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ALASKA HEALTH CARE COMMISSION

THURSDAY, JUNE 14, 2012

8:01 A.M.

FRONTIER BUILDING, ROOM 896

3601 "C" STREET

ANCHORAGE, ALASKA

VOLUME 1 OF 2

PAGES 1 THROUGH 240

1 particularly for Bob and Tom, if you would just push the
2 button and then push it off when you're done.

3 COMMISSIONER HARRELL: So I'm Colonel Tom Harrell from
4 JBER Hospital.

5 COMMISSIONER ENNIS: Emily Ennis, Fairbanks Resource
6 Agency, and I'm representing the Alaska Mental Health Trust.

7 COMMISSIONER URATA: I'm Bob Urata from Juneau, Alaska.
8 I represent primary care.

9 COMMISSIONER BRANCO: Pat Branco, the CEO of Ketchikan
10 Medical Center.

11 COMMISSIONER CAMPBELL: Keith Campbell. I'm from Seward,
12 and I have the awesome job of being the consumer rep,
13 representing everybody in the state of Alaska. Thank you.

14 COMMISSIONER HIPPLER: Allen Hippler, State Chamber of
15 Commerce.

16 COMMISSIONER KELLER: Wes Keller, Alaska State House. I
17 represent the Wasilla area.

18 COMMISSIONER STINSON: Larry Stinson, physician.

19 COMMISSIONER MORGAN: Dave Morgan, Alaska Health
20 Care/Primary Care.

21 (Audience Introductions Indiscernible - away from mic)

22 CHAIR HURLBURT: Thank you very much. Again, welcome,
23 everybody here.

24 COMMISSIONER ERICKSON: Just a reminder, too, for those
25 of you who are in the audience to make sure that you've signed

1 in on the back table. I'd appreciate it. Thank you.

2 CHAIR HURLBURT: Colonel Tom Harrell, as he introduced
3 himself, is the Commander from the JBER Hospital and is in the
4 role designated to represent veterans and veterans' health
5 care in Alaska. JBER Hospital, as we all know, serves active
6 duty, retired veterans in Alaska, and we welcome you. Your
7 predecessor was a valued member of the Commission, and we know
8 that your life changes the (indiscernible - voice lowered),
9 and we welcome you coming in. Maybe if you could share a
10 little bit about your background and interests here, please?

11 COMMISSIONER HARRELL: Sure enough. Well, first of all,
12 I would extend greetings from Dr. Friedrichs from Hawaii. I
13 just spoke with him this morning. He gets up, as you all
14 know, fairly early in the morning. So he and I have chatted
15 just before coming in here, and he says hi to all of you.

16 So for me, I'm married with three children. One of them
17 is here with us. Christa (ph) is 16. Our two oldest boys are
18 in University at Florida State. I've been here a little over
19 a year.

20 Background-wise, I'm a career Air Force Officer. My
21 training is as a cardiologist and an electrophysiologist, and
22 I also have been a flight surgeon in the Air Force. I've done
23 both clinical medicine, aerospace cardiovascular research, and
24 now, of course, as you said, I get to be in the position of
25 being in command of the JBER Hospital. As you know, it's a

1 DOD/VA Joint Venture hospital and so we're very interested in
2 how we can partner with the community in terms of being able
3 to deliver that care.

4 From a personal perspective, my interest in this
5 Commission is that I've spent a good bit of time working with
6 health care policy, in particular, federal civil integration
7 and how we can work together in terms of delivering the best
8 patient care within the communities that I'm in. So that's
9 what drew me to the Commission and to apply.

10 CHAIR HURLBURT: Thank you very much and welcome.
11 Although Colonel Harrell and Dr. Urata are the two newest
12 members on the Commission, Dr. Urata is someone whom I've
13 known for the longest time, I think, going back many years,
14 and Bob, if you could just kind of give a little bit of your
15 background, where you're from, what you do, what some of your
16 interests have been, please?

