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ALASKA HEALTH CARE COMMISSION

WEDNESDAY, OCTOBER 12, 2011

8:02 A.M.

FRONTIER BUILDING, ROOM 896

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PAGES 277 THROUGH 395

1 the day, since we only have half-a-day and then circle back
2 around to costs and a conversation about workforce and long-
3 term care. Does that sound fair? Does anybody have any
4 questions?

5 So if you want to turn in your notebooks then, the
6 documents that you have behind tab two -- and I printed copies
7 of the existing drafts out for folks in the audience again,
8 too. Those are also in the back of the room for folks in the
9 audience who are here in the room.

10 And starting with primary care -- again we're behind tab
11 two, strengthening patient-centered primary care. I'm not
12 going to -- we don't have time. We're not going to wordsmith
13 individual statements. Since we've had a couple conversations
14 about these statements already, I'm just going to ask,
15 starting with the Findings, does anybody have any suggested
16 improvements or questions related to the patient-centered
17 primary care findings?

18 COMMISSIONER HIPPLER: Yes, Deborah. This is Allen
19 Hippler. In the primary care findings, I would like a
20 statement. In slide number 12, the next slide, there's the
21 talk about what a patient-centered primary care requires,
22 which is a partnership with patient and family. Then you have
23 information, skills, and tools. There should be a statement
24 in there saying that they should be incentivized to take
25 personal responsibility for their health care.

1 COMMISSIONER FRIEDRICHS: Allen, just to clarify, so
2 you're saying that we should pay people to care about their
3 welfare? I'm not sure, but you said that we should
4 incentivize them to be engaged in their care. Could you help
5 me understand what that means?

6 COMMISSIONER HIPPLER: A big problem with the allocation
7 of resources in health care is the third-party payer system
8 where an individual does not have to pay for his own health
9 care. The patient-centered medical home, if it is an
10 additional layer of care and an additional monitoring of the
11 patient without the patient being invested in his own health,
12 I find it hard to make the leap that that will reduce health
13 care costs. The patient, somehow, has to be involved in -- I
14 would say it would be a more of a negative incentive. The
15 patient has to share some of the costs.

16 COMMISSIONER FRIEDRICHS: And I think that's an important
17 distinction because incentives often are interpreted as
18 providing some monetary reward; if you do what we want, you
19 know, we'll pay. Many companies are doing that now. We'll
20 give you an extra day off or we'll pay you X amount of money
21 if you will do these preventive screening tests. And so I
22 would just offer the caution that, if you what you're
23 describing is accountability, personal accountability for
24 doing -- for taking care of yourself, that.....

25 COMMISSIONER HIPPLER: I agree with you.

1 COMMISSIONER FRIEDRICHS: All right. Thanks.

2 CHAIR HURLBURT: I think there are different kinds of
3 examples, I believe, and maybe tell me if it's what you're
4 thinking.

5 Safeway System has gotten a lot of attention wherein they
6 feel they've been successful in reducing, as an employer,
7 their health care costs by incentivizing people to take
8 smoking cessation programs, to be physically active, to do
9 other things.

10 Providence has been trying that here, and I'm not sure
11 what the result has been. I've heard Dick's been kind of
12 positive, and Bruce has said we haven't gotten much out of it.
13 So I'm not sure whether Dick's just be more optimistic as a
14 doc and Bruce is the numbers guy or what, but that's been
15 going on with employers. There are the negative and the
16 disincentives. If you smoke, you have to pay more. But then
17 what may be bothersome to some people but is fairly common --
18 for example in the Medicaid program that I was with before
19 coming back here, we did provide incentives for women to get
20 mammograms for them to have their appropriate prenatal visits
21 for getting the kids immunized, and it really was -- you know,
22 in a pejorative way, you say it was bribing to do it. They
23 ought to be doing it in their self-interest, but it really did
24 help us achieve those results.

25 Now are some or all of those things, Allen, kind of what

1 you're describing or is that different?

2 COMMISSIONER HIPPLER: I didn't have any specific
3 examples in mind, Doctor.

4 COMMISSIONER ERICKSON: Can I make a suggestion, Allen,
5 for you and the rest of the group to respond to? What we're
6 getting into and the -- we could have this conversation all
7 morning, and it's an issue that we haven't studied as a group
8 yet. It's actually on the list for our potential agenda for
9 2012, and I think we're -- the Commission, in our Vision and
10 Values Statement, has captured, in concept, what you're trying
11 to get at, that we think that individuals need to take -- they
12 need to be encouraged and empowered to take responsibility for
13 both their own health and for purchasing health care. So as a
14 general value, we've already stated that and accepted that,
15 and we've been learning, throughout the past year, about lots
16 of examples where we actually can control costs if we can
17 engage patients more in taking responsibility.

18 So as a general concept, we've already bought into that,
19 but I think we have a lot more conversation the next level of
20 detail down about how that plays out in terms of cost-sharing,
21 benefit design, plan design, those sorts of things. The
22 employers' role in both designing those benefits and those
23 plans and working with their employees is an important part of
24 that as well, and I think we have a lot of learning we could
25 do about that. There are lots of examples, both in Alaska --

1 Providence and the University system are a couple that come to
2 mind as well as national business industry representatives,
3 like Walmart and Safeway and some others that we could study.
4 So would -- is that something you would be willing to table
5 for 2012? Wes?

6 COMMISSIONER KELLER: I think Allen gave up too easy.
7 Part of it is we're going to be communicating these findings,
8 and I think that, even though -- you know, we all -- you know,
9 we -- I agree that it's already there, and we've -- you know,
10 there is consensus there, but when we're talking specifically
11 about primary care, it seems like that that -- you know, if
12 there is going to be a reform, that's such a foundational
13 essence to success, you know, that I began to say oh, okay;
14 you know, I've got to take care of this for myself. If we can
15 bring that realization around, it just seems like we can
16 encapture that somehow, you know, in the findings and not
17 detract from what we have represented.

18 COMMISSIONER DAVIDSON: I think we've been really
19 disciplined about study first and then take that information
20 that we have gleaned that is beyond just our personal
21 experience and formulated a strategy, and I think we should
22 stick to that principle. I think we haven't -- I think we all
23 have lots of personal anecdotal information about this, and I
24 think, if you ask the question right now if we have consensus,
25 I know I would object to including that right now. I think we

1 don't have enough information.

2 COMMISSIONER FRIEDRICH: Thanks, Val, and I agree with
3 what we have in our vision as a starting point. It's a
4 stakeholder that yes, there is personal responsibility. You
5 know, again speaking from the federal standpoint, one of the
6 struggles that we're looking at is we've gone from the 1920s
7 in which, if you wanted health care, you worked really hard
8 and then you got whatever health care you could pay for to
9 this period from the 1930s to roughly today where the
10 government assumes some responsibility, and now, this has
11 shifted from the government augmenting what the individual can
12 do to it is a primary governmental responsibility to take care
13 of everybody's health care, whether they take any
14 responsibility.

15 Now we're saying that not only is the government
16 responsible for taking care of the cost of everybody's health
17 care, but we're going to pay them with money from other
18 taxpayers to do the things that we're trying to do for them.
19 It's an interesting pendulum swing that, philosophically, has
20 some pretty significant implications, especially in a state,
21 like Alaska, where we talk about individual responsibility and
22 autonomy and those attributes of being an Alaskan.

23 So I would echo Val's comments. This is one where, on
24 the surface, I think we all agree that there is absolutely a
25 need for personal accountability and responsibility, but what

1 this Commission proposes, I think, can be easily
2 misinterpreted or misconstrued in a much broader context than
3 detract from our overall recommendations, unless we really
4 spend some time thinking through how to do this.

5 COMMISSIONER KELLER: Okay. I give up. Part of that was
6 just to encourage Allen. I mean, this -- I mean, I have
7 gotten to know some of you a little bit more than he has, and
8 it took me a while, you know, again to relax a little bit with
9 this group, too.

10 COMMISSIONER ERICKSON: I appreciate that very much and
11 actually appreciate very much that Allen hasn't really been
12 shy, I don't think, and you need to continue that. We
13 appreciate your thoughts and suggestions. Yes, Val?

14 COMMISSIONER DAVIDSON: I just wanted to make one quick
15 observations of the Findings and sort of our Recommendations.

16 I think we use a lot of really -- I think I agree with
17 the Findings. I don't really have a problem with what the
18 Findings are. I think we use a lot of really big fancy words,
19 and I think that we should probably just say what we mean.
20 And sometimes as I'm reading these bullets, it's hard to get
21 past those words to find what it is that we're really saying.
22 And one of the things that I always consider in our reports
23 is, if this document is something for all Alaskans, how would
24 I translate this into Yupik? And I'm not sure that I could
25 necessarily do that. So I would just -- yeah (affirmative).

1 Exactly. Simplified statements, I think, would be really
2 helpful.

3 CHAIR HURLBURT: Maybe, could you give an example, and
4 maybe just to push back a little, this isn't -- the
5 commissioning isn't for our report to the public, but it's to
6 the Legislature and the Governor. And so documents that you
7 put out to the general public anywhere you want to have stay
8 at a sixth grade level of reading for anywhere in the country
9 for any public, but that's not what this is, is it?

10 COMMISSIONER DAVIDSON: I think the fact that we have
11 500-and-some folks on our ListServ indicates that the public
12 is probably really interested in the work that we're doing,
13 and if we're going to be writing statements, they should be
14 probably be easily understood by whomever happens to want to
15 read them, and I'm assuming that legislators will also share
16 some of this information with constituents. So for example,
17 if you're looking for a specific example, under the primary
18 care findings on slide 11, just read that third bullet out
19 loud;

20 (Whereupon a portion of slide 11 was read as follows:)
21 The renewed emphasis on primary care and new models of
22 primary care are borne out of a convergence in the
23 evolution of medicine and changes in patient needs. The
24 vast increase in medical knowledge over the past several
25 decades has led to more complexity in the management of

1 medical knowledge and also increased specialization of
2 medical practitioners. Improvements in the prevention
3 and control of infectious disease and injury have been
4 accompanied by a higher prevalence of chronic disease in
5 the population, which has led to a shift in patient care
6 needs from acute episodic care to chronic care
7 management.

8 (Whereupon reading of a portion of slide 11 was
9 concluded)

10 COMMISSIONER DAVIDSON: I think we have several concepts
11 in there. Just, I'm not really sure what the point is.

12 COMMISSIONER ERICKSON: Yeah (affirmative). Well, I
13 think the point was to make sure that I was capturing the main
14 points that you all want to make. So what if -- what I'll do
15 is try to pull some of these issues and discussions about the
16 issues into the narrative description and then simplify the
17 finding bullets by.....

18 COMMISSIONER LAUFER: (Indiscernible - away from mic)

19 COMMISSIONER ERICKSON: I think, by the time we get to
20 the final, final report, we will be simplifying the finding
21 statements especially, not the recommendation statements so
22 much, but the finding statement.....

23 COMMISSIONER FRIEDRICHS: Now if we're going to talk
24 about evolution, I really think we need to get creation in
25 here as well.

1 (Pause for background discussion - indiscernible - away
2 from mic)

3 COMMISSIONER MORGAN: No. It's not. I want to just make
4 a real quick comment on the ListServ. If you actually look at
5 the ListServ, I'm surprised it's so small because we keep
6 forgetting in some ways, but in a lot of ways, we all
7 understand how complex, but how many dollars are involved in
8 this industry. I think, if you really took that ListServ and
9 did a matrix, most of them are working for interest groups,
10 non-profit groups, their boards of directors. A lot of them
11 are volunteers, but they are on MGMA, Public Health
12 Association, legislators. I mean, if you really looked at
13 that ListServ, I would be surprised that AARP -- I'm not
14 saying anyone is bad. I'm just saying, if you look at the
15 ListServ, the great majority are representing interest groups,
16 and someone that has some part of this pie at one side or the
17 other -- there may be 50 or 60 individuals who are interested,
18 but they're people who have interests and are retired and not
19 necessarily more of an interest the same way as maybe a hunter
20 would be with the Game Commission, but I would bet you 400 of
21 them are tied to this industry, one way or another.

22 And second, simplifying is okay. Sometimes it's just
23 very difficult for a commission, like this, not to make it in
24 very complex wording simply because look at the people we have
25 around the Commission. Most of deal in a lot of this, and we

1 almost have a mind set that you've got to use graduate
2 education words to prove that you graduated with a graduate
3 degree, but simplifying is okay with me. Usually when you
4 simplify, that's when it turns into an all-day meeting though.

5 COMMISSIONER DAVIDSON: So were you advocating for more
6 multi-million dollar words or fewer? I couldn't tell.

7 COMMISSIONER MORGAN: No. I was just doing an
8 observation.

9 COMMISSIONER ERICKSON: Moving on. Any other questions
10 or suggestions related to the Findings? Moving on then to the
11 Recommendation statements. Yes, Emily?

12 COMMISSIONER ENNIS: This is a question related to,
13 perhaps, more detail about a particular statement. It's on
14 slide 16 when we were talking about.....

15 COMMISSIONER ERICKSON: Could you reference the number
16 because I've inserted some slides, so your printout is.....

17 COMMISSIONER ENNIS: It's page eight, and it's the number
18 four, Primary Care - RECS, recommendations.

19 COMMISSIONER ERICKSON: Number four. Got you.

20 COMMISSIONER ENNIS: All right. So a little 16 on that
21 right bottom corner.

22 COMMISSIONER ERICKSON: So Recommendation No. 4?

23 COMMISSIONER ENNIS: Yes. Yes. And this pertains to the
24 infrastructure support that has been evident, I guess,
25 particularly, in North Carolina to encourage, or I guess

1 support, to make sure we have the adequate staffing, and where
2 I'd like to begin with this is just the acknowledgment that,
3 if we're going to involve behavioral health support in primary
4 care or primary care and behavioral support services,
5 regardless of the way we make this happen, the realization
6 that, right now, Alaska really struggles with having adequate
7 behavioral health clinicians available to us.

8 So in order to be able to, at the point we get ready to
9 implement, have a cadre of behavioral health clinicians, you
10 know, even thinking aside about psychiatrists, et cetera, but
11 just folks that can do care management and address the
12 behavioral health needs, we need to begin thinking about how
13 to facilitate an increase in that workforce. And there need
14 to be incentives, such as the loan repayment, which we've
15 talked about, but something I've learned about recently are
16 some of the licensing silos that inhibit or delay the creation
17 of this behavioral health clinician workforce.

18 So again, I don't know if the infrastructure support is a
19 catchall word that's adequate enough to address the needs to
20 look at licensing. For example, one of the big delays and
21 barriers to behavioral health clinicians' development is the
22 need for a year-long supervision, and to find those
23 individuals in the workforce who are willing to supervise or
24 can supervise is one challenge, and then again to get a new
25 behavioral health clinician hooked up to take part in it or a

1 student hooked up in that clinical supervision is just very,
2 very difficult. And so to be able to address that need to
3 facilitate the expansion of this workforce for the new primary
4 care model is important, and I just wasn't sure whether this
5 needs to be in the finding or maybe there just needs to be a
6 little stronger word added to support.

7 COMMISSIONER ERICKSON: Well, I would suggest that the
8 reason we have workforce and health information/health data as
9 kind of foundation pieces is those run through all of these
10 issues so much, and if we try to get too specific about those
11 specific issues on each of our individual strategies, we're
12 not going to be focused enough in addressing them.

13 And the workforce issue, while it's a critically
14 important issue -- I don't mean to underplay it -- I'm not
15 remembering it as a particular attribute for patient-centered
16 primary care learning that we had from the innovative states.
17 They were talking more about this model and how to support
18 this model, and I think the need for the workers to be there
19 is implied.

20 COMMISSIONER ENNIS: And while I could agree, I think the
21 very inherent piece in the new model is that care manager and
22 whether that care manager is or isn't an expert in behavioral
23 management is something we're not sure yet, but I would
24 venture to say that any care manager would need to have a
25 background in behavioral health interventions and care

1 management. So that's why I brought it up. You know from
2 what I've heard, it does seem to be an important piece in the
3 model of that care management piece.

4 COMMISSIONER ERICKSON: Uh-huh (affirmative), and we've
5 captured it here. If there is something we need delve into
6 related to workforce development for this team, is it
7 something that we should put on our agenda specifically for
8 2012? And if not, if you think we're still missing something
9 important here, then what I'd like you to do is to entertain a
10 motion for a specific change.

11 COMMISSIONER ENNIS: I really had a question for the
12 Commission to see if they felt that was something that was
13 missing. We could delay to 2012, but I wanted to ask the
14 question.

15 COMMISSIONER DAVIDSON: I guess I'm -- a couple of
16 comments. One is I'm trying to figure out what change we
17 would make here to be able to address your concern because I
18 agree that it's not clear, that it should be included. So are
19 wanting something changed under the resources piece?

20 COMMISSIONER ENNIS: It would be under the infrastructure
21 support, but again, this slide, as I read it, really
22 references what we learned from the North Carolina model.
23 It's, you know, what they recommended needed to be in place,
24 so it may not be the best spot for that to add that, other
25 than maybe saying infrastructure support. You know, maybe

1 there is another word, and I can't come with it, but I wanted
2 to bring this up.

3 COMMISSIONER DAVIDSON: Thanks.

4 COMMISSIONER LAUFER: I guess some feedback on this, but
5 one of the things that I worry about here is the timeline.
6 You know, on 17, it says front-end investment will be
7 necessary, but you know, will take two to three years before
8 return on investment is realized. We're talking, really,
9 decades, you know. If somebody is on a Statin and their blood
10 pressure is controlled and they don't get diabetes through
11 diet and exercise, these are the primary tenets of the
12 patients in a patient-centered medical home. Three years into
13 it, you're just paying for medications and visits. It's ten
14 years or 20 years. It's a much longer timeline. This is a
15 much bigger timeframe than a, you know, two-year trial.

