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ALASKA HEALTH CARE COMMISSION
DENA'INA CIVIC & CONVENTION CENTER
600 W. 7TH AVENUE
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1 Residency Program in 1995 in conjunction with Northeast
2 Medical Center, has a unique model, which he probably will
3 comment on during his talk. He served as Director of the
4 Residency Program until he assumed the role of Director of
5 Graduate Medical Education in 2001. He has been actively
6 involved in health policy on the state and national levels.

7 He has served in the state of North Carolina as Assistant
8 Secretary of Health for the State Department of Health and
9 Human Services where he was responsible for the health
10 divisions of the Department, as well as serving as the State
11 Medicaid Director.

12 He was an early leader and developer of the nationally-
13 recognized Community Care of North Carolina program, which
14 received the 2007 Annie E. Casey award for innovations in
15 government.

16 Dr. Dobson was named the North Carolina Family Physician
17 of the Year in 1992, and he's received the North Carolina
18 Academy of Family Physicians Distinguished Service Award five
19 times. In 2004, he was presented the Academy's Lifetime
20 Achievement Award for his lifelong commitment to the specialty
21 of family medicine.

22 Dr. Dobson currently presides as one of the delegates of
23 the American Academy of Family Physicians Congress of
24 Delegates as a board member of the North Carolina Institute of
25 Medicine.

1 Dr. Dobson has ties to Alaska. He may comment on it.
2 His wife is an official teacher with the Iditarod and comes up
3 here regularly, so he knows Alaska. He has talked about
4 places, like Wasilla that Representative Keller is from, and
5 places that much of our country doesn't know.

6 I think we won't take the time to introduce the
7 Commissioners to you because we do want to take the time for
8 the webinar. As Deb and I talked with Dr. Dobson, we were
9 just very excited for him to come up and what he has been
10 doing is very innovative. So I'll turn it over to you and
11 welcome. Thank you for coming.

12 DR. DOBSON: Well, thanks, Ward. It's a pleasure to be
13 here. It was refreshing to get an introduction as a real
14 doctor. Usually when I get introduced, it says former
15 Medicaid Director, Brookings Institution, you know, all the
16 policy kind of stuff, but it does kind of remind me, you know,
17 of my roots, and you know, why we all do this health care.

18 And absolutely, my wife is up here for the summer
19 conference for the Iditarod. She's been up here a ton, and I
20 think I'm spending the weekend with one of your colleagues
21 there in Wasilla, Bob Doty (ph), who is a friend of mine from
22 the Academy.

23 So it's a pleasure to be here and talk to you a little
24 about North Carolina's experience, and as you can tell, I've
25 got a little eclectic background. I started as a solo doc and

1 still live in the same town, still see patients occasionally
2 when I go home, and if I don't have clinics scheduled, I see
3 them at the grocery store and everywhere else, if you know
4 what that's like in rural communities across this country.

5 You know, I think there's something to be learned from
6 really putting health care back at the local level, and I
7 learned that very well trying to run the State Medicaid
8 program in North Carolina and the complexities involved in
9 trying to get something that works for every community,
10 whether you're in North Carolina where we have big cities and
11 very rural areas where they, sometimes, have more ducks than
12 they do people living there and the health care community may
13 be one doctor, a pharmacist, and maybe a health department, if
14 they're lucky in that country, so to a big city with an
15 academic medical center, like Duke or UNC.

16 So you've got to figure out how to make health care work,
17 and we, in this country, are really at kind of a crossroads of
18 trying to find something in this national dialogue around
19 health reform that will do that. My bend is that you can't
20 solve it from the capital, whether that's D.C., or you know,
21 Juneau, or wherever you are. You have to find ways to
22 organize the communities to be accountable and create a
23 framework that works for everyone.

24 So maybe in this discussion of what we've done in North
25 Carolina, you'll find a glimmer of hope of something that you

1 can do in Alaska. In many ways, you guys -- we have a lot of
2 parallels in our -- even though we're on the East Coast, a
3 pretty long plane flight, but you have your rural and urban
4 areas and you have, you know, a strong history. So hopefully
5 in your work, you will find something here that will be useful
6 to you.

7 So we're going to talk about Community Care, and it's
8 been an evolution. It's not something we dreamed up
9 yesterday. It's been a decade or more long.

10 (Pause - advancing slide show)

11 DR. DOBSON: Just the framework. I'll talk a little bit
12 about our vision of where we started out in North Carolina and
13 then about what we've built over the -- what our structure is
14 like and how it works, and a little bit about results because,
15 I think really, the notion is people question, if you do
16 something, like this, does it really give you what you need --
17 and some things about next steps. But I think the big thing
18 is that North Carolina is not Alaska. You've got to take the
19 lessons we've learned and apply them here, if it's to be
20 useful.

21 Just the framework. Dr. Berwick talks about the Triple
22 Aim, and I think this is exactly right. We need to be talking
23 about better care for individuals. People need and deserve
24 the best care, but beyond that, it is taking care of our
25 communities. If we just episodically do good for patients, we

1 haven't really improved the health of our population.

2 And then the final thing is that we've got to do
3 something to bend the cost curve and to make health care
4 sustainable because, currently, it's not, and if we don't do
5 something, we'll end up with price controls or regulation or
6 something much more onerous than any of us really would like
7 to see.

8 So you know, we started over a decade ago building on a
9 Medicaid program called old PCCM, Primary Care Case Management
10 Model, that was in place in many states, saying that, you
11 know, we really think that a strong primary care system with
12 better coordination and collaboration at the community level
13 will improve health, but also save money, not in a regulatory
14 sense, just better care. And we didn't dream this up in
15 Raleigh. We went out and asked the people who actually took
16 care of patients, what makes it hard for you to take care of
17 patients, and asked people in the community what they didn't -
18 - you know, what they found problematic, and it's like, I
19 can't find my way around the system. If you're a rural doc,
20 I've got a complicated patient who is on Medicaid or whatever.
21 I don't have any help. It's all on me to try to figure out
22 how to get them through the system. And so that's what we set
23 out to fix.

24 So in this day and time with budget crisis and many
25 states are seeking to reduce Medicaid costs, as an entitlement

1 program, it's onerous on state budgets. We just went through
2 that session. I can talk a little bit about that in a minute.
3 But most people have no choice, but through either reducing
4 eligibility, changing benefits or reducing rates, going to the
5 provider community and hitting the rates. I think we have a
6 case to be made that, if you improve care, you can reduce
7 costs without all those harsh measures.

8 This is all about taking the variation out of spending.
9 It's take the easy money out by improving care. I think there
10 is a lot of national dialogue about this. This is Medicare,
11 but it's not unlike Medicaid. Some of the private insurers
12 have taken this out a little bit by creating regulatory, you
13 know, mechanisms and an insurance-based utilization review
14 things, but I would argue that, at some point you know, that
15 money spent above the line for managing, you know, the
16 insurance part of this is not as effective as managing it
17 below the line in a (indiscernible - voice lowered) health
18 care system.

19 This is our states for, you know, quality and costs, and
20 as you see, it's a scatter, and you know, there's a lot -- you
21 know, I see a Tools (ph) book here who I've got the privilege
22 of working with over the last while at Brookings, and it just
23 states that, you know, we're all over the place on this and
24 just spending more money does not mean better quality. We
25 have to -- you know, we really have to get serious about

1 trying to look at what we're doing.

2 Also I think we're seeing a movement for health care
3 providers. You know if you've been in health care a long
4 time, this is -- we all operate -- our success metrics have
5 all been about how many patients -- how many clicks do we do,
6 how many people we bring in, are we growing, are we getting
7 bigger, are we providing more stuff, what's our market share,
8 and do we have leverage to get contract prices.

9 I think the future dynamics are going to start shifting
10 to quality, efficiency, how well you can partner, is your
11 health care spend per capita and your population health
12 justifying the rates that you're getting. So I think we're
13 going to be seeing a lot of changes in how things are done and
14 what makes this successful in the future, but it's not going
15 to be on a dime. I think, as we've seen with the ACO
16 regulations, it is -- that may be a future state, but people
17 can't go from zero to 60 in two seconds. It's going to have
18 to be built over time.

19 A friend of mine, Aaron McKethan, who works at ONC with
20 the Beacon Community Program, you know, did an article in
21 *Health Affairs*. It talks about uniting the tribes, and I'm
22 going to pose this to you because it creates a framework for
23 what we've done in North Carolina. He talks about, you know,
24 over the last decade, we've had a lot of policy people talking
25 about how we fix health care, and we talk about, you know, of

1 course, IHI with Dr. Berwick, the quality tribe. You know,
2 all we need to do is concentrate on quality and health care
3 will get better. And then, of course, there's the payment
4 reform tribe. If we pay our providers better, differently,
5 you know, everything will be fixed. My favorite one is we
6 give every doctor a computer that health care will be fixed,
7 and we've put a lot of money in IT these days.

8 And then from the last Administration, the transparency
9 and consumer choice tribe saying, you know if we just make it
10 all transparent and grade providers, patients will choose the
11 best providers. Well, that -- if you're in a rural area, you
12 understand that's great, if the best care is five hours away.
13 It doesn't do me any good if I have chest pain. You know, my
14 community is what's important.

15 So I think, you know, potentially putting all these
16 together in a coherent, you know, program is important. And
17 also, what about provider tribes? You know, we've spent the
18 last two decades -- and I start feeling old because I've
19 gotten gray hair, but I have seen health care become more and
20 more shallowed and fragmented as we -- primary care doctors
21 don't go to the hospital anymore. We don't have communication
22 between our specialists, like we used to. It is a very
23 different, you know, landscape for medicine these days.

24 A very challenging time ahead, not only for the federal
25 government but for state governments, particularly the

1 economy. I'll just -- this is our framework. We had a \$2
2 billion revenue shortfall for the General Assembly this last
3 session. Our FMAP was going away because Medicaid is an
4 entitlement program, and it's counter-cyclical, right? When
5 the economy is bad, more people qualify. It's there for
6 people. Rolls get bigger, which puts additional stress. And
7 we had a change from a Democratic to Republican General
8 Assembly, who were not looking to increase taxes as a
9 solution. And so you know, something's got to give there.

10 Our hospitals were scared to death that we were going to
11 get commercial mass care coming in and taking it and cutting
12 the underpinnings out of the safety net reimbursement
13 structure, and of course, the panic of how to deal with 2014.
14 That was our -- you know, what we were facing, and I'm not
15 sure -- I assume you guys are similar. I know you have a
16 little different structure for revenue, which is good. So you
17 don't have the quite the crisis and gun to your head as the
18 rest of us, but the work is still there to be done.

19 Medicare and Medicaid challenges are pretty real. You
20 know, lowering reimbursement reduces access and increases
21 cost. I mean, I think we can show that.

22 Reducing eligibility or benefits has been limited for
23 states. The real problem is that, you know, we know we talk
24 about ACOs, we talk about this, and we talk about it in the
25 form of populations who are not your high costs, right? You

1 know, the people who have the highest costs are also the
2 hardest to manage. They're -- your (indiscernible - voice
3 lowered) Medicaid. They're your sick elderly. And none of
4 this that we're talking about is really talking about
5 addressing pulling together all the disparate needs of
6 providing coherent delivery system that connects home care,
7 nursing home, mental health services, other social supports
8 that we've (indiscernible - voice lowered) out there as well
9 and connecting it well to your primary care base and your
10 physicians.

11 You know, our notion is clinical management and
12 utilization control really is the successful strategy long-
13 term. It is really what you are talking about in bending the
14 cost curve.

15 So our key vision and principles were to build a better
16 health care system for North Carolina, starting with public
17 payers because people, quite frankly, don't get too concerned,
18 at least in our state, about Medicaid. I mean, they don't
19 feel like you're going to -- you know, the competition is not
20 as great for trying to do something for Medicaid.

21 We felt like the strong primary care was foundational to
22 a high performing system, but you ask the primary care doctors
23 and they say, we need help managing this population. Give us
24 something that makes our job easier, if you want us to take
25 care of the hardest and sickest. Also give us a little

1 control. I mean, don't run it from Raleigh. Make it local.

2 Timely data is essential. We have all this data in
3 claims. It's never shared with people who can do something
4 about it.

5 We must build a local health care system that's
6 sustainable and built on itself.

7 Physician leadership is critical. You have to have
8 physicians at the table. I used to say, when I was Assistant
9 Secretary, the power of the pen is where the prescription is.
10 Doctors sign almost every order that happens. We just haven't
11 given them the tools to do what we need to be done and the
12 knowledge, you know, of what's going on with the patient.

13 Improving quality of care provided -- if you improve
14 quality of care, costs will go down.

15 And a risk model is not essential for making this work.
16 I can show that we don't have incentives. We have engaged
17 physicians and hospitals managing the Medicaid program, and we
18 don't have incentives and we don't have risk. The risk is, if
19 we don't do it, they cut our rates. I mean, I guess that's
20 inherent risk. But it is doing the right thing, and I still
21 believe there is a significant part of that in this health
22 care system. So it is about shared accountability.

23 Our key tenets, a public-private partnership, so no
24 matter what political persuasion you are, we're about the
25 private health care system managing the public program. It is

1 a public-private partnership. It's managed, not regulated.
2 It's a clinical partnership, not a financing mechanism.
3 That's what Community Care is. It's community-based,
4 physician-led. It's bottom-up. We cut costs primarily by
5 better quality and efficiency, and providers like it because,
6 you know, we've given them some ownership in the improvement
7 process and tools, and it's local.

8 So our goals were: improve the care of Medicaid and
9 control costs, give everyone a medical home, a primary care
10 physician. And I'll say to our specialty colleagues, medical
11 home is more than just -- it's not necessarily a specialty
12 because we have some specialists serving for Medicaid as
13 medical homes for our patients. If this is truly patient-
14 centered, it's who assumes the responsibility for caring for
15 that patient. So it could be an oncologist. It could be, but
16 they have to do the whole deal, right? And so there's a lot
17 of pediatric subspecialists who have taken on that role,
18 surrounded by the same resources our primary care doctors
19 have.

20 Community networks capable -- and here's the thing, if
21 you're in state government. I couldn't deal with 14,000
22 providers, one-by-one, right, at the state government. So
23 creating these local networks, I have -- you know, we have 14
24 points of accountability for making sure things are
25 implemented and done, so that local networks tie this together

1 and they also have the flexibility to improve the management
2 of chronic illness. So they have some flexibility in design
3 to fit rural and urban settings. So the same thing, you know,
4 that works in Anchorage won't work Bethel, right? Same thing
5 that works in Charlotte or Raleigh does not work in Mount
6 Pleasant, North Carolina, where I live.

7 So what North Carolina now has is a statewide network of
8 medical homes and population management systems to address
9 quality and utilization; 100% of the savings go the State.
10 The State loves it. We came in \$100 million under budget last
11 year. They got to rebase, and it helped them with their whole
12 budget.

13 It's a private sector solution for Medicaid management,
14 and savings are achieved through partnership rather than
15 opposition to doctors and hospitals.

16 So, "How it Works." We have primary care medical homes
17 for 1.1 of our 1.4 million individuals. We are working hard
18 to get 100% of our Medicaid folks in the system, and that
19 includes people in institutions as well as outside. We're now
20 managing 80,000 duals. We have 4,500 primary care doctors,
21 92% of all the PCPs. So there are a few primary care doctors
22 who are not in Community Care. Almost all of them are in
23 Raleigh, Chapel Hill -- I mean, they're in the urban areas
24 where they may not, at the current time, take care of
25 Medicaid. However, I'll tell you, we are getting ready to do

1 state employees and working with Blue Cross and others, and
2 they will be part of Community Care very shortly.

3 These local -- we link local community providers to these
4 not-for-profit community systems, which our required elements
5 of a community network are the majority of primary care
6 doctors have to be in it, your local hospital has to be in it,
7 your local health department has to be in it, which is very
8 different than most managed care because we believe that the
9 public health infrastructure is extremely important to this
10 Triple Aim piece -- and any other community providers
11 necessary to improve care.

12 We fund -- and I'll show you how this works in a minute -
13 - we not only give the primary care doctors additional PMPM
14 payments to be part of this, but we fund the network so they
15 can provide either directly, embedded, or shared resources,
16 such as care managers who help the docs coordinate care. We
17 have now put pharmacists in the networks, whose job it is to
18 help, you know, look at medication regimes and work with the
19 primary care doctors. When patients come out of the hospital
20 with 28 medicines, whose responsibility is it to look at that?
21 And the primary care doctors don't have time to call the
22 specialists and try to make some sense out of it. We have 26
23 networks embedded in our practices and networks to help with
24 that. They've asked us to add psychiatrists. So we now have
25 a psychiatrist in every network, and their job is not to see

1 patients. Their job is to work with the primary care doctor
2 to try to re-zipper the mental health system back because, as
3 you'll see in some of our data in a little bit, a whole lot of
4 patients have coexisting mental health conditions, and getting
5 their care right involves making sure that is coordinated.

6 And then we pay for part-time medical directors. So if
7 you are a primary care doctor in a system, like this, you may
8 get, you know, 20% of your salary paid to be your community's
9 medical director for this network because it is about
10 coordinating your colleagues and networks together around,
11 what do we need to do next, what is it going to take to get
12 this done in the community?

13 So how it works from a state level is we identified
14 priorities. When I was the State Medicaid Director, I would
15 often go to our big state meetings and say, guys, I've got a
16 problem with X. When I was there, it was, I've got a problem
17 with mental health. You know, what can you do to help me?
18 And I'm willing to put some money in it to do this, and
19 networks will pilot solutions. They'll say, we'll take it on,
20 and once we figure out what works, then we turn it into a PMPM
21 payment and do it statewide. So it really is a bottom-up, you
22 know, test what works.

23 So the State has priorities. They give an enhanced
24 payment to the networks and docs for this. The networks pilot
25 the solutions. We monitor implementation. They share best

1 practices across the state, and then the state provides the
2 network with data to be able to do this, and then the cost
3 savings/effectiveness are evaluated, you know, usually
4 retrospectively. We're now getting to where we're looking at
5 stuff really in real-time. I'll share with you some of the
6 Mercer and Treo data that we've got on what we've done.

7 So again, the networks are not-for-profit. They receive
8 a PMPM. That PMPM could be provided by the network to hire
9 people directly or it could be passed through to a large
10 practice. Noah's practice may actually get money to hire the
11 extra staff he needs, or the health system may it get it, or
12 it may be a shared resource among multiple practices.

13 Primary care gets an additional PMPM payment per member,
14 per month, you know, an add-on payment to participate to help
15 compensate for, you know, doing the quality stuff versus
16 everything having to be a visit, and it's not much. It's just
17 a recognition of the fact that this is more than just per
18 patient visit kind of work.

19 We provide resources to manage the rural population. We
20 have a central office now that manages this whole thing. So
21 one of the things I did before I left state government,
22 concerned about the changing in state government and the loss
23 of continuity of leadership, we moved a lot of the stuff to
24 the central organization to provide for the development of
25 this program.

1 We have Medical Management Committees that meet statewide
2 and locally, and our networks hire management staff. That's
3 our map. It was self-generated. It would probably change.
4 It'll probably change a little bit over time, but I'm not sure
5 how Alaska would do this, but I'm sure that, you know, it's
6 not a legislated thing. It's people deciding which
7 communities want to work together. We said you couldn't have
8 a single one. They have to be big enough to make sense, which
9 is why the, in the East, they're a broad geography because
10 that's sparsely populated and some of mountains are sparsely
11 populated, but then you'll see, in the middle of the state
12 where our population centers are, that you may have two
13 counties. Well, they have more population than the whole east
14 does. But it really is self-generated as far as partnerships.

15 Again, each network has a Clinical Director. Someone
16 known in the community gets paid a little extra stipend to
17 organize the practices and folks for this, you know, community
18 work, provides oversight of quality and service on the State
19 Committee. There's a little typo there.

20 The Network Director is usually a Care Manager or someone
21 who just kind of manages day-to-day operations, and we provide
22 assistance for embedded Case Managers or Care Managers. They
23 could be Case Managers. They could be -- you know, most of
24 them are nurses. Some of them are social workers. You know,
25 we don't tell them what they need to be, but their job is to

1 be a value-added resource to the practices. So they do a
2 little of everything, including home visits. Some of -- as
3 we've gotten into the more complicated patients, we've
4 actually put Care Managers in the white space kind of between
5 hospital and doctor's office to manage that transition. Our
6 PharmD's assist with Medical Management of high cost patients.
7 And as I said earlier, psychiatrists assist with mental health
8 integration.

9 This will give you a list of all of the projects. We
10 started over a decade ago, so we started with asthma in women
11 and children, mainly in children, then diabetes. Dental
12 screening and fluoride varnish, I mean, you guys actually have
13 had a little experience with this. I mean, we got asked
14 because we had such poor access to dental health service for
15 children, where the Community Care would pilot having primary
16 care doctors do dental screenings and paint teeth, you know,
17 with fluoride, which we did and rolled it out statewide and
18 had huge impacts, and we paid the primary care doctors for it.
19 It's now called "Into the Mouth of Babes." One of our state
20 people came up with that.

21 Pharmacy Management, ED, Congestive Heart Failure,
22 Chronic Care Program about, particularly, A, B, D, which are
23 the multiple chronic illnesses, Behavioral Health Integration,
24 Palliative Care, and now Pregnancy Home, and this is going to
25 be an interesting project because it's really aimed at

1 providing some standards around elective inductions and a
2 whole bunch of other things to try to reduce variations in
3 care across the state.

4 That's our capacity, and it's hard to -- you know, if
5 you're in our state, that's a wow, you know, but it depends on
6 the size of your state, but the fact that we have the majority
7 of primary care doctors involved is a wow nationally, I think.
8 And some of our docs don't even know what Community Care is.
9 They're in it, but they don't know it because it's always
10 meant to be behind-the-scenes. It's not -- it's just this --
11 it's like Intel inside, right? You know, who cares what your
12 CPU thing is, it makes your computer, and that's what
13 Community Care is meant to be. It's this missing piece in the
14 health care system.

15 Our chronic care process, when we started looking -- you
16 know, a little background of why we went to this next stage is
17 that, you know, when I went into the Department, we had great
18 results in women and children. We were growing it two, three,
19 four percent, and that included eligible growth, you know,
20 best practice for women and children, but if you've ever
21 managed Medicaid, you know that's two-thirds to the recipients
22 and only one-third of the cost. My ABD budget was growing at
23 double digits, and it's the sickest patients. So I went to
24 Community Care and said, are you willing to do this? And they
25 said sure. I mean, they're in our community. They're the

1 ones that -- you know, the patients that are hardest to
2 manage. And we started this process. So again it was piloted
3 and employed statewide, and you'll see some of our results,
4 which is why we're going to all Medicaid recipients will be in
5 this program.

6 Our group looked at the chronic care population and said,
7 you know, one, we've got to stratify and we've got to find out
8 who is impacted, and you know, figure out what a system looks
9 like. So our networks have gotten pretty, and I won't go over
10 this in detail, but really looking at, you know, how do we
11 build something at the community level that's coherent for
12 high need populations? I'm talking a lot about Medicaid, but
13 understand this stuff works for Medicare. It now for -- and
14 we've got some of our private payers are saying we'd get much
15 better impact if we used you to help us impact these
16 specialists because you are resources on the ground that we
17 don't have. So we're getting a lot of discussion around a
18 single system multi-payer.

19 One of the keys to this is the Informatic Center, and the
20 uniqueness of our public-private is that, although we are all
21 the private providers, including FQHCs -- I mean, we're -- you
22 know, we have the rural health clinics, we have the private
23 docs all in these networks. We have created this central
24 organization that is quasi-state, quasi-private. So we get
25 all the Medicaid claims. Every time a bill is paid, we get a

1 mirrored copy of everything in the Medicaid agency's system
2 and then we put analytics to it and feed it right back to the
3 networks, patient-specific to the place -- you know, the
4 people who need to see it. And so what really makes this work
5 is our ability to use claims to really help practices do
6 better and really manage populations, again giving the
7 information to people who can do something about it.

8 I think we started out having this, but we did it by
9 hand. We did evaluations and then handed it to them in paper.
10 Now it's live in real-time. Any primary care provider who
11 works for us can see all their patients and everything that
12 ever happened. I'm going to show you in a minute a use case
13 of why this helps, and it'll be very clear what the value of
14 this is.

15 With Health Information Exchanges, we build electronic
16 records and start sharing real clinical data. I think that it
17 will get even better because it's not just did they get it or
18 not, but you'll see what values are. But you've got to start
19 somewhere, and you know, the information you have at-hand is
20 always better than no information at all.

21 So we're now incorporating all types of stuff. So we use
22 the claims to look at utilization. You know, we're providing
23 data back to primary care and mental health and specialists.
24 We look at diagnoses. We look at costs. We look at
25 individual and population level, care alerts back to the

1 communities and practices.

2 One problem with using claims, since you don't get real-
3 time, ED, and hospital data because they don't -- you know,
4 hospitals take a while to bill, but part of the importance of
5 public health as a partner is that part of the Bioterrorism
6 Surveillance System is that hospitals give the public health
7 twice-a-day feeds of everyone who shows up, who is admitted,
8 who is -- it's not a bill, but we -- we're in the stream of
9 that, so we get twice-a-day notification of any of our
10 patients who end up in the ED, you know, not their final
11 diagnosis, but what they showed up with and when they are
12 admitted to the hospital. So it gives us the ability to go do
13 something. We used to send our Care Managers by the ED every
14 morning to look at the list to see who had been in. So it's
15 low-hanging. It was kind of low-tech, but it still worked.

16 We've built a Care Management System that everyone works
17 on. We're building a Pharmacy Management System. So you
18 know, having been on the receiving end of saying we need a med
19 reconciliation program, so I get three medication sheets and
20 none of them are alike, one from the hospital, mine, and one
21 that someone else did. So whose job is it to really find out
22 what the patient has? And that doesn't include the top of the
23 refrigerator and windowsill set of medicines that never got
24 reported. And so part of our Pharmacy Home is to create a
25 work space where pharmacists can help us do this, and we

1 actually can see what they filled and provide some useful
2 information.

3 We're looking at quality, and again the Informatic Center
4 gives reports back. The most valuable thing is now we've
5 turned it on to providers, so when they sign on, they can see
6 it all. And here's where I want to show this little demo, if
7 that's okay.

8 We -- our doc said, you know, I'd really like to see
9 this, and particularly, the hospital ED docs and others said,
10 you know, it'd be really nice if I got this information in
11 front of me while the patient was still here. So we've now
12 created a -- this is, like a little five-minute use case demo
13 that we use for our people who are getting ready to log on
14 here, but I think it's worth seeing. And this is one of our
15 family docs who actually works in our central office helping
16 design some of this who is talking about it, but she practices
17 in a FQHC so she knows real-time.