17 COMMISSIONER URATA: I was born and raised in Wrangell,
18 Alaska many years ago and was on the third class of WWAMI,
19 which is the medical school program with the University of
20 Washington, and then did my family medicine residency at the
21 University of Washington and then served for four years at
22 National Health Service Corps in Holly Park, which is a low
23 income housing project and then transferred to SEARHC in
24 Juneau, where Ward became my boss, and served there for a
25 couple of years and then went into private practice from there

1 and have been in private practice in Juneau since 1986, served
2 on the Board of Directors for 17 years as part of the regional
3 hospital, currently am doing kind of a part-time medical
4 director program with Wrangell Medical Center, and I also
5 served on the first Strategic Health Care Task Force, which
6 was the predecessor to this program when Governor Palin was in
7 office.

8 My interests are primary care, end of life care, and
9 working trying to figure out how we're going to take care of
10 all of us when we get old, geriatric care here in Alaska,
11 which, I think, is an area that needs a little bit more
12 attention.

13 CHAIR HURLBURT: Thank you. You might just mention the
14 handout that, I think, all the Commissioners have, when you're
15 not here, was something that Bob was one of the leaders in
16 working out there in Juneau, but it has universal
17 applicability. It's extraordinarily well done. We have the
18 handout here. The major focus for our August session will be
19 end of life care, and this is some background for that, but I
20 think you will find this of interest to look at to see what
21 has been done there in Juneau. It will be of personal
22 interest to you, will also be of good background for our focus
23 the next time that we meet.

24 A couple of other folks came in. If you could just
25 introduce yourselves and say who you represent? Karen?

1 MS. YEW (ph): Karen Yew (indiscernible - away from mic).

2 CHAIR HURLBURT: Thank you. The next -- before I turn it
3 over to Deb to lead the next portion here, I just want to
4 comment. We're going to have -- Pat Luby is going to share
5 some comments and some observations with us that we requested
6 that he do. These came, in part, out of an interview that Pat
7 had. I think probably almost all of us would be aware that
8 Pat's going to be moving on to a new chapter in his life and
9 leaving Alaska. Those of us who have been involved in health-
10 related affairs and other issues, whether it's on the local
11 level with various interest groups at the legislative level,
12 have known that Pat has been such a highly respected and
13 always hard-working, always present, engaged individual
14 representing not only his employer, AARP, but really
15 representing us all in a very thoughtful and respected way.
16 And so I think we want to take this opportunity to express, on
17 behalf of the Commission, certainly on my behalf, a thanks for
18 all that you've done for so many years in Alaska and to bid
19 you well and Godspeed as you move onto a new chapter there.
20 Deb, I don't know if you wanted to say just a little bit more
21 before we turn it over to Pat.

22 COMMISSIONER ERICKSON: Yeah. Actually, come on up, Pat,
23 please. Thank you. The only other thing I wanted -- I would
24 mention, just referring to the agenda, is that our plan -- and
25 Pat, if you wouldn't mind staying at the table with us and

1 participating in the conversation, if you feel comfortable
2 doing so, what we'll do is kind of use your thoughts on your
3 experience over the past 40 years working with health policy
4 at the federal and state level as kind of a jumping off point
5 to have a little bit more of a conversation about the
6 Commission's role in shaping health policy and the future of
7 the Commission.

8 MR. LUBY: Thank you, Deb. You know, when I first went
9 to work for AARP, they used to refer to us as "the boys in the
10 office." I haven't heard that expression in a real long time,
11 but 40 years make me think about some of the stories that Dr.
12 Hurlburt has shared with us when he first came to practice in
13 Dillingham and some of the changes that we've seen.

14 I went to grad school at the University of North Carolina
15 and studied gerontology. In 1972, there were four programs in
16 gerontology in the entire country, and the federal government
17 was aware that there were boomers out there. We weren't going
18 anywhere. There were going to be a lot of us, and trying to
19 figure what to do about those boomers.

20 One of the first things I did when I interned in D.C. was
21 go to a meeting about something that they referred to as
22 health care reform. They said we needed to do something about
23 making sure that everybody in the country had access to some
24 type of quality care and insurance.