16 COMMISSIONER ERICKSON: Emily -- oh, go ahead, Jeff. Go
17 ahead.

18 COMMISSIONER DAVIS: No. Just to add to that, I think
19 it's actually both, and perhaps what's being referred to here
20 is -- and if we looked at the North Carolina experience, it
21 did take them about ten years because it took them a while to
22 get traction, but there, I believe, some immediate effects,
23 such as reduction of emergency room visits, those sorts of
24 things, but yes. And there is what you've just described,
25 which is lifestyle-related changes that happen later on.

1 So I think the point this is trying to make, which is
2 important from the investor's point of view, is don't expect
3 an immediate return. I think that's the point that's being
4 made. It will take years, and some of it may take decades.

5 COMMISSIONER ERICKSON: I just wanted to clarify
6 something though, too. This is not specific to the North
7 Carolina model. Actually, there were these attributes in all
8 three of the models that we studied and so I didn't -- we were
9 -- and I wanted to make that clarification because we were
10 purposefully trying to not get too specific and too
11 operational to a particular model, but took what we learned
12 about all of them that seemed common to their success. Paul?

13 COMMISSIONER FRIEDRICHS: Thank you. Emily, your point
14 is one that I was thinking about last night also, and we heard
15 that excellent update from the Workforce Committee or
16 Commission yesterday, and as I reflected back, we have
17 specific Findings and Recommendations on workforce
18 development, such as the need to improve the licensure process
19 here in Alaska. And I know we have typically not gone back
20 and reiterated recommendations just for the sake of saying
21 ditto or we told you this was important last year, and it's
22 still important.

23 I would ask for the Commission's thoughts on whether we
24 should briefly revisit our recommendations on the workforce in
25 light of the presentation that we heard yesterday, and two

1 specific thoughts on that. I personally think it is worth
2 commending to the Legislature and to the Governor the fact
3 that what were two separate bodies for long-term care, for
4 example, came together, that the Workforce Commission has done
5 some remarkable things in their area. I mean, there are some
6 very tangible things that have happened in the last year,
7 which run the risk of being lost in all of the different
8 discussions along the way.

9 We have an opportunity to highlight those in our annual
10 report because we've heard the testimony on them, and whether
11 it's the long-term care one and it could be as brief as a
12 paragraph that says, you know, the Commission was very
13 encouraged to learn of the progress made in the past six
14 months with, you know, the development of the plan and the
15 commitment to come back with more details. A stakeholder, if
16 you will, or a stake -- a placeholder -- that's what I was
17 looking for -- to let the Legislature know that some very
18 impressive things are happening here in the state and that
19 they should anticipate seeing something next year.

20 On the workforce side, the fact that two groups that were
21 doing very similar work agreed to come together, pool their
22 resources, and actually accomplish something in a year, I
23 don't know about you-all's bureaucracy, but in mine, we call
24 those miracles and that's -- you know, they're worth
25 celebrating. I mean, we write whole chapters in the Bible

1 about miracles. It'd be kind of nice, I think, to compliment
2 them for what they've done and then also, if they're specific
3 -- and I need to go back and look at our old recommendations,
4 but if there are specific recommendations that we made that we
5 need to modify based on their testimony, I think that's within
6 our purview to do that. We may not need to reiterate all of
7 them, but there are a couple that they addressed, which, I
8 think, we would want to modify slightly. And I'll make the
9 offer, if the Commission is willing, that I'll do that on the
10 plane this afternoon, if I can find my notes and then send it
11 to people electronically to look at.

12 COMMISSIONER ERICKSON: That's -- yeah (affirmative). I
13 think that's a great suggestion, and I would -- and I
14 appreciate your suggestion that we not try to do it right now
15 and do it over email and your offer to kick it off. Thank
16 you.

17 And Emily, I don't know if you can see what I wrote on
18 the flip chart here as a placeholder because it's not that the
19 issues you are raising aren't critically important to put them
20 in our parking lot, but again, I think it would take more
21 discussion related to patient-centered primary care, patient-
22 centered medical home specifically. Both having a sufficient
23 supply of workers for these teams that need to support the
24 model is critically important and also making sure that they
25 have sufficient training for the role that they're going to be

1 playing is also important. As far as behavioral health and
2 primary care working together, there are all sorts of issues,
3 everything from reimbursement, which we partially addressed,
4 to the culture change and different requirements for
5 documentation and all of those things that all play into their
6 training and development that we could spend a lot of time
7 talking about and might want to put it on our agenda for next
8 year.

9 COMMISSIONER ENNIS: That would be great, and I'd also
10 add, perhaps, a third point there as to identify and reduce
11 the barriers that may currently exist to growing this
12 workforce, such as licensing silos. And I appreciate, Colonel
13 Friedrichs, your recommendation to keep this topic moving
14 forward in our report.

15 COMMISSIONER FRIEDRICHS: Before we leave this point, for
16 those of us with a Louisiana public school education, on 4(e)
17 -- Southern Louisiana it was; absolutely. Thank you, because
18 North Louisiana has a better school system than South
19 Louisiana.

20 So for those who have not had the benefit of listening to
21 the many hours of testimony here, just reading 4(e) by itself
22 is a little confusing. Might I suggest minor wordsmithing
23 there?

24 Infrastructure support for medical guidance, including a
25 medical director for clinical management and improvement, case

1 managers, pharmacists, and behavioral health clinicians.

2 I think it clarifies what we were trying to get to there,
3 that -- so after medical guidance, remove the slash and
4 replace it with the word, comma, including.

5 COMMISSIONER KELLER: Can I ask a question on that?
6 Emily got me thinking about it. Is support the right word? I
7 mean, because doesn't that imply pre-existing defined or does
8 it not? I mean, I was thinking maybe support and definition
9 or support and clarification. That's a question, honest.

10 COMMISSIONER ERICKSON: I think we used that word because
11 we didn't want to be too, again, directive about how exactly
12 it would happen, but in all three of the models that we
13 studied, the medical guidance through a medical director for
14 clinical management and improvement was included. They all
15 used case managers in some way and supported them in different
16 ways. They all had pharmacy and behavioral health support
17 available to them, but they did it in slightly different ways.
18 And so we're trying to be clear that these are components of
19 the infrastructure that need to be available as part of
20 supporting the team without, again, getting to operational
21 that the state should hire all of these people and make them
22 available or the state should investment money or private
23 insurers should all pony up. They did it different ways in
24 different states, and we were trying to find the balance
25 between acknowledging that these were important features, but

1 not saying how to do it; does that make sense?

2 COMMISSIONER KELLER: Yeah (affirmative). I do
3 understand what you're saying, and I understand how we got
4 there. I just -- my brain is going, trying to think how can
5 we say this a little different, you know.

6 COMMISSIONER ERICKSON: Emily?

7 COMMISSIONER ENNIS: Would infrastructure development and
8 support capture it?

9 COMMISSIONER KELLER: I think that gets back to the same
10 issue that Deb says, that that implies that the Commission is
11 directing a development. So maybe a clarification of where we
12 -- maybe -- let's see. We've already made it clear, right,
13 that this is a product of the providers and not top-down,
14 right? And so it makes in that context. Or I'm sure that
15 didn't help anything. I'll shut up.

16 COMMISSIONER ERICKSON: Are you comfortable enough with
17 it or do you want to suggest a specific change? Any other
18 questions or discussion around the recommendations? Allen?

19 COMMISSIONER HIPPLER: All of these primary care
20 recommendations are around the patient-centered medical home.
21 There was a discussion earlier, and I would like to see -- or
22 I'd like to throw it out there for discussion. There is
23 primary care that recently, because of new developments in
24 technology, can be given over the telephone or over the
25 Internet, and there are regulatory and liability issues that

1 prevent medical care providers from dispensing this care or
2 discouraging them from doing so. And it could be that this is
3 something we talk about next year, but we have talked about it
4 a little bit this year. And since one of our goals is to
5 increase care and reduce costs, that seems like pretty easy
6 pickings there to put a recommendation to somehow limit
7 liability and decrease regulatory burden for medical care
8 professionals who are dispensing care over long distance.

9 COMMISSIONER DAVIS: Yeah (affirmative). That's an
10 interesting point, Allen, that you raise. I wonder if it's
11 something that we should think about putting on our list for
12 2012 and look at the whole question of using technology to
13 expand access as an adjunct to this, and I've thought about
14 this, that part of making, I mean, a patient-centered medical
15 home successful is same-day appointments. Well, how do you do
16 that with limited resources? Well, maybe, as you suggest, you
17 know, telephonic, Web, video, whatever it is, is a way to do
18 that, and I mean, we should look at the whole picture and see
19 what the impediments are. Maybe they're regulatory. Maybe
20 they're liability. Maybe they're technological. You know,
21 who knows what they are, but I think that's worth our
22 investigation.

23 COMMISSIONER STINSON: Allen, I totally agree. I had the
24 opportunity to go over to ANMC and watch what they're able to
25 do remotely with telemedicine, and they're even able to have

1 health aides look into patients' ears hundreds of miles away,
2 and the otolaryngologist can either record it and look at it,
3 much like email, at their convenience and then say what they
4 would like to do, or if it's real-time, they're able to tell
5 them exactly what to do right then. Now that's in the ANMC
6 system. In the civilian world -- I don't know what else to
7 call it -- you have the problems with liability. You have the
8 problems with billing issues. You have these other barriers,
9 and I would love to see those barriers reduced because ANMC
10 uses this quite effectively and it eliminates very expensive
11 travel that wasn't necessary.

12 (Pause for background discussion - indiscernible - away
13 from mic)

14 COMMISSIONER ERICKSON: (Indiscernible - away from mic)

15 COMMISSIONER LAUFER: The regulations have changed.

16 COMMISSIONER ERICKSON: (Indiscernible - away from mic)

17 Sorry about that. Anyway, we already have some
18 recommendations related to that, and I think more learning
19 around the barriers was being suggested. I tried to capture
20 the main issues that came up related to barriers that we could
21 study next year because one of the things we didn't look into
22 specifically was -- we could go a lot further than just the
23 telephone, too, in these access questions.

24 COMMISSIONER LAUFER: A couple things real quick. One
25 difference between that system and the civilian system is

1 somebody else paid for the toys. And then the other is that
2 the otolaryngologist is salaried and is happy to see that. If
3 I were to send a video to a private practice otolaryngologist,
4 the only incentive for them to look at it is that I may refer
5 to them, and this is a problem.

6 Really, this is hard for me to articulate, but a really
7 important part about that North Carolina model and the reason
8 I was so enthusiastic about is the absence of carrots and
9 sticks. You know, it's making the system better and allowing
10 the doctors to work better, and my fear is that everyone is
11 ultimately trying to influence the behavior of patients.
12 Since you can't do that, we're going to punish the front line
13 and force the doctors to do it, which is going to make the job
14 even harder and even lower reimbursed, and there will be
15 flight from it.

16 So last night after our meeting, I went home to a check I
17 had to sign for almost \$19,000 to license one more of our
18 doctors for our EMR for the elusive benefits. All the studies
19 say that it reduces productivity now by something like 20%,
20 and we're supposed to get this meaningful use incentive back,
21 which we haven't seen, and you know, obviously, the federal
22 monies are disappearing so we're not holding our breath on it.
23 At the same time, I got an email from the Alaska President of
24 the AFP who tells me AFP may be leaving the -- what is it
25 called -- the utilization -- URV? RUC Committee -- over

1 reimbursement for doctors, and what was initially an incentive
2 program for docs to meet markets of meaningful use has changed
3 and morphed into a -- what's it called -- budget neutral
4 incentive. So in other words, some will be punished and some
5 will be rewarded. And remember, this is not about care. This
6 is about documentation of care, and this is exactly the wrong
7 thing because it's more work, more documentation, more
8 computer time, less interface time with patients for a game,
9 and it's really important, somehow, that we incorporate it in
10 this. These have to really be useful, meaningful things that
11 make the job smoother and more efficient and more -- have more
12 positive impact on people's lives and not just more, I don't
13 know, burden. Burden; yeah (affirmative). I was thinking of
14 some more ugly word.

15 COMMISSIONER FRIEDRICHS: I'm trying to be politically
16 correct. It's a struggle.

17 COMMISSIONER LAUFER: Thanks.

18 COMMISSIONER BRANCO: All the things Noah said are pretty
19 accurate for today, but I think this is a valuable thing for
20 us to deal with for our 2012 recommendations and get more
21 information as well because this is the shift that's going to
22 happen.

23 And to Allen's earliest question of the day, how do we
24 incentivize patients or how do we incentivize ourselves, this
25 is one of those no-cost incentives to get patients engaged

1 much more -- these are Gen X, Gen Y, Gen Me. The folks who
2 live on these things and are much quicker, they're going to be
3 able to do an e-visit and comply with their physicians'
4 requests through these vehicles, and the incentive is going to
5 be instant care that fits their lifestyle without taking half-
6 a-day off of work to go in, strip naked, get on a table and
7 wait for a little while in order to be evaluated and told you
8 have an earache. They already know they have an earache.
9 What they need to be able to do is transmit that view.

10 So I think this is really worthwhile to aim at both. Is
11 that you naked? I'm sorry. Don't show us.

12 COMMISSIONER MORGAN: What I was about to say is -- Dr.
13 Baskous, who is my doc -- I just got a notice it's time for my
14 six-month physical tests, and while we're sitting here, I have
15 the appointment. It's confirmed. I know when to be there. I
16 know what they're going to do, and I know when to go by after
17 this meeting and get the blood tests. Now this is a very low-
18 cost process to do for Dr. Baskous, and nobody made him do it.
19 No one incentivizes him to do it. He did it because he told me
20 he's up to be able to see 20% more patients because his front
21 desk is communicating to me electronically in real-time.

22 Now the last time I went in, I got my test results back
23 this way within two or three days, and I could review them and
24 then make comments to send back to him. And I know that Dr.
25 Tierney is doing the same thing with some of our case managed

1 patients up over at the hospital. Now there are now toys,
2 other than this, and at the other end. So I agree with what
3 you're saying.

4 COMMISSIONER ERICKSON: We've had some other hands up.
5 We really need to keep moving, you guys. So Keith, Allen, and
6 then Paul is the order that I saw; is that.....

7 CHAIR HURLBURT: Yeah (affirmative).

8 COMMISSIONER ERICKSON: You're probably watching.

9 COMMISSIONER CAMPBELL: Just one point. I think, if
10 we're going to park this in technology and support, we need to
11 have a follow-up. We discussed it in '09, I think, about the
12 impediments of licensing across state lines, if you're going
13 to be asking your support maybe in Washington or somewhere
14 else, if you're going to be liaising with that, yeah
15 (affirmative), across state lines specifically.

16 COMMISSIONER HIPPLER: Noah, I understand that you're
17 tired of people beating you with sticks because of the health
18 care industry's problem, and the point of the discussion, at
19 least as I intended it, was not to introduce any sticks but
20 rather simply eliminate whatever barriers might keep doctors
21 who simply wish to do it from doing it. In my mind, most
22 doctors most of the time would probably not do this ever, but
23 there are many doctors, especially those serving far-flung
24 patients or with patients with whom they've had a long history
25 and with whom there is some trust, where it's cheaper for

1 everyone to do this long-distance, and it takes a very short
2 amount of time.

3 So my idea is to isolate regulations and barriers that
4 are specific to the state of Alaska or over which the state of
5 Alaska has some influence, those barriers that we can then
6 identify and determine if there is anything we can do. For
7 example, there is liability in seeing a patient over the
8 Internet, you know, because, if something goes wrong, well,
9 why did you give this patient a prescription without seeing
10 him? And it could be that the answer to that is maybe a
11 little draconian. Maybe there is a new measure that simply
12 limits malpractice under certain conditions over the Internet.
13 I don't know, but we need to talk about it.

14 So my idea is no more -- not sticks, but rather just
15 identify barriers and see what we can do to eliminate them and
16 then let the market choose.

17 CHAIR HURLBURT: Paul?

18 COMMISSIONER FRIEDRICHS: So I think Allen offered an
19 absolutely intriguing opportunity for 2012 and that would be
20 for the Commission to invite stakeholders around the state to
21 bring us their perceived barriers to the transformation of
22 health care and let the Commission then shift through that and
23 come up with recommendations. What a fascinating report that
24 would be a year from now to look at that and then thoughtfully
25 go through those barriers and make recommendations on which

1 ones to tackle first. I think that's brilliant.

2 Back to the recommendations that we had before, so when
3 we had the telephone conference, one of the concerns that I
4 had shared -- and it may be that the consensus was that these
5 were are not valid concerns, but I am sensitive to being
6 overly general and then having the impact of some of these
7 recommendations lost. For example, 5(a), which we spoke about
8 briefly a moment ago, front-end investment will be required
9 for implementation and may take two to three years before
10 return on investment will be required. All true statements.
11 The real impact of that though was -- for example in North
12 Carolina, if we put in "e.g. in North Carolina," in three
13 years, they realized a \$1.7 billion -- or whatever the number
14 was -- return on investment of something, I know we talked
15 about that, but I don't remember.....

16 COMMISSIONER ERICKSON: Yeah (affirmative), and I think
17 what I -- where did I put it? What I -- look at -- I don't
18 know what slide you have it on now, but look at the screen
19 instead of looking at your paper. You have it in your paper,
20 too. What I suggested was, for the purposes of these -- and I
21 don't know that we should put them in the Recommendation
22 statements because it will make them so long, but I promised
23 to make sure that they were referenced in the narrative and in
24 -- maybe in the Finding statements, but just to prove to you
25 that I am paying attention, I included this slide with -- and

1 these are bullet-specific to Community Care of North Carolina.
2 I have them for the other models we studied as well. So does
3 this help?

4 COMMISSIONER FRIEDRICH: Yes. And I remembered seeing
5 them somewhere. Just between the different binders and
6 slides, I wasn't sure, but my plea would be to make those
7 readily accessible to whoever is reading the report because,
8 you know, for someone who is getting ready to go to D.C. to
9 beg for a few pennies next week, if you tell me that I can get
10 \$8 back for every dollar spent, boy, that's a lot more
11 interesting than there will be a two to three year delay
12 before I see (indiscernible - voice trailed off).