18 Is there any sound on this thing? If not, I've listened
19 to this enough I could probably over-dub my own voice on the
20 demo. If not, we'll just talk through it.

21 That's all right. I should have -- I added this in this
22 morning. I thought they'd probably like to see this demo.
23 But before you, this is on our website. So you can go to --
24 and I'll show that to you at the end. When you go to our
25 website, there is a lot of information about our program.

1 It's freely shared with other states.

2 I'll talk over it. It's running. So this is our
3 Provider Portal. So our docs sign on, and they'll see their
4 list of patients. In this one, they looked -- this looked up
5 a patient who is John Doe and it's a child, and she is sitting
6 there pointing around, but it tells you who the previous PCP
7 was and their phone number.

8 In this section down here -- I don't know if I can do
9 this right, but it gives you the visit history of everything
10 that this child has had. So this child actually came into see
11 Holly with a pea in the ear, and she can go in there and see
12 that, well, little Johnny actually had peas in the GI tract,
13 had stuff in the GI tract, has a problem with this particular
14 issue and also sees that the immunization are out-of-date and
15 hasn't been in for Well Child, and you can see how many ED
16 visits and management, which is really important.

17 This case is really about an older lady who has increased
18 renal function, who came into the office and we're trying to
19 figure why is her renal function going bad. She's got bad
20 arthritis, and you'll notice -- you can see "Medication Fill
21 History." There is 100 prescriptions on here, and you can see
22 all the office visits. You can drill down and see what's
23 going on, but the moral of this story was that you can see the
24 patient is on a lot of medications, but by sorting it by type,
25 you can see that the patient is on three different anti-

1 inflammatories all at the same time, which is what's causing
2 her renal insufficiency, but you would not know that as a
3 primary care doctor because you only prescribed one of them.
4 You know, two other providers did. So getting into the claims
5 history and seeing what they've had filled solves this
6 problem.

7 The last use case is -- and when we get to the end of
8 this -- the ED doc who has a patient coming in with a story
9 that had been in the ER previously, and had some sort of
10 surgery and was in extreme pain, and needed some pain
11 medications, and was having severe belly pain. And then you
12 go up here and you look and you can see 218 ED visits in the
13 last 18 months. That should give us some suspect. And you
14 can drill down and actually see what goes on, and she'll go
15 over this in just a second. Is it pausing? That's all right.

16 What the ER doctor was able to see was to go down and
17 look at every ED visit, which hospital was his, all the
18 medications the patient had had, and this patient had this
19 long list of medications from multiple sources, had a
20 substance abuse problem, had had -- I think this case had 150
21 CT scans, seriously, in the last 18 months because every
22 hospital in the (indiscernible - voice lowered). This is real
23 stuff. I mean, this is identified, but this is really what
24 goes on in the unmanaged population that we deal with. And so
25 the ED doctor had, right in front of them -- didn't need to do

1 a CT scan, didn't need to make a referral, you know, back to
2 the primary to get substance abuse counseling, and not give
3 them more pain meds.

4 COMMISSIONER LAUFER: Go see an oncologist (indiscernible
5 - away from mic).

6 DR. DOBSON: Well, maybe so. And so the power of having
7 information to help make this work is important. Let's go
8 back to our slide set.

9 If you have five minutes, it's worth looking at that on
10 our website. Holly does a better job than I just did, but it
11 shows you that -- you know, we haven't gotten this real slick-
12 looking, but all the information is there and linked. So docs
13 can go see what really is necessary to see for their patients.

14 COMMISSIONER LAUFER: Are you employing your own
15 software? This is Noah Laufer, a family doc. Are you writing
16 your own software?

17 DR. DOBSON: Yeah.

18 COMMISSIONER LAUFER: Great.

19 DR. DOBSON: That's why this is all Open Source. So this
20 will give you a notion of how this works with Medicaid. The
21 flow of money -- people actually -- how does this really work?
22 Well, Medicaid still pays fee-for-service. This is value-
23 added, right? We don't really go and change how providers are
24 paid. So Medicaid pays the fee-for-service for all the
25 providers, just like they do, and they give Medical Home a

1 little extra fee. Then they give our network some money to
2 provide this wrap-around service. The networks then, you
3 know, fund our central organization, which does the IC, the
4 Informatic Center, to provide value-added resources.

5 How this works for other payers -- and this is, like, how
6 we're working with Medicare and potentially -- well actually,
7 state employees and Blue Cross as well is the same thing. We
8 don't mess with the fee-for-service piece of this. In this
9 case, Medicare sends funding for the PMPM for the Medical Home
10 and the networks through the central office. It goes through
11 the network, then goes to the providers. But the same thing
12 happens is that, you know, we manage the populations. And so
13 this is a value-added service for building out the Medical
14 Home infrastructure statewide.

15 So does this work? I mean, if I were listening to me and
16 I was a primary care doctor, I would be saying yeah, this is
17 exactly what I'm talking about. This is what needs to happen,
18 but does it work? I mean, if you're a payer, does this work?
19 And you know, the answer is I think I can say that it does, at
20 least in North Carolina it does, and we would love to see
21 this, you know, tried other places. There are a lot of states
22 who are going down this road, but this is an evidence of
23 impact, you know. So the green line is -- in the early 2000s,
24 we had women and children, right? So that's where we were
25 doing mainly that. In 2005, you know, we were really trying

1 to get this statewide. And then in 2000, you start seeing
2 where our costs curve for Medicaid. This is the yearly budget
3 expenditures, and this is truth of advertising. This is all
4 Medicaid expenditures, not just -- so it's not just Community
5 Care, but it shows you the potential impact of this program
6 because, since 2004, we've had a steady decrease in the rate
7 of annual increase of expenditures of Medicaid. And actually
8 in 2011, we will go to true negative numbers, taking money out
9 of the program, tax dollars out of the program, without
10 cutting significant benefits. A little bit of tweaking on
11 rates over the time simply because of the politics of all of
12 this, but we've preserved a pretty high -- we're not like you
13 guys. I mean, you've got a number one in Medicaid rates and a
14 few other states, but we're in the top five in the country of
15 what we pay for rates for providers compared to some states
16 who are paying 68% of Medicare for their Medicaid and no
17 wonder no one will see that again.

18 But this is probably the most telling slide. You know,
19 we had Mercer working with us for years, and people challenged
20 their methodology. Then we got Treo, which is from the
21 Northeast. It does work in New York and a bunch of other
22 commercial companies to come in and risk-adjust our data and
23 start giving us some analytics, and we asked them to look at
24 the last three years, a three-year snapshot of our work on ABD
25 and then the total program. And so they went in and risk-

1 adjusted and looked it up, based on their experience, how we
2 had done in bending the cost curve. And the answer was \$1.5
3 billion over three years that we bent the cost curve. Now
4 \$1.5 billion, we have a \$10 billion program. So it's still a
5 lot of money.

6 COMMISSIONER LAUFER: The care has dramatically improved.

7 DR. DOBSON: But it's all about care. It's all about
8 care. So you know -- and this is duplicatable year-after-
9 year. Treo said that we've done this kind of savings off the
10 curve since 2005. So we're starting to get multiple people
11 looking and saying, you know, this really does, you know, pull
12 the improved care and lower the cost curve.

13 At the same time, this is quality. So our quality
14 metrics compared to HEDIS are significantly higher. We're in
15 the top 10%. Of all of the things we're working on, we're in
16 the top 10% in the country for Medicaid managed care, a hard
17 population to be providing quality care in.

18 This will look at -- this slide talks a little bit about
19 the data of our distribution of members and where the money
20 is. It goes back to, you know, what I said earlier is that
21 most of the population, 60% of the population is, you know,
22 non-aged, blind, disabled children, and you understand
23 Medicaid is very categorical of how we -- but it's basically
24 women and children and then Aged, Blind, Disabled is the other
25 bucket. And you see most of the people -- and the women and

1 children aside -- but all the spend is over on the other side.
2 And in fact, most of the inpatient preventable spent -- in
3 other words, keeping people out of the hospital, emergency
4 room, and improving care -- is on the sickest of the sick, the
5 Aged, Blind, Disabled; 62% of your opportunity costs are not
6 in women and children. It's people that frequent the hospital
7 and have complex problems.

8 So over the last few -- since 2007 when I rolled out ABD
9 to the Community Care networks, they've enrolled increasingly
10 more complex patients. This is a (indiscernible - voice
11 lowered) risk adjusters applied, and so the complexity of risk
12 scores for people managed in Community Care versus the ones we
13 still have on the outside, you're starting to see this change.
14 So you would expect that we would, you know, start taking on
15 the really high spenders and our performance would get worse,
16 but in reality, our spend versus the unenrolled -- this is,
17 you know, a 10% to 12% delta between, you know, those not
18 enrolled versus those who are enrolled. So we actually have
19 seen a 3% to 7% reduction in costs based on expected, while
20 the unenrolled costs were going up for the same period.

21 Again if you think about populations and where your real
22 costs are, it's keeping people out of the hospital, right? So
23 our inpatient per member per month spend has gone down 6% for
24 our population of ABD, the sickest of the sick. It went up
25 25% over a four-year period for the other population. That's

1 a huge delta in costs.

2 The number of admits were decreased compared to the
3 unenrolled. At the same time, our costs per admit stayed
4 about the same. So you think that the people who were
5 admitted were going to be sicker, so therefore, their costs
6 would be higher, and it's really not true. I mean, I think
7 probably because we're better at managing when they do go in
8 the hospital, the costs are not worse.

9 This is, you know, changes in population preventable
10 admissions and readmissions, and let me just make this
11 comment. I've started to say this nationally is that, you
12 know, we are very focused on readmissions nationally. I mean,
13 it's the big thing. I will tell you that the money is not
14 there. That's not where the real money is. It's keeping sick
15 people out of the hospital the first time, and this will tell
16 you why. PPA is Potentially Preventable Admissions versus
17 Potentially Preventative Readmissions. And you'll see the
18 delta in that is really striking, reducing admissions by 12%
19 versus them going up in the unmanaged population.

20 Likewise, these are the patients we've enrolled, and you
21 start really understanding how many people in these high need
22 populations also have coexisting chronic mental health
23 conditions and the importance of working to better collaborate
24 and get the systems working. It's not making one system, but
25 it's just getting the systems talking to each other and

1 coordinating the care across.

2 This shows a little bit about preventable admissions and
3 readmissions for AFB for those with chronic mental illness,
4 and you'll see that, over the three years, the preventable
5 admissions has a slightly decreased number of admissions. So
6 as we get people better care, their admission rates go down
7 and the readmissions have not changed as much, actually.

8 So again, the real opportunity cost is in the potentially
9 preventable admissions with people with chronic illness, and
10 you know, people who have untreated mental health issues or
11 uncoordinated care will end up in the ED, and what do we do
12 when they show up in the ED? We have to admit them because we
13 can't get it all sorted out. And so part of the low-hanging
14 fruit for making this work is having a coordinated system.

15 This just looks about real dollars, how this is really
16 money spent out of Medicaid each month for this population.
17 You'll see each year is progressively less, not more. So it's
18 not just reducing growth rate. It's actually -- with the same
19 reimbursement, flat reimbursement, it's actually reducing the
20 spend.

21 So let me -- before we wind down, let me talk a little
22 bit about some of the other stuff we're doing and we'll talk
23 some, you know, questions and answers.

24 This is really system development. So you know, we're
25 doing it with Medicaid, but we're also working with Medicare.

1 We have a 646 demo we started working on years ago, back when
2 Mark McClellan (ph) was at CMS, and our notion was, well,
3 we're managing these populations. Well, the dually-eligibles,
4 those with Medicare and Medicaid, we're trying to manage, but
5 all the savings go to Medicare when we do it. And wouldn't it
6 be nice if we could give Medicare recipients the same, you
7 know, wrap-around service? It would make my parents happy to
8 be able to use the same people in my practice. You know,
9 they're 87 and they -- you know, if it weren't for my
10 partners, they would have a hard time navigating the system.
11 And so we started a 646 demo to be able to extend Community
12 Care to the duals and Medicare, also a dual planning grant to
13 do something statewide, like this, for all dually-eligibles.

14 We also have a multi-payer demo where not only Medicaid
15 and Medicare, but also Blue Cross and state employees will all
16 invest in the same local infrastructure. In our state, that's
17 70% of all patients. So we've taken our four most -- seven of
18 our most rural underserved counties with high disparities, and
19 we're doing the high intensity Community Care build in those
20 communities to see if we can really bolster the primary care
21 workforce and build something that will make a difference.

22 We're aligning this with HIT and the ONC's efforts. Our
23 AHEC system is -- our regional extension centers work with
24 Community Care. They're our partner. They're our additional
25 resources.

1 One of our networks is the Beacon Community. We're
2 working with the CHIPRA grant to look at children and design
3 pediatric EHRs, and we have challenge grant to build out that
4 pharmacy module I was telling you about. You know, I don't
5 really have time to talk about that, but it's a web-based
6 space that all of the patient medication lists come together,
7 including their fill history, and pharmacists who are part of
8 our system can go online and make notes and do the things.
9 The Care Managers can go in there when they make the home
10 visit and actually put the four other medicines that were on
11 the counter, and then it gets consolidated with some
12 (indiscernible - voice lowered) and it goes back to Noah in a
13 way that he can use -- he or she can use in their practice.
14 So it creates a communication space around medications, so
15 it's important.

16 This is, you know, our map of where we're doing all types
17 of initiatives, beyond just Medicaid. So you will see a
18 significant part of the state is doing something in a multi-
19 payer fashion on this chassis.

20 I think I'm going to flip through these pretty quickly.
21 They're in your package, but it's, like, two slides on each of
22 these things I blew through, the 646 demo, the multi-payer.
23 Again it's using PMPMs to pay the primaries and the networks
24 to work beyond just Medicaid, but all payers. The Beacon
25 Community. Dual eligibles. CHIPRA. ONC. Let me see.

1 Once you've built this, I think we're suddenly seeing
2 that payers and large employers are saying this is a superior
3 way to interact with our provider communities. It doesn't
4 matter who pays the bill, right? So this would work for
5 commercial managed care, as well as others. This is about,
6 you know, a joint effort to build out the provider community.
7 And we're adding specialists to this because, as we get sicker
8 and sicker patients -- this is not just primary care. This is
9 cardiology, oncology. I mean, it's the health care group.

10 So we're building robust data systems. We're enrolling
11 specialists, just like we do. Your entry fee is, you know,
12 let's do quality, let's do costs, and let this be a provider
13 run system.

14 We've got a statewide Medicare initiative on the table,
15 you know, with CMS. We want to test shared savings models,
16 but again -- and part of that will be investing in prevention
17 with some of the savings.

18 I think where we're going wrong with health reform is, if
19 the goal is to reduce the cost curve, we're creating another
20 profit, you know, motive as the first order of business versus
21 the first order of business being reducing the cost curve.
22 And we're collaborating with other states. And on our
23 website, you'll see -- and at the end of my slides --
24 Commonwealth Fund funded us to create a toolkit for everything
25 we do, which you'll get to see our network contracts.

1 Everything we do should be -- should and will be there for you
2 to steal or use, if you so choose.

3 Our lessons learned are pretty simple. Primary care is
4 foundational. Data is essential. It has to be timely and
5 patient-specific. Telling me how I did last year does not
6 help me take care of patients this year. It has to be
7 patient-specific data to help guide who -- which patients of
8 mine aren't getting the care they need. I need to know that,
9 so that I can do something about it.

10 Additional community-based resources are necessary for
11 managing populations, particularly for those with the highest
12 need, and they're best if they're located in the practice.

13 Local networks build local accountability and better
14 collaboration. So getting collaboration going in our
15 communities, without talking about mergers and acquisitions,
16 it's a community-based accountability for what's going on in
17 communities.

18 Physician leadership is essential. You've got to be
19 flexible. Health care is local, just like politics. And you
20 can tell I've been in politics a little bit, but it is very
21 local. Representative Keller can tell you. I mean, what you
22 do in Anchorage doesn't work in Wasilla, right? It's very
23 different.

24 The other thing, you've got to make wise choices. This
25 is about what makes Community Care work, and why docs are so

1 engaged in this is they get to do something. They see it work
2 in their community. They get to take ownership of it. And
3 then the next thing is easy, right? So you know, you've got
4 to be wise in your choices of projects, quality, and costs.
5 Don't choose (indiscernible - voice lowered) and childhood
6 obesity as your first metrics of success because the outcome
7 is out there. It's worth doing, but you've got to pick stuff
8 that's there in front of you that can be fixed. And once you
9 build that infrastructure, then handling -- you know, we're
10 getting ready to make sure every school, every child gets BMIs
11 done that get reported back because a lot of our networks have
12 made school nurses part of the infrastructure of this program.
13 They're with the kids everyday.

14 So there are a lot of things you can with this, if you
15 build the right chassis in your local community. So choose
16 wisely, I guess, is the last lesson.

17 If you want more information, this is our website. I'll
18 give you, and they can pass out, the link to the Commonwealth
19 Fund toolkit that has -- they funded us. It's got all the
20 modules that we've worked on, whether it's how the networks
21 are set up. It's our mental health integration. It's our
22 pharmacy. All our stuff will be there for you guys to get,
23 and as we tell every state, we're here, if we can help you.
24 We don't have a big infrastructure to go do consulting work,
25 but we have really engaged folks, and this is everyone from

1 Duke University. You know, our biggest medical centers to our
2 most rural areas are engaged in trying to figure out how this
3 works, and they all take great pride and ownership of some of
4 their innovation that they've spawned with this collaborative
5 approach. So with that, I think I'm out of time and ready for
6 maybe a few questions.

7 CHAIR HURLBURT: Thank you very much, Dr. Dobson. That
8 was outstanding. Our plan is, about 9:30, we have what we're
9 calling a Reactor Panel of some of the innovators here in
10 Alaska. So we'll have five individuals who will do that, but
11 let's take this time now for questions and comments from the
12 members of the Commission to you. Maybe let me start.

13 Looking back, you've been in this for a long time. I
14 think we've all been very impressed. What would you do
15 different, if you had it over again? It sounded very good,
16 but what would you do different?

17 DR. DOBSON: Well, I don't know that we would do things
18 differently. We would do them quicker. I mean, we were
19 feeling our way around. I mean, remember when we started
20 this, we had no idea how it would turn out. All our networks
21 are very, very different because, when we started pilots in
22 '88, '98, and '99, we had six or seven different pilots, and
23 you know, one was a horizontal pediatric network with just
24 high volume pediatric practices. Others were -- one of them
25 was an academic center. One was a community health center.

1 As kind of the lead agencies, everyone has kind of migrated to
2 these open, you know, network models. If we -- we would have
3 not taken ten to 12 years to develop this. We would have
4 developed in three to four years, if we knew what the right
5 thing to do -- if we knew what we know now back then, I think
6 we would have probably started earlier engaging specialists in
7 this.

8 The other part is that -- you know and this is just a
9 political, you know, comment. This was about being below the
10 radar. We built this, you know, without a lot of political
11 fanfare. It was underground. In fact, a lot of our docs
12 didn't even realize what Community Care was because they just
13 knew it was this nice set of resources that were suddenly
14 appearing in their office and they didn't have to pay for it,
15 and they really liked it, and they got to go to these meetings
16 and do things, but they didn't -- it wasn't branded. It was
17 not -- so it wasn't very coherent. And so the political
18 reality of that is that, because we were under the radar, it
19 made us a little bit vulnerable every session that came up of,
20 you know, we didn't have the political oomph, so we were
21 always defending ourselves.

22 We've now branded ourselves. We've now, you know,
23 created the central organization with some, you know,
24 infrastructure, and we've made sure all our representatives in
25 all our communities understand the importance of what they

1 have built that's real. And so when, you know, this session
2 came around, all our elected officials really understood that
3 this was really grass roots and this was big. I mean, this
4 was their communities that were doing this and could take
5 pride in the fact that their community helped save, you know,
6 a bunch of millions of dollars for the state, which saved
7 school teacher jobs. I mean, that's the real reality of
8 politics. So that would be something we would do differently
9 as well is start out with a little bit more structure.

10 CHAIR HURLBURT: Maybe, at least the first time anybody
11 asks a question, if you could just identify who you are, what
12 you do, who you are representing here on the Commission for
13 Dr. Dobson. So Noah?

14 COMMISSIONER LAUFER: This is Noah Laufer from Primary
15 Care Doc here in Anchorage. This is -- we ended yesterday's
16 session with the way we end all of them. Well, you know,
17 that's a lot of complaining. What are we going to actually
18 do? And this is the closest thing I've heard to where I see,
19 you know, real progress, and probably one of the most exciting
20 things is I'm sitting next to Jeff Davis, who is here with the
21 insurance industry, and he is squirming and wiggling and
22 writing things down as fast as I am. So it's really neat.

23 The most remarkable thing, to me, about it is the general
24 absence of carrots or sticks, you know, and I don't really
25 want carrots. I want tools, and I definitely don't want

1 sticks or anybody who has the authority to have a stick behind
2 me. And it's just incredible. A lot of this sort of echoes
3 what my experience was in residency. I had a PharmD. I had a
4 psychologist. I had Case Managers, and I don't have that now.
5 And I have to applaud and suggest that we do this because it's
6 based on faith and the good intentions and goodwill of the
7 existing medical community to do the right thing for our
8 communities, and it's there. I can tell you it's there, and I
9 love this. I really -- it's inspiring.

10 DR. DOBSON: I think -- and another thing I wish we had
11 done, I wish we had done more work early on, as we're doing
12 now, of proving ROI. I mean, so you put -- I mean, if you're
13 in health care -- I mean, I was a payer, right? But I had
14 trust that, if I put this money out here, I would be able to
15 see it on my bottom line, but we haven't gotten really good at
16 predicting that enough where, you know, if you're a business
17 person, are you willing to spend two years' worth to get your
18 ROI on the back end? And we have to show what that's like.

19 So if you're Blue Cross or you're someone, you're going
20 to put this money out for PMPM. Where is -- you know, how
21 does that come out? And that's exactly what the insurers are
22 looking at now. It's like I think I can figure out how to do
23 that because it's not a lot of money, and it inherently makes
24 sense, but you've got to do that.

25 The other thing is that, when we started this, the State

1 didn't -- I mean, we got private money to fund the first two
2 years. When we started this, we had foundations and private
3 industry put unrestricted money up to help us build this first
4 small snapshot that become Community Care in the, you know,
5 late '90s. It wasn't a state appropriation. As soon as it
6 got going, then it became a state appropriation.

7 The other big thing we did was, when we moved into ABD, I
8 got us a \$6 million appropriation from the Legislature, then
9 it gets matched with federal money, to test ABD. Once you
10 show the ROI, you can bake it in -- I mean, once you know what
11 that cost is, you can put it in the cost of your program,
12 which is what we've done. So I would -- I think we could look
13 back now and with pride, saying that \$6 million appropriation
14 gave me \$1.5 billion of, you know, savings, which is -- you
15 know, that's a pretty good return on investment, one-to-ten,
16 right? So that's not a bad deal.

17 COMMISSIONER DAVIS: Thank you, Dr. Hurlburt. Dr.
18 Dobson, thank you. That was really exciting, and it's not
19 that Noah and I are that smart, but the conversation that we
20 had yesterday was largely the same concepts that you are
21 laying out, and I think what is so exciting is that.....

22 CHAIR HURLBURT: Could you introduce yourself?

23 COMMISSIONER DAVIS: Oh, I'm sorry. I'm Jeff Davis. I'm
24 the President of Premera Blue Cross Blue Shield of Alaska, so
25 pleased to meet you and have you here. Thanks, Ward.

1 But what is so exciting about this is that there are a
2 lot of similarities between the circumstances you described in
3 North Carolina and Alaska, and there is really no reason,
4 other than not putting the effort into it, that we couldn't
5 achieve something similar here and that's very exciting to
6 see. Thank you so much.

7 DR. DOBSON: I think, in the political context, we talk
8 about medical home, and medical home is really -- as Noah
9 said, it's how we used to train, right, I mean, in primary
10 care. And so the medical home construct is really about good
11 primary care and the resources necessary. I think what's
12 missing is what North Carolina -- is networks of medical homes
13 that create a community system.

14 Our yet-to-be defined work is, how does that plug in with
15 specialists and everyone else? I mean, that's just yet-to-be
16 done work, but I think there are opportunities, particularly
17 in states like yours, is that we have a dominant, you know,
18 insurer, and I'm sure you know Brad Wilson is our new CEO at
19 Blue Cross. I mean, I think everyone is looking for how do we
20 do this better? And we've had some great conversations of,
21 say, if we build this delivery system that works right, it
22 works for all payers.

23 COMMISSIONER LAUFER: I want to actually ask a question.
24 There are a couple things about training and retention of
25 physicians. Is this something that is -- have you seen a

1 change? Are you better able to retain or attract physicians
2 because we have a manpower issue and it's going to get worse?

3 And then the other thing is, in the residency component
4 of what you're doing, is there more effort put into training
5 for preventative care?

6 DR. DOBSON: Well, I think we've been fortunate in North
7 Carolina. We've done pretty well, even through the down
8 years, in primary care training. I'll say, anecdotally, that
9 Mark Robinson, who is our Residency Director who took over for
10 me, says we have the best recruited year. You know, the
11 quality and the numbers of people wanting to train in North
12 Carolina is really high, and I'd like to say it's because, you
13 know, there is a lot of energy around this system where, you
14 know, primary care physicians or people who want to be primary
15 care physicians are seeing that it's needed, it's wanted, it's
16 supported, and there is some job satisfaction there.

17 So I mean, if you want more primary care doctors and you
18 want more people doing this work, you have to have happy
19 primary care doctors to recruit and a system that's
20 supportive. It's not just about money, right? So I think I
21 have seen that to be the case. You know, understand that our
22 residency programs are key to this, if you look at who cares
23 for those patients. And someone asked me, how did I get into
24 state government? This is a funny story.

25 So I got into doing health policy because I was upset as

1 a Residency Program Director about the precepting rules that
2 were interfering with my ability to train. So I went over
3 there and realized that they didn't have good policy support.
4 So I started getting involved in state government doing
5 policy, you know, from my Residency Director job. So it is
6 all connected that -- you know, making sure that your
7 physicians are engaged.

8 I think we're going to have a problem because our
9 workforce demands are far greater than our ability to train
10 right now, and there's such a lag in getting people out there,
11 but what we are seeing in these programs -- this Pharmacy Home
12 program, for instance, we're finding all types of very
13 innovative ways to use our PharmD's, our Clinical Pharmacists,
14 but they're not independent providers. They're members of the
15 medical home team, and the docs are perfectly happy getting
16 the clinical pharmacists helping with their diabetic patients,
17 making home visits, doing things that, you know, unclutter our
18 primary care doctors' time. So I think we're going to see
19 some interesting things tested over time.