25 In 1972, I was telling our staff yesterday, Medicare was

1 seven years old. Medicaid was passed almost as an
2 afterthought. If you go back and you read the congressional
3 testimony from that period, they said well, you know, Medicaid
4 is just for poor people. It will never be that expensive, so
5 we don't have to worry about the costs that might be
6 associated with it. No one ever considered the fact that it
7 might also be used for long-term care and would, basically,
8 pay the nursing home costs for many older Americans.

9 I was born in 1946, the first group of the boomers. We
10 were probably the luckiest of the boomers also, but we were
11 the pig and the snake going through our entire careers. They
12 had to build more kindergartens. They had to build more grade
13 schools, more high schools. The community colleges basically
14 came about because there were so many of us and the
15 universities couldn't handle us all.

16 And now there is a lot of us still around, and we're all
17 hitting age 65 and will be for the next several years. There
18 are 75 million of us, and one of the problems, obviously, that
19 we are going to bring with us is cost and health care
20 coverage, and it's one of the things that you certainly will
21 be dealing with.

22 You know, when you go back to looking at some of the
23 earliest evidence-based things that we did in this country, in
24 the 1950s, we began to have, primarily, older women who were
25 in nursing homes or some type of a -- in some cases, it was

1 referred to as a county home. And what they discovered was
2 that, after they were there for a while, they got much better,
3 you know, and the quality of care -- everybody said we must be
4 responsible for this, this up tick in their status. Actually,
5 it turned out that most of them were malnourished. They were
6 women who had lost their husbands, and they were not taking
7 care of themselves from a nutritional standpoint, and their
8 health status went down. They ended up in what we call
9 senility or organic brain syndrome. We didn't know about
10 Alzheimer's disease back then. We didn't know about any of
11 these other problems, but malnourishment was the primary
12 reason.

13 One of the things that came out of that was we started a
14 programs. We figured that, if we could serve people one good
15 meal a day, we might be able to keep them out of long-term
16 care, and obviously, save money because the government ended
17 up picking up the cost for much of that long-term care. So we
18 started things, like Meals-on-Wheels. We started congregant
19 meals for older people. It wasn't because we liked to give
20 older people a good meal. It was because we wanted to save
21 money, you know, but it was good public policy that worked out
22 well for the individual citizen. It also worked out well for
23 the government that had to pay for it.

24 I remember talking about this one time when I was
25 teaching a class in gerontology, and there were two older

1 women in the class, and they said, well, you know, we won't
2 have that problem. Why wouldn't you have that problem? They
3 said, well, we have microwaves, you know, and it turned out,
4 in their view, one of the best medical advances that had ever
5 been made was microwaves and the fact that they could make
6 sure that they were well-nourished. One of them said, you
7 know, before I had a microwave, sometimes I'd come home and I
8 was tired from working, and I'd put some bread in a cup of
9 milk and that was my dinner. You know, I don't do that
10 anymore. And one of the things that we have seen is terrific
11 status changes in that.

12 Tobacco is one of the things that I know this state has
13 done a lot of work on, and it's one of the problems that we
14 continue to have, but it's one that we are working to solve.
15 You know, the social norms that we used to have -- when I was
16 in the Army in Vietnam, with every one of our C-rations, we
17 got a little pack of four cigarettes, and I was in a remote
18 area along the Cambodian border, and whenever we got re-
19 supplied by helicopter, we used to get what was called an SP-
20 pack. It was the American Red Cross. When would open up that
21 pack, there were Pall Malls and Kools, and it was primarily
22 tobacco in there, courtesy of the American Red Cross.

23 Well, we've made a lot of advancement since then.
24 Certainly, the military has done an awful lot to try to reduce
25 tobacco abuse, but the state, this state, I think, has done a

1 tremendous amount of work to reduce tobacco abuse. I think
2 our state tobacco prevention program, especially our
3 advertising that goes out on mass media, has done an awful lot
4 to reduce adult smoking, helping them to stop as well as
5 making sure the kids don't start.