13 COMMISSIONER MORGAN: I -- when you -- those numbers come
14 -- their -- you'll like this, Wes. Their Legislative Audit
15 went in and looked at the system at three years, five years,
16 and ten years, and it's actually on their website, a link to
17 get to the Legislative Audit, and you can pull it up. So it
18 wasn't them saying that. It was the Legislature that put some
19 of this money in, had their Legislative Audit Bureau -- I
20 don't know what ours is called, but I know we have one.

21 COMMISSIONER KELLER: Budget and Audit is the short term,
22 Legislative Budget and Audit.

23 COMMISSIONER ERICKSON: And actually, all of these
24 findings were independently derived as well. They weren't
25 from the organization's own evaluation. So other questions or

1 suggestions related to patient-centered primary care
2 Recommendation statements?

3 If there are none, could we entertain a motion to approve
4 the Recommendation statements as draft for public comment at
5 this point?

6 CHAIR HURLBURT: Is there a motion? Keith. A second?

7 COMMISSIONER ERICKSON: Pat?

8 CHAIR HURLBURT: Pat. Any discussion?

9 COMMISSIONER ERICKSON: We're taking a vote, you guys.

10 CHAIR HURLBURT: All those in favor of the motion? All
11 opposed?

12 (Pause)

13 COMMISSIONER ERICKSON: Moving along, let's go on to
14 Trauma System, and starting with the Finding statements again,
15 we're not going through these individually. Any questions or
16 comments, concerns about the Trauma System Finding statements?

17 (Pause for background discussion - indiscernible - away
18 from mic)

19 COMMISSIONER ERICKSON: We have our attorney -- we had
20 our legal consult at the same time. Moving on to
21 Recommendations then -- yes, Allen and then Val?

22 COMMISSIONER HIPPLER: Actually, Val had mentioned this
23 earlier about the readability of recommendations, and when I
24 was looking this over, I made a note. I'm going to read this
25 to you,

1 (Whereupon a portion of slide 20 was read as follows:)
2 A strong trauma system is comprehensive and coordinated,
3 including public health system capacity for studying the
4 local epidemiology of the burden of industry in the
5 population.

6 (Whereupon reading of a portion of slide 20 was
7 concluded)

8 COMMISSIONER HIPPLER: That was a little rough for me.
9 I'm the layman here, and one of the reasons you have me is so
10 I can see things that I don't understand. My understanding of
11 the word epidemiology, for example, is you're looking for root
12 causes; is that accurate?

13 COMMISSIONER ERICKSON: I'm sorry, Allen. I actually
14 thought I had changed that, based on your comment about this
15 at the teleconference. So I will attempt to wordsmith that
16 right now, while we.....

17 COMMISSIONER HIPPLER: Okay. All right.

18 COMMISSIONER ERICKSON: We'll replace epidemiology with -
19 - let's see if I can remember how I did it.

20 COMMISSIONER FRIEDRICHS: I thought you just took out
21 "the local epidemiology" out and just said "studying the
22 burden of injury in the population."

23 COMMISSIONER ERICKSON: Thank you. Yes, Val?

24 COMMISSIONER DAVIDSON: So I noticed that, in our other
25 recommendations, we have really strong statements like

1 "recommends the state of Alaska support," and in this one, we
2 recognize, and I'm not sure if that would be a legislative
3 citation or not, but I would suggest this change, "recommends
4 the state of Alaska support a strong trauma system for Alaska
5 and include the following attributes in planning for
6 improvements." So delete.....

7 COMMISSIONER ERICKSON: Any objection or questions?

8 COMMISSIONER DAVIDSON: Before you do that, can you
9 capture my recommendation? So if you do a bracket around
10 "recognize that," so we know what we would be replacing. So
11 it would be "support" instead of "recognizing that." And then
12 delete the word -- so put a bracket also around "is
13 essential." So it would then read, "recommends the state of
14 Alaska support a strong trauma system for Alaska" or maybe
15 "that includes the following attributes."

16 COMMISSIONER ERICKSON: Any questions or objections? I'm
17 just not fast enough on my laptop. Hearing no objections, I
18 don't -- I'll defer to the Chair probably on this. I don't
19 know that we need to take a vote on every change, if
20 everyone's agreeing, if nobody is objecting. So folks are
21 nodding their heads. Nobody is objecting.

22 CHAIR HURLBURT: We can go through, and then at the end,
23 take a vote.

24 COMMISSIONER ERICKSON: Good. Okay. Yes, Paul?

25 COMMISSIONER FRIEDRICHS: On the, I guess, second sub-

1 bullet beginning with "emergency medical service capacity," I
2 offer to the Commission to add between the words "and safe"
3 the insertion of two words, "coordination of," "and
4 coordination of safe transportation." And my point in
5 bringing that up is that, as we've worked with the Trauma
6 Commission and with other groups that are interested in this,
7 one of the attributes of a trauma system that we lack in this
8 state is a medical coordination center, the one number that
9 Life Flight or Guardian Flight or the Air National Guard or
10 whoever can call to say who has got the next operating room
11 and OR team that's available. There is no such function
12 today. There is no such capability that exists today to do
13 that and so that would clarify what, I think, the discussion
14 is getting to, you know, (indiscernible - voice trailed off).

15 COMMISSIONER ERICKSON: So your suggestion is to add,
16 after stabilization, comma "safe coordination" or just.....

17 COMMISSIONER FRIEDRICH: No. It would say,
18 "stabilization and coordination of safe transportation."

19 COMMISSIONER LAUFER: The issue there is with multiple
20 injuries or multiple casualties, a large disaster. My
21 hospital in Seattle, when I was a resident, lost all power
22 through a series of serious goof-ups, and there were almost
23 200 people there and 14 people on vents and they had to leave.
24 That was all coordinated through Harborview by phone, and
25 there's got to be somebody who knows how to do it who is there

1 all the time or those people might have died. Picture
2 helicopters in a holding pattern and lines of ambulances and
3 that could easily happen.

4 COMMISSIONER ERICKSON: Any questions? Thumbs-up to that
5 suggested change. Any objection to that suggested change?
6 More thumbs-up. Any other suggestions for the draft Trauma
7 System Recommendations? Pat?

8 COMMISSIONER BRANCO: It's, essentially, a question, and
9 the only reference to the American College of Surgeons is in
10 the last recommendation there, that it's that we continue to
11 work towards the recommendation of that study.

12 The one question I've got is ACS establishes the standard
13 for trauma centers, and it isn't a simple standard to achieve,
14 but it is also a hallmark standard of compliance with being a
15 designated trauma center at whatever level. The State
16 authorizes Level IV trauma centers, but it's with an
17 established set of criteria. I would add an attribute that
18 says that, once we have established criteria whether they're
19 ACS or state-mandated, that it is an attribute, that, in order
20 to be a certified trauma center, I think it should be in here,
21 not just inferred. I didn't make that very clear, did I, that
22 there's a level of certification or standard to be met by each
23 of the trauma centers in our state.

24 COMMISSIONER FRIEDRICH: Pat, if I'm tracking you, I
25 think that's a wonderful clarification. Are you advocating

1 that we would modify this to say something along the lines of,
2 following trauma, "including appropriate certification of
3 trauma levels for all hospitals?"

4 COMMISSIONER BRANCO: That's a good way, and the words
5 "and maintenance of."

6 COMMISSIONER ERICKSON: I guess I should capture that,
7 but then I have questions about what -- how we're changing the
8 nature of this recommendation by that addition.

9 COMMISSIONER BRANCO: It's not the changing of the
10 recommendation. It's one of the attributes.

11 COMMISSIONER FRIEDRICHS: Because he is absolutely right;
12 that was part of the ACS report is that all hospitals be
13 certified, so that you can build that system. You need to
14 know who is a Level IV, who is a Level III, who is a Level II
15 and that would be a helpful linkage to what the state has
16 already done in incentivizing hospitals to pursue
17 certification.

18 COMMISSIONER ERICKSON: So it's suggesting that the State
19 continue ongoing support for maintenance of certification. I
20 guess that's the distinction, but maybe it's.....

21 COMMISSIONER BRANCO: And again, I'm not being terribly
22 clear. It's adding the formality part of it. I mean, if this
23 was Joint Commission, we would say every hospital in the state
24 of Alaska has to have Joint Commission certification or be
25 blessed by state survey process that they're upholding a level

1 of quality. It's absent in here that there is any formality
2 or quality standard achieved. It's implied. I'm just simply
3 recommending that we add it as an attribute that says we
4 ascribe to this level of quality in all of the facilities that
5 become trauma centers of whatever caliber; is that better?

6 COMMISSIONER ERICKSON: Okay.

7 COMMISSIONER FRIEDRICHS: That creationism should be
8 taught in all schools in Alaska, and.....

9 COMMISSIONER LAUFER: That's Louisiana. You've got
10 to.....

11 COMMISSIONER FRIEDRICHS: I'm sorry; that's Louisiana.
12 Wrong commission. Or Kansas, whichever. I'm sorry. I get
13 them all confused. So after trauma, "including achievement
14 and sustainment." So the last word of the sentence "surgeons
15 committee on trauma, including achievement and maintenance of
16 certification of appropriate trauma status for all Alaskan
17 hospitals." And we can wordsmith that, but that's, at least,
18 a starting point.

19 CHAIR HURLBURT: I think it's not just operational, which
20 we need to avoid, but are you implying that what you're
21 suggesting here should be a requirement, that the Governor's
22 office and the Legislature should require that as a part of
23 the license that's granted to operate a hospital? Some states
24 have.

25 COMMISSIONER FRIEDRICHS: And in your wise way again,

1 you're opening up the pandora's box very gently to see how far
2 we want to go with this. So for those of you who have been
3 part of the Trauma Commission discussions, this has been a big
4 discussion of how far should the state go. Should we require
5 certification as a contingency for continued licensure?

6 The approach that the State has taken thus far is to
7 incentivize it by offering to subsidize, at least, part of the
8 certification process, in the hopes that hospitals will go
9 after and achieve this certification. I don't, personally,
10 sense that there is any political will to move, at this point,
11 from a carrots-based approach to a stick-based approach, nor
12 do I personally advocate for making it a requirement for a
13 hospital to maintain their licensure yet. I think that we're
14 seeing good progress around the state. I think all but two
15 hospitals now have started the process to become certified.
16 As long as that trajectory continues, I don't see the need to
17 become more punitive. If goodness is happening on its own, we
18 cheer them.

19 COMMISSIONER ERICKSON: I have a -- Allen, go ahead.

20 COMMISSIONER HIPPLER: I would ask, if our goal is to
21 have all hospitals achieve this certification -- I don't know
22 anything about this certification. Nevertheless, I'm going to
23 assume that it is expensive and it requires some redundancy;
24 is that accurate?

25 COMMISSIONER FRIEDRICHS: So as Pat had mentioned, there

1 are five potential levels of certification. A Level IV
2 certification can be done by the State, and right now, I don't
3 believe the State is charging anything for that. That's
4 actually a volunteer -- a group of volunteers who come out, do
5 the visit, and then will recommendation certification for
6 Level IV status. Level III and Level II -- or Levels III, II,
7 and I status require a site visit by the American College of
8 Surgeons with a multi-thousand dollar charge associated with
9 that in order to obtain the certification. So for three and
10 above, there is, clearly, a fee involved in moving with that.
11 For IV, there is some cost to the facility, but it's much
12 lower.

13 From the standpoint of redundancy, I am not sure if I
14 understand the implications of that. When I think of
15 redundancy, I think of asking people to do the same task more
16 than once or adding something on that they're already doing.

17 One of the attributes of the American College of
18 Surgeons' certification process has been to build on what the
19 Joint Commission already requires hospitals to have. It's a
20 robust process improvement system within the hospital. Then
21 they require that you have a subset of that focused
22 specifically on trauma care, so that you have medical
23 education available to the staff as well as a very candid and
24 recurring at how well you care for trauma patients and then
25 identify those areas for improvement, a building improvement

1 plan, and then document that you've implemented those
2 improvements and seen a change. So it is redundant in the
3 sense that it's a process improvement requirement, but it's
4 one that's focused specifically on your trauma patients. Does
5 that help?

6 COMMISSIONER HIPPLER: It does. My initial reaction is
7 that I think it's probably best left to the individual
8 hospitals to determine whether or not they want to pursue
9 that, and I'm not sure if it's appropriate for the state of
10 Alaska to say that hospitals should achieve that
11 certification.

12 CHAIR HURLBURT: Pat?

13 COMMISSIONER BRANCO: I have one more piece on that as
14 well. Take the community of Sitka with two hospitals, a
15 community hospital and a SEARHC hospital there. That's one
16 form of redundancy that would be unnecessary to have two Level
17 IV trauma centers in one small community and even worse would
18 be to compel them both to have a trauma center.

19 CHAIR HURLBURT: A little -- maybe expand a little on
20 what Paul said, Allen. This system of certifying and
21 categorizing trauma centers is the normal practice around the
22 country. Anchorage is the largest city in the United States
23 without a Level I or II trauma center. We're not big enough
24 to have a Level I, except for most of the population. ANMC is
25 Level II. They do take care of a number of non-Native

1 individuals, but they don't have the capacity to take care of
2 everybody. Alaska is the only state in the country without a
3 Level I or II for most of the population. It's well-
4 documented in the literature that, when you have hospitals
5 that go through the certification process, particularly at the
6 top end, Level I's and Level II's, and also in the Canadian
7 literature as recently as about ten months ago, that you're
8 survival by trauma victims is significantly better.

9 So there is the balance between we don't want to be
10 controlling. Senator Coghill, who probably has achieved more
11 credibility and more knowledge than anybody around and who has
12 championed this, very clearly has a bias that we should do it
13 by incentivizing by the care rather than mandating for the
14 same reason we're all talking about here. On the other hand,
15 my personal assessment is that it's not impossible that, at
16 some point, he might say hey, we've tried this and it's not
17 working because, in a number of states, including a number of
18 other red states, it is mandated that the hospitals go through
19 that because it does result in increased survival. Noah?

20 COMMISSIONER LAUFER: I think one way to think of this is
21 that trauma medicine, unlike what I do, is, more than probably
22 anywhere else in medicine, very allorhythmic. You know, it's
23 checklists, and it all happens in an hour, the first hour, and
24 it can be multiple victims, and it costs money. So there is
25 no incentive, really. You know, if you're a specialty

1 hospital and you're making a lot of money doing other things
2 to be prepared, but it's a question of being prepared and it's
3 dependent on these checklists, I think the best place in the
4 world's probably trauma in Baltimore. You know, the whole
5 roof is helipads. It's up on stilts. They can bring in 20-
6 some ambulances at once. The elevators have x-ray equipment
7 in them, so that, you know, full body scans are done while
8 you're going from the helipad to the operating room, and they
9 don't screw around.

10 Now we can't have a shock trauma here because it would
11 be, you know, a couple -- \$500 million sitting there empty
12 most of the time, but we do have an obligation to be prepared,
13 and it is, like I said, allorhythmic. You've got to be ready
14 before it happens, and it's little things like, you know,
15 you're the family doc in Seward, you know, are you ACLS
16 trained, are you PALS trained? If an infant comes in and is
17 not breathing, do you know what to do, at least the basics to
18 stabilize them?

19 So it would be better if it's a carrot than a stick, but
20 it also has to happen.

21 COMMISSIONER ERICKSON: Can I ask a question about the
22 statement? Oh, I'm sorry. Go ahead, Allen.

23 COMMISSIONER HIPPLER: I'm not following the "it has to
24 happen," and I don't see why it's the State's business to give
25 a carrot or a stick to a hospital to incentivize its

1 certification.

2 COMMISSIONER LAUFER: It's a function expected of a
3 hospital for which the hospital is not likely to be
4 reimbursed, but it must be maintained. It's when it really
5 hits the fan that it matters, and you know.....

6 COMMISSIONER ERICKSON: One of the things that Allen
7 might not realize is that the State already is providing the
8 carrot for that and so we're not debating that. I think the
9 suggestion might have been, do we require it at this point
10 rather than just incent it? So we're not -- but I guess, are
11 you questioning whether, if we are suggesting that that needs
12 to continue, that we maybe shouldn't suggest that that needs
13 to continue?

14 COMMISSIONER HIPPLER: It sounds pretty heavy-handed
15 still.

16 COMMISSIONER ERICKSON: Well, are you making a suggestion
17 -- do you not agree with addition of this statement?

18 COMMISSIONER HIPPLER: I do not like it. I think it's a
19 -- if it were acted on, it would simply increase costs.

20 COMMISSIONER ERICKSON: Val and then Paul?

21 COMMISSIONER DAVIDSON: Could you agree to it if we
22 removed the word all?

23 COMMISSIONER HIPPLER: Yes.

24 COMMISSIONER ERICKSON: A friendly amendment? We're not
25 being quite that formal with our parliamentary process here.

1 CHAIR HURLBURT: But isn't the reality that the all means
2 one or two hospitals? Because everybody else is going for it,
3 except the most important one, not because the hospital
4 doesn't want to.

5 COMMISSIONER FRIEDRICHS: Three years of trying to
6 understand this particular issue in great detail, I'm
7 convinced that incremental improvement is the most that we can
8 hope for. I do believe the Commission can help that
9 incremental improvement by continuing to keep this
10 recommendation clearly stated. I'm no longer optimistic
11 enough to believe that we'll see it in the near-term with the
12 two largest facilities. I think taking out the all is fine,
13 and I would support that.

14 The issue is going to be that steady drumbeat. I believe
15 that the citizens of Alaska should be able to receive the same
16 quality of care as the citizens of other states, and as you
17 pointed out, we stand alone in not providing a trauma system
18 and not developing a trauma system to care for our trauma
19 victims in a state in which trauma is the number one killer,
20 up to the age of 45. So not only would this save lives, but I
21 do believe, actually, Allen, that there is good documentation
22 that it would save money because you prevent the loss of
23 income from those who die. You also prevent the long-term
24 rehab for people who are appropriately cared for in the first
25 hour after injury. But I think this is a good compromise that

1 gets us one step further along the road, and I'll leave it to
2 the Commission in the future to continue to make the merits of
3 it.

4 COMMISSIONER LAUFER: Just very quick, this is an "I-
5 told-you-so" issue. Something big happens. The Commission
6 discussed it. They didn't come down with a firm statement. I
7 mean, it's the ultimate political disaster. You know, why
8 wasn't the hospital ready? That's an expectation of the
9 community. What are they there for? You know, everyone -- if
10 you asked people on the street, they'd say, oh yeah
11 (affirmative), the hospital is ready, you know. It's an
12 expectation.

13 COMMISSIONER ERICKSON: We really need to keep moving
14 here. So if we're adding to improving or clarifying the
15 recommendation, we have lots more to go. So with that -- 30
16 seconds.

17 COMMISSIONER MORGAN: The only example I have of this is
18 in economics, i.e. the night before the whole banking system
19 was going to crash -- and I mean, whole banking system -- they
20 called in all the major banks and said, guess what? All of
21 you are taking TARP (ph) money. Everyone is. We don't want
22 any kibbitizing (ph) at the end of this. We have to save the
23 system. So the real question is, you'll have incremental
24 change, but overall, the economics of getting there -- it is a
25 lot of money and adds to fixed cost. So if it's a choice that

1 we're going to do it, then the Commission has to decide
2 whether we're going to be put -- whether we're going to --
3 it's all of us are going to do it. If we're going to wait for
4 some people or someone to come forward to do it and take the
5 hit, more than likely, you won't have anybody step forward and
6 take the hit.

7 COMMISSIONER ERICKSON: We're not going to solve the
8 problem of which hospitals are doing what today. We're just
9 trying to get at a general policy recommendation, and I have
10 one question and concern related to this study back to the
11 earlier change we made on the other recommendation. We are
12 recognizing and emphasizing the importance of the whole system
13 and the integration of the whole system. And is the focus --
14 and I understand that the research shows that having a
15 designated trauma center is what effects cost and quality in a
16 positive way and outcomes, but I'm curious about whether those
17 studies were of trauma centers that had these other attributes
18 in their system. And if that's true then, are -- by calling
19 out the trauma center status specifically in what was our more
20 general recommendation, are we focusing -- putting too much of
21 the focus on that and not enough on the other parts of the
22 system, the pre-hospital, the coordination element, those
23 sorts of things?

24 COMMISSIONER DAVIDSON: I think we have five or six other
25 recommendations. So I'm just going to ask the question, is

1 there any objection to this recommendation as drafted?
2 Because I think we could continue having a lot of conversation
3 about this topic, but there are six other recommendations that
4 we have to go to.

5 COMMISSIONER ERICKSON: I have concern, based on the
6 question I just asked, but I don't get to vote. So we'll
7 leave it up to the voters at this point.

8 COMMISSIONER FRIEDRICHS: I believe that your concern is
9 well-addressed within the language here, based on what I know
10 of the trauma system certification, and I second Val's motion.
11 If I may call the question in this matter and recommend we
12 move to a vote?

13 CHAIR HURLBURT: Any discussion? All those in favor of
14 Val's motion say aye? Opposed? It's unanimous. Thank you.
15 Mea culpa. Pandora's box.

16 COMMISSIONER ERICKSON: Was that -- I'm sorry. I was
17 writing and not looking. Was that unanimous?

18 CHAIR HURLBURT: Yes.

19 COMMISSIONER FRIEDRICHS: And now for a totally non-
20 controversial issue, obesity.

21 COMMISSIONER LAUFER: At the State of Reform thing, I
22 don't know how many people heard Dr. Kiessling speak, but it
23 really was funny because he looks at the audience and he says
24 -- you know, he's going on and on about the cost of health
25 care and actually driver, which is you, the guilty audience

1 that's going to die and suffer, and he said, I can look out
2 and tell you, you know, half the audience is obese. And then
3 he said, but I can say that without, you know, fear of a lot
4 of recrimination because only 10% of you will be offended
5 because the other 40% are delusional, and it was hard -- and
6 he went on to rag on skinny people who exercise and want their
7 knees replaced, so they can wakeboard and kitesurf. But it
8 was really a bomb.

9 COMMISSIONER ERICKSON: So let's take just -- can we try
10 to keep it to five minutes? Ten? A quick break.

11 9:26:51

12 (Off record)

13 (On record)

14 9:36:15

15 COMMISSIONER ERICKSON: In the interest of time, I'm
16 going to restart without our Chair and all of our members at
17 the table. I get to take the gavel.

18 COMMISSIONER FRIEDRICHS: Madam Acting Chair?

19 COMMISSIONER ERICKSON: Paul and then Val?

20 COMMISSIONER FRIEDRICHS: This is certainly a weighty
21 matter.

22 COMMISSIONER ERICKSON: A weighty matter?

23 COMMISSIONER FRIEDRICHS: So I was just checking to see
24 who was listening there. That's all. I withdraw my comment.

25 COMMISSIONER ERICKSON: Val?

1 COMMISSIONER DAVIDSON: So I thought the first part of
2 this recommendation -- or sorry. I skipped past the Findings
3 and went right into Recommendations because I think the first
4 part of the recommendation really is a finding, "overweight
5 and obesity as a worsening public health crisis."

6 COMMISSIONER ERICKSON: Well, we put that in the
7 Findings. We restated it in the recommendation because we,
8 without being too directive, wanted to make sure that state
9 government was acknowledging that this is -- that's why that
10 recommendation -- it's restate in the recommendation.

11 COMMISSIONER DAVIDSON: Well, can I finish and then you
12 might be able to see what I mean? So my point, really, was
13 that you don't -- I didn't really get to what it is that we're
14 recommending until the very end of this statement, and I think
15 that we probably should catch people in our very first breath.

16 And I think what this recommendation is trying to do is
17 to recommend that the state of Alaska address overweight and
18 obesity through programs that are evidence-based and grounded
19 in best practices and that first efforts should focus on diet
20 and physical activity with young children and young people and
21 raise public awareness of the grave risks of overweight and
22 obesity. I think that's the point of this recommendation, but
23 I had to read it about four times to figure that out.

24 COMMISSIONER ERICKSON: I wasn't typing fast enough, but
25 rather than trying to change the existing recommendation, I'm

1 going to retype the whole thing. So can you restate that one
2 more time? Sorry; I know.

3 COMMISSIONER DAVIDSON: I think what I said was,
4 recommends the state of Alaska implement programs to address
5 overweight and obesity. I think there is something missing
6 there, but we'll come back to it. And then period. First
7 efforts should -- I don't like the word target and children in
8 the same sentence.

9 COMMISSIONER ERICKSON: I know; I agree.

10 COMMISSIONER DAVIDSON: First efforts.....

11 COMMISSIONER ERICKSON: Focus? How about focus?

12 COMMISSIONER DAVIDSON: Yeah (affirmative), should focus
13 on diet and physical activity for children and young people
14 and raise public awareness or implement programs to --
15 whatever -- public awareness of the grave risks of overweight
16 and obesity or maybe of the health risks instead of grave,
17 although grave is probably eventually, if left -- yeah
18 (affirmative). It's true.

19 COMMISSIONER HIPPLER: Mr. Chairman, thank you. I think
20 that's much better stated, Val. I also struggled through
21 this, and the one thing in our recommendation that we seem to
22 be saying before was we should use the media to raise public
23 awareness, which it sounded like public service announcements
24 to me, which I didn't really think are very useful. In your
25 recommendation, you say raise public awareness; could you tell

1 me how that would be effected?

2 COMMISSIONER DAVIDSON: I guess I intentionally left it
3 broad, so that people could do what was right for their
4 communities. So for example, for some people, it might be
5 posters. For other people, it might be open gym nights. For
6 other people, it might be -- I mean, it's really broad, so
7 that people and communities can implement programs that are
8 really effective for that population, something that people
9 can relate to.

10 CHAIR HURLBURT: I think one of the analogies is looking
11 at what happened with tobacco, where the media was used
12 effectively and it's more than PSAs. It's purchased time also
13 where there were the educational things. There were the media
14 campaigns that made fun of the use of tobacco, and it was one
15 of the factors that changed our cultural norms.

16 So the intent is to educate the public and to change the
17 norm where, for example, when Noah was describing the funny
18 comments that were made in the other meeting there, but the
19 reality is that 30% of people who are overweight think they're
20 of normal weight and 60% of people who are obese in the lower
21 obese range, 30-35, think they're just a little heavy. So a
22 part of it is to change expectations and understanding of what
23 normal is because the normal does tie to a significantly
24 longer, healthy life there. So I think it's more than PSAs,
25 and it was effective. Probably tobacco is the closest

1 analogy, although my bias is overweight and obesity will be a
2 much bigger challenge. Pat?

3 COMMISSIONER BRANCO: And I think it was MatSu School
4 District that made the significant changes in the diet of the
5 high school, in particular, and Dr. Hurlburt has issued a
6 challenge to me, personally, and I hope to every hospital and
7 health care provider in the state to eliminate these to
8 functionally change the paradigm in our organization, so that
9 the healthy foods, the availability of healthy foods becomes
10 the norm rather than forcing people to opt-out when they're
11 drawn to the sugar. I'm drawn to the sugar. If it's not
12 there, I'm making choices among a healthier array than I can
13 find. And so it's a paradigm shift and so it's somewhat
14 media-based in helping to change the influence that we have on
15 the population at-risk. So it's a broad array, and I think
16 media is just one short word to try to capture more of that.

17 COMMISSIONER HIPPLER: I noticed that we got rid of the
18 overweight part of "overweight and obesity," which I
19 understand that that's -- that we like to remind people that
20 overweight isn't good, too, but grammatically, it didn't flow
21 and it doesn't make sense to say overweight and obesity. So I
22 appreciate that.

23 COMMISSIONER ERICKSON: And I was actually going to wait
24 until we were done with this conversation and say that I just
25 noted the change. Allen had suggested this change to me, and

1 I told him we could talk about it with the Commission and so I
2 wanted to go ahead and note it, just to save time.

3 Actually, two changes that he had suggested to me over
4 email were just so the title isn't as awkward, unless somebody
5 has a different suggestion, if we just refer to this as
6 obesity, and we'll still acknowledge that the condition is
7 both overweight and obesity in all of the narrative, but just
8 the title for this section would just be obesity in Alaska.
9 Does anybody have any objection to that change? Go ahead.

10 COMMISSIONER LAUFER: That's just a clinical thing.
11 Overweight and obesity are matters of degree based on BMIs,
12 but I think, for the general public and the legislators, it
13 probably doesn't make any difference. But these are cultural
14 shifts, so, like with smoking, I never talk to somebody and
15 say, gee, you know smoking is bad for you, and they say wow,
16 really? God, I didn't know; I'll quit today. You know, that
17 doesn't happen anymore, and no one argues with me anymore.

18 And now the same is true of weight. I leave the BMI
19 table in the room, so that the person has already looked at
20 it, and I walk in, and they look pissed. They say this thing
21 says I'm obese. I say, oh well, you know, I didn't, but the
22 piece of paper there does, and is that something you want to
23 address because, you know, everyone knows it's an issue. It's
24 not easy to lose weight. You know, it's not just like you
25 need the news, but that realization is the first shift. And

1 frankly, I kind of agree with Allen. I don't know how much
2 sort of energy or money the state should spend on it. It's a
3 cultural change that is happening, and you know, we can take
4 credit for it in 15 years, but it's kind of happening on its
5 own. We have an obligation to push it a little bit, but I
6 don't know how much, you know. I mean, there are billions and
7 billions of dollars of books written on it.

8 CHAIR HURLBURT: I think the argument I would give for
9 the State being engaged is I see it as the dominant public
10 health challenge of our time, and the State does get involved
11 in public health challenges. We are living at a time when
12 it's quite possible, even likely if we don't change, that
13 American kids being born will not live as long as their
14 parents did for the first time since the beginning of the
15 country. So I say it is a valid public health issue.

16 COMMISSIONER LAUFER: You know, radical out-of-the-box,
17 but I think we could spend it better by, say, regulating
18 access to soda or reinstating school sports programs or
19 saying, if you live within a mile of school, you need to walk.
20 I know no one would like these, but you know, the reason we're
21 overweight is we have access to holiday meals all the time.
22 There is plates of donuts. They have flaxseeds in them, so
23 they're healthy -- over there. And how many people walked or
24 rode their bike today? You know, we made it. We've achieved
25 the healthy great life, but.....

1 CHAIR HURLBURT: But you can't get there without
2 education.

3 COMMISSIONER LAUFER: Yeah (affirmative).

4 CHAIR HURLBURT: And you know, the government can't do
5 that by (indiscernible - voice lowered) -- we don't live in
6 that kind of a country -- without public support and that
7 takes education. Pat?

8 COMMISSIONER BRANCO: I'm going to call the question, and
9 I'll make the motion.

10 CHAIR HURLBURT: Any discussion?

11 COMMISSIONER HIPPLER: Is this motion for the
12 Recommendations?

13 COMMISSIONER ERICKSON: For the Recommendation as
14 restated in the second bullet, with that first bullet going
15 away entirely.

16 CHAIR HURLBURT: Any discussion? All in favor aye? All
17 opposed? It's unanimous.

18 COMMISSIONER ERICKSON: And that was unanimous, aye?

19 CHAIR HURLBURT: Yes. Yes. Thank you. Val?

20 COMMISSIONER ERICKSON: I wanted to note, really quickly
21 before Val goes, one other change in the Finding statement
22 that Allen had suggested and that was changing the word
23 disease to condition, and I'm seeing heads nod. I don't think
24 we need to take a vote on that. Folks are agreeing. Thank
25 you for that suggestion, Allen.

1 COMMISSIONER DAVIDSON: Just in the interest of time, I'm
2 noticing that we have four more Recommendation categories and
3 some of them are quite weighty and meaty and really huge, and
4 it just seems like, every time we get to the Recommendations,
5 our commentary reverts back to our Findings, and I think, if
6 we can be more disciplined in focusing on what exactly we want
7 the Recommendation to say without sort of reliving everything
8 that we've learned in the Findings, maybe we'll be able to get
9 through all of these four, and I wonder if, maybe in the
10 interest of time, are there particular -- do we need to go in
11 the order of these slides or perhaps we could leave the
12 immunization one to the last and deal with maybe payment
13 reform, behavioral health, or transparency first?

14 COMMISSIONER ERICKSON: Well, I would just like to get
15 through -- I think your suggestion is very good, and I agree
16 with your first suggestion. I'm hoping that we could be done
17 with immunization in just a minute and check that one off and
18 just keep going. Are we not going to be able to do that? Is
19 there going to be.....

20 (Pause for background discussion - indiscernible - away
21 from mic)

22 COMMISSIONER KELLER: I do have something I want to bring
23 up on immunizations, but I think it's very brief. I.....

24 CHAIR HURLBURT: Go ahead.

25 COMMISSIONER KELLER: Well if we're there, just in the

1 Findings, I would just recommend a finding that does some
2 explanation or promotion of our Alaska immunization program.
3 I think Dr. Hurlburt could come up with that very easily, and
4 the reason I think it's significant is because of the concerns
5 that are out there, you know, amongst the public, safety and
6 effectiveness, and saying hey, as a state, we're taking
7 responsibility here for safety and effectiveness; we have a
8 good program. And so I don't think it would be hard, and I
9 hope, not too controversial.

10 COMMISSIONER ERICKSON: I will add a finding related to
11 that and then on to the recommendation then.

12 COMMISSIONER DAVIDSON: I move the adoption of the
13 recommendation as drafted.

14 COMMISSIONER BRANCO: Second.

15 COMMISSIONER ERICKSON: Any discussion?

16 CHAIR HURLBURT: All in favor aye? Opposed? Okay.

17 COMMISSIONER ERICKSON: Thank you. Behavioral health,
18 straight to the recommendations.

19 CHAIR HURLBURT: You know, just thinking back on Val's
20 question, Val is going to need to leave, and just out of
21 consideration of you, Val, was there one you particularly
22 wanted us to take before you had to go?

23 COMMISSIONER ERICKSON: Are you leaving? When are you
24 leaving?

25 COMMISSIONER DAVIDSON: (Indiscernible - away from mic)

1 COMMISSIONER ERICKSON: Oh, okay.

2 COMMISSIONER DAVIDSON: (Indiscernible - away from mic)
3 I have a comment. So I thought the first bullet was really
4 great in terms of integrating behavioral health with primary
5 care, but I think the second bullet -- and I'm not exactly
6 sure how to make this work, but I thought the second bullet
7 was kind of thin. Behavioral health is more than just about
8 primary care. Primary care is really where you -- is our
9 biggest opportunity to be able to catch it at its first
10 instance, but I think we need to spend some time on, now that
11 we've caught it, what do we do about it because, right now,
12 people can expect to wait six, nine months if they're ready
13 for treatment today, and it just seems like we're not quite
14 there. The second bullet seems to be about primary care, and
15 it.....

16 COMMISSIONER ERICKSON: This was one of the challenges
17 that we ran into with this issue. What we were doing was
18 actually studying the burden of behavioral health challenges
19 in the population. We weren't studying the service delivery
20 system, but what happened was, when we asked Director Stone to
21 come up with some suggestions for improving population health
22 generally related to behavioral health -- because that was the
23 issue we were discussing, and we weren't discussing access to
24 behavioral health services, and again, it's not that that's
25 not critically important. It just -- we have to stay focused

1 and on our agenda, or else we're not going to get anything
2 done. So that's why -- these were the three suggestions she
3 had made related to overall population health support related
4 to behavioral health, and it's more service-oriented than the
5 more public health type stuff.

6 COMMISSIONER DAVIDSON: Then I would recommend an edit to
7 the second bullet, and delete everything after the fourth line
8 where it says "methodologies for state supported behavioral
9 health services." I would delete the rest of that and add a
10 period at the end because I think the first bullet is all
11 about that facilitation. I think you've already done it. I
12 think the second bullet should really be about the behavioral
13 health services, and I think deleting that, does that.

14 COMMISSIONER ERICKSON: Did I get the brackets in the
15 right spot? Any other suggested changes? Entertain a motion?

16 COMMISSIONER BRANCO: Is it my turn? I'll make a motion
17 to adopt the recommendations.

18 COMMISSIONER MORGAN: Second.

19 CHAIR HURLBURT: David. Any discussion? All those in
20 favor of the recommendations as amended, aye? Opposed the
21 same? It's unanimous. Thank you.

22 COMMISSIONER ERICKSON: This is very helpful. On to
23 Payment Reform. I'll ask if there are any burning issues
24 related to finding statements before we move on to
25 recommendations.

1 COMMISSIONER HIPPLER: I do have one. The very first
2 bullet talks about current fee-for-service payment structures,
3 "reward delivery of high numbers of costly services." That's
4 probably correct, and I would add onto that. I would say
5 current fee-for-service and third-party payment structures.
6 Fee-for-service without third-party payment wouldn't result in
7 this distortion.

8 COMMISSIONER ERICKSON: Does anybody have any objection
9 to that change? Okay. Any other questions or comments about
10 the current draft of the finding statements? So moving on to
11 recommendations.

12 COMMISSIONER DAVIDSON: Just one comment. I don't have a
13 change. I just wanted to applaud your emphasis on value in
14 the first recommendation.

15 CHAIR HURLBURT: I'd raise a question, I think, won't be
16 quite as much a can of worms as the last one, but do we want
17 to specify at all an All Payer Claims Database for Alaska,
18 like many states have?

19 COMMISSIONER ERICKSON: That is specified in our next set
20 of recommendations related to transparency, and what I tried
21 to do to show the link is, under recommendation three for
22 payment reform, note the importance of health data reporting
23 measurement and analytic capacity.

24 CHAIR HURLBURT: I see I was forgetting that. I thought
25 we had it and then I didn't see it, so thanks.

1 COMMISSIONER ERICKSON: Val and then -- what's your name?
2 Jeff.

3 COMMISSIONER DAVIDSON: I had a question on bullet -- on
4 recommendation number three. It recommends the state of
5 Alaska develop health data reporting, et cetera, et cetera, et
6 cetera, and I thought we keep a hearing a theme from providers
7 and et cetera that they're already providing all kinds of data
8 and information and it's really -- so I just want to make sure
9 that we're not going to be -- is our recommendation here using
10 the existing data and transforming it in a way that's useable
11 or is this going to be interpreted as requiring yet another
12 transmission of data? It's not clear, to me, what that is
13 asking for.

14 COMMISSIONER ERICKSON: Jeff?

15 COMMISSIONER DAVIS: Val, my point may tie to your
16 concern, and I was going to suggest that, in recommendation
17 three, we specifically say, you know, for example, All Payer
18 Data -- what are we calling it, All Payer Claims Databases, so
19 as an example of the kind of data collection we're driving
20 because that is focused on payers, not on providers. So it's
21 taking existing -- reporting that providers are already doing,
22 having the payers then report that in a way that can be used
23 for these purposes. See what I'm saying, Deb? So I'm trying
24 to tie it to the transparency finding.

25 COMMISSIONER ERICKSON: I see what you're saying. I'm

1 just -- I'm questioning what.....

2 COMMISSIONER DAVIS: As an example, so not just saying
3 this is what -- but as an example or such as.

4 COMMISSIONER ERICKSON: I understand what you're saying.
5 I would question whether that's sufficient to get at the issue
6 that Val is raising.

7 COMMISSIONER DAVIS: Fair enough. That's one way.

8 COMMISSIONER ERICKSON: If Val thinks so, then -- and if
9 Noah thinks so.

10 COMMISSIONER LAUFER: We could put, you know, a word like
11 meaningful in there. That would be helpful to me. And
12 apparently, this is the battle that the AFP is in right now.
13 They would prefer simple, clearly meaningful data points that
14 are reported by somebody other than the physician because, if
15 it's just a wish list of what you want your doctor to do, you
16 know, it becomes ridiculously onerous, and often, is not
17 valuable. Yeah (affirmative).

18 And the other -- there are a couple different little
19 things. You know, the electronic medical record systems are -
20 - there are 900-and-some in the country, and they don't
21 communicate, and data is not put in right, and you know, it's
22 just a mess at this point. And on top of that, medicine
23 shifts and changes. So what's meaningful now is not
24 meaningful in the future, you know. There was just a urology
25 one; Vitamin E and selenium was supposed to prevent prostate

1 cancer, and it turns out your risk goes up by 17%. So how
2 long will it take of bureaucratic measure to catch up with bad
3 data? A long time. And for that three years that I'm doing
4 what I think is right for my patient and arguing with them,
5 I'm being dinged, and you know, told I'm the bad doctor. You
6 know, it's ridiculous. Health care should not be legislated,
7 the specifics.

8 CHAIR HURLBURT: I think, around the country where the
9 reality is, we have less data than almost anybody else, but
10 the sources of the data are either payers or hospitals, and
11 you know for the practical reasons that Noah has talked about,
12 it really isn't put -- the physician data comes from the
13 payers, from the claims data and that's pretty good.

14 COMMISSIONER LAUFER: But this can be fairly specific in
15 that, you know, you can't bill, unless vital signs on a chart
16 and the labs are numbers, which are easily transmittable and
17 comb-able and comparable.

18 CHAIR HURLBURT: Pat?

19 COMMISSIONER BRANCO: So I view this recommendation as a
20 very wide -- from my perspective, there would be increased
21 cost in complying with an extra provision of data, more people
22 hired just to do data mining and transmission to accomplish a
23 goal that we already believe in. Payment reform is necessary.
24 Karen Perdue, yesterday, mentioned that we ought to look at
25 the All Payers piece. So it's for the next recommendation

1 with a feasibility study, what are we actually -- and more to
2 Noah's point, what's meaningful data? What can we actually
3 have an effect on? What are the data sources that can get us
4 there with the least amount of cost that I would have to cost-
5 shift to the payers. Again, no organization can absorb that
6 cost. So this seems to be an awfully broad recommendation to
7 get data that will provide meaningful information for us to
8 act on, and I don't have a recommendation for how to narrow it
9 specifically to get the most meaningful data, but getting the
10 information is critical to making this a successful
11 recommendation for real health payment reform.

12 COMMISSIONER ERICKSON: Can I suggest that -- do we agree
13 that we need -- without getting into the specifics, do we need
14 a common set of health data that we, payers, providers,
15 patients, everybody, can trust.....

16 COMMISSIONER BRANCO: Yes.

17 COMMISSIONER ERICKSON:in order to move forward
18 with some sort of payment reform? I think that's what this is
19 meant to get at without trying to get into, again, the next
20 level of weeds, which maybe we can get into a little bit in
21 our transparency recommendation. Val?

22 COMMISSIONER DAVIDSON: Except I -- you know, now that I
23 look at it and sort of take a breath and read it again, I
24 think the lack of detail and the lack of specificity is going
25 to give somebody all kinds of leeway to say, oh look, this is

1 what they meant. This is what they said, and I think we
2 should be careful on something as important as this issue.

3 COMMISSIONER BRANCO: So to Karen Perdue's point
4 yesterday and the one I'm reiterating here is, perhaps, a
5 feasibility study should be a low-cost endeavor in order to
6 find out what is the real useful data that we should be mining
7 and what payer sources, if it's All Payers or if there is a
8 good collection that we can get inexpensively, we might be
9 able to do just that and have a specific recommendation to
10 that.

11 CHAIR HURLBURT: Could -- to get at Val's comment and
12 your concerns, could you be specific because the terms do have
13 meanings and they are used nationally? All Payer Claims
14 Database means all payers, including the State, plays in that
15 game, and for hospitals, the hospital discharge reporting,
16 which you do now. So you can look at your hospital and get
17 the kind of data, readmission rates, and various things that
18 you look at in the hospital without really imposing more of a
19 burden on you, but it would be recommending that all hospitals
20 would do that.

21 COMMISSIONER BRANCO: If that were the case, I would be
22 very comfortable with this recommendation. There is an
23 implied broadening of the data mining needed to get at genuine
24 payment reform. It's not just discharge data. That's one
25 small factor of our payment issues, and as we become more

1 medical center rather than hospital, it's no longer the
2 inpatient business that's at play. It's home health and long-
3 term care and clinics and all the operations that we engage
4 in. So the payment reform is much broader, and this
5 recommendation is fairly broad, too. If it was only discharge
6 data, inpatient and outpatient discharge data, no sweat.
7 That's already accounted for. Then this recommendation would
8 be unnecessary, other than having an analytics staff evaluate
9 the data and provide useful recommendations from their
10 perspective.

11 COMMISSIONER LAUFER: I think this is being pushed
12 towards nationally already, right, and the idea would be that
13 the meaningful data points are chosen by doctors and
14 hospitals. So I mean, it gets at these fundamental questions,
15 what's health? We did a longitudinal study of your patients,
16 and ultimately, they all died. What the hell's wrong? But it
17 should be driven by, I think, the docs, and ultimately in a
18 way, by the patients, really. What's meaningful to you?

19 COMMISSIONER FRIEDRICHS: If I may offer an observation -
20 - and this is kudos to my colleagues and the VA -- their bonus
21 structure for their clinical staff actually is based on
22 outcomes/measures, but they do let the staff choose which
23 outcomes/measures on which they would like to focus that year
24 and so there's -- you can't cherry pick. You can't say well,
25 I'm doing really well in these five, so I'm just going to keep

1 choosing these five over and over every year, but they offer
2 them. Here's all the stuff we can measure. Here's what
3 you're doing right now and then you pick five of them. And I
4 offer that as an observation of an enterprise level decision
5 to give some level of autonomy and ownership of that data
6 along the way. It seems to have worked well for them, based
7 on their outcomes.

8 COMMISSIONER ERICKSON: I'm wondering if we're talking
9 about two different data uses though. What we were attempting
10 to address in this recommendation wasn't -- and to, I think,
11 Pat and Val's point, this was too broad -- so broad that we
12 weren't being specific enough, but we were trying to augment
13 our other recommendations related to the need for payment
14 reform specifically, that we need better than we have now data
15 that payers and providers especially who are going to need to
16 work together on business deals and come to business
17 agreements, that they need to have a common set of data that
18 they agree on in order to be able to reach these agreements
19 about they're going to pay for care differently.

20 COMMISSIONER LAUFER: This is going on and on, and this
21 is the discussion happening in everybody's head, but you know,
22 it would be easier, I think, for Jeff to sell insurance if he
23 could say this is how much it costs and this is what you're
24 getting. Here's meaningful benefit to, you know, your
25 employees, and this is how health care cost is going to be

1 lowered. So the question for me is then, like I said
2 yesterday, what do you want me to do? What do we focus on?
3 What is actually our job in this preventative medicine world,
4 this wellness medicine world? And I think that, if we're
5 going to be asked to make people healthier, the measure of
6 health needs to be docs. And all of these new plans or ideas
7 say we're going to pay you, but you know, some part of your
8 payment is going to be dependent on how good a job you do. So
9 if we're going to put all that effort and our life into this
10 calling, it should be meaningful and not just -- what was the
11 term -- a burden; yeah (affirmative).

12 COMMISSIONER ERICKSON: Jeff?

13 COMMISSIONER DAVIS: Thanks. I'm hearing three things or
14 more, one, the concern that the lack of specificity makes it
15 open to interpretation that could be too broad. I'm hearing
16 that we don't really know what it is we're recommending and
17 perhaps we should look at, you know, feasibility and efficacy
18 of the data. And so perhaps we could answer all of those by
19 changing our recommendation to that the State conduct a
20 feasibility and efficacy review of the establishment of two
21 things, the All Payer Database and all hospitals participating
22 in the discharge database. So we limit it, but at least,
23 those are the two big things. And then I think it's later on
24 in transparency -- so since we're talking about payment
25 reform, at least, we'd have that as a starting point.

1 And then to your point, Noah, maybe it then evolves into
2 something else, or maybe in the feasibility and efficacy
3 study, we find what is meaningful and not just a burden.

4 COMMISSIONER LAUFER: So would the result of this be you
5 could say, for the community, here's a group of people who are
6 doing really badly and we're spending a lot of money on them
7 and evidence shows that we could do better? Is that -- you
8 know, because that's really what we're looking for is the low-
9 hanging fruit, the people we could really help and the people
10 we just need to have our attention turned to or the disease
11 states or whatever.

12 COMMISSIONER DAVIS: I think that's maybe down the road,
13 the result. I think, initially, it's a little bit like -- I
14 hazard to do this, but a little bit like the Milliman study is
15 that we don't know what we don't know because there is no
16 place to look. We don't know what's going on from the big
17 picture hospital side. We don't know what's going on big
18 picture All Payer. So we're guessing as to where the problems
19 are in some circumstances. If we had All Payer and could
20 connect it, then that would lead us. That would say fact/
21 fiction. No, that's not a road. That's not a productive
22 road. This is a productive road and lead us on to something
23 else. That's how I'm viewing it.

24 COMMISSIONER ERICKSON: So if All Payer Claims Database
25 and hospital discharge databases are, my understanding

1 essentially, the state of the art and what all states either
2 have or are moving to as the two major kind of complementary
3 data sets, what are we going to accomplish with doing a
4 feasibility study, if we all agree that we don't have
5 sufficient data for making these decisions right now and that
6 Alaska is behind the curve? Dave?

7 COMMISSIONER MORGAN: It's like I go back to my analogy
8 of pornography. I can't define it, but when I see it, I
9 recognize it. My suggestion is taking what you're suggesting,
10 which is a Milliman-like study approach to find these things
11 out, but I think we should have the money allocated to the
12 Commission. My experience, especially in the bureaucracy of
13 state government, things get delayed, slowed down. I think,
14 after we get our final Milliman report and while we're
15 digesting it, we should let another contract to do exactly
16 what we're talking about now, and it doesn't have to be a
17 massive contract, but if we do it through the Commission and
18 the money is allocated, I know it would be done within three
19 to six months, not over years where, basically with cost
20 containment just in state government, it's sort of, well, it's
21 going to be one of the 18 things we're going to get done this
22 year. So whatever we come up with, if it's a study,
23 feasibility study, literature review, let's do it through the
24 Commission. Let's let a contract. We had a couple of
25 presentations of organizations that do this. So let's go down

1 that road.

2 COMMISSIONER ERICKSON: Go ahead.

3 COMMISSIONER BRANCO: I have two points. One is an
4 example to Noah's question to Jeff, and strictly on payment
5 reform, what would health information data provide that could
6 actually shape that? It's already in the Health Reform bill,
7 but one action going on right now is reducing payments for
8 hospital readmissions for congestive heart failure within five
9 days. This is -- don't pay for that. That would be a health
10 reform that we could have data-driven with exceptions and
11 clauses built in, but the analysis of hospital discharge data
12 and the All Payer isn't as prolific across the nation yet.
13 There's certainly a move in that direction, but as I stated
14 earlier, discharge data is really, really minimal data for
15 driving specific actions on payment reform. Payers can tell
16 me, based on discharge, the number of pneumonia patients that
17 discharged and an average cost per stay of \$4,600. Perhaps
18 that's too high when your cost is only \$3,000. That's a
19 shrug-of-the-shoulder piece of data. It's not really
20 meaningful in how we manage the pneumonia patient into the
21 future because the hospital data isn't broad enough to really
22 help drive the value equation.

23 COMMISSIONER LAUFER: What I'm looking for is something
24 that, you know, is beyond the state government, which is
25 actually happening among doctors, physicians, and payers. And

1 what we need, I think, help with if we're going to change this
2 -- and there are many doctors who don't feel -- we don't feel
3 this is "our problem," but in any case, what we need help with
4 is here is some fertile ground. Here is a disease state that
5 we're really doing a bad job at and we're losing money at.
6 And then, you know, we can coordinate. We can coordinate with
7 the payers. We can coordinate with the hospital, the hospital
8 lists, and the outpatient docs and say, how can we do a better
9 job at managing congestive heart failure or diabetes or COPD
10 or pain? Pain is a great one. But what we need to kind of
11 know is where should we be looking. Where is the starting
12 point, the low-hanging fruit? And I think, you know, the
13 information isn't perfect for sure, but I mean, Jeff said
14 he'll get me a list of problems. But I think that's the place
15 to start, and there is an incentive to do that. So you know,
16 maybe the cardiology group works with an outpatient group or
17 works more closely with whomever and say here are, you know,
18 clear, easy places where the community could do a better job
19 and save some money, but we don't know where the light is that
20 should be shined.

21 CHAIR HURLBURT: Allen and then Paul?

22 COMMISSIONER HIPPLER: Thank you, Doctor. So I just
23 wanted to bring up that, in transparency in our
24 recommendations, we recommend to develop an All Payer Claims
25 Database. And then in this one, we're recommending.....

1 COMMISSIONER ERICKSON: Yeah (affirmative). I think
2 we're actually talking about changing both sets of
3 recommendations at this point.

4 COMMISSIONER FRIEDRICH: I'd just offer the caution, and
5 I'll go back to another role that I play as the Air Force Rep
6 to the American Medical Association. Some states and
7 organizations have misused this data to implement an economic
8 privileging or economic credentialing process, which in the
9 short term, may appear to be cost-effective, but in the long-
10 term, often can be very counterproductive. And my point in
11 offering the VA example is, again, Alaska is building a system
12 that doesn't exist today. You know, there is just not this
13 whole infrastructure.

14 The challenge for Alaska and the opportunity is to build
15 it in a collaborative fashion, so that, if you collect this
16 data, the clinicians who are, essentially, being judged by it
17 have an opportunity to participate, if they choose to, in the
18 interpretation of the data. And I'm not sure -- you know,
19 that's getting a little wordy to put into a recommendation,
20 other than to say whether it's under transparency or payment
21 reform care that data interpretation should include or should
22 the opportunity for all involved parties, both clinicians and
23 -- going back to Allen's excellent point of the beginning of
24 the morning -- patients to provide input on the interpretation
25 of the data. From a patient-centered standpoint, ultimately,

1 this data should not be solely a tool for payment reform, i.e.
2 cost containment. It should be a tool, as you're describing,
3 for improving the quality of care and improving the patient's
4 perception of quality of care.

5 COMMISSIONER DAVIS: This discussion reminds me a little
6 bit of that famous health care economist Yogi Berra who said,
7 if you don't know where you're going, you're liable to end up
8 someplace else. And we don't know where we're going because
9 we don't know where we are. We're in double jeopardy. And I
10 can -- we can work our data, but that's only one piece of the
11 puzzle. So I think I agree completely with what you said,
12 Paul. Within a human endeavor, this can be misused, so let's
13 make sure it's not by having everyone involved.

14 But also to Noah's point, we need a broader view to know
15 where the low-hanging fruit is, which is why, you know without
16 any input from my Chief Information Officer, I'm saying yeah
17 (affirmative); we need an All Payer Database because it is
18 important, and I cannot tell you how many times we've tried to
19 go down a path that's either involved with transparency or
20 quality and we get to the point we say, but there is no
21 available data for Alaska, and I would like to see the day
22 when we don't have that conversation anymore and we can go
23 past that. So thank you.

24 COMMISSIONER KELLER: This is probably redundant, but the
25 question, I guess, that I'm having in my mind is, how far can

1 we go in this recommendation to actually how the data is going
2 to be used? We've got the consumer, the patient. We've got
3 the businesses. We've got the providers all looking at this,
4 but you're also going to have policymakers looking at it,
5 whether it's at the legislative level or whatever. You know,
6 I mean, so when we make the recommendation for this, we want
7 as much entered as possible, I'm not sure how far we can go to
8 control how that's used anyway. So I don't know how. I mean,
9 I just get lost when I try to think about the recommendation
10 including, for example, favoring the providers looking for
11 where they can catch the low-hanging fruit, for example. I
12 mean, just, you know, every user of this data is going to have
13 a different angle.

14 CHAIR HURLBURT: Deb, if you've got wording?

15 COMMISSIONER ERICKSON: Yeah (affirmative). I've been
16 typing away, and I don't know what any of this means. I want
17 to go back and comment on Dave's suggestion that, if we're
18 going to suggest any sort of study, I would agree that, if we
19 just make a general recommendation, then we're going to be
20 sitting around three years from now waiting for the State to
21 do a study, and if we really do need to do a study first, then
22 I would agree that the Commission just needs to do with our
23 existing budget within our agenda. So I guess that's one
24 comment I have, and this will not be in our recommendation
25 statement, but I just threw it here so it was all on the same

1 page, showing up now on our screen as number five that we
2 would add that to our agenda. And I tried to capture, in
3 that, that these feasibility and efficacy studies would look
4 at the use of this data not just for payment, and for payment
5 reform, and also for supporting clinical process improvement.
6 Does that get at the issue that you were -- is there a better
7 way to word that, do you think?

8 COMMISSIONER FRIEDRICHS: I guess, if I might offer, that
9 data collection or a central data repository should be a tool
10 rather than data improvement because that's -- I'm not sure --
11 data improvement is a term that I'm not completely familiar
12 with, but data collection should be a tool for quality
13 improvement and payment reform. Cost containment is, again, a
14 potential outcome of payment reform, but part of what Noah was
15 getting at, which I absolutely agree with, with payment reform
16 would be appropriate (indiscernible - voice lowered) for
17 primary care, for example, and that's not really a cost
18 containment issue as much as it is a reform issue. And if you
19 put a period right there and then just take out the
20 development -- I think you can take out the data development
21 part, but just say data analysis and use decisions should
22 involve clinicians, payers, and patients.

23 COMMISSIONER ERICKSON: What if I include -- I mean, it's
24 not just analysis and use. It's actually collection. I mean,
25 we want clinicians to have input into identifying what's going

1 to be collected, right?

2 COMMISSIONER FRIEDRICH: Yeah (affirmative). That's a
3 fair point. And the biggest one that, you know, we've
4 struggled with in other states has been the QD (ph) mix. If,
5 you know, New York, for example, started reporting data on
6 some of their clinicians and initially did not report that Dr.
7 Laufer was taking care of very ill patients and Dr. Friedrichs
8 was taking care of very healthy patients, they just said that
9 Dr. Friedrichs' patients had fewer deaths and Dr. Laufer's
10 patients died more frequently, so everybody thought I was a
11 good doctor, except those people who knew me, then, you know,
12 so there's that important filter piece where someone has to
13 look at it and say yeah (affirmative), but we need to include
14 this caveat as you're presenting this data, and whether that
15 comes from the patients or from the clinician, there still
16 should be an opportunity. We really have the chance to do
17 that right up front.

18 CHAIR HURLBURT: Are we ready for a motion? Thank you,
19 Val. You're leaving us, right?

20 COMMISSIONER ERICKSON: Before we have a motion, let me
21 suggest what we're making a motion on. I think we are
22 removing what was recommendation three and replacing it with
23 what shows on the screen here now as four. The new
24 recommendation would read, "the Alaska Health Care Commission
25 recommends the state of Alaska develop health data collection

1 and analysis capacity -- capability/capacity as a tool for
2 quality improvement and payment reform. Data collection
3 analysis and use decision should involve clinicians, payers,
4 and patients." And then our 2012 agenda item we'll discuss
5 separately, unless it needs to be accompanied by that. It
6 doesn't? Okay. So that's the change, replace existing number
7 three with the new number three, which reads here is number
8 four with.....

9 CHAIR HURLBURT: Allen?

10 COMMISSIONER HIPPLER: I'm sorry, Val. I have a quick
11 question. I'm really sorry. So if a -- you say data
12 collection analysis and use should involve patients. So the
13 use of data should involve the patients; what does that mean?

14 COMMISSIONER FRIEDRICHS: So I would offer that, if
15 you're going to use any patient-specific data, HIPAA requires
16 that the patient have an opportunity to concur with that, and
17 there's an education piece that goes along with that. If
18 you're going to use aggregate data, let's say for a study that
19 we want to do on patients with chronic pain and treatment
20 options for them, there are mechanisms to do that by which you
21 inform the patient that the mass of data will be used, and
22 they can opt out of it. We, as an enterprise, I believe, have
23 an obligation to patients to tell them that their data is
24 going to be used in some fashion. Again, it gets back to that
25 patient-centered aspect of it. Ultimately in the purest form,

1 the patients should own their data. They should have the
2 right to say what we do or do not do with it, and well at
3 least, offer editorial comments to it. They can't change
4 their BMI, no matter how much they want to wish that they were
5 not obese, but they could put in, "I don't look that fat," if
6 that makes them feel better.

7 CHAIR HURLBURT: Does that help, Allen? Okay. Are we
8 ready for a motion? Keith. And second, Noah. Any
9 discussion? All in favor, aye? Opposed the same? Okay. We
10 have one other area left, transparency, and we've actually
11 discussed the recommendations there. I think that
12 transparency and payment reform are, clearly, two different
13 areas, but as we can see, there is a close relationship there.
14 Deb, I don't know if you want to have any comments on that?

15 COMMISSIONER HIPPLER: Dr. Hurlburt?

16 CHAIR HURLBURT: Yes?

17 COMMISSIONER HIPPLER: I have a comment on transparency.
18 In our first bullet point -- oh, you're on the second one. In
19 the first bullet point on slide 36, which, of course, Deb has
20 changed the numbers, so I think it's her 40.....

21 COMMISSIONER ERICKSON: So are you talking about Findings
22 or Recommendations? That will helpful.

23 COMMISSIONER HIPPLER: Findings. We're still on
24 transparency findings, right?

25 COMMISSIONER ERICKSON: Yes. Yes.

1 COMMISSIONER HIPPLER: We talk about empowering consumers
2 and health care providers with access to information on the
3 cost and quality of care. I think I would add a bullet after
4 that saying that, currently, patients lack incentives to see
5 value. The reason is because, even if a consumer knows and
6 understands the cost of care, for a large portion of the
7 population -- for some people, they would care deeply. For a
8 large portion of the population, they have no incentive to
9 seek value. Or I just don't pay for it and let somebody else
10 pay for it.

11 CHAIR HURLBURT: Anything else?

12 COMMISSIONER FRIEDRICHS: Allen, would you entertain a
13 friendly amendment to modify that to say, "patients have few
14 incentives to seek value?" I think there are some who do look
15 at it. I get patients who come in and have done their
16 Internet research and want to spend an hour talking about what
17 they heard on Oprah and that's great. So there are some who
18 do it, but there are few incentives, other than their personal
19 information.

20 COMMISSIONER HIPPLER: How about "some patients lack
21 incentives?" Instead of "patients have few incentives," we
22 could say "some patients lack incentives." I would prefer
23 that.

24 CHAIR HURLBURT: Anything else on the findings? The
25 recommendations are pretty specific here. Yeah (affirmative)?

1 COMMISSIONER BRANCO: They're beautifully specific, and I
2 just want to endorse them as being right on target for what we
3 should be doing, and the state encouraging all hospitals
4 participate in the discharge database, inpatient and
5 outpatient is really, really important. Secondly, the
6 Hospital Association is committed to adding emphasis to all
7 hospital participation.

8 CHAIR HURLBURT: Right. Yeah (affirmative). So we're
9 coalescing there. Is there a motion to accept the
10 recommendations on transparency? Allen?

11 COMMISSIONER HIPPLER: So we're leaving in the
12 recommendation to develop the All Payer Claims Database here?
13 Okay. I was confused with the last one, and I didn't have
14 time to ask questions before Ms. Davidson left. Do we still
15 have a recommendation in payment reform to conduct a study on
16 whether or not we should form an All Payer Claims Database?

17 COMMISSIONER ERICKSON: We actually don't have a
18 recommendation for the state of Alaska to do it. What I did
19 was put it on the Commission's 2012 agenda that the Commission
20 will study.

21 COMMISSIONER BRANCO: I have one more comment in here,
22 and because it isn't transparent yet, one of the key
23 challenges that's in our findings as well, but it's not in the
24 recommendations, I'm hoping that, one day, we get to the point
25 where price transparency exists in our state, in particular.

1 Hospital X being able to talk to Hospital A, Physician A talk
2 to Physician B about the pricing strategies that we employ.
3 That being very careful because price fixing and the drive of
4 referrals, the violation of STARK, antitrust, all of those
5 issues are there. However, there is the potential to have
6 aggregated data where we can truly talk to each other about
7 keeping costs under control.

8 Today, I have no clue what the charges across the state
9 are for parallel procedures in any other hospital. I just
10 don't know and that's a crippling feature when we have that
11 incomplete data and so I would advocate that we keep it in our
12 findings and continue to work towards price transparency.

13 CHAIR HURLBURT: Noah?

14 COMMISSIONER LAUFER: No.

15 CHAIR HURLBURT: Okay. Any other comments? Is there a
16 motion? Second? All in favor, aye? Opposed same? Okay.
17 Shall we take a break now and come back with our 2012 plan?
18 It seems like a natural place. About ten minutes.

19 10:35:36

20 (Off record)

21 (On record)

22 10:44:29

23 CHAIR HURLBURT: We want to talk about our planning for
24 2012 at this point. On the handout that Deb had for us,
25 you'll find that on page 20.

1 COMMISSIONER ERICKSON: Where are you at? What's 20?

2 CHAIR HURLBURT: Well, just one back of that is what you
3 have. I just have the.....

4 COMMISSIONER ERICKSON: The colorful ones. Good. That's
5 what I wanted to.....

6 CHAIR HURLBURT: Yeah (affirmative), the Potential
7 Agenda.

8 COMMISSIONER ERICKSON: Still behind tab two in the -- it
9 should have been in the front. Well, I don't know how --
10 maybe you didn't put it together that way. Or do you have it
11 pulled out? I think you have it pulled out, Noah, to your
12 right. No, to your right. That's it. That's it.

13 A little bit further on in here, I actually have kind of
14 a simplified outline of the things that were on our list, but
15 I thought it might be helpful -- it may or may not be helpful,
16 but just to revisit the graphics that we had used to try to
17 organize the ideas, the different strategies that we were
18 considering, and as we identified what we were going to study
19 for this year, we used these graphics that were organizing
20 strategies in a couple of different ways around, let's see,
21 potential strategies for driving improved value in health care
22 delivery, improved access, focusing on prevention, statewide
23 leadership information, infrastructure, and workforce as the
24 foundation pieces.

25 So we have a variety of strategies and areas of study

1 organized in these different ways. If this continues to be
2 helpful or not, I don't know, but what I did was I went
3 through our color coding to identify the things that we
4 currently have in our recommendations. So this first slide,
5 for example, for value where we've continued to develop
6 recommendations related to innovation and primary care,
7 evidence-based medicine, now adding price and quality
8 transparency and what we were calling value-driven purchasing,
9 I think we'll just have that generalized and leave it
10 generalized for payment reform. We were intending, at the
11 beginning of the year, to focus specifically on bundled
12 payment systems, but I don't think we had the -- we had some
13 more foundational work we needed to do before we got into
14 those specifics, I think.

15 So the things related to the strategies, related to
16 driving value that have been on kind of our parking lot I've
17 colored here in yellow. So end-of-life care has come up a few
18 times and that was something that Wayne used to be a champion
19 for. The health plan and benefit design is related to the
20 employer's role. It's not limited to that, but it's very
21 related to that. Fraud and abuse. Malpractice reform.

22 So anyway, I'm not going to dwell on these slides, unless
23 any of you, in particular, want to dwell on them or use them,
24 and just go on to the list of potential 2012 agenda items, and
25 a couple of points about why we're identifying this now. We

1 would like to put the preliminary list out for public comment,
2 invite back comment from the public on whether they think our
3 plans for what we're going to focus on in the next year,
4 whether they think that we're on the right track and if they
5 have suggestions or feedback on that, and this is going to
6 determine how we spend our time and our resources next year as
7 well, this next calendar year. So it's important that we get
8 that set now, partly understanding how slow government can
9 move, and we need to start working towards getting contracts
10 in place, if it's going to involve more study.

11 So any questions about what we're doing right now, just
12 drafting the list of areas that we want to continue studying
13 about the current system and strategies for innovation that we
14 want to study for the coming year and develop recommendations
15 around?

16 COMMISSIONER LAUFER: Are these listed in any, you know,
17 particular list of hierarchy because.....

18 COMMISSIONER ERICKSON: They are not. I've only -- they
19 are not prioritized on this list, and I've organized them a
20 little bit around -- well, the bottom bullet -- an assumption
21 that we're going to continue, at least, tracking our existing
22 recommendations and then the -- I guess I don't -- I have them
23 organized around whether they're related to studying the
24 current system or innovations in patient-centered care -- or I
25 guess this is a foundational piece. Anyway, I've organized

1 them around our process, and they're not in priority order.

2 COMMISSIONER FRIEDRICH: So I'll offer the caveat that
3 this is my last meeting. I will be in Korea for the December
4 meeting. I'll remain involved as we finalize our report for
5 this year.

6 So my comments are suggestions for those of you who will
7 be on the Commission next year, and I think Allen's comments
8 about barriers is an absolutely fascinating opportunity to get
9 into, really, a number of the items that are on here, whether
10 you want to call them innovations, transformations, whatever
11 "ation" term you want to use. Letting -- offering the
12 opportunity, at an early meeting next year, for the health
13 care enterprise to come to us with their barriers as they
14 perceive them would be the first time that I can think of that
15 a state has opened up in such a fashion and the Commission has
16 taken that and looked at it. So I would just offer, again, I
17 think that was a brilliant suggestion that he raised. It
18 might help further shape the agenda for the remainder of the
19 year and certainly could make for a dynamite report at the end
20 of next year.

21 COMMISSIONER ERICKSON: So I've added that a potential
22 agenda item, state of Alaska barriers -- it's not worded very
23 eloquently -- perceived by health care providers to
24 innovation. I'm getting the concepts there. I'll make it
25 sound prettier.

1 COMMISSIONER FRIEDRICHS: Yeah (affirmative), but I would
2 offer, you know, that it's patients, providers, payers. I
3 mean, really this, hopefully would be a wide enough
4 opportunity that you could input from the different facets of
5 the enterprise.

6 COMMISSIONER ERICKSON: Other suggestions? Yes, Keith?

7 COMMISSIONER CAMPBELL: A question, did I dream it? Are
8 we going to have a section in our report at some point of any
9 noted successes? I don't know that we've had many so far, but
10 we would anticipate having some, moving this beast a little
11 bit, and would we note those in the report to the Legislature
12 and the Governor, if and when we achieve any success?

13 COMMISSIONER ERICKSON: We being?

14 COMMISSIONER CAMPBELL: The Commission's report to them.
15 If.....

16 COMMISSIONER ERICKSON: Whose success?

17 COMMISSIONER CAMPBELL: Well, of the system. Say we get
18 payment reform or some of this (indiscernible - simultaneous
19 speaking).....

20 COMMISSIONER ERICKSON: It's woven in.

21 COMMISSIONER CAMPBELL: Woven in, but.....

22 COMMISSIONER ERICKSON: Relevant to each of the themes.

23 COMMISSIONER CAMPBELL: Yeah (affirmative). I understand
24 that, but I -- to me, it might be a little subtle for the
25 casual reader. I don't know.

1 COMMISSIONER ERICKSON: For each of the categories of
2 issues that we're studying and if you go back and look at the
3 2010 report, I'm planning on doing the same thing in 2011 is,
4 in each chapter, there is a discussion of what's happening
5 today in Alaska related to that particular strategy or issue,
6 very specific, the Primary Care Association.....

7 COMMISSIONER CAMPBELL: See, it's even too subtle for me.

8 COMMISSIONER ERICKSON: You just didn't -- you just don't
9 sleep with that report under your pillow. Well, so what are
10 you suggesting, if describing it in the narrative is too
11 subtle?

12 COMMISSIONER CAMPBELL: Well, I don't have a preconceived
13 idea of how it ought to be highlighted, but it's just
14 something that I was thinking. It just popped into my head.

15 COMMISSIONER ERICKSON: Are you suggesting that we
16 should, in addition to studying barriers, we should also
17 study.....

18 COMMISSIONER CAMPBELL: Well, if those barriers come down
19 at some point, then we ought to note them.

20 COMMISSIONER ERICKSON: Oh, sure. Sure. Sure.

21 COMMISSIONER LAUFER: Is it worth, or you know, safe to
22 point out or differentiate between barriers at a state level
23 and barriers from PPACA or federal level? You know if we do
24 have an opportunity to say, you know, here's a significant
25 barrier, a specific aspect of the federal law that we'd like

1 an exemption from, it might be a useful thing for us to do.

2 COMMISSIONER HIPPLER: I'm no fan of federal regulation,
3 but that being said, I think that our comparative advantage is
4 handling state activities. I think we have a little more
5 control over that. We have more influence on that. I suppose
6 it's possible, if we found one regulation, that we could argue
7 because our state is so far-flung it shouldn't apply to us.
8 We could try, but I don't see that as a recipe for success.

9 COMMISSIONER ERICKSON: Other suggestions for issue areas
10 to add before we start? I think we need to do a little bit of
11 prioritization because I don't know that we'll be able to do
12 everything that's on this list. Yes?

13 COMMISSIONER DAVIS: What about the things we have in the
14 parking lot? Are we adding those by implication or should we
15 deal with those?

16 COMMISSIONER ERICKSON: So I will add, let's see,
17 workforce. What else do we have up there? Does somebody else
18 want to go for a walk and grab that other piece of paper for
19 me that I can't see?

20 COMMISSIONER FRIEDRICHS: Your federal dollars at work.

21 COMMISSIONER ERICKSON: Thank you, sir. So use of
22 technology to support access, one of the things that's on here
23 that was already on our list that was, at least, in part
24 addressing this, patient/provider shared decision-making
25 support tools, and that included technology.

1 COMMISSIONER DAVIS: I was thinking -- if I may, Mr.
2 Chair -- that we were talking about something different. When
3 I'm thinking about this subject, I think about Noah talking
4 about the primary care physicians in town who aren't working;
5 they want work part-time. And I think about figuring out a
6 way to enable that person to be, you know, doing electronic
7 visits at 9 o'clock at night when their kids are in bed and
8 the person who wants to have a conversation with the physician
9 kids are in bed. That's what I'm thinking about when we think
10 about access. You know, it's Web visits. It's telephonic.
11 It's e. It's whatever it is, and I'd like us to explore
12 further to expand access, which is different than data and/or
13 support tools, in my view.

14 COMMISSIONER LAUFER: Expand being paid for access.
15 Here's a quote this morning, "Hi, doc, I've torn the Achilles
16 tendon or something on my left foot; do I need a cast? It's
17 extremely painful, and I'm using crutches at the moment. I
18 did the same thing, just as severely, in August, and after a
19 week or so, it seemed to heal, but I guess it's not always
20 that way. Thanks."

21 Liability. No pay. You know, I'm emailing him back. I
22 made the mistake a couple years ago of letting my email slip,
23 and I have two. There is one about a prostate as well. I'm
24 happy to do this, but right now, I'm not being paid, and I
25 could be sued, and it's not being adequately documented to

1 document that I'm a good whatever, again and again.

2 COMMISSIONER DAVIS: So what I envision -- and this is to
3 Paul's point, that we're thinking about creating a new system;
4 I'm just making this up -- is that, rather than pirate your
5 email address and send you an email, your patient knows that
6 they can go -- I'm making this up -- online to Medical Park
7 Family's website and set and e-visit appointment with you at 6
8 o'clock because that's when you've said you're available, and
9 you get paid for it, and it gets documented, and blah-blah-
10 blah and that's what I'm thinking about.

11 COMMISSIONER LAUFER: We're doing that now, but we're not
12 getting paid for it and that's the worry is that we won't get
13 paid, but we'll be penalized if we don't.

14 COMMISSIONER DAVIS: Let me just share with you, as
15 perhaps an indication of a trend, that we're working right now
16 to say this is how you would be paid for that, you know, and
17 to specify it because, I mean, this is not -- you think that
18 should be simple. I just send him a bill. Well, we had an
19 experience with one client who was paying for telephonic
20 visits, and we found some providers who were taking advantage
21 of that and running up, you know, \$1,200 bills for a phone
22 call, seriously.

23 So what we're saying and what we're trying to do is, and
24 as part of this whole investigation I think we need to do,
25 what are the characteristics of a legitimate e-visit or video

1 visit or telephonic visit? You know, what are the parameters
2 around that, so that it's not \$1,200? It's, in fact, less
3 expensive to do that than more expensive. So I'm with you.
4 You need to be paid for the work you do. Let's make it easier
5 for a member because, from an employer's point of view, they
6 don't want somebody taking a half-day off. You know from a
7 patient's point of view, I don't want to take a half-day off,
8 but I want -- I need to have that interaction. Let's make it
9 a \$60 five-minute interaction that's convenient for both of
10 us, and you get paid.

11 COMMISSIONER FRIEDRICHS: I just offer that, actually,
12 that service does exist already here in Alaska. We turned it
13 on in December of this year for DOD participants. It's based
14 on a system that started in San Francisco, and they have
15 already developed a payment methodology in California for
16 using this. It's the non-Humana system, basically, non-Humana
17 providers who developed it. So it's out there, and I would
18 just commend that, as you all look at this if you opt to go
19 down that path, you may want to invite those folks who are
20 already providing it. The VA has a similar system in which
21 they can document and attribute an appropriate level of effort
22 to an e-consult or an e-visit along the way. So those tools
23 are all out there. Yeah (affirmative).

24 The challenge is to set some sort of a state level
25 policy, and I think this is where, perhaps, bringing Paul

1 Sherry (ph) and the e-Health Network folks back might be
2 interesting because they've made a great deal of progress and
3 they may be able to share some insight on how they can offer
4 that to those who are participating in the e-Health Network,
5 the Alaska e-Health Network as well.

6 COMMISSIONER ERICKSON: Anything else that you would add
7 to this list before we start taking some of the things that we
8 think are less important off?

9 COMMISSIONER LAUFER: It just needs some editing. You
10 know, genetic advancements are happening, and they're going to
11 be expensive and we don't really have any control over that.

12 COMMISSIONER ERICKSON: So is that -- would you suggest
13 that we take it off? It came once.

14 COMMISSIONER LAUFER: Yeah (affirmative).

15 COMMISSIONER ERICKSON: It's a significant issue. Are we
16 going to learn anything that's going to advise our policy
17 recommendations by studying it? You're suggesting not, I
18 think. So would anybody want to advocate for leaving it on?

19 COMMISSIONER LAUFER: It's premature. Yeah
20 (affirmative). Right.

21 COMMISSIONER FRIEDRICHS: I concur with taking it off the
22 list for Alaska right now. I'll just share with you that it
23 is actually happening very quickly in a number of sectors of
24 the health care industry, and it is -- this is the next big
25 wave of changes in health care delivery. For example, a large

1 employer with multiple millions of employees who collects.....

2 COMMISSIONER ERICKSON: Paul, can you put your mouth a
3 little closer to the mic? Pull it. Can you pull it? There
4 you go.

5 COMMISSIONER FRIEDRICHS: (Indiscernible - away from mic)
6 That may be a sign from God that I should stop talking. I
7 would agree with taking it off for this year, and I'll just
8 summarize by saying that, perhaps, leave it on there for 2013
9 because I think that you're going to see some pretty
10 remarkable stuff come out in the next six to 12 months on it.

11 COMMISSIONER LAUFER: These things are going to get
12 really hot in the next years. You know, like, we have all
13 these responsibilities to maintain the confidentiality of our
14 records, but the company 23andMe, you do an oral swab and send
15 it in and they tell you what part of, you know, the world your
16 ancestors are from. Google just bought that company. They
17 have data they can extrapolate to your children from it. It's
18 valuable information. My telephone knows how fast I drive.
19 My car will, shortly, whether I stop to see a mistress on the
20 way home or how often I go to the liquor store. Your doctor,
21 especially a patient-centered medical home primary care doc,
22 could know whether you're having too many beers or whether you
23 went into atrial fibrillation or your blood pressure changed
24 or your weight changed when you got on the scale in the
25 morning and what your blood sugar is. You know, it's a brave

1 new world, and your credit rating agency knows if you're up at
2 two in the morning and bought a ShamWow or bought jewelry, or
3 you know, went to dinner more frequently or less frequently
4 than you normally did, and all of this is -- it's out there
5 and that's why Silicon Valley is booming, and it'll be used.
6 For instance, I don't believe, for long-term care, the pre-
7 existing condition exclusions apply. There you go.

8 COMMISSIONER ERICKSON: One -- go ahead, Paul.

9 COMMISSIONER FRIEDRICHS: May I put a plug in? The
10 support healthy lifestyles, the rural sanitation piece, you
11 know, I'll go back to our discussion yesterday about those
12 attributes of a health care system which have the greatest
13 impact on overall health and quality of care.

14 Alaska is one of the few states, I think, in which there
15 still is an issue of sanitation and both adequate and
16 acceptable water supply availability. Val's not here, but
17 we've talked about doing it for this year and we pushed it
18 back. Again with the recognition that I won't be here, I
19 would encourage the Commission to consider re-looking at that.
20 I know Norton Sound has done an excellent job of fleshing out
21 the requirements for their part of Alaska. Some of the other
22 corporations have done so as well, but that's clearly within
23 our purview and something that would have a greater impact on
24 the health of Alaskans than many of the other things we've
25 looked at.

1 COMMISSIONER ERICKSON: I just bolded "rural sanitation"
2 for now. The one thing that's missing -- I'm not hearing
3 anybody else wanting to add anything. The one thing that
4 might be missing still is that we added a little bit ago or
5 talked about a little bit ago Allen's question about patient
6 incentives and disincentives, and I read it into, but it's a
7 little more focused on this, the employer's role in health and
8 health care in terms of both the design of worksite wellness
9 programs and the design of employee benefits and plans. So is
10 that enough for what we'll study next year, assuming we study
11 the employer's role in health and health care, or do you want
12 to go more broadly than that on the question of incentives and
13 disincentives? I think we can learn a lot, to the extent that
14 there is something to be learned. At this point, there is
15 still a lot of research going on related to what works in
16 terms of incentives and disincentives.

17 COMMISSIONER HIPPLER: Yes. I would like that as a
18 subtitle of "diagnosis current problems" -- is a perverse
19 incentive on the behalf of individuals to overuse health care
20 services.

21 COMMISSIONER BRANCO: I have a potential addition, and we
22 heard it yesterday. The strong emphasis on Worker's Comp
23 claims and the incredibly high cost in this state and having
24 an impact. Part of that seems to be access to medical
25 professionals to help limit time loss. There are a great

1 number of things that we might study, evaluate, and make
2 recommendations on, but I heard that as a huge cost driver in
3 this state.

4 COMMISSIONER ERICKSON: I'm sorry. Specifically Worker's
5 Comp?

6 COMMISSIONER BRANCO: Worker's Comp. Don't know which
7 category it would fit in or if it's something that we should -
8 - or 2013.....

9 COMMISSIONER ERICKSON: Well, I'm going to put on the
10 list for discussion purposes.

11 COMMISSIONER STINSON: Deb, I talked to the people in the
12 state of Washington, including the Worker's Comp people, and
13 they used the term hyper-consumerism, and they applied that
14 across all spectra, including Worker's Comp, and they're
15 trying to figure out ways to manage or avoid or educate
16 against hyper-consumerism, but that applies not only to the
17 patients. That applies to the physicians and the other
18 facilities because it's a joint problem.

19 COMMISSIONER ENNIS: Thank you. I believe that
20 individuals in a workplace are a wonderful, captive audience
21 for influence of responsibility and better health care and
22 wellness activity. So I definitely would encourage this. We
23 just did a utilization review of our agency, 400 employees,
24 and what I found is that there was a remarkable under use of
25 their health benefits, both the 100% paid wellness checks --

1 and we're predominantly women in our health care workforce --
2 and overall a very low utilization, which was dramatic as we
3 were looking at ways to approach cost containment of our
4 expensive benefit plan. So I'll just throw that out. We're
5 going to look into it to see why it is. While we're trying to
6 encourage wellness activities in the workplace, we certainly
7 don't want to suddenly double the utilization either. So it's
8 just an interesting scenario that's occurring for one company,
9 but do want to encourage us to continue to look at worksite
10 wellness because, you know, it is, again, a captive audience
11 that you can influence in many ways with really little effort.

12 COMMISSIONER ERICKSON: I think we have a complete list.

13 CHAIR HURLBURT: On the printed document, you had the
14 item on further cost and utilization studies with question
15 marks, and I think that's off there now. I think we heard,
16 yesterday, we do want to go ahead with skilled long-term care
17 and pharmacy.

18 COMMISSIONER HIPPLER: Mr. Chairman?

19 CHAIR HURLBURT: Yes, Allen?

20 COMMISSIONER HIPPLER: We have an item called Patient
21 Provider Shared Decision-Making Support Tools, including
22 technology, under Innovations in Patient-Centered Care; what
23 is that?

24 COMMISSIONER FRIEDRICH: Yeah (affirmative). I believe
25 that's the discussion that we were having earlier is my

1 recollection, the tools that were available to allow the
2 patients and providers to work more easily together -- replace
3 the face-to-face visit.

4 Mr. Chair, if I may, on a point of personal privilege,
5 I'm going to need to leave to grab a bite of something and
6 then head out to the airport. I would just like to say thank
7 you for the opportunity to serve with you on the Commission,
8 and I wish you -- I'll continue to help as we finish up the
9 report for this year, to the extent that you will allow me,
10 and I owe you some comments on the workforce piece, but it
11 really has been a privilege and a pleasure to be part of this
12 Commission, and I wish you all much success next year as you
13 continue to work on building a system for Alaska. Thank you.

14 COMMISSIONER ERICKSON: If we have nothing more to add to
15 this list for now, let's see if we can clarify and then weed
16 out because we're not going to be able to do all of these
17 things. Yes, sir?

18 COMMISSIONER MORGAN: I'm bifocal. I can't see up there.
19 Did you add the part about the study for the data collection
20 and transparency to the list or is that not where that goes?
21 Remember?

22 COMMISSIONER ERICKSON: I did. I did. I can't see it on
23 the screen, a feasibility study for All Payer Claims Database.
24 It's probably not worded quite right, but yeah (affirmative);
25 it's there. And so if we -- I'm going to highlight the things

1 that I'm hearing advocacy for. And what I'd like to do is ask
2 if there is anything on this list that anyone would want to
3 advocate taking off, that you would identify as a lower
4 priority for now, understanding that we are going to have to
5 take some of these off?

6 COMMISSIONER HIPPLER: I could be wrong. Have we already
7 made a statement about fluoride in the past?

8 COMMISSIONER ERICKSON: We have not. We heard, in public
9 testimony, about concerns that communities are making
10 decisions to move away from fluoridation of public water
11 systems and the health impacts of that decision.

12 COMMISSIONER HIPPLER: Still, I -- if something has to
13 go, I would choose that.

14 COMMISSIONER ERICKSON: Pat?

15 COMMISSIONER BRANCO: And I'm hoping that the second from
16 the bottom one, health information infrastructure, is already
17 captured as we do the data mining efforts, so we could take
18 that one off. It doesn't change much.

19 COMMISSIONER ERICKSON: Well actually, this will.....

20 COMMISSIONER BRANCO: Is it separate?

21 COMMISSIONER ERICKSON: No. This all stays on. We're
22 not taking that off. And that is to Keith's point earlier
23 that we will continue, over time, tracking what's going on in
24 the state relative to any recommendations we've made.

25 COMMISSIONER BRANCO: Got you. I'm not going to offer

1 anymore.

2 COMMISSIONER ERICKSON: You can come up with another one
3 that should come off. Yes, Emily?

4 COMMISSIONER ENNIS: Yesterday, we heard an excellent
5 presentation by Duane Mayes on long-term care, and in that
6 report, he indicated that they aren't complete -- they have
7 not completed their study, and it was a report and research
8 that we asked for. So I do believe we need to continue
9 following long-term care issues in 2012.

10 COMMISSIONER ERICKSON: For the Patient-Provider Shared
11 Decision-Making Support Tools, is that similar enough to the
12 e-visit? It really was getting at -- yeah (affirmative). It
13 really is something different.

14 CHAIR HURLBURT: It's different. It's fairly specific.
15 That's something that can wait, I would think.

16 COMMISSIONER LAUFER: It's evolving on its own. There is
17 a healthy market, I think, in the gold rush that's happening.
18 Lots of people think there is money there, so they're working
19 on that, you know. Quest has an app; you can have your labs
20 sent to you right away already, and it's creating more work
21 for us. No. It's great.

22 There's one thing that they eluded to in the study for
23 long-term care yesterday that I think might be important and
24 that's the demographics of the bubble, and if you note from
25 2030-2034, it's flat and then it goes down. And it might be -

1 - I mean, that's awfully long-term planning, but that's going
2 to matter. The State is going to end up over-billed for some
3 things, and it might be worth keeping an eye on the
4 demographics, or you know, always keeping that in mind, that
5 we are really dealing with a generational bubble of costs.

6 COMMISSIONER ERICKSON: Well -- Pat?

7 COMMISSIONER BRANCO: Are we going to take an active role
8 in advocating for or against malpractice reform? I think that
9 one can -- that's just, as it occurs, we'll provide input, but
10 I don't think we'll have an active role.

11 COMMISSIONER ERICKSON: Other ideas for taking things off
12 the list or moving them to 2012?

13 COMMISSIONER HIPPLER: Under innovations, we have end-of-
14 life care. Is that something that we expect innovations or
15 are we -- was it just thrown in, is that a current problem,
16 end-of-life care?

17 COMMISSIONER ERICKSON: Yes. Yeah (affirmative). It's
18 something actually that -- it was your predecessor who used to
19 raise this regularly as an issue. We heard from Donna Stevens
20 yesterday, and she had testified before, and I had passed out
21 the article yesterday afternoon that she referred to a recent
22 JAMA article, Journal of American Medical Association, on
23 higher costs at end-of-life, and there are a couple of
24 different aspects that we could be studying next year related
25 to this. I mean, we wouldn't study without studying both and

1 that's the issue of -- well first of all, another comment.
2 Folks joke when we talk about end-of-life care that nobody
3 knows when they're going to die. We don't know when that last
4 year is going to happen, but that's a good thing because we
5 really would have rationing if we knew when we were all going
6 to die. But to the point that we have evidence that there are
7 much higher costs in those last few months to year of life,
8 there is more and more evidence, what Donna was testifying to
9 yesterday, that creating space for a conversation and doing
10 some things, making some decisions early before there is a
11 health crisis significantly lowers cost. There is research
12 that provides evidence of that.

13 Then also there are system support services, palliative
14 care, that, if there is adequate access to those sorts of
15 services at the end-of-life, that also significantly reduces
16 cost, and it's not just about cost. Not only does it improve
17 cost, it improves quality and contributes to giving the
18 patient more choice in their final decision-making rather than
19 having the medical system make the choice for them. And so
20 that's why it's on the list, and I think, why Wayne had
21 advocated for it regularly and actively in the past when he
22 was on. So I'm seeing a number of indicators that it should
23 stay on.

24 COMMISSIONER HIPPLER: Let's just move it up into the
25 "diagnose current problems" as opposed to "innovations."

1 COMMISSIONER LAUFER: How about down into "support
2 healthy lifestyles?" That's a radical thing, but I've said it
3 before. You can be healthy on the last day of your life, and
4 the hospice movement comes out of humanity for one another,
5 not out of cost containment. And you might have noted that
6 she said they're a non-profit funded solely by donations.
7 Those are people who have been there. They've experienced it.
8 They've dealt with a dying loved one.

9 COMMISSIONER ERICKSON: And I will put it wherever you
10 all agree it should go. I would say that it is an innovation
11 in making care more patient-centered and that's why it's under
12 that category right now, but we can figure out where it
13 belongs another time, I think. Are we agreeing to leave that
14 on? Keith?

15 COMMISSIONER CAMPBELL: The fraud and abuse part, isn't
16 everybody in the world doing that, Medicare, the Feds, the
17 State, I'm sure, on the Medicaid system and things like that?
18 I just wonder if there is anything new to be said about that,
19 other than don't do it.

20 COMMISSIONER MORGAN: This is Dave. I sent out -- I made
21 a -- or my department made a matrix of, just on the state
22 level, all of the different reviews/audits that the State does
23 and who does it and why. That's not counting some of the CMS
24 Fed stuff. I think, other than, you know, maybe noting or
25 even adding the federal matrix, if you did look at it when I

1 sent it out, maybe we should just say hey, here they all are,
2 and this is all that's going on. Enough said. Maybe we could
3 combine some. If there is any suggestion, maybe we can
4 combine some of them. So when I used to work in a hospital a
5 long time ago, there was one year where I had three sets at
6 the same -- our internal auditors, some guys -- this was in
7 Indiana -- from State Rate Review and some Feds. The problem
8 was they were all fighting over the same record, so I had to
9 referee who got what when. So I think it's okay to leave it
10 in, but why not just do one more short inventory of the
11 federal part, stick it in, and hey, can we combine some of
12 this stuff?

13 COMMISSIONER ERICKSON: What if we -- what's that, Pat?
14 I was going to suggest maybe, since a lot is being implemented
15 -- a lot of the changes in the Affordable Care Act, those 32
16 provisions, most of them are taking effect this year. What if
17 we move this to our 2013 agenda and figure out where we're at
18 in terms of all of the layers of federal and state fraud and
19 abuse provisions at that point?

20 COMMISSIONER LAUFER: I think we should leave it in until
21 Linda Hall has had a chance to look at it because it is
22 important to her and there probably are innovations in
23 actually preventing fraud and abuse. Right now, it's just in
24 there so you can say this how we're going to pay for
25 everything by eliminating fraud and abuse, but that's

1 political.

2 COMMISSIONER MORGAN: I look at it as, if we leave it in,
3 people won't ask well, what about fraud and abuse kind of
4 thing?

5 COMMISSIONER ERICKSON: That's why we have our list of
6 pending issues though. It would be easy, on one hand, to
7 compile information about what's happening now in more detail.
8 On the other hand, we have very little -- you have one staff
9 person and little money, and we need to take some things off.
10 So.....

11 CHAIR HURLBURT: But as David suggests, would it make
12 sense to have it on just the continued tracking category?
13 That it's.....

14 COMMISSIONER ERICKSON: But we never described it in the
15 first place, so we're not continuing to track it. We have to
16 do it in the first place. We have to study it in the first
17 place and then we'll continue tracking it after that.

18 COMMISSIONER MORGAN: Well, like I said, I sent out to
19 the group, when it came up with our newest member, a matrix.

20 COMMISSIONER ERICKSON: But we haven't spent time delving
21 into it and learning about it in a meeting and so.....

22 COMMISSIONER MORGAN: Well, I don't -- wherever you put
23 it is okay. I don't think we need to do that. I think there
24 are plenty of people doing that. I just think we need to, at
25 least so that everyone will know, hey, here is what's going

1 on. Go to page 89 or something. And we don't have to keep up
2 with it, just, you know -- or do what you want. It doesn't
3 matter.

4 COMMISSIONER ERICKSON: Let me try to be more a little
5 more specific about what we need to -- what we're identifying
6 right now. What we're identifying right now are issues that
7 we're going to spend time learning about and discussing in our
8 meetings that I'll spend time researching and that we might
9 spend money on contracts. So do you want to spend time in our
10 meetings during 2012 learning about and discussing fraud and
11 abuse?

12 CHAIR HURLBURT: Anybody think we should? No.

13 COMMISSIONER ERICKSON: Nobody thinks we should, so we
14 will take that off. And again taking these things off means
15 we're just moving them to another parking lot.

16 COMMISSIONER BRANCO: I hope, if they're taken off, they
17 go away from our lives.

18 COMMISSIONER ERICKSON: Wes?

19 COMMISSIONER KELLER: By using the same criteria, I
20 struggle with rural sanitation. Maybe some of you can
21 enlighten me. We all know the problem. We all -- it just
22 seems like it's down to such a pragmatic level of who gets the
23 check and how much to make it fair, you know, and I just -- I
24 don't know what we do with that as a Commission. I mean, we
25 advocate for rural sanitation at any rural population center,

1 but what do we study? You know, what do we recommend? I
2 mean, the recommendations are so intuitively obvious that, you
3 know, I just -- anyway, I struggle with that being on the list
4 right now.

5 COMMISSIONER ERICKSON: I think one of the reasons we had
6 put it in the parking lot for 2012 is that it's called out
7 specifically in our statute. Uh-huh (affirmative).

8 COMMISSIONER LAUFER: Sort of a public health pyramid
9 would be instructive to include in the document, you know,
10 that says these are the foundations, you know, potable water,
11 tertiary or sewage treatment, immunizations, you know, the
12 basics because I fear a little bit what happened in Washington
13 where immunizations for children aren't covered because it's
14 not legally mandated that they be covered by Medicaid, I
15 believe. You know, you can't build your building by pulling
16 bricks out of the foundation. It is a little -- it's pretty
17 basic, but it might be useful to just have a diagram.

18 COMMISSIONER KELLER: One more element of that that may
19 be worth nothing. I'm not an attorney, but just an
20 observation. We do open up to potential lawsuit if we go --
21 you know, if we get real energetic in that one, you know,
22 there's a risk there, too. So.....

23 CHAIR HURLBURT: I don't know what we would add to that.
24 I agree with Wes. I think that everybody in the state
25 recognizes we are behind the other states. We still do have

1 folks that do it. It probably may be the single most
2 important thing you can do to improve health status, but I
3 don't know what we would add to that. I think IHS, I think
4 HUD, the State, others continue to put funding into it. The
5 costs per unit of housing are incredible in some situations,
6 but it's the reality that we face.

7 COMMISSIONER HIPPLER: Thank you. Let's talk about
8 pharmacy cost analysis real quick. In the coming year, will
9 an analysis of pharmacy costs help us? And maybe they will,
10 and if so, then we should discuss it.

11 CHAIR HURLBURT: I would say that we're still pretty
12 naive in how we give pharmacy services here, and I think there
13 is opportunity to look at costs to analyze them to see what
14 the difference is and then, perhaps as a follow on to that,
15 look at better ways of buying pharmacy. Pharmacy, for a
16 while, was the fastest growing segment. Overall, it's kind of
17 leveled out, but the so-called specialty pharmaceuticals are
18 now growing very, very rapidly. They're probably still 1% to
19 2% of total health care dollars, but these are the ones that
20 are the \$1,000, \$10,000 a month costs, and I would advocate
21 that we do become more educated about that and look at the
22 options.

23 COMMISSIONER CAMPBELL: I recall that, as one of the cost
24 driver, pharmacy was one of them that we were going to study
25 additionally. Also the cost of regulation, if we could get

1 some study on that. I don't know how that was worded, but I
2 know we parked it someplace yesterday, but I don't see it in
3 here. But I think that, if we're looking at cost drivers,
4 pharmacy is one and the cost of regulation and duplication of
5 inspections and all of this -- just like Dave was saying a
6 while ago, I had the same thing happen to me throughout my
7 career because I was rural, but I was also on the road and
8 easy to get to.

9 CHAIR HURLBURT: Can -- do you think that's feasible to
10 do? I think that would be wonderful, if we could, but is it
11 feasible?

12 COMMISSIONER ERICKSON: We did -- and we haven't
13 revisited the paper that I typed up last night where it's
14 captured as an issue. It wasn't captured as something that we
15 said we would study further, and we were done adding things to
16 this list.

17 COMMISSIONER KELLER: It's kind of covered in the first
18 thing that Paul talked about, too. You know if we get the
19 providers, the consumers, everybody identifying the
20 roadblocks, hopefully, we could even make that an invitation.
21 If we have them come, you know, please make us aware of, you
22 know, regulations that you perceive that are causing the
23 problem.

24 COMMISSIONER ERICKSON: I'm hearing more advocacy for
25 some process to identify barriers to innovations specifically

1 created through state laws and regulations, so should I bold
2 that? Because I'm going to suggest I don't think we should do
3 more than three diagnosing the current problems and
4 understanding the current system. I can get this. And so we
5 have three, and there was a lot of discussion. I hadn't
6 bolded it, the e-visit and use of technology to support
7 improved access and all of the learning around that. So we
8 have three in each of those two areas. We've lost, but we
9 haven't lost entirely because it's here -- I feel bad taking
10 rural sanitation off without Val's voice at the table, but
11 I've taken it off based on the conversation we've had here.

12 COMMISSIONER KELLER: How about asking her, you know, to
13 suggest what the Commission could do as a point of an email or
14 whatever for all of us, you know, so we don't leave her out of
15 that process?

16 COMMISSIONER ERICKSON: And then support for healthy
17 lifestyles is part of the employer's role. So the three
18 issues that we've included under current studies and under
19 innovations, are those the highest priority, from your
20 perspective?

21 COMMISSIONER HIPPLER: I will -- I'll throw out a word
22 for two others, Worker's Comp and (indiscernible -
23 simultaneous speaking).....

24 COMMISSIONER ERICKSON: I should clarify. If you're
25 advocating for adding something more, you need to suggest

1 which of the highlighted things are a lower priority that
2 should come off.

3 COMMISSIONER HIPPLER: Why is there only three things
4 that we can discuss?

5 COMMISSIONER ERICKSON: Because we have a limited amount
6 of time for discussion and learning together during the
7 Commission meetings, and we have limited resources in terms of
8 staff and money for doing the research and pulling the
9 information together.

10 COMMISSIONER HIPPLER: So we have a total of six bolded
11 things?

12 COMMISSIONER ERICKSON: Yes.

13 COMMISSIONER HIPPLER: And that's what we can do?

14 COMMISSIONER ERICKSON: During 2012.

15 COMMISSIONER HIPPLER: Okay. I still think that Worker's
16 Comp would yield greater results than a pharmacy cost
17 analysis. So if this is an issue of we're going to take one
18 off to put one on, I would be in favor of looking at Workman's
19 Comp.

20 COMMISSIONER ERICKSON: One question I have -- we're not
21 -- I wonder if we're getting too specific on individual
22 programs. If we're not -- if one of the ways we're limiting
23 our scope -- if you think back to the slide yesterday at the
24 beginning of what is not within our charge, is it within our
25 charge to make -- we said it's not within our charge to make

1 specific programmatic recommendations related to individual
2 state programs. Is there learning that we're achieving in
3 more general policy recommendations we're making that are
4 going to help, eventually, to address the Worker's Comp
5 problem or are we getting too specific if we delve into a
6 specific state program?

7 COMMISSIONER KELLER: If I can respond, I'm an NFIB,
8 National Federation of Independent Businesses -- I'm one of
9 their favorite legislators. This is just, you know, in the
10 context of revealing where I'm coming from, and I see
11 Workman's Comp as a hugely important issue, you know, for
12 business in the state of Alaska. The thing to keep in mind, I
13 think, is that, if you look at the piece of the overall
14 picture in economics, it's a small piece. If you look at it
15 as an issue, it's very, very big. It's not like we're the
16 worst in the U.S. It's big. We've got to deal with it, and
17 there are suggestions on the table. I think, before the
18 Legislature, there are several bills in, and it's kind of
19 there in our minds. So even though I see the importance of
20 the issue -- it's big in my mind; it's big in my motivation --
21 I don't know that it's appropriate for one of our priorities
22 is my feeling.

23 COMMISSIONER STINSON: I also know there are a lot of
24 other committees and other commissions that are studying this
25 ongoing because they've asked me, and I've testified. So

1 there is another whole segment that is looking at that issue
2 in great detail.

3 COMMISSIONER ENNIS: It also plays a part of employer
4 health and health care issues. I mean, you can't separate it.
5 When you're influencing your employees to lead healthy
6 lifestyles, you are, in a sense, promoting prevention. I
7 mean, we look at our Worker's Comp all the time in terms of
8 the wellness of the employee involved, and it's questionable.
9 So I don't know that it needs to come up, but it will
10 naturally fall into that area.

11 COMMISSIONER ERICKSON: Pat?

12 COMMISSIONER BRANCO: Same comments, but I want to add an
13 admonition in support of Allen's point. If we haven't done
14 anything, if no progress has been made, this ought to be
15 number one on our agenda in 2013, if there has been no
16 progress on this. Safe work environments, they're not only
17 safe for our employees in our different organizations; they're
18 safe for the State, and they're really impactful on the costs
19 of health care, in particular.

20 And with apologies, I have to run to the airport as well.
21 So I vote in support of the potential 2012 agenda. I trust
22 you all implicitly that whatever is added or subtracted from
23 this point forward will be fully agreeable.

24 COMMISSIONER KELLER: I've got a few things I want to add
25 after he leaves then.

1 COMMISSIONER BRANCO: My ox has been gored.

2 COMMISSIONER ERICKSON: I think folks are -- yeah
3 (affirmative). Thanks, Pat. I would suggest that we have a
4 quick review of the draft that will go out for public comment
5 over teleconference in ten days to two weeks. I see heads
6 nodding. And so what I'll do is just write up what we'll
7 include related to these. I forgot one that's really
8 important that we keep putting off. What we need to do, at
9 some point, is finalize our list for measuring improvement in
10 statewide health care delivery systems. We need to finalize
11 that indicator list.

12 So if we have some general agreement and we can vote over
13 teleconference on the final list, on the seven items now that
14 are bolded on here for our 2012 agenda, I don't think we need
15 to take a vote, unless you think we need to.

16 CHAIR HURLBURT: I don't think so.

17 COMMISSIONER ERICKSON: We can't. Did we lose our --
18 one, two. Identifying barriers to innovations created by
19 state laws and regulations, studying the feasibility of an All
20 Payer Claims Database, Milliman-type study of the SNF and
21 pharmacy costs. SNF is Skilled Nursing Facilities. And then
22 the employer's role in health and health care, end-of-life
23 care, use of technology to support access, and identification
24 of indicators for measuring statewide health care delivery
25 system improvement, so the seven items that are bulleted on

1 that list right now.

2 COMMISSIONER HIPPLER: (Indiscernible - away from mic)

3 COMMISSIONER ERICKSON: I just said that we should --
4 we've put it off for a couple of years, and we need to
5 finalize a list. We have a draft list.

6 COMMISSIONER HIPPLER: Okay. So -- well, let's talk
7 about that because you had stated that you only had resources
8 to do, I guess, seven.

9 COMMISSIONER ERICKSON: Yeah (affirmative). I was -- we
10 can't talk about it anymore.

11 COMMISSIONER HIPPLER: So indicators for measuring
12 statewide health care delivery system improvement, I don't
13 understand what that means.

14 COMMISSIONER ERICKSON: Why don't we talk about it over
15 teleconference? And I'll send you the list that -- it's
16 actually in this handout that we had drafted a couple of years
17 ago. So understanding that this is still a draft and we'll
18 vote on it over teleconference, and again, it will still be
19 draft, just for public comment. And my computer is not going
20 to cooperate anyway. Do we have any final questions or
21 comments before we sign off? Do you want to adjourn us?

22 CHAIR HURLBURT: Okay. I want to thank everybody for
23 coming. I'm going to join the airport delegation also. I
24 appreciate you being here. I appreciate anybody online, and
25 we'll be talking in a couple of weeks.

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TRANSCRIBER'S CERTIFICATE

I, Lara Jury, hereby certify that the foregoing pages numbered 2 through 395 are a true, accurate and complete transcript of the Alaska Health Care Commission Meeting held on October 11 - 12, 2011, as transcribed by me from a copy of the electronic digital sound recording to the best of my knowledge and ability.

November 21, 2011

Lara Jury