20 I know that Duke piloted some clinic-specific -- some
21 inner city clinics. They went and found out where all the
22 patients who had the highest needs were and sent one of their
23 nurse practitioners out there. They were part of the medical
24 home team, and the doc went out there once, but they just went
25 into some of the high need areas and created a little clinic

1 out there and staffed and saw huge results by putting
2 something where the patients were. I mean, you guys have
3 experience with that in a lot of your villages, right?

4 CHAIR HURLBURT: Maybe Wes next and then David?

5 COMMISSIONER KELLER: Representative Wes Keller. You
6 mentioned, in passing, savings shared -- how to share savings
7 model and that just -- my mind has been going. We want this
8 to be physician-led. You made that point, and I think that's
9 right on the money. You got grant money, private grant money
10 to start. Where did you spend the money? I mean, did you
11 start with a central office? Did you start with a pilot
12 network? If you told us, you know, I missed it and got
13 interested when I was thinking about how we're going to apply
14 this, and I was wondering about if there are different models
15 shared saving use, you know, or what.

16 DR. DOBSON: Well, we currently don't have shared savings
17 for Medicaid. I mean, we have a demonstration project with
18 CMS that we started in 2005 negotiating, which was intended to
19 be, if we managed dually eligible Medicare and Medicaid and
20 states putting the PMPM into providing the resources for
21 people who are Medicare and Medicaid and they have decreased
22 medical costs, that's all Medicare savings. And our notion
23 was that well, we ought to share that with federal government
24 and bring that back to North Carolina. The majority of that
25 goes to the networks and the providers, and they committed to

1 spend it not just in their pockets, but for, you know, public
2 good, prevention and other things. We're early in that.
3 Those were early discussions that occurred pre-ACO, all this.
4 So part of that discussion was with Mark and working that
5 piece with the PGP demos that were out at the same time,
6 setting some of the framework around shared savings. But I
7 would say that, you know, how we started was simply about who
8 is going to invest that first dollar to get the ROI.

9 So let me just say, when we did the pilot, we got private
10 money because the Legislature didn't have the ability, and
11 it's hard for Medicaid to do pilots, you know, because of
12 statewideness. So we did the first, you know, two years on
13 private money paying for the PMPM payments for the shared
14 resources. Then we saw this works really works pretty well,
15 and we started then using our PCCM authority under Medicaid to
16 roll it out statewide, which we did.

17 You have the authority now through Medicaid to do this.
18 So it doesn't -- you just have to have the state
19 appropriations to start it. There is a lot of opportunities
20 under current legislation, the Health Fund which is 90/10.
21 There is a lot of opportunity for most of this to be borne by
22 the federal government, at least for a few years, to get it
23 going. So you know, you would have a much easier way of
24 starting a program, like this, than we did back when we
25 started it. But again, it's the notion of you -- it really

1 takes -- when you invest this way, it's not a, I do it this
2 year and I get savings by the end of the year. It takes a
3 while, and unlike when you -- if you're trying to manage a
4 budget, this is hard to do on beginning the fiscal year and
5 getting the results by the end of the fiscal year. You have
6 to, you know, invest. It takes a year to two years to really
7 start reaping the significant savings. So as we tell other
8 people, you know, be prepared to invest a year or two and then
9 you will have your savings going out the back end and that
10 would be the same thing Jeffrey needs to know. If you're
11 talking about Blue Cross, am I willing to invest for a year or
12 two? And now for North Carolina, it's pretty easy because
13 it's baked in. We expand the program. We know when the money
14 should be hitting. We can actually predict some of this, and
15 expansions -- we just keep building on the program, so
16 pregnancy homes this year. We're getting ready to do health
17 homes, which will -- you know, expanded case management. So
18 we keep layering things on top of this and making it better.

19 CHAIR HURLBURT: Dave?

20 COMMISSIONER MORGAN: Nice presentation. It's nice to
21 talk to someone without an accent, too.

22 CHAIR HURLBURT: Could you introduce yourself?

23 COMMISSIONER MORGAN: I'm sorry. Dave Morgan, Primary
24 Care Association, SouthCentral Foundation.

25 I guess I have -- my question has an A and a B, and it's

1 not that intellectually a big deal question.

2 The first question is, I notice we use a lot of HEDIS
3 standards where I work, and I was looking at your HEDIS
4 standards, which are very impressive, I have to say. I'm
5 assuming that your system that tracks every -- reports what's
6 going on into, which you've developed, also tracks from that
7 the HEDIS standards. I noticed you put in the diabetes and
8 the cardiac, cardiovascular. I'm assuming you have others.
9 You have a cadre of -- so I thought you could talk about that
10 for about three or four minutes, basically how people -- how,
11 in the weeds, as we say around here, you get information into
12 that system and then how that germinates or produces the HEDIS
13 standards and reports, and I'm assuming, the way you're
14 talking, it's like everything goes in today. You could start
15 pulling data about this tomorrow after midnight or something.

16 DR. DOBSON: Well, since we developed this from grass
17 roots, physicians started out saying let's work on asthma,
18 let's work on diabetes, and we asked them what metrics they
19 wanted to use.

20 So the physicians really decide on the quality metrics
21 and measurements. Well in this day and time, they almost
22 always choose the national standard, if there has to be some.
23 But even now, you know, we primarily pull real-time claims
24 from things like -- or real-time data from claims, pharmacy,
25 things that we can get real-time. We do have -- lab data

1 comes in real-time, but it's not 100%.

2 So going back to when we first started this, we have a
3 relationship with AHEC, which is our Area Health Education
4 Center, who partner with us -- and they're in every community
5 -- and we contract with them to go in and do chart audits for
6 the real quality data that you're talking about, what our docs
7 want to have reported. And so when we -- you know, about
8 twice a year, we do, you know, chart audits and quality
9 metrics that get reported in to see, are we moving the quality
10 measure, if we can't get it real-time. It's unlike the
11 insurers. The insurers have to go in as well, and we've
12 conversations saying well, why are we all sending people into,
13 you know, pull clinical data? Why don't we just do it
14 together? And we actually are having that discussion now, but
15 AHEC does that for us. They are our partners. They also help
16 our practices. So the same people who are auditing are also
17 helping the practices do some practice transformation and
18 support, so it becomes less onerous. It's not someone coming
19 in and judging you. They're actually part of your team that
20 come in and help you. And our community health centers are
21 all part of this as well.

22 So what gets reported in a quality? Most of the real-
23 time data is still claims until we get a real clinical feed.
24 And the quality data tends to be more chart extraction after-
25 the-fact. Does that make sense?

1 COMMISSIONER MORGAN: Absolutely. I guess, how many
2 HEDIS quality standards do you have now totally?

3 DR. DOBSON: Well, since we're not an insurer, we're not
4 required to have a bunch. We measure what we're working on
5 and have worked and continue to work on. So it should be on
6 our website. I don't know the numbers, but it's -- you know,
7 it's not an insignificant number of measures that we're doing.

8 COMMISSIONER MORGAN: So basically, if a physician or a
9 physician group or a community health center play, they
10 basically agree to follow or to provide this information for
11 the network, basically, right?

12 DR. DOBSON: Sure. I mean, yeah, but it's their network
13 so.....

14 COMMISSIONER MORGAN: Right. I know, but.....

15 DR. DOBSON: Absolutely.

16 COMMISSIONER MORGAN:if they want to join -- say
17 there is already one there or one in process and they want to
18 join the group or the.....

19 DR. DOBSON: That's what (indiscernible - simultaneous
20 speaking).

21 COMMISSIONER DOBSON:they basically agree to play.

22 DR. DOBSON: It's kind of -- you get a PMPM. You work on
23 quality and do this.

24 CHAIR HURLBURT: Keith?

25 COMMISSIONER CAMPBELL: Keith Campbell. I am the

1 Consumer Rep here, and I have two questions. One, has this
2 help that's available to, like, solo practitioners in a very
3 remote area cut down on your turnover and constant recruiting
4 that seems to happen in a lot of our rural communities here?

5 Secondarily then, I haven't heard any real discussion of
6 patient satisfaction. I understand the Medicaid population,
7 but those two things, how do you -- and how do you measure
8 patient satisfaction?

9 DR. DOBSON: Well, one, this is well-received by patients
10 because it's not a -- making the health care system better for
11 them makes them happy. It's not a -- it's not they're not
12 getting it. They're getting extra stuff. So our patient
13 satisfaction is really pretty good. It's better than -- I
14 mean, it's gone up, and I can't remember what it's called, but
15 we do the standard statewide, you know, patient stats for
16 recipients of Medicaid. It's gone up every year, and some
17 communities will have dips, but you know, it's there.

18 When we set this up, we have the Department of Social
19 Services as a required member of our networks. It was our
20 first -- you know, we recognized that we need to have some
21 connection to the consumers. That's who we chose to be the
22 consumer -- you know, represent consumers when we started
23 these networks. So it is a required piece. So they are the
24 ones closest to the action on eligibility. It's an open
25 network, so people can change docs. It's not closed at all.

1 They can change every month, if they want to. We just track
2 it. And we don't mandate them to enroll. Some people are
3 still outside, but now it's becoming a little bit of an opt-
4 out as it's become more universal. And your other question?
5 That was consumer.

6 COMMISSIONER CAMPBELL: About physician turnover in
7 extreme rural counties?

8 DR. DOBSON: Well, it's a problem all over the country.
9 You know, Office of Rural Health is where this came out of,
10 and we were one of the -- you know, Jim Bernstein (ph), is,
11 you know, one of my mentors. So he was one of the founders
12 and one of the gurus nationally for rural health recruitment.

13 So I would say this has certainly helped. I'm really
14 looking at this multi-payer demo where we have an all-payer
15 support. The reason we chose seven rural counties with high
16 disparities and trouble keeping a primary care workforce is
17 our thought was it would be an opportunity to show, if you
18 really provided not just Medicaid doing this, but all payers
19 supporting the primary care system, just the PMPM alone for
20 the, I don't know, all-payer piece for a rural doc will raise
21 their salary \$50,000-\$60,000. That PMPM, for just
22 participating, gives them a -- if it's not just Medicaid,
23 Medicare, and then you give them also the resources so they're
24 not totally overwhelmed in practice as the single resource,
25 you know, for a community where they will have some high

1 needs. So we're hoping that will show.

2 Anecdotally, I think it's certainly helped. It's helped
3 with our recruitment, and we'll see. I mean, this is probably
4 a five to ten-year thing. If we outrun everyone else in
5 building our primary care, we'll say it's a win.

6 CHAIR HURLBURT: I think we'll take one last question
7 from Paul. We're on the time for our Reactor Panel. While
8 Paul is making his comment or his question, if the Reactor
9 Panel could gather at the table, then we'll move into that.
10 And I know Noah has another question and some others may, too,
11 but the next hour-and-a-half will really be just kind of Phase
12 II of this discussion. So if you had some questions, we'll
13 have the chance. I think, probably, we'll need one more
14 chair, but if the Reactor Panel could be moving to the table,
15 and Paul, could you go ahead with your question?

16 COMMISSIONER FRIEDRICHS: Thank you. Paul Friedrichs.
17 I'm an Air Force urologist representing federal and military
18 medicine here, and we've been trying to roll out the medical
19 home model in both the VA and the DOD for a number of years
20 now.

21 One area in which we've differed within our system is how
22 much of mental health to fold into the medical home model.
23 The VA has incorporated almost all of their mental health
24 assets into primary care. The DOD has taken a smaller
25 footprint and put maybe one primary care provider per large

1 clinic. It appears that your structure is more similar to
2 that in which you have one, maybe two psychiatrists per
3 region. So the first question was related to that. If you
4 could comment on how much you've really integrated mental
5 health or assisted integrating mental health support into the
6 primary care clinics?

7 And the second question has to do with the use of
8 physician extenders. You mentioned the importance of
9 physician leadership. We found that the only way that we've
10 been able to move forward is to rely heavily on doctors of
11 nursing practice, on nurse practitioners who don't have Ph.D.s
12 and on then on physicians' assistants, and I wondered if you
13 could comment on the role that they play in your model. Thank
14 you.

15 DR. DOBSON: Absolutely. The mental health issue is -- I
16 think we have been, one, incented and tried to move to a co-
17 location model and embed mental health providers in primary
18 care settings. I started an incentive program before I left
19 the Department that provided some initial grant money and
20 changed some reimbursement stuff around Medicaid to allow that
21 to occur. So I'll just say, in my practice, I have embedded
22 Ph.D. psychologists in all our practices, and they do quite
23 well and actually are very busy. It's not statewide, so it's
24 moving that direction.

25 But even with that, that's not enough. I mean, that gets

1 you into the -- that opens the door to make sure that you
2 capture and can, at least, handle some of the mental health
3 issues, but you know, we've spent many decades creating a
4 parallel system. And so there is still mental health
5 resources that need to be accessed and coordinated, and part
6 of the notion of the psychiatrist at the network level was to
7 have a knowledgeable person who could try to pull those two
8 systems together and create some of the referral patterns and
9 communication patterns necessary to do that. So in that
10 sense, we're probably a little bit like the DOD versus the VA
11 in how we're approaching the community build out of this. We
12 can't just suddenly just bring all of mental infrastructure
13 into the primary care system. I just don't think that's going
14 to work because you have -- it would like saying we need to
15 take all (indiscernible - voice lowered) cardiology and put
16 them in a primary care office, right? I mean, there are some
17 specialty needs, you know, in mental health that need to be
18 out, but better coordinated. So I think we'll see that. And
19 I really do like the work that, you know, DOD and VA are doing
20 around medical home. We have a lot of military assets in our
21 state, and we're working very hard to try to make sure they're
22 coordinated. In fact, we've got a couple of our networks that
23 that's some of their key -- you know, trying to coordinate the
24 civilian workforce with the military workforce, particularly
25 for families and folks in the National Guard. So I think

1 there is still a lot of work to be done, but I hope that
2 answered it, but I think it's.....

3 COMMISSIONER FRIEDRICHS: Absolutely. And then the
4 second question about extenders?

5 DR. DOBSON: Oh, yeah. I'm sorry. Yes. We have a lot
6 of mid-levels, PAs, and nurse practitioners who work. You
7 know, I think, from the political standpoint, there is a lot
8 of movement about independent practice, but the reality is
9 this needs to be team-based practice. And so -- and that goes
10 for pharmacists as well. You've heard me talk about the
11 extended pharmacists' role, but it only works if they are part
12 of the medical home team, either virtual or otherwise, where
13 there is communication versus setting up separate silos. So
14 yes, we have all our -- you know, a lot of our rural health
15 clinics, maybe, mid-level only, with physician supervision.
16 We have a large number of nurse practitioners who work in
17 different areas. So again, I think, in the concept of a
18 medical home team, virtual or otherwise, you know, we're going
19 to need all the providers we can, including nurses with
20 additional skills, working at the top of their license to meet
21 the need of the population.

22 COMMISSIONER FRIEDRICHS: Thank you very much for that.
23 And if I could just pass on my thanks. I think North Carolina
24 has been very innovative in your program to take military
25 medics, train them as PAs in your program, and then, you know,

1 they commit to continue to work there (indiscernible -
2 simultaneous speaking).

3 DR. DOBSON: That's where, you know, the PA program
4 started.

5 COMMISSIONER FRIEDRICHS: Absolutely, and we're very
6 grateful for that support.

7 CHAIR HURLBURT: Thank you. We'll move on to Phase II.
8 We have what we call our Alaska Early Innovators Reactor
9 Panel, and each of the Innovators will have something to
10 present on what you're doing. And then we'll have time for
11 discussion with the Commission, and we would include Dr.
12 Dobson in that. I'll just very briefly introduce the members
13 of the panel.

14 Dr. Harold Johnston, who Dr. Dobson has already
15 mentioned, is known -- this is a former colleague with a
16 background as a Family Medicine Residency Director. The
17 Family Medicine Residency that Dr. Johnson directs is the only
18 free-standing residency here in the state and has been a
19 wonderful resource with a high percentage of the graduates
20 staying and providing services for Alaskans.

21 Mr. James Shill is the CEO of the Tanana Valley Clinic.
22 Fairbanks has been a little unlike Anchorage. Typically
23 outside the tribal health system, the military health system,
24 the VA system, typically practices is in very small groups or
25 solo practices for physicians. Dr. Laufer's group of 12

1 physicians is pretty big for most of Alaska. Fairbanks has
2 been a little different, with two historical clinics there.
3 And Banner Health, which has had the management contract for
4 many years with Fairbanks Memorial Hospital, recently
5 purchased the Tanana Valley Clinic there. Banner Health has
6 extensive background in the Southwest part of the country,
7 with integrated delivery systems with hospitals and physician
8 groups there. And so this is kind of a new thing for Alaska
9 here, a new opportunity for us.

10 Kevin Munson -- and I may have the details a little
11 wrong, Kevin. I apologize if I do. But Kevin is the CEO with
12 the MatSu Health Services, Inc., and my understanding is that,
13 historically, this was a mental health program, a behavioral
14 health program which started that way and then expanded into
15 the medical aspects of it. And so now it's comprehensive, but
16 rather than adding behavioral health to the physical health,
17 mental health, went the other way and is a very strong asset
18 and resource for the folks in the MatSu Valley, which is the
19 most rapidly growing part of our state, population-wise.

20 Dr. Bob Onders is a Clinical Director for the Kodiak Area
21 Native Association. Alaska was the first state in which all
22 of the tribal health programs were governed and operated by
23 the Alaska Native groups there. The first was out in Bristol
24 Bay, in Dillingham, and I know you know Alaskan geography
25 there. But KANA, Kodiak Area Native Association was one of

1 the early corporations and has operated the clinic there in
2 Kodiak for a number of years and has always been engaged in
3 doing a number of innovative things. There is close
4 coordination and collaboration in Kodiak between the private
5 sector and the Kodiak Area Native Association clinic.

6 And finally, Dr. Laufer, whom you had a chance to talk
7 with a little bit, leads a practice of 12 family medicine
8 physicians here in Anchorage, and without being called
9 formally a patient-centered medical home, every time Noah
10 describes his practice, that's what he is talking about.

11 So I'm not sure what order you all plan to go in or if
12 you have an order. If you have an order, that's fine. If
13 not, you can start at the top of the list with Dr. Johnston.

14 DR. JOHNSTON: Can you hear okay? This microphone is a
15 little distant. Let me see. Yeah. Thank you very much for
16 the opportunity to address the Commission and to react to Dr.
17 Dobson. When I met him in March, he was here for the
18 Iditarod, and I got very excited at the prospect of learning
19 more about what's going on in North Carolina. So I'm real
20 happy to see that he's come back, and thank you for sharing
21 with us what you have.

22 My interest in this comes from being the Residency
23 Program Director in Alaska and the concerns about training and
24 health workforce. As we have been looking at the future of
25 family medicine in the United States, it's been looking pretty

1 rough for a while because very low interest in family medicine
2 on the part of medical students, and for a few years, actually
3 declining numbers of medical students going into family
4 medicine. In the last match, I think it was 42% of the
5 physicians in family medicine were filled by U.S. seniors
6 graduating from medical school, and the other 60% or so were
7 filled by international medical graduates, a sign that U.S.
8 students who have the greatest range of opportunities to enter
9 residency training are choosing other specialties and that's
10 been thought of by many in the industry as reflecting the fact
11 that family medicine is low-paid, and with increasing demands
12 for quality and increasing amounts of paperwork and
13 regulation, the lifestyle has become less attractive than it
14 had been in the past.

15 So as health reform has happened and we start looking to
16 the future where there are going to be somewhere in the
17 neighborhood of 30 to 40 million more Americans seeking each
18 to have a personal physician and the supply of primary care
19 doctors in the United States already very, very short, we can
20 imagine a future where we're going to have a crisis in
21 provision of primary care.

22 So as I've been looking at what we can do to improve
23 that, a couple things have come up. One is the advent of the
24 patient-centered medical home concept seems to be very
25 attractive to physicians because the effect of it, where it

1 has been implemented, usually is that the physician
2 satisfaction goes up, patient satisfaction goes up, the amount
3 of paperwork and workload that physicians do tends to go down,
4 to some degree, as a team is deployed to help with a lot of
5 the stuff that physicians have traditionally had to do
6 themselves.

7 So we've embraced this idea of the patient-centered
8 medical home, and this year, we were fortunate to become
9 certified as a Level I, and hopefully by the end of year,
10 we'll be a Level III patient-centered medical home under the
11 NCQA designation.

12 How can that advent, that process of a patient-centered
13 medical home be extended beyond a privilege program, such as a
14 residency program, which is supported usually by a hospital,
15 as in our case and by the state? It seemed like an impossible
16 project because, in order to extend the benefits of a patient-
17 centered medical home to all the practicing doctors and to be
18 able to get patients into those kinds of practices wherever
19 they go, there has to be a system to enroll the private
20 practicing physicians into the concept, into the arrangement,
21 and as I've looked around at ways to do that, it's been very
22 difficult to envision a way that it could happen. Suddenly, I
23 hear from Dr. Dobson about how they did it in North Carolina.

24 So this system seems, to me, to be almost an ideal way to
25 go about moving the health care system in primary care to a

1 patient-centered medical home model. As Noah said earlier,
2 there are no sticks; there are no carrots. Well, there's a
3 little bit of a carrot in the sense that there is a per member
4 per month, which may raise the physician's salary a little
5 bit, but it's not a major carrot. The major carrot is just
6 better care for your patients and an easier method of
7 practice, and who wouldn't want that?

8 So the workforce in Alaska is in place. We don't have
9 enough primary care doctors here, but at least, we have a
10 deployed workforce of primary care doctors, which could be
11 enrolled into a program, like this, and you know, we'd see,
12 systemwide, the benefits.

13 I'm very happy to hear that the physician satisfaction
14 has gone up in the North Carolina program as well as the
15 patient satisfaction. I had a question, which was around the
16 comparison of this program to the primary care case
17 management, which many Medicaid programs do. I had heard, in
18 other places, that primary care case management didn't yield
19 the financial benefits as much as what I've heard this one
20 does. So maybe, if Dr. Dobson can answer that at some point,
21 it would be interesting to me.

22 I think that our family medicine residency program is
23 still faced with a little bit of difficulty, which is that, as
24 we have gone to a patient-centered medical home, we've added
25 some additional staff. We have a pharmacist now, for example.

1 We have a number of behavioral science people, which are
2 integrated with our program, but we haven't come to -- we
3 haven't solved the problem of how to pay for the additional
4 wrap-around services. So we're kind of moving forward amoeba-
5 like, and you know, if we run into an excess cost, we draw
6 back that little piece of our pseudo-pod. But there has to be
7 a way that the wrap-around services, the additional effort
8 that has to go into a patient-centered medical home can be
9 paid for.

10 As I mentioned to the Commission the last time I was with
11 you, the benefits of a patient-centered medical home accrue to
12 the payers, whereas the costs accrue to the primary care
13 providers. And the exciting thing about this Community Care
14 of North Carolina is that there is a way that those savings
15 can be redistributed to help cover the cost of the program,
16 and it happens in a very benign and sort of natural method.
17 So I'm very excited about this and look forward to
18 participating, and you know, helping as people -- you know, as
19 we move forward with it, if that's what we choose to do.

20 DR. DOBSON: The comment on the PCCM programs that were -
21 - that we actually grew the North Carolina program out of, as
22 you recall, the construct of those were typically paying the
23 primary care doc. It was giving a Medicaid recipient a
24 medical home, you know, a primary care physician and paying
25 them a little extra to coordinate, and mainly, to keep them

1 out of the ED. And that's how they were typically structured.
2 And so while they were well-received and they actually did
3 have some impact, they fell short, including our own state, in
4 helping Medicaid manage the program because it was Medicaid's
5 relationship with one doctor in one practice. It wasn't
6 coordinated in a way, and if you see what we've done with
7 Community Care, when we went and talked to the docs and asked
8 them, why doesn't this work, it's like well, the patients I
9 need help with who are impactable are ones that are hard for
10 me to guard, right? I mean, they're not ones coming in. I
11 need something more.

12 So that was what our experiment was is that, well, what
13 is the more that our primary care doctors need? We had great
14 access for our Medicaid recipients in the old PCCM days. It
15 just didn't help the state manager's budget because the people
16 who were costing the money, as you see, were a different group
17 of people who were not totally primary care dependent. And it
18 was borne out of the old view managed care days where you've
19 got to get primary care's permission to go to the specialists.
20 That's how it was originally set up and that's what was the
21 failing. It's not the permission. It was the additional
22 coordination and resources to help the patient, you know, not
23 help the Medicaid agency on that.

24 And I think, to your comment about support in aligning
25 payer versus, you know, practice, I think what we see in our

1 residency programs is relief because, at least for Medicaid,
2 and in particular, our residencies who take care of a large
3 number of Medicaid, they now have a revenue stream that helps
4 support the people that you're talking about in that PMPM
5 versus, you know, just having to go it alone. I will say it's
6 making a lot of residencies start saying -- you know, start
7 looking at the education and service mix because, you know, we
8 do pay for education, but it's a different revenue. But
9 having that additional PMPM to support the team that supports
10 residents and care has really helped a lot of our programs
11 support this. I know our program just added an additional
12 clinical pharmacist, and we've fully deployed mental health,
13 and it's economically viable, which is a good thing.

14 With Beacon, we're actually looking at taking Beacon
15 funds and seeing what this really looks like scaled out, you
16 know, in an all-payer kind of model, and what you see is that
17 every doctor's office gets resources, not just one shared
18 among everything. You can really scale this where you get the
19 embedded resources closer and closer to the patient in the
20 practice, if it's in an all-payer model. I don't know what
21 it's going to look when it's there. It may be that you can
22 support an extended team with a two to three doctor practice.
23 So imagine that. If you have a two or three doctor practice
24 that has a behavioral medicine specialist and a pharmacist and
25 a care manager or two embedded in that in our community,

1 that's pretty out there, but I don't know that it's not
2 doable.

3 CHAIR HURLBURT: Mr. Shill?

4 MR. SHILL: Dr. Dobson, thank you for coming. It was
5 enlightening, informational, interesting. As Dr. Hurlburt
6 says, in the Interior in Fairbanks, we have a bit of a unique
7 system, having lived in Anchorage twice and the Kenai. We
8 deliver 90-plus percent of the primary care to an urban
9 environment, in terms of Alaska. And I think one that you
10 said is primary care physicians want to do the right things
11 for their patients. It's part of the culture of primary care.

12 With our 40 primary care physicians, we've come to a
13 point -- and we're not actually owned by Banner Health. We're
14 actually owned by the local hospital foundation and operated
15 by Banner Health. The hospital foundation, we're partners,
16 sisters to the hospital and so we work together to try to
17 coordinate and integrate the care for the best of the
18 population. A big piece of this was taking care of the
19 federal and state payers, the TRICARE, Medicare, and Medicaid.

20 And part of that is doing the programs that you're
21 talking about with the health care, the health disease
22 management programs. We have a Coumadin clinic, and in March,
23 we started a diabetes clinic. We're going to start a
24 hypertension clinic by the end of the year. All of these are
25 unfunded. We're doing it because it's the right thing to do,

1 and I hope that we, as a state, recognize what North Carolina
2 has done with this. They've left the fee-for-service payments
3 and then added PMPM, and I look at my clinic and say well,
4 that would help us fund some of these things that we're doing
5 because it's the right thing to do. So I hope we -- and I
6 would encourage the State to be flexible. I think, as Dr.
7 Hurlburt said, there are different models. It's different in
8 Kodiak, and you know, everywhere. But for -- you know, I
9 think this would be a great thing for us. I don't know if
10 fantastic is too strong a word. It would be great, if we
11 could do something, like that. And I think another thing Dr.
12 Dobson said is the real savings come from preventing
13 admissions, not readmissions, and I think we've been so
14 focused on readmissions. And what we're doing here with these
15 health programs is trying to prevent actual admission, the
16 initial admission, through the diabetes

17 And this case management issue, I think, is important.
18 Having been in the mental health system, you know, we used to
19 -- there, it's paid. You go by and you take care of these
20 mental health patients. You're making sure they are taking
21 their medication. You really have to be aggressive with these
22 certain high users, and really, that's what we're doing,
23 having nurses call up. You know, the people with the
24 hypertension clinic we're going to start, you know, come and
25 get your -- you know, take your blood pressure. If it's not,

1 then we send them back to the doc. It's managing this. So
2 you know, I think there are a lot of good things.

3 One question I have for you, Dr. Dobson, you said non-
4 enrollees; what does that mean? Can someone choose to say,
5 you know what, I don't want to be part of this?

6 DR. DOBSON: Yeah. In Medicaid, you know because it's
7 categorical, you can't require people to join, but if we have
8 all their doctors -- you know, if we have all the doctors
9 engaged, it makes it a little easier.

10 When I say non-enrollees, it's people we haven't
11 identified. We haven't connected with a doctor and started
12 paying the PMPM yet. Understand, I mean, you would have the
13 same situation here in Alaska. You've got people on the
14 rolls. Where are they? Where do they live? Who are they
15 seeing? They may have seen the ER here. I mean, trying to
16 track people down and getting them, you know, engaged is
17 sometimes hard, and we, as physicians, just wait until they
18 show up, right? We don't have a list that's, you know,
19 reliable in a community of who is in our community that we're
20 trying to take responsibility. So when I say enrolled, we
21 know they're out there because we're paying bills on them. We
22 haven't tracked them down. We haven't figured out how to --
23 and then have the conversation with them. Who is your doctor?
24 We want to get that person some resources to help you. And
25 yeah, they can refuse it, I mean, because it's a volunteer

1 program, but it really is trying to attach them to a network
2 and a practice is what we talk about enrollment.

3 Back to your other comment about what you're doing,
4 absolutely, flexibility is extremely important. I will tell
5 that, depending on where you are, we're seeing a lot of our
6 folks moving away from disease-specific, you know, for
7 Coumadin clinics, for instance. If you're in Bethel, it's
8 hard to have a Coumadin clinic because there is not enough to
9 support a clinic-specific model, but you need the same level
10 of care and resources. So we're trying to figure out -- in
11 some of chronic disease stuff, we're seeing the most needy
12 patients have diabetes, hypertension, and a bunch of stuff.
13 So we're really starting -- you know, concentrating on these
14 high need, multi-disease patients who are the most impacted.
15 But we have our medical centers in our large areas, like you
16 would have in Fairbanks and others, that can make that, you
17 know, the clinic model work very well. So you have to be
18 flexible enough to allow that to occur. And I do believe, if
19 you give the communities and the providers some flexibility in
20 design of how this works, they'll come up with some pretty
21 good stuff.

22 I'll just tell you there is nothing that you've seen
23 today here that I've cooked up on my own. I mean, this is
24 real people in real communities who have gone out and said I
25 think I've got an idea; I can do this. And if it works, by

1 golly, people just -- I mean, they'll migrate to it. It's our
2 strength and our weakness. We don't have one -- I mean, we've
3 got multiple ways of doing things.

4 CHAIR HURLBURT: Kevin?

5 MR. MUNSON: I appreciate the opportunity to talk to the
6 Commission, although I feel somewhat as an outsider coming in,
7 and I think that, potentially, characterizes behavioral health
8 and health care.

9 Some time ago, medicine kind of metaphorically lost its
10 mind, and the mind wandered off and created its own little
11 world and that world ended up convincing policy makers and
12 funders to fund it independent of medicine. And so we end up
13 with community mental health that is really based not on a
14 medical model but based on a psychosocial recovery model, even
15 in the conversation that we have today about patient-centered
16 medical home, you know, we, as we're trying to wrestle with
17 this whole idea about how do we put the mind back with the
18 body.

19 We're a community mental health center. Actually, we're
20 now a community behavioral health center because, at some
21 point, we rejoined our substance abuse behavior with our
22 regular behavior and become co-occurring in our attention and
23 competency and addressing. And so we thought, well, you know,
24 we really need to put the mind back into the body. And so
25 actually for the last 25 years of my practice, I've been

1 trying to get back into health care.

2 It started out when I tried to establish a private
3 practice with a number of colleagues where we were going to
4 have physicians and therapists join together, family
5 practitioners, an OB/GYN, and a couple of therapists. We
6 ended up not setting that practice up, but I did end up with a
7 co-located practice with a family physician, a pediatrician,
8 and a OB/GYN and did that for a while, in addition to the
9 public practice I was doing.

10 In 2003, the community came to our agency and said, you
11 know, we would really like to create a community health center
12 for the core of Wasilla, and of all of the agencies around,
13 you seem to be in the best shape to be able to go pursue that
14 and so that had been part of the vision and dream of our
15 agency for some time. We had tried, in the '90s, to out-
16 station clinicians in the private practices that were in the
17 community, and it was an idea that was great, but it was too
18 early, too soon, and there wasn't -- we weren't able to
19 demonstrate value.

20 So we began putting our community health center together
21 and so we were co-located. We were in the same building, and
22 we, occasionally, would wave to each other, and gee whiz, we
23 started sharing the same patients. We have the same
24 Administration. And so we began really talking about what is
25 this integration thing all about. It's not just simply

1 occupying a similar space or hallways away from each other,
2 but it really is something more than that. And we began a
3 pretty vigorous conversation and that vigorous conversation
4 has lead us to doing physical modifications to our facility
5 that will allow us to co-locate mixed providers so that
6 they're in each other's hip pocket and so they have the
7 opportunity to talk to each other, to share with each other,
8 to deliver care to our clients and our patients together.

9 We've learned some real interesting lessons through this
10 whole process, and I want to share some of those with you.
11 And if I have time, I'd also like to take the opportunity to
12 perhaps answer the question that you asked Melissa Stone
13 yesterday which is, you know, what policy things do we need.

14 It's really all about the person and not about the
15 diagnosis, and I think it's been mentioned here several times
16 that many of funding and many of our structures are
17 categorical and they're categorical around diagnosis, but that
18 diagnosis is something carried by a person and that's a whole
19 person who has lots of needs, medical needs, social needs,
20 spiritual needs, all kinds of needs.

21 And really what good care and effective care is all about
22 is about the relationship, the relationship that's established
23 between the caregiver and the individual who is seeking relief
24 from some issue that they have. And while we have lots of
25 really good and effective techniques and technology and we can

1 heal the body and we can assuage the spirit and we can help
2 people to change their lives, fundamentally, the thing that
3 produces that change is the power of that relationship. And
4 so systems need to be able to create those opportunities for
5 the individual to create and maintain those relationships and
6 that relationship needs to be with the team because not
7 everybody can deliver everything that everybody needs all at
8 the same time. And with that is we have created teams. We
9 have created teams that hope to exploit peoples' abilities to
10 practice at the top of their competence and the height of
11 their license.

12 Yet at the same time, we're really looking to have people
13 who can deliver competent care who is the least credentialed
14 who can do it, so that the primary care clinician does what
15 the primary care clinician can only do and the things that
16 other people can do, they do it for both the patient and the
17 primary care provider, that the nurse only does those things
18 that the nurse is only able to do and that other people do the
19 things for the nurse. The behavioral health clinician does
20 that only which they can do and the things that other people
21 can do to help with the behavioral health management of this
22 individual gets done.

23 Unfortunately, you know, reimbursement models that we
24 currently exist with don't really support that kind of idea.
25 We have a long history in behavioral health of territorialism

1 and tribalism. We have the social work tribe, and we have the
2 licensed professional counselor tribe, and we have the
3 licensed marriage and family therapist tribe, and we don't
4 want each other to -- even though we do exactly the same
5 things, and when you really take highly-trained competent
6 individuals and you put them in the room and you observe them,
7 you can't tell which one is the social worker, the marriage
8 and family therapist, or the professional counselor because
9 they all, pretty much, do a lot of the same things. They walk
10 out of the room, and they explain things very, very
11 differently, but they, essentially, do the same thing with the
12 clients. They deliver good care. They deliver relationship-
13 based care. But our reimbursement systems only allow certain
14 people with certain letters behind their names to do certain
15 things and that leads to clogs in our system because we have
16 far more people who need that than we have folks who have that
17 particular connection of things behind their name.

18 The other thing that we found is that communication is
19 incredibly important and that's why we're putting our staff
20 into each other's hip pockets. They've got to be able to talk
21 to each other. They've got to be able to share. They've got
22 not only have that informal settings in terms of formal hand-
23 offs and warm hand-offs, but they need the hallway
24 conferences. They need the catch-as-catch-can.

25 And we're also moving to an electronic health record. We

1 currently have a fully-integrated electronic health record for
2 our community health center. We are not fully electronic on
3 the behavioral health side. We're purchasing a new package.
4 Just as a note, there isn't a package out there that does both
5 well. There are packages that do each very well, but not one
6 that does both of them together well, and smooshing them
7 together has been a really interesting journey with our
8 vendor.

9 Workforce is critical. In order to really deliver
10 integrated and coordinated care, you need to have the right
11 people doing the right things and you need to have the teams
12 put together, and we have an incredible shortage of workforce.
13 We're currently down two FTEs of mid-level psychiatric
14 resources, and we're not the only one. There's a real
15 critical shortage in the state. And those folks are really
16 critical to help, both to provide those services to our
17 severely mentally ill and seriously emotionally disturbed
18 folks, but they're also critical to be the consultants to our
19 primary care physicians who manage many of these people, both
20 medically and also manage their psychiatric medications. And
21 so they need that consultation. They need that support. They
22 need that case conferencing that occurs.

23 Integration takes a lot of time, and we're funding it out
24 of our own pocket because nobody is willing to pay for it, but
25 it's the right thing to do, but it's enormously complex

1 because there are all kinds of fiscal implications because our
2 reimbursement systems don't play nicely with each other. I
3 have a prospective payment system for my community health
4 center, and I get certain people who get paid to do certain
5 things.

6 On the behavioral health side, I'm in a fee-for-service
7 environment for fees that, quite frankly, do not adequately
8 cover the costs of delivering the care. I have a -- because I
9 have all of those wonderful things, I have a compliance and
10 risk management structure, that is extremely expensive, to
11 keep me clean with Medicare and Medicaid in making sure that I
12 dot all my I's and cross all my T's. And much of the
13 documentation that we do and much of the reporting that we do
14 -- and in behavioral health, the average is about -- for every
15 hour of service we deliver, there is, at least, 30 minutes of
16 documentation that goes to support that, and most of that
17 documentation adds nothing to quality. It keeps ourselves out
18 of jail. It really doesn't do an adequate job of
19 communicating what's going on to our colleagues. It's mostly
20 there as a risk management and as a process management control
21 strategy in terms of how our reimbursement systems and how our
22 management systems have tried to produce care. They've tried
23 to produce care by monitoring process, not really paying
24 attention to outcome.

25 And so, you know, the "so what," the question that you

1 asked yesterday, the "so what," what would be the takeaways?

2 One takeaway, for us, would be workforce development. It
3 would be expanding medical training and expanding the
4 opportunity, particularly -- you know, my particular bias is
5 psychiatry because people practice where they've been trained.
6 You know, if I could dream for a moment, maybe even bringing
7 medical education up to Alaska. It's providing for the
8 opportunity for people who can legitimately do the work to
9 have the right to get reimbursed for the work. For example,
10 the Feds only reimburse LCSWs in a federally-qualified
11 community health center. The states have the option of
12 additionally credentialing and qualifying people to credential
13 LMFTs and LPCs to also do that work. There is a price tag to
14 that.

15 Expand mid-level education. We are currently seeking
16 individuals who are both cross-trained as mid-level nurse
17 practitioners for family practice and who also can practice
18 psychiatry in the state of Alaska. Our national recruiting
19 firm tells us that there are only 1,300 of those folks in the
20 entire country.

21 Smooth out licensure, develop reciprocity, get licenses
22 done quicker. Our Medical Director, when we brought her on
23 several years ago, actually got her permanent license before
24 she got her temporary license, and I know that particular
25 office has been working and fixing things, but there are more

1 improvements that could help. You know, change the
2 reimbursement models. I really like what was presented this
3 morning about what's going on in North Carolina, that the fee-
4 for-service still works, but that you add value by adding some
5 additional reimbursement to help people to get the job done.
6 Pay for quality. Pay for what it is you're really looking to
7 produce.

8 Experiment, experiment, experiment. You know, we are
9 very fond, as I heard yesterday, of saying, you know, Alaska
10 is different, and we're different, just like everybody else.
11 But you know, the solutions that will work in Anchorage and
12 the solutions that will work in MatSu are not the solutions
13 that are going to work out in Dutch Harbor. They're not even
14 probably the solutions that are going to work out up in
15 Fairbanks. So we need to experiment. We need to innovate.
16 We need to figure out what works, and I really like the idea
17 that it's community-developed, community-based community
18 solutions.

19 Data becomes really important, but systems often get
20 very, very data hungry, and I really like the idea of asking
21 the providers what kind of data they want to use to track what
22 things. Currently, much of my reporting that I do for the
23 State has little to no value, but it's those things that we're
24 so used to doing and somebody thinks it would be a good idea
25 or some researchers thought this would be a cool piece of

1 information to collect.

2 The other thing is, if you are going to collect the data,
3 please give it back to us. Let us know how we're doing. Tell
4 us what's going on with the data that we gave to you, you
5 know, and standardize it.

6 Yesterday, it was mentioned that DHS has 60 databases.
7 Currently, we report into two of those databases, and most of
8 what we report into the second one could be gotten out of the
9 first one. We already report into Medicaid for claims data.
10 Most of what we report into AK AIMS, which is the Division of
11 Behavioral Health reporting system, about 80% of it could be
12 captured out of claims data.

13 Through reimbursement reform and through some other
14 reforms, you know, reduce the compliance burden and that's not
15 just for behavioral health. I mean, that's for all of health
16 care. Reduce the compliance burden, so that we can spend more
17 time actually doing what we need for our folks. And I think,
18 with that, I'll stop.

19 DR. DOBSON: Yeah. I've got just a couple things. I'll
20 just throw a few sound bytes out, without elaborating too
21 much. I think this notion of integration of mental health is
22 important. I think, when we started that, we assumed that we
23 needed mental health people in, you know, primary care
24 offices. That's important for access. But when we asked
25 people who really did this, our mental health folks said no,

1 we need medical people because our -- you know, everyone is
2 scared to death of these chronically, persistently mentally
3 ill, and they have health needs, and they're the ones that are
4 unmet. So it was the reverse of co-location.

5 Related to policy, I would say yes because, in this
6 mental health paradigm which tends to be about social supports
7 and a lot of stuff, and forgive me, but squishy kind of stuff
8 that's hard, where you have multiple providers, what states
9 have done is they've policed them to death, reams of reports,
10 because we don't know how to know what's right, you know, to
11 manage populations of people and providers, even more so. So
12 you get a lot of scatter.

13 So there is a lot of opportunity for policy change with
14 the right connections with state government that will drive
15 this forward. I mean, of all the things when I was in state
16 government that I got needs policy changes it was around
17 mental health providers and other, you know, practitioners.
18 For instance, so you have a co-located mental health provider.
19 How come they can't both charge on the same day, right? It's
20 simple things, but as a policymaker and a payer, it makes you
21 really nervous to turn that loose without some structure of
22 accountability, which is why you get resistance.

23 Data is the other thing. We've always said we can't talk
24 to each other. Yeah, I know that we happen to know that there
25 are these people taking multiple medicines, but we can't tell

1 you about it. That's ludicrous. I mean, you have to create -
2 - you know, patient protections are important, but also, you
3 know, a meaningful exchange of information for the benefit of
4 the patient is important. So those are things you have to get
5 back.

6 Let me go back in, you know, previous comments. I didn't
7 mean a comment I made about disease-specific clinics. I don't
8 want to throw any cold water on that because that's where best
9 practice is generated, but you have to go beyond that because
10 you have to say, how do I deliver that to everybody, which
11 means, if you're in a place where that works and you've got
12 the population, you know, it works, but the problem we've had
13 over decades is that you can't expand that to rural areas
14 where there is a physician of one. That patient with
15 hypertension/diabetes deserves the same level of care. So
16 when you start building these things, you've got to think
17 systemwide of how you're going to take that to the entire
18 population.

19 And one more little sound byte that struck me when -- I
20 want to be a little bit -- just put this in the back of your
21 mind because we do a lot of talking about of top of license
22 and stuff, but at the same -- so I'm going to challenge people
23 with this a little bit. We talk about the need for a personal
24 enduring relationship and trust with the patients they have,
25 and having practiced in a rural area, you know, for, at least,

1 the first part of my career and still living there, I will
2 tell you that, if I only saw patients when it was at the top
3 of my license, I would not have the opportunity to develop the
4 trusting relationship over the time with the patient, which I
5 need to help them deal with the crisis when it comes in their
6 lives. So some of the trusting relationship idea with
7 patients is in the nothing visit, where I actually have time
8 to talk to them about their family and develop that, that the
9 nurse could have done or someone else could have done, but
10 unless we figure out how the team is there -- that I'm still
11 involved in that visit in the down times of care over the
12 continuum, that trusting relationship won't be there.

13 So in that political dialogue of creating teams and
14 having only those people do what they can do the best, just
15 understand we also want -- physicians really do desire a
16 trusting relationship, and it only occurs over time and with
17 providers. So just put that in the back of your mind.

18 CHAIR HURLBURT: Thank you. Bob, could we go on with the
19 KANA program?

20 DR. ONDERS: I'm the Clinical Director of the Kodiak Area
21 Native Association that was founded in 1966, tribally run by
22 our Board of Directors. It's ten federally-recognized tribes
23 of Kodiak Island, and we provide both health as well as social
24 services. And by health, we have, luckily, medical,
25 behavioral health, dental, pharmacy, and a community health

1 aide program as well.

2 Just to give you a little background, I went to the
3 University of Wyoming, family practice residency, did eight
4 years in Cody, Wyoming, and I see a -- I have a perspective --
5 and I've been up in Kodiak for three years. Cody was a
6 referral center to Billings, Montana which is two hours by car
7 or shorter by plane. We were a fee-for-service, very much
8 free market, and then coming -- and dissatisfied with
9 bankrupting, repetitively, patients, and the system that was
10 generated by fee-for-service came to Kodiak, a very similar
11 town, size-wise, captive patient-wise.

12 I work in a different system. We work with the private
13 group. We share call with the private group. We share call
14 with the community health center. We also work with
15 Providence Hospital on Kodiak and are intimately connected
16 with Valerie and her organization and ANMC with SouthCentral
17 as well. And we make connections in a way that isn't fee-for-
18 service and that we're able to deliver care, I think, in an
19 efficient way, and I would be curious -- and a question would
20 be, I understand your model, but how do you get away the
21 specialty connection without a fee-for-service reimbursement?
22 I can contact an orthopedic surgeon by phone, by telehealth,
23 the ENTs. We're in a system that's driven to lower costs by
24 letting me provide that care in Kodiak, and I think that's a
25 great system to work in as a family practitioner or primary

1 care provider because we have access to these specialists who
2 aren't financially driven by the patient visit and that, to
3 me, was a big difference between working in Cody for eight
4 years.

5 The other thing is -- I think Keith touched on this as
6 well with his question, and I would be curious on the
7 Community Care of North Carolina, how much patient ownership
8 do they have in the decisions that are made by the Medicaid
9 departments, both politicians and providers, because, in the
10 system I work in, we're strongly beholden to the customer
11 owners. They are our Board of Directors. We do a lot of
12 patient satisfaction surveys, and we are moving to the medical
13 home model, but those changes that we make are only made in
14 congruence with the patients, that they agree to have those
15 changes done, and I would be curious on how you incorporate
16 that.

17 But to go over the process and what we've gone through in
18 the last years -- and I agree with you when you said the only
19 thing you would change maybe would be the rapidity of how you
20 change things because what we've been able to do is, by
21 focusing on key points, leverage points with the medical home,
22 our care -- and we have a lot of data related to this -- has
23 significantly changed. So what we focus on, I think
24 primarily, is -- I think six points is what we focus on for
25 our medical home model is access as the base because I don't

1 think -- and everyone talks about workforce. If you don't
2 have access, you can't start doing these other changes. And
3 then continuity is the other thing, and Noah commented on
4 this, too. And the private group in Kodiak has that strong
5 because, if you don't have that relationship-based care, the
6 other things don't happen. And so in some way, if changes are
7 going to be made, you have to address access and continuity,
8 and keeping people where they're at in rural areas, keeping
9 people -- fill those job slots. And I wasn't part of that,
10 but I joined into a group that has been consistent in Kodiak.

11 Once we were able to do that, then we transitioned to the
12 third thing, team-based care, and switched to case management,
13 switched to placing MAs on the floor instead of nurses. And
14 then we, in 2008, started clinical information systems. On
15 that base of access, continuity, team-based care, it's amazing
16 how quick you can change things.

17 So on our numbers, what we report at the GPRA indicators,
18 which is the Government Performance Reporting Act to Congress.
19 Tribally, we're electively reporting those, but I mean, we
20 went from a consistent -- which includes the diabetes
21 measures, heart disease measures, cancer screening measures,
22 immunization measures. So there are 21 measures. Dental
23 measures. We went from ten to 12 regularly to 21 out of 21.
24 Last year, 21 out of 21. This year, we're one of four sites
25 in the country to do that out of 200 reporting. I think, once

1 you get that base, you can really change things quick and
2 that's a short timeframe where we're able to improve those,
3 and I'd compared our numbers to the HEDIS 75th percentile
4 easily, no problem, because GPRA is a lower bar, but it's
5 incredible how quick you can go from, in two years, a 30%
6 colonoscopy rate to 70-plus percent by having the case
7 managers, having the access, having the continuity.

8 And then, to me, the patient activation and community
9 engagement are the last key factors, and I would be curious on
10 how the State would and how Community Care of North Carolina
11 addressed patient involvement and community involvement in the
12 process of change.

13 We've had -- and within the tribal health system of
14 Alaska, we've been facilitated in these changes as well, and I
15 think any program that the State starts the facilitation would
16 be good. So we're working, both nationally and regionally,
17 with the Improving Patient Care initiative, which is the
18 Institute for Health Care Improvement faculty on IHS teams
19 that are -- there are 11 sites this year in Alaska doing this
20 that are facilitated by these people who have been through the
21 changes already. So having some sort of regional
22 facilitation, and then the other thing is we have -- ANTHC
23 runs an Improvement Support Team that collects data for us in
24 these 11-plus sites. Other sites have gone through it other
25 years to allow us to connect regionally with best practices in

1 a manner that we can do it. The Internet is great. WebExes
2 are great, so that we can see if -- the YK/Bethel area, I
3 know, has great -- and data sharing -- women's health
4 management in their pap smear rates and their mammogram rates
5 that I can interconnect and find out what they're doing in
6 Bethel or I can interconnect up in Fairbanks with what their
7 doing well up there. So to have some sort of connection
8 between all these regions so that you can share best
9 practices, and ANTHC is doing that for us.

10 And then I guess related to that, I'd be curious on your
11 comments on fee-for-service, how you got around that or is it
12 worth getting around because we're driven by costs and we do a
13 lot of our visits without the patient coming in, and it leads
14 to patient satisfaction. It leads to good care because we can
15 get to it real quick, and that access point may be email. It
16 may be phone calls to the case managers, but there is no
17 reimbursement for us. And in my facility, that's okay, but in
18 most facilities, that's not, and the same with the specialty
19 level at fee-for-service. I can manage a lot of things, if I
20 have help from a specialist remotely, but I need that help and
21 that specialist isn't getting paid to help me.

22 And then I would curious, what areas in Community Care
23 did poorly because I'm sure there are areas that it didn't
24 work and did terrible, and they have the same hospitalization
25 Medicaid rates as they did before and after Community Care,

1 and I'd be curious if access and continuity were the primary
2 problem because, unless we address that, you can make any
3 program you want, if docs are turning over every six months or
4 you have locums in for years -- and KANA has been through that
5 in the past -- no program the State mandates is going to help
6 that. I mean, I'd be curious if you agree with that or
7 disagree with that.

8 And then the patient input component, Don Berwick is huge
9 in patient activation and patient ownership in their care that
10 they're given, and how is Community Care delivering that?

11 DR. DOBSON: Thanks. We're on a journey. I'm not going
12 to sit here and say that, you know, Community Care is the end
13 all, I mean, because we -- you're exactly right. We learn
14 from our failures. You know, we do have networks who don't do
15 as well. Is it access? Yes, it's access. Is it -- you know,
16 some of them may be our big health systems who are so
17 entrenched in their community has this (indiscernible -
18 recording interference). It's really hard to break that
19 cycle. So it's variable.

20 I think that the tribal health system here, as have a lot
21 of community health centers, has kind of gone down this road
22 and may be further along than we are in the rest of the
23 country in this notion of team care in realigning incentives
24 and doing things.

25 When I was testifying in Congress, Senator Sanders was

1 talking about, you know, isn't the community health center --
2 we need to expand them because they seem like the answer, and
3 my comment was, Senator, we need to have -- virtual community
4 health centers are all across this country. I mean, it's not
5 an either/or. It is that we need -- I mean, the principles
6 for what makes tribal health work and community health centers
7 work need to be instilled all through the health system. You
8 just can't go replace them all and so that's what we're on.

9 We happened to start on this journey a little different,
10 you know, through Medicaid and fee-for-service, and you can't
11 change it all, and we haven't near where we need to be.