6 We've seen both wonderful advances with prescription
7 drugs. We've also seen tremendous problems because of those
8 advances. My paternal grandfather died when he was 49. My
9 father died when he was 86. My father had all the illnesses
10 that my grandfather died of at age 49, and by the time he was
11 86, he took 12 different medications, and he lived almost
12 twice as long as his father. So that's been a wonderful thing
13 for many Americans.

14 We do need though to focus on costs, and we have been
15 focusing on costs over the years. You know, we started out
16 with HMOs and Managed Care. Back in the early '90s, we had
17 what we called Business Health Coalitions. I was working in
18 Texas at the time, and Dallas had a Business Health Coalition,
19 the people that were paying for health care, a lot of HR
20 people, and they would get together once a month and say, what
21 did you do to reduce your company's health care costs this
22 month? Fort Worth had one, but even smaller communities, like
23 Tyler, Texas, had their own Health Care Coalition.

24 One of the things that we need to do is bring that back.
25 The business community has been AWOL for a long time. They're

1 the ones who are paying for a lot of this. Government also is
2 one of our largest employers, and we need to get them also
3 working to say, what can we do to reduce some health care
4 costs?

5 I know some of you are (indiscernible - voice lowered) of
6 need and health planning. I served on a health systems agency
7 in Kansas, and we made recommendations. At that time in
8 Kansas City, we had 16 CAT scans. Sweden had one. And one of
9 the things that, obviously, we were all trying to figure out
10 is, you know, can you reduce expensive technology and the
11 abuse, in some cases, of technology, and we made a lot of
12 recommendations, every single one of which was overturned at
13 the governmental level. Our Certificate of Need didn't work
14 that well. I think it's working a little bit up here.

15 And then Medicare is part of what we call the DRGs,
16 diagnostic-related groupings. And when I was in Dallas,
17 Parkland Hospital, our public hospital, there, they looked at
18 the DRGs, and one of the concerns that Medicare had was trying
19 to reduce health care costs. So they would assign a payment
20 based on each DRG, and it was really a miracle, a medical
21 miracle because, in six months, the most common DRG in
22 Parkland Hospital disappeared. No one had that problem
23 anymore. There was another DRG that paid a little better and
24 that became the most common DRG in Parkland Hospital.

25 So one of the things that everybody has to realize that

1 it is a business. It's a health care business, and people do
2 have to make sure that their organizations can survive
3 financially and that's one of the problems that we will always
4 be dealing with.

5 Some of the downsides to the prescription drug issue
6 certainly are the costs. Dr. Hurlburt heard me say this the
7 other day, and Deb. You know, before the 1990s, it was
8 illegal to advertise direct to consumers. People were not
9 watching television and finding out that, if they took that
10 pill, they would float like a butterfly and they could carry
11 their kids, four kids on their shoulders and run through the
12 park.

13 Now if you talk to providers, they will tell you, yes, I
14 have people coming in everyday asking me for that purple pill
15 or that prescription that I saw on television, and
16 unfortunately, a lot of our providers give in instead of
17 counseling those folks no; you don't really need this. What
18 you need to do is go on a diet or you need to stop drinking so
19 much or you need to get some exercise. People are going ahead
20 and getting that prescription. That's one of the problems
21 that we do have. If we could figure out how to make it
22 illegal, so that you could only advertise to the people who
23 were authorized to prescribe, we would make a lot of headway
24 in terms of our costs and probably in terms of our much better
25 quality of care.

1 I think this state has done quite a bit of good work, I
2 think, on looking at prescription drug care costs and figuring
3 out how they could align with other states and try to reduce
4 some of those costs. We do it in the Medicaid program. The
5 VA does it. Providence Hospital does it. But Medicare
6 doesn't, you know. And here, we have one of our biggest
7 payers in the United States, and the pharmaceutical industry
8 is so strong that they have been able to prevent Medicare from
9 doing bulk purchasing. I mean, it's silly. We even talk
10 about, well, maybe if we re-import drugs. They were made
11 here, first of all, and then we sold them to the Irish, