bit of that is there. What's included and what's not, just a
12 quick footnote, I'm not looking at that right-hand, which are
13 health-related expenditures that would, arguably, go into the
14 prevention column, including fitness, you know, diet/exercise
15 kinds of activities.

16 Just by way of background, the estimates I have seen
17 nationally, suggest that right-hand column is probably another
18 15% of national spending on top of the left-hand column that
19 we mostly focus on because the data is more easier [sic] to
20 capture.

21 Overview today, we're going to touch on the spending and
22 spending growth, look at who pays for health care in Alaska,
23 touch on what factors are driving health outcomes, based on
24 some of the studies and the context those studies were done
25 in, look at some of the opportunities to improve value in

1 health care, and then talk a little bit about the Alaska
2 context and follow up on, I think, the morning's conversation.
3 A couple quick notes. You've seen it before, but I wanted to
4 emphasize the compound annual growth rate in health care
5 spending across the decades. It's basically gone, across the
6 '80s, from being almost 11% in Alaska, moderated at about
7 eight over the '90s, the 2000s, and we project, even with the
8 demographic change and based on national trends, we're going
9 to drop down just under 7% annual growth.

10 Now those are big annual growth rates, even at almost 7%, if
11 we look at billions of nominal dollars because we're climbing
12 from \$3.5 billion, let's call it, in 2000 up to about \$7.5
13 billion today, on up to about 14 for 2020.

14 Even with that deceleration in the annual growth rate of the
15 Alaska health care expenditures, the health care expenditures
16 appear on track to reach about three-quarters of oil wellhead
17 value in Alaska by 2020. With or without the Affordable Care
18 Act, you're getting close to three-quarters of oil wellhead
19 value. It's a pretty substantial growth rate against the
20 primary economic driver that we have.

21 As you may recall from the last presentation, we talked a
22 little bit about what do we know about what's driven annual
23 growth in the past. If you look at 1960 to 2007, technology,
24 income represent somewhere around 30% to 40% of the annual
25 growth rate in health care expenditures, medical price

1 inflation, change in insurance coverage, and demographic
2 effects are down in kind of that 10% range of the compound
3 annual growth rate. That's the history.

4 As we look forward over the next ten years, we're having a
5 large increase in insurance coverage and we're having a large
6 increase in an aging population. So we've got two strong
7 pushes up in insurance coverage and demographic effects, and
8 the question mark is, what will be the impact on these other
9 factors? Will they moderate or not, and if so, how?

10 Now I think it's important to understand the context of the
11 demographics because we hit on it, and frequently, I'll talk
12 to people and they'll nod their head yes, but I really want
13 you to appreciate what we're looking at over that time period,
14 the '60s, '70s, '80s, '90s, 2000s, up to 2007, that slide we
15 were just looking at. The demographics in the United States,
16 we had workers per retiree ranging from about four-and-a-half
17 to five-and-a-half over that long period of what I'll call
18 moderation. It was a decline, but pretty moderate in terms of
19 how many workers were covering the retirees. This is what
20 we're facing in the next 20 years, a relatively rapid change.
21 So the number of workers per retiree declines rapidly. That's
22 what's driving the anxiety among the analysts and the
23 actuarials going, we got a lot of cost pressure coming.
24 The good news is some of the other large countries also have
25 similar problems. So from a competitive advantage, we may be

1 see that. There is some moderation there in the data, but the
2 relative magnitude, as you can see when you're getting up to
3 about 10,000 per capita out there about at 80, is quite a bit
4 different than the (indiscernible - voice lowered) that you're
5 getting in close to about a thousand.

6 I think it's important to note, going forward, the
7 demographics piece has grown. So population and age mix as we
8 go out the next ten years and get me to about a quarter of the
9 health care cost growth and our projection, and if you
10 remember back here, the demographic effects are clearly less
11 than a quarter. So that's really what we're fighting when we
12 look at the data at a high level is the demographics are
13 driving it pretty hard.

14 Who pays for health care? In the end, the households pay.
15 They're paying for it. There are a lot of intermediaries and
16 a lot of potential for cost-shifting. Households pay out-of-
17 pocket costs in deductibles and co-pays to their health
18 providers. Some of them are health services not provided by
19 health insurance. There is direct payment for insurance
20 premiums to a health insurance company. There is the deduct
21 for health insurance out of wages and benefits. Employers
22 paying those wages and benefits and then, in turn, paying for
23 health insurance there or a third-party administrator. We've
24 got government tax payments, and households are also paying on
25 the purchase of goods and services who, in turn, are paying

1 taxes and benefits frequently.

2 So what we're trying to do when we're totalling up our costs
3 in the next slide is look at the distribution of some of these
4 intermediaries. How much is employer? How much is direct
5 from the household? How much comes out of government
6 programs? But keep in mind, in the end, the households are
7 paying for all of it, one way or another.

8 Alaska data. Who is paying for health care in Alaska? Keep
9 in mind we're about \$7.5 billion. Employers are roughly 40%.
10 Government programs are roughly 40%, and individuals out of
11 sort of near-term dollars, about 20. All right. This is a
12 more detailed split on this same analysis. So here's our
13 employers. Here's employers split into private business,
14 state and local government and federal. So you can see the
15 distribution. Government programs here, you'll note, are
16 federal government about 30% Medicare and Medicaid. You've
17 got about 9% by state support of Medicaid. You've got about
18 1% of the total is local government support, frequently of
19 hospitals and a few other programs. And then, as you look at
20 the individual slice and look deeper into it, what we've got
21 are basically out-of-pocket direct insurance costs and then
22 the payroll deduction values. We're trying to split it all
23 out. So what do you have? You have a lot of different payers
24 coming from a lot of different angles, and frequently, they
25 don't see the first dollar and that gives you sort of a sense

1 of who is paying for care. Yes?

2 COMMISSIONER ERICKSON: I just wanted to make sure I
3 understand. So the 40% and 40% are split between employers
4 and government programs?

5 MR. FOSTER: Yes.

6 COMMISSIONER ERICKSON: But if you take the share of the
7 employers that are government employers, you could say that
8 government is paying more like 60% for health care; would that
9 be fair?

10 MR. FOSTER: You can easily add up the slice. So state and
11 local government through -- as an employer.....

12 COMMISSIONER ERICKSON: And federal?

13 MR. FOSTER: And federal. And you add those up, and the
14 government programs and the state -- you've got this piece
15 right here. So you're getting into that 60% range.

16 COMMISSIONER MORGAN: This is more for projection time, but I
17 know that I was reading an actuarial report that our tiers and
18 (indiscernible - voice lowered) level one or tier one.

19 There's a bunch of unfunded -- well actually, I heard someone
20 say that the health benefit is more dollars than the pension.

21 I'm assuming, since they're unfunded, they are not in your
22 analysis, especially for the state budget or for the overall
23 computation of total cost?

24 MR. FOSTER: I have not independently developed an estimate in
25 this analysis of what the underfunded about might be.

1 Particularly given the litigation that's occurred, I'm not
2 going to dive into that one without more cover, but yes, it's
3 clearly an issue, and it's quite enlightening to look through
4 the public documents that are available on the litigation to
5 see what the nature of the debate is and to understand, I
6 think, the liability there.

7 Let's look ahead and talk a little bit about, all right, we've
8 got a lot cost growth going on. What do we know about what
9 drives health outcomes? And we're going to talk a little bit
10 about value and what do we mean, at least, when I use the term
11 value, and how do I look for opportunities to improve health
12 value as I look across various analytical work trying to
13 understand relative -- the relative value that we got from
14 home health or some payment reforms, if we bundle payments,
15 what might we be able to achieve, and then talk a little bit
16 about the Alaska context.

17 Let me stop here for a just a minute and talk about value in
18 health care. The work of Michael Porter, I think, in this
19 area has, for me, been quite enlightening, and I think he's
20 really come down and said all right, let's focus in. What
21 really is the goal? It's got to be value for patients. We've
22 got to be very, very focused on patients and ask, what is the
23 health outcome that we get for the dollar we spend? How are
24 we helping the patients?

25 We've got to make sure we do rigorous discipline measurement

1 of that value because, without that rigorous discipline
2 measurement of that value, how do we know whether we're moving
3 it or not? And that, I think, is a particular challenge in
4 health care, having recently done some work for CDC trying to
5 tease out what's driving health care outcomes. When you get
6 down to data and basically look at individual case histories
7 and try and compile them into a population of -- let's say a
8 study population of 3,000 -- really understand what's driving
9 changes over time, it is not a trivial exercise. There are
10 lots of confounding effects, and to do a decent job, you
11 really do have to have a pretty good understanding of what's
12 going on, on the ground. What are the potential confounders?
13 What's really driving the change? And did the intervention
14 that we do really make the difference or did something else
15 have an impact? And I just offer that up as just recently
16 coming up from one of those exercises and going wow, this is a
17 tough challenge to figure out what value are we getting. The
18 dollar part is the easy part, and it has it's challenges.
19 It's separating out the confounders that is a challenge, and I
20 -- my hat is off to the physicians who try and do that in the
21 course, ultimately, of just a few minutes with a patient when
22 it's, clearly, a very complex enterprise.
23 Anyway with that, a couple of important things on what drives
24 health outcomes. I'm going to look at two, and I'm going to
25 characterize them as illustrative slices through historic

1 data, one of them from 2002, one of them from 2010, trying to
2 get to, what are the factors that are contributing to early
3 death, premature death in the U.S.? Behavior, genetic
4 predispositions, social circumstances, access to quality
5 medical care, and environmental exposures.

6 As you work your way around the pie -- and this is one that's
7 been repeated in many publications is why I offer it up --
8 genetics might be 40%. Or excuse me, behavior 40, genetics
9 30, social circumstances 15, access to quality health care
10 might be ten, and environmental might be five.

11 That's one slice through historic data conducted in 2002,
12 basically looking back over roughly about a 20-year time
13 horizon on data, attempting to figure out what it is that's
14 driving premature death on that particular data set. That's
15 one way to look at it and one slice through the data.

16 Coming forward to 2010 -- and it actually uses 2002 data,
17 which is another case of where you really see sometimes people
18 trying to tease out the confounders and really understand what
19 is driving the causes. What are the causal drivers?

20 Frequently, they'll fight amongst themselves in a study group,
21 and it'll take years to really sort it out.

22 Quality Adjusted Life Years Lost By Age 65, *American Journal*
23 *of Public Health*, September 2010 is when it's published. They
24 went looking, and they looked at poverty, smoking, obesity
25 separate and distinct from overweight, education, high school

1 versus more than high school, binge drinking, health
2 insurance, race, and overweight as a separate and distinct
3 category from obesity. So we work our way around. They came
4 up with poverty for about 20. Smoking was a big one, another
5 20. Obesity, call it close to 20, and education about 20%.
6 And then a bunch coming in at four to five, basically binge
7 drinking, health insurance, race, and overweight.

8 So what's the point? What you look for and when you look for
9 it may have a material impact on your results. We have to be
10 very mindful of it's easy to pick a list and go, this is what
11 we think might be out there and then go comb the data and you
12 find it. It's really important to have multiple perspectives
13 whenever you're going in and trying to understand what it is
14 that's driving change, and I just want to emphasize that
15 because I see it again and again where sometimes we get in the
16 habit of racing in when the reality is these things can be
17 really quite complex.

18 Let me also sort of plant a seed as somebody who is doing
19 projections and trying to think about behavioral patterns and
20 genetic predispositions and social circumstances as what could
21 very well be a very big piece of the health puzzle.

22 While access to quality medical care may be a small piece,
23 it's clear, to me, that the medical industry is also looking
24 at how to approach and how to improve behavioral health, how
25 to address genetics, and how to address social circumstances.

1 The medical home model, for example, is really trying to get
2 at behavior and social circumstances, trying to reach in
3 there.

4 Technical innovation. If you're trying to get upstream and
5 watch either nature or science or other more specialized
6 journals and look at what's going on, we've got a lot of
7 research trying to get upstream into the genetics
8 predispositions and understand what's going on there and what
9 therapies might work.

10 Here's my takeaway from that. If we're successful in these
11 areas, we need to then be mindful of what will success be.

12 It's not unusual, when I'm doing the modeling and the
13 projections, to go I'm going to extend life years out a bunch
14 and go from 80 to 90 or 90 to 100, right? You're out in those
15 ranges and then you're going, what am I getting? And
16 particularly if the morbidity isn't compressed at the end,
17 what am I getting? That's a challenge when I'm looking at
18 cost models because what I could be doing -- and it comes
19 frequently in the data sets that I'm looking at -- is I'm
20 increasing cost by improving health care outcomes, and it
21 compounds itself because, if I take care of Disease A,
22 Diseases B and C now become much more prominent in that 80 to
23 90 range. And so you just want to be mindful of -- at least
24 in my mind, I want to encourage people, don't over-promise on
25 the cost equation side, if you're going in and making an

1 intervention. You may improve quality. You may improve
2 quality of life. But be very mindful about that compression
3 of morbidity, whether it occurs or not. There is a lot of
4 evidence on both sides, depending on what you're looking for,
5 and just want to encourage caution there.

6 Now I'm going to go through about three or four, basically,
7 consulting groups trying to frame up, what are the
8 opportunities and how do we look at them in some organized
9 fashion, so that we don't get lost in all the different stuff?

10 How do we organize it and think about it?

11 And I like the McKinsey Global Institute, their intervention
12 matrix from 2008. What are we doing? We're raising
13 awareness. We're changing incentives. Sometimes, we're
14 instituting mandates, and then frequently, we're taking direct
15 action.

16 On the prevention side, for example, on direct action, we're
17 building water and sewer systems. We can have mandates that
18 restrict air pollution. On the incentives on the prevention
19 side, we give people incentives based on lifestyle changes.

20 We can give them bonuses to have a health savings account.
21 You all are very familiar with lots of efforts to educate the
22 public on diet, exercise, smoking, safe sex, but I think it's
23 a useful framework for thinking about sort of how intense is
24 the intervention and across the dynamics. What are we trying
25 to influence, the prevention piece, how value conscious buyers

1 are, how much capacity we may have in the system? The
2 Wennberg book talks a lot about the supply side and supply-
3 driven costs, the quality, cost competitiveness, and
4 financing. So that's just one way to frame it up. And I
5 think if you'll look at it, when you get the slide packets,
6 you'll notice there are several areas in there that are ones
7 that you guys are talking about and on your list.

8 The Comwell (ph) Fund, in bending the curve in December of
9 2007, tried to look a list of policy options, many of which
10 you'll recognize, and say, what do we think, if we go after
11 these, the net cumulative savings in health care might be over
12 ten years? And then I always go and go through the extra
13 exercise, which the consultants frequently don't do, and
14 convert that to what is the percentage, how big is, you know,
15 a billion dollars when I'm at the national scale, just to get
16 a feel for it.

17 So the cumulative impact on health care expenditures for the
18 nation over that ten-year period, their estimate on the Center
19 for Medical Effectiveness and Health Care Decision-Making is,
20 if you really aggressively pursued, essentially, a publication
21 of what's really effective and what's not, you might be able
22 to pick off one percent of the health care expenditures.
23 Obesity. If we took a fresh run at that and had a relatively
24 big program, we might get 0.08%. And so that's their cut at
25 bending the cost curve. And so when total up their laundry

1 list, many of which will be familiar, you might get to a six
2 percent total impact, but I think the one is particularly
3 helpful for the overall sense of the scale, and I'll show you
4 why that one's probably optimistic, but the relative value, I
5 think, is sometimes helpful to look at.

6 RAND. If you look at RAND Health Compare and they've -- their
7 website has been up, and they basically started the project in
8 2005, and they got some new data in 2011. What options have
9 the potential to decrease waste? When you dig down through
10 their data, their suggestion is bundled payments and medical
11 malpractice are the two areas where there is evidence to
12 suggest you have a pretty good chance of reducing waste, and
13 if you will, getting more value for the dollar.

14 If you look down the list, a host of other interventions that
15 are frequently mentioned -- uncertain, no impact, no evidence
16 -- you'll find they're pretty hard at going down the list and
17 going we're really not sure there is a lot of evidence to
18 support some of the contention. So I would -- if you want to
19 look at the skeptics, I'd go to RAND, and they frequently do a
20 pretty thorough job at going, what is the evidence that we
21 have on any particular initiative? Yes?

22 COMMISSIONER FRIEDRICHS: Could you -- if we have time, could
23 you spend just a moment expanding on the bundled payment and
24 medical malpractice? What -- specifically, what aspect of
25 that because both are so contentious?

1 MR. FOSTER: Clearly. The -- mostly, what they're looking at
2 in bundled payment is the transition from fee-for-service to
3 some form of bundled payment for episodes. And they've looked
4 at a variety of specifications and concluded that, by looking
5 at a variety of different specifications to convert from fee-
6 for-service to bundled, across the span, not just one but
7 several different initiatives, they all seem to look like
8 they're going to improve the prospect of decreasing waste.
9 One of their estimates suggested it might be 3% or 4%. Some
10 of the others down at two or three. It really does depend on
11 the specification and sort of the base conditions you're
12 applying against, but I think the takeaway from RAND is,
13 across a lot of different specifications and different
14 applications, it looks like bundled payment is a pretty good
15 bet to get you value.

16 Medical malpractice. Again across a bunch of different
17 specifications about changing that dynamic, the evidence there
18 suggests that we're going to decrease waste. There is a lot
19 of defensive medicine in the system. Clearly, there is a lot
20 of debate about how much, but their view is there is still a
21 lot in there and that, if you really look hard at medical
22 malpractice, you're going to get improvements and eliminate,
23 essentially, wasteful testing and diagnostics out of the
24 system.

25 And so if you get a chance, you can dive into their website,

1 and it's really relatively well-organized compared to a lot of
2 them, so you can go down and see the specifications they're
3 looking at and the research they're looking at in order to
4 come to the conclusions.

5 COMMISSIONER FRIEDRICHS: I'm trying to walk that second part
6 through to Alaska. My recollection is that they're looking,
7 especially, at tort reform. The construct of what they're
8 describing to decrease defensive medicine is a political
9 solution that is loosely described as tort reform. I think
10 that we have some attributes of that already here in Alaska.
11 Is that from the (indiscernible - simultaneous speaking).....

12 MR. FOSTER: Yes.

13 COMMISSIONER FRIEDRICHS:pertain to us? We've done that
14 much of this.....

15 MR. FOSTER: We've already made progress on it, and if I look
16 at the Medicare position payment, essentially the medical
17 malpractice component of that cost, that's gone down
18 dramatically over the last ten years in Alaska. You know, I
19 can't -- I have not done sufficient analysis to tell you how
20 much more room there is, but I can say we've had success there
21 relative to other states.

22 Potential savings from eliminating health spending over ten
23 years, Kelley & Fabius with Thomson Reuters looked at
24 unnecessary care, fraud, and abuse in efficiencies and errors,
25 administrative inefficiencies, lack of care coordination,

1 preventable conditions and avoidable care. They took, as the
2 aspirational goal, let's try to hold national health care
3 expenditures at a constant percentage of GDP. For those of
4 you familiar with the sustainable growth rate for physician
5 payments, that's, essentially, the same aspirational goal.
6 Their estimate is that will require roughly a 10% reduction in
7 expenditures compared to the trend over ten years and that's
8 the relative scale of what percentage of national health care
9 expenditures can we get, if we go after these different
10 categories. How much do we think is there to mine? How much
11 waste can we get out and improve the value that we get?
12 Now I'm going to dive down into their unnecessary care list to
13 see what they have for initiatives. And of course, this is an
14 attempt to look at the national picture, and depending on
15 where you're at, you may have higher or lower levels of care
16 coordination, but you'll note some of these are relatively
17 small, and you'll have to look at their underlying publication
18 to really appreciate they think we're -- that the system, if
19 you will, is perhaps better adapted than many people realize
20 and there isn't as much care coordination and preventable
21 problems that are not being addressed today as there maybe
22 were ten years ago and that a lot of the conversation today is
23 based on data from ten years ago, and we're further along than
24 that. And so that's really what you're seeing when they are
25 downgrading these relative to what you might hear in some

1 other stuff is they're trying to look not just backwards but
2 forwards and go, how much is left in this area and where is
3 the rest of the gold, if you will, if you're going mining?
4 So in Strategies to Reduce Unnecessary Care, maybe 4% to 5% of
5 national health expenditures might be in this stack of
6 strategies, and I bring it up partly because, I think, you'll
7 recognize a lot of them. How do we engage the consumer? How
8 do we encourage patients to become better consumers of health
9 care? How do we give them information, so they know what
10 they're up against? And how do we give them some notion about
11 its comparative effectiveness? How do we help with evidence-
12 based benefit designs? How do we reward beneficiaries for
13 taking care of themselves? That's number one on their list.
14 How do we engage that piece? How do we get to that behavior
15 and that social sort of setting and engage that? And in order
16 to facilitate that, how do we improve our systems and our care
17 coordination?

18 Medical home and culture of health, you'll hear a lot more
19 about that. Patient safety and quality improvement is high on
20 their list. We've got to get to a culture of performance
21 improvement. It's frequently there within individual teams.
22 The challenge is to get Bridgett (ph) from the individual
23 teams across to the other teams they're working with who
24 aren't necessary in the same facility.

25 Finally, the one that I like to emphasize is we've got to

1 simplify the reimbursement and reduce the opportunities for
2 fraud and waste, and it requires us to engage the community,
3 and it's both patients and providers. As you know probably
4 either from direct experience or from relatives, the pile of
5 bills is daunting to sort through when you get them. We've
6 got to make the billing process easier, and we've got to, I
7 think, provide carrots there, not just sticks. We've got to
8 promote recognition for payment integrity that works.
9 All right. The Alaska context. Then I'm done. Then we can
10 open it up. Just a reminder about the Alaska market, let's
11 call it 710,000 people. Employer-sponsored
12 insurance/individual market may be 350,000 to 360,000, the
13 Indian Health Service about 130,000, military about 100,000,
14 Medicaid about 135,000, Medicare about 65,000, uninsured about
15 100,000. Keep in mind there is double coverage in here and
16 maybe even triple coverage, and there is movement in the
17 course of a year between many of these categories. It's a
18 relatively small market and lots of different payers.
19 I think it's helpful to think about the flow in the course of
20 a year. If there is 100 people in your population, they're
21 basically taking care of themselves in one form or another.
22 In any given year, about half of them will make a visit to a
23 primary care. Almost a third now in the U.S. population gets
24 to a specialist in a year, about a third. Almost 20% of the
25 U.S. population gets to an emergency room in any given year,

1 and about 6% of the population makes it to an inpatient care
2 visit in the U.S. And as you know, there are lots of
3 different ways to flow through, either directly to the ER,
4 directly to a specialist through primary care, and get
5 assigned, and it's that flow that, I think, we need to have a
6 slightly better understanding than we do today to really
7 understand, if we make a change, what might happened and how
8 do the patients benefit from it.

9 Finally on the Alaska context, the relative sizes in that \$7.5
10 billion. Pioneer Home and API, a little over \$90 million now.
11 Community Health Centers, a little over \$150 million. DOD and
12 VA, I think, are around \$300 million. Tribal Health is coming
13 up on a billion dollars all together. And then the balance of
14 the private providers, hospitals, physicians, all the
15 equipment, pharmaceuticals, sort of all the rest of the stuff
16 is in that bunch there. It's a little under \$6 billion. So
17 that's the context we have, about \$7.5 billion over about
18 700,000 people.

19 And I want to thank you again for the opportunity to share
20 some of the research that we've been doing and some of the
21 analysis of the market that we've done and look forward to any
22 questions you might have.

23 COMMISSIONER BRANCO: Thanks very much, Mark. That was --
24 there were some real eye-opening moments in there, and one is
25 tracking along my -- sort of Jeff's reference to I'm a quick

1 learner. It only takes me about 35 years to evolve into a new
2 learning.

3 The RAND piece with bundled payments, the opportunities for
4 reducing costs, bundled payments, malpractice, and then
5 complementary with the Kelley piece on getting rid of
6 unnecessary care, there are sort of -- my new awakening and
7 new reality of what Deb mentioned in the shift from fee-for-
8 service pieces into bundled payment pieces as well, but it
9 expands beyond -- it's counterintuitive, to me. I've been in
10 the treating health care as a retail sales adventure in which
11 higher volume equals higher revenue, which distributes to
12 greater care and better payment for physicians. That retail
13 (indiscernible - recording interference) and what we're seeing
14 is more evidence on that, that, when we do an episode of care
15 and bundle that payment, it rewards efficiency. Adding an MRI
16 when it may just be a defensive piece doesn't really pay the
17 bill (indiscernible - recording interference) care and the
18 physician's diagnostic skills come more into play than the old
19 reliance -- it's almost going backwards to the right way of
20 doing medicine, doing diagnostic studies based on the skill
21 and professionalism of the physicians without having to do the
22 defensive pieces just to answer (indiscernible - background
23 noise). There may be a lawyer or two around. I won't say it
24 that way, just to be safe.

25 So I think this is really eye-opening for me, and it's

1 starting to help me evolve into the biggest cultural change
2 that will occur to me in my lifetime and that's shifting for
3 fee-from-service for health care into episodic care for the
4 benefit of the patient, involving the patient, reducing waste.

5 I really appreciate the information.

6 UNIDENTIFIED MALE: So to follow on to your epiphany
7 description, which is spot on, I mean, I think that's the
8 challenge is I go to all these meetings when, you know, all of
9 us kind of sit there and say wow, this is not the same
10 discussion we thought we were having five, or even ten, years
11 ago.

12 When we talk about transition from fee-for-service to bundled
13 payment, trying to translate a vernacular that many of us have
14 heard in other contexts, is that really going back to a more
15 capitated model in which, in an ideal, someone assumes
16 responsibility for a particular patient and is paid for the
17 care of that patient, whether on an episodic level or on a
18 defined period of time level? You're trying to take what you
19 laid out with an integrated delivery system, with a medical
20 home model, with an engaged patient. That could be the
21 patient who takes responsibility for their care and has a set
22 amount of model. That could be a clinician. That could be a
23 system. Is that a translation of what you're describing so
24 carefully in your words there?

25 MR. FOSTER: Yes, and you'll note we don't use some of the

1 older terms because they're associated with some challenges
2 that occurred in the past, and I think that's why I try and
3 avoid them and I think why others have tried in a public
4 discussion, but essentially, what you're trying to do is pay
5 on a -- pay for a population and the real challenge we have is
6 that we risk adjust those populations we're paying and that is
7 not a trivial exercise. And so this whole -- if you will, the
8 whole initiative really depends on how well we're able to do
9 that. We're moving to a model where we're attempting to go,
10 let's not do fee-for-service. Let's pay for the person and
11 their health, and essentially, pay on a per person/per month
12 or annualized basis and get at that, and I think that's the --
13 it's that basic specification that people are trying to get
14 their hands on, but the fundamental challenge that it does
15 place on us is, how do we adjust for risk for any particular
16 population that you're trying to serve? And I think our tools
17 there are underdeveloped.

18 COMMISSIONER LAUFER: Thanks, Mark. I'm rarely this excited
19 by statistics and economics, but this is the same conclusion
20 that primary care docs all over the country have come to, and
21 what they're doing is concierge medicine. I will take care of
22 you for a year, 24/7 for -- it ranges. I've seen prices range
23 from \$1,500 to \$10,000 a year, and the beauty of that, for us,
24 is it is a bundled payment, but it cuts out all the
25 administrative -- it's a harsh word, but parasitism.

1 There are too many layers of regulation, federal and state and
2 insurance requirements and administration, you know, coding,
3 billing, all this overhead that we have to cover, and you
4 know, you can operate a concierge practice and take care of
5 600 people and have one employee and be available 24/7. I
6 think that's the real threat to the existing system. It's
7 become so archaic, and you know, byzantine that patients and
8 physicians who are really the people in the game, other
9 providers, are going to duck the entire system.

10 The big problem with that is it leaves out that percentage of
11 people who are most expensive, and we're going to end up with
12 a tiered system of county hospitals that are terrible and
13 poorly paid for and everybody else getting good care.

14 The insurance trend towards high deductibles is pushing this
15 along because, if I have a \$5,000 a year personal deductible,
16 I have catastrophic coverage only, and I can go out and buy a
17 primary care physician for \$2,000 or whatever you pay per
18 year, but the people are solving it themselves, independent of
19 policy, at the state or national level. And I would encourage
20 this, particularly since the numbers of people going into
21 primary care are dropping rapidly and we will have more
22 choice. You know, do I want to work for a huge cumbersome
23 bureaucracy that hits me over the head or do I want to have a
24 private practice with a limited number of people I know well
25 and can really participate over a long period of time in the

1 narrative of their life and help them be healthier and they
2 cooperate with me because we are adults? You know, I see them
3 because I agree to see them, and they see me because they want
4 to see me. That's very rewarding, but it's going to leave a
5 huge void, but we're being forced in that direction. I could
6 go on, as you know, forever.

7 MR. FOSTER: Right. I do want to make one -- as an analyst
8 for the market, that trend clearly has a lot of impetus.

9 There are some tapping of the brakes on that trend by
10 mandating insurance requirements, and in particular, the one I
11 have in mind is you can't -- in the exchange, you won't be
12 able to get a big deductible. Your deductible is coming down.

13 So the amount of money that you have in that first dollar to
14 serve that market may be diminished. In terms of flexibility,

15 you'll have sort of a specified benefit package, and if that
16 benefit package enables that money then to flow to the
17 concierge medicine, it might work, but it's just another layer
18 that you'll have to work around. That's all.

19 COMMISSIONER LAUFER: Yeah. It's like water, you know. A lot
20 of Medicare recipients would be happy to do that. They're
21 asking me to do it. They're coming in and asking. And
22 everyone is thinking of this.

23 I was approached by a commercial real estate guy last week who
24 I know, and he said, I've got the perfect place for you. I
25 said, well, I'm not interested in commercial real estate. He

1 wants me to open a concierge practice. It is great. I could
2 walk there.

3 Anyway, the other thing is this difficulty of grasping, you
4 know, what are we buying, that's why I was so insistent on,
5 you know, what's healthy, at the meeting in Juneau, and that
6 has changed. We will all live with disease and disability and
7 pain in our lives, and the question is, do you do that in a
8 healthy way or in a not healthy way? And all of these -- that
9 low-hanging fruit that affects cost, you know, obesity and
10 smoking and drinking and education, all that, the way that
11 that's changed by medicine is by a long-term, personal, one-
12 on-one relationship with somebody you trust. And for me to be
13 that person, I am a traditional healer in our culture, and I
14 have to be able to sit down and say look, Joe, I've seen you
15 for 20 years. I know you well. You know, the drinking really
16 is an issue. It's time to get your shit together. Is this
17 the narrative you want to have in your life? I can't do that
18 if I am the representative of a large institution that's
19 trying to cut costs, or you know, my power has been taken from
20 me by the system. I have to be one person to another person
21 who cares about them and knows them over a long period of
22 time.

23 If you really want to do the risk, I should be responsible
24 geographically for 1,000 people for my whole career and that
25 community is responsible for finding my replacement. I'll

1 stop.

2 COMMISSIONER MORGAN: I guess this is more directed at that
3 group that's not in the group you're talking about. I know
4 you saw it because I saw you carrying it yesterday.

5 There is an article in *Health Care Financial Management* of a
6 pilot project by Advent Health who -- their program, besides
7 being a health care organization, also pays for health care,
8 and they did a pilot group of high utilizers in their group,
9 and they basically established a medical home. This isn't
10 data ten years ago. This is data for '08 and '09.

11 They, basically, implemented a patient home in this pilot
12 which they are now expanding. Remember this is not for all of
13 their members, but just for the high utilization group, the
14 10% or 15% that use 80% or 85% of the health care costs. And
15 they basically dropped their per member cost from around
16 \$1,700 in '09 down to \$1,000 in '10 and had a return on
17 investment of 12 in implementing the program, but it was a
18 true medical home with all the stuff. It would be a Level III
19 medical home program for their pilot group. They didn't do it
20 for everybody, you know.

21 So I was just thinking, could it be that a lot of the things
22 that are on your slides, when you look at them in the
23 aggregate, that there would be a significantly large
24 percentage of savings in chronic or high utilization groups?

25 Probably if you equate it to the total costs, it would be

1 close to what you come up with, but that might be the first
2 and fastest area to, at least, control health care inflation,
3 or at least, stop the growth; is that rational?

4 MR. FOSTER: And I think it's a fair characterization of what
5 I see from the professional peer review literature and from
6 the management publications is that, in the tradition, we're
7 targeting areas that are very high cost to start with, and I
8 think the particular study there, when you really look at the
9 sample, they're down to the top two percent or one percent of
10 the population. Let's look at our most expensive two percent
11 and figure out what's going on there and pilot that and then
12 take lessons learned and see if we can move that further down
13 into the population, and I think I see that pattern pretty
14 consistently across the literature, you know, and it's a great
15 place to start. I mean, any of the data I've seen from Alaska
16 is consistent with other stuff I've seen from other states,
17 you know, five percent drive maybe 50% to 55% of the costs. I
18 get over -- you know, one percent is driving 20% to 25%. What
19 are those high cost cases, and what's going on there, and is
20 there something about our process? From the beginning all the
21 way through the episode of care, all the way out to when that
22 person goes home and gets well -- however we define that --
23 what can we do differently? And I think that's where you
24 start.