12 So let me talk about a couple of those things. You know,
13 we've taken inch-thick, mile-wide. We're trying to cover all
14 of North Carolina and then we'll build it down to be more
15 robust. The patients, I mean, we used our Social Services as
16 the proxy because we're virtual systems. Yeah, we would like
17 more, you know, patient engagement in the management of
18 Community Care, but because we are a quasi-public program, we
19 do get quite a bit of public comment at the local level into
20 our networks, and since it's a highly political piece, we get
21 a lot of public comment in what we do. It's pretty
22 transparent.

23 We haven't gotten near as far along as we would like to
24 because of the restrictions of Medicaid to creating patient
25 incentives in ownership and health issues, which is extremely

1 important level of achievement, but we're going there. And if
2 you would say what we would look like in the next five years,
3 we, hopefully, will have some of the elements that you've got
4 in the tribal health system, but we're starting again with
5 fee-for-service, and then we're adding this PMPM thing, and
6 then we'll start moving in flexing things up.

7 Let's talk about specialists in hospitals a little bit
8 because, I mean you know, you've got to figure out how to deal
9 with that, and if you're in a closed system, you, obviously --
10 if you're a Kaiser or a Geisigner or whatnot and everyone
11 works for the same organization, but that's not the reality of
12 Alaska or a lot of places.

13 So the answer is, so what do we tell our specialists
14 colleagues in our networks of why they need to do this and
15 support you in what you do? And there is always a low-hanging
16 fruit in that relationship because they have the same issues
17 we do, just different. If you're an orthopedist, if your
18 primary care doctor can keep the undifferentiated back pains
19 out of their office or the chronic back pains out of their
20 office and you have a support system and you're an orthopedist
21 and you can do more surgery and less office visits for stuff
22 that's not necessary because you're part of -- you don't
23 necessarily have to fix the fee-for-service system to pay them
24 to deal with you because they get something in return. It's
25 back to why the primary care doctors belong to this. We're

1 not paying them a whole bunch. We just make their lives
2 easier being part of this, and that's what we're telling our
3 specialists is that, you know, this is a give and take. You
4 know, you get and you give in this public program. The same
5 thing with hospitals, I mean.

6 So let's talk dollars and cents. I just showed you that
7 all the money came out of hospitals, right? And that becomes
8 a difficult equation for people. Are we hurting hospitals'
9 bottom lines? And the answer is, ultimately, yeah, we're
10 taking unnecessary stuff out of the most expensive place.
11 That's not necessarily a bad thing. It's a bad thing if it's
12 a cliff and it occurs suddenly, but if we're reducing growth
13 rate and we're doing it in an incremental fashion, it means we
14 don't need to build as many beds in the future. And anyone
15 with a three or four-year horizon can plan adequately for that
16 piece.

17 So in all this discussion of shared savings around well,
18 we need to all be in there because we're going to lose money,
19 so we need to replace it with savings, the answer is well, if
20 we're doing it for that reason, it's the wrong reason,
21 replacing this money over from this pot to replace something I
22 lost that I probably shouldn't have had to start with, you
23 know, avoidable hospitalizations and readmissions. But if we
24 do a line slope and everyone has got, you know, the right
25 incentives, to-give-to-get kind of mentality of being part of

1 the system, it can work, I think, by having those honest
2 discussions because it's less risky for people because they
3 don't have to change their corporate structure. They can
4 still, you know, rock on and it's not risky because we're
5 trying to find a better of doing this. So you know, you're
6 point is right on, you know, what we need to do next, more
7 patient engagement, more community, you know, stuff, looking
8 for opportunities with specialists and hospitals and mental
9 health to pull this together. I mean, we're just -- I mean,
10 North Carolina is just, you know, the tip of the iceberg, and
11 as you saw on one of our slides and if you go on our website
12 you'll see, we've got variations all over the place. So we've
13 got really good networks at one thing and not so good at
14 another, and it is all about raising all boats. And I think
15 that, hopefully if you guys start down this road, we'll learn
16 from you. I mean, we've just created a framework to move
17 forward, I think, that's worth looking at.

18 COMMISSIONER MORGAN: Number one, Dr. Edy (ph) just
19 walked in. So I think you two ought to talk a little, but
20 don't let him see your website. I've been looking at your
21 website and kind of sharing it, and I've been sneaking a look.
22 It's very good. If I can use it and understand it, it's
23 really, really good.

24 I think, just as a sidebar comment, that we're kind of
25 siloed, too, but more from systems. We have a VA system. We

1 have an Indian Health System. We're kind of bleeding around
2 and getting some integration, especially in community health
3 centers. Half the community health centers are owned and
4 operated by tribal organizations, mainly in the rural parts of
5 the state. But especially what you've done sort of brings the
6 other part of this that we really don't discuss a lot, which
7 is the -- I call it the Medical Management -- MGMA guys, the
8 single practitioners, the specialists in the groups, and this
9 presents a third group that we can interact with and develop
10 some of these concepts from case management to your
11 integration approach that we use, a lot of us use. So this
12 has been very good. I think it will be very useful, and it'll
13 probably be part of some our recommendations for sure. If
14 it's not, I'd be greatly surprised.

15 DR. DOBSON: I think that what we're trying to do is
16 create a virtually integrated system without change, and you
17 guys are closer to us than probably some other states. I
18 mean, a lot of states have a very two-tiered system. The
19 public system is over here and then all the private physicians
20 are over here, and they don't cross over very much for
21 Medicaid or for, you know, high-risk Medicare. And I will
22 tell you that, you know, all our hospitals take Medicaid.
23 It's distributed. We have, you know, our more safety net
24 hospitals, but it's distributed. And the fact that 94% of our
25 primary care doctors take Medicaid is very atypical in most

1 states. You're very much -- the private sector out there is a
2 workforce that needs to be harnessed and organized. It's
3 through -- it's a lot cheaper to do that, and the thing is
4 that, if I'm a doc and I'm only seeing 10% Medicaid, I'm still
5 important to the State in delivering the care to the
6 population because we can't build enough community health
7 centers if we try to do it in a two-tier -- we just can't
8 build enough, fast enough to manage that, and when you get
9 into a rural area, you can't do that, right, because that's
10 the importance of trying to get single system, multi-payer is
11 that you can scale this to the right piece, and it's the
12 importance of Fairbanks and the model that James was talking
13 about. I mean, you've got to go where your delivery system is
14 and organize it in a way that is accountable.

15 CHAIR HURLBURT: We have our final Reactor, Dr. Laufer.

16 COMMISSIONER LAUFER: I guess I'll try to keep it brief.
17 I'm thinking about 100 different things at once. Sorry.

18 First of all, I can't tell you how much of a breath of
19 fresh air this is to see a system that's been allowed to grow
20 organically work, without the big carrots, without the sticks,
21 without everybody being employed or owned by somebody, and
22 that is the answer, and it's difficult and scary. It's like
23 parenting, you know. You have to be 100% engaged and
24 involved. You're 100% responsible, and you're about 2% in
25 control. But that's really the only way it's going to work.

1 It's hard for me to talk about my practice without
2 feeling like I'm going to run an ad for the place because I
3 feel passionately about it.

4 Something that people need to understand is, when a doc -
5 - a medical student decides to go into primary care, we are
6 passing up much more lucrative opportunities, and all through
7 my training, I was told I should do something else, whatever
8 whoever was mentoring me did, and usually, you know, shown
9 nice homes or fancy things, and that's why I should do it.

10 I think our -- we love to say Alaska is different, but it
11 actually is, and the practice that I'm in is like an heirloom
12 varietal. They're gone. We have never allowed the
13 administrator to have control over the doctors. We have
14 always had control over it, and this is a rare thing, and this
15 is why we're happy. You know, we have an excellent
16 administrator who could easily handle much bigger practices
17 and has, has run hospitals and multi-specialty groups, but my
18 colleagues and I decide what he gets paid. I do a big
19 inventory review of his performance. I report it elsewhere,
20 and we are in charge, and that's really critical, and it
21 answers these questions.

22 I don't have a manpower issue at all. I got called
23 yesterday from a doc in the community working in a different
24 system who wants a job, the eighth one this year. You know,
25 this is in the setting of a national shortage. We have

1 tremendous longevity. We've been in town 42 years. We still
2 have original docs working. The guys who retire want to come
3 back. You know, we're doing well, and why is that? It's an
4 island, this tree that's still growing in the garden that
5 missed the Ice Age. We didn't get, you know, beat up and
6 battered and bankrupted by, you know, various ideas. And if
7 you think about evolution, often, it's a little branch that
8 manages to survive. Then grows the rest.

9 We are primed and ready for integration that you're
10 talking about and would jump on it, and we've been looking
11 towards these ideas a lot, and I've talked to Jeff about it
12 before as well as the CMO for the national group, Blue Cross,
13 Dr. Corn (ph). We're ready to do this.

14 We have strategic planning meetings every year, and these
15 are very interesting. In the last one, our mission statement
16 was actually -- we talked a lot about the medical home, and
17 you know, becoming a medical home is kind of an odd idea
18 because, you know, it's sort of in the eye of the beholder,
19 particularly if -- you know, we're not chasing federal grants
20 or whatever. We don't want to deal with that, and the
21 conclusion was well, we are a medical home and we want to be
22 recognized for that and then also improve in all these ways
23 that are promised by the future.

24 So we see 50,000 patient visits a year. You only see an
25 M.D. It's same-day or next day, and we offer everything that

1 a primary care clinic could offer. We don't have a PharmD or
2 a psychologist. We would love to, really love to, but we have
3 all the services, and like I said, 42 years, tremendous
4 continuity, feedback from patients which is exceptionally
5 good, no problems getting docs or people who want to come work
6 for us.

7 There are a couple really important things. We see all
8 forms of insurance, and if you're going to really provide
9 continuity, you have to do that because, you know, 52% of kids
10 in Alaska are born on Medicaid, Denali Kid Care, and people
11 more and more are getting old. There is a huge bubble of
12 people who are graduating into Medicare, and I don't know that
13 we're going to be able to afford that, but we continue to see
14 Medicare and we see just shy of 5,000 visits a year in
15 Medicare, about 10% of our patient visits, and it's 8% of the
16 population. I don't know if we're doing our share, but we're
17 doing a hell of a lot better than a lot of other people and we
18 still get flack about it, about not having a wide open door
19 policy, but we can't. The community is not holding up its
20 share.

21 We're open six days a week. Most people have a doctor
22 they are attached to and have a long-term relationship, and
23 they usually have a second or third, you know, favorite, and
24 they probably have someone they don't want to ever see again,
25 but you know, the whole point of that is to allow that.

1 As far as becoming more of a medical home, we've adopted
2 an EMR. As an organization, we're far more of a starfish than
3 a, you know, spider, if you've read the book. I'm nominally
4 the President, but I have to convince the other 11 arms that
5 I'm actually going the right direction or want to go in the
6 right direction to get them to come, which presents
7 difficulty, and the real problems for us are standardization
8 of basic practices and preventative care, which we -- I think
9 you guys would be shocked at how little training there
10 actually is in preventative care in primary care, and what we
11 need is better tools. But I can tell you, it isn't really
12 financially motivated.

13 We are aware that what we have is a gem and fragile, and
14 we're very, very protective of it, and I know that's true of
15 the other primary care clinics because we're now talking to
16 each other a lot about this. We don't want what we do
17 threatened, and it's not financial. It's because it defines
18 us. It's a calling. And we -- you know, the world is full of
19 good-intentioned do-gooders who destroy things.

20 That's why this program, this -- what do you want to call
21 it -- network of networks is so appealing. It's organic.
22 It's the right way to go, and it really doesn't matter what
23 your system is. If you participate in it, we can work
24 together. I can't tell you how inspiring it is.

25 DR. DOBSON: Thanks. Your comments just reinforce a

1 couple things I'd like to say. One, you know, you are exactly
2 right; co-leadership is extremely important, physician-
3 administrator co-leadership. If you see, our networks are
4 that way, and our organization is that way. When I was a
5 Medicaid Director, it was that way. It's a co-leadership
6 model.

7 You're right about medical home. Medical home is a
8 political construct to certify what we do. I mean, so what if
9 we really needed -- if all we needed to do to fix some of the
10 stuff was good primary care with a little extra, you know,
11 help, right? That's what we've shown. It's not built on any
12 certification process, although we're going to go back and get
13 all our docs certified, but it really is about networks of
14 medical homes or networks of primary care. So that's
15 important.

16 Your comment about, you know, the payer mix, it is true.
17 I mean, our group -- and we'll commiserate. I mean, our
18 meeting every year of our board meeting from my practice,
19 which is very large, all family medicine, included the
20 benchmark of, are we taking care of the community, which
21 means, in aggregate, we've said we have to -- if our community
22 has 10% uninsured, we should be taking care of 10% uninsured.
23 And we benchmarked every year that our practice, in aggregate,
24 saw the -- took care of our share of the -- and the thing that
25 you get with these Community Care networks is peer pressure is

1 a great thing. It allows for that honest conversation to say,
2 you know, hey, Jeffrey, you're not taking care of -- you know,
3 how come you only have half as many Medicare patients as I do?
4 I mean, what are we going to do with all these people, because
5 they're my parents? It's get it really local when you do
6 that, and being a politician, you know, that really works very
7 well because it's really connected right back to the
8 community, and people change their Medicaid.

9 And you know, I built my practice, when I first started,
10 as a solo physician because I was the one who would deliver
11 babies and take Medicaid. Well, guess what? They have
12 relatives who are not. They have parents who are not. And
13 they always grow up and get jobs, a lot of them do. Contrary
14 to what people think about Medicaid is that they do grow up
15 and get jobs and have families and that's our patient
16 population.

17 The other thing is prevention, I mean, and we've been
18 talking this for decades and decades and decades and decades.
19 And something that we tell our legislators is that you can't
20 take all the money. We're going to save, but you've got
21 reinvest some of it. How we grew Community Care -- if they
22 took all the money, we wouldn't have grown Community Care. So
23 part of the savings has to be a reinvestment to the next PMPM
24 project. So you're putting money back to incrementally do
25 this. There is not enough money to pay for prevention because

1 there is a hard ROI, if you're an insurer.

2 And so my take home message is back to this same thing,
3 choose wisely what your projects are. It's the notion of we
4 know where savings are. It's tertiary and secondary
5 prevention, people we know have the disease that we can do a
6 better job and save money.

7 So what we do with patients we're keeping out of the
8 hospitals, what do we do with that \$1.5 billion of savings is
9 extremely important. So the notion of being able to take a
10 piece of that and investing it and start moving upstream
11 towards the real goal, which is primary prevention, which is
12 why we -- in North Carolina, when we went to CMS saying we
13 want a share of the savings, we committed a significant
14 portion of that savings be reinvested in the community as the
15 community saw fit, and guess where they think they want to put
16 it? I mean, I can't tell them, but they're going to put in
17 childhood obesity and public health issues that we can't --
18 we've, for decades, had trouble adequately funding in this
19 country because we don't tie it to anything else, and the
20 savings are too far out to create a business case for people
21 just to put money in because, if Jeffrey put it in this year
22 for primary prevention, their ROI -- they're going to be on
23 some other insurance by the time -- he'll never get an ROI on
24 his money. But we've got to understand that that's got to be
25 a collective investment, and the only way you can do that is,

1 you know, unite the tribes, I guess is back to the original
2 notion that this has to be a group effort, and you know,
3 people, you know, say, what's the secret sauce? It's
4 uniformity of effort, data, and collaboration. Those are the
5 three. That's the uniform. That's the secret sauce of North
6 Carolina's program.

7 COMMISSIONER DAVIDSON: I had, I guess, a question or
8 maybe more of an observation and then maybe a question. Just
9 from your presentation and just the conversation we're having,
10 it just feels like what you're really talking about is a
11 modified public health model, and some of the things that are
12 already happening in much of our state because, quite frankly,
13 we're the only provider there.

14 I'm sorry. I forgot to introduce myself, (indiscernible
15 - speaking Native tongue) Valerie Davidson, Alaska Native
16 Tribal Health Consortium.

17 And I guess I want to go back to a point that Paul made
18 earlier, which is that I haven't really heard much about
19 consumer engagement, about what we're really all in this for.
20 We're really all in this for people, and so much of the
21 conversation has really been about physicians and physician
22 training, physician satisfaction, et cetera, et cetera. I
23 guess, from my perspective, I think physicians are wonderful.
24 I think they're incredible. I love my primary care doctor.
25 He's incredible. His name is Dr. Norris. I'm fortunate. I

1 receive my health care, as does my entire family, from
2 SouthCentral Foundation, and we receive excellent care. But I
3 think one of the reasons that that system works so well is
4 because the physicians aren't the be-all, end-all. They are
5 merely a tool and a resource to be able to make sure that
6 people are happy, and I mean I know from my experience, my
7 physician is happiest when I, as the patient, am happiest.
8 And I think, to the extent that he has to sort of occupy the
9 other part of his day with those things that perhaps aren't so
10 as enjoyable as spending time with patients, then we should do
11 what we can to sort of eliminate those barriers to success.

12 I mean, like the whole notion -- it was mentioned
13 earlier, data collection and all of this data that we collect
14 from these multiple sources, 60 different sources that the
15 State is currently collecting, et cetera, et cetera. Well if
16 you look far enough and deep enough, everything is a great
17 idea to someone. The question is, to what end? What is the
18 data being used for, to whose benefit does it accrue? And I
19 mean, what we're seeing in health care is really what I sort
20 of affectionately call the flat screen TV phenomenon. I mean,
21 ten years ago, nobody would have paid \$1,000 for a big TV.
22 It's really a question of value. What value do people -- I
23 mean, do -- people are spending a ridiculous amount of money
24 on a flat screen TV. People aren't complaining about the cost
25 of TVs. They think they are getting incredible value for what

1 it is that they're buying, and the same phenomenon is or isn't
2 happening in health care.

3 The challenge I think we're having is that people aren't
4 seeing the value, necessarily, for what it is that they're
5 purchasing, and the flat screen TV phenomenon isn't happening
6 in health care from an individual's perspective. They don't
7 feel like, by spending, you know, five or ten times more, that
8 they're getting a better product, and I think that could be
9 for a variety of reasons.

10 But I guess, just going back to the whole notion of
11 community engagement and person engagement of individuals at
12 the community, I mean, our goal in the tribal health system is
13 to try to get care as close to home as possible, which means
14 somebody in a community of 200 people or 300 people -- average
15 village size is 350 people -- have some kind of health care
16 provider, typically a community health aide, behavioral health
17 aide as well, if we're fortunate, but there is somebody there
18 who is from that local community who knows everything you
19 never wanted them to know and everything you wanted them to
20 know about you and that person -- talk about a relationship.
21 That person -- I mean, my community health aide, when I was a
22 little girl, knew me before I was born. I mean, she was
23 friends with my mother, and I mean, it's that kind of a long-
24 term relationship. And there is nothing more terrifying than
25 being -- working in a system in which you are employed as a

1 part of that system and sitting down at the dinner table at a
2 big family gathering and being called to task by your mother
3 or your grandmother for what she thought was less than good
4 quality service, and not in English, which she may not be
5 comfortable in, but in Yupik, which she is quite fluent in,
6 and you know, those things, you never, ever -- I mean, talk
7 about community engagement. You're going to hear about that
8 for the next 40 years, and you strive for perfection 100% of
9 the time because those ladies are tough and that's what they
10 demand.

11 And I guess I'm also concerned about -- the other point
12 that Paul made earlier was, what about other kinds of provider
13 types? In Alaska, we're very fortunate. We have a community
14 health aide model. We also have, based upon the success of
15 that program, a behavioral health aide model. We also have a
16 dental health aide model, and we have some of the challenges
17 in licensure and recognition. Some of these professions are
18 incredibly -- what's the world I'm looking for? Paul, help me
19 out.

20 COMMISSIONER FRIEDRICHS: Demanding?

21 COMMISSIONER DAVIDSON: I would say some of those
22 professions, one in particular -- I won't say which one it is
23 -- are very, very territorial and very challenging of just
24 being able to get your foot in the door. I mean, we created
25 an alternative provider type, and we were sued by their

1 national organization and their state society. And so I guess
2 I don't have a question, just -- I mean, I guess I'm trying to
3 get your take on what you know about Alaska and sort of some
4 of our challenges that we face. What are some of the kinds of
5 things that we can do relatively quickly in Alaska to help to
6 make that work quickly here?

7 CHAIR HURLBURT: Let me just do a time check. We've got
8 about two minutes left in the session and then a break, and
9 then we do have another session, if you can stay with us, Dr.
10 Dobson?

11 DR. DOBSON: Sure. I'm yours for the day.

12 CHAIR HURLBURT: If we want to talk about some of the
13 things that we're starting to do with the patients that have a
14 medical home here and then there will be about 45 minutes for
15 the Commission to talk again, if you could stay with us
16 through that?

17 DR. DOBSON: Absolutely.

18 CHAIR HURLBURT: So we will need to head toward a
19 scheduled close, as scheduled today, for Dr. Dobson and
20 myself, at least, and Deb. So go ahead, then, maybe kind of
21 briefly anyway, and then we'll take a short break.

22 DR. DOBSON: Well, I'll make -- I think, Valerie,
23 actually, you and I corresponded back when you were talking
24 about that issue with the -- related to dental. Anyway, once
25 upon a time.

1 I'll say value, absolutely. The tribal health system
2 actually should be -- the principles around which you are
3 talking about are absolutely true. We put public health in
4 our Community Care, our network for a reason, and it is that
5 and Social Services were the connection to the community, but
6 the reason that we're where we are is that the business of
7 medicine and what goes on in medicine really, it's the
8 delivery system that needs to be fixed, right? We can't
9 really get there, and people perceive value where -- you
10 experience something, just like I do in Mount Pleasant. It
11 takes me -- if things aren't going well, it takes me an hour-
12 and-a-half to go to the grocery store to get, you know, milk
13 and bread because everyone knows me, and I get stopped on
14 every aisle. If you're in the rest of America where there has
15 been all this transientness, there is not that accountability
16 anymore and patients no longer pay for their care. They are
17 not part of the purchasing of value. They buy insurance, and
18 it's transparent to them how much it costs. It's not
19 transparent to them -- they go in, and who knows what the ER -
20 - the \$2,000 earache in the emergency room costs? There is no
21 connection. So you know, you're living in the world where
22 people really are accountable for -- and there is some value,
23 and what we need to create is that connection back for people
24 to have some vision into the fact that it's not fixing the
25 system and that's the problem we have with policymakers

1 because, you know, they send -- being silos and they're in,
2 you know, 300, you know, people communities or places where
3 they can get direct feedback of how broken the system is.

4 One last comment is, you know, I had a conversation with
5 the Minister of Health in Scotland, and we were having this
6 conversation around the fact that, regardless of who pays --
7 you know, a lot of the countries in Europe and elsewhere, you
8 know, have different -- you know, they have government payers
9 or single payer or different payment systems. We argue about
10 how it's paid, but some of the real differences of what make
11 them work -- and we were trying to draw the connection of
12 something Scotland does that Community Care is sort of like --
13 is the notion of public accountability in a region again.

14 Back to your point, there is some public accountability
15 for the health of the community that ties everyone together.
16 Scotland has that, actually. The fact that they are a single
17 payer makes no difference.

18 Community Care is starting to provide that in our
19 communities. It becomes now the public accountability. If
20 things aren't working well, you know, our legislators know who
21 to call and everyone is a partner on that, right? So there is
22 no escaping "ain't my job" anymore. So that's where the
23 dialogue occurs. So you're exactly right.

24 The next piece is around consumer engagement. And
25 believe me, when people go for -- when Community Care starts

1 talking about different provider types helping us do our job,
2 it's a very different conversation for regulators and people
3 than if a provider group says I want to go start billing and
4 doing something. It changes the dialogue around opening this
5 up, which is why we didn't ever have any trouble with the
6 issue that you were talking about, different people doing, you
7 know, services to solve a problem because it was Community
8 Care who piloted and deployed it, and it became a very
9 different political conversation. And we didn't get
10 (indiscernible - voice trailed off).

11 CHAIR HURLBURT: I'd like to thank the Reactor Panel for
12 sharing with us here and Dr. Dobson. We'll take a brief
13 break. Be back at 11:15. That gives us 12 minutes, and then
14 we'll get started with the next Panel.

15 11:03:26

16 (Off record)

17 (On record)

18 11:16:50

19 CHAIR HURLBURT: If we could ask folks to take their
20 seats and the Panel gather at the table, the Commissioners sit
21 around the other tables. The next half-hour we have
22 scheduled, we want to talk about some things, some plans, some
23 things that have been happening here. We're pretty early in
24 the process of the patient-centered medical home.

25 This morning is, basically, totally devoted to that, but

1 we have three panelists who will be joining us at the table,
2 Marilyn Kasmar, the Executive Director of the Alaska Primary
3 Care Association, Chuck Fagerstrom from the Alaska Native
4 Tribal.....

5 UNIDENTIFIED FEMALE: (Indiscernible - away from mic)

6 CHAIR HURLBURT: Not joining us, okay. And nobody else
7 from there, Kim or Deb? Okay. And Kim Poppe-Smart who is the
8 Deputy Commissioner for the Department of Health and Social
9 Services and who is responsible for the Medicaid program here
10 in Alaska. So I guess we just have the two of you now.

11 So what we'll want to hear is what you folks are doing,
12 what your organizations are doing, what your plans are, and if
13 we have some time for interaction, then we can with the
14 Commissioners, and Dr. Dobson was going to be with us, too.
15 Marilyn, do you want to go first? You're at the top of the
16 list. Or Kim?

17 MS. POPPE-SMART: No. I'm going first. I have to do
18 some level setting here.....

19 CHAIR HURLBURT: Please.

20 MS. POPPE-SMART:because you asked -- you just set
21 me up to give you a whole lot of information that I don't yet
22 have for good reason. If I had it, you all would know it.

23 So from a Medicaid perspective, as you know, we had the
24 Legislative Medicaid Task Force that convened over the course
25 of the year and submitted a number of recommendations to the

1 Governor's office. Very, very recently, we received a thumbs-
2 up from the Governor's office to go ahead and start our
3 planning on those projects. That does include the Medicaid
4 medical home model.

5 So that opportunity, as we described it during the
6 Legislative Task Force meetings, was to establish, at least,
7 four pilot medical home projects, rural, non-rural, tribal,
8 non-tribal, and see how it goes.

9 So how are we going to do this? Those are the nuts and
10 bolts that we don't have yet. This is a very new announcement
11 for us. So what we're doing is gathering our resources to
12 facilitate the conversations with stakeholders, what are the
13 standards that we need to look for in these pilots as we
14 evaluate proposals going forward? How are we going to know
15 that they are successful or they have potential to be
16 successful over time? Success being measured in a multitude
17 of ways, including not only cost-savings, but are recipients
18 engaged, are providers satisfied, and are the needs being met
19 of the system in general, Medicaid recipients getting the care
20 they need?

21 So we are looking at holding stakeholders meeting. We
22 are encouraging dialogue with other payers who are interested
23 and also pursuing a similar type activity because I know
24 providers are not going to say you're a Medicaid patient; I'm
25 going to treat you this way. You're a Medicare patient or a

1 Blue Cross patient; I'm going to treat differently. Or you're
2 a state of Alaska employee; I'm going to treat you
3 differently.

4 So those are all groups that may be interested in what
5 we're doing and may want to follow up closely with us or even
6 hold hands as we start on this journey. So those doors are
7 open. We hope to have some dialogue there.

8 We also recognize the need for technical assistance along
9 the way. You don't just suddenly become a medical home model
10 because you say you're doing a pilot. There are providers in
11 the communities, across the state at different levels of
12 readiness. Some would consider themselves fully operational
13 medical home models at this point in time. That's great. If
14 they want to sign up for a pilot, we've got some ready-made
15 data we can start collecting and that's good for us.

16 For others, there is a lot of work that needs to be done.
17 What are the IT systems, the data points that need to be
18 collected? How do we engage recipients because, in the
19 Medicaid world, there is this thing called choice and
20 recipients do have a choice. We can't force the medical home
21 upon them. So how do we encourage that relationship that
22 promotes patient responsibility in the process, but develop
23 that relationship so that individual continues to want to go
24 back to the same provider, the primary care provider over and
25 over again for their needs?

1 There are many aspects of technical assistance we have
2 seen modeled in programs across the country, so we'll be
3 receiving feedback, doing our own research, and bringing all
4 of that together, and this is why I say, as we have those
5 stakeholder group meetings and you all are engaged, the
6 providers in particular are engaged, you'll know where we're
7 at.

8 We had a target date for October 1st. We're holding to
9 that. What that means is we certainly aren't going to have
10 full-fledged, you know, operational medical homes developed
11 overnight, but we will be incrementally incorporating those
12 elements that make up a medical home over time, starting in
13 October. That's still our intention. You all know the
14 Commissioner. The Commissioner is a "get her done" kinda guy.
15 I follow pretty closely behind. So we expect to do this. We
16 expect support and engagement from those who have interest.

17 Participants or recipients, we anticipate they will
18 largely be represented through advocacy groups at the table as
19 we meet with folks. Certainly, multiple agencies within our
20 own department will be engaged, Public Health, Behavioral
21 Health, IT Services. So it's a big wheel, lots of spokes, but
22 we are committed, definitely committed on this path because we
23 see it's the way to get the right care to the right patient at
24 the right time, hopefully, for the right amount of money, and
25 to engage recipients and promote that patient responsibility

1 that we have -- we, in Medicaid, have not, in other avenues,
2 necessarily promoted. So we hope to interject that largely
3 through our Medical Care Advisory Committee. This is an
4 interest they've taken on this year. They will be working on
5 some medical education materials or patient education
6 materials along the way from a Medicaid perspective to promote
7 that patient responsibility along the way. So level setting
8 done. What questions do you have for me? None?

9 I would encourage you to hold us accountable on this.
10 While I say we are committed, we're committed to lots of
11 things. So continue to ask questions, check in with us, where
12 are you. We want that engagement. We want that dialogue with
13 you.

14 COMMISSIONER FRIEDRICHS: So thank you very much for
15 that. So if the Medicaid [sic] Advisory Committee is going to
16 be -- if I understand you correctly -- advising you on this,
17 is there a role that you see for this Commission in further
18 discussions about the medical home model?

19 MS. POPPE-SMART: Absolutely. The Medical Care Advisory
20 Committee is going to be working on patient education
21 materials specifically. That is one project they've taken on
22 for the year. Absolutely.

23 This Commission has done a great job of providing
24 opportunity for education for us to put the finger on the
25 pulse of the interest in medical homes to begin with, which is

1 very important. We have observed and entertained and engaged
2 in dialogue that has been initiated with this group, and we're
3 appreciative of that. Certainly, continued dialogue, I think,
4 is essential. Spot checks, where are you at with this, how's
5 it going, I think you have reason to be interested in that and
6 want that feedback. I anticipate you'll be providing some
7 recommendations.

8 Alaska Medicaid, of course, is not the only payer. We're
9 not the only decision maker in this, but we are probably in
10 the best position to promote medical home model at this point
11 in time. So we'll listen to those recommendations, and as
12 they can be applied to Alaska Medicaid, we'll certainly pay
13 attention to them.

14 COMMISSIONER FRIEDRICHS: If you don't object, may I
15 follow on? So along those lines then, with the report coming
16 due in just a few months here -- a draft in, what, four months
17 that we have to have ready, Deb -- are there specific
18 recommendations from the discussions that we've had so far
19 that you believe would be helpful in outlining where we should
20 go with this, my first question?

21 Second question, we heard excellent discussion this
22 morning about all payer models and pilot programs that looked
23 at pooling resources from different payer sources. We've also
24 heard a lot of discussion, throughout the life of this
25 Commission, on the challenges in rural communities in which

1 you have the demographic which may largely be cared for by the
2 tribal system, but also may depend on Medicaid, TRICARE, VA,
3 or other payers for part of their health care. Are you
4 looking at pilots that would encompass some all-payer model to
5 optimize the resources available in rural communities? Thank
6 you.

7 MS. POPPE-SMART: At this point, we would -- we do not
8 anticipate throwing aside any model, pilot model that's
9 presented to us that appears to be viable and certainly would
10 promote any that are multi-payer supported. So as far as
11 recommendations go, certainly anything that promotes multi-
12 payer systems in this arena is appreciated for recommendation.

13 While we know that it may take many, many years to get to
14 the end result that we're all seeking, the reality is we're a
15 little bit ahead -- we will be a little bit ahead of the curve
16 here in that many states have gone before us. We can take the
17 best of the best, as we have observed from them, and those
18 elements that applicable in Alaska. So as stakeholders come
19 to the table, we anticipate they'll be able to come informed
20 and promote those best of the best opportunities.

21 The other area where we think we're ahead of the curve,
22 as we move this along is that we don't have managed care here.
23 So we will realize savings earlier than other states have
24 where they're entrenched in managed care and have already, you
25 know, realized the early savings in programs. We'll save

1 because there won't be duplication of services. We'll save
2 because there will be earlier intervention, greater access.
3 That's our vision anyway. That's what we anticipate will
4 happen.

5 So back to your recommendations, I think continued
6 support beyond the pilots certainly is something that we'd
7 like to see with stakeholder engagement in evaluating the
8 success of the pilots over time.

9 COMMISSIONER CAMPBELL: Who is going to be the ultimate
10 decision maker as you move down this path? Is it going to be
11 a collaborative thing or is there going to be some quasi-czar,
12 and where are your decision points?

13 MS. POPPE-SMART: I believe we'll have a facilitator.
14 Whether that is a staff person or a contractor is yet-to-be
15 determined. I suppose, ultimately for the Department, the
16 Commissioner, along with the Governor's office, is the
17 decision maker on some things, not on everything. All of it
18 will be -- all decisions will be made with the consideration
19 of all stakeholder input that's been provided. Of course, the
20 decision maker isn't ultimate authority. It also rests with
21 our federal partners who provide lots of rules and regulations
22 for us to follow, as we're looking at Medicaid reimbursement.
23 So there are multiple czars, multiple masters, as it were.
24 The Commissioner and myself as Medicaid Director will,
25 ultimately, be the ones to do that dance and try and make it

1 all work.

2 CHAIR HURLBURT: Somehow in the planning phase, it always
3 looks like we have more time than when we get to the
4 implementation phase. So Emily, if you have something, and
5 then I think we need to move on because we'll have Marilyn and
6 Bob also to share with us.

7 COMMISSIONER ENNIS: Very quick question. What will be
8 the incentives for the applicants for pilot projects?

9 MS. POPPE-SMART: Emily, that's yet-to-be decided. Of
10 course, stakeholders will input on that.

11 When we mocked up the information that we provided to the
12 Medicaid Task Force, we used some models that existed in other
13 states that are a PMPM model, where we have a cash incentive
14 for per member per month. That's not the only way to do
15 business, and we're open to hearing how stakeholders would
16 like to see that presented. And then, of course, we have to
17 consider what we can do within the restrictions of the
18 Medicaid program.

19 CHAIR HURLBURT: Thank you, Kim. Marilyn?

20 MS. KASMAR: Good morning. Can you hear me okay? All
21 right. I'm Marilyn Kasmar. I'm the CEO of the Alaska Primary
22 Care Association, which is a membership association of the
23 community health centers, rural health clinics, and other
24 safety net providers around the state.

25 I'm speaking, specifically, about the community health

1 centers today, but we have actually had interest in the
2 patient-centered medical home model from all of our members.

3 What I'm doing today is an update to the information that
4 I've provided in the past about what we're up to. So in terms
5 of the roles and status of statewide initiatives, the health
6 centers -- the Primary Care Association has passed a
7 resolution in support of the health center -- of the patient-
8 centered health care home model, and we are actively seeking
9 support to fund transformation activities within our members.

10 Within the PCA, we have hired a staff person for whom
11 this is the focus of what they do in terms of providing
12 support to the clinics, providing training and technical
13 assistance. We've also brought training to the state over a
14 year ago. A year ago April, we brought the Primary Care
15 Development Corporation to kind of kick-off a learning
16 initiative about patient-centered health care home, and we've
17 continued to provide webinars and additional training and
18 technical assistance about the model. The webinar series that
19 the Commission has hosted has been widely attended by members
20 as well.

21 We have established a Board Committee that is working on
22 a position which will actively align the patient-centered
23 medical home development. I keep wanting to call it patient-
24 centered health care home. Patient-centered medical home
25 development and ACO development with our strategic initiatives

1 and funding requests that will be coming forward from us. So
2 we're working on the model for that and the data collection
3 measures and those kinds of things, pulling that together.

4 We currently have, in the budget before the Governor
5 right now, \$875,000 for medical home planning for our sites.
6 That will be a competitive application. It would apply to
7 access funds to help them transform, or begin their transform
8 activities. And a status update about kind of where folks are
9 at with that, they are, as Kim mentioned, all over the map in
10 terms of where they're at with their readiness. Some have
11 actually already achieved Level III. Others are just at the
12 very beginning, but as I said before, they're all really
13 interested in working with this.

14 There have been some initiatives at the regional level.
15 And by region, I mean Region X, which is Alaska, Idaho,
16 Oregon, and Washington. And we work with the Primary Care
17 Associations in those states on joint activities that can
18 benefit health centers in all the states, and one of those
19 activities is a health systems transformation initiative.

20 So we have hired a facilitator, Roger Chafoynay (ph).
21 Some of you may be familiar with him, and he is providing
22 facilitation and kind of guiding the people, the organizations
23 that have signed up with this initiative, along in the journey
24 of transformation. It's kind of a learning team. They're
25 having monthly webinars, frequent phone calls, frequent times

1 where they come together to talk about how they're doing and
2 what they need to be doing to keep moving forward. That was
3 kicked off with a two-day training in May in Seattle, and
4 there will be another two-day training in October in Seattle.
5 In between, they're meeting via webinar and phone, and the
6 whole idea behind this is that the kick-off got them going,
7 and Roger and the continuing activities are to keep the
8 organizations focused as they move forward.

9 There has been a lot of -- I think we hear that
10 consistently. The need for training and technical assistance
11 as people move along through this is really great. So that is
12 one of the big things that needs to continually be provided.

13 There are numerous foundations around the country that
14 have been supporting pilots and demonstrations. I think
15 you're familiar with those. I think we'll continue to see
16 more of those.

17 At the national level, the Bureau of Primary Health Care,
18 which is the division in HRSA where the health center program
19 is funded out of and managed. They're planning to announce a
20 competitive opportunity for health centers for small grants;
21 \$25,000 is the number that's been tossed around to assist
22 health centers in moving forward.

23 The focus, I think, will be for care coordination and
24 data collection. That opportunity hasn't been announced yet,
25 but it's coming out pretty soon. So that will be announced.

1 That will be an activity or an opportunity for our members to
2 access.

3 And then I think you've heard about Medicare
4 demonstration project that was just announced about a week
5 ago, 500 demonstration projects for the community health
6 centers around the country. Sites had to meet certain
7 requirements to be invited to apply; 1,400 invitations went
8 out; 500 demonstration projects will be granted, and it will
9 provide training and technical assistance and six dollars per
10 member per month, per beneficiary per month, to help those
11 health centers move forward in their transformation
12 activities.

13 So the Primary Care Association's role has been to
14 provide a framework and guidance and technical assistance and
15 training, working with our members who have already achieved
16 great success, helping our members who still need training and
17 technical assistance and kind of moving everybody forward on
18 the activity. It is a pretty complicated journey for them, as
19 you've heard, and it yields great rewards and great
20 satisfaction, but it isn't an easy thing to achieve so we're
21 standing by to help, and we are looking forward to working
22 with the State on the activities that we know are going to be
23 announced and working with the Commission. Thank you.

24 CHAIR HURLBURT: Thank you, Marilyn. Dr. Bob Onders,
25 maybe if we could ahead with you, and then if we have any time

1 at the end, we could have questions.

2 DR. ONDERS: I was just asked to comment a little bit
3 about -- for Charles, who was supposed to be here, the
4 Improving Patient Care Project that ongoing through the tribal
5 health system in Alaska, and I guess, more to make you aware
6 of what is going.

7 IHS started this project Improving Patient Care, which is
8 a transition with facilitation to a medical home model in the
9 tribal and IHS systems, and it's based on Ed Wagner's Chronic
10 Care model, but it's specific to the beneficiaries of American
11 Indians and Alaska Natives across the country.

12 So the goal is the same as what medical home goals are,
13 to improve the access and continuity of care, decrease
14 utilization of emergent and urgent care, improve staff and
15 patient satisfaction, and also have results, as for us,
16 reporting through the clinical reporting systems as well as
17 the Government Performance and Results Act measures.

18 It's facilitated through the Institute of Health Care
19 Improvement, and I think the Commission, being familiar with
20 that -- Doug is a faculty member on that. A lot of the
21 faculty do these transformations, even for private practices.
22 It's the same thing, and I think, like, Noah would benefit
23 just as much as we are from these facilitators.

24 So what we've done is gone through the Dartmouth Green
25 Book Practice Assessment to get a good idea on how we function

1 as a clinic and then begin the change process, and what
2 they've facilitated with us is Jerry Langley -- he has worked
3 with Deming, with the Toyota industry back in the '50s on
4 change processes, and I think that's been key for us is
5 recognizing the changes that we make impact multiple things,
6 and in order to have effective change, we have to have people
7 in the right places. We have to build will. We have to do
8 motivations, and we have to have a standard way of making
9 those changes. And I think this process through the Improving
10 Patient Care initiative has helped our organization, and I
11 think it's the same thing you guys are looking to do, and
12 there are great resources out there.

13 We use the PDSA, Plan-Do-Study-Act, method when we do
14 changes, just to make sure we have an aim. We measure what we
15 change, and to do that on a regional basis, which Charles was
16 supposed here to speak to, there is -- out of IPC, there is a
17 Regional Improvement Support Team, so there is an Alaska
18 region for the tribal facilities, and there are 11 sites
19 participating this year in this transformation, that try to
20 coordinate locally. I'm a firm believer that those changes --
21 there are resources within our region in different pockets
22 that, if we just connected them all, know how to make these
23 changes in order to develop medical home.

24 The Nuka model that SouthCentral does is a great resource
25 for urban settings and then a lot of their principles are

1 applicable in the more rural settings, but interconnecting
2 everyone in a single model is good.

3 But this is the process that we've been through and it
4 sounds like something that may be happening on a statewide
5 basis and be available to everyone which, I think, has been
6 great for us.

7 CHAIR HURLBURT: Thank you. We've got a few minutes for
8 any questions specifically to address the Panel from the
9 Commission Members. Linda, please?

10 COMMISSIONER HALL: Thank you. And this is not for
11 anyone specifically, but I'm looking at a direction that, I
12 think, we're very impressed with right now, and I'm listening
13 to some -- well, to me, I've heard pieces of all of these at
14 times, but as I sit listening to each of you wondering and
15 wanting to make sure, as we make recommendations and we move
16 forward, and you each -- as somewhat different entities,
17 you're working on similar models. It kind of strikes me, is
18 there a way we can set up networks between the various models,
19 but not duplicate resources? That's probably where I was
20 going to start is a concern with, if you have a Medicaid pilot
21 and you have one at the tribal entities and you're all kind of
22 looking to do a very similar -- either a medical home or
23 patient-centered medical care, those kinds of things, are we
24 in jeopardy of duplication of resources in one area and lack
25 of resources in another?

1 MS. POPPE-SMART: I'll take the first shot at that. I
2 don't know that we are there. You know, this is a new journey
3 for us, and the State hasn't been involved at the same degree
4 as others have to this point. I do think there are ways we
5 can synergize. Specifically as we look to technical
6 assistance and data collection, et cetera, we don't want to
7 duplicate and make additional measures that are not
8 beneficial. So as the state really advances on its journey,
9 we will have, I'm sure, more dialogue with our partners in
10 this and identify those ways that we can collaborate and the
11 ways that we can bring those resources together and avoid that
12 duplication of effort, ultimately. That would be my hope, and
13 as we add additional payer sources, again, we're going to just
14 serve to shore up those support systems.

15 DR. ONDERS: I think I was thinking the same thing as you
16 though because we're also involved in a rural quality -- a
17 HRSA grant, rural quality improvement grant, which is -- IPC
18 has no dollars associated with it. We're doing it because
19 it's the right thing to do, and we -- as an organization and
20 how we're funded, there are benefits to improving care, and
21 also, we're beholden to our beneficiaries very much so. So
22 improving their care is mission-driven. But this HRSA grant
23 is like -- we report on a monthly basis all our stuff to IPC,
24 and we do the same exact thing to the HRSA grant. I worry
25 that you're going to just report all these different things,

1 and we could join the NCQA and then we would report to them
2 and pay money to report to them and get that sticker on our
3 outside. There could be a lot of potential for duplication of
4 similar services, and I think being here maybe will help the
5 Commission be aware of what's out there already.

6 MS. KASMAR: I totally agree with, actually, all three of
7 you, and I would also add that I think we really need to work
8 to create synergies wherever possible, standardization of the
9 collection of data and the way we're measuring success with
10 these projects, and also, as much as possible, reduce
11 competition for resources because, from the clinic's site
12 perspective, you know, organizations are all different sizes
13 and shapes, and sometimes, the larger ones have more resources
14 for going after funds and going after resources, kind of acing
15 out the little guys, but the little guys also need to, you
16 know, have the opportunity. So I think, as much as possible,
17 working so that we can be sharing resources, while amongst all
18 of the stakeholders, is really important.

19 CHAIR HURLBURT: One -- maybe Noah, did you have a
20 question? Yeah, Noah and then Pat and then that would be it.

21 COMMISSIONER LAUFER: The thing that was so refreshing
22 about your talk earlier is that, you know, it's a step beyond
23 competing for grant money or for somebody's pet project or
24 whatever. It's the openness. So when I see a patient from
25 the Native system which, to me, is very closed and they're

1 asking me for pain medications, which would be a reason for
2 them to leave that system, I would love to know if they have a
3 pain contract or if they already got scripts or if they saw
4 someone else in the community already because then I can
5 provide good care. That just should be there. It should be
6 there now and should be opened, and it's pretty difficult to
7 figure that out.

8 On the other hand, if I want to spend some of their money
9 and order a CT scan, that's not really, I think, my right
10 because you're in a system that's trying to control that, and
11 I don't mind sending them back, but I should be able to do
12 that openly also, where I talk to the primary care doc that
13 they would normally see and say, you know, they're here. They
14 have this concern, and I don't want to do it. It's about
15 openness. It costs less and avoids duplicity. And you know,
16 we're all willing participants in taking good care of people.
17 So you know, like I said, we don't go after grant money. I
18 mean, I guess, if somebody wanted to give it to us, that would
19 be interesting, but they don't.

20 We can't -- you know, Dr. Eby was telling me, next door,
21 there are people talking about the same thing, but we're not
22 talking to them, which is kind of, I think the term is,
23 ironic. Yeah.

24 CHAIR HURLBURT: Did you have a comment, Dr. Dobson?

25 DR. DOBSON: Yeah. I think the opportunity, I mean --

1 you know, we've experienced the same thing with CMS or HRSA is
2 that every grant our new program comes with is reporting, and
3 it tends to silo things. And what we're seeing with central
4 organization is the State is using Community Care's central
5 office to be kind of the conduit. So we've been one data
6 system that reports for everybody, even though we may not even
7 do the grant. In fact, the community health system is going
8 to contract with us to do data warehousing, so they can report
9 to their federal folks and among themselves, as far as the
10 HIE.

11 So I think, you know as you look at this, it's really
12 important to think about this shared resource notion among
13 multiple providers. It doesn't mean that you're not going to
14 still do it in your own organization, but it's sharing data
15 and also the leverage of trying to make some sense of not
16 getting siloed by a new program development, and we've had
17 that conversation with CMS. You know, we've got seven things
18 going on, and eventually, we're going to run out of
19 communities in-state to do it in because they won't let you
20 overlap them and the controls and all that kind of stuff. So
21 it's something that's a real nice role for the State to play
22 to help coordinate as well between multiple federal agencies
23 and know what's going on, so that you can really leverage that
24 DOD. All the things that have to impact the State from the
25 provider standpoint are the same providers, right, and the

1 same communities.

2 CHAIR HURLBURT: Pat and then Paul?

3 COMMISSIONER BRANCO: Just very quickly -- and I don't
4 mean to be the one to throw cold water on any warm feelings,
5 but I have to. And so unfortunately in today's world -- and
6 I'm a strong advocate of handshake agreements and liking each
7 other and sharing resources, but we live in a world of anti-
8 trust lawsuits in which the small player, if they are not
9 included, has the right and has the power to say I was
10 excluded purposefully from this game, and the more we
11 cooperate, sometimes, we work into the stark (ph) laws. So I
12 don't mean it to be cold water, but these need to be on our
13 awareness level, too, to be sure that we stay clean and well-
14 intentioned in all of our work. So I commend you for your
15 work, too.

16 CHAIR HURLBURT: Paul?

17 COMMISSIONER FRIEDRICH: Thank you, sir. Sounding
18 perhaps a similar note of caution from a slightly different
19 perspective, having just come back from a week in which every
20 specialty -- the Primary Care Specialty Society was describing
21 the consulting programs that they are now selling on the
22 medical home. Every independent state is looking at who they
23 have hired and how much they're spending to bring into their
24 Medicaid organization on the medical home. This is now the
25 cottage industry of the decade, I think, for medicine, and I

1 would offer the observation that, you know, as Dr. Dobson
2 said, there is an incredible opportunity for the State to play
3 a role as an information broker, and I think we've done some
4 of that and I'm very grateful to have been a part of that with
5 the sessions, Deb, that you've set up, and I commend you for
6 that.

7 I think that we can also, hopefully, be the voice of
8 reason to say that we don't need to bring in -- or at least
9 discourage, to the extent that we can do that, bringing in the
10 plethora of consultants from the Lower 48 where every program
11 has to bring in their own consultant to describe to them what
12 the medical home model is. You can spend an enormous amount
13 of money on that.

14 What we've done within DOD and within the VA is have
15 teams that have done that are centrally-funded, resources that
16 we have identified, a lot of IHI products that -- some that
17 we've stolen from North Carolina because they've really done
18 some excellent work there. You've built the nucleus for that
19 already with the presentations that you've brought in, and I
20 would offer to the Commission that we have an opportunity to
21 collate that in a way and share that for the State, and
22 hopefully, save some duplicative effort.

23 The second part, as I've thought through the
24 presentation, Kim, that you shared, I'm struggling to
25 understand how we'll get from where we are today to 1 October,

1 and if I understand the timeline, between now and then, we
2 have to define what we're going to do, go out and find the
3 people who want to do it, validate their grants for it, and
4 then award grants for them to move forward.

5 MS. POPPE-SMART: I don't think there is a grant attached
6 to it.

7 COMMISSIONER FRIEDRICHS: Okay. I would, again, offer
8 from the DOD and the VA experience that that's an optimistic
9 timeline, as I think you touched on in your comments there,
10 but if we can help in -- again this is now directed back to
11 the group, if we can help in our report by emphasizing that
12 this is not something, as Dr. Dobson said, that you can do at
13 the beginning of a fiscal year and reap rewards from within
14 that fiscal year. I mean, this really does take some thought
15 and effort.

16 On the DOD side for a clinic to stand up a medical home
17 model usually is six to 12 months of pre-work, in which you're
18 changing your access templates. You're changing your
19 policies, your business procedures, doing a lot of organized
20 learning, as Deb has tried to help us to do, and then
21 beginning that process. We've been doing it now for almost
22 two years in our facility and perhaps are 60% through our
23 initial checklist of things that we wanted to accomplish, in
24 part, because of staff turnover and the war, and you know, the
25 Japanese disaster and other things that happen, but this is

1 not a journey where you say, wow, let's do this pilot, and
2 next year, we'll, you know, save \$300 million. It hasn't
3 worked that way, and I hope we can help by capturing that in
4 our report, so that the expectation management is done up
5 front and you're not left with folks wondering why we didn't
6 accomplish more by December.

7 MS. POPPE-SMART: Yeah. Yeah. I know. We want to
8 manage those delusions, as it were. And as I said, you know,
9 we don't anticipate we'll have fully operational medical home
10 models under this pilot starting in October, but we will, at
11 least, be able to start having the conversations about how we
12 collect the data, identifying our beneficiaries or our
13 recipients who are in that provider practice and starting to
14 create a mechanism to provide that claims data, so they can
15 have that history. So no, it's not a fully operational system
16 that we're looking at, but we want some activity occurring as
17 of the first of October, so we are demonstrating that we are
18 absolutely committed to this project. There should be no
19 doubt that the Commissioner is very committed to moving
20 forward with this model. There will be a lot of questions
21 along the way and a lot of bumps along the way, a lot of
22 learning, which is what pilots are all about.

23 CHAIR HURLBURT: I'd like thank the Panel very much, and
24 we'll move into our discussion. A comment about Noah's
25 comment, in the state of Washington, at least for the million

1 or so individuals that are enrolled in Medicaid, unless they
2 are coming to your office and paying you cash and paying the
3 pharmacist cash for the controlled substance, which, as Larry
4 has said, happens -- but that, if Medicaid is paying, you
5 would know that, in the system that's working in our
6 neighboring state to the south.

7 Now as we talk in the next half-hour or so about our
8 recommendations, we're specifically talking about developing
9 recommendations that will go into the report and the
10 recommendations that we give both to the Governor and to the
11 Legislature on January 15th.

12 As Kim said, her self-perception and her boss' perception
13 of her is that she is a get-it-done person and so things are
14 going to be happening, and Marilyn and Bob and others. So we
15 are specifically talking about recommendations for January, as
16 far as our formal transmittal goes, and that puts some context
17 around it. But I think, related to what Paul was saying --
18 and I don't know if you were able to listen to the earlier two
19 webinars, but the three webinars, including the one today, my
20 sense was -- I've gotten a sense from earlier cautions that
21 you don't get a payoff tomorrow, but that the timeframe --
22 today, what I heard from Dr. Dobson was the most optimistic
23 timeframe is when you really start seeing a payoff and that's
24 based on real world experience, and it sounded realistic, to
25 me, but it's not going to be tomorrow and it's not going to be

1 January and it's not going to be next July, but it's still not
2 a bad timeframe, from what I heard. So I think that should be
3 a part of the context of what we do.

4 So let's talk about patient-centered medical home
5 recommendations. If we have time, which I don't think we will
6 -- if we do, we can talk about some other things. I accepted
7 Deb's assignment to me to make some suggestions about some of
8 the things we talked about yesterday. We may want to take
9 those, if we can set up a phone conference for a couple of
10 hours sometime while it's still fresh in our minds, and I'll
11 keep those.

12 So let's start out and try to focus on patient-centered
13 medical homes, recommendations that we would make, the target
14 of the recommendations being the Governor and the Governor's
15 Office and the Legislature here in Alaska. Deb, yeah?

16 COMMISSIONER ERICKSON: If it would be easier for you to
17 talk about recommendations by just making some observations, a
18 set of observations first, we can do that, or if you really
19 just want to dive right into recommendations, we can do that,
20 too.

21 CHAIR HURLBURT: And I would like to invite Dr. Dobson to
22 consider himself a member of the Commission for the purposes
23 of the next 30 minutes because he has been there/done that
24 more than any of us have, and those Alaskans heard our
25 comments. Yeah, Keith?

1 COMMISSIONER CAMPBELL: I've had a nagging thought and
2 feeling that we haven't, in this whole discussion, really
3 defined what quality or value we expect, other than in just
4 generalities. Should we be a little more specific, so the
5 goals that we are going to aim for at X years out -- other
6 than that, I think, you know, we'll end up in the old book of
7 *The Art of Motorcycle Maintenance*, driving ourselves crazy,
8 and then we have some sort of parameters here. It's just
9 been, I guess, bothering me a little bit, and I think maybe
10 that's one of the things we ought to, at least, think about
11 because, if you don't know where you're going and what you
12 expect to get out of the end, it's just futile.

13 COMMISSIONER BRANCO: This has been a thoroughly
14 enjoyable day, and I've really enjoyed your presentation and
15 the dialogue with the two Panels as well.

16 As a Hospital Administrator in one of the areas you
17 pointed, there may be a loss in the future.

18 We were handed a book yesterday, or some of us got it a
19 little bit earlier, and there is a terrific quote inside the
20 cover of the book, and if I paraphrase it wrong, too bad.

21 CHAIR HURLBURT: *Tracking Medicine* that you may be
22 familiar with.

23 COMMISSIONER BRANCO: And the quote is from Sinclair
24 Lewis, and it applies to me and me alone at this very moment.
25 It says, if you want to block understanding, the biggest

1 barrier to understanding is having your salary contingent upon
2 you trying to understand it, and it's some paraphrase of that.
3 So I'm trying to be selectively ignorant on this, but I do --
4 in my community, we're it. We have all the clinics. It's us.
5 Behavioral health is us. We have the clinics, the home
6 health. We are a holistic community by design or by default,
7 and it's mostly by default. I think this is a wonderful fit,
8 but there are a lot of hurdles for us to overcome to help us
9 understand, even when we don't want to understand, me in
10 particular.

11 CHAIR HURLBURT: Larry?

12 COMMISSIONER STINSON: I think almost everybody here has
13 said it one way or another, but communication between all of
14 the different entities, between -- I don't really like the
15 term silos, but it's really true. If I get somebody who is a
16 dependent wife from the military and they want a prescription
17 for their Vicodin and I don't know that they're already
18 getting a ton of it on Base, that's a problem. Or we do give
19 people who are ANMC beneficiaries that we treat, and I can't
20 get lab results. I can't get radiology results. I can't get
21 any of their prescriptions. And so it's -- and we have sent
22 in before requests over and over and over again, and you just
23 never get it. And so you have to take the patient at their
24 word, and then later on, I'll talk to Dr. Klauson (ph) over
25 the phone and find out, oh my, and so there are some real

1 built in barriers that need to be broken down. And like Dr.
2 Dobson said, someone needs to take the lead in trying to break
3 this down, and it's going to have to be a big powerful entity,
4 such as the State or somebody who has got the pull and the
5 personnel to do something like that.

6 CHAIR HURLBURT: You and Noah have made the same point.
7 To be clear, are you talking about you cannot get that
8 information electronically, you cannot get it by a phone call,
9 or you cannot get it with a patient consent and asking for the
10 information, or none of the above, just to be clear about what
11 both you and Noah are saying?

12 COMMISSIONER STINSON: I don't know what the politically
13 correct answer should be, but the answer is none of the above.

14 DR. DOBSON: This is a little bit deja vu having, you
15 know, this conversation. I think the answer is yeah. Why
16 don't we have a central organization that is public-private?
17 It's to create the data use agreements to handle -- you know,
18 an agent of the State has created this organization for which
19 we can create an agreement between the practice, the network,
20 and the central organization, the State, for which we can now
21 legally share data because it's right to know. I mean, it's a
22 framework.

23 CHAIR HURLBURT: Is Fort Bragg or VA hospitals in on
24 that?

25 DR. DOBSON: Soon to be. Soon to be. And the other part

1 of state government is around the anti-trust issues, right?
2 We're doing this on behalf of the taxpayers of North Carolina,
3 and it's why we started with Medicaid. And so there is
4 something to be said about the State's role in this. It's the
5 proper role of government that's creating a framework. It's
6 accountable to the people. Otherwise, we'll be -- and it's
7 hard to get ourselves out of this conundrum we're in, you
8 know, in this country.

9 So let me just -- advice. As you said, I mean, you go
10 forward with a set of principles, right? You know, we have to
11 define the quality and the value for why this is important for
12 the state of Alaska, and you can do that pretty easily, I
13 mean, certainly starting with the public payers, and the
14 public payers are beyond Medicaid. It's state employees, too,
15 right? I mean, there are a lot of public-funded health care
16 that goes out there that you could throw in the mix for that.

17 The other thing is that, once you've done that, I'll go
18 back to the -- I think I said it, but let me say it again.
19 You really have to be targeted in what you do, and it's set on
20 a set of principles. It's like, you know, uniformity of
21 action. So we've got to decide we're going to do something
22 and then we have to approach it with data because transparent
23 data is kind of the thing that moves this and then a framework
24 to allow the flexibility for people to react to that, and I
25 think the State and the state Medicaid agency is certainly a

1 good group to do it. There is, like I said, health home, you
2 know, incentives to start pulling some of this together, but
3 again, I think this group and others is a good framework.

4 So you know, the last comment is that I think I kind of
5 heard a piece -- say okay, if you're -- medical homes -- you
6 guys have got a lot of primary care out there. It's not
7 organized. But if I were going to take the first step, it
8 would be helping your Medicaid Director solve a reimbursement
9 problem on the highest need patients, which may have less to
10 do on a long-term thing about building out what we're thinking
11 about medical homes. It's the 20 patients in your practice
12 that cost her the most money and that may just be simply
13 information and something in the community that's not there
14 now. That's the low-hanging fruit.

15 So if I were starting back with North Carolina -- you
16 know, we started with all the pediatricians. We were doing
17 really good stuff around ASTHMA and stuff. Our \$1.5 billion
18 was the hooking onto these really complicated mental health
19 and other patients and giving them a Care Manager, and I
20 might, if I were doing it again, start there because it will
21 give me the savings to fund the build out of something bigger.
22 Does that help?

23 CHAIR HURLBURT: It's the 2%?

24 DR. DOBSON: Two percent, yeah. Yeah. I would start
25 there and that gives you time to really do the hard work of

1 practice transformation stuff, which is your long-term.

2 CHAIR HURLBURT: I think that's where your mind is, Kim,
3 isn't it? Yeah. Emily?

4 COMMISSIONER ENNIS: Yes. Speaking again about the long-
5 term care system, which is a big part of our health care
6 system, but often, we don't recognize it because these are
7 assisted living homes. They're group homes. They are
8 individual families getting some support to maintain their
9 loved one with a disability or dementia in the community.

10 I think having a Care Manager could provide so much
11 resource and support to helping those individuals stay at
12 home. We have to remember that the person with dementia or
13 disability is a compromised patient, in terms of being able to
14 be engaged or to represent their own needs. They depend on
15 their provider, sometimes not a family member. Sometimes a
16 young person that is entry into the field, the direct service
17 worker who represents their needs, and as much as we'd like to
18 think they can do that adequately, it's not always the case.

19 So a Care Manager would just go so, so far in making sure
20 that those patients needs are represented and making sure that
21 the resources are there to keep the person in the community.

22 CHAIR HURLBURT: Did you have something earlier, Noah?

23 COMMISSIONER LAUFER: I was just thinking of an anecdote.
24 I'm pretty happy with the way we do what we do, but it could
25 certainly be better. But I was at dinner the other night with

1 a bunch of people who grew up here, including another doctor,
2 but the phone rang and the host answers the phone and has this
3 little conversation, and we say oh, who was that? And he
4 said, oh well, my lab had surgery on her hip and that's the
5 vet. She called -- this is the third call, you know, to see
6 how she's doing, and then he looks at us and he said, you
7 know, you losers never call, you know.

8 So if we really are accountable, you know, to whom? I
9 would much rather be accountable to the patient or the
10 community than to some endless list of forms and checks and
11 boxes. You know, we have 82 employees who deal with the
12 paperwork of appeasing this unappeasable system, a system that
13 actually doesn't want to be appeased. They want to say well,
14 we never got the fax for preapproval of this or that, and
15 you've got to send it again. And you know, it's a system
16 that's built on passive aggression. If we just put up enough
17 resistance, you know, 3% of the guys will say I never wanted
18 to be on Statin anyway and they quit, and it saves millions of
19 dollars in the short run. I want to be accountable to my
20 patients and to the community. That's fine with me, and I'd
21 love to be calling at home.

22 By the way, the lab is not able to, you know, speak for
23 himself, but the caretaker is called.

24 COMMISSIONER STINSON: Going back to Emily's point and
25 going back to the presentation by Dr. Dobson, the other things

1 that I really liked about his presentation on the Care Manager
2 is, in most practices, you don't have the resources to fund
3 these other things that you know help, Case Managers, Care
4 Managers, the PharmD, the psychology or psychiatric. The
5 ability to pick up a phone and be able to get mental health
6 support over the phone would be amazing. It would be
7 wonderful.

8 So going back, she brought up the Case Manager. We need
9 to bring up the other things that most practices cannot
10 afford, and even if -- I'm not volunteering Community Mental
11 Health or I'm not volunteering the Mental Health Trust or I'm
12 not volunteering Medicaid, but if there were people who could
13 put those resources available, even for six medical home
14 practices in Anchorage but they could pick up the phone and
15 there would be a PharmD that they could talk to, psych
16 support, the nurse case manager who is following the top 2%,
17 5%, whatever designated, which I know, in Washington State,
18 resulted in literally cost-savings of millions -- again when
19 you target the high end users -- that would be wonderful.

20 CHAIR HURLBURT: Val, how are we doing in the "so what"
21 and getting to recommendations?

22 COMMISSIONER DAVIDSON: I guess I think we're not there.
23 I think that one of the comments that was made earlier is sort
24 of this notion of being able to assess, to be able to
25 autocorrect. So what is the mechanism that we have in place

1 so that, as we move forward -- I mean, we're all going to be
2 making the very best informed decision we possibly can at the
3 time we're making that recommendation and as those things are
4 implemented. Once we get into it though and we're doing
5 something we've never done before, that's a whole other host
6 of information, and we need to build in a plan to be able to
7 do an assessment of how we're doing and a quick autocorrect to
8 be able to correct those mistakes early rather than
9 perpetuating those missteps into the future, so as not to be
10 where we are now.

11 And I guess I just want to reinforce -- I mean, it sort
12 of goes along with what we said before at a previous meeting,
13 which is that, you know, everybody is all up in a panic and
14 freaked out because of, oh my gosh, health reform. Health
15 reform has been happening for hundreds of years. The
16 challenge we're all having is that so much reform happened so
17 quickly by virtue of this piece of legislation, which is why
18 people are all freaked out, but it's been happening over time,
19 and I think we need to be mindful of the fact that who is
20 going to drive this for us in Alaska as we move forward,
21 whether we are in an Administration that agrees with the
22 Affordable Care Act or not. Leaving all of the politics
23 aside, how is this going to impact real people and who is
24 going to drive that change?

25 DR. DOBSON: I would agree with that. You have to create

1 a learning system, and the change has to be incremental. If
2 you asked me what we would have done better in North Carolina,
3 we would have created more monitoring, so we would be a little
4 quicker on the draw to figure out what we were doing and what
5 it was doing.

6 I would tell you -- and let me just share with you. I
7 mean, I was at the Institute of (indiscernible - voice
8 lowered) meeting on value-based purchasing, and whether you
9 agree with the Accountable Care Act or not, health reform is
10 happening, and it's happening by the private sector demand for
11 it to happen. And we did Community Care before Accountable
12 Care, and I mean, a good thing actually, but the comment was
13 made -- we were having a conversation about value-based
14 purchasing, and one of several of your big employers was
15 there.

16 When you talk about big industry who pays the bill for
17 health care in this country, they made the comment that it
18 used to be, as a company, health care was your 12th, 10th list
19 of things that determine your stock price and your bottom
20 line. Now almost all of them said it was one of the top two
21 or three determinants of your bottom line, and there are
22 companies, including a couple in the energy industry as well
23 as big companies, that said we now are looking at moving job
24 based on the fact that -- of the health care spend. And so
25 we're going to have incredible pressure to change what we do.

1 And so I think, to a state, I would say, if you're looking
2 politically for an economic development strategy, health care
3 spend and education are your job creators and have a lot to do
4 with your future. And you guys are in a pretty good place
5 right now, but to keep in that place is fixing this.

6 COMMISSIONER LAUFER: It sounds like, one or another, you
7 have to start somewhere and build a skeleton, and I know this
8 is not the way you guys did it, and you said you have to be
9 very careful about the choices you make, but we've been, just
10 as a clinic, struggling with this. How do we start to get in
11 the habit of doing things the same as one another?

12 Fairly low-hanging fruit with a very big paycheck, in my
13 mind -- and this is a question -- would be a program for
14 diabetes. The metrics you measure are not controversial. I
15 don't think anybody would argue with sort of the basic things
16 that you have to measure. The State could do it. The
17 insurers would like it. Employers would like it. They're
18 already doing it.

19 I have a couple patients with Kroger that have hired
20 nurses within their own system and do labs at their own
21 pharmacies -- this is the Fred Meyer stores -- because they're
22 just trying to lower costs. They just can't bleed anymore.
23 And we could do that as a state. The Governor could have an
24 initiative to address diabetes. Well, it would irritate the
25 people who sell soda. And that could be a framework because

1 then you pull in all the other people. You could start with
2 the disease data. Does that make sense at all?

3 DR. DOBSON: Yeah, but I would add though, to really do
4 this, you need -- we need to also ask Jeffrey what is it Blue
5 Cross needs, you know. Our conversations with our insurers is
6 we need our docs to prescribe generics. We need them to be
7 engaged, so I can get uptake for programs that I already have.
8 And it's that connection. So the answer is yes, I mean, to
9 diseases and to aligning some effort around -- that can
10 benefit -- I mean, we're building a radiology decision support
11 tool in our Informatic Center, and it's a joint effort between
12 Medicaid and Blue Cross. Now go imagine that. So suddenly,
13 you now have something that really creates some value for both
14 private and public payers.

15 CHAIR HURLBURT: So that's a tool available freely to all
16 practitioners, helping them make evidence-based decisions on
17 what diagnostic imaging parameter they're ordering?

18 DR. DOBSON: Yeah. It replaces the -- it, hopefully,
19 will eventually replace radiology, you know, benefit
20 management systems. Mother, may I?

21 The advantage that it has for Blue Cross is that we now -
22 - it can be extended into the hospital in places that -- you
23 know, you typically can't do it in an insurance thing because
24 it's the radiologists and the doctors running it, right? So
25 you know, it's not there, but it's slated to be stood up by

1 the end of the year. Again it's finding what helps both
2 payers in an effort. So it is disease, but it's also looking
3 at things that you can do.

4 COMMISSIONER LAUFER: The question is, basically, how do
5 we get an initial structure up to start building on?

6 COMMISSIONER FRIEDRICHS: So you know, last night and
7 this morning, I was looking back at the report from 2009, the
8 report from 2010, and perhaps, Dr. Hurlburt, you and Deb could
9 help with some clarification.

10 We have very generic recommendations. You know, life is
11 good. Death is bad. We should save money. We should have
12 high quality. Is that our goal, as we're talking about
13 medical home for this year, that we're going to say that, you
14 know, we continue to find that medical home is good and the
15 current system is bad, or what level of granularity are we
16 striving to reach with our Findings and our Recommendations
17 this year?

18 COMMISSIONER ERICKSON: My understanding was that you all
19 wanted to, when you asked to continue studying patient-
20 centered medical homes for this year, dig in deeper and
21 understand better how improving the delivery of health care
22 through the patient-centered medical home could be done. So
23 we're getting down -- in 2009, we recommended -- and we didn't
24 call it patient-centered medical home, specifically because we
25 thought, even then, that it was too much of a buzzword and it

1 was more of the concept that we wanted to promote. We said we
2 wanted to foster the development of patient-centered primary
3 care in the state and suggested it should be done through some
4 preliminary pilots and that's what our Deputy Commissioner was
5 referring to, the recommendation this group had made a year,
6 year-and-a-half ago. But now I'm imagining that, with this
7 learning that we've been through, you all, based on these
8 observations that you've made from what you've been learning,
9 can come up with some more specific recommendations.

10 CHAIR HURLBURT: Yeah. I think some things, life is good
11 is the right kind of recommendation. For other things, we
12 want to be more granular. Maybe Jeff had something and then
13 Val.

14 COMMISSIONER DAVIS: Yes. I'd like to answer the
15 question Dr. Dobson posed for Noah to ask me, which is the
16 right question. Well, at least, what do I need? And I was
17 looking through your slide here, and I need the graph that
18 shows what has happened to cost trend in your state. That's
19 what I need and that's not what I need. It's what my clients
20 need because they're dying and trying to pay for health care,
21 just as you described. And we're sitting here in a situation
22 with costs that are 65% higher per member per month than our
23 nearest neighbor in the Lower 48, and you know, businesses are
24 making decisions about where they're putting people. Paul
25 shared with us DOD is making those decisions and that's not

1 good for any of us. That's what we need to solve for. And so
2 where I'm taking hope in this is that the concepts that you've
3 laid out, which, you know, are almost so simple that it's too
4 good to be true. Well, people, if they talk to each other and
5 you bring the right expertise to bear, you can actually have
6 an effect on someone over time on something that you don't
7 control, but they do, but you've got to have influence to make
8 that happen. Wow, that's crazy, you know, to think that that
9 would work, but I think it can.

10 And so what I'm sitting here struggling with -- and
11 you've demonstrated that it can -- is, all right, how do we
12 take that forward because it's all about the people, and I
13 think it's -- you know, it's not clear, to me, if there is --
14 you know, if we could leap to a structure, like you have, with
15 the central office or if it needs to be, as you just
16 suggested, you know, Noah and I, or whomever, pilots -- Larry
17 pilots something that says we will bet here -- I'm making this
18 up, but I'm not committing to this publicly. I'm just
19 speculating what could happen. We'll bet the money to fund
20 these people that you tell me you need to get this 2%, you
21 know, under, you know, better. All right. And we'll bet on
22 that, and we'll see what happens for three years. I mean,
23 maybe -- do we have to start with something, like that, and
24 demonstrate a success while Larry has got something else going
25 and Marilyn has got something else going, and then out of

1 that, you say, wow, if we coordinated better, how about a
2 public-private partnership, but just to leap to that, I'm
3 afraid we end up kind of doing the same old stuff again. And
4 what we have to do to get out of this is -- it sounds trite
5 and silly, but fundamental transformation. We've got to quit
6 doing the stuff that we're doing. So okay, we'll pay for
7 services that you need without worrying about who is going to
8 bill for them or send in the bill or any of that stuff. Just
9 use them, and let's get this done. Wow, that makes so much
10 sense it is almost too good to be true, but that's what I hear
11 you describing, that that's what's happening, and it's
12 happening -- it looks different in Ketchikan than it does in
13 Anchorage or it looks like different in Fairbanks than it does
14 in Anchorage, and it looks different in the village than it
15 does -- but you know, sometimes if you try to coordinate the
16 whole thing, you get nowhere and you just have to start with
17 something that works and then build on that. I don't know if
18 that helps, but this slide, that's what I need. That's the
19 answer.

20 DR. DOBSON: Well, you know, that's interesting because,
21 absolutely, the advantage Medicaid has is that it pays a flat
22 pay, you know, fee schedule. So when you measure this, you're
23 really looking at people and utilization. The problem that I
24 worry about with all the ACO buzz and all the reorganization
25 is that, you know, so what does drive your medical officer

1 ratio and what we have to charge. Well, it's a combination of
2 utilization and also price, right, and price is dictated by
3 size and a whole bunch of other things that are not in there,
4 and you can't normalize for that, but we can get a piece of
5 this off for private insurers by getting the benefits of the
6 utilization control, and then ultimately, it's up to the
7 private insurers because that is the anti-trust thing is that
8 we can't get into price, but if we can take that utilization
9 curve down, then Blue Cross and other insurers will figure out
10 how to do the other piece. That's why they've spent two
11 decades trying to build -- and the insurance part is all the
12 utilization control that's only getting partial penetration
13 and so that is the opportunity to have, I think.

14 CHAIR HURLBURT: I think we've got Val, Linda, Paul,
15 Noah.

16 COMMISSIONER DAVIDSON: I guess, if I may be so bold, I
17 really would like to concede my time to probably the earliest
18 innovator of medical home model. I see that Dr. Eby is here,
19 and I'm certain he has some recommendations for lessons that
20 SouthCentral Foundation has learned in terms of implementing,
21 being the Joint Manager of the Alaska Native Medical Center,
22 and having those rural experiences as well, and I'm willing to
23 lip sync and move my lips so he can use me as a ventriloquist
24 or whatever, but if I may be so bold, Dr. Eby, do you have
25 recommendations for what we could do that would make this

1 possible in Alaska? I can move my lips, if you want me to,
2 but I think we would be -- we would have a -- we could make a
3 terrible mistake.

4 DR. EBY: Well, I'm not known for being brief, but I'll
5 be brief. I wrote myself three things that I think are
6 absolutely critical for you all, and I'll wear also my
7 Rasmussen Foundation Board of Directors hat because part of
8 what Rasmussen is doing in this state is trying to convene
9 people around statewide problems as a convener.

10 And I think your biggest, massive take home message from
11 today is this North Carolina example of a centralized
12 coordinating place, and this is what the State can do. The
13 State can fund -- and I'm sorry. They need to either not fund
14 you and do something else or do something in addition to you
15 because what's needed is a -- so we do a lot of work with
16 Saskatchewan right now.

17 In fact, the leading organization that's helping drive
18 change for the entire province is Saskatchewan with millions
19 of people is us, SCF. And what they have is a Health Quality
20 Council funded by the State, and it's, you know, a dozen
21 people whose full-time job it is is to convene people, to
22 problem solve, to find the trainers, to bring them in that
23 everyone can learn from, so that you don't have these 25 or 30
24 trainers coming in to do all the pieces, as you were
25 mentioning earlier, and this state has nothing like that. And

1 so the Commission kind of convenes, and Medicaid Task Force
2 kind of convenes. Rasmussen is doing convening right now
3 around substance abuse and behavioral health things. The
4 State needs to do this. They need to hire, you know, ten
5 people and have an office that convenes and brings best
6 practices and brings trainers and makes all this available, at
7 a cost, to other people to join and you get to a lot of stuff
8 that you all have been talking about. I think that's number
9 one, and that's, essentially, what you did in North Carolina,
10 exactly what you did, right, and then the content kind of
11 carries.....

12 DR. DOBSON: (Indiscernible - away from mic)

13 DR. EBY: So number one. Number two is, I think -- I was
14 listening on the phone earlier before I could come here, and
15 Kevin, I thought, just hammered something else that the State
16 desperately needs to do, which is, if you get into these high
17 cost people, this 5% and 10% of people that drive so much of
18 the cost, almost without exception they have complex social
19 disintegration, behavioral mental health, and so forth issues,
20 and the State requirements right now around behavioral and
21 mental health completely paralyze and make it impossible to do
22 anything decent in that arena that's whole person oriented.

23 So in our system, we have this whole mental health
24 division that's just paralyzed in their ability to do anything
25 with it because of Medicaid requirements around intakes and

1 documentation and stuff around mental behavioral health that
2 are just obscenely paralyzing. So that would be my second
3 point, and I'm never opinionated.

4 And then number three is I would offer up that, as we sit
5 here and speak, we've got 250 people paying \$2,500 a head to
6 sit over there and learn from, supposedly, one of the best
7 primary care medical homes in the country. We are the main
8 innovation driver for the entire province of Saskatchewan
9 right now. We're having huge influence in the entire country
10 of Scotland. We've already made big influence in British
11 Columbia. So we have a whole training institute. We have
12 faculty. We have materials. We have curriculum, and it's all
13 around patient-centered medical home and longitudinal platform
14 to transform entire health care, and it's right here in
15 Alaska, and I think we'd be willing to be in conversation, but
16 it shouldn't be -- it should be facilitated through a state-
17 sponsored, state-funded neutral body, like a -- not a Health
18 Commission, like you're doing it, but a Health Quality Council
19 or something, like that, that is a driver-coordinator, just
20 like you've heard happened in North Carolina. Thanks.

21 CHAIR HURLBURT: Wes, could you go ahead and then we'll
22 go back to Paul?

23 COMMISSIONER KELLER: (Indiscernible - away from mic)

24 CHAIR HURLBURT: No, go ahead. That's okay.

25 COMMISSIONER KELLER: Well, it's kind of on that topic,

1 so thank you. And it was actually originally the question I
2 wanted to ask Dr. Dobson, and then Doctor, you brought it up,
3 but this central office or central group, I saw it was a
4 501(c)(3), and did you categorize it as public-private? And
5 the question that has been bouncing around in my head, and you
6 actually kind of went there, was maybe the Commission has a
7 role that it could play there and we ought to, at least,
8 consider that because Alaska is a small town, and a lot of
9 work went into, as we know, getting this thing put together,
10 so that there is good, you know, cross-section representation,
11 and maybe there is a role there beyond -- just a suggestion to
12 throw it on the table -- our traditional role. We can expand.
13 We can do different. We can maybe contract, but the
14 recommendation maybe ought to consider what this central
15 office ought to be anyway. That's.....

16 COMMISSIONER FRIEDRICH: Thank you, sir. Dr. Dobson,
17 question back to you, and I forget which of the speakers made
18 the comment -- I think it may have been Noah -- that any of
19 these transformative efforts begin with providing capacity for
20 the patients' needs. That's certainly been our experience,
21 both in the VA and the DOD. If you deploy a whole bunch of
22 primary care folks, you can have the most perfect Case
23 Managers and every other support in the world, but in the
24 absence of the primary care docs, a lot of this falls apart.

25 This is our third time at bat trying to roll out

1 something along the lines of a medical home model in the Air
2 Force, in particular, and the first two times, both efforts
3 lost steam because competing demands, workforce challenges
4 dissuaded people over time. They didn't see the expected
5 benefits, usually because we didn't have enough primary care
6 providers to do all the things that we needed them to do.

7 I would welcome your thoughts on or advice to us if we
8 paint that the picture that, in primary care right now, we are
9 considered an underserved market. The American College of
10 Physicians has identified a dramatic shortage of primary care
11 internists in the state. The AFP has found the same thing.
12 The American College of Emergency Physicians has highlighted
13 the shortage of access to primary care.

14 In the absence of new primary care physicians springing
15 from the earth, and you know, some remarkably successful
16 recruiting campaign early on, are there other recommendations
17 that you would have in an access-constrained model that would
18 avoid disillusioning the bill payers?

19 DR. DOBSON: You're right. I would say we love hiring
20 military docs out of the -- because they really do well in our
21 -- I mean, that aside, I think one of the things that you do
22 have to be careful of is your primary care workforce. I think
23 that, if we're careful and we put additional resources --
24 which means mid-levels -- and helping primary care physicians
25 understand how mid-levels integrated into the medical home can

1 actually unburden you. The same thing with Care Managers and
2 pharmacists and what not. So I think that it's not making
3 them busier, but allowing them to care for a larger
4 population, a larger village, if you say.

5 So I think that would be worth special attention, as you
6 do anything, and monitoring what happens because, if you do
7 what we've done in the last decade -- and probably what's
8 happened, like many of our -- you know, we've had that same
9 issue as the thought. That's why PCCM -- we're just giving
10 the same person more to do, and it doesn't work. And so I
11 think what's made it -- at least, ours showing a glimmer of
12 success is that yes, indeed, we understand that giving, you
13 know, Noah and other primary care doctors additional resources
14 is a smart business move. It makes them recruit more docs,
15 people that want to do it. It allows us to train people in
16 that model and keep them around, and I would think Alaska
17 would be a pretty, you know, attractive place. I mean, I'm
18 sitting here looking at the fact that -- you know, I go to
19 Alabama where they pay 68 cents on the dollar for Medicaid,
20 and they don't have anybody to care for the folks. I mean,
21 you're in a pretty attractive place to, at least, start, and
22 you also understand what community-based care is like because
23 you have to because of the geographic isolation.

24 So I think that needs to be part of your equation and
25 workforce needs to be part of that, monitoring what happens,

1 showing people models that work that are okay because that
2 will take some of the fighting over, you know, who does what
3 down.

4 COMMISSIONER FRIEDRICHS: I guess, if I could, just a
5 clarifying question and then a comment. It is certainly
6 easier to be attractive in June than in January here.

7 DR. DOBSON: Then I would make sure all my recruiting was
8 around that time.

9 COMMISSIONER FRIEDRICHS: But the clarifying question, we
10 found that 1,500-to-1 was unsupportable over the long-term at
11 our primary care clinics, both for pediatricians and for
12 family practice docs, even with mid-levels helping to
13 distribute the workload. We're now down to around 1,250
14 patients enrolled to a primary care provider, either mid-level
15 or physician with a lower acuity primarily for by the mid-
16 levels, the higher acuity by the physicians. Have you all
17 found similar relative benchmarks that you used when looking
18 at workforce to -- and where I'm going with this again is
19 calculating the capacity that you need for a population for
20 which you are trying to care?

21 DR. DOBSON: Yeah. I don't know that I've got any good
22 data for you. I would say yes, at least, what we have is
23 pretty similar to that, but understand, if you're in an
24 integrated health system, most of them calculate 2,000-to-1 as
25 the right workload. And so the key -- and I'll say this for

1 Medicaid and the players -- is finding how to care for a
2 population on a patient visit because therein lies your
3 problem. I can do a phone call a lot faster than I can -- or
4 I can do an email or I can do things of caring for populations
5 a lot differently. I can see at Foodline a lot more
6 efficiently, quite frankly, than I can in my own office. You
7 understand me. Billing and all the compliance stuff and
8 stuff.

9 So there are opportunities there. I think that's a piece
10 of work that really needs to be done nationally is I don't
11 think we've really gotten there. Now obviously, group health
12 has done some work of really downsizing panel size, seeing
13 what the right size is, and it's lower than 1,200 actually,
14 but that would be a great contribution to the effort as you
15 guys look at this is, what is the right number mix in the
16 learnings from that, and what delay do health workers in have
17 in communities, how do you connect them, how do you connect
18 school nurses, how do you connect the resources in to the
19 primary care physician to make that worth doing?

20 CHAIR HURLBURT: Maybe two, Noah and then Larry, and then
21 we do need to wrap-up, and Dr. Dobson and I will disappear at
22 one.

23 COMMISSIONER LAUFER: A couple, I hope, really quick
24 things. One is, if I do do it by phone, do I get paid for
25 that? That's a quick question. Sorry.

1 DR. DOBSON: Well, I'll just say maybe it's part of your
2 PMPM.

3 COMMISSIONER LAUFER: I like that. That's fine. Another
4 is that webinar that we had with the group out of Oregon, the
5 insurance-based people who were -- he attributed a lot of
6 their inspiration to the SouthCentral Foundation. When he was
7 asked -- you know, it's the things that don't -- are not said.
8 Somebody said well, has this translated into savings? He said
9 well, our hospital admissions are down. Well, has this
10 translated into savings? And he said well, you know, we're
11 looking into that. We're not sure if the hospitals didn't
12 just increase what they're charging and that's a potential
13 pitfall for this, and if it's going to be measured, it has to
14 be everybody. And I'm aware, acutely aware, that, if I do a
15 better job, if we fix this, the biggest employer in the state
16 and most powerful political entity in medicine is threatened.
17 And if we do a good job, it will be smaller and less relevant,
18 and I don't think they're going to like that, and I certainly
19 don't want to have a target on me in regard to that. So
20 anyway, that has to be taken into account, if we're going to
21 measure the success of a pilot.

22 And then the final question is, you mentioned that, in
23 some of the big urban centers, some of the docs are not part
24 of the network, and I was wondering, are those, you know,
25 concierge docs or closed practices or do they not see any

1 Medicaid at all? You know, who are those folks, do you know?

2 DR. DOBSON: Yeah. It's people in urban areas who choose
3 not to do much Medicare and Medicaid.

4 COMMISSIONER LAUFER: Of all types probably?

5 DR. DOBSON: Yeah. I mean, and some of them are
6 concierge. Some of them are others, but it's not unlike any
7 other place in the country. I'm sure you have that in
8 Anchorage.

9 COMMISSIONER STINSON: Dr. Dobson, this is for you again.
10 The private-public committee, who comprises that?

11 DR. DOBSON: The networks are required to be 501(c)(3)'s
12 or not-for-profit and have to have, you know, hospital --
13 majority of primary care physicians, FQHCs, the primary care
14 workforce -- the Health Department/Social Service's minimum.
15 They have a board. Then their board gets to put -- the
16 central organization is a 501(c)(3) owned by the 14 networks
17 with a contract with the state. You know, I have charged them
18 to create it when I was in the Department. And so it's a
19 membership organization. Our board is representatives from
20 the communities. If I were doing it again, it would be
21 slightly different, have more public members. It would have a
22 more direct link with the state, and we would probably require
23 open meeting laws -- you know, open meetings for transparency.
24 That gets us further down the road, but that's what we are
25 now. And so we do have this deemed status with the state. We

1 are their management structure for the delivery system of
2 Medicaid.

3 CHAIR HURLBURT: You would have one board for, like,
4 (indiscernible - voice lowered) county, for a lot of people?

5 DR. DOBSON: Each region has its own board.

6 CHAIR HURLBURT: Yeah, but there's, like, Charlotte, you
7 know a host of people, you would have one board?

8 DR. DOBSON: Yeah. It's very interesting because, in
9 some of these communities, you have your two biggest
10 competitors sitting, you know, there together. Now it doesn't
11 mean they have to get along, and I'll tell you the money flows
12 back to the community. I mean, after you leave the board
13 meeting, everybody is back in their shell, but it does put a
14 place of transparency into the community of -- that's where
15 the issues of well, who is really taking of the Medicaid
16 patients, who is taking care of the public's interest in this?
17 It gets called out in these meetings pretty clearly. And
18 that's why I say the state's hand in that is extremely
19 important because, you know, you guys get it, you know, when
20 you -- I mean, you have to deal with the Legislature. So it
21 gives us an arm to really address these issues.

22 CHAIR HURLBURT: Thank you all. We are not where Val
23 wants us to be, but we're on the way. And I think probably we
24 can take, Deb, what you are capturing and bring that down to
25 some specific recommendations. We've got this. It will help

1 facilitate our recollection of our discussion today. Does
2 that sound reasonable?

3 COMMISSIONER ERICKSON: It sounds reasonable to me. One
4 of the things that I wanted to mention -- and we have -- what
5 do we have? We have 20 minutes left. I can wrap-up in five
6 minutes at the end. So I just want to make sure, in terms of
7 recommendations -- we just captured lots of ideas -- if there
8 is anything in particular you want to make sure gets noted
9 that you feel might not have been noted.

10 There was one thing that I have felt, not only all
11 morning but in every phone I made to folks around the country
12 looking for the right innovators to bring to help us learn,
13 calling around the state to Dr. Onders and to James in
14 Fairbanks and talking more with Harold, what we hear from Noah
15 at every meeting, especially, is that vision needs to drive
16 this, and the vision and the passion is there. And one of the
17 things we heard as lessons learned in every one of our
18 presentations is providers want to do the right thing, and
19 it's not about the money. And if you let money drive the
20 reason you're doing this, it's not going to work. It's going
21 to fail. It needs to be based in purpose. So I think that's
22 important, an important takeaway, and I haven't heard anybody
23 around this table actually voice that, while I've been feeling
24 it in every conversation I've had.

25 The other thing, just back to Val's point, I actually

1 really wanted to bring -- Dr. Eby was at this presentation
2 that I was able to be at in Denver a couple weeks ago and
3 really had wished that -- I think it was webinared, but it
4 wasn't recorded, or at least, made available, but the new CEO
5 of IHI, who took Don Berwick's place, Maureen Bisognano -- I
6 knew I wasn't going to pronounce that right; thank you -- did
7 the most amazing presentation on learning from patients in
8 order to improve systems, and I really would have loved to
9 have played that for you, and I was going to even try to
10 repeat one of the stories that she told and put some slides in
11 here, if we had time. We don't have time to do that. But I
12 think, to Val's point, we haven't heard it emphasized enough,
13 but it is, I think, one of the foundational pieces, and I
14 think it's kind of assumed. I'm seeing people nod their
15 heads, but I think it's real important that we don't allow it
16 to just be assumed, that we're real intentional about it.
17 Paul?

18 COMMISSIONER FRIEDRICH: Deb, I'm so glad to hear you
19 say that, and that's why I asked my question about granularity
20 because, I mean you know, we can write a book on the medical
21 home model, just from the presentations we've heard, and those
22 books are out there. I think there are some fundamental
23 things that we should articulate, so that, as the Legislature,
24 as members of the Governor's staff read through this, we
25 really do capture those fundamental tenets that this is --

1 well when you call it the patient-centered medical home, it
2 really is centered around the patient. I mean, while there
3 may be discussions about payers and pilots and whatnot,
4 ultimately, it is about the patient, and if you do that right,
5 then you realize the savings. You realize the improvement in
6 quality and access of things we were specifically chartered to
7 do.

8 What I hope will happen next -- and I throw this out to
9 the Commission for discussion -- is -- although I did not dial
10 in for the two prior webinars, I've gone through the slides --
11 there is excellent lessons learned out of both of those
12 slides. There is great material that we've heard briefed
13 during this meeting. There is an opportunity, while this is
14 somewhat fresh in our mind, I think, for us to go through
15 those, distill out the key findings, and then derive from
16 those the recommendations we want to capture in our report,
17 and I'd encourage us to do that in the next two to four weeks
18 while it is somewhat fresh in our mind, rather than waiting
19 until October to do that at the meeting we have designated
20 because I will not remember it in October nearly as well as I
21 will today or tomorrow.

22 CHAIR HURLBURT: What do you think, if we try to set up,
23 like, a two-hour session, which will not be easy to do for
24 everybody, and it is summer and we probably have to recognize
25 we won't get 100%, but to do that within that timeframe, two-

1 three weeks?

2 COMMISSIONER FRIEDRICH: I, personally, would strongly
3 encourage that we do something like that and give everybody a
4 chance to sleep on this a little bit, go back through the
5 slides again, and you know, the way that we've done this
6 internally when we've rolled some of this out is that we, as
7 an executive team, have gone back through all the material
8 independently, come up with our own lessons learned, and then
9 reconvened after hearing all the speakers and experts to kind
10 of capture those and figure out which ones, as a group, we
11 were going to highlight in our report, but if we do that in
12 the next few weeks here, I think that may be much more
13 fruitful than waiting several months.

14 CHAIR HURLBURT: Keith and then Larry?

15 COMMISSIONER CAMPBELL: I think that we should lead by
16 example here. We had Melissa come in yesterday, and you wore
17 your other hat and gave us a presentation, and I think it's a
18 shame that she wasn't here today.

19 CHAIR HURLBURT: She was here for a while.

20 COMMISSIONER CAMPBELL: Well, I didn't happen to see her,
21 but anyway, but we had a conflicting meeting. And I think, if
22 we're going to lead by example and break these silos down,
23 then she and those kind of people ought to be in the room when
24 we have these kinds of discussion, so they don't get it third-
25 hand, and it brings everybody -- maybe not officially to the

1 table, but like Dr. Eby and the people we had here. And I
2 just think that, if we're ever going to break those silos, we
3 have to lead by example.

4 COMMISSIONER STINSON: I agree with Paul exactly, but if
5 we could do maybe a couple renditions by email, which you've
6 done in the past, Deb, that is much more convenient because
7 then, if it's midnight and I'm just looking at my email, I can
8 address that, and that gives us a little bit more flexibility.

9 COMMISSIONER ERICKSON: I will do that. I was going to
10 suggest -- rather than having you all -- I mean, certainly,
11 you can do that anyway, but I will give you a draft this time
12 to respond to before the meeting that we'll try to get
13 scheduled two weeks from now.

14 COMMISSIONER FRIEDRICHS: And if I could just note for
15 the record that, if we had a trauma system, that would make it
16 easier to implement the medical home model. I did -- it's an
17 inside, somewhat of inside joke there. But I did send out a
18 summary, just as Ward had said, that, you know, he had
19 summarized his presentation. I did send out a summary of the
20 trauma presentation from yesterday, a very draft summary for a
21 future discussion as well.

22 CHAIR HURLBURT: Can we maybe just have just a very few
23 minutes, but feedback on the meeting, the process of the
24 meeting, scheduling how it ran?

25 COMMISSIONER KELLER: This isn't feedback. I've just got

1 a gavel for you. Not criticism at all. I've got to tell you
2 I have a lot of empathy for trying to chair a high-octane
3 meeting. I spent most of my life trying to avoid that, you
4 know. And so that's what I was doing the last two days, so I
5 really empathize.

6 So you know, a gavel is a symbol of some of the most
7 valuable things in America, as demonstrated here in this room,
8 and it has to do with respect and appreciation for each
9 person's words, you know, and what this represents is the
10 concept that we're all created equal and that what we have to
11 say is valuable. It represents the Mason's Manual or whatever
12 manual you want to pick, you know, and what that's designed to
13 do is to give each person a chance and a platform to be able
14 to use, you know, it in a way equally, you know, and that's
15 his job, right?

16 So when we see the gavel, hey, it's just a symbol of
17 Ward. We've given him the responsibility to give us equal
18 time, and this group has demonstrated respect and appreciation
19 for each other and so it's symbol of that.

20 This particular gavel is a scrap piece of, what do you
21 call it, Purple Heart, and it's a product of the Special
22 Session. One of the few -- I've got a shop smith crammed in a
23 storage shed, an 8x12. Anyway, thank you for your hard work.

24 COMMISSIONER FRIEDRICH: Along those lines, I think, you
25 know, one of the pieces that I continue to struggle with is --

1 and I know, Deb, you had mentioned that you had spoken to some
2 of the speakers about this, but given how valuable everybody's
3 time is and an interest in hearing everybody's opinion, I
4 would advocate that we continue to very tightly prescribe how
5 much time a speaker can speak and allow time after that for us
6 to discuss it, and if possible, come to some of our Findings
7 and Recommendations immediately after that presentation.

8 I think there are really two parts to that
9 recommendation. The first one is ensuring the speakers
10 understand the intent of the presentation to us, if it is --
11 you know, to help us understand an issue, and there are
12 specific recommendations that they are making to us, if they
13 can flesh those out because that's powerful because I struggle
14 sometimes to understand what the recommendations are in some
15 of the presentations.

16 And then affording time afterwards for that discussion
17 that you so nicely described there, so that we can try and
18 capture the essence of what we, as a Commission, are taking
19 away from this, while it's still fresh in our minds. And
20 again, I'll beg for forgiveness for short-term memory that's
21 getting shorter and shorter, but I'm generally concerned with
22 any group that I belong to that, if we delay coming up with
23 our assessment until many months after the fact, we will miss
24 things by omission, not by intent.

25 CHAIR HURLBURT: One of the things that made Melissa's

1 presentation yesterday long was because it was very good and
2 everybody was very interested, but she was asked a number of
3 questions and that, virtually, made it impossible for her to
4 hold it down to half-an-hour. Do we want to have it open or
5 try to be more rigid about holding questions until the end?
6 Val?

7 COMMISSIONER DAVIDSON: I think that, while there are
8 many challenges in Congress, one of the things they do really
9 well is congressional testimony, and when you're on a Panel,
10 you get exactly five minutes to speak and that's it, five
11 minutes, and you have provide your recommendations in five
12 minutes. You're allowed to submit a written document,
13 PowerPoint, whatever you want to do, but your spoken testimony
14 is five minutes, no more than five minutes. Every single
15 person on the Panel speaks. There are no questions until
16 every Panel member has had the opportunity to speak, which
17 sort of allows people to sort of put those thoughts together
18 and where there may be cross-pollination of ideas, and then
19 the bulk of the time is spent on asking questions and getting
20 to what, I think, we're missing here at the table, which is
21 asking the questions, getting down to the nuts and bolts
22 because, honestly, I mean once people get a mic, it is really
23 hard to get -- I mean, myself included -- them to keep their
24 comments concise.

25 So one thing Congress does well, five minutes per speaker

1 and they focus on recommendations. That's it, five minutes.
2 Every single person speaks, and when they're done, no
3 questions until all of the Panel members are done, and then
4 open the floor for questions and that's where the bulk of the
5 time is spent.

6 CHAIR HURLBURT: So could Melissa have covered her
7 material in five minutes in a way that would have met our
8 needs and then we could pursue the rest in question periods,
9 do you think, for example?

10 COMMISSIONER DAVIDSON: I think we all got the material
11 in advance. I mean, there are issues that many of us know
12 well. I mean, even if you say, you know, ten minutes, seven
13 minutes, whatever, but I mean, there was some of the
14 background information that we all know. We've lived it.
15 We've heard it over and over and over again, meeting-after-
16 meeting-after-meeting, when what we're missing was the focused
17 discussion on what specifically are the recommendations, and
18 the most important piece is, what are we, as a Commission,
19 going to do about it? Do we have any questions, clarifying
20 questions, and the dialogue that needs to happen among us to
21 be able to get where we need to be because, when we start
22 getting to the juicy stuff, we typically have about five to
23 ten and maybe, if we're lucky, about 15 minutes for the stuff
24 that we really need to work -- we're really asked to do.

25 CHAIR HURLBURT: So the generic recommendation would be

1 compress the time for presentations and expand the time for
2 questions to the presenters and discussion among the
3 Commission members.

4 COMMISSIONER DAVIS: Thank you. I agree with some of
5 what Val says, but I'll offer a slightly different viewpoint.

6 I think, one thing, it's great that you have a new gavel
7 because, I think, part of the Chair's responsibility,
8 especially with a shiny new gavel, and opportunity is to --
9 you know, we have a plan. We're following a plan, but to
10 modify things as you go along, based on your judgment.

11 So I would say a set time for the presentation, based on
12 the materials. Certainly, Dr. Dobson needed more than 15
13 minutes today to go through this, and it was quite valuable.
14 And I found what Melissa had to say yesterday also quite
15 valuable, but a set time, whether it's.....

16 DR. DOBSON: Not giving us five minutes, too.

17 COMMISSIONER DAVIS: Right. Right. You know, and it's
18 interesting to have Congress held up as an example of
19 anything, but I understand your point, Val, but a set time
20 based on the value of the material, the newness, the
21 uniqueness, but that could be whatever you believe that needs
22 to be, and then a set time for question and answer.

23 And some presentations are -- lend themselves to being
24 listened to entirely and then questions. Others, they lend
25 themselves to questions as you go because the richness is in

1 the dialogue, and I believe, with Melissa yesterday, that was
2 the case. I learned a lot from the dialogue, but it was -- as
3 a presenter, it's frustrating because you're being
4 interrupted, but that's the richness. So you know, we can
5 have the format that says usually we hold questions until the
6 end, but I'd say the Chair's prerogative is to change that at
7 any point in time.

8 In our company, our CEO of the bigger company, his name
9 is Gubby Barlow, and we call it "Gubby Rules," which is hold
10 the questions until the end, and sometimes that works well,
11 and sometimes it does not. So I just think we can be more
12 flexible than Congress. Thank you.

13 COMMISSIONER BRANCO: I do agree with Val. One of the
14 most frustrating things our governing board has endured for
15 years is endless reports and a lot of people reading
16 PowerPoint slides to them, one at a time, when they've already
17 got the material ahead of time. So all of our presenters now
18 -- I apologize -- are given about ten minutes to 15 minutes,
19 and if they have 40 PowerPoint slides, they're going to show
20 two or three that are the key. Everyone is to have done their
21 homework, read ahead, two to three slides that are the
22 highlights, the incredibly important things to know, and then
23 dive right into questions because we can't always divine what
24 the intent is of every PowerPoint slide, based on the bullets
25 on there and that will drive our questions, but much longer on

1 the question time. So I do agree with that.

2 CHAIR HURLBURT: Two minutes left.

3 COMMISSIONER LAUFER: I want to shake this up a little.
4 I agree with that, if you're using parliamentary rules and
5 trying to allow people to represent predetermined agendas, but
6 we are in a time of dramatic danger. The country, the funding
7 of the Native system and the military, and everything is under
8 great threat. We don't need everybody to speak about their
9 agenda. We need a radical paradigm shift in the way that
10 medical care is provided, and it is going to be threatening,
11 and it is not a time of normal rules.

12 COMMISSIONER DAVIDSON: I guess my frustration has been
13 that, once we start the questions, it's, like, the same people
14 are asking the question and then there is follow-up, and it's,
15 like, the same person asking the question over and over and
16 over again, and I want to hear what the point is of the whole
17 presentation and also, after hearing the whole presentation,
18 have the opportunity to be able to ask a question, and I feel
19 like we don't really have the opportunity in terms of our time
20 management.

21 CHAIR HURLBURT: So your suggestion, to me, is that I
22 should be more proactive in identifying or asking people to
23 comment, rather than waiting for a raise of hands. I've tried
24 to keep order doing that and respond to everybody, but not so
25 often, like I did one time with you today, but to try to reach

1 out where I thought somebody had something to say when they
2 weren't offering it, can I improve on that, you think? Please
3 be honest.

4 COMMISSIONER KELLER: Thanks. I know we're done, but
5 just a disclaimer. I did not mean to be suggesting that we
6 should run a tighter ship. You're doing great. It's just
7 that, you know, it's more a symbol to respect each other, you
8 know, and I would make a point for the prerogative of the
9 Chair, you know. I mean, I'd like to hear -- like Dr. Eby
10 showing up, you know, what a fantastic opportunity, and I'd
11 hate to think that we, as a Commission, had a five-minute
12 limit on something when there is a good opportunity there. So
13 that was more a symbol of, you know, your authority.

14 COMMISSIONER ENNIS: I believe we may need to prepare our
15 presenters a little differently. We are asking them to
16 provide us information. I'm not sure we're always asking them
17 -- and Deb, you can correct me if I'm wrong -- to answer the
18 "so what" and come with specific recommendations. I think
19 many of them have come to give us a body of information for us
20 to consider. So I don't know if we're preparing them to come
21 with specific recommendations. We should.

22 COMMISSIONER ERICKSON: Yes, and I did, following the
23 last meeting -- you made the same request at the last meeting,
24 and I did a little PDSA last night with myself because I did
25 ask the presenters to try to be concise, try to get things to

1 us ahead of time, try to answer the "so what" question, and
2 come with recommendations, and I thought of some ways -- and
3 Dr. Hurlburt got an earful from me about how easy it is to
4 tell surgeons what to do at one point. But I will think
5 through how to do it differently next time.

6 One other thing that has been a challenge for me, too,
7 and -- a couple things. One is, looking at the issues that we
8 wanted to just -- that I was identifying as things we just
9 needed to learn more about, I wasn't imagining we were going
10 to be developing recommendations about, but it's too hard for
11 all of you to not need to come up with some recommendations
12 related to anything you're learning. So I think I've learned
13 that. So any of the learning items on the agenda, because
14 some of those have been just learning items, from now on,
15 we'll make sure that everything has enough time.

16 But then the other issue is, that's why we've been trying
17 so hard to keep things off the agenda that people keep
18 bringing to the table. There is so much that's critically
19 important, but everything we add to the agenda, it's taking
20 away from the delivery system change, transformation that we
21 need to drive in order to control the bottom line and improve
22 quality. So that's a plea to you to keep from adding new
23 topics.

24 At the next meeting, we will be having two, I hope,
25 outside speakers, one for sure. So I'm not going to limit