25 COMMISSIONER LAUFER: I just would like -- and I think this is

1 really a question for you, Noah. Now you used a term that I
2 kind of understand, but I guess I'm looking for, is there a
3 significant difference between a medical home and a concierge
4 practice?

5 COMMISSIONER LAUFER: That's a great question. The medical
6 home term started in the early '60s. It was, I think, a
7 pediatrician who came up with it, and it was sort of an ideal
8 of what primary care does. It depends who you ask. Now that
9 it's a popular term, there is going to be all kinds of
10 certifications and you do this or that. Frankly, I think
11 that's, you know, baloney. And the goals of a medical home,
12 the kernel of value there is kind of elusive, and it is,
13 essentially, a concierge practice. That's what they're trying
14 to do.

15 The concierge movement -- and I think the word I find a little
16 kind of offensive -- it's kind of silly -- yeah, it has
17 connotations that, you know, there will be shoji screens and
18 you'll get a foot massage or whatever, which they do in some
19 of the fancy ones. You have to work for Microsoft. But no,
20 it's the same concept.

21 My fear is that the value there, if institutionalized, will
22 disappear. It's elusive, and how do you measure, you know,
23 something that grows over 20-30 years, you know, the real
24 value of it? When I see a -- somebody I saw yesterday, I walk
25 in the room and she grabs her chest and says, doctor, I'm

1 dying, but see, I've seen her for ten years, and she always
2 says that and so I didn't, you know, call 911 and race her to
3 the hospital. I know her well. But yeah, it's essentially
4 the same thing.

5 I don't think, in the long-term, that a concierge thing is
6 going to happen. It's people, patients, and doctors fleeing a
7 system which has, you know, become absurd. I don't mean to be
8 offensive, but you know, I'm also an employer and we pay 33
9 cents on the dollar for benefits. I signed a check yesterday
10 for \$92,000 for health care. You know, it's -- we can't
11 afford that. I mean, what?

12 Anyway, there isn't a difference, but you know, the goals are
13 different. The narrative of your life, are you happy? Are
14 you dealing okay with these diseases and illness? You know,
15 yeah, we could do this, but you know, ablative therapy for
16 AFib at your age is going to cost \$100,000 in Alaska and the
17 chances that it's going to still be a benefit in two or three
18 years are low, you know. Is it worthwhile? You know, having
19 these personal, long-term relationships is of great value to
20 people. Clearly, they are willing to pay a lot for them.
21 So it's not a different concept. It's a different name, and
22 it's a different way for us to get paid. We have 82
23 employees, and the idea of having two good employees and
24 getting -- I have to come up with over \$3,000 a day just to
25 cover overhead and that's absurd, and it's because of

1 extrinsic pressures on the clinic.

2 We have two full-time coders just for Medicare for less than
3 three percent of our revenue. We have, you know, oodles and
4 oodles of employees, all of whom need ridiculously expensive
5 benefits, just to deal with the outside world of, you know,
6 fill in this, you didn't do that, we didn't receive that fax.

7 Yeah, we know we faxed it. Well, you did. That's the wrong
8 form. And you know, it's just absurd at this point, and I
9 would like to get to the point where I deal with the patient.

10 They walk in, and they say hey, you don't look busy, doc.
11 I've got \$100 and a chicken. Great. I'm not busy. You know,
12 we could get back to that, and we will because it's gotten too
13 onerous to put up with all the requirements. The federal
14 requirements for meaningful on the EMR are amazing. It would
15 take two hours per patient.

16 CHAIR HURLBURT: Pat?

17 COMMISSIONER BRANCO: Just a real quick definitional piece,
18 too. One of the dangers of talking about concierge medicine
19 is the California version of boutique medicine. If you've got
20 cash, you can buy anything you want. You can bypass the
21 system, have a full body MRI, and have a radiologist read it,
22 and you'll have things removed that you never would have known
23 were there. A whole different concept.

24 So it does come down to payer relationship, too. It's not
25 just an individual setting up a one-to-one relationship and

1 payment, and I'm talking medical home, not the pure concierge
2 service. So there's a vast array of things that will come out
3 of this.

4 CHAIR HURLBURT: Noah, let me ask you what you see as the
5 difference between a concierge relationship with your patient
6 for primary care services for \$250 a month and a capitated
7 contract with Jeff at \$250 a month for primary care services
8 with a one-year required lock-in of your patient, recognizing
9 that Jeff is going to ask for encounter data, which is a
10 societal good as well as a Premera need but more easily come
11 by with an electronic medical record system?

12 COMMISSIONER LAUFER: The easy answer on that is risk. If you
13 come and see me and say you'll give me \$250, I'm happy with
14 that. If I get \$250 for this year, if I document and I know
15 that I'm dealing with a much, much more powerful adversary --
16 that's the wrong word -- across the table who -- a partner
17 who, next year, can say well, yeah, you did a great job. This
18 year, it's \$240, and we want more documentation, and you have
19 to do this and that and this, and you need to have an extra
20 employee to, you know, comply with the requirements. That's
21 not going to work.

22 What we're looking for is to reduce -- in a complex system, to
23 reduce the number of people in the game, and I don't want
24 Premera to pay me. I want the patient to pay me. They've got
25 skin-in-the-game then.

1 An example of this is one of my partners does Suboxone, which
2 is a treatment for getting off of narcotics, which is a plague
3 in our society, and you can only see him if you've already
4 seen a psychologist and you pay cash. If your parents pay, he
5 won't see you. You, the patient, have to have what you guys
6 call skin-in-the-game. It's therapeutic for the patient to
7 pay. It's important.

8 CHAIR HURLBURT: Trying to leave aside the issue that you
9 would probably not cover the laboratory services under your
10 concierge payment or under a primary care capitated payment,
11 how would you handle differently the individual in your
12 practice who wants a Vitamin D level who does not have
13 osteopatia, he does not have rickets, he does not have some
14 congenital Vitamin D deficiency, how would you handle that
15 yourself as opposed to Jeff saying we will not pay for that,
16 unless you provide us a medical reason why it should be done?

17 We will not pay for that as a routine screening tool.

18 COMMISSIONER LAUFER: That's an excellent question. My
19 personal practice style is sort of minimalist, to not do
20 things that are necessary, but I don't make as much money as
21 some of my partners as a result of that. I like to think, you
22 know, I'm lily white and pure and I would do exactly the same,
23 but I doubt that I would because I've seen -- my medical
24 school was bought out and the docs became employees, and you
25 know, some of it turned on a dime, you know, from you need the

1 CT scan to, geez, why did you order that CT scan? The kid was
2 not knocked unconscious. His parents watched him. He has no
3 nausea, vomiting, or neurologic signs. We don't need it
4 because we've got to pay for it ourselves. And I probably
5 would change. I'm sure that my rationale for doing it would
6 change, but I already -- I do it -- I do the Vitamin D test
7 with a conversation about how it's probably a fad, to some
8 degree, and they're likely to be low by current standards. If
9 we do a replacement, I'll use a pattern of replacement that
10 gets enough people to the level they need to be that I don't
11 need to do a repeated test, and you know, this is somewhat
12 frivolous. Most people appreciate that, particularly if I
13 say, you know, look, I'd make more money if I did this, but
14 that's really not the right thing for you. But you know, I
15 guess I'm willing to give up income to feel that I'm an
16 idealist, and probably most doctors are.

17 Most of this expense and waste and extra stuff, and you know,
18 reactionary medicine to avoid getting sued and all that -- the
19 docs honestly feel that they're doing the intellectually and
20 the correct thing for their patients. It's not an overt
21 behavior. It's a more subtle one that's cultural, and
22 yeah.....

23 CHAIR HURLBURT: (Indiscernible - simultaneous speaking) the
24 vast majority of the time. I think you're right. It's not
25 sinister.

1 COMMISSIONER LAUFER: Yeah. I have almost never seen a doctor
2 behave that way, and the one I did see in medical school was
3 pushed out of the community quite quickly.

4 CHAIR HURLBURT: One more question and we'll take a break.
5 Paul?

6 COMMISSIONER FRIERICHS: So what? I mean, that was an
7 absolutely wonderful description of the problem. Let's walk
8 this through what we've talked about for the last year that
9 there are lots challenges, lots of confounding factors, which
10 make it very difficult to identify successful strategies for
11 bending the curve. Where do you see your report going? Is
12 this kind of the gist of it right now? And I say this as
13 someone -- you know, just as Pat said, I mean, I think your
14 description is -- having just spent five days having the same
15 discussion in Chicago, yours is better than what we heard
16 there, and we pay a lot more money to the contractor there.
17 But having said that, where is the so what part of this?

18 MR. FOSTER: I think the so what part really comes down to the
19 people that are around this table and the networks that you
20 have.

21 Knowing that description, what do we know -- each of the
22 people around the table, what do we know about the areas that
23 we work in and the people that we work with that -- you know,
24 what do we know that suggests where we're going to change our
25 systems, in view of the information that we have and in view

1 of sort of the basic principles about engaging customers and
2 treating them as customers and not someone -- you know and
3 bringing them in -- what system improvements do we need to put
4 in place to support that effort, and you know, what do we need
5 by way of data to make sure that we're, in fact, doing things
6 that yield value results?

7 So I really think that -- you know, I could sit here and
8 prescribe a lot of things. I think, at some level, it's the
9 community has to look in their networks and go, what do we
10 know about what we're doing that we need to change and then
11 really bring that back, and I suspect Dr. Hurlburt has some
12 other information he has collected from talking to a lot of
13 people that will help do that. I think that's the so what
14 from the work that I'm doing.

15 CHAIR HURLBURT: Yeah. We'll go ahead and take a break until
16 10:15. And Mark is here, so if there are some other things,
17 Mark will always be gracious about continuing the discussion
18 then. Thank you, everybody.

19 (Off record)

20 (On record)

21 CHAIR HURLBURT: Can we gather back together again?

22 (Pause)

23 CHAIR HURLBURT: John, if you can hear, this is Ward. We're
24 just trying to get folks back from the restroom.

25 MR. PICKERING: Yes. Great. I can hear you.

1 CHAIR HURLBURT: Thank you. Sorry. We're just a little late
2 getting started again.

3 MR. PICKERING: No problem.

4 CHAIR HURLBURT: I think we can go ahead and get started.
5 Most of us are here now. This next section that we have, you
6 have the material in your notebook behind Section 3, and this
7 contains some slides.

8 John Pickering, who is Principal and Consulting Actuary with
9 Milliman, will be talking with us about the project and the
10 contract we have with them. As you look toward the back of
11 the section, you have the RFP and the contract agreement that
12 we have. Deb and I have talked with John on the phone. Deb
13 has talked with him a number of times on the phone.

14 This contract is designed to look at the costs of health care
15 in Alaska, the drivers of the cost of health care. We will
16 have comparisons with other Pacific Northwest states, Idaho,
17 Washington, Oregon. We've also tried to pick a couple of
18 other states that have small populations and are largely rural
19 and face some of the challenges that we have, namely North
20 Dakota and Wyoming.

21 There has been some concern, I believe, expressed from some
22 providers about what this contract is and who the target is.
23 Dr. Laufer, helpfully, suggested that it might be helpful to
24 meet with the Physicians and Surgeons Association, and I met
25 with their board and talked with them about that. One of the

1 One of the things that we learned from Dr. Friedrichs, from
2 Paul is that the VA system here had also contracted with
3 Milliman, helping them understand the Alaska market, where
4 we've been told, or Paul has shared with us, DOD is looking at
5 whether or not they station people in Alaska because of the
6 high cost of health care here.

7 So Milliman has the national and international experience.
8 They have, more recently, the Alaskan experience working with
9 VA and with DOD on some issues. So I think they are very
10 well-positioned, and in the conversations Deb and I have had
11 with them, they are anything but naive in our field and about
12 our state even. So I think they are well-positioned to do
13 that.

14 So with that, John, let me turn it over to you, and if you
15 could go ahead and share where you are now and what your plans
16 are going forward? Thank you.

17 MR. PICKERING: Great. Thank you, Ward. And I'll just add
18 one thing about Milliman. We are headquartered in Seattle.

19 So while that may not be real, real close to Alaska, it's
20 about as close as you can get without being in Alaska.
21 My goal today, I'll give you the overview of the project we're
22 going to perform for the Commission and hit the high points
23 and the takeaway, you know, what we're trying to find in the
24 project and then I'll take questions at the end.

25 Let me tell you a little bit about myself before I get

1 started. I have right around 15 years of experience as a
2 Health Care Actuary. Most of that has been with Milliman,
3 although about four or five years of it was with Premera Blue
4 Cross. And while at Premera, I had the opportunity to work on
5 Alaska physician fee schedules, so I have knowledge of the
6 area from the health plan side as well as more recent
7 consulting work.

8 But with that, let me launch into an overview of the project,
9 and I'll call out the slide numbers as I move forward. So I'm
10 on slide two now.

11 The project really has three main components. The first will
12 be looking at billed and allowed unit cost for professional
13 services, and as Ward mentioned, we're going to be looking at
14 this across states and also across payers. I'll provide more
15 detail on that in a moment here.

16 The next component will be a similar analysis, but focusing on
17 inpatient and outpatient hospital costs rather than
18 professional.

19 And then the third piece will be looking at the drivers behind
20 those costs, trying to understand, you know, what is driving
21 the -- what we'll likely find our high unit costs in Alaska.

22 I wanted just to relay a quick story. Early in my career, I
23 was doing some work on a project in Alaska and surprised by
24 how high the fees were in Alaska relative to, you know, states
25 down here in the Lower 48, and the response I got from my

1 question was, Alaska is just a different entity. Alaska is
2 just different. So we're pretty now to be able to actually
3 dig in, quantify the exact difference, and try to isolate the
4 drivers of what is causing Alaska to be different.

5 Flipping to slide three then, looking at the details of the
6 professional study we're going to do, the goal is to quantify
7 unit cost differences among states and payers. And when I say
8 unit cost, I'm looking at price per service. So if you think
9 of, you know, an office visit, procedure code 99213, you know,
10 how much do commercial payers pay for offices in Alaska versus
11 Washington, Oregon, et cetera?

12 The way we're going to go about this is we're going to look at
13 the top 25 procedure codes overall as well as by specialty.

14 You can see the specialties printed in this slide. I won't
15 read through those all, but you know, for most of the top
16 specialties, we'll be looking at the top 25 procedure codes.

17 And for each code, we'll look at reimbursement by state,
18 Alaska, Washington, Oregon, Idaho, Wyoming, North Dakota, and
19 then in speaking with Deb and Ward, we added Hawaii in there
20 for commercial business, as we understand that could be
21 interesting.

22 In terms of the payers we'll be looking at, of course, we'll
23 be looking at commercial payers, but we're also going to look
24 at the allowable fees paid by Medicare, Medicaid, TRICARE,
25 Worker's Comp, and then also the Veterans Administration and

1 when they pay providers outside of their system, what those
2 allowed rates are.

3 We'll also look at billed charges in Alaska versus these
4 comparison states, and our goal won't just be a single-point
5 estimate for each procedure code, but rather we include the
6 mean, the median, and the 80th percentile. Those are
7 meaningful, really, for the commercial rates because,
8 obviously, different commercial payers will have different
9 rates, potentially even to different providers, and also for
10 billed charges, I don't think the range of fees is meaningful
11 for Medicare or Medicaid where you're paid off one schedule.
12 But the overall goal of this professional analysis then is to
13 understand the price differences or the unit cost differences
14 among states and among payers.

15 Turning the page then to the next slide, slide five, the
16 hospital analysis, the goal here is really analogous to the
17 professional analysis, except, of course, for hospitals. We
18 will look at inpatient and outpatient services separately, and
19 as with professional, we'll be looking at both the allowed and
20 billed unit cost level.

21 Of course on the professional side, we're looking at it on a
22 per procedure basis and using, you know, procedure codes as
23 the case-mix adjustment, essentially.

24 On the hospital side, we're going to use a tool that we've
25 developed internally. It's called the Milliman Hospital

1 Evaluation and Comparison system or HECS for short, and what
2 that does is it assigns relative value units to all hospital
3 claims, both inpatient and outpatient claims. In a lot of
4 ways, you can think of this as mapping, you know. For
5 example, you have Medicare, relative weight for inpatient, and
6 relative weight for outpatient.

7 You can think of this process as if we're mapping in Medicare
8 relative weight to inpatient, Medicare relative weight to
9 outpatient, and then dividing the allowed amount on a claim or
10 a group of claims or the billed amount on a claim or group of
11 claims by those relative weights. The difference between our
12 approach and just using Medicare weights is that we believe
13 the relative value units that we've developed better adjust
14 for case-mix than do those Medicare weights. So you know, if
15 you're familiar with relative value units either on the
16 professional side of the spectrum or on the facility side, I
17 think you can understand the general approach, which is
18 assigning relative value units and then dividing either
19 allowed or billed dollars by those relative value units, and
20 the relative value units that we do use are developed to
21 provide a robust case-mix and severity adjustment among
22 patients.

23 So we plan to apply that to, essentially, re-price both
24 commercial claims and Medicare claims, which will provide unit
25 cost estimates for commercial payers and Medicare payers, and

1 we'll do this in Alaska as well as all the comparison states.
2 And then we'll also pull the fee schedules, the hospital fee
3 schedules for Medicare, TRICARE, the Veterans Administration,
4 and Worker's Comp, and look at those, probably express those
5 as a percent of Medicare, and based on our findings from
6 Medicare, be able to then quantify those, the prices paid by
7 each of these payer categories.

8 On the next slide, I list the primary data sources we plan to
9 use to conduct this analysis. For commercial claims, the data
10 source will be the Thomson Reuters MarketScan database. This
11 is a database that's comprised of data submissions, claims
12 data submissions, from both large employer groups and some
13 health plans, although the majority of the claims come from
14 large employer groups. But as a conglomeration of data from
15 many different groups, it does include many different payers
16 in the data, many different commercial payers in the data,
17 which allows us to get a more market level sense of payment
18 rather than just one payer's fee schedule.

19 For the Medicare allowables, of course, we have the publicly
20 available Medicare fee schedules, but we'll supplement that
21 with analysis of the Medicare 5% sample, which for those who
22 aren't familiar with that, that's, essentially, 5% of all
23 Medicare claims. So it's a pretty robust and large database,
24 as well as the MedPAR data, which is a database that contains
25 all Medicare inpatient discharges and OPPS data, which is a

1 database that contains all Medicare outpatient hospital
2 payments that were paid under the Outpatient Perspective
3 Payment System.

4 And then combined with that commercial claims data and that
5 Medicare claims data, we'll be, as I said, pulling the fee
6 schedules from these other entities, Medicare, TRICARE, VA, et
7 cetera to bring in and estimate their allowed fees relative to
8 both commercial and Medicare.

9 So those first two components of this project are really to
10 quantify what is the difference in price between Alaska and
11 the comparison states as well as by payer.

12 The next phase then -- and I'm moving to slide seven -- is to
13 try to understand what drives the differences in those input
14 prices, you know, assuming, based on other work we've done and
15 common sense, that the Alaska -- we'll find that the Alaska
16 prices per unit are quite high.

17 And our plan on this driver analysis is to first look at
18 several data sources we have fairly readily available and
19 essentially see what they tell us, and from there, potentially
20 try to unearth other data sources.

21 So the data sources that we have readily available and we'll
22 use first, we want to start with a look at commercial premium
23 levels. Obviously, commercial premium levels aren't -- I
24 wouldn't think of, typically, as a driver of the unit cost
25 level. I would think of it as the other way, with the unit

1 cost level being a driver of the commercial premium levels,
2 but we still think it's interesting to have those premium
3 levels quantified as well as to be able to look to see if
4 differences in unit cost prices are similar to differences to
5 premium prices.

6 But then drilling down on the hospital side, we're able to
7 look at hospital operating cost levels on a case-mix and
8 severity-adjusted basis. We have a process in which, for
9 every hospital, we're able to benchmark it's operating costs
10 on a common scale, so that we can compare the results against
11 other hospitals. So through that analysis, we'll be able to
12 look at hospital operating cost levels in Alaska and see if
13 they are significantly higher than operating cost levels in
14 the other states.

15 We'll also look at hospital margins, both all payer margins
16 and Medicare-specific margins. Obviously if hospitals are
17 receiving higher per unit payments, one would think that
18 either the cost level is going to be higher or the margins are
19 going to be higher or both, you know, some combination
20 thereof. So by looking at both of these components, we'll be
21 able to quantify, you know, what is occurring.

22 One element that will effect those hospital operating cost
23 levels is the case-mix adjusted average hospital length of
24 stay, so we will take a look at that as well.

25 On the physician side, one piece of information we'll look at

1 is physician compensation levels. We have two surveys
2 available in which we can compare physician reimbursement --
3 or total compensation rather by specialty, I believe, between
4 Alaska and some of these comparison states. Not all of the
5 comparison states are available, but we should get a good
6 comparison to be able to understand whether, you know,
7 differences in unit cost payment per service translates to
8 higher compensation or not.

9 Another source we're going to dig into is looking at
10 commercial payer discount comparison. Now obviously,
11 comparing discounts across two providers is, you know, wrought
12 with difficulty, given that their bill charge master is likely
13 different, but we do think it can be interesting to look at
14 discount comparisons to -- as being suggestive of the ability
15 of commercial health plans to negotiate rates. It can be a
16 measure of negotiating leverage, or on the other hand of
17 providers, negotiating leverage. And on this one, it may be
18 interesting to compare professional versus facility in Alaska.

19 I suspect we may see some differences there.
20 So our plan then is to look at those initial analyses and see
21 what we can synthesize from those results and lead us to
22 additional investigations.

23 On the next slide, we list a few additional sources that we
24 may look into. The first one I list, health care utilization
25 rates, MedPAR recently did a very interesting study in which

1 they looked at just relative value units, so stripping out the
2 price component, you know, the cost per service, but just
3 looking at relative value units delivered to Medicare
4 beneficiaries in different MSAs. That -- you know, that might
5 not speak directly to a driver of a unit cost differential,
6 although it could, but you know, that may shed some light on
7 key differences between the delivery of care in Alaska and
8 elsewhere.

9 Another source we'll likely look into is demographic
10 differences between Alaska and the comparison states. You
11 know, one key consideration to providers, obviously, is the
12 uninsured population and especially the hospitals to the bad
13 debt they may face from the uninsured population. So you
14 know, to the extent there are significant differences in the
15 mix of the population, be it uninsured, Medicaid
16 beneficiaries, Medicare beneficiaries versus commercial or
17 self-funded payers, those, you know, combine to impact the
18 overall reimbursement level to providers, since each of these
19 payers pays at a different fee schedule. So we'll investigate
20 the impact of those demographic differences.

21 Another one I list here is hospital occupancy rates. That's
22 one that, along with the hospital average length of stay, can
23 be a driver of the hospital operating costs. So depending on
24 what we see in that operating cost analysis, we may dig deeper
25 and drill into the occupancy rates.

1 You know, a couple others that come to mind which we'd like to
2 include -- we're still searching for some good data sources --
3 would be the providers per 100,000 of population to, you know,
4 get a sense of whether it's just a shortage of providers in
5 Alaska that could be affecting prices, as well as hours worked
6 per physician. Like I said, we're still searching for good
7 data sources for those. So you know, what we ultimately use
8 and include will be dependent on what we can find there.
9 In terms of the timing of our report, we just recently signed
10 the contract with the Commission. We're going to -- we plan
11 to deliver results in two phases.

12 The first phase will be the Professional and Hospital Pricing
13 draft report, and we plan on delivering that by September 1st.

14 The Commission will review that, provide feedback to us, and
15 we'll incorporate that feedback, and then we plan on the final
16 report being delivered on October 31st.

17 The second phase will be the drivers of the cost analysis with
18 the draft report being delivered by October 15th and then the
19 plan to get feedback on that with the final report being
20 delivered on November 15th.

21 We're excited about this. We're looking forward to the work.

22 As Ward mentioned, we've recently done some fairly similar
23 work for the Veterans Administration, so I think we have a
24 good basis to launch this analysis from and we're looking
25 forward to it. And with that, let me open it up for

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questions.

CHAIR HURLBURT: In looking through this and listening to John's presentation, there are some what I would consider omissions, you might consider omissions, and that is due to the RFP that we put out. It did not have some things in there that, if we were doing it right again today, would be there.

So we are intending to deal with that going forward. Like, you don't see anything in there about pharmaceutical costs and that's a significant component for us up here.

So that, John won't be able to respond to any questions on specifically, but it's Deb's and my intent going forward that we will make that a part of the body of data that we are gathering, and there will be some other specific areas, like that.

Now if there are some questions, if you could identify yourself, both by name and maybe your discipline or who you represent? So we'll start with the Hospital Administrator, with Pat Branco, who is the President of the State Hospital Nursing Home Association this year, John.

COMMISSIONER BRANCO: Good morning, John. A quick question. I'm the CEO of Ketchikan Medical Center, and Ward just said, the Chairman of the State Hospital Association.

On the hospital side, I'm wondering if the data will demonstrate or differentiate between critical access hospitals and PPS or does that even make a difference, but half the

1 hospitals in the state are critical access, so it's a pretty
2 significant thing and probably comparable to Wyoming and North
3 Dakota in that relationship.

4 MR. PICKERING: Yeah, that's a great question, and obviously,
5 especially the Medicare rates -- obviously, Medicare pays
6 different to critical access versus PPS hospitals, and to some
7 extent, we'll be able to capture that. Our commercial data
8 source doesn't identify the specific hospital. So in our
9 commercial comparison, we won't be able to isolate a critical
10 access hospital from a PPS hospital. In our Medicare work, we
11 will be able to identify the specific hospital because it's --
12 you know, the identifier is in the data. So to the extent we
13 can identify critical access and look at those separately, we
14 will. Like I said, we should be able to do that for Medicare,
15 but given the data that we have for commercial payers, we will
16 not be able to make that distinction.

17 COMMISSIONER BRANCO: Thanks.

18 COMMISSIONER DAVIDSON: This is Valerie Davidson, Alaska
19 Native Tribal Health Consortium, and I represent tribal
20 health.

21 The question I had was about a driver for remoteness,
22 location, and also just the general higher cost of living. So
23 for example, Alaska would be very -- it would be a very
24 different comparison for somebody who had to travel from
25 Chevak to Bethel, which is a \$580 round-trip, and then from

1 Bethel to Anchorage, another -- if you're lucky, a \$400 round-
2 trip, just to be seen by somebody in Anchorage. Communities
3 that are -- for example, Bethel, we are very fortunate right
4 now. I think the cost of heating oil is only \$6 a gallon,
5 which is about the same as the price of gas. Some of the
6 clinics though in the surrounding villages are paying \$11 a
7 gallon for heating oil, which is the same price for a gallon
8 of gas. And so the cost of being able to keep those
9 facilities open is much higher than it would be, even in
10 Anchorage, and then, obviously, much more than a place like
11 somewhere in the Lower 48 in one of the states that you're
12 looking at. I mean, just as an example, a gallon of milk in
13 communities that are lucky to be able to get it -- in Bethel,
14 it's \$9 a gallon.

15 So for the -- I guess I'm wondering about the remoteness and
16 whether you're factoring that in, and many of the communities
17 that are served by these regional hospitals and the clinics,
18 they're only accessible by air. So it's a very different
19 equation for somebody who has to jump on a plane, or at least,
20 one plane, maybe two planes, to get the car versus somebody in
21 Washington State or even in Wyoming who can get in their cars
22 and drive for two or three hours because, in addition to that,
23 is also the cost of freight for being able to ship your
24 medical supplies in, all of the pharmaceuticals, all of the
25 nutritional things, I mean, everything that you need to be

1 able to run a facility, all of those costs are included -- or
2 those costs aren't included, so you have to add the cost of
3 freight, et cetera. And then the other factor is that, when
4 you have medical waste, if a facility isn't capable and a
5 community doesn't have the capability to dispose of that
6 medical waste, then all that stuff has to be shipped back.
7 So I guess I'm wondering, what opportunities there are to
8 include remoteness, cost of living, extra freight, all of
9 those things among your drivers?

10 MR. PICKERING: Good question. A couple things come to mind.

11 It's easier on the hospital side for us to look at those
12 costs, and I realize that, in a lot of these communities, they
13 wouldn't have a hospital, so that doesn't address your point
14 100%, but you know, to the extent you have some far-flung
15 hospitals, we will be able to look at hospital operating costs
16 by facility so that, you know, potentially we'd be able to
17 look at, do these more remote, smaller hospitals show a higher
18 operating cost than, say, a hospital in Anchorage? So that's
19 one way we can get at the remoteness concern.

20 Another thought is, for our physician analysis, we do have the
21 ability to look at that by the -- you know, not just Alaska as
22 a whole but by the geographic area in which the physician
23 practices. Now what we see in the claims data would be the
24 payment levels as opposed to the underlying costs of the
25 practice, but you know, it's possible that payment levels for

1 professional services, we might see that they're higher in
2 these remote areas, you know, due to these costs that you
3 mentioned, compared to Anchorage. I'm really not sure if
4 we'll see that or not, but that's one way we can try to look
5 at those differences.

6 CHAIR HURLBURT: Thank you, John. Maybe Noah, did you have
7 one and then Dave?

8 COMMISSIONER LAUFER: I'd like -- this is Noah Laufer from
9 Primary Care, a family doc in Anchorage, and I just want to
10 voice a concern about this.

11 I think we're going to find it's more expensive and probably,
12 with regard to physicians, we're reimbursed better, but it's
13 really not a surprise that people are willing to live in
14 Hawaii or Seattle, if they get paid less because they get to
15 live in Hawaii or Seattle and not in Anchorage where your wife
16 has to tolerate, you know, months of darkness or more remote
17 places where we didn't even consider going.

18 But anyway, the problem I have with this is it's going to, at
19 best, give us the data to allow us to align ourselves with the
20 rest of the country. The rest of the country is failing. The
21 health care system is failing. We need information that
22 allows us to have a better system than the rest of the country
23 and that's a different issue. And what I'd like to see is
24 not, you know, that we charge 15% or 20% or 50% more or twice
25 as much as somebody in a different community. I want to know

1 the actual cost of a hospital stay overnight and what I'm
2 getting for that and that's a totally different question.
3 It's probably beyond the scope of this study, but you know,
4 we're trying to catch up with a system that's bankrupt. I
5 don't think that's a high enough goal.

6 MR. PICKERING: Yeah. I guess I would just respond with, you
7 know, one piece of the study that might address where you're
8 coming from, Noah, would be looking at the health care
9 utilization rates from that MedPAR study, summarizing those
10 for Alaska versus these comparison states to look at, you
11 know, the actual delivery of care. You know, aside from the
12 per unit price of care, how is care being -- is care being
13 delivered efficiently? Is utilization efficient or
14 inefficient, you know aside from the price per service?

15 COMMISSIONER MORGAN: I was just going to make a suggestion
16 that

17 CHAIR HURLBURT: Please identify yourself.

18 COMMISSIONER MORGAN: I'm sorry. Dave Morgan, Alaska Primary
19 Care Association. It's the first time I've ever been
20 criticized for not speaking loud.

21 The Department of Commerce has an economic magazine or issue
22 that they give out monthly and quarterly called *Trends*. One
23 of those issues, every year, has a differential by region for
24 the state. So if you looked at that, it might give you a
25 better feel for what Val is talking about.

1 But I would also endorse what Noah is saying, in that --
2 especially the MedPAR usually might be where -- might be the
3 section that will be the -- the corners will be worn down for
4 you anyway, that would have more of that type of data. So I
5 think some of that's in there, not all of it, but at least a
6 start to give you the utilization of quality metrics.

7 But also for Val's point, there is a document done. I think
8 it's by Goldsmith out of the University, who contributes to
9 it, and every year -- I have them all, going back, like, 12
10 years -- it has the differentials by region that basically all
11 of the figuring -- the school board, the school costs, and all
12 that stuff by region that everybody accepts in the state. So
13 I mean, why reinvent the wheel? Why not just go to what we're
14 using in all these other departments, treatises, and concepts?

15 It's just a suggestion.

16 And Mark -- if Mark was still here, he would say, oh yeah,
17 I've got -- probably in his briefcase, he's got the last three
18 or something to help him do what he's doing.

19 CHAIR HURLBURT: Linda?

20 COMMISSIONER HALL: Thank you. I think there's an.....

21 CHAIR HURLBURT: Can you identify yourself?

22 COMMISSIONER HALL: I'm sorry. Linda Hall. I'm the Director
23 of the Division of Insurance and a representative of the
24 Administration on this Commission.

25 One of the reasons, I think, we're doing this is we have a

1 report due at the end of the year, January 15th to be specific
2 -- I just looked it up -- to the Governor and to the
3 Legislature. This is a question -- these are the people who
4 we make recommendations to, and if we're to be effective, they
5 will begin to implement, and sometimes, that takes money,
6 funding, support, and these are questions that we may have
7 data from a variety of sources that answer, but I think I've
8 heard, with some regularity, from Legislators that this is the
9 kind of information they would like. And so I think part of
10 our reason for deciding to go ahead with it was to be able to
11 supply the information that they're going to look for when we
12 take them a recommendation to do X and ask for funding to do
13 that.

14 CHAIR HURLBURT: Paul?

15 COMMISSIONER FRIEDRICHS: Thanks. Paul Friedrichs. I'm the
16 CEO of the Air Force VA Hospital representing the federal
17 health care system.

18 First, you had mentioned that you were looking for data on the
19 -- informative data on physician per some population subset,
20 and that data has been collected a couple of times. There is
21 a 2006 report on workforce that has that breakdown by
22 specialty which, I think, it's open source. It's on multiple
23 websites.

24 And then, didn't we just publish another report out of ASHNHA
25 last year on this that has an updated breakdown? So if that

1 would be helpful, John, that may be something that -- you
2 know, that has already been done and could be integrated into
3 the analysis that you're conducting. It might save us, and
4 save you, from having to recreate the wheel on that.

5 MR. PICKERING: Yeah, that'd be fantastic. If you could maybe
6 pass along the path that that can be found, to Deb? And also
7 maybe, Dave, if you could pass -- if you know the path of the
8 document you were referencing, if you could give that to Deb
9 and she could maybe be, you know, a point of contact to us
10 that would pass those along to us, that would be great.

11 COMMISSIONER FRIEDRICH: And I think, to follow on Linda's
12 comment there and in response to Noah's concern, you know,
13 again having had an audit with 20 auditors out at our facility
14 six weeks ago now looking at whether to decrease our presence
15 in Alaska or to grow it, I agree with you. These are exactly
16 the questions that people are asking as a baseline. Do we
17 continue to invest in Alaska or not? And if we do, then what
18 are looking for?

19 And Noah, I guess what I would offer with that is that there
20 is an opportunity, if we -- you know, it would be no surprise
21 to say that health care is more expensive in Alaska. The
22 opportunity that comes from that though and what I personally
23 hope will come out of our report is, here is how to better
24 spend that money. You know, this is not about, gee, can you
25 spend as little as Louisiana? This is about, if you're going

1 to build a good health care system, here's what a good health
2 care system looks like. Here is how much you are spending
3 today for the same amount of money. If you assume X, Y, and
4 Z, you could get these changes, which we would assume would be
5 improvements. But that's where I hope the Commission would go
6 with this is, here is where we are today, which is what this
7 would give us, and then we come up with -- as I asked Mark,
8 the "so what" part -- the recommendations to take back to the
9 Governor and the Legislature to consider that, if you do X, Y,
10 and Z for the same amount of money, you could get improvements
11 here for less money. These are the risks that you'll accept.
12 And then the third part I want to just bring up -- and this is
13 really for everyone -- you know, Mark's presentation really
14 was excellent this morning, and his comment about malpractice
15 costs and the costs of defensive medicine as a subset keeps
16 coming up. I've heard anywhere from 2% to 5% of the overall
17 cost of health care can be attributed to that. Do we have any
18 data to support the assumption that I've made over the last
19 several years that we have achieved savings by virtue of the
20 tort climate that exists in Alaska? Has that analysis been
21 done to suggest whether that is another area in which we
22 should be looking for additional savings? Thank you.

23 CHAIR HURLBURT: Linda?

24 COMMISSIONER HALL: Linda Hall. The question you just asked
25 about savings and do we have any data on tort reform falls

1 under my jurisdiction, and we are tasked with doing some type
2 of report on the effectiveness, based, at least, on premiums
3 from the tort reform efforts, and we've had a really difficult
4 time finding an economist who can work with us. We've not
5 really been able to provide what I would consider an adequate
6 report. Although we do a report periodically, it's not what I
7 would like it to be because we've not really ever found a good
8 source.

9 I can comment on med mal premiums in Alaska, and while they're
10 not the lowest in the country, I've seen a couple studies of
11 very specific practice areas, and we're in about the middle of
12 the country. They're certainly not as high as some of the
13 states where we've seen, you know, mass rebellion, I guess for
14 lack of a better term, but our premiums are kind of in the
15 middle ground.

16 CHAIR HURLBURT: We have two more, Noah and then Emily and
17 then we'll finish John because some of these have been
18 comments rather than questions, and if you could respond. So
19 Dr. Noah Laufer and then Emily Hughes? Emily, go ahead.

20 COMMISSIONER ENNIS: Thank you. Emily Ennis. I represent the
21 Alaska Mental Health Trust. In looking at your last slide,
22 you were talking about the health care utilization rates, and
23 I just have a question about the value units delivered that
24 you described that you were going to be taking a look at. It
25 seemed, to me, like that's a bit of softer data, and I'm just

1 is being delivered, aside from prices, you know just looking
2 at how much care is being delivered, you know ignoring the
3 price component.

4 COMMISSIONER ENNIS: All right. Thank you. I think that
5 perhaps can be related somewhat to the discussion of payment
6 levels versus cost services. We certainly know that, often,
7 there are discrepancies there, so thank you.

8 CHAIR HURLBURT: Maybe one -- Noah, did you have a follow on
9 comment? You don't. Okay. John, I guess we're at the end of
10 our time here. Do you have any final comments with us? We
11 very much appreciate your being with us today, and we'll look
12 forward to when you're up here meeting with us face-to-face,
13 but do have any closing comments, John?

14 MR. PICKERING: Yeah. I would just add that thank you for the
15 couple of people that volunteered information and sources
16 today. If, over the next month or so, you think of other
17 information that you would think would be valuable for us to
18 look at, please don't hesitate to pass that along to Ward or
19 Deb for them to pass over to us, and we look forward to
20 digging into this, and yeah, we have an onsite presentation
21 later in the year, so look forward to meeting you all.

22 CHAIR HURLBURT: Great. Thank you so much. And related to
23 John's invitation, as I've been with ASHNHA and ASTHMA and the
24 Physicians and Surgeons Association, obviously when we have an
25 RFP and we have a contract, we have certain confines we

1 operate in, but the invitation that John just extended, I have
2 extended to those who are saying we want to have a good
3 product. We want to have a credible product. We're not
4 looking for scapegoats. And if -- that you all, as
5 Commissioners, or those organizations or others have comments
6 or suggestions as we go along, we very much would welcome them
7 coming in. Yeah, Deb?

8 COMMISSIONER ERICKSON: Well, I just want to remind the group,
9 too, that we did form a subcommittee that hasn't been able to
10 meet yet, and Dave and Pat and Jeff and Noah and Ward are the
11 subcommittee for this particular project, and I will try again
12 -- I wanted to try to convene this group prior to the first
13 planning conversation that Ward and I had with the
14 consultants, which was just last week, actually, before we
15 finalized signing the contract, and we should meet, at least,
16 monthly, if we can, for an hour just to make sure that we're
17 keeping the subcommittee up-to-date on the status of the
18 project and have an avenue for you all to continue providing
19 some -- a little more frequent input and feedback on how the
20 study is progressing.

21 So I'll be following up with the five of you again over email,
22 trying to find a time that will work for everybody, but does
23 it sound reasonable to you? Do you think it's enough time or
24 too much time to meet once-a-month for an hour over the
25 telephone? We'll start with that. Very good.

1 Any other questions about the subcommittee? I think we're
2 maybe ready to move on.

3 COMMISSIONER FRIEDRICHS: This is Paul. Just to say well done
4 to Deb for pulling this off. I mean, to get a contract --
5 your bureaucracy may be much better than ours, but to get a
6 contract through and awarded that sort of, kind of answers
7 some of the questions that we originally thought we were
8 interested in, that's -- I mean, that's truly extraordinary,
9 so well done.

10 CHAIR HURLBURT: It is extraordinary. When I called Dick
11 Mansager, thinking about taking this job, Dick and I having a
12 common background in many ways, Dick said, it's even worse
13 than it is with the Feds. So it was wonderful what Deb was
14 able to pull off. She worked night and day on it, but it
15 worked really well. So thank you, Paul.

16 We're ready to go ahead and move over. Again thank you, John.
17 We're on to the next section. Paul Cartland is here, and Paul
18 is the Health Services in the Department of Health and Social
19 Services, leading up the efforts that we have on the Health
20 Information Exchange, and Deb has been talking with him.
21 We're going to hear about that and then we'll move on and
22 Deb's going to talk about Commission business with us. So
23 between now and noon, Deb, I'll just leave it to you and to
24 Paul.

25 COMMISSIONER ERICKSON: Sounds good. Paul, are you

1 comfortable with me operating your slides from up here? Does
2 that work okay for you?

3 MR. CARTLAND: That's fine.

4 COMMISSIONER ERICKSON: Because, if it doesn't, you can come
5 sit up here, too.....

6 MR. CARTLAND: That's okay.

7 COMMISSIONER ERICKSON:if that makes you more
8 comfortable. I was actually going to start for just a couple
9 of minutes before handing it over to Paul. Commissioners, you
10 have your -- these two presentations in your notebook behind
11 tab four, and these two particular presentations, I don't
12 think, are posted online yet, but they will be in the next few
13 days.

14 But just again to provide a little more context to provide a
15 little more context for what Paul is going to be talking about
16 and to update you on where we're at with some other things
17 related to Health Information Infrastructure, again this is
18 one of the three kind of foundational cornerstone pieces of
19 the health care delivery system and for health care reform
20 that we identified early on that we need to be mindful of.

21 It's the theme that runs through everything we're talking
22 about is the importance of data and the use of good data and
23 information for decision-making.

24 And this was just the series of graphics that we looked at, at
25 the last meeting, where we actually changed the identification

1 and the name for that cornerstone from Health Information
2 Technology that we thought was a little too specific to Health
3 Information Infrastructure, and since that time, I've had an
4 opportunity to work more with Paul but also have been invited
5 by him to participate in a couple of workgroups in the
6 Department that, because of meaningful use requirements,
7 groups from across the Department -- one of the things that's
8 real exciting to see related to this is starting to get past
9 some of the siloing, and folks from different parts of the
10 Agency, who maybe didn't even know each other existed before,
11 but were responsible for different sets of data across the
12 Department, are coming down and sitting down together and
13 talking about the use of data, driven by the federal
14 meaningful use requirements. But as a result of that, I feel
15 more comfortable. I know the Department probably has, I don't
16 know how many, Paul, databases, at least -- you want to.....

17 MR. CARTLAND: We're up past 50 and counting.

18 COMMISSIONER ERICKSON: I was thinking about 60. So we're
19 approaching 60 databases that the State Department of Health
20 and Social Services -- understanding this is just one
21 component of data, but an important component. But what I've
22 done is pulled from that 60 what I think are most significant
23 in terms of databases that hold data that is used for some
24 sort of decision-making related to public health or to health
25 care services, at least by the government. We touched on,

1 to participate in the database, and 40 other states, besides
2 ours, participate in the national hospital discharge database
3 that's the health care utilization program, HCUP for short.

4 Currently right now, or at least during 2010 and to-date, I
5 think it's possible that some of the smaller hospitals still
6 might be getting ready to submit of their 2010 data, but as of
7 the last report that I had, we had 11 hospitals in our state
8 reporting 2010 data; 16 had not. That includes API,
9 Northstar, and the long-term acute care hospital here in town.

10 So I just am talking about and identifying some of the
11 challenges related to that. Again, we'll be including that on
12 the agenda the next meeting.

13 I wanted to also give you a real quick update on -- excuse me.

14 For folks who are on the line, anybody who is listening over
15 teleconference, if you could please mute your phone, we'd
16 appreciate it. We're having technical difficulties again
17 today, if you -- trying teleconference through the sound system
18 doesn't allow us to go into lecture mode. So again anybody
19 online, if you could mute your phone, we'd appreciate it.

20 One more quick update before I turn things over to Paul is --
21 well, what we might do is just disconnect the teleconference,
22 if the noise doesn't stop. So for folks online, if you don't
23 mute your phone soon, we're going to have to sign off the
24 teleconference to keep from distracting the meeting. Thank
25 you.

1 I wanted to update you on the information system for community
2 access to public health data that you all had heard about at a
3 few of the previous meetings, a group of community leaders, at
4 one point, coming and saying that this is an important
5 priority for them, and we had learned from some Division of
6 Public Health staff that there is a model system out there
7 that they would, with some dedicated resources, be able to
8 develop.

9 Well, as a result of those conversations and the continued
10 good work of those staff and interest of the important
11 community leaders, the Division of Public Health has been able
12 to allocate some resources to begin implementation of that
13 system and are looking forward to rolling out the first phase.

14 It'll include behavioral risk factor surveillance data in
15 December, by December. So I wanted to update you on that. We
16 might hear a little bit more about it at our next meeting as
17 well, but thank you. And it's really because of the interest
18 and attention of this group that the -- Commissioner Streur
19 for Health and Social Services is paying attention to what's
20 happening with the hospital discharge database now, and we
21 have the attention of the leadership of the Division of Public
22 Health to the community information system, so we appreciate
23 that.

24 I'm going to turn the mic over to Mr. Cartland now, again our
25 Department of Health and Social Services Health Information

1 Technology leader, to just give you some updates about how
2 things are going in the world of electronic health records and
3 the Health Information Exchange.

4 MR. CARTLAND: Thanks, Deb, and if you would go ahead and go
5 to slide two, please?

6 This is the status of the Electronic Health Record incentives.

7 Once again, we estimated that there may be 2,500 eligible
8 providers. We have not had the uptake that we had hoped for.

9 We're continuing to look at that and trying to find out what
10 the barriers are, what the issues are. We have made 29
11 payments, for a total of \$616,250. We have no hospital
12 payments as of yet. We're anticipating that Ketchikan may be
13 the first, and we're hoping that happens in July. It's okay.

14 It's good to be first.

15 But you know, we're looking at, what are the things that are
16 the barriers? And one of the things that has been a barrier
17 is the 30% Medicaid patient volume for the providers. Where
18 that has been particularly a barrier is in the tribal
19 providers. Recently -- it was either last week or the week
20 before, CMS came out with a new ruling that allowed the tribal
21 clinics to be treated as FQHCs, regardless of whether they
22 were paid as an FQHC or not, which allows them to use
23 additional uncompensated care, needy, et cetera in calculating
24 that 30% in counter-volume. There are a couple of open issues
25 around that, and we're looking for CMS to provide us some

1 additional clarification, but we're anticipating that that
2 will allow a significant number of providers to qualify that
3 may not have qualified previously. Any questions on the EHR
4 incentive program?

5 COMMISSIONER ERICKSON: Paul, can I just mention something,
6 especially for Pat to be aware of? I had heard, not too long
7 ago, from a leader at one of our hospitals here in the state
8 who hadn't understood that, where health care professionals
9 had to choose between either the Medicaid or the Medicare EHR
10 incentive, qualifying hospitals were allowed to participate in
11 both programs and so that might be something --just your
12 comment reminded, Pat -- you might want to take back to your
13 ASHNHA board to make sure that all of the hospitals understand
14 that they have that opportunity that professionals don't.

15 MR. CARTLAND: Absolutely. Thanks, Deb. And another thing,
16 there's a lot of confusion and a lot of misinformation about
17 this program that is out on the Internet and everywhere else.

18 For the Medicaid program, the provider doesn't have to have
19 the Electronic Health Record installed and operating to get
20 the first year payment. There are a lot of people that, I
21 think, are waiting until they're up and running. That's not a
22 requirement in the first year. So you know, we're trying to
23 get that word out. The REC is trying to get that word out.

24 We're having workshops.....

25 COMMISSIONER ERICKSON: Tell folks what the REC is.

1 MR. CARTLAND: I'm sorry. Thank you. The Regional Extension
2 Center. The Regional Extension Center is under a separate
3 Cooperative Agreement with the Office of the National
4 Coordinator. They're tasked with assisting primarily the
5 small providers in applying for and becoming meaningful users
6 of Electronic Health Record technology. So they're out having
7 regular luncheon workshops. We've had onsite workshops in the
8 Juneau area, in the Anchorage area, in the Fairbanks area most
9 recently, just a couple Saturdays ago, trying to get that word
10 out that, you know, this is available, this is what you have
11 to do, and it's not as difficult as it might seem.

12 The next slide, please, Deb. The Health Information Exchange.

13 As I think I told you before, we were waiting on approval of
14 the State's Health Information Technology Plan. That was
15 formally approved by the Office of the National Coordinator on
16 the 9th of June. It was almost an 18-month process to get it
17 approved, but we're there, just in time to submit our update,
18 our annual update.

19 They came out for a visit two weeks ago to review our
20 progress. One of the things that they were impressed with was
21 the State's internal Health Information Technology governance
22 that Deb was referring to just a few minutes ago where we're
23 getting all of the players within the Department together to
24 talk about how we use data, who has what, and trying to break
25 down some of those silos, so that was a good thing.

1 The Health Information Exchange is up and running in a pilot
2 form. There are four pilot sites: Fairbanks Memorial
3 Hospital, Tanana Valley Clinic, Tanana Chiefs Conference, and
4 the Bristol Bay -- that one. Thank you.

5 What they're doing is they are sending live data to the Health
6 Information Exchange. We expect that to continue through June
7 and July and hope to stand up or begin on-boarding additional
8 facilities in August. Any questions on that?

9 COMMISSIONER LAUFER: Just a quick question, are these pilot
10 sites using the same EMR system or different ones?

11 MR. CARTLAND: No. They're not all using the same EMR.

12 COMMISSIONER FRIEDRICHS: This is Paul Friedrichs. Can you
13 clarify where we are, as far as what fees the State is going
14 to charge for the HIE? I know that there's been some
15 discussion about that. The funding piece for this has been
16 dynamic.

17 MR. CARTLAND: I'll speak to that a little bit. The State
18 isn't charging for participation. When we contracted with the
19 Alaska e-Health Network, we contracted with them to be the
20 board to procure and manage the Health Information Exchange.
21 So the governing board of the non-profit Alaska e-Health
22 Network is determining the fees. I'm trying to think -- Jeff,
23 you're on that board, right?

24 COMMISSIONER DAVIS: I think that's still being worked out,
25 Paul. I haven't seen anything definitive, but I think I've

1 missed the last meeting or two.

2 MR. CARTLAND: There is a sliding scale fee. There is a -- I
3 believe the fee for a provider has been set. I believe the
4 fee for a hospital has been set, but I'd have to get back to
5 you on what exactly they are.

6 COMMISSIONER FRIEDRICHS: And again, I think, going back to
7 your question about barriers to participation, it's certainly
8 been one of the points of interest as to what exactly is the
9 initial and the long-term cost to participate.

10 MR. CARTLAND: Absolutely. Next slide, please, Deb.
11 I want to talk just for a couple minutes about meaningful use.

12 As part of the Health Information Exchange Cooperative
13 Agreement and as part of the Electronic Health Record
14 incentives, there are some guidelines that the State has to
15 facilitate as part of the Cooperative Agreement and that
16 providers have to meet as part of the EHR incentive program,
17 and one of the key ones is around meaningful use.

18 What I've listed here is what the State has to ensure is in
19 place so that providers can begin to meet the meaningful use
20 requirements that they have to meet for Medicare right now,
21 for Medicaid in year two of their program. So we have to
22 provide, at least, one method for providers to do e-
23 prescribing, at least one method for providers to receive
24 structured lab results, and one method for electronically
25 exchanging clinical information.

1 Next slide, please. So what we're doing is we're standing up
2 around e-prescribing. We're standing up in e-prescribing
3 portal. We're starting that with Medicaid. It will,
4 ultimately, talk with the new MMIS, but we're standing it up
5 this summer. It's an e-prescribing solution called Cyber
6 Access. It's a standalone portal. Some of the things that
7 the providers will be able to see through that are patient
8 demographics, patient profiles, drug histories, claims
9 information, and some medical history information, and we'll
10 start rolling that out to the primary care community first,
11 and we're hoping that that happens in the next couple weeks.

12 Questions?

13 Around structured lab results, the Health Information Exchange
14 is going to support sharing of structured lab results. If
15 somebody is a member of the Health Information Exchange and is
16 already on-boarded, they'll be able to transfer that
17 information natively. If they are not already on-boarded --
18 in other words, their EHR isn't talking directly with the
19 Health Information Exchange -- we will still be able to allow
20 folks to share lab results or receive lab results, share
21 patient clinical information using what's called the National
22 Health Information Network Direct Protocol which is,
23 essentially, a secure email solution, and we expect that to be
24 in production in August of this year. Questions?

25 So talking about state meaningful use, one of the things that

1 Deb eluded to earlier was I've invited her to participate in a
2 number of workgroups. We have a Clinical Meaningful Use
3 Workgroup that is looking at how the State uses information,
4 what information we're collecting, trying to break down the
5 silos, as we mentioned earlier, defining what all do we have
6 because nobody had a singular list, and I think that's kind of
7 important. And then as we're discussing what information we
8 have and what information we're collecting, we're also talking
9 about, how do we, the State, leverage the Health Information
10 Exchange? What information do we want to collect via the
11 Health Information Exchange rather than having providers
12 report it individually, directly, so that we can lower the
13 workload on the providers so that there is less multiple
14 reporting?

15 But one of the key things that I'm beating on folks about is
16 we don't want to collect information just because we want to
17 collect information. What are going to do with it? How are
18 we, the State, going to be a meaningful user of this data?

19 What are we going to use it for?

20 Next slide, please. Yes, sir?

21 COMMISSIONER FRIEDRICHS: I'm sorry. Before you leave that
22 slide, just so I understand, would that include the portal
23 project that we had heard about previously that New Mexico and
24 other states have in which the State displays the data that it
25 has collected, so that those who have provided it can see what

1 is out there and others who are working on the same project
2 can use that data?

3 MR. CARTLAND: That's absolutely within the scope of what
4 these workgroups are going to be discussing. We want to know,
5 you know, what do we have, what are collecting, what are doing
6 with it, and then we'll look at, how do we make that available
7 back to the folks that provided that information in a
8 meaningful way?

9 COMMISSIONER FRIEDRICHS: Thank you.

10 MR. CARTLAND: Next slide, please. One of the focuses of your
11 group is patient-driven health care. One of the things that
12 we are implementing through the Health Information Exchange is
13 the availability of a personal health record. The intent,
14 right now, is to make that available using the MyAlaska -- the
15 same user name/password protocol that you use to go file for
16 your PFD or renew your driver's license or get a business
17 license, use that same framework, that same authentication
18 framework and pass that through to the Health Information
19 Exchange, so that people could have access to whatever
20 information exists about them within the Health Information
21 Exchange in the form of a personal health record. We're still
22 working through the details of how we make that work, but that
23 is our intent and we're hoping to make that available towards
24 the end of the year. Questions? Yes, sir?

25 COMMISSIONER CAMPBELL: Under the MyAlaska server, have you

1 had any problems with confidentiality over the years that you
2 know of, like the Permanent Fund Dividend and things of that
3 nature, being hacked?

4 MR. CARTLAND: I'm not aware of any problems that have
5 occurred using MyAlaska. One of the things that we're doing,
6 however, is we're reviewing the whole privacy and security
7 protocol, and MyAlaska will have to comply with HIPAA and
8 everything else or access to the personal health record,
9 however we do it, will have to meet those same stringent
10 requirements, as well as the requirements of the high tech
11 act, et cetera.

12 COMMISSIONER BRANCO: Any thoughts -- since this is the
13 patient-driven category, any thoughts on allowing some limited
14 editing capability, like my current medication list, what I'm
15 really taking versus what the doctor thinks I'm taking?

16 MR. CARTLAND: Those are some discussions that have to occur
17 yet, but.....

18 COMMISSIONER FRIEDRICH: (Indiscernible - away from mic) drop
19 down menus (indiscernible - away from mic).

20 MR. CARTLAND: That's certainly on our radar, but that's --
21 but we have to make it available first.

22 COMMISSIONER BRANCO: But again, that's part of the concept of
23 patient-driven interaction with the Electronic Medical Record
24 and the Exchange?

25 MR. CARTLAND: Absolutely.

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COMMISSIONER BRANCO: Good deal.

MR. CARTLAND: Understood. Last slide, please.

One of the things that came out of the Cooperative Agreement visit two weeks ago is that, within the next 30 days, I have to provide our breakthrough goals, and they've defined those as "bold, audacious statements of achievement around which your state and its leaders can strive beyond the state Health Information Exchange Cooperative Agreement program." And I have to outline those goals related to health improvement in 2011 and indicate how we will measure progress in six months, one year, and five years, and obviously, I would love your input.

COMMISSIONER LAUFER: This is Noah Laufer again, Primary Care. If you're looking for wins, which I would imagine you are, I would do a bit with the electronic prescribing because we're already doing it. Patients are amazed. They go, it's there already? And it's sort of low-hanging fruit that you could win on, and the flip side of that is getting the pharmacies to cooperate. You know, the script gets there, but they don't fill it. They're not going to take a medication, put a name on it, and take it out of their inventory until they see the whites of their eyes, and they want the patient to shop in their store, waiting. But it's miraculous. It's actually the part of the EMR that I enjoy a lot, and I suspect it's reducing errors. So go for that one. Some of the other stuff

1 I wouldn't hang my career on.

2 MR. CARTLAND: We are, at the last time I saw, somewhere near
3 the bottom in utilization of e-prescribing nationally. So
4 you're right. That is low-hanging fruit.

5 COMMISSIONER LAUFER: I would wonder just how up-to-date that
6 is because it's only in the last few months that a lot of the
7 pharmacies have had the capability to receive an e-prescribing
8 script, but it really is cool. It's being used as a business
9 generator by pharmacies as well because we'll get requests and
10 then we call the patient. They say, what are you talking
11 about? I'm not even taking that anymore. So I'll be quiet.

12 MR. CARTLAND: My only concern with that is they're talking
13 about breakthrough goals, and I don't know that they're going
14 to -- they're looking for us thinking out of the box. And so
15 if you've got some ideas, some thoughts, I'd love to hear
16 them.

17 COMMISSIONER LAUFER: I said I'd be quiet, but another thing
18 that would really be helpful would be to have resources for,
19 you know, credible sources of information for people, so the
20 websites for various societies for, you know, I don't know,
21 (indiscernible - voice lowered) Disease Society, or you know,
22 whatever because people really want that, and when they go on
23 the Internet, they end up, you know, often in a page that ends
24 with, you know, just for \$80 a month, you can have this
25 miraculous acai berry vitamin combination cure and that's

1 disheartening. So you know, sort of screened, reliable
2 sources would be great and cheap.

3 CHAIR HURLBURT: Noah, I want to give you another chance to
4 talk, too, because Paul has asked me a question that kind of
5 puts him in between a rock and a hard place. The numbers are
6 very low on people who have signed up for that, and Paul is
7 trying really hard to get more people to sign up. So one of
8 the questions is, what is meaningful use and what's going to
9 be required? Paul has asked because we've advocated that
10 immunization data be put on there.

11 The reality is that we're doing awful in the state in terms of
12 immunization, and if we get immunization data in there, we
13 have that immunization, in some communities, public health
14 nurses can then work with the local docs about getting
15 immunizations up. In terms of the tribal health program, we
16 do very well, about 90%. The rest of the state is awful. How
17 much of a hurdle for you, as a family medicine doc, is it to
18 make you decide not to sign up, if you have to have
19 immunization data in there, or is that not really a
20 significant factor?

21 COMMISSIONER LAUFER: I think, for us, immunization data is a
22 good requirement. That's fine. It's really more of a
23 logistical issue because, remember, the people we see don't
24 see us exclusively and so my data is often poor, and if I put
25 it in there, I'm an under-performer, but then, you know, a

1 mom, somewhere in the filing cabinet at home, has an
2 immunization card from a pediatrician and they actually are
3 up-to-date, but I like the idea of that kind of data because
4 it's, you know, a zero or a one computer-friendly data. You
5 got it or you didn't get it and that's fine.

6 The more onerous things, for us, are, like, the idea of a
7 completed patient summary of the visit for a Medicare patient
8 who I see for 16 different things that must be available
9 within 24 or 48 hours or whatever. I'm never going to be able
10 to do that, and the data I get from people who do try to do
11 that, like from emergency rooms, is absolutely worthless
12 because it's an algorithm-generated, you know, you have
13 bronchitis and this drug interacts with whatever. It has no
14 value to me.

15 Generating wish lists of things that you'd like -- you know,
16 gee, the doc should do this -- remember, that's another five
17 minutes or two minutes or ten minutes for me or having to hire
18 extra staff, and it's more reason for me to want to duck out
19 of the (indiscernible - voice lowered) system, you know,
20 abandon my Medicare patients, and get away from it. So it has
21 to be black and white, useful stuff, clinically relevant, and
22 data that can actually be of value.

23 I have a nurse who asks everybody if they wear their seatbelt,
24 and she has an accent. She's from India. And people get
25 really offended. What the hell? Why does she care if I wear

1 a seatbelt? Well, that's one of the requirements.

2 COMMISSIONER BRANCO: Really quickly, to jump on there, and it
3 may be cutting edge -- I doubt it, but it may be one that we
4 could hang our hats on and that is the fact that almost every
5 patient in the state and probably in the country goes to
6 multiple physicians, dentists, and one of the most important
7 pieces of information you can have is, what are they seeing
8 the others for. So a shared problem, even a problem list and
9 a shared medication list, I think, would be invaluable and
10 fairly easy to do, if you have a common platform.

11 MR. CARTLAND: And those things are certainly part of what the
12 Health Information Exchange is going to be doing for us. If
13 you don't mind, Doc, I'd like to kind of play off of your
14 question.

15 There are four public health options or public health-related
16 options that the State can request CMS's permission to make
17 mandatory versus menu set in the meaningful use.

18 One of those is participation in the immunization registry,
19 and we think that's valuable. What we're concerned about is
20 how many people might choose not to participate, if we were to
21 add that as a mandatory piece, so as you're thinking about
22 that.

23 COMMISSIONER FRIEDRICHS: I'm curious, when you talk about the
24 very low utilization of e-prescribing, when we look at the
25 different systems that do use that, are you talking about non-

1 integrated health care system clinicians who have very low
2 utilization? I mean, we have 20% of Anchorage enrolled to our
3 system, and 100% of those patients use an e-prescribing
4 system. So could you clarify what you meant by that?

5 MR. CARTLAND: The data that we used is the national data from
6 Surescripts, which I'd have to go back and look, but I think
7 we were somewhere down around 49th or 50th in what they
8 claimed as e-prescribing utilization.

9 COMMISSIONER FRIEDRICH: And so I just offer that that -- you
10 know, if I recall correctly, that is for independent practices
11 that are using a commercial e-prescribing system. That does
12 not capture the situation here in Alaska with the Tribal
13 Health Consortium, with the VA, with the DOD, in which
14 virtually all of our prescriptions are done. And so it's not
15 as dire as that data would suggest, and there may be a good
16 news story, if it comes to defining how to access the Health
17 Information Exchange. And again, I'll share with everyone
18 that we are in the middle of a very -- not heated, but
19 interesting discussion with our pursestring keepers in D.C.
20 over whether or not to participate.

21 Part of the challenge is understanding what we're signing up
22 for right now with the Alaska e-Health Network because there's
23 a real reluctance in a fiscally-constrained environment to do
24 something that we agree would be beneficial, if you're not
25 really sure what you're signing up for and what it's going to

1 cost the taxpayer or (indiscernible - voice lowered), or what
2 exactly we're going to get for it, and I'm sure that, and I'm
3 sure that would (indiscernible - voice lowered). As large
4 integrated health care systems, there is a limit to how far
5 out on the limb we can go before we saw it off behind
6 ourselves, and this is an area that we would like to
7 participate in and partner with you on, once we understand
8 what exactly we're going to be signing up for.

9 To go back to your audacious goals, a question. I think an
10 easy one with the technology that exists today, and one that
11 we've heard of repeatedly from different presenters here, is
12 the ability to display the data that we already possess here
13 in Alaska, and I want to offer that -- you know, audacious
14 from the standpoint that we would join the three other states
15 that do it well right now. That's fairly audacious, to be
16 among the top five states to get out in front of taking the
17 information which the State possesses and sharing it with
18 those who have provided it, but more importantly, sharing it
19 with the patients, so that they can see what information is
20 available. That's a fairly audacious goal. The technology
21 exists. The cost, as we've been briefed previously, is
22 relatively low. I think we identified that as one of our
23 potential recommendations, based on the presentation that we
24 had two meetings ago. So I would offer that to you as one
25 audacious goal that would be very exciting on many levels.

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Thank you.

MR. CARTLAND: Thank you.

COMMISSIONER LAUFER: This is Noah Laufer again. I'm just thinking this might be a plea, but if you think of the evolution of medical records, as recently as probably 40 years ago, the medical record was a note card and a filing cabinet that said pneumonia, May 3rd. That was it, and it has evolved into the soap note and the various different evolutions of it, but if you want it to be valuable in the long run and used, it needs to remain a tool of the physician, and it's a tool that enables us to provide better care over the long-term.

The problem with the notes that I produce now is it's a requirement of so many aspects of the review of the systems and elements of the physical exam and the appropriate code, it no longer belongs to me. It's a medical, legal, and billing document and that's why it's deteriorating and becoming useless to us, and that's part of the appeal of ducking under this whole system. So if you make sure, whatever you do with it, that is a tool for better caring for people, then I think you'll succeed.

COMMISSIONER FRIEDRICHS: If I may though, is this a tool that should belong to the physician, or in a patient-centered medical home model, is this a tool ultimately that should belong to the patient, in which the physicians and others contribute?

1 COMMISSIONER LAUFER: In my fantasy world, it's actually a
2 document that's created by both myself and the patient and it
3 acts as a long-term health diary for them, and it would
4 include things, like you know, here is a graph of your weight.
5 Remember when you were 18? You know, gee, here's where you
6 got divorced and you saw me six times, and you know, your
7 sugar got out of control, and here's when you got healthier
8 again. I like that idea, but I'm probably of a newer
9 generation in that I really actively want to recruit the
10 participation of the patient in modifying the narrative of
11 their life, and I don't mind them, you know, contesting or
12 adding to the chart note or whatever. But you know, there are
13 a lot of things people don't want in their note, particularly
14 when, say, the State is using it to measure whatever.
15 Yesterday, I saw someone and I was worried about her cardiac
16 risk, and I said, you know, well, have you ever used cocaine,
17 and she looks at me, you know, untrustingly, and she says,
18 well you know, I moved to Alaska in 1972, and I was a single
19 woman. I was, like, so yes? I don't want that in my chart.
20 Well, is that why you don't have a nasal septum? You know,
21 these are things that people don't want publicly known. They
22 don't want you combing the data. They definitely don't want
23 the insurance company to know, but it's relevant to her
24 health. And so again, it's a private document that belongs to
25 the doctor, and I think, the patient, but I don't think I'm in

1 the majority on that.

2 COMMISSIONER DAVIS: So this could be a big idea that's going
3 to be a bad idea, so I'll need the physicians to weigh in on
4 this, but I'll just throw it out here.

5 So we've heard before that one of the barriers to more
6 effective care, providing more effective care is the fact
7 that, when you write a prescription, you know, half the time,
8 it's never filled, and you don't know that. So if we had e-
9 prescribing and the pharmacies reporting, somehow, what is
10 purchased and that got matched up, and if it wasn't picked up
11 in a week and you got a note, that maybe could be a tool that
12 would help you provide better care or get your patient
13 involved in having better outcomes and give you tools that
14 would drive participation in something that, potentially, is
15 important. So tell me if that's a bad idea.

16 COMMISSIONER LAUFER: Of course, it depends on your
17 perspective, but I like that. And fairly frequently -- I saw
18 someone the other day. He was still coughing. I said, did
19 you take the antibiotic? No. Well, you know, it's expensive,
20 and you told me I wasn't dying. So it was, like, well, you're
21 back and you would probably be better, if you had done this.
22 Centricity, which we use and I'm not actually a fan of, has a
23 function for that, and you can check the use, and I use it for
24 narcotics, and I have already uncovered people I was
25 suspicious of who are using multiple providers, filling too

1 many narcotics, and I've addressed it up front or dismissed
2 them. And the outliers are recipients of Medicaid and
3 Medicare and the cash payer, but the data is already there for
4 the insurers, and I think it's going to make for savvier
5 narcotic abusers, but you know, they didn't anticipate that I
6 could just press a search mode and say well, gosh, you know,
7 why did you see three doctors that week and you got scripts
8 from all of us, you know? And that's very nice, for me, not
9 for people making a living reselling pain medications.
10 So it's there. There's incredible promise with this, but
11 you've got to remember, what's the goal?

12 COMMISSIONER FRIEDRICHS: Yeah. Jeff, we have that
13 capability. Our system matches up not only every prescription
14 filled anywhere in DOD, but any prescription that we pay for,
15 that DOD pays for, and so I can see all of that, and exactly
16 as Noah said, that's where the ethical discussion comes in
17 because the patient does not necessarily want us to know what
18 they -- again we're talking about the outliers, the ones who
19 are trying to do something that they probably shouldn't be
20 doing.

21 Where it is still a struggle because of sheer volume of non-
22 compliance is to go back through in a large system, like ours,
23 with, you know, 60,000 patients enrolled between the DOD and
24 the VA here to see the number of prescriptions that are not
25 filled and to go back. If you can get it all the way down to

1 the individual provider level, it's still an enormous number
2 and so what do you with that data then when you get it, other
3 than to acknowledge at the next visit that, gee, Mr.
4 Friedrichs, you know, as Noah said, why didn't you take those
5 antibiotics that I prescribed for you? But the data can be
6 obtained. What we've struggled with is what do you with it
7 because there is just so much of it.

8 COMMISSIONER STINSON: Actually, I think Noah and Paul hit
9 most of the points. In pain management, it's absolutely
10 essential. Other states, Washington State, Florida, and
11 there's other states who already put in measures to monitor
12 exactly what you're talking about. I think Alaska should be
13 part of that, and that's actually kind of an ongoing
14 conversation for a possible change in the way Alaska does
15 things that I've been having outside of this Commission with
16 other people.

17 CHAIR HURLBURT: Go ahead, Deb.

18 COMMISSIONER ERICKSON: Thank you very much, Paul.

19 MR. CARTLAND: Thank you.

20 COMMISSIONER ERICKSON: Well, we are about a half-an-hour
21 behind time, but I think we could make it up in one minute.
22 What I will do is just refer you to tab five, and you should
23 have added one more piece of paper from the packet you got
24 this morning back there, our voting log, but you have a draft
25 Public Communication and Engagement Plan that was actually

1 drafted in May of 2009 with the first Commission right before
2 I had to leave the Commission to go work with Public Health
3 for six months. But this actually incorporates the changes
4 that the first Commission had wanted, and we're, I think,
5 doing some good things. We'll be continuing to develop the
6 use of the website. We have close to 500 people on our
7 ListServ now, and every time I log into the system, there are
8 two or three more addresses in there. So folks are starting
9 to get wind of our work and tracking a little more closely
10 what we're doing.

11 And then our Financial Status Report⁵ is in here. I just
12 would note one of the things that's going to -- we're going to
13 underspend our budget this year for a couple reasons, and I
14 would note, too, that I have 25 years with the State. I've
15 worked for democrats and I've worked for republicans, and it
16 was always a sin to underspend your budget if you worked for a
17 democrat and a sin to come close to spending all of it if you
18 were working for a republican, but I still flinch at
19 underspending a budget.

20 This is primarily the Milliman contract, which is a
21 significant chunk of change because the amount of time it took
22 to get it in place is going to be charged to our next state
23 fiscal year. We had hoped to spend it all this year, and we
24 really didn't get started until close to halfway through the
25 fiscal year and got Rich's position onboard. I'm confident we

1 will have no trouble in spending all our money next year, and
2 since we didn't have money up until now the Department has
3 been eating our cost and actually overspent the program's
4 budget because of us, and they've made it clear that they're
5 going to appreciate having some of this money to make up some
6 of their shortfalls this year.

7 But if you have any questions about our budget or our spending
8 for this year, any suggestions about the Communication Plan,
9 quickly right now and then we'll break for lunch, and then if
10 you have something more, we can follow up later. Linda?

11 COMMISSIONER HALL: I was just going to ask, can't you
12 encumber some of those funds in this fiscal year?

13 COMMISSIONER ERICKSON: That's one of the things I'm arguing
14 with the fiscal staff over. Paul?

15 COMMISSIONER FRIEDRICHS: Thank you. Linda, going back to
16 your question which I'm still grappling with in my mind after
17 Mark's discussion there, is it that you have not been able to
18 find someone to do the study on the impact of tort reform here
19 in Alaska, someone with the subject matter expertise to do it,
20 or is that another area in which the Health Care Commission
21 could assist in the next year or so?

22 COMMISSIONER HALL: It is sometimes finding a person with the
23 appropriate background and expertise, but actually finding how
24 we measure impact of tort reform, and realistically, the only
25 one we've tried. I mean, we've tried to find others, but

1 we've done it based on a general liability premium, med mal
2 premium, those types of things because we don't have any other
3 real objective concrete measurements. So it's kind of a
4 double thing.

5 COMMISSIONER FRIEDRICHS: And I guess, going back to our
6 charge and to what we've heard over the last year or so here
7 in the Commission, Mark's presentations highlighted the value
8 of looking at that. He appears to have demonstrated the
9 ability to look at many components of health care expenditure
10 and dig into that. And so I would offer, maybe as an open
11 item as we're looking at where best to spend the dollars that
12 we have, would that be something that we, as a Commission,
13 should look at, if it's one of the two areas identified by
14 others as most ripe for cost-savings and we have someone here
15 in Alaska who appears to have an ability to do that? I'd
16 throw it out there for discussion.

17 COMMISSIONER ERICKSON: Larry?

18 COMMISSIONER STINSON: I agree with Paul, and there must be a
19 good way to do it because Texas passed a much more
20 comprehensive tort reform bill, and they have put out lots of
21 data, very positive data about the impact on their health care
22 costs with that. So whatever tool, mechanism, group that they
23 use to analyze that, that might be a place to start.

24 COMMISSIONER LAUFER: There are not a lot of providers of
25 medical malpractice insurance in Alaska. They know what the

1 claims data is, and that's gone down. We got rebate checks
2 this year and last year because we're doing well. Changing
3 the practice of physicians is a much bigger thing and that is
4 cultural, and it's going to take many, many decades. That's -
5 - you know, it's not like I can say, oh wow, there's tort
6 reform; I can wing it now. You know, it doesn't work that
7 way. Everything I do I feel, you know, in my heart -- and I
8 think all doctors do -- that I'm doing the right thing and
9 that's ingrained from, you know, early childhood. That's not
10 going to change even in ten years. It's going to take -- you
11 know, we have doctors trained all over the country here in
12 Alaska, and they bring with them their biases and training and
13 culture, and you know, whether it's tinnitus or tinnitus or
14 whatever and that's not going to change rapidly, but tort
15 reform is hugely important. It's just -- I would go after the
16 data. What's the claims data, how's it changed, and is it
17 preventing people from practicing?

18 COMMISSIONER ERICKSON: Pat and then Keith?

19 COMMISSIONER BRANCO: Really quick, the almost immediate
20 impact we recognized right away was in physician recruitment.
21 It really, really helped to recruit physicians to this state
22 (indiscernible - simultaneous speaking).

23 COMMISSIONER LAUFER: How about we ask the personal injury
24 lawyers whether it's a fertile place to practice or note and
25 look at -- you know, that's the real measure of it.

1 UNIDENTIFIED MALE COMMISSIONER: Television ads.....

2 COMMISSIONER LAUFER: Yes.

3 UNIDENTIFIED MALE COMMISSIONER: (Indiscernible - away from
4 mic)

5 COMMISSIONER ERICKSON: Keith?

6 COMMISSIONER CAMPBELL: Well from my years on the MICA board,
7 which is the State (indiscernible - voice lowered) Medical
8 Malpractice Board (indiscernible - voice lowered), and we, as
9 a board, made up our minds that we would pay a legitimate
10 claim very quickly for a truly injured patient, but the
11 lawyers who persisted in coming after -- you know, chasing
12 those ambulances who spend every dime of your premium dollar -
13 - and it took about three or four years before that curve went
14 way down, and I think -- I don't know what doctors and the --
15 or the Norcal is doing now, but that had an impact. But it's
16 intuitive that tort reform works. Now we just have to prove
17 it.

18 COMMISSIONER ERICKSON: Paul?

19 COMMISSIONER FRIEDRICHS: And again, if I may, you know, part
20 of the discussion, and Pat nailed it, our interest in this
21 across the federal system is exactly what you described in
22 your recruiting piece. We know we will never provide all the
23 care we need here in Alaska. If there is no improvement in
24 the ability to recruit physicians and other health care
25 providers to Alaska, we know there will continue to be

1 shortages, which will get worse. I mean, that's just a
2 statement of fact. It's not an opinion. And so if what
3 you're describing helps, that factors into many areas that
4 we've looked at as a Commission from workforce areas to access
5 to care and so on and so forth.

6 The other piece of this though goes back again to, if we're
7 spending \$1.5 billion in Alaska on Medicaid right now and we
8 know that X percent of that is attributed to defensive, then
9 you begin the physician education, the clinician education to
10 say, I'm sure you're excited that your premiums are low. Now
11 here is what that means to you. This is where you begin the
12 cultural change that you're talking about, and proactively
13 show them exactly what practicing in Alaska is like. I mean,
14 you know, there's a multiple -- there are multiple attributes
15 to this discussion that would open up opportunities to rethink
16 how health care is being provided, as you said, in a
17 partnership with the physicians and also with the patients.

18 For the patients who come in and demand certain things and
19 then threaten a lawsuit, well, so here's how that works in
20 this state. You know, Larry and I just had a discussion about
21 a shared patient, and it's very nice that both of us are in
22 agreement to say no because we know that, in this state and in
23 our respective systems, we're actually able to do the right
24 thing, no matter how much a patient may threaten us, and they
25 may still take us to court and we may still pay some money to

1 a lawyer, but it's a very different environment than if my
2 hospital was in some other state.

3 COMMISSIONER ERICKSON: My suggestion would be maybe I could
4 follow up with Linda, but also touch base with ASTHMA and with
5 ASHNHA because I know they've been paying attention to this
6 and probably would have some ideas about how we might go
7 forward with doing some sort of more formal study to analyze
8 this, and we'll see -- and APS as well, Alaska Physicians and
9 Surgeons. Is that good? Good. Thumbs up.

10 We now have just 20 minutes for lunch, but boxed lunches are
11 in the back of the room. We will be reconvening. It's about
12 ten after 12. We'll be reconvening at 12:30 for our public
13 hearing, and for everybody in the room who is not on the
14 Commission, please join us for lunch, but if you would allow
15 the Commissioners to pick up their lunch first so they could
16 get started and get back to the table, I'd appreciate it.

17 Thank you.

18 12:08:25

19 (Off record)

20 (On record)

21 12:53:38

22 CHAIR HURLBURT: Let's come back together. There are a lot of
23 comments, but we'll take the time that we need. We'll take
24 the comments first from anybody that's here in the room in the
25 audience and then open it up to folks who are on the

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telephone.

I understand Donna Stephens signed up here, so if you could come forward, please? And then maybe if you could identify yourself and who you are representing, if anybody, and then we'd be pleased what you have to say, Donna.

MS. STEVENS: I'm Donna Stephens. I'm the Executive Director at Hospice of Anchorage. I've lived in Alaska for 40 years. Eight of them were in Fairbanks, and the rest of them have been here in Anchorage. I've been involved with Hospice of Anchorage as a volunteer for about close to 30 years and started volunteering as Executive Director and eventually was hired, because I wanted to be hired and stop volunteering.

After two years of volunteering, that was enough. Hospice of Anchorage has been here 30 years, and we are your volunteer hospice. That means, mostly, that we don't charge for services. We have paid staff. I'm paid. My registered nurses, licensed clinical social workers are paid, but we do not charge for services. We are not a Medicare-certified hospice.

What I wanted to talk about was just the importance of end-of-life care, and I understand that you had a good slide about how expensive that is today. I wanted to hope that this would be an area that would get some special attention from the Commission.

Medical advances in the last 30 years have just been dramatic.

1 We now can care for people with chronic illness in advanced
2 age in ways that we could not and so now it's very hard to
3 tell if people are living with their disease or their advanced
4 age or dying from. And people are often unwilling to have --
5 don't know how to have the conversation about where is that
6 line with living with and dying from, and we often do -- much
7 more is done to people or done for people than anybody really
8 wants, but people want to do what's right and they don't know
9 how to have the conversation.

10 So what I'm advocating for is helping people to have the
11 conversation, and it needs to be something that we're all
12 comfortable with. It's not just physicians that are doing
13 this. It's families. It's cultural. It's all of us
14 together.

15 There is a program coming up in August that will be on KAKM,
16 "Consider the Conversation," and I'll send Deborah the dates
17 so that she can send it to all of you. I think one of the
18 nights is going to be a Saturday, so hopefully, you'll have a
19 TIVO or a recorder to record that program and watch it.

20 So that's basically what I wanted to share with you, that I
21 think this is an important part of looking at our health care
22 as a whole. If there are any questions, I'd be glad to.....

23 CHAIR HURLBURT: Any questions?

24 MS. STEPHENS: Thank you very much for your time and for your
25 hard work trying to figure this out.

1 CHAIR HURLBURT: There was a recent kind of online poll that,
2 I think it was, *Health Leaders* magazine published, and they're
3 not quite done, but it's kind of like a tennis finals match-up
4 as to what has been major changes, and one of the later
5 contenders on what has made a big difference has been the
6 hospice movement in the country. There have been so many
7 wonderful things about it. So thank you for what you're doing
8 with that, and thank you for your passion about that because
9 it has been a wonderful thing.

10 MS. STEPHENS: It's a privilege. I am honored -- we are
11 honored to do the work. Thank you.

12 CHAIR HURLBURT: Thank you. Is there anybody else in the
13 room, in the audience here, with any public comments? Let's
14 open it up to online. Are we on the mode on the phone where
15 we can hear anybody? Is there anybody online who has any
16 comments to make, if you could identify yourself?

17 (Pause)

18 CHAIR HURLBURT: It sounds like we don't have any. Again, I
19 appreciate everybody that is online that has called in and for
20 the interest that you have.

21 We have moved from being a little behind to now being a little
22 ahead, it looks like, which will help because we have a busy
23 agenda. Julie, are we ready to maybe go ahead and start?
24 The next item on the agenda that we have is behind tab six in
25 your book there, and this will be the talk about Alaska Trauma

1 System Issues and Improvement Initiative. We have four
2 panelists: Dr. Regina Chenault, who is the Alaska Trauma
3 System Review Committee and currently practices at Regional
4 Hospital; Dr. Frank Sacco, Alaska Trauma System Review
5 Committee, a surgeon at Alaska Native Medical Center; Dan
6 Johnson, the Director of the Interior Region EMS Council, who
7 will be talking particularly about some of the pre-hospital
8 aspects; and Julie Rabeau, the Alaska Trauma Program Manager
9 for the Division of Public Health in the Department of Health
10 and Social Services.

11 Our plan had been that each of the presenters would have about
12 15 minutes to present and then we wanted to have a half-hour
13 available for discussion. Since we are ahead a little bit, we
14 probably don't have to be -- I'm sorry?

15 COMMISSIONER ERICKSON: One of the things I was going to
16 mention that I didn't get a chance to tell you about it is
17 that Dr. Chenault got stuck in Seattle and is probably on an
18 airplane right now. So Dr. Sacco is going to do the whole
19 presentation for the Trauma Center side.

20 CHAIR HURLBURT: So that sounds good. Thank you. I wasn't
21 aware of that. What we'll do is probably, Frank, if you're
22 going to do the whole thing, maybe figure about a half-hour or
23 up to a half-hour for you. And then what I want to just
24 comment, we have Rich Wooten, who is our kind of gatekeeper
25 here, and we actually should be pretty good on time, but as

1 you get five, three, two minutes, he'll give you a flash card
2 there, but I think we should be fine on the time. We set that
3 up because we have a busy agenda, but we should be good on
4 this.

5 COMMISSIONER ERICKSON: I just wanted to point, for the
6 Commission members, that you have -- and I want to point it
7 out because you have so much paper already, but you just
8 received three additional handouts. One is from ASHNHA, a
9 report on the status and interest in trauma center designation
10 on the part of Alaska's hospitals. And then there are two
11 spreadsheets that look very, very similar, but one is 2009
12 status and the other one is 2005 to 2009, Collector
13 statistics. So I just wanted to point out that you just
14 received, while you were on lunch, those extra handouts on
15 your notebooks. Yes, Val?

16 COMMISSIONER DAVIDSON: Could we ask whomever is having that
17 Windows sound to just mute their phone or is that us?

18 COMMISSIONER ERICKSON: Yeah, we've talked to the conference
19 operator before to try to see if there was something we can
20 do, and it's the teleconference system. So we just have to --
21 the clunk is people going off, and the ding is people coming
22 on, and there's nothing we can do about it. Pretend like it's
23 your kids sitting in the back of the room playing their video
24 games and tune it out.

25 DR. SACCO: We're all set. Can people hear me now? Great.

1 have to remember about trauma and serious injury is that, for
2 every one person that dies, three people are left with
3 permanent disabilities, and one of the reasons I got
4 interested in this is almost every family that I have met, if
5 you talk to them long enough, no matter what you're seeing
6 them for, they have been touched. They either have had an
7 injury or have had a family member, and those, a lot of times,
8 have ended up with changes with people being able to work.
9 It's been a tremendous emotional toll on families, but we live
10 with it everyday up here in Alaska.

11 This is just another way of looking at it. This is leading
12 causes of deaths of everything, disease, heart disease,
13 cancer. You can see the leading cause in blue is
14 unintentional injury. If we add in suicide and homicide,
15 which are often traumatic, you'll see that it goes up even
16 higher and that, really, we think of all of the attention we
17 pay to heart disease and cancer and think of it of what we
18 talk about when we talk about injury here.

19 Another way. The bottom line, trauma, the adjusted mortality
20 rate in the U.S. The pink line is Alaska, going back over 30
21 years, and the yellow line is Alaska Natives. We are
22 substantially higher than the rest of the country, so it's a
23 big burden. Like the rest of the country, motor vehicle
24 crashes is the leading cause of death. Firearms come in
25 second.

1 Hospital costs. Alaska trauma patients in 2009 from the
2 trauma registry cost over \$121 million and that's a
3 conservative estimate. That doesn't include physicians' fees.
4 Medicaid and Workman's Comp was over \$26 million and 900
5 hospital admissions. If we look at all of the hospital
6 admissions for trauma, about a fifth of them were
7 uncompensated.

8 So this slide is something to keep, when we're looking at the
9 problem of trauma as a disease. When we look at how people
10 die from trauma, about half of them die immediately. So when
11 the plane hits the ground, it doesn't matter how good the
12 medical care is. The only way we're going to have an impact
13 on that is injury prevention. Fifty percent of the folks are
14 potentially salvageable, and we are going to take care of
15 those folks. We're not going to have a choice whether we take
16 care of them or not; we are going to take care of them.

17 When we talk about trauma systems, what we're talking about is
18 the system is hospitals, personnel, public service agencies
19 that have a preplanned response to caring for the injured
20 patient.

21 So we're based on the military model, which you've all seen
22 and you hear about. It's getting the right patient to the
23 right place in the right amount of time and that doesn't
24 always mean to the closest place, but we've thought out ahead
25 of time of, something happens to somebody, we know the best

1 way to get them there, and each step of the way they'll get
2 optimum care. So we have to combine facilities. We have to
3 make sure that personnel are trained, that we have good ways
4 to move patients, and that we've also thought about where
5 patients actually go, how we triage them from place-to-place.
6 Why do we do that? Well, there have been a number of studies.

7 The seminal study was the *New England Journal Review* that
8 looked at the number of different studies. There is a 15% to
9 20% improvement in the survival of seriously injured patients
10 when there is a trauma system in place and that means a
11 substantial increase in productive working years.

12 And another statistic, again, is that, if you look at
13 productive working years, there are more productive working
14 years lost from trauma than cancer and heart disease combined,
15 just because trauma effects a lot of younger folks.

16 Inclusive systems, where everybody is involved, from the
17 prehospital folks to the stabilization facilities to the
18 definitive care, work the best, every link. The right thing
19 has to be done at each step in order to get the optimal
20 results.

21 The other thing that's been noted is that a lot of the issues
22 we talk about in developing a trauma system are the same
23 things that we look for when we are trying to have a statewide
24 disaster response, and I'll talk a little bit more about that.

25 Trauma systems. Facilities. I think many people have heard

1 about the different levels. Just to review it very quickly,
2 Level I centers are the most definitive care centers that have
3 specialists, that deal just with trauma. They're often
4 involved with doing research, which is a big requirement for
5 that. They're not that frequent. In fact, the state of
6 Washington has one Level I trauma center for the whole state,
7 Harborview. Oregon has two for the whole state. Alaska
8 probably doesn't have the medical resources and research and
9 residencies and fellowships that are involved to have a Level
10 I center. We do have a Level II center, and we do have the
11 medical capabilities to actually have more than one Level II
12 center. We have the specialties and do have the resources to
13 do that. We have Level III centers, where there is general
14 surgery and orthopedics, but no neurosurgery capability, and
15 Level IV where there is no surgical capability, but like a lot
16 of our rural facilities, are essential to make sure that the
17 patient gets stabilized and moved to the right place.
18 Trauma System Training. There is an alphabet soup of courses,
19 but basically, there is training available for every level
20 from doctors to the general public. There's specialized care
21 as far as burn care training, and Alaska does pretty good.
22 Providence Hospital, Alaska Regional, Alaska Medical Center
23 all do outreach of putting on these programs for people all
24 around the state, and it's essential to have people trained at
25 every level, if we want to get the best outcomes.

1 The EMS system, how we move folks through, is essential. It's
2 the network, the nerve fiber, how we move patients to the
3 right places. We need to have guidelines, so that folks know
4 where to take folks and how specific injuries, such as severe
5 burns or spinal cord injuries, should be handled.

6 So why do all this? This is trauma systems. This is what
7 happens. These are regional trauma systems, looking at
8 preventable deaths. In other words, people who died and was
9 there an opportunity to save them if the right intervention
10 had been made. When we look at kind of these urban areas,
11 there was substantial decrease in preventable deaths after
12 implementation of a trauma system. If we look at motor
13 vehicle crashes in statewide systems, the same thing, a
14 substantial decrease in mortality.

15 This slide is actually a good slide to keep everything in
16 perspective. If we look at trauma systems, their effect on
17 crash mortality, you can see on the far left that there is a
18 substantial decrease. If you look at some of the prevention
19 issues, like restraint laws, primary restraint laws have a
20 very significant decrease. 0.08 alcohol level also
21 contributes to it. And if you look at what happened when we
22 increased speed limits in different areas, there was an
23 increase in mortality.

24 Even in Alaska -- you know, people always say Alaska is
25 different. It might not work up here, but where we have

1 designated and undesignated facilities, there is a difference
2 in mortality, looking at over 7,000 patients. And even for
3 patients, if we break it down in the patients that are moved
4 that come in Status I -- in other words, unstable injured
5 patients -- their outcomes are better at designated
6 facilities.

7 Around the country, I think the interesting thing about this
8 slide is this shows the growth of different levels of trauma
9 centers around the country. I think, if you look at the Level
10 IV's and V's, you can see the tremendous growth, and I think
11 this is the realization that, if we want to have a system
12 where everybody participates, the right thing has to be done
13 right from the start, if you want to get the optimal outcome.
14 This is the United States in 2009. I think it's interesting.

15 You can see some states mandate participation of everybody,
16 and you can probably guess which states those are. There are
17 other states that have kind of lagged behind somewhat.

18 Arkansas actually had been probably further behind than we had
19 up until about two years ago when they made a big commitment
20 and have just funded development of a statewide system.

21 Alaska, you can see, has several facilities, or the only one
22 Level II center, and we have several Level IV's, which I'll
23 talk about.

24 So what about Alaska, what have we done compared to the rest
25 of the country? In 1993, EMS was given authority for

1 designating trauma centers. This was about the time that
2 trauma systems were being developed around the country.

3 Hospital participation was voluntary. There were no
4 incentives or disincentives to participate. It was just a
5 voluntary system. The standards adopted were those of the
6 American College of Surgeons, which kind of set the benchmark
7 and most states used them or have criteria based off of them.
8 And they set up a process for outside review for Level I, II,
9 and III trauma centers, so that it would de-politicized. The
10 Level IV centers, as in most states, are evaluated instate by
11 instate reviewers.

12 So where are we 18 years later? Twenty-four hospitals in
13 Alaska. We have, basically, five designated centers. There's
14 only one Level II center, the Alaska Native Medical Center;
15 four Level IV's, Norton Sound, Mount Edgecombe, YK, and Sitka
16 Community Hospital. Nine other facilities have had reviews or
17 consultations, but haven't met standards. And obviously, you
18 know, you don't need to be a trauma center to take care of
19 trauma, and people are getting taken care of. Two centers are
20 providing care for multiple trauma patients. There are other
21 centers that have surgical capabilities, and there are also
22 two military hospitals that are certainly part of our system
23 that are non-verified at this time.

24 So Alaska is the only state in the United States that doesn't
25 have a designated Level I or II trauma center for the majority

1 of the population. Alaska Native Medical Center is a Level
2 II. Most of the patients that come and see us are Natives.
3 We do take non-Natives as emergencies, but most of the people
4 that are non-Native are going to get their trauma care at non-
5 designated facilities now. Anchorage is the largest city in
6 the United States without a designated Level I or II trauma
7 center.

8 So, insanity. Insanity is doing the same thing in the same
9 way and expecting a different outcome, something that I've
10 been guilty of on a number of occasions.

11 The State, DHSS, actually took on this problem and helped
12 support a visit by a Trauma Systems Consultation Committee of
13 the American College of Surgeons. As well as reviewing
14 hospitals, the American College of Surgeons puts together
15 multidisciplinary teams to look at whole state systems, and
16 they came up in 2008 to, hopefully, help us with some
17 suggestions to promote a sustainable effort. They had done 17
18 states previous to that.

19 So to cut to the quick, whenever you ever hire a consultant,
20 the first thing they do is tell you everything you do right
21 and how nice you are and how thankful they are that you're
22 here and then they tell you the other things.

23 So the first thing they did was tell us all the good things,
24 that there are a lot of committed individuals up here, that we
25 do have extensive networks for transport, that there are three

1 large medical centers with extensive subspecialty expertise
2 within the state, and we have a very good relationship with
3 Seattle, which freely accepts our patients. We do have one
4 Level II center, and others have started to look at becoming
5 verified.

6 The Trauma Registry was a big asset in that all hospitals
7 participate, and we are able to get some meaningful data out
8 of the registry for a number of years.

9 Injury prevention activities have been well-established, and
10 there have been some initial efforts at legislative change.
11 Our challenges, I think, are similar to all over the country.
12 The public is really not aware of trauma system issues. There
13 are limited resources, and there were few incentives for the
14 hospital to participate in Alaska. And we really hadn't done
15 a good statewide evaluation of system performance.

16 So in summary, they said, "several facilities have sought and
17 achieved verification and designation as trauma centers;"
18 however, few of the facilities that serve the majority of the
19 population have made a similar commitment to achieving
20 nationally recognized standards of care.

21 So what do they recommend? Establish a second Level II trauma
22 center. They recommended mandating participation of all acute
23 care hospitals within two years, within appropriate -- to
24 their capabilities. They recommended studying pediatric
25 trauma care and trying to come up with a better plan for that,

1 determine a method of providing financial support, implement
2 triage and trauma activation protocols, and hire a full-time
3 trauma system manager.

4 So what have we done? Actually, DHSS has created and filled
5 the trauma manager position, who is starting to develop the
6 statewide trauma plan. The Trauma Systems Review Committee
7 has worked on metrics to measure the trauma system
8 performance, and legislation was actually passed that creates
9 an incentive for facilities to participate.

10 The Systems Review Committee, which I represent, has
11 widespread geographic participation. We meet twice a year.
12 We oversee Level IV verifications and the Trauma Registry.

13 We've also developed some guidelines for a number of
14 conditions, and we're looking at trauma system performance
15 improvement.

16 The legislation was introduced by then-Representative John
17 Coghill, now Senator Coghill, and Senator Bettye Davis. It
18 passed both Houses unanimously in April 2010. It was signed
19 by the Governor and basically created a fund to support trauma
20 care when it was given at designated trauma centers.

21 Participation remains voluntary.

22 So it allows hospitals some funding to help with some of the
23 issues I talked, training and the extra time commitment to
24 make sure that there's always a level of care that's available
25 when somebody is injured. The money is only for facilities

1 that have been designated by the State. And since the passage
2 -- and actually, I think that the legislation has been more
3 effective than I actually anticipated that, of the 19
4 hospitals that hadn't pursued this, 17 of them have asked for
5 applications or consultations. So the intended purpose of the
6 legislation, I think, has been more than realized, at least in
7 its early stages here.

8 So some of the things that we can do with the system, and I'll
9 just go these briefly, but Head Injury Guidelines. Patients
10 with minor head injuries are often seen in rural remote
11 facilities without CT scanners, and less than 1% of them will
12 ever really need surgery and need to be in a place with
13 surgery, but because of anxiety, a lot of times, these
14 patients are being Medevac'd around the state. Guidelines
15 were developed and validated to show which patients could be
16 observed at their own home facility.

17 It was done by an Ad Hoc committee of the Trauma Systems
18 Review Committee. We used private physicians, tribal
19 physicians, people from around the state, urban areas, rural
20 areas, neurosurgery, emergency medicine, all of these
21 specialties, and it was rolled out over the next year. It was
22 implemented at different levels in different places.

23 In the tribal system, which we had the best data for, you can
24 see what happened was that, even though a number of patients
25 that were Medevac'd, the number of unnecessary transfers went

1 down significantly, actually 75%, and actually 12 unnecessary
2 Medevacs were prevented during this small pilot year, and
3 \$300,000 in savings of Medevacs were realized.

4 In the University of New Mexico, a similar thing. A lot of
5 hospitals now, especially, have CT scanners. A lot of
6 patients have minor injuries, but have an abnormal CT scan.

7 Very few of those patients actually need to go see a
8 neurosurgeon.

9 What we have now is there is high quality digital studies can
10 be sent by telemedicine, and what they do is those studies are
11 sent in. A neurosurgeon can look at them and say, why don't
12 you keep the patient until tomorrow, repeat the scan, why
13 don't you send them in right away, or don't worry about it at
14 all. They were able to decrease 42% of the Medevacs in places
15 that had -- small hospitals that had CT scanners, but no
16 neurosurgery capability. So as you develop a system, these
17 are some of the things that we are looking at that we can do.
18 Trauma Center Designation. A community hospital, Level II in
19 Idaho, basically, they looked predesignation and after
20 designation, and they looked what happened with the length of
21 stay and mortality for their patients as well as the cost, and
22 they found that the impact of designation was favorable in all
23 of these and that, again, is a large community hospital, not a
24 big university center.

25 So to touch on public awareness, it's interesting, a very nice

1 poll done in 2004. After hearing a description of a trauma
2 center, most Americans feel it is extremely important to be
3 treated, if you are really badly hurt, at a trauma center.
4 Almost nine of out ten feel that it's similar to other public
5 utilities here, as far as the fire department or the police
6 department. It's really a non-partisan issue. Everybody has
7 potential to get hurt, and they all want this.
8 The majority of the public thinks it's important to have it.
9 Most people think they already have it, and many of the people
10 in this survey -- and it's true in this state -- think they're
11 already covered. They're not.
12 So what we anticipate, what we're looking for is an integrated
13 systems that addresses trauma from injury prevention through
14 acute care and rehabilitation.
15 I think, when you look at the system, this is where the
16 facilities are. To my eye when we look at this, there is
17 actually not one system. There is actually three areas.
18 There are three systems, and Alaska is a big state, and I
19 think, when we're talking about developing a system, we have
20 to think of those three different areas. They have different
21 concerns.
22 Southeast Alaska is a maritime community. It has traditional
23 medical and economic ties to Seattle, and we need to take
24 advantage of that as we develop our systems.
25 Anchorage/Fairbanks area has got a good road system, lots of

1 medical facilities and expertise. It's not that different
2 than a rural state in the west. It really isn't that much
3 different than Wyoming and some others. So the system that we
4 have there is going to be a lot different than Southeast,
5 where there isn't much of a road system and has other
6 traditional ties.

7 And then the unique thing to Alaska, obviously, is the Bush,
8 which has very unique issues and has an association with
9 Fairbanks and Anchorage, and triage protocols and the system
10 we develop for that is going to have to have some unique
11 features to it, with a lot of involvement in each of these
12 areas by the people who live and work there.

13 So Trauma Systems. I want you guys to think about trauma
14 systems, but I want you to expand it and not just think about
15 trauma. The way trauma systems are set up is to take care of
16 people with time critical problems. Now think about. There
17 are other time critical conditions that aren't trauma. And
18 having a trauma system, how you move a patient through the
19 system is the same way you move a trauma patient. All of the
20 things that we're looking at, readiness and training,
21 preplanning, best practices, evidence-based, review of the
22 performance by outside people and also internally are all
23 things that we would want, whether we're looking at trauma or
24 cardiac care or obstetrical emergencies of GI bleeders,
25 communication.

1 So basically what we're talking about when we're talking about
2 a trauma system is we're talking about some way to deal with
3 acute time-dependent condition, and development of a trauma
4 system won't just improve outcomes for trauma patients but has
5 the potential to improve the outcomes for all of these other
6 conditions. And all around the country, the same paradigm has
7 been started. The cardiac programs with the STEMI programs
8 where prehospital folks are identifying people having a heart
9 attack, so that the cath lab can get there and be ready when
10 the patient arrives. This is all based off of this trauma
11 system paradigm.

12 The other thing is disaster preparedness, which again, think of
13 the things I that I just listed back there: readiness,
14 preplanning, best practices, communication. What are the
15 elements that you would want to see in your disaster response?
16 So I think that it's important to think of this as more than
17 just a little niche problem of just taking care of injured
18 patients.

19 What have been the barriers? Some of the concerns by hospital
20 administrations: the extra costs; physicians haven't always
21 been supportive; there hasn't been a big demand from the
22 community for reasons that I discussed.

23 Providers. I think there is a tendency for folks to say,
24 well, we do fine. There are no financial incentives, and I
25 think there is certainly an inherent reluctance to be involved

1 with anymore rules and regulations of anything.

2 I think that also it's very important to know that the
3 stability and health of the prehospital system is going to be
4 essential to making this work.

5 So conclusions. You know, I hope I've been able to convey
6 that, you know, trauma is a major health burden for Alaskans
7 and for state government. Trauma systems save lives and
8 money. We've made limited progress in developing a statewide
9 system, though things are optimistic. And the creation of the
10 trauma fund seems to be having the desired effect.

11 The Action Items, what we would like to see going forward.
12 The Trauma Fund, which was originally funded with \$2.5 million
13 of state money, \$1.1 has been paid out to date. If all
14 hospitals were designated -- and in order to get there, I
15 think it will be a four or five year process to get everybody
16 designated -- it would be about \$5 million a year to support
17 this, and this is actually other states. I know Arkansas is
18 about \$20 million a year, Georgia about 50-something million,
19 Wyoming and New Mexico put in about five to ten. But anyways,
20 I think that we've made a good stride, and I would hate to see
21 the Trauma Fund dry up, which it will after next year. So I
22 think we need to keep replenishing that fund.

23 The other thing is the Trauma Registry, which a lot of the
24 data that I showed you guys came from the Trauma Registry. It
25 is an incredible tool, and it is essential, if we really want

1 to be able to look at the system and how we function and even
2 how the small hospitals are going to use the Trauma Registry
3 to do their own performance improvement. It's been able to be
4 maintained through lean times and other for, you know, 20
5 years, but it is always in danger and now more than ever of
6 being able to support it.

7 I would like to say that, you know, the prehospital system --
8 and Dan is going to talk a little bit more about it -- this
9 won't work, and we have big challenges, unless we can maintain
10 the prehospital system. One of the biggest challenges is that
11 we have a diverse, large volunteer component, and unlike an
12 urban system which has its own infrastructure, the rural
13 places really depend on the State to provide training to keep
14 them up, to do the housekeeping and certifications that need
15 to be done in order to keep what is largely a volunteer system
16 intact.

17 Eventually, we would like to roll the rehabilitation and
18 prevention parts of trauma into prehospital and into the acute
19 care setting, and I can go on about that, but that's a vision
20 for the future.

21 So ultimately, we are going to take care of injured patients.
22 This isn't something that we choose to do or not choose to do.

23 We're going to take care of them. The question today is not
24 if we'll take care of them; the question is, how are we going
25 to decide to do it?

1 We can continue to do it like we do, which often results in
2 excellent care, but often results in suboptimal care. So the
3 question isn't if; it's how we decide we want to do it. We
4 can use a method that's been adopted by most of the country
5 and has been proven, and I hope that this is the direction
6 we'll continue in.

7 And ultimately, you know, why is it important? It does make a
8 difference, and if us, our families, our neighbors were hurt,
9 this is the care that we would want. And I think that, with a
10 small amount of investment, we can continue to make progress.

11 Thank you, guys, for your time.

12 CHAIR HURLBURT: Thank you, Frank, for that outstanding
13 presentation. We can take some comments and questions.

14 Keith?

15 COMMISSIONER CAMPBELL: It strikes me, at the very last, you
16 mentioned how, at least, most of outside of Anchorage depends
17 on the volunteers, and I suspect you were looking for a carrot
18 on how to find funding that it takes to run this system, \$5 to
19 \$10 million in the out years. Is there any way you could
20 quantify the amount of volunteer time by these (indiscernible
21 - voice lowered) scores or whatever the term de jour is use
22 that as a -- well, maybe for the Legislature to parlay that
23 free stuff, in essence, to a budget, a sustainable budget.

24 DR. SACCO: I think that's a good point. I think that it
25 would be very interesting to know. I think it may be hard to

1 come up with though. We may be able to get some ballpark on
2 that. I think one thing for the prehospital folks, like I
3 talked about, is that, you know, we have tried to maintain
4 standards here in Alaska, medical standards, that are as good
5 as the rest of the United States. So in other words, we
6 expect our prehospital providers that are an EMT or a
7 paramedic to provide the same kind of care that an EMT or a
8 paramedic in the Lower 48 does and that's what we should do.

9 We should take national standards.

10 In order to keep meeting those requirements and in order to
11 meet that training, a small volunteer unit, it's just too
12 onerous for them to do that kind of support stuff, but if the
13 State can provide that, if a state central office that can run
14 those kind of programs can do that, that's a tremendous help,
15 you know, for that, and I think Dan can probably speak to
16 this, too.

17 MR. JOHNSON: What Dr. Sacco was telling you is absolutely
18 true. Concerning your question, there have been efforts from
19 time-to-time made in trying to quantify the amount of
20 volunteer effort, but it's very difficult because there are so
21 many different entities, organized and non-organized, that are
22 involved, but it is a question that, I think, is very
23 important, and at least, a good faith effort should be made to
24 do that, which we have done from time-to-time.

25 One of the problems with the voluntary system that we have,

1 which indicates a need for state involvement in it is that, as
2 you know, a lot of the rural areas of the state are
3 unorganized. There is no local government, no local
4 authority, no local tax base, no means of support, and the
5 volunteer system continues and thrives in spite of that.
6 On the other hand, there are major expenses involved that are
7 beyond the ability of a local voluntary organization to
8 support through bake sales and other fund-raising needs, such
9 as training, certified training at the highest national
10 standards, equipment, things like that. So I guess the
11 message there is that the volunteer system is very important
12 in our state and it does require -- possibly different than
13 other states, it requires more state support of the system as
14 opposed to local support because, in a lot of cases, the local
15 support just isn't there.

16 MS. RABEAU: I was going to also comment that 80% of all
17 prehospital agencies are volunteer within the nation, which is
18 a staggering statistic, but interesting as well. And through
19 the state-funded or support through state trauma systems, they
20 receive training, education, and other EMS support through
21 that.

22 CHAIR HURLBURT: I wonder if maybe we should go ahead with
23 Dan's and Julie's presentations because we will have time at
24 the end for questions and you guys may cover some things, if
25 the questions are getting more directed toward you now.

1 COMMISSIONER ERICKSON: For the folks on the phone, a number
2 of you have just tied on, and we are having some technical
3 challenges with the teleconference. We're not able to put it
4 on lecture mode. So we would ask, if you all could, please,
5 mute your lines, we would appreciate it. We're hearing some
6 background noise. Thank you.

7 CHAIR HURLBURT: If there weren't any other questions
8 specifically for Dr. Sacco -- yeah, Larry?

9 COMMISSIONER STINSON: It seems like the Trauma Fund incentive
10 had its usefulness, and just like tax credits, it got the
11 behavior going in the right direction. What do other states
12 do to keep their trauma systems going? Are they typically
13 supported by the state on an ongoing basis?

14 DR. SACCO: I'm glad you asked. There are a number of
15 approaches. One is, like you said, you know, they can support
16 it with incentives. Some states mandate it. They tie it into
17 hospital licensing or Medicaid patients or they incentivize
18 Medicaid payments. So in other words, you get a higher
19 Medicaid payment if you are a designated center.
20 Other states, and I know there are some Alaska constitutional
21 issues, but they have directed funds. So there would be
22 speeding surcharges, licensing fees, ammunition taxes, you
23 know, I mean, there have been a plethora of directed, you
24 know, revenue that goes to the Trauma Fund in different
25 states. Alaska, you know, I think that's a little bit more

1 difficult, as I understand, as far as collecting revenue, and
2 I'm sure it has come up many times, but that's what they do.
3 You know, occasionally, there is federal money that has been
4 designated. The most recent legislation actually identified
5 the Affordable Health Care Act or the Access to Care Act --
6 excuse me -- did identify over \$220 million for trauma system
7 and trauma center support. Whether that money actually gets
8 appropriated, I think, is probably -- I wouldn't take the bet
9 right now, but there has been, over the years, federal money
10 that has come in. I think there is a handout that lists --
11 yeah -- all of the different methods of funding, and you can
12 see that, a lot of times, they are kind of directed taxes.

13 COMMISSIONER LAUFER: I think this is a quick question, but
14 has the national reform, the promise that this 20% of patients
15 who are uninsured now will be insured, doesn't that change the
16 economics of trauma and make it more potentially a profitable
17 part of medicine, and is that part of the reason why people
18 are now signing up?

19 DR. SACCO: I think it potentially could change, well, the
20 face of medicine, you know.

21 COMMISSIONER LAUFER: Yes.

22 DR. SACCO: And trauma patients also. I think that, actually
23 you know, a lot of the patients -- even though there is a
24 large uncompensated share, there is, you know, access with
25 trauma patients to auto insurance and some other sources of

1 funding so that, if there is a big blunt trauma component that
2 hospitals -- it's not a big loss leader, you know. What
3 becomes hard for some of the Level II trauma centers is to
4 provide that level of availability of specialists. What we
5 want to do is that, no matter what time you get hurt, there is
6 an OR and there are trained people available, so that the
7 level of care is always going to fluctuate, but it never goes
8 below a certain level and so that's what the extra costs go
9 into.

10 COMMISSIONER LAUFER: The other question -- you know, Alaska
11 is different. We like that, but say we had shock trauma from
12 Baltimore right here in Anchorage and Level IVs everywhere and
13 excellent Medevac, we still probably wouldn't get up to par
14 with the rest of the country as far as survivability, just
15 because of the distance. Is that a fair assumption?

16 DR. SACCO: I think that's fair. I think that is fair, but if
17 we couldn't get 20% -- if we got 5% to 10% of 500 people,
18 think about that. That's an extra person a week, you know,
19 and I think that's certainly worth it when we think about what
20 we spend.

21 COMMISSIONER LAUFER: Would this make Alaska more appealing
22 for military folks?

23 COMMISSIONER FRIEDRICHS: Well, I'm glad you asked that
24 question. Absolutely. I mean, that's one of the things that
25 we're struggling with right now. We've been trying for three

1 impact Alaska, and I think one of the important statistics
2 that Frank touched on there was, when we look at trauma beyond
3 the very particular benefit, this is a population that
4 directly is impacting the military side because we're a
5 younger and more active population. If you look at the VA,
6 which is an older population, Medicare is still older. Trauma
7 becomes less of an impact, but trauma very directly pertains
8 to our population.

9 Going back to another question that you asked about, could we
10 get to the level of the rest of the United States? I think
11 the answer is also no. What we've found -- and again as
12 recently as three weeks ago, I was having this discussion in a
13 different meeting in Ohio -- the trend in the United States --
14 and Frank, please correct me if I mis-speak on this -- is
15 moving towards payment systems in which the majority of
16 physicians are now employed physicians and are being paid for
17 taking call.

18 As we've changed the entire dynamic of health care delivery,
19 limiting resident work hours, that's taken a big workforce out
20 of most of our large hospitals. So you're seeing a transition
21 within health care systems to paying physicians to take call.

22 If you do that, you then enable a pool of physicians to be
23 available to support better quality after-hours care, which
24 translates into better overall outcomes because you're not
25 forcing a resident to work 120 hours and then fall asleep in

1 the middle of a code.

2 So there is a big switch that's happening throughout the
3 United States health care system. Again I think, going back
4 to the point you made this morning of, you know, where do we
5 want to go with our health care system, how do we deliver
6 excellent care in Alaska? That's that audacious goal question
7 that, hopefully as a Commission, we can answer. We don't want
8 to meet the minimums of the United States. We want to deliver
9 excellent care, and how best do we do that? Thank you.

10 CHAIR HURLBURT: Larry?

11 COMMISSIONER STINSON: I actually have a question for Jeff
12 because, with your background and with the insurance, what is
13 Blue Cross Blue Shield's experience with trauma centers? Does
14 that provide better care or do you have any data or anything
15 off of that?

16 CHAIR HURLBURT: Yeah. There is good national data available
17 that -- the old -- correct me, Frank, because you know better
18 than I do -- what Frank cited out of the *New England Journal*
19 was a report a few years ago, but just in the December issue
20 of the *Journal of the American College of Surgeons*, there was
21 an article out of Canada basically reaffirming what Frank
22 stated as a national experience, and they were particularly
23 looking at ones and twos, but the trauma center designation
24 being a part of the system, meeting the criteria, has that
25 kind of significant impact, positive impact on survival. Am I

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correct on that, Frank?

DR. SACCO: Yeah. I think that it's been looked at a bunch of different ways, but everybody comes out with the same conclusion, different, you know, percentages or amounts of benefit, but it's been looked at in Canada and the United States. It's been looked at, at individual hospitals, as I eluded to the one study up there from Idaho, but I think it's clear and it's what, I'm sure, you guys have heard. When we talk about medicine, we talk about, you know, systems of treatment, evidence-based care, performance review, you know. I mean, those are kind of the elements that go into, you know, this approach to trauma care.

CHAIR HURLBURT: Thank you. Why don't we go on next? Dan Johnson who is the Director of the Interior Region. Our state is divided up into large regions and then, within the regions, there are subsidiary jurisdictions, and Dan is the Director of the EMS System, Prehospital EMS System throughout that whole, large central part of Alaska. So Dan, we could turn it over to you next, I guess.

MR. JOHNSON: I don't have a lot prepared, but I'll be very happy to answer questions. Just as a brief background, I'm responsible, right now, for the interior of the state. The state is, for purposes of EMS coordination, divided into seven regions. Three are private, non-profit organizations, such as our own. Three are associated with Native corporations, and

1 one is part of the North Slope Borough local government. We
2 coordinate and facilitate EMS in our regions briefly.

3 In past lives, I have worked for two different Native
4 corporations. I've worked in the community health aide
5 program and some other statewide health issues. So while my
6 perspective right now is somewhat limited, when it comes to
7 questions, I might be able to answer questions that are
8 outside of my current area.

9 You know, what Dr. Sacco has reported on in his presentation
10 is -- exactly identified issues in prehospital trauma care,
11 the distances involved, the organizational system -- or the
12 volunteer organizational system we work in, the issue of non-
13 certified facilities and inconsistency as to what they can
14 provide and when and where to transport.

15 In most communities, the decision of where to transport is not
16 a decision that has to be made because there is only one
17 option, but on the other hand, there are, at times, options of
18 where to take a patient, whether to go to Fairbanks or go
19 straight to Anchorage or whether to go straight to Seattle in
20 some cases.

21 So those protocols and decisions do need to be developed, and
22 I think the State might have a role in that, but what I'd like
23 to emphasize is the data system that we have or don't have for
24 prehospital EMS, and of course, including trauma care. But as
25 Dr. Sacco said, the systems that support trauma are the same

1 systems that support other medical emergencies. And our state
2 is just now making progress in developing a comprehensive
3 system for collecting prehospital EMS data, and I want to
4 emphasize that the State has a tremendous role in that. It
5 needs to be coordinated on a statewide basis.

6 The data set, as it's developed and refined, has to be
7 coordinated on a statewide basis, but it has to be in
8 partnership with the providers and the regions to make sure
9 that that data is useful, as has been mentioned earlier, and
10 that the effort of providing the data pays off for the people
11 who are providing it. And you know, we work with not only
12 volunteers, but we work with very focused and action-oriented
13 people. And the idea of data and the future benefits of the
14 data is often a difficult sell for the people on the street.
15 And so that's why we have to work together, make sure that the
16 data is useful to people, that the method of recording the
17 data and submitting the data is efficient, that the software
18 and the procedures that we developed are compatible with the
19 software and procedures that are already in existence or help
20 people develop the capabilities, and then we can make better
21 decisions on what sort of people we need trained out there in
22 the prehospital setting. Do they all need to be paramedics or
23 is the lower level of EMT or ETT adequate for the sort of
24 patients we see? Is the transportation for the types of
25 patients? Is it optimal? Is it the best we can do?

1 We don't even have good data on the various steps in the
2 response timeline for a lot of areas. Now I believe the urban
3 areas have better data than the rural areas, but even in the
4 city of Fairbanks and the Fairbanks North Star Borough that
5 I'm familiar with, they're still just in the very first stages
6 of developing those statuses. So I want to encourage.....

7 CHAIR HURLBURT: Excuse me, Dan. Just a second. Somebody on
8 the phone just answered another phone call. If you could mute
9 your phone because we can hear you? Thank you very much.

10 MR. JOHNSON: So I guess the main message I want to bring to
11 you, in addition to what Dr. Sacco has mentioned about the
12 prehospital system, is that the State really needs to have a
13 role in developing a meaningful and efficient system of
14 collecting prehospital data and that system has to be
15 compatible, both data in and data out, with the Trauma
16 Registry and other data systems that facilities use, so we can
17 all share data and start making decisions on the basis of that
18 data.

19 CHAIR HURLBURT: Yes, Pat?

20 COMMISSIONER BRANCO: Thanks very much, Dan. I have a kind of
21 multi-part question, and I think Dr. Sacco did a really good
22 job of tying in the trauma system with the prehospital care,
23 and I'm curious, from your point of view, is it the
24 proliferation of EMS services and the speed of access to those
25 patients, and eventually, to hospital care or is it

1 interventions done at the scene that reduce the mortality in
2 the long run? And the third part of this is, what role does
3 the medical directorship play in keeping those EMS services
4 vibrant?

5 DR. SACCO: I think that it's actually both and that we have
6 seen improvements in outcome. Sometimes, it's just getting
7 people there fast, but there are some very basic interventions
8 that have to be done and need to be done. And it goes back to
9 the ABC's that we're all taught. And you know, I think what
10 those things can be focused on -- as long as people are
11 getting feedback and things like that, we can develop that
12 capability. And you know, having been here, you know, first
13 working up in Kotzebue in 1984 and buying Alaska Airlines
14 seats and sticking the patient on the Alaska Airlines plane, I
15 mean, it is amazing, you know, the amount of resources and the
16 training and the prehospital training that has gone on, so it
17 is both.

18 That said, I've also seen a number of patients just because
19 they got them here faster. And the efficiencies that Dan
20 eluded to, sometimes Norton Sound -- I'm going to give kudos
21 to them. You know, instead of using a hub and spoke where it
22 goes from the village back to the regional hospital and then
23 in from there, they've identified patients that, if they're in
24 the village and they know that they can't add the care, they
25 send the team out to the village and then they go straight in,

1 and you save a lot of time, a lot of efficiencies. The same
2 thing can happen in the Interior region. If we have a patient
3 with a bad head injury, maybe we shouldn't be going -- we
4 should be going from Tok to Anchorage, not Tok to Fairbanks.
5 So I think those sort of prehospital protocols and things,
6 like that, can make a difference with time.

7 And I forget the second part of your -- the medical
8 directorship. When we go and we look at these regions, it
9 becomes very clear that, you know, there are standard
10 principles of care should be given, and you know, themes that
11 we want them to follow, but the decisions and the actual plan
12 have to be made at the local area because the medical director
13 and the prehospital folks, they know their resources. They
14 know the capabilities. And sometimes I know, to get down to
15 it, in some of the villages, the medical director may know
16 that these health aides, whatever they say is that's the
17 truth. We need to go. In other ones, it may be more
18 variable. So it has to be though. You need strong medical
19 directors, and the plans have to be made at a local level
20 following kind of accepted principles.

21 MR. JOHNSON: Just to expand just a little bit concerning
22 speed to higher level of care, I was involved in EMS
23 extensively in the '80s and then I got out of it for about ten
24 years during the '90s and came back in about ten years ago,
25 and the huge improvement I saw which, I think, is an amazing

1 improvement in our system is the development of dedicated air
2 ambulances. That didn't exist in the '80s, and I did those
3 Medevacs that Dr. Sacco is describing in the back of 185s and
4 206s, and you know, it was an adventure, but it wasn't good
5 for the patient and it wasn't quick. So that's a major
6 improvement and that's a good example of a state role in
7 improvement of the transportation system because those
8 services are now certified, and to meet those certifications,
9 they have to meet standards of equipment and readiness and all
10 that good stuff and it's to the benefit of the patient.

11 So I just wanted to reiterate that, and I think another sort
12 of unheralded benefit of that is how it reduces stress on the
13 community health aide to have a bona fide team of responders
14 respond from a phone call. And it reduces the stress on those
15 primary care providers and improves patient care. It's good
16 all-around.

17 CHAIR HURLBURT: Thank you. We'll have some other time later.
18 The third presentation we have is by Julie Rabeau. Julie --
19 as Frank kind of summarized some of the recommendations from
20 the survey that the American College of Surgeons Committee on
21 Trauma did here, one of the recommendations that they made a
22 clear recommendation was for the Alaska Trauma Program
23 Manager, and we looked for some time and then Julie was
24 identified and came in to the job.

25 Julie has roots that go back into Alaska long before Julie and

1 well before statehood when her mom and dad as a young nurse
2 and a young doc met and fell in love in Kotzebue, and she was
3 only a gleam in their eye at that time, but a longstanding
4 Alaska heritage, and then as a nurse, worked in the very
5 highly respected, extremely busy Level I trauma center in
6 Clark County in Las Vegas in Nevada and so had that extensive
7 clinical background, came up here with the tribal health
8 program, and then we were able to woo her to come over to the
9 State, and has brought great wisdom, great knowledge, great
10 experience, and a lot of passion to what she has done, and I
11 think has clearly fulfilled the dream that the American
12 College of Surgeons set out for us here now. So Julie, if you
13 could ahead and then we'll open it up for questions.

14 MS. RABEAU: Thank you. And I was actually born at the Native
15 hospital, the old one, too. So we do go back a long ways.

16 Basically, I want to thank Dr. Sacco for speaking to the
17 Commission and Dan as well. It was an excellent presentation,
18 and there is not a lot for me to expand on for that, with the
19 exception to understand that the trauma system is a
20 standardization of care, where it starts in the smallest of
21 communities at your Level IVs through your prehospital,
22 through rehabilitation. And what that does is, with those
23 standardization of care, it improves patient outcome, as we've
24 seen statistically all along, up to 25% where we've seen that.
25 And so that's probably one of the most important aspects that

1 we try to bring through education, through standardization,
2 through the trauma plan, and within the prehospital through
3 field triage criteria, and hospital care. Also through that,
4 what the trauma system does is it gives that specialized and
5 most capable care.

6 As they were saying, trauma centers, specific trauma centers
7 have the specialized care and training from their physicians
8 down to their radiology staff as far as the treatment and care
9 of trauma patients, and this is how their outcomes are
10 improved.

11 The other thing I wanted to talk about just briefly is the
12 Alaska Trauma Registry. We have made inroads, just great
13 strides in the last eight months, with the Trauma Registry.
14 When I came on just a little over almost two years ago, it was
15 in dire straits. We had lost our funding due to non-
16 reporting. We had no validation done on our data, and we had
17 disinterest from our supporting partners. We've kind of risen
18 that phoenix from the ashes.

19 We restarted the Trauma Systems Registry Subcommittee, which
20 has done a phenomenal job of working together with all of our
21 partners to the point where, now, we have taken from 2006
22 data. We are, for the first time ever since 1991, the
23 beginning of the Trauma Registry, in compliance with
24 regulation for our trauma centers. So we're proud of that
25 fact. We have all 24 hospitals reporting, up through 2010

1 data. We've had a remarkable resurgence and training through
2 some funding that we've received through the rural flex grants
3 to train our partners, and we've looked towards that.

4 The important part is we've also looked at validation, and
5 this is hugely important to our stakeholders as far as any
6 sort of research, as any sort of receiving funding as well.

7 And through the hard work, we've received one grant for a
8 validation study, but this does not help us support the day-
9 to-day functions of the Trauma Registry.

10 The other important part about the Trauma Registry, not only
11 do we do injury outcomes, but we are the sole database in
12 Alaska that collects information on poisoning and toxic
13 events, toxic events of radiation, heat-reduced temperature,
14 and air pressure injuries and fatalities. So we've kind of --
15 we go above and beyond what's required.

16 We do also, nationally and internationally, produce and track
17 the 24 performance indicators for all hospitals in Alaska. We
18 report those nationally, and we report those to each facility.
19 So I guess as well, like we said, at this point, it's costing
20 us about \$80,000 a year to maintain services for the Alaska
21 Trauma Registry. We've done a phenomenal job within the past
22 year to upgrade and to remain current and valid for our
23 stakeholders, and we hope to look for continued support.

24 CHAIR HURLBURT: Thank you, Julie. Yes? I will open it up
25 for questions now on really anything, any of the three

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panelists. Pat?

COMMISSIONER BRANCO: One of Dr. Sacco's slides had some of the reasons there might be resistance from physicians and new groups or new hospitals coming into a trauma system, getting the designation, whether Level IV or III or II.

We've been on the path for Level III now. I live in Ketchikan, and so to put it in remoteness perspective, even though it feels like it's closer to the Lower 48, we're still 700 miles from Harborview, 800 from Anchorage. We are a long, long way from tertiary care. So it's important that we have the surgical capabilities on our island. We're there. We've gone through the American College survey.

One of our -- so one physician resistance that wasn't on your list and caught me completely by surprise was sort of the *Field of Dreams* moment; if you build it, they will come. And he said, oh my God, I don't know if we want more to come. If we become a trauma center, do we get more trauma? And it's a profoundly significant statement from him because that practice in Ketchikan, and I think in a lot of places in Alaska, it's a courageous practice. You're taking a general surgeon, or two of them, as being the only surgical capability, an orthopedic surgeon, and these are the broadest generalists who may get a chest case that they haven't done in a year or since residency. It's a terribly courageous practice, but it's also -- you know if you get right down to

1 the core, it's a scary practice. They don't know what's going
2 to come through the door, and trauma is that. These aren't
3 trauma surgeons.

4 So I just commend to you that some of the resistance is
5 profoundly real, but one that we still need to address.

6 DR. SACCO: I think that that -- you know, I've heard that. I
7 mean, I have actually visited, actually not all of the
8 hospitals in the state, but many of them and talked with the
9 medical staff and taught courses and done consults.

10 When you really think about it though -- and I was just down
11 in Wrangell and Ketchikan -- you're not going to get anymore
12 trauma. People aren't going to fly, you know, miles to come
13 to Ketchikan when they're hurt. I mean, they will fly from
14 the areas that you're getting now, whether it's Prince of
15 Wales Island. You're already getting those patients.

16 What this isn't about again is if you're going to get it; it's
17 how you do it. And what we've usually tried to explain to the
18 docs is that you're going to have to see this patient anyways,
19 and what I like about it, on a personal level, is, if we have
20 a seriously injured patient, well, the way that it works
21 within the trauma center is, at that moment, that patient is
22 potentially the sickest patient in the building. So you
23 mobilize the resources, whether it's x-ray, whether it's extra
24 nursing, and they all come and they help take care of your
25 patient. Now if I don't do that, I can go down to the

1 emergency room, and you know, I'll be asking for something and
2 waiting and things just take longer. So usually once docs
3 actually realize that, all of a sudden, I've got the power to
4 have everybody at my fingertips for the next half-hour and I
5 can get everything done in a half-hour or 40 minutes instead
6 of two hours, actually, they say, this is okay, you know, but
7 I think there is that fear and that's been expressed to me.
8 But I think, if you look at the Trauma Registry, we know in
9 the state, you know, there is 5,000 admissions and that's
10 probably what it's going to be, you know. So I think it's
11 unfounded, but it's certainly not that I haven't heard it
12 before.

13 COMMISSIONER BRANCO: I didn't make the claim that it was a
14 rational fear.

15 MS. RABEAU: And the other point to make is the support, not
16 only through the support of the trauma staff or the trauma
17 team is learning from their expertise through education, is
18 also the support through the American College of Surgeons.
19 They even offer programs. What we're even looking at is for
20 damage control surgery and that's hugely important. We see
21 that as a big issue in rural medicine here and rural trauma
22 because 65% of all mortalities for rural trauma patients --
23 that need emergency surgery have a higher mortality rate.
24 And so through the American College of Surgeons, that support
25 from Level II trauma centers or Level I trauma centers --

1 they're a higher level of care, which we see through the two
2 Sitka community hospitals. They are telerading (ph) their
3 scans to Harborview, and they're getting a consultation
4 through that, which is kind of taking away the onus on the
5 man, the surgeon that's there at the smaller facilities, and
6 as well through the support and the expertise of training and
7 education for their staff and having things in order and
8 that's what -- and that standardization, that's what makes the
9 process better. Thank you.

10 COMMISSIONER FRIEDRICHS: You touched on this in one of your
11 slides and your comments. It echoed a discussion that we had
12 before your arrival about why are we talking about trauma. I
13 mean, there is a plethora of problems to solve in health care
14 in Alaska. Why focus on this one or spend any time on this
15 one instead of talking about some of the others?

16 In one of your slides, you said that, if you implement a
17 trauma system, you actually see secondary improvements in
18 other areas. Could you expand on that a little bit about what
19 you meant when you talked about obstetrical care and other
20 types of emergent care?

21 DR. SACCO: Yeah. I think that, just like you were talking
22 about some comments how medicine is changing with the way we
23 staff emergency rooms and provide call coverage, I think that
24 one thing that we've seen is, when we talk about medical care
25 -- you know, when we talk about cancer care and things like

1 that, we're not necessarily talking about something that's
2 time critical, when we really want to have the resources or
3 really a lot that we should do.

4 But when we talk about trauma, just like that slide would show
5 the mortality, you know, in the first few hours and in the
6 first few days, we're basically talking about time critical
7 condition, and it really is the same as somebody who is
8 bleeding from an ulcer. It's the same as an obstetrical
9 complication or somebody who has an MI or a stroke where, now,
10 we have therapies that are available that are very time
11 critical that only work if they are done within a certain
12 amount of time. And so the way we move patients around,
13 whether they are hurt or whether they are having a stroke or
14 whether they're bleeding from an ulcer or an obstetrical
15 emergency, having that system works the same. And actually
16 within the hospital, the way that the hospital responds to a
17 trauma patient is not any different than the way they respond
18 to somebody who is bleeding and having an emergency. So this
19 helps. This system approach helps not only the care in the
20 facility, which a lot of hospitals have mentioned to us when
21 we've gone back for re-reviews at the Level IVs, but also how
22 you get other patients out and to the right place.

23 So that's why, like I said, at the end, I want you to think of
24 this as more than just the trauma system, but the model we
25 have on how to implement the system basically comes from the

1 trauma system. And you know, I think it's a proven model, and
2 like I said, you know, born in the military and translated to
3 civilian world and validated over and over. So this is really
4 a good -- gives us a good roadmap on how to go because we're
5 going to take care of those patients. We have no choice. We
6 can decide not to do this program, but we're going to take
7 care of these people. We're just going to do it. It's just
8 how.

9 MS. RABEAU: I think another important part to mention from
10 that, through the Trauma Care Fund that's gone out for this
11 last fiscal year to some of our Level IV facilities, they've
12 used that for equipment, and I can think of one of our Sitka
13 hospitals. They're going to purchase a Level I transfuser
14 with theirs. Well, that Level I transfuser is
15 multifunctional. They have a tremendous amount of hypothermic
16 patients secondary to water. And so by them receiving funding
17 for their Trauma Care Fund, not only will this Level I
18 transfuser resuscitate trauma patients that have a hemorrhage
19 or hypovolemic issues, but they'll also be able to save
20 hypothermic patients because it has the warming vent -- or the
21 warming mechanism, which they do not have at this point. So
22 we're proud of that fact. They look at it as a global issue
23 when they are looking at their funding uses as well. So it's
24 been an important aspect for our smaller facilities.

25 COMMISSIONER MORGAN: This is mainly a comment on, if you look

1 in the Alaska Health Status Indicators in our books, it has a
2 section on injuries and safety, and one of them -- and I don't
3 know if it's relevant, but it has an injury indicator of
4 unintentional injuries by death, occupational fatal injuries,
5 and then the same two slides, in other ways, where there
6 wasn't a death, they are huge compared to the United States.
7 The graphs are way -- on page 27, it's way above the -- the
8 United States average looks like it's, like, 35 per 1,000 or
9 something, 40. Ours is close to 60. It's in the -- it's
10 section seven. It doesn't talk about these types of traumas
11 specifically, but I suspect they're in there, especially on
12 deaths or deaths that haven't occurred from occupational
13 injuries.

14 I worked in the Aleutians for almost eight years. We didn't
15 have a lot of them, but when we had somebody have a crab pot
16 fall on them or a gunshot to the head through an accidental
17 discharge while hunting or something, it was really a matter
18 of luck. Luckily, the few times that I was around when I was
19 down there, I guess, God was smiling. Our dock from ANMC
20 happened to be in Cold Bay. The person was in Falls Pass or
21 King Cove. I mean, everything worked out, and we were able to
22 get him on a jet with -- I'll date myself -- Reeves Aleutian
23 and get them up here into the trauma center, and they have
24 saved lives. They have saved eyesight. We had a senior chap
25 who had an accidental discharge from a family member of a

1 firearm. It started out like, well, we don't know when she's
2 going to die to she's going to lose her eyesight to, well,
3 she'll be back in six weeks and can go back in six months and
4 go back to work, but it was because there was a trauma center.
5 I mean, that's the only -- it's not a question, but it's just
6 a comment about actually looking in the health statistics I
7 think you're going to talk about maybe, but I'm assuming that
8 that kind of stuff is in these, I would guess, right,
9 especially occupational?

10 The worst injury I've ever seen working in hospitals and
11 clinics, it sounds crazy, is a crab pot fall. You know, one
12 of those big ones, you know, like the deadliest seas you see,
13 but we -- out at Dutch Harbor, and every once in a while, we
14 would get somebody in where that -- actually where they would
15 fall on them, one or two a year, and that was the most -- it
16 was just a horrible injury, and it was always critical, and it
17 always involved a head injury. They don't wear helmets.
18 Luckily, they might be wearing a vest, maybe. But I get the
19 point of the conversation, and I'm not a clinician.

20 MS. RABEAU: All occupational injury is recorded through the
21 Alaska Trauma Registry. So primarily, most of all your injury
22 data is through the Alaska Trauma Registry.

23 COMMISSIONER CAMPBELL: The 2008 report on the trauma system,
24 how many of these recommendations have you worked through so
25 far, would you estimate? I don't need an exact count.

1 DR. SACCO: Worked through or accomplished?

2 COMMISSIONER CAMPBELL: Take your pick. Easy.

3 DR. SACCO: Yeah. I think that, you know, we've probably
4 discussed all of them. I think that some of the
5 recommendations, like we talked about as far as additional
6 facilities and mandates and things like that, I think that the
7 things, and I think I pointed out in the talk, that we have
8 been able accomplish, one was the Trauma Program Manager,
9 which basically is somebody who gets up everyday and that has
10 ownership of trying to develop this program and plan and
11 that's a huge step, and we couldn't make any progress on the
12 others until this position was filled.

13 And I think the other thing is the legislation, like I said,
14 which has been really a kind of reinvigorated process that was
15 kind of -- you know, pretty static.

16 The other thing is the trauma plan, the trauma system plan,
17 trying to develop a plan that meets national standards, and
18 Julie has been working on that, but that will allow us, one,
19 to have a roadmap, and I just eluded to things, like
20 rehabilitation and prevention, but this will give us a
21 comprehensive plan to look at trauma as a disease, just like
22 we look at heart disease has prevention, acute care, and
23 rehab, and she's been working on that.

24 That also -- on a practical level, when we go to apply for
25 federal money and federal grants, what they want to see is

1 that your approach and how you do is that you have a plan that
2 meets the model trauma system plan, which is developed by CDC.

3 So I think we've made a lot of progress. I think that, you
4 know, we've kind of focused on getting the facilities to buy
5 in, and I think we are starting to make some progress.

6 I would like to make a comment, if I may, about injury
7 prevention in trauma centers because, I mean when we look at
8 those numbers, let's face it; injury prevention is a huge
9 component of what we do. But when you think about it, what's
10 one of the biggest risk factors for trauma, one that we all
11 know? Alcohol. People drink and that is a risk factor, just
12 like high blood pressure or cholesterol would be for heart
13 disease.

14 What was done in some -- there were some really neat studies
15 done at Harborview and that have subsequently validated all
16 over the world and at now 37 studies. When you drink and you
17 hurt yourself, it's a teachable moment because you see the
18 consequences of your action as opposed to many people drink
19 unsafely but aren't physically addicted to alcohol, so
20 probably less than 5% to 10% are physically addicted to
21 alcohol are folks that we see that are the repeat visits to
22 the ER two to three times a week. To have an impact on their
23 drinking, very, very tough to do, but there are a lot of young
24 people, especially young men, that drink unsafely. They have
25 jobs. On the weekend, they drink, but they drink in an unsafe

1 way. They smash up their snowmachine. They break their
2 femur. They do all these things.

3 If you look at what happens to those folks, one, you can't go
4 to them and say you're an alcoholic and you're addicted. They
5 know they're not, and they're not, but they've had unsafe
6 behavior.

7 If you see them in the hospital -- and this was done at
8 Harborview -- and you do a brief intervention -- it doesn't
9 necessarily have to be done by a psychiatrist or a doctor. In
10 fact, it's probably better done by a nurse than a doctor. You
11 are able to change their behavior at one year so that, if you
12 look at readmission rates for people that have the
13 intervention and those that don't, that just have usual care,
14 Harborview was able to show that it was 50% less ER re-
15 admissions and re-admissions. Not only has this been
16 validated, but CMS pays for it now. So if CMS will pay for
17 it, you know that it's probably got pretty good data with it.

18 This is now a requirement for trauma centers in order to
19 become a Level I or II trauma center, and we are trying to
20 expand in this state, even for Level IV trauma centers. You
21 need to have a program that identifies these folks and does
22 the brief intervention while there. This is bringing injury
23 prevention into the acute care setting, and I think this is a
24 wonderful opportunity because we have wonderful injury
25 prevention programs that live out here, and we have acute care

1 that lives here, and this is the way to bring the two together
2 to take advantage of the teachable moment. It seems to have
3 the most effect, like I said, not on chronic alcoholics, but
4 on especially young men, you know, 18 to 25, that have just
5 done unsafe behaviors. So this is a -- if I wanted to put
6 this another way, the trauma system is a way of delivering
7 focused injury prevention to an at-risk population as opposed
8 to public service announcements.

9 COMMISSIONER CAMPBELL: (Indiscernible - away from mic)

10 DR. SACCO: Actually, there was a -- just as an aside, they
11 looked at patients that drank and had the consequences, and
12 having a wife was almost as effective as going through the
13 BURT (ph) program. So you have a spouse that's there to
14 remind you of the consequences of your actions.

15 COMMISSIONER LAUFER: Just two real quick things. One thing
16 is I would think that Alaska, particularly the Level IV
17 people, need more support than anywhere else because they're
18 just not seeing the volume. You know, if you're a small
19 community in Anchorage, it'll take ten years to see what you
20 might see in a big city in a week. And so they need extra
21 support and extra training.

22 And the other thing is I like to inject a little sort of color
23 into these things. I did trauma rotation in Philadelphia as a
24 medical student, and I was shocked because I saw several
25 people on an eight-week rotation twice, and I thought, what is

1 going on? And the fellow said, well you know -- this guy who
2 was in the second time, he said, you know, normal people
3 aren't drunk and drag walking on the, you know, side of a
4 freeway and getting knocked off and fall in front of a bus.
5 That doesn't happen to most of us. And they were doing every
6 single patient gets a drug and alcohol intervention, no matter
7 what.

8 DR. SACCO: We do that at our hospital, realizing the easiest
9 way to do it is just make it for everybody, but you know, the
10 benefit, I think, is going to be, you know, for that
11 population. I think what you talked about with the rural
12 hospitals, one of the things we do is called the Rural Trauma
13 Team Course and what that course is, is it's a one-day course
14 that we put on in the rural community, and the course is taken
15 by docs and nurses and prehospital and the radiology tech and
16 the clerk, all together, and they form into teams because
17 that's the way they see patients, and we do a half-day of
18 teaching. And then in the afternoon, we go through scenarios.

19 And one of the things we do when we talk about that is just
20 what you said. They do not see the volume of trauma that --

21 in order to maintain expertise. And so just like the
22 military, what do you do? You train. And what we hope to do
23 with the course is give them an approach to what you do when
24 that patient comes in because what I tell them is that you
25 don't see the volume, but what you do see is you're going to

1 see people with as bad an injury as anywhere in the United
2 States and you're going to have to take care of them because
3 you're not going to have a choice. You can't send them
4 anywhere else.

5 So I think that's the message, and I think that, you know,
6 Julie and Dr. Chenault and a number of people have been very
7 good about trying to get the Rural Trauma Course out to the
8 rural facilities, and it's really been well, well received and
9 it is something that we need to continue.

10 COMMISSIONER BRANCO: That show has been on the road in
11 Ketchikan, and let me tell you, it was really warmly received
12 and implemented and taken advantage of.

13 I only have one disagreement with you on the alcohol piece and
14 that's our demographic is slightly different. It's not the 18
15 to 25 year olds being stupid. It's the 45 year-old six guys
16 from Oklahoma who came here to go fishing or take loaded
17 weapons into the woods.

18 DR. SACCO: Well, that's hopeless. We should just give up on
19 that anyways. It's not.....

20 COMMISSIONER BRANCO: That's not a moment of training?

21 DR. SACCO: It's not worth the effort.

22 COMMISSIONER FRIEDRICHS: I want to just commend this Rural
23 Training Course because these are all volunteers, the surgeons
24 and the other folks who teach that course. And this goes back
25 to the point, I think, that Dan was making about this that,

1 you know, this is where really dedicated people have stepped
2 up to fill a void, and the question, as we become bigger, more
3 populous, and try to develop sustainable programs is, where do
4 we want to go with this because the corollary that we've seen
5 in the military is, as you fix one part of it, you do reap
6 those secondary benefits.

7 So when we build this system that can air vac someone from
8 anywhere in Afghanistan to a trauma center within 60 minutes,
9 we use that same system, as you said, for anyone who has an
10 acute appendicitis, who has, you know, whatever type of
11 emergency, and you improve the outcomes for all of those
12 patients removed by an improved system. It takes that
13 commitment, but also that long-range vision of where do we
14 want to go? And I think, you know to go back to the
15 discussion this morning, that's partly the value of looking at
16 this because this has, I believe over time, proven to be kind
17 of the leading edge of a system level intervention to improve
18 the care that you provide.

19 CHAIR HURLBURT: Yeah. I'll get into it some in our next
20 section there, but everybody has mentioned prevention, and
21 there really are prevention things that can work. The
22 prevention things -- you know, we talk a lot about cost of
23 medical care and the large number of dollars involved. The
24 prevention things don't tend to generate, whether it's in
25 Noah's practice or whether it's this, the revenue. And our

1 EMS system here -- when I came on the job here just a little
2 under two years ago now, our EMS section, our EMS program was,
3 frankly, in grave disarray and were running about \$1.3 million
4 over-budget, and those dollars were not there. And so we had
5 to make some drastic changes, and some of those changes had
6 some adverse impacts. But the volunteers that have been
7 around the state, folks like Frank and Regina, have really
8 been supportive and worked through difficult times on this.
9 Now in prevention, there are some neat things about Alaska.
10 Most of us have heard of the "Kids Don't Float" program, which
11 is a national program now. It started in Homer, Alaska and
12 spread in the state and spread around the country and saves
13 kids by putting the life jackets out there for people. So
14 there have been some innovative things done.

15 The funding for the EMS things comes largely -- the non-
16 clinical, the prehospital portions come through the Department
17 and through Public Health, largely there. Some of the funding
18 is just the operational money. They've mentioned (ph) the
19 money to operate the Trauma Registry, which is really critical
20 to keep going to doing what we're doing and has been there a
21 long time.

22 The first time that Pat's hospital went through the survey to
23 become a Level III trauma center, there were a couple of
24 reasons why they weren't ready. One was internal, but one was
25 the State was just flat out falling on its face at that time

1 in not maintaining the Trauma Registry. In fact, we were
2 pretty convinced that we were losing two years of data, but
3 through just sweat and hard work and a miracle, I think, we
4 were able to recapture all that and reconstitute the Registry,
5 so that we didn't lose that valuable data, but it does take
6 ongoing support to have that.

7 We have -- there is a budget item each year known as Code
8 Blue, and this is about, I forget, \$425,000 or \$450,000 a year
9 and that's money that has been coming almost every year that's
10 through the State General Fund budget that the Legislature
11 appropriates and then is matched, usually like, to the tune of
12 four or five-to-one with mostly federal dollars. Some other
13 dollars may come locally or through a foundation or something
14 else. That's what buys most of the ambulances that you see
15 around the State in the rural areas and does a number of
16 things.

17 Last year in the Governor's budget for the most recent
18 legislative session, that funding was not in there, but
19 Governor Parnell met with ACEMS, the Alaska Council on
20 Emergency Medical Services, and they brought that up to him,
21 and I think it was an oversight. It just happens, you know,
22 with a huge budget and all the items, that there wasn't any
23 intent to drop it. But when they brought that up with the
24 Governor, he was very understanding and heard what they were
25 saying and was supportive when the Legislature put that back

1 in there and signed off on that, and that was in this year's
2 budget.

3 There's also communications money, which is not in the budget
4 every year. It wasn't in the budget this most recent year,
5 but that's a special fund that comes from maintaining the
6 communications capabilities around the state, which are
7 critical to communicating when we have a disaster, whether
8 it's along the highway system or off the highway system.
9 So there are a number of sources that they come, but I think
10 the State gets very good value for the funding that's there.
11 It is a challenging state to maintain those kinds of systems,
12 and if you tried to quantify the dedication and the commitment
13 that the folks that Dan works with and his counterparts in the
14 other regions, Frank and Regina and others, Julie and folks
15 and EMS have, it really serves the state well.
16 I'll talk about it a little bit later on, but it is something
17 that we wanted to talk about with you and just make folks
18 knowledgeable about. Noah, did you have something? Go ahead,
19 please.

20 COMMISSIONER LAUFER: I was just musing, you know. I see,
21 actually, a lot of Native patients out of their system,
22 apparently, and young people are always looking for some
23 opportunity to learn something in the village and that's a
24 huge draw. How about you have online, competitive
25 BLS/APLS/ACLS simulations tied to scholarships at UAA for the

1 winners? They love that stuff.

2 DR. SACCO: Actually, I think it's a good point. I have a
3 chance to put in a pitch for something else that we've pushed
4 is the ETT course, which is, you know, kind of a enhanced
5 First Aid course, 44 hours that, you know, teaches trauma and
6 some other emergency care for First Responders and things.
7 What we've done is we've put it in the high schools in the
8 rural areas, and one, the kids love it because it's hands-on
9 doing stuff. The other thing is it exposed them to the
10 medical field. It also helps replenish the prehospital
11 staffs. So a number of places, including Kotzebue and Sitka
12 and other places around the state, have got this -- it's
13 institutionalized now and the kids really compete to do it,
14 but it's also a good way because the course -- people are more
15 aware of injury prevention when they're learning 40 hours
16 about taking care of injuries, and it's a great thing for
17 rural areas, and we certainly support disseminating this out
18 as much as we can.

19 MS. RABEAU: Another thought is, because we've been working
20 closely with some of our other rural states, like Wyoming,
21 Montana, and such, and seeing the need for education for those
22 rural communities, we are starting to work with the Emergency
23 Nurses Association and the American Trauma Society to where we
24 can offer some of these higher level trauma courses, like the
25 Advanced Trauma Life Support -- or not ATLS, excuse me, but

1 the Trauma Nurse Core Course and some other types of trauma
2 training courses through telemedicine, and what they're
3 allowing us to do is giving us about a year to go out and test
4 them off didactically. It's been successful in Montana and
5 Wyoming. I've spoken, personally, with the ENA and the
6 American Trauma Society about this, so we're looking at,
7 hopefully -- especially, too, our Level IVs, amping up their
8 education as far as that, so they can support their lone
9 physicians out there in those communities to give better
10 trauma care.

11 CHAIR HURLBURT: Anything else? Great. Thank you all very
12 much for that, that really fine presentation, and thank you
13 all, too, for what you're doing. We're a little ahead. Why
14 don't we take a break now for about 20 minutes and come back
15 together at 3 o'clock for our next presentation. We'll be a
16 few minutes ahead then, and maybe we can break 15 minutes
17 early. Thanks.

18 2:37:54

19 (Off record)

20 (On record)

21 3:06:38

22 COMMISSIONER ERICKSON: Well, welcome back, everybody. I
23 think we're about ten minutes ahead of schedule at this point,
24 which is good. We have plenty of time.

25 For our last agenda item of the day today, I'm going to just

1 fill in for our Chair while he has taken off his Chair hat and
2 put on his Director of Public Health Hat.

3 We are -- just as a reminder, one of our priorities for this
4 year is -- as part of understanding the current condition of
5 our health system and the health of Alaskans, one of our
6 priorities is to understand population health status better
7 and identify Alaska's top health challenges and priorities.
8 And in the State Department of Health and Social Services, we
9 have two separate agencies. Public Health is primarily
10 responsible for physical health population-based prevention
11 activities, where the Division of Behavioral Health Services
12 is responsible for mental health and substance abuse related
13 prevention and services. And so we invited both Dr. Hurlburt
14 and Melissa Stone, the Director of the Division of Behavioral
15 Health with the State, to share this presentation time, so we
16 can make sure that we're understanding the health status
17 issues across the -- a more holistic view, in keeping with our
18 new definition.

19 So I'll go ahead and turn things over to you now, Ward.

20 CHAIR HURLBURT: Thank you, Deb. We've got about an hour-and-
21 a-half scheduled for this, and our plan is that Melissa and I
22 will each have about a half-hour for presentation and then a
23 half-hour for discussion. I'm going to go first. If there
24 are questions that anybody wants to ask, nobody can stop you
25 anyway, but the plan was, for the most part, to have the

1 discussion after the presentations. And one reason that this
2 may be helpful is, for example, one of the things that Melissa
3 is going to talk about, and some of you are probably familiar
4 with it, is the ACES study that was done by Kaiser, showing
5 the dramatic impact on physical health issues of some things
6 that fall into behavioral health background there.

7 So while we have two separate presentations, it's very clear
8 that there is a close tie and a relationship. And so for the
9 most part, I say, if there are questions earlier, that's fine,
10 but for the most part, if we could go ahead and have both
11 Melissa and me present and then have our discussion time.

12 The material for our presentations is behind tab seven in your
13 book. One of the things -- it's a fairly thick section there.

14 One of the things that you'll see there is Alaska Health
15 Status Indicators, the 2009. This is put out, I think, every
16 other year by the Division. It comes out in December, so this
17 was just -- this was published in December of 2010, and this
18 goes over more of the physical health status things.

19 Just behind that, there is a section with some of the
20 behavioral health status information there. And my
21 presentation is largely taken from this, but with a little
22 different focus on priorities. I've singled out four priority
23 areas there and want to talk about those in terms of health
24 status, in terms of challenges to health, in terms of
25 prevention of obesity and overweight, which is why we had the

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small cookies here.

Just before we started now, I told Paul that when -- during maybe between us, we can pass out the free cigarettes and see if that would help, too. Anyway, so I want to talk about those things.

The four areas that I want to focus on -- and in this publication on Health Status Indicators, there are much more there than the four, and there's not time to really get into them all, but -- and I will say, for each of these, why I selected those to talk about, but I want to talk about the issues related to overweight and obesity among Alaskans and among Americans related to tobacco use, related to immunizations and unintentional injuries. The unintentional injuries, of course, relate to the presentation we just heard from Frank and Dan and Julie there.

Overweight and obesity now, I believe, and the complications of it, is the greatest public health challenge facing our country and facing our state. The direct medical costs related to the complications of overweight and obesity are greater than those for tobacco. Tobacco still kills a few more.

Tobacco is a big issue. I'll talk about very gratifying progress that we've made in the state, but the challenges that we still have.

Our immunizations I mentioned this morning where we're pretty

1 close to the Red Lantern award, if we don't have it, in
2 immunizations generally in Alaska and then unintentional
3 injuries where, as Frank pointed out, we're number two to New
4 Mexico, and it is the biggest killer for Alaskans age one to
5 age 44.

6 On the overweight and obesity, in the presentations that I
7 make on that, I have this map that you see, but a whole series
8 going back and then kind of, like an old stereopticon or
9 something, I guess, flip through them and you can see the
10 colors changing back from the early '80s to today, where
11 obesity has gotten worse and worse and worse and worse. So
12 that overall, nationwide and in Alaska, a third of adults are
13 obese; a third are overweight. That's defined by Body Mass
14 Index, 30 and above for obese, 25 to 30 for overweight, normal
15 being 18 to 25, which is about a third of Americans, and just
16 a tiny, tiny fraction underweight below 18.

17 For kids, it's generally reported in terms of a percentile
18 there, but it's still related to weight and height, and as
19 many as 40% of Alaska's children are overweight or obese.
20 This is worse than it has been, so we're on the road to above
21 findings being worse. And the rates of U.S. childhood
22 overweight and obesity have tripled over the past four decades
23 there.

24 The states that are the reddest there are the worst states,
25 generally the southern states, West Virginia to Oklahoma, and

1 then down to the deep south, but we're in the next group, the
2 next worse. Colorado, of the states, is the only one that
3 shows there as the lowest group, but still a problem in
4 Colorado.

5 Now there was an article published in JAMA in 2003 in which
6 CDC noted that the estimated lifetime risk for females born in
7 the decade just ended is 38.5% and for males 32.8%.

8 Currently, we estimate about six and probably going up to 8%
9 of adults are diabetic in this country, and we are spending
10 huge, huge amounts of money on the complications of diabetes,
11 with renal failure, with heart attacks, with blindness, with
12 loss of arms and legs.

13 In my own personal experience, the American Indian population,
14 outside Alaska particularly, was much into this early, and in
15 the Southwest, the Pimas and the Papagos were in a situation
16 where the adolescent males were weighing ten pounds more on
17 the average every decade. And when you see what's been
18 happening in Alaska more recently, that's not far off from
19 what we've been seeing statewide, all races in Alaska. But
20 back in those days with the Pima and the Papago people, that
21 way, if you went to the Phoenix Indian Medical Center, which
22 is kind of the counterpart for ANMC in Phoenix there, and you
23 went on the surgery ward, it was an amputation ward, with
24 folks there who had gotten infected feet and toes and so on
25 and were losing their limbs. And so it's a huge problem.

1 There are certain disparities, as you note there. Hispanic
2 females, more than 50%, have a lifetime risk of diabetes due
3 to obesity and overweight as a complication of that, and
4 Hispanic males, more than 45%.

5 That means that, if you are a female and diagnosed with
6 diabetes at age 40, your life expectancy is 14 years less than
7 if you don't have diabetes and that's related to the
8 overweight and obesity. If it's a male, it's almost 12 years
9 less.

10 Now it's a little bit dark, but Sara Bourne (ph), my assistant
11 who puts these together in nice-looking forms for me, found
12 this actual advertisement, and this comes from Kentucky Fried
13 Chicken, and it says, "complete your meal with a mega jug for
14 just \$2.99 more." And at the bottom, it says, if you do this,
15 we will donate one dollar to the Juvenile Diabetes Research
16 Foundation. There seems to be some lack of logic into what
17 they're doing there, but that's reality. That's a real
18 advertisement that was there.

19 Now the direct medical expenditure in 2008 -- these are not
20 the work loss costs, not lack of productivity costs and other
21 things -- direct medical costs related to diabetes, \$147
22 billion annually, not quite that of tobacco, but approaching
23 it. And in Alaska, that means almost half-a-million dollars
24 back in 2008 that's coming out of our economy of our state
25 there.

1 And one of the realities is that, if you talk to individuals
2 who are overweight or obese -- and a lot of the data that we
3 look at is self-reported data, and generally, that tends to
4 understate the rates of obesity and overweight. But the self-
5 perception is that about 70% of people who are overweight,
6 meaning a BMI of 25 to 30, regard themselves as being of
7 normal weight. Those who are obese, those who have a BMI of
8 over 30, most of them, about two-thirds, believe that they are
9 overweight and not obese. So the self-perception is
10 incorrect.

11 And some folks have criticized *The Greatest Loser*, a popular
12 TV program, because it gives you an image of obesity that is
13 very far out on the end of the curve and not what it is for
14 the majority, the two-thirds, of the American population
15 that's overweight or obese. These are the folks that are out
16 at the fractions of 1% that are the 350, 400, 450 pounds and
17 so on. But this is an extensive problem that continues to get
18 worse. And one of the -- I heard an interesting comment the
19 other day, obviously from somebody who didn't pull the
20 democratic lever in the election, but they said the real
21 health care improvement that we have is what Michelle Obama is
22 doing and not what the President is doing, but I think there
23 is some truth in that, and I am just so delighted that she has
24 picked, as her thing as First Lady, overweight and obesity and
25 activity and eating habits in kids because that's really

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important.

The little cartoon in the center is somebody. Holy Toledo! They're looking at the scale. Basically, it says \$1,900 a year more in medical care costs if you're obese there, for every man, woman, and child.

This generation of Americans that have been born in the last decade, as was noted in the report that came out over Michelle Obama's name, may be the first generation of Americans who do not live as long as their parents did, since our country began, because of the medical complications of overweight and obesity.

Now presently, that causes about 365,000 premature deaths a year. Diabetes causes about a third of that number of premature deaths, diabetes and its complications. The other things that I mentioned, heart disease, hypertension, stroke, and so on are there.

To put that in context, the pandemic flu that we had last year, 2009-2010, caused 1,642 deaths in the United States. We dodged a bullet. It was not 1918-1919, but we mobilized a lot of effort. We spent a lot of money. We had a lot of media campaigns, rightly, to get people immunized, but that was the number of deaths there, a tiny fraction of the 365,000. AIDS, for example, causes about 15,000 deaths a year. Where we now can deal with AIDS, it's become, in some ways, more a chronic disease. We cannot cure anybody yet from AIDS, but

1 gratifyingly reducing our incidence of smoking that we have.

2 So what are doing here in Alaska? We have ATCO, Alaskans
3 Taking on Childhood Obesity, and this is an interagency task
4 force that has been particularly looking at the issues in our
5 young people, in our children. We know that, compared with
6 when any of us were in school, there is less PE now. Many
7 schools don't have PE. The University of Alaska system
8 doesn't train teachers in PE. Recesses tend not to be related
9 to physical activity. Soda pop machines have been a big
10 generator for PTA funds, which has become important to the
11 schools when they may be under-resourced, at times.

12 So ATCO was a group. The Commissioner of Department of Health
13 and Social was on that, the Commissioner of Department of
14 Education and Early Development, or Carol Comeau, Pat Carr,
15 formerly with the Department of Administration was on. So it
16 was an interagency group looking at the issues of childhood
17 obesity and asking what we could do about that.

18 There have been requests for funding for the past three years,
19 has not developed enough of a constituency yet, although there
20 was an add-on in the Legislature that the Governor signed off
21 on to get us some money to kind of keep us where we were
22 because the small amount of federal money that we were getting
23 has been dropping off and ended, actually, the end of last
24 August. So it got us through this year.

25 There is a legislative item that came through the capital

1 budget, and I'm, at least, keeping my fingers crossed that it
2 will survive the Governor's pen for a veto, as he tries to get
3 that budget down to what he feels is a reasonable level for
4 the State to pay for capital funds. It's kind of unusual to
5 be there. So there is some interest, but not enough yet.

6 The plan had been to target the school kids for PE programs,
7 to have recess times be physically active, to have after-
8 school programs, getting kids active, and then some things
9 have been done. There have been some successes.

10 The Anchorage School District -- and Carol Comeau has been
11 very interested and very supportive -- did get sugar-sweetened
12 beverages out of the Anchorage schools. The MatSu School
13 District followed along and did that. They've tried to
14 improve the diets where now so many kids -- that's where they
15 get two meals a day, breakfast and lunch, in the schools and
16 trying to make those diets more healthy.

17 The MatSu School District actually, measuring from -- I can't
18 remember the exact years now -- about 2003-2004 to the present
19 -- is seeing a bending of the curve. They've actually seen a
20 little down trend in the rate of obesity and overweight, but
21 there, the Municipal Council, the School District there has
22 really taken this on, taken it very seriously, got sugar-
23 sweetened beverages out of the schools, tried to get the kids
24 more active, and it seems to be helping.

25 Anchorage has kind of flattened out. They're not trending

1 down yet, but that's hopeful.

2 We also, with resources, would plan to try to have some media
3 campaigns to begin to change the culture. Noah has mentioned
4 a couple of times today what we're talking about in terms of
5 changing the health care system to make it more evidence-
6 based, to have a system where the kind of practice that Noah
7 describes that he does should become more and more the norm,
8 the way physicians and patient interrelate and work together.

9 That is a decades-long process. I think this is, too, but
10 it's something that's important now.

11 On the tobacco use, which still kills more people a little bit
12 in Alaska and nationally than overweight and obesity does, now
13 the medical costs are actually a little bit less than they are
14 for the direct complications of obesity, but we've seen some
15 success. Alaska has been, and in some ways still is, one of
16 the worst states across the country in terms of smoking.

17 Smoking has been very common up here, but we have now reached
18 among our adolescents aged 14 to 17 -- and this is an
19 absolutely huge success -- we're at 15.7%, which puts us
20 number seven among the 42 states that report that. That is an
21 incredible success. The median, as noted, 18.2% there.

22 For adults, we've also seen improvement. We're down just
23 below 19% now and that's a 30% decline just since 1996. It
24 used to be that we were well over 50% of our adults smoked and
25 used tobacco in other forms.

1 What this decline in the last 15 years means -- since 1996,
2 there are 8,000 Alaskans alive today who would not be alive if
3 we hadn't seen this improvement in smoking rates in our adults
4 and in our adolescents. It means we have saved and avoided
5 \$300 million in health care costs and that's really huge. Now
6 we're at 18.8%. The Puget Sound area is about 12.2% or
7 something. California is 12.5%. The best state is Utah,
8 about 9.8% or 9.9%. As my former counterpart from Utah used
9 to say, it really helps when most of your citizens think
10 they're going to go to hell if they smoke or drink, and I
11 think I've said that to you all before. But it provides a
12 benchmark for us that, if they can do it in Utah -- I'm sure
13 they're trying to do better -- but it's a target that we can
14 aim toward.

15 Now our biggest challenge remains with Alaska Native adults.

16 They have dropped below 40%. They're down to 39.something
17 percent who smoke, but that's our biggest problem. Now
18 probably the group in this state that initially took this
19 challenge on for the whole state was the Alaska Native Health
20 Board back when they were -- the way they were formally
21 structured before ANTHC came along and they were more into
22 program areas, but they have been a real champion for this and
23 have showed the way, a lot, for the states there, but it
24 remains a huge problem.

25 Other uses of tobacco remain a differential problem among the

1 Alaska Native population. You can still walk around the
2 Bethel area that Val just came in from and see little four-
3 year-old with a circle on the back pocket of their jeans
4 there, and the smokeless tobacco is used as a pacifier in
5 infants, in little kids still.

6 So there is a lot of work to be done, but every one of the
7 Alaska Native Health Corporations is very dedicated, very
8 engaged to that. If you walk through the Bethel hospital,
9 they have the smoking cessation clinic there with some real
10 dedicated people there, but it remains a challenge for us.

11 Now why have we seen this success? Part of it is that we've
12 had money to be able to do it. This -- each year, CDC ranks
13 all the states in terms of a standard they established for
14 your anti-tobacco use efforts, and basically, it's just based
15 on population as to how much money you should spend. And
16 Alaska is number one among all the states. We don't spend
17 quite what they think we should be spending, but we're close.

18 So we're number one among the states. Most states are well
19 below 50%, and it's gotten worse and worse and worse.
20 Christine Gregoire, as many of you will remember, was kind of
21 the lead Attorney General from Washington State when she was
22 Attorney General before she became Governor, with the tobacco
23 settlement money for these hundreds of billions of dollars,
24 which, among other things, has provided some of these anti-
25 tobacco use efforts, and they've robbed most of that, and I'm

1 to see in your handout than it is there, actually is just a
2 little older data than what's on the left, which is newer
3 data, but that shows our ranking and shows the breakdown by
4 ethnic group and so on there.

5 Now we don't have that funding source for overweight and
6 obesity that we have for tobacco and that's what's paid for
7 when you see the "Dear Me" letters on television, which I
8 think have been effective when you see the other media kinds
9 of things. That's what's paid for that. We don't have that
10 kind of funding source for obesity, and even if we get some,
11 it'll be much less, but it has made a difference, but it still

12 has taken decades and decades to get there. When I was
13 younger, the doctor smoked Lucky Strikes because they were
14 good for your health. Camels is good to your T-zone. That's
15 the throat, and I forget what the other T was.

16 I recently read a book called "A Biography of Cancer," I
17 think, which was kind of interesting, and they went through
18 some of the history, just reminding me of what I have lived
19 through where, even well after it was recognized of the causal
20 relationship between tobacco use and specifically cigarette
21 use and lung cancer and heart disease and other things, how
22 there was so much (indiscernible - voice lowered) and denial
23 in an immoral way by the tobacco companies in combating this
24 and that still goes on now. And we know, when you have sugar
25 taxes put on, that the sweetened beverage industry will work

1 against it and call it a challenge to your freedom, and I
2 think we often make that decision on our own part. But having
3 the money has made a big difference in this, in improving the
4 situation, but it does remain a big problem for us.

5 Now I'd like to talk about immunizations a little. There is
6 some incorrect data here, unfortunately, that I would just
7 clarify. The seasonal flu exam, CDC initially reported that
8 we were the best for the senior population in the country.

9 That was not correct. There was an error, and I don't know
10 exactly what it was, but in calculating that. So we were, I
11 think, far from the best on seasonal flu. That was up there
12 as a success, but just a few days ago, learned it was not.

13 These are the immunization completion rates for the 19 to 35
14 months old, and on this, we are about number 49 among the
15 states. If you look -- again as I mentioned this morning, if
16 you look at the population served by the tribal health system,
17 they're about 90%. That's where we ought to be as a country.

18 As a state, we've been about 57%. And so if you take 90% for
19 the 18% to 19% that's Alaska Native people, it means the rest
20 of the state is way worse than that. That is not very good.

21 When I was in my early career and probably most of the docs in
22 the room, we learned what we called usual childhood diseases.

23 Well, that is -- you probably wash your mouth out with soap,
24 if you talk about that. They are not usual. They should not
25 be usual, and they can be fatal. They can have dreadful

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complications.

There are folks who believe, for example, there is the (indiscernible - voice lowered) that the measles vaccine, is it, I think, is related to the cause of autism, and there were publications in *British Medical Journal* (indiscernible - voice lowered) -- I get them mixed up, which one it was -- purporting to document that. It came out in the other one, and I think the (indiscernible - voice lowered) is the one that corrected it. Not only -- that was not just a misinterpretation of data. That was fraudulent data. That was fraudulent on the part of a physician who was an advocate, who ardently believed that they caused autism, and he manufactured his data to support his claim, and it achieved widespread circulation and belief in a peer-reviewed, well-respected journal, and we're still living with that. The worst immunization rate for these 19 to 35 months old in Talkeetna, and Talkeetna may have the highest percentage of PhD's of any small community in this state. They are bright, educated, intelligent people that make some dumb decisions. Joe McLaughlin, who is our outstanding State Epidemiologist, was over in New Zealand running some Class V rivers, which is what he likes to do when he is not ice climbing, and visited some friends who were the son and daughter-in-law of a friend from Talkeetna, and they were living in New Zealand, and they were not having their children immunized, and he said, you've

1 got to listen to me for the next two hours. So he talked with
2 them.

3 Number one, they didn't think that there were diseases, like
4 measles or mumps or chicken pox, in New Zealand. So he went
5 online and got from the New Zealand health department and
6 showed them that, absolutely, it was there.

7 And then they also had a belief that, if their children did
8 contract a natural disease, they would have better immunity
9 than if they took the immunization, but they totally ignored
10 what I saw in my early career as a young doc in Kanakanak
11 before we had measles vaccine, where every time we had
12 measles, we had little kids come in and die with measles
13 pneumonia, measles encephalitis, the complications that you
14 get from measles, or that you saw women who got German measles
15 having early abortions or having congenital abnormalities of
16 the babies that they were bearing.

17 These are not benign diseases and so they shouldn't be called
18 usual childhood diseases, and they are totally preventable
19 today. They're still around. I think none of the other docs,
20 probably, in the room can remember seeing patients on iron
21 lungs, like I did, but that was real in my lifetime and that's
22 totally preventable with polio vaccine.

23 So we're not doing a good job, as a state, in our
24 immunizations and specifically in our childhood immunizations.
25 Part of the reason we're not doing as well is that we have so

1 many more shots that we give kids and that really is a hurdle.

2 If you think of these poor little infants having to get 15
3 shots, that's a lot of shots and it hurts the mom or the dad,
4 whoever is bringing them in, every time they get a shot. It
5 also costs about \$1,500 now just for the vaccine. Six to
6 eight years ago, it was maybe \$400 to \$500. It's now \$1,500
7 because the costs of the vaccines have gone up and there are
8 more vaccines, but there have been some remarkable successes.

9 Hepatitis A, which is the kind of hepatitis you get from
10 eating contaminated water or contaminated food, causes
11 jaundice, causes problems, had periodic epidemics here,
12 periodic outbreaks in Alaska, particularly in Southwest
13 Alaska, and there would be swings. There would be some years
14 there wasn't much, and some years, it would go way up. But
15 overall, one of the highest rates of Hepatitis A in the world,
16 we had a major push -- again particularly, the tribal health
17 programs had a big push in Southwestern Alaska in getting
18 people immunized for Hepatitis A. We now have one of the
19 lowest rates of Hepatitis A, particularly in Southeast Alaska,
20 but to a somewhat less extent, throughout the state, and
21 that's a major success.

22 Hepatitis B, which is the injection-type hepatitis which you
23 get from contamination with blood -- surgeons can get it.

24 Sometime in my life, I got Hepatitis B. I don't know when.
25 But if you cut yourself when you're operating on a patient who

1 has Hepatitis B in their blood, if you're an IV drug user, if
2 you have sex with somebody who has Hepatitis B, you can
3 contract that. That is also vaccine-preventable.

4 Hepatitis C is not yet at this point. Hopefully, someday it
5 will, but Hepatitis B and C both are a leading cause of
6 hepatocellular carcinoma, and at one point -- it's less now --
7 hepatocellular carcinoma was the most common cancer around the
8 world, with the Hepatitis B totally preventable.

9 The efficacy studies for Hepatitis B, when MERCK first
10 developed their vaccine, were done right here in Alaska.
11 MERCK funded it. They were done, again, centered in Southwest
12 Alaska, but done statewide. Brian McMahon, who is still here
13 working with CDC and ANMC, led those studies on the side.
14 Huge success here, and the incidence of Hepatitis B has gone
15 down, but these are preventable diseases that, overall, we're
16 not doing a very good job on.

17 This, again, shows coverage by the specific vaccine. As you
18 can see, some are better and some are worse. Let me just go
19 through those.

20 Another disease I want to mention because of the success that
21 we've had, here's -- it just shows the curve of the reduction
22 that we have, and since that was developed, it's gotten
23 better.

24 19:01:48

25 (Missing portion of recording due to recording equipment

malfunction)

19:18:36

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3 MS. STONE:use of preventive medicine and self-care. A
4 few more things. People with mental illness have the lowest
5 earning level and household income. I mentioned this.
6 Although isn't specifically a health impact, it certainly is a
7 social impact. Approximately 90% of individuals who died by
8 suicide had a mental disorder, and 40% had visited their
9 primary care doctor within the month. The question of suicide
10 was seldom raised. Ninety-four percent of primary care
11 physicians failed to diagnose substance use disorders
12 properly.

13 So with that kind of as a background, again the four areas
14 that I'm going to concentrate on further are family
15 violence/adverse experience, alcohol and other drug abuse,
16 suicide, and mental health, specifically depression and
17 anxiety.

18 I wanted to start showing you this, which I hope you can see
19 better in your packet than here. This is the Alaska Screening
20 Tool. Let's see. On this computer, I don't know how to
21 increase this, but this is the Alaska Screening Tool. This is
22 a questionnaire that we use in the Division of Behavioral
23 Health that's administered to every person who is enrolled in
24 behavioral health services in the state of Alaska, which is
25 behavioral health being people enrolled for substance abuse

1 and mental health services. And these questions -- and we can
2 give you a bigger copy, if you can't see the one that you
3 have. The questions relate to mental and emotional status
4 questions, questions about abuse and neglect, that is adverse
5 experiences. There are questions relative to brain injury,
6 relative to fetal alcohol in the past, suicide risk, and
7 alcohol and other drug use. Yes?

8 COMMISSIONER STINSON: Is that available somewhere online to
9 copy or to borrow?

10 MS. STONE: That should be on our Division of Behavioral
11 Health website, and we can probably get you a copy also.

12 COMMISSIONER STINSON: Thank you.

13 MS. STONE: So the results from this chart that you're seeing
14 show the incidents of these conditions in every person
15 enrolled in behavioral services that are managed by Division
16 of Behavioral Health, and you can look at those numbers
17 yourself and see the incidents, which is quite high. And of
18 course, these numbers are relative to the people who are
19 already in service. This is not about the general population,
20 and we don't have these numbers, for example, children or
21 families in Office of Children's Services. We don't have this
22 information on Juvenile Justice. We don't have these numbers
23 relative to Medicaid recipients in general. So this is the
24 population of people already in service.

25 UNIDENTIFIED MALE COMMISSIONER: (Indiscernible - away from

mic)

MS. STONE: And I'll be talking about that in just a minute.

In fact, I'm just about there, two screens away.

Relative to family violence -- so setting the stage then, we have -- as you see then from our Alaska Screening Tool, we know the incidents of these conditions in our Alaska population. So relative to family violence, in 2010, the State undertook an Alaska Victimization Study. The study was supported and paid for by the Council on Domestic Violence and Sexual Assault and the Governor's Office with their DVSA initiative, and the study was undertaken because the Uniform Crime Reports didn't include a lot of information that was important in order to have a baseline for family violence in the state of Alaska.

So here, you see some kind of foundational levels in the state of Alaska for violence; 47.6% of adult women in Alaska experienced intimate partner violence in their lifetime, 9% in the last year. Thirty-seven percent of adult women in Alaska experienced sexual violence in their lifetime, 4% in the last year. Twenty-seven percent of adult women in Alaska experienced alcohol or drug involved sexual assault.

This study is being repeated right now in the state, and it is being applied in rural areas with some difficulties because the study is a phone survey, and the ability to reach people by phone in the rural areas is proving some problems, but we

1 are trying to get the data on a rural basis.

2 COMMISSIONER DAVIDSON: So is it difficulty reaching people by
3 phone or is it translation?

4 MS. STONE: Reaching people. I believe they have some way
5 that they randomly get numbers, and phone numbers in rural
6 areas have been randomly assigned and they don't actually
7 belong to people. So they call up a lot of numbers that don't
8 actually have anybody assigned to them, I believe is the
9 problem. It's an odd problem.

10 COMMISSIONER DAVIDSON: So I'm just recalling a similar job
11 that I had in a summer when I was in college at UAS, and we
12 were doing a similar randomly dialed thing for the State, and
13 there were no Yupik speakers or (indiscernible - speaking in
14 Native tongue) speakers during the -- and I don't know if
15 that's an issue. So we had a lot of just trying to get to
16 find out if that was the right person. People didn't even
17 understand. You know, they didn't know who it was and they
18 would just hang up.

19 MS. STONE: And I don't have the specifics, Valerie, but I
20 could -- we could find out how that's being handled. Andre
21 Rose (ph) is the person most responsible for that and is
22 probably in the next room tomorrow because the DVSA group is
23 meeting, so we could actually talk to him on it.

24 So the Adverse Childhood Experience Study, Dr. Hurlburt
25 mentioned. I wanted to be sure to bring to your attention in

1 answer to your question, Mr. Branco. This study by Vincent
2 Felitti and his compatriots in Kaiser Permanente is actually
3 quite old, from 1998. And the studies, if you look at them,
4 are more recent, and it's because they had quite a bit of
5 difficulty getting these studies published, and even once
6 published, he will tell you, if you talk to him, that there
7 hasn't been a lot of interest in them. They are contrary to
8 our traditional way of thinking, and it's been very -- he's
9 not seen this information integrated in the way that he would
10 have hoped.

11 Interesting about this study is that the origin of the study,
12 as I cite here, was an obesity program that they had where
13 people who were grossly obese, 200, 300, 400 pounds, were
14 significantly successful in weight loss and yet dropped out of
15 the program. This came to their attention, and they were
16 concerned about it. So they thought, well golly, maybe we'll
17 just ask the people what's up with that. So they asked the
18 people, what's up with that? And in a series of questions,
19 they -- one of the questions that got a positive response was
20 whether or not the person had been abused as a child. So
21 based on that, they then went about this study. So it was the
22 obesity study that influenced their thinking about what might
23 be going on that influenced people.

24 One more piece about that obesity part. They took great pains
25 to talk individually with the people who, I guess you would

1 say, failed in their project and gained their weight back and
2 had some really compelling communications with the people when
3 they asked what happened and people would volunteer that it
4 was related to adverse experiences in their childhood. And
5 one particular comment that I feel is really significant was a
6 woman who said that she was just so happy to have been asked
7 because she was afraid that she would die and no one would
8 ever have asked what happened to her. So that's the kind of
9 thing we're talking about here.

10 This study then, through the people who went through Kaiser
11 Permanente, at one point in the study -- and this study was
12 redone at numerous times. So at one point, 26,000 adults were
13 -- went through their system, and in going through their
14 primary care system, 70% agreed to participate in the study,
15 where the questions that are on the following page were asked.
16 And one of the very interesting things about the study is that
17 the average age of the people is 57. They were 80% Hispanic,
18 80% white, which included Hispanic, 74% had attended college,
19 44% were college grads, and they were pretty equally men and
20 women. So this was largely a middle-class working sample.
21 This is the questions that were asked, and if you could read
22 the Alaska Screening Tool that I showed you earlier, these
23 items are represented now in our Alaska Screening Tool.
24 So you can read these. The Adverse Childhood Experiences,
25 ACES, related to physical abuse, emotional abuse, contact

1 sexual abuse, growing up in a household with an alcoholic or
2 drug user, a member in prison, a mentally ill, chronically
3 depressed or institutionalized member, a mother being treated
4 violent, both biological parents not being present. And the
5 study measure was very simple. One positive answer, one
6 point. It wasn't a complicated study.

7 You have, in your packet I believe, the main Felitti study
8 that has the methodological parts of kind of the baseline for
9 his work. There are other papers that you could look up
10 online or I'm not sure if you put them on the website, right?

11 Net yet, but we have them.

12 So the findings, ultimately, were that the ACES were common,
13 though typically concealed and unrecognized. ACES had a
14 profound impact 50 years later because, when they looked at
15 the information even 50 years later, they were seeing the
16 determinants which were the -- they saw definite correlations
17 with smoking, heart disease, diabetes, obesity, unintended
18 pregnancy, depression, suicide, alcoholism, and injected drug
19 abuse. And if you look at the study, you'll see how, as the
20 number of ACES increased, the incidents of these different
21 correlates increased.

22 COMMISSIONER STINSON: You could chronic pain and pelvic pain
23 to that list, too, because there are very good studies that
24 correlate that, and we deal with that in the clinic all the
25 time. Thank you.

1 MS. STONE: So going on to another topic, Alcohol and Other
2 Drug Abuse, looking at some information that is Alaska-
3 specific, we see that alcohol use, heavy drinking, and binge
4 drinking among adult and youth in Alaska is historically
5 higher than national averages. Binge drinking in Alaska is
6 among the highest in the nation. The marijuana is pretty
7 interesting. Eight percent of Alaskan adults use marijuana,
8 20% between 18 and 25 and 25% of students in grades ten, 11,
9 and 12 use marijuana.

10 The drug of choice in Alaska, excluding tobacco, are alcohol,
11 cocaine, methamphetamine, marijuana, and pharmaceuticals.

12 UNIDENTIFIED COMMISSIONER: (Indiscernible - away from mic)

13 MS. STONE: I am not sure. That information is from the 2006
14 Annual Drug Report by the Alaska Bureau of Alcohol and Drug
15 Enforcement. My guess is that yes, that would be in order,
16 but I'd have to find out.

17 UNIDENTIFIED COMMISSIONER: (Indiscernible - away from mic)

18 MS. STONE: Would be higher, yeah. Consequences are that --
19 again this is very relevant to Dr. Hurlburt's presentation.
20 Nearly 25% of all hospitalized injury patients had suspected
21 or proven alcohol use injuries. The leading causes of
22 premature death and years of potential life lost are strongly
23 associated with substance abuse.

24 Moving on to suicide and its impacts, I think that you are
25 probably aware of some of these facts about suicide in Alaska.

1 We, unfortunately, lead the nation, and you see in -- between
2 2000 and 2009, there is very little change, certainly not a
3 significant improvement. The rate of suicide among Alaska
4 Native people is two times that of non-Native. In 2009, twice
5 as many non-Native Alaskans committed suicide as Alaska
6 Natives. Persons aged 15 to 24 and 25 to 29 are the age rate
7 groups with the highest rates of suicide. Sixty-four percent
8 of deaths are by firearm. Males complete suicide more often
9 than females, but females attempt more often.

10 The next page shows the specific and numbers of suicide across
11 the state, where, not surprisingly, the highest numbers are in
12 Anchorage and the highest rate of suicide is in the Northwest
13 Arctic.

14 I thought to include this information about the Alaska Follow
15 Back Study because this was an interesting study that was
16 conducted -- I believe it was in 2003 -- that is Alaska-
17 specific. Interviews were done with survivors of people who
18 had committed suicide, and a variety of questions were asked
19 of them. And of course, while people would like to see a
20 direct cause and effect because we would really like to be
21 able to say this is exactly what we need to do to stop this,
22 that's truly not possible, but I think, as you look at this
23 Alaska-specific information, it certainly gives you some
24 indicators of what was going on with the folks who did end
25 their lives.

1 Particularly relevant to the conversation here is that 62% of
2 the people were taking prescription medications for mental
3 health problems at the time of their death, 35% had a parent
4 with a diagnosed mental illness, 78% did not think they were
5 getting the mental health care they needed, and of course,
6 this is stated by the survivors. The survivors say that 59%
7 experienced an event that caused shame, and my guess would be
8 that, relative to those last two bullets, the survivors
9 probably had a different perception of those things than the
10 person would have had, whether higher or lower, I'm not sure,
11 but the family member might not have truly known what the
12 financial, alcohol, or drug problems, or sexually-related
13 problems truly were in that person.

14 And the same on the next page. Some of these probably are
15 under-represented because the family member might not have
16 known the extent to which these problems existed. I think 36%
17 abused as children seems pretty low, so I would question that.

18 There certainly is a predominance of alcohol or other drug
19 abuse as a problem.

20 As I talk briefly about mental health, depression, and
21 anxiety, this is an interesting kind of entree into this
22 subject because one of the things I need to be sure that you
23 understand about our behavioral health system in Alaska is
24 that the services paid for through grants and Medicaid
25 services prioritize the populations of people who are

1 seriously mentally ill. That is adults with serious mental
2 illness, children with serious emotional disturbance, and
3 people with substance use disorders.

4 So depression and anxiety are, in our ways of thinking,
5 general mental health problems, and our system per se does not
6 deal with general mental health problems so that, as this is
7 coming into our, you know, kind of perception as an area of
8 interest, the lack of our system dealing with it has been
9 really on purpose. We've been dealing with a different level
10 of psychiatric illness in the population than this general
11 mentally ill population who experience depression and anxiety,
12 which is being recognized now as being absolutely instrumental
13 and absolutely related to whole health. And it's certainly
14 that the field didn't recognize this, and I don't think the
15 State, over the years, didn't recognize it. It's the extent
16 of the problem and the cost to do something about it, and I
17 think that, as you probably are having conversations about it
18 as we're looking at -- and I'm giving some of the answers
19 here, but as we're looking at how primary care and mental
20 health issues can coordinate, we're able to get at some of
21 these general mental health issues that the system really
22 never attempted to address.

23 COMMISSIONER FRIEDRICHS: Along those lines, we've heard
24 anecdotal comments, and I think some of them were made at
25 different sessions here with the Health Care Commission, that,

1 at one point, there were 200 inpatient mental health beds, and
2 we're down now to around 80 staffed, inpatient mental health
3 beds for a variety of reasons.

4 And then also an interesting comment, at the All-Alaska
5 Pediatric meeting that I attended several months ago, the
6 funding would run out, I believe, in 2013 for some of the
7 state run adolescent mental health residential programs and
8 that those services, which we had been able to provide here in
9 the State would end at that point and those patients would
10 have to go back to the Lower 48 for care.

11 Can you validate either of those? Does that ring a bell at
12 all?

13 MS. STONE: The second comment that you're saying rings no
14 bells, so I don't know what that would be in relation to
15 there's no money. That could be referring to the "Bring the
16 Kids Home" initiative, narrowing down in, I believe, 2014, but
17 it certainly isn't implied that people are going to be sent
18 anywhere as a result of that. The whole intent of that
19 initiative was to establish a system that would prevent that
20 through the years that the program has been operating and
21 focusing change on the system. So that might be what you're
22 referring to, but that's certainly not expected to be what
23 happens.

24 Relative to your first question about Alaska Psychiatric
25 Institute, certainly, the Institute has downsized over the

1 I misunderstood your comment, but that was part of a plan,
2 that we're actually doing well because of that?

3 MS. STONE: No. I think the two problems are unrelated. I
4 don't think that general anxiety and depression are the
5 general diagnoses that people are coming in to the Alaska
6 Psychiatric Institute with. They're coming in with more
7 serious kinds of difficulties than that.

8 The problem, relative to people waiting in communities right
9 now is pretty complex, and it has to do with a range of
10 complex -- the need of some complex community services, which
11 certainly aren't at the level of outpatient treatment for
12 depression/anxiety. It relates more to things, like housing
13 for people who are seriously mentally ill, substance abuse
14 treatment for people with co-occurring disorders, intensive
15 case management for people who need intensive assistance in
16 order to keep from revolving through the system. So those
17 folks are definitely at a different level than that general
18 mental health. I don't think those two problems are
19 correlated.

20 What is correlated though, I believe -- and I think that the
21 data would show it -- is the relationship between the general
22 mental health issues, depression/anxiety, relative to people's
23 -- their health impacts and their health conditions being more
24 chronic as a result of that. So I think those are two
25 different levels of service in the system.

1 COMMISSIONER FRIEDRICHS: As we put together recommendations
2 and kind of try to draw out of each of these presentations, I
3 guess, at least on the federal side, what we've identified is
4 a continuum in which someone who may initially be depressed,
5 if they are not able to access the care they need, either
6 because of a fear of stigma or whatever else, can progress
7 down that continuum to requiring a much higher level of
8 intervention, at which point -- especially if they can't
9 access it, then they make poor decisions to engage in self-
10 injurious behavior.

11 So what I'm trying to pull together out of your presentation
12 here is, where are the opportunities to improve our system? I
13 mean, you've laid out some very discreet statistics that help.

14 How do we make that system better?

15 MS. STONE: And I think I have them for you at the end. I
16 hope so. So the two things that I.....

17 CHAIR HURLBURT: Noah, did you have a question?

18 MS. STONE: Sorry.

19 COMMISSIONER LAUFER: There are just a couple comments. One
20 thing is I think that there is not a receptive audience in
21 medicine for this kind of data because it's incredibly wishy-
22 washy, and you know, I look at that and I think, you know, how
23 accurate could that possibly be, just based on reporting and
24 these things that show up statistically? I mean, these aren't
25 markers for mental health disorders. They're markers for poor

1 health, poor health of a community, a family, a person,
2 genetics, and those are -- it's too ephemeral.
3 And when I see a patient as a primary care doc, I don't think
4 they have a mental health problem or a physical health
5 problem. I think, they are unhealthy, and they smoke and
6 that's unhealthy, and they're terribly depressed and that's
7 unhealthy, and they were abused and that's unhealthy. And you
8 know, it's the wrong way to approach it.

9 And the other thing I have to say is, when I see somebody and
10 they have a mental health problem that is severe enough that I
11 need help, they're left in a void. There is no access to
12 care. There is no continuum, except if you're wealthy enough
13 or well enough insured to pay \$450 an hour, you might get into
14 a practice. Those, generally, are people who are actually not
15 that sick. And you have to have extreme mental health issues
16 to be admitted or to get care otherwise, and it's a great
17 frustration to me. I'm not a psychiatrist, and I am forced to
18 do psychiatry a lot, and it's a wishy-washy field. People
19 carry diagnoses that, even if you go to the DSM for and look
20 at them, are wildly inaccurate across the entire field.

21 MS. STONE: And I'm not sure what you're meaning by wishy-
22 washy, but I think that we're speaking the same thing relative
23 to.....

24 COMMISSIONER LAUFER: How could you get an accurate measure
25 from a telephone poll about things that people might tell one

1 person in their life, might never tell anyone in their life,
2 something that I get told occasionally after knowing someone
3 for a decade or longer? You know, I'm not going to answer,
4 yeah, by the way, I was, you know, a participant of whatever,
5 you know, fellatio with my father. People don't talk about
6 that. They're not going to answer that accurately. I'm
7 sorry. That's just my feeling, but I think a lot of these
8 statistics are thrown around and they're highly political.
9 You know, there was one that got me personally; 94% of primary
10 care physicians failed to diagnose substance abuse disorders
11 properly. How the hell do you know that? Does that mean it's
12 not in the chart? That doesn't mean I didn't know. It's a
13 terrible -- you know, it's -- to say that you have a sense of
14 accuracy where you can say 94%, right away, it de-legitimizes
15 the value of the statement because that's an impossible thing
16 to measure.

17 MS. STONE: And I would have to go back and look at that
18 specifically and see if that was a specific study to see if
19 substance abuse was mentioned in a chart, on what basis was it
20 made, was it based on, you know, a specific series of
21 questions. I couldn't tell you. I could look for that
22 information.

23 COMMISSIONER LAUFER: The completing of forms with fill-in-
24 the-dot is not enough. We're talking about intensely
25 personal, long-term relationships with people where I may not

1 write it down, and often, it's not written down, and often,
2 it's a process over many years that you're helping somebody
3 with. It isn't -- it's not algorithmic. It's the same
4 problem I keep, you know, running into. We're not -- you
5 know, people don't have discreet anything.

6 MS. STONE: Right. And I don't disagree. I think that trying
7 to bring this to numbers is trying to make a case for the
8 things that you're saying. These things exist. How do you
9 measure that they exist, so that we deal with them because it
10 appears to be, from these numbers, that the lack of our focus
11 on them is contributing to the lack of success. So I think
12 it's an attempt that didn't exist ten years ago to try to put
13 these pieces together, as primitive as it might be with some
14 of those pieces.

15 COMMISSIONER LAUFER: I would agree with that, but all good
16 doctors, at least, you know, forever have been holistic. You
17 can't, you know, take care of somebody's appendix, if you're
18 not aware of the other issues in their life, and I've seen --
19 my entire training, I've seen super specialists get on the
20 phone and scream at the electric company that this person
21 cannot go home from the hospital and not have power in their
22 home. You know, people who care, care. That's why, you know,
23 the secret of caring is caring. And these are not new
24 concepts to us, and it's kind of -- it's sort of offensive to
25 think that that's what it is. We do need better behavioral

1 health, a lot, and if we pay for it, then we will get it. I
2 mean, I feel like I'm too upset, but.....

3 MS. STONE: Well, you know, I don't have a problem at all with
4 what you're saying. I think that, you know, you're
5 representing the reality in, you know, a compassionate view
6 that this needs to be dealt with. I'm not sure that I would
7 agree that this is largely happening. I think it largely
8 doesn't happen, your concern.

9 UNIDENTIFIED COMMISSIONER: (Indiscernible - away from mic)

10 MS. STONE: Right. Right. And how routinely is that
11 happening? You might be saying that you're getting it through
12 relationship. I hear you saying you don't believe you could
13 get the same thing through screening. I don't know where you
14 start. I don't know where you start. I'm glad we're
15 discussing, but I will get to the end.

16 COMMISSIONER ENNIS: Melissa, I just don't want to move
17 forward from this slide without speaking to the point of the
18 increase of our elderly population and the related mental
19 illness or mental health disorders they are experiencing and
20 the lack of readily available treatment and support for them.
21 And many of them we're helping can't continue to be served in
22 community settings, but that is growing increasingly difficult
23 with the numbers and with the lack of available treatment or
24 even education and support for the providers in those
25 community settings. So you know, we risk, you know, both our

1 elderly and our individuals with complex co-occurring
2 disorders blowing out of those residences and being placed in
3 more expensive settings.

4 I think, for a number of years, but we're just seeing growing
5 incidents of individuals, say, with developmental disabilities
6 who have incidents of behavioral health issues that are
7 creating greater and greater problems for community services,
8 and many of those are starting to be sent out of state, and
9 the concern is that that is expensive to the state of Alaska
10 to buy out-of-state care, away from their families. It almost

11 harkens back to the early '50s and '60s when the only
12 treatment for them was with an airplane ticket out of state.

13 And we really don't want to see a "Bring the Adults Home," I
14 think we've heard, situation in which we are -- we send more
15 and more out, and yet hopefully, bring them back later.

16 Right now, the lack of available behavioral specialists to
17 help community providers, the lack of psychiatrists and other
18 psychiatric support to help with medication regimes, all of

19 that are factors that, when you say mental health or
20 depression/anxiety are seen as general health concerns or
21 conditions, you know, we're really facing such a need to
22 develop or bring that under the behavioral health field. And

23 I know you're well aware of this, but I just felt I wanted to
24 make that point once again.

25 COMMISSIONER FRIEDRICHS: I guess I'll go back to my original

1 question. There is a very receptive audience here, and having
2 flipped through and looked to the end of your slides, to the
3 extent that we can get to that and get that part out, I don't
4 understand the recommendations that you have and how they
5 relate to the questions we've been asking. It's probably my
6 fault, but I'm very interested in hearing the recommendations.

7 MS. STONE: Good. So let me go quickly to this next
8 information, which we recently pulled together, which looked
9 at behavioral health Medicaid claims and looked at the volume
10 and number of, what did we call them, encounters per client
11 and the cost per client of people receiving behavioral health
12 services reimbursed by Medicaid.

13 So this the first time that we had pulled up this information,
14 and I think this is information that we will be able to look
15 at and learn from as we analyze it further. Some significant
16 things here that we certainly had no awareness of are, I think
17 -- is it Dr. Stinson? Yes? Oh, I'm sorry. I can't read --
18 I'm sorry.

19 (Pause)

20 MS. STONE: The greatest number of people served with a mental
21 health diagnosis is physicians and nurse practitioners, 17,264
22 people served in a one-year period, representing 47% of all
23 the mental health recipients being reimbursed in the Medicaid
24 system and that's not with mental health practitioners.
25 That's with your general practice people, with the number of

1 encounters per client you see and the cost per client, with
2 the largest volume being the nine to 21 year olds.

3 Community mental health centers are there in the middle,
4 having served 13,659 people, which represented 37% of the
5 folks with an average number of encounters of 39.3, and this
6 is where you see this is the people we're serving in community
7 mental health centers. It's a different population. We're
8 serving chronically mentally ill, with a lot of time, with a
9 fair amount of money. It's not the same population. And then
10 in Indian Health Services, you see some different figures,
11 lower numbers, the percentage that they're serving, numbers of
12 encounters, 2.5, and cost per client. So again this is pretty
13 dramatic information for us that we hadn't looked at until
14 recently.

15 And then the next slide looks at this kind of a different way,
16 specifically for the 22 to 64 year old group, which
17 represented about half. That huge group represented half of
18 the behavioral health Medicaid claims, and here is where they
19 were served, mainly in other, with more encounters in
20 community mental health, and then the nine through 21 year old
21 group.

22 What are we doing? I wanted to just show this slide, relative
23 to the numbers of people served in the behavioral health
24 system. This is the number served in FY09 and FY10 for
25 seriously emotionally disturbed kids, SMI adults, total mental

1 health, substance use disorders, and co-occurring. This is
2 people served -- this is back to the behavioral health system,
3 not the Medicaid recipients served throughout the system, not
4 your folks, just our folks.

5 So I wanted to mention some of the things that are happening
6 quickly. The DVSA initiative, I mentioned these folks are
7 actually are next door in a two-day meeting. The Governor's
8 initiative "Choose Respect," has focused attention on the
9 impacts of domestic violence and the necessity, Dr.
10 Friedrichs, to intervene earlier, that we're not going to
11 improve the end, if we don't put prevention into that equation
12 and not just look at arrests and convictions, but get at the
13 front end.

14 So we have a million-or-so dollars in rural pilot projects
15 where we're funding rural communities to look at their own
16 determinants, whole health determinants of what's going on
17 with DVSA and have a chance to intervene. We're funding
18 trauma informed care so that our behavioral health system is
19 attending to, specifically, who is coming into their system
20 with trauma in their history -- and dealing with it in
21 behavioral health, we need to make sure we're paying attention
22 to that -- and then improving the integration between
23 behavioral health and victim services, which is pretty
24 important. If we agree that these folks are the
25 representations of these adverse experiences, then we really

1 The Bethel Community Service Patrol and Sobering Center was
2 that community's assessment of their problem, which was to
3 look at the chronic inebriates in their community and
4 basically bring them into a safe center for sobering and work
5 through interviewing and relationship to move them into
6 treatment.

7 Norton Sound is currently engaged in developing a Community
8 Wellness Center concept for their community.

9 Relative to suicide, I'm going to move quickly through these.

10 You can read this. This is different things that are
11 happening.

12 So let's get into this, what more can we do? So Dr. Felitti
13 says that, by virtue of doing the screening and then asking
14 people who had an adverse child experience, what did it mean
15 to you, what was the impact on that, he believes that has a
16 significant impact. And unpublished -- and you all can talk
17 to him about this; he has not been able to get it published --
18 he says that that process, asking those questions and asking
19 that follow-up question, decreased doctors' visits by 30%
20 because somebody is engaged. That's not even with an
21 intervention. That's asking questions of people, and it has
22 to do with relationship, I think. It has to do with
23 engagement. It has to do with giving people hope, I think.

24 It has to do with a number of things.

25 So this first idea of the potential to see -- I mean, there is

1 potential. I don't know how we would do that, but there is
2 potential for implementing these ideas into our system.

3 Going on to alcohol and other drug abuse, SBIRT stands for
4 Screening, Brief Intervention, and Referral to Treatment.

5 There are studies that I can give you. I don't know that I
6 actually have the reference for you here. The U.S. Preventive
7 Services Task Force and other expert panels have determined
8 that a process of screening, brief intervention, and referral
9 to treatment relative to alcohol and other drug abuse is
10 effective, and basically, this has to do with asking people
11 about their alcohol and drug history, telling them briefly,
12 gosh, do you know this could be bad for you, making referrals,
13 to the extent that their problem is indicative of a need for
14 referral, and going on into treatment.

15 Whole health are the ideas that we've been talking about
16 already, including the potential for use of Peer Support
17 Specialists. There is a chronic disease self-management
18 program, for example, at Stanford University which uses peers
19 in an evidence-based, disease self-management program that, I
20 think, people feel has promise.

21 The idea of care management as a concept is to look at these
22 folks, particularly, who have complex needs, the people that
23 we talked about before with co-occurring depression and other
24 chronic medical diseases, and provide particular attention and
25 case management to those folks to assist in their case

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management.

Screening and early identification of behavioral health needs, I think that this is pretty basic that, if we're not finding out about it, we don't know about it. And then the bottom line bullet is, if we find out about it and know about it, what are we going to do about it. We've got to have an integrated system that deals with it.

That integrated system can look like a lot of different things, and across the country, you've been hearing with your presentations that, indeed, it does look like a lot of things.

It can mean good referrals back and forth. It can mean primary care that has behaviorists embedded in the program. It can look like behavioral health programs that actually have health care people in them. It can mean good sharing of continuity of care of records, which certainly is not something that -- I think we don't do very well. That's -- I got to the end.

CHAIR HURLBURT: I've got a question. If you do the screening and you don't react to it, you don't do anything about it, that might only make things worse. I bared my sole, and nobody cared.

So where you do the screening, I think, you know, what I hear, what maybe is (indiscernible - voice lowered) in a primary care physician's office, say, as opposed to a school.

So if you do it in a primary care physician's office, you have

1 the challenge of what are the resources available, but you
2 also have the challenge, is that a reimbursable service?
3 Probably not. And it's not a quick thing to do, when the
4 meter is ticking on running the office, as Noah keeps
5 reminding us.

6 So if we're talking about, like with the Medicaid Task Force,
7 taking some kind of early and tentative steps into the medical
8 home where we're going to have three or four pilots of a
9 pretty limited medical home, not the medical home like
10 Southcentral is doing now where you do have behavioral health
11 there, but more in the setting like where Dr. Laufer is, do we
12 -- and I don't know; this is why I'm asking and maybe you
13 don't know either, but could we construct that, if we believe
14 that there is going to be this 30% offset, so that that could
15 be a part of the pilot, that, if a Dr. Laufer takes the time
16 to do that screening, can be a reimbursable service and he
17 would provide, under what CMS would allow us to do, for
18 Medicaid, which will be, generally, a high risk population?
19 MS. STONE: Well, you know, I'm just Melissa Stone and that
20 was a lot of loaded questions, including CMS, but you know,
21 relative to a pilot, I would think that these are the kinds of
22 things we would want to consider, and you know, I would
23 welcome us to talk to Dr. Felitti himself. I mean, he would
24 be very eager to talk to us about how this might happen and
25 how, in a pilot, we might construct this in a way that we

1 could measure those results and see the validity.

2 COMMISSIONER LAUFER: I just want to say something very quick.

3 That's excellent idea. And all of the family medicine
4 training programs, including the one I was in, have
5 psychologists integrated into them. We had two psychologists
6 in our clinic, and I really miss that, but we can't -- there
7 is not an economic model to incorporate one into my working
8 clinic today, but it would be fantastic.

9 COMMISSIONER STINSON: All chronic pain patients have a
10 psychologist as part of the training, and it's a required
11 rotation. And I agree with Noah. And everybody I see, if
12 they're really bad enough, then maybe they can get into API.
13 If they're Medicare, I have to contact -- I've got about four
14 or five people because nobody else will take them. There are
15 about four or five. If I dicker with them and make sure I
16 give them, at least, one or two good referrals also at some
17 point, I can rotate my Medicare people so that they can
18 actually get care. It's almost like a barter system in
19 private practice, and it's kind of sad, but that's literally
20 what we do. We keep a list, so we don't send too many to any
21 one of them because then they'll stop.

22 COMMISSIONER CAMPBELL: Melissa, I was surprised to hear that
23 you were surprised about the number of patients in primary
24 care that needed these kinds of services. Thirty-five years
25 in my experience, half the family practitioners would moan

1 about spending 60% of their time taking care of their problem
2 children, and they were all, basically, of mental health or
3 depression or something like that. So I don't know why we
4 would be surprised at that number that shows up here, and this
5 is probably not horribly scientific. I don't know how they
6 did the study, but it doesn't surprise me that those numbers
7 are there. I heard it all my career.

8 COMMISSIONER LAUFER: Those problem patients, or whatever, I
9 wouldn't even say that it's mental health. It's the human
10 condition, you know. And it could be any -- you know, there
11 is a broad, broad spectrum, but it's not uncommon. It's often
12 the real issue in the room, if you listen.

13 MS. STONE: And I think the surprise, to me, is that it's
14 actually diagnosed and treated as that, as opposed to just a
15 human condition, because people come in depressed. I mean,
16 people come in not functioning, and generally, they aren't
17 then diagnosed as depressed. You just think, oh my gosh, that
18 person has certainly got something going on. So calling it
19 something and diagnosing it as it's something under Medicaid
20 is, I think, is what's surprising to me.

21 COMMISSIONER LAUFER: I would agree. Inroads to that end are
22 being made by the pharmaceutical industry, which is very
23 anxious to have us get people on their meds, you know, the new
24 ones that really work, not the old ones we told you last year
25 were really great.

1 MS. STONE: Well, there's certainly another whole conversation
2 about that, and I am not, personally, saying that an answer
3 here is depression screening. I didn't put that on here. You
4 might decide that that's what you want on there; I didn't put
5 it on there.

6 COMMISSIONER FRIEDRICHS: So going back to some of the
7 discussions we've had, our task is to find ways to help bend
8 the cost curve to improve access to care and to improve
9 quality of care. We've heard in other sessions about the
10 shortage of mental health providers. In particular,
11 psychiatrists are one of the top five under-resourced medical
12 specialties in Alaska. I wondered if you could -- in the
13 context of what you've presented here, what recommendations do
14 you think the Commission should bring towards workforce issues
15 and mental health?

16 And then the second one that -- again if it's in here, I
17 apologize. I'm not seeing it. There is a consistent theme
18 about delays and being able to access higher acuties of
19 mental health care in Alaska, one that we're very concerned
20 about, when we keep a patient in the emergency room for 24
21 hours or have to admit them to a non-mental health inpatient
22 bed because there is no mental health bed available, and I
23 don't understand where that's addressed in here and what
24 recommendations you have to help us help the Governor and the
25 Legislature improve that aspect of access and quality of care.

1 MS. STONE: Boy. Relative to workforce, I believe that using
2 all the levels of practitioners maximally is important, and
3 I'm not sure that's being done. I think that, for example,
4 engaging general physicians and nurse practitioners in being
5 able to help us with the sustained recovery for people who are
6 seriously mentally ill, I don't think, is being tapped into.

7 Now that's kind of more my problem than yours because,
8 generally, people are more interested in the generally
9 mentally ill, but I'm not sure that that's being maximized.
10 I'm not sure to what extent we're engaging the family practice
11 physicians who are seeing so many people in these categories
12 to help with people who are stabilized at the middle levels of
13 mental illness and substance abuse disorder.

14 So I think that's something that we could do in a way that
15 would be helpful to communities and to practice and to help
16 then those folks get into the health care system because one
17 of the things we see is that those folks aren't getting into
18 health care in the first place and their chronic illnesses are
19 causing us high dollars. So if we could get those chronic
20 people into general practice appropriately maintained, perhaps
21 we would have a better total disease management of them. So
22 that would be one thing.

23 You know, I think looking at what's going on with the Peer
24 Specialists relative to whole health is something to be looked
25 at. It's emerging. It is certainly a place to generate new

1 workforce, specialized, you know, not -- you know, peers who
2 have experienced diabetes being trained relative to, you know,
3 a group of people experiencing diabetes, and perhaps those
4 people have mental illness and diabetes and then they can
5 relate even better to one another. So I think that that's
6 thought to be a place that perhaps is emerging that would
7 expand the workforce.

8 Nurse practitioners, certainly physician extenders, I think
9 are important in this model. I don't know. Beyond that, I
10 don't know that I have a panacea there.

11 COMMISSIONER ENNIS: Melissa, I really have appreciated some
12 of these recommendations, you know, addressing the lack of
13 psychiatric resources, the lack of emergency beds, lack of
14 maybe the ability to move from primary care into behavioral
15 health treatment, but one I have to keep coming back to is our
16 lack of behavioral specialists and resources embedded in
17 community-based, long-term (indiscernible - recording
18 interference). We simply don't have those resources.
19 Somehow, we need to make that happen so those long-term care
20 providers have the ready access in the community, whether --
21 somehow -- if it can be embedded into that service delivery
22 system, or at least, ready access to it, I think it's going to
23 be very important now and in the future.

24 CHAIR HURLBURT: Val?

25 COMMISSIONER DAVIDSON: So I was looking at the behavioral

1 health Medicaid claims. It would be really interesting to
2 have a breakdown of what those kinds of services were
3 provided. So for example, it's sort of this broad category of
4 behavioral health is kind of.....

5 (Pause - recording interference with teleconference)

6 COMMISSIONER DAVIDSON:like providing a list of -- I
7 mean, I imagine if we had a list of these are all the primary
8 care services that were provided by population. It's not
9 detailed enough for it to be helpful. It's a great first
10 start, but it would be really helpful if we had a more
11 specific list of what exactly -- what kind of services were
12 being provided.

13 MS. STONE: I think that's possible.

14 COMMISSIONER DAVIDSON: Thanks. I'm trying not to take these
15 interruptions personally.

16 (Pause - teleconference interference)

17 COMMISSIONER BRONCO: To piggyback on Emily's comment and some
18 of your answer to the workforce issues, you know, I counted
19 our blessings when we successfully recruited a psychiatrist to
20 our community, and his condition of employment was I don't
21 want to do any inpatient work and I want to be an outpatient
22 psychiatrist. And so I took what I could get, and it still
23 falls, everyday, on to our family practice docs to manage the
24 inpatient treatment and the around-the-calendar care and
25 treatment of these folks in our community. The strong benefit

1 we got is this psychiatrist is a warm and gracious human being
2 and is ready at the end of the phone to be a ready consultant,
3 but will never come in to help manage an inpatient.

4 MS. STONE: Well, I think that comment is relevant to your
5 second question, which I didn't answer, and I think that total
6 community engagement of the -- in the solutions for people
7 with behavioral health emergencies is necessary in order to
8 solve those problems you're talking about. And right now,
9 we've got kind of a voluntary system. People can choose not
10 to take care of these folks and then they wind up in emergency
11 rooms, and we really need to, I think, enhance that system so
12 that the community and the hospital system have more
13 involvement.

14 COMMISSIONER FRIEDRICHS: And if I could clarify, I mean, you
15 know, Pat, I absolutely appreciate your comment because we've
16 been in the same position where we've sort of had the
17 ultimatum, I will come to Alaska, but I will only do this
18 percent of what someone in my specialty would normally do, if
19 you paid them, you know, half of what we're paying to get them
20 up here.

21 My question is driven because I absolutely support what you're
22 doing. I mean, everything that you've laid out defining the
23 problem is spot on and tracks with what we've seen on the
24 federal side. The challenge that I think all of us are
25 running into -- and the Commission is probably tired of

1 hearing me say that -- is the "so what" part. So what do we
2 do now, if we're going to craft a recommendation in this
3 year's report that says we have heard repeatedly that there is
4 a shortage of providers and the workforce studies show that,
5 in 2006, I think, we were short 17 psychiatrists below the
6 level that would match just the access to care and the mean
7 for the United States, regardless of our higher suicide rate,
8 higher obesity rate, higher sexual trauma rate, and all those
9 other stats that you talked about?

10 And I ask this, you know, as sincerely as I can to someone
11 with much more experience than I have, how can we craft cogent
12 recommendations or what would be the best recommendations to
13 offer, engage in the community? I mean, we ask Dr. Laufer to
14 work harder because he's only really working 18 hours a day,
15 and if he would work 19, then, you know.....

16 MS. STONE: Needs to talk to more people, engage more people.

17 COMMISSIONER FRIEDRICHS: Yeah, you know, but that's the
18 challenge. I mean, there is, you know, 13 internists in
19 Anchorage that will see Medicare patients. You know, there's
20 -- and so as we look at what are the solution sets that we can
21 offer, we keep coming back to the problem statement and not
22 coming up with a whole lot that I have taken away from the
23 discussions. It really lays out here are things that we can
24 do, either at the community level or at the system level, to
25 impact this very fundamental problem that, I think, you

1 beautifully articulated here, and I would welcome feedback
2 from the rest of the Commission. I'm struggling with this
3 because, I mean, this is my reality in our hospital every
4 week. We've got people that we keep there, not getting the
5 care, not going to the appropriate inpatient mental health bed
6 because there is no bed for them to go to.

7 Part of our response to that is, you know, we are now trying
8 to come up with the resources to open our own limited
9 inpatient mental health unit at Elmendorf to take care of, at
10 least, some of those patients, but there has got to be a
11 better solution than each of us individually kind of flailing
12 about at the hospital level, you know, rather than working as
13 an integrated system to tackle this problem. I would very
14 appreciate any other thoughts you have on it.

15 MS. STONE: Well, I don't know that I have a simple answer. I
16 think, particularly in Alaska where these needs are in every
17 community, no matter how rural -- and then the question is,
18 how do you meet -- particularly if we're talking about the
19 person with the behavioral health emergency, which I think is
20 what you're talking about, you know, that's very complicated.
21 If you have somebody in Toksook Bay, I mean, there is just as
22 liable to be a person -- yes, yes -- so you know, every level
23 of care having -- you know, maximizing capacity relative to
24 competency and workforce is kind of the answer. How do you
25 get there when people can choose what they want to do or not,

1 which, to me, is part of the problem here? I didn't realize
2 this was kind of a problem in general practice -- you know,
3 other kinds of practice, since my world's different, but it's
4 -- well, it's certainly a problem in my area as well.

5 COMMISSIONER LAUFER: I just want to mention I talked about
6 this idea of concierge medicine or whatever. This would make
7 it a lot, lot worse because, if I'm going to have 600 people
8 that I'm really responsible for and answer the phone for 24/7,
9 I think I might weed out some of these people who want to talk
10 to me everyday and that's going to get worse. And part of it
11 is just sort of the daily reality in primary care. You know,
12 I come in and my schedule fluctuates because we really have
13 same-day access, and I look and I'll see a name and it's,
14 like, you know, I'm already behind.

15 MS. STONE: It's going to get me.....

16 COMMISSIONER LAUFER: You know, and I loved to take care of
17 these people. I really want to help them, but you know, it's
18 just -- it's too much, and it's that kind of thing that pushes
19 people away from them. I'd love to have a psychologist work
20 with us. That'd be great. To me, it's a question of
21 economics. We don't get paid enough for it. We've looked at
22 it. We've had people come in. We even had -- our only mid-
23 level was a PA who had a background in psychology, but it just
24 doesn't make sense. Until it's reimbursed, it's not going to
25 happen.

1 And then one more thing, you know, we provide insurance for
2 our employees and then the law comes along that says, if
3 you're going to provide behavioral health insurance, it has to
4 be a parity with other health insurance, which increased our
5 liability by millions of dollars, but you don't necessarily
6 have to provide it at all. There we go, you know, because
7 we're not going to take on, you know, millions of dollars in
8 liability that we don't need to, and I'm exposed to, you know,
9 somebody's kid is using OxyContin, and all of a sudden, this
10 is some, you know, \$100,000 rehab bill that really doesn't do
11 anything for their quality of life, but we still have to pay
12 the bill. So that was an easy business decision for us, and
13 it hurt to make it, but that's happening all over the country,
14 or it happened all over the country. It's probably changing
15 now.

16 CHAIR HURLBURT: Let me put my Chairman's hat back on and
17 think we probably should wind this down now. Thank you. If
18 there are some individual comments, I don't know if you can
19 stay a few more minutes, Melissa, but obviously, you've
20 generated a lot of interest.

21 I would like to really urge folks to be here promptly in the
22 morning. We want to start right at eight. We have -- I hope
23 it's going to be going an outstanding program. Dr. Dobson
24 from North Carolina will be here. There will be some
25 breakfast snacks out 20 or 30 minutes ahead of that, so I

1 would really urge everybody to be on time in the morning. But
2 can you stay a few more minutes, Melissa?

3 MS. STONE: Sure.

4 CHAIR HURLBURT: Because this has been a really good
5 discussion. Deb?

6 COMMISSIONER FRIEDRICHS: So just a question then. We've
7 heard a lot of information today, and I know, at some of the
8 prior meetings, we had tried to kind of assimilate that and
9 flesh out recommendations or where we wanted to go with some
10 of this. Are we going to do that? As I look at the schedule
11 for tomorrow, is there a time for us to do that? I see 30
12 minutes at the very end for wrap-up; is that where we'll do
13 it?

14 CHAIR HURLBURT: That's it.

15 COMMISSIONER ERICKSON: That's it. That's it, but we can do
16 some follow-up, too, over email and teleconference. That's
17 what we're going to have to do, but we do have time at the end
18 of the agenda tomorrow.

19 COMMISSIONER MORGAN: Well, there's another whole area that we
20 really didn't get into dealing with -- this will only take a
21 couple of minutes. I'm going to do this in writing and send
22 it in, but in our rural areas and our community health centers
23 and primary care centers out there, primarily, we have a real
24 reimbursement problem on, number one, the way the State
25 defines integration virtually -- if you're using mid-levels or

1 behavioral, let's make sure you're not going to be reimbursed
2 or reimbursed at such a low level it's not going to happen and
3 that needs to be addressed, but physician extenders outside of
4 the docs, the psychologists, the mid-levels, the
5 behaviorialists, which could be one way to help in this
6 workforce development, but we still use the medical -- I'm
7 originally a biller guy. We still use the medical model in
8 doing behavioral health, which is you come, you get a
9 diagnosis, you get a plan, you get paid for fulfilling that
10 diagnosis. Rehab is, basically, under attack by everybody.
11 And when you come into a primary care center and you have a
12 behaviorialist or a mid-level and they're part of an
13 integrated team, they're basically not reimbursed.
14 So in order to have those extenders, especially in the rural
15 areas of the state, that really -- I mean, it's really hard
16 for Falls Pass to have a psychologist or Sand Point or some
17 places, like that. They're more likely -- or could get a
18 behaviorialist or a mid-level or even a CHAP who is certified,
19 the current new certification in behavioral health. Having
20 some reimbursement, some reasonable reimbursement would help
21 alleviate this problem, especially in our clinics, our
22 community health centers, and our rural parts of the state,
23 and I'll bet you that's what Val was going to say. I'm
24 willing to bet. But we'll put this in writing and submit it.
25 COMMISSIONER DAVIDSON: So I guess -- thank you for your

1 presentation. I guess I'm having a "Paul" moment, if I may,
2 which is a.....

3 COMMISSIONER FRIEDRICH: God help you.

4 COMMISSIONER DAVIDSON:which is a compliment because, I
5 guess, I'm having trouble figuring out, are you recommending
6 the issues in slide 32 and slide 33 as recommendations that
7 the Health Care Commission should take up for -- because I
8 guess I didn't hear what the recommendations were, and the
9 other only thing I heard, well, we need to engage the
10 community, but I don't know that people know what that means
11 and it sort of feels like -- I used to be a teacher, and it
12 sort of feels like the conversations we had in the education
13 system about, well, kids aren't learning. Well, we need to
14 engage the parents. It was almost like, well, it's not really
15 our problem. It's really the parents' fault, and parents need
16 to become engaged, but parents were really looking to us, as
17 teachers, to really provide a baseline of recommendations of,
18 you know, here is how you can become involved. Here is what's
19 happening with Johnny. Here is what is happening with Susie.
20 Here is what's -- you know, these are the things that have
21 been successful in other places and these are the kinds of
22 things we'd like to implement here. And this just feels like
23 that same conversation in another context. We're really good
24 at describing the problem, but I'm not really hearing an
25 outline for recommendations for implementation of what we can

1 do to fix the problem.

2 MS. STONE: Well, and I think that I'm not presuming to make
3 your recommendations for you. The things that I had in here,
4 the two things that really, I think, are significant, I think,
5 are different are screening for behavioral health issues in a
6 routine way and maybe that's different or not different, but I
7 don't think that routine screening happens. So I think that's
8 one thing.

9 I think that screening and intervening relative to substance
10 abuse problems is different. Routinely screening and
11 intervening and referring for treatment for substance abuse,
12 in some systems in our state, happens, but it's largely not
13 happening across the board, and I think there's a pretty good
14 recognition that that's a pretty big problem, but we're not
15 screening for it, and we're not even screening for it and then
16 saying to somebody, gosh, talking for three minutes about, you
17 know, do you want to improve this, you know, what would it
18 take for you to improve this, and you could have someone
19 helping with that, but that conversation doesn't have to be
20 that long to be impactful. So that's two things that, I
21 think, are specific.

22 And a third that I think is pretty specific is integration of
23 care. We really aren't integrated. We've got silos
24 happening. And again there are some places -- you know,
25 Kevin, you know, is going to talk to you tomorrow. We've got

1 a couple places where behavioral health is integrated. We
2 have some integration happening in the tribal system, but in
3 primary care in general, it's separate. So how would we do
4 that? What would that look like? I mean, I think those are
5 different things than we're doing now.

6 COMMISSIONER DAVIDSON: Thank you. That's what I was looking
7 for. And I guess the other piece is I thought we had, at a
8 couple of maybe two or three Commission meetings ago or maybe
9 all three -- I wasn't here for the last one, but one of the
10 things that we asked for was that, when we hear these
11 presentations, a part of the expectation for the presenters is
12 being able to answer the "so what" question and what
13 specifically are your recommendations for the Commission, and
14 I just want to make sure that we're actually doing that to
15 make sure that we get to that point. And maybe it could be,
16 you know, 25% of our time is here is the information and 75%
17 of the time here are our recommendations, and then us around
18 the table talking about what does that look like for different
19 parts of the state, what does that look like for an insurer,
20 what does that look like for a primary care provider, what
21 does that look like in a rural area, what does that look like
22 in a critical access hospital, what does that look like for
23 the military because it feels like we're -- we keep almost
24 having the right conversation, but we never quite get there.
25 And so I would just urge that we re-frame our time, and maybe

1 and other drug abuse, specifically SBIRT, I think that there
2 is evidence that that is something for us to consider. Whole
3 health, the idea being -- I think that's related to the idea
4 of integration of primary care, but it's how do you practice
5 what it is you're talking about relative to the practitioners
6 that need to be at work, if you're going to do whole health as
7 opposed to a medical model of health. Screening and early
8 identification gets at that idea of using the AST. I mean, is
9 there value in using not just the Adverse Childhood
10 Experiences, but screening for other kinds of impacts, FASD,
11 head trauma, whatever? How you do that, so you're not
12 spending your whole time with people doing questionnaires, of
13 course, is important. Although I think Felitti said that that
14 was not a complaint. People filled those questionnaires out.

15 COMMISSIONER FRIEDRICHS: Deb, I guess -- and I echo the
16 comments that have been made around the table on this. My
17 concern is, at least for me, my short-term is no longer what
18 it was, and if we wait until October to reflect back on what
19 we discussed today and capture it, I know I will have lost a
20 lot of it.

21 I'll make the offer, at least for the trauma piece, and I
22 would ask if anyone else is willing to go back and pull out
23 some of the nuggets that they heard from the other
24 presentations today and bring them back to the Commission
25 with, here is what we think some of the take-homes were we

1 want to capture in our report. Here are the recommendations
2 that we can begin thinking about, so that we, at least, have
3 something from today to throw on the table. And maybe
4 everybody's short-term memory is better than mine, but I'm
5 genuinely concerned that we will get to October and say, wow,
6 that was a great briefing, and I wish I could remember exactly
7 what it was that we thought we wanted to say.

8 COMMISSIONER ERICKSON: Yeah, we will do that over -- through
9 email is what you're proposing over, like, the next weeks in
10 the short-term?

11 COMMISSIONER FRIEDRICHS: I'd be happy to try and bring the
12 trauma summary back tomorrow for folks to look at while it's
13 still somewhat fresh in their mind, and I guess I would ask,
14 as a second part of that, if others are willing to take some
15 of the other pieces that maybe they've got some personal
16 experience with and summarize it or come up with a starting
17 point for discussion. You know, I think one, in particular,
18 is an absolutely crucial one, and it may be that where we are
19 with this discussion right now is that we all agree it's
20 crucial. We agree that there are many attributes of it that
21 we don't understand and that one of our recommendations is
22 going to be that 2012 is where we really focus on this and
23 these are the studies that need to be done to help us focus on
24 it. Or maybe somebody had an epiphany that I've yet to
25 experience because I am just absolutely struggling with this

1 and our whole system is. If there is a way that we can
2 compress tomorrow's schedule a little bit to allow time for
3 that discussion, I would ask that we do that.

4 So again, I'll make the offer. I'll bring back a summary on
5 the trauma piece because I'm most familiar and comfortable
6 with that, and if anyone else is willing to do that, like on
7 the health care spending in Alaska -- phenomenal presentation,
8 what are we going to take out of that? You know, what's the
9 next step out of that one because, holy smokes, that was a lot
10 of stuff to digest and figure out how to present back to the
11 Legislature? Thank you.

12 COMMISSIONER DAVIS: Well, not to be presumptuous, Melissa,
13 but I'm sensing that we perhaps didn't do a great job of
14 saying we'd like to know what, you know, your recommendations
15 are because we don't think that's presumptuous; we think
16 that's taking advantage of your expertise. So if you were
17 willing, perhaps you could contemplate that because this is
18 such a big area and come back with the outlines of what you
19 would recommend for our consideration. I think this is really
20 important, and I don't want to do an amateur job in trying to
21 summarize what you have spent your career doing. If you would
22 be willing to do that, at least from my perspective, that
23 would be very helpful.

24 MS. STONE: Uh-huh (affirmative).

25 COMMISSIONER DAVIS: Since you're nodding your head yes, I

1 take that you are agreeing to do that.

2 COMMISSIONER ERICKSON: And Ward, could you do the same with
3 the physical public health piece, specific recommendations for
4 tomorrow?

5 CHAIR HURLBURT: Yes.

6 COMMISSIONER MORGAN: I think -- I personally think what Val
7 and everyone is saying is, I think, we spend a lot of time
8 going through presentations, but I think maybe we can make the
9 presentations more a synopsis of what we were given because, I
10 think virtually everyone around this table, has looked at what
11 we were given. Some of us have actually read the book that
12 you gave. And maybe instead of spending 30 minutes or 45
13 minutes on what we would like to see in that final report or
14 recommendations, why don't we somehow carve out two hours, so
15 that we can have some quality time and hear some testimony so
16 that you don't have to not sleep for two weeks trying to come
17 up with those things in the report and kind of do them as we
18 go? And then we can revisit them and refine them, and you
19 know, they evolve over time.

20 And I'm going to write -- I've written up some stuff on
21 patient home that would be helpful for the State and the
22 Legislature to do to kind of expedite that activity, and I'll
23 bring that tomorrow. I'll be presumptuous and do that. But
24 it's not a criticism. It's more of, man, you know, October is
25 coming quick, I think.

1 COMMISSIONER LAUFER: First, I want to make sure there is no
2 personal criticism, and the -- well, the statement of the
3 problem is easy. That's why we keep doing that because, you
4 know, we're heading towards a cliff. Yeah, you know, God,
5 we're going fast. But if we came up with one genuine,
6 innovative new idea, that would be a real accomplishment, I
7 think, particularly one that could translate around the
8 country. I mean, that would be really huge, just one kernel.
9 So I'm not surprised by the process being this frustrating.
10 It's not easy to come up with a new answer to a problem that's
11 sinking a country. So just one gem -- and a half.

12 COMMISSIONER FRIEDRICHS: One of the speakers said they were
13 challenged to come up with a bold and audacious proposal
14 (indiscernible - away from mic) 18-month timeframe
15 (indiscernible - away from mic).

16 COMMISSIONER ERICKSON: Thank you, Melissa. And we'll
17 reconvene tomorrow a little bit before eight, and we'll have
18 breakfast about 7:30.

19 5:27:21

20 (Off record)

21 **SESSION RECESSED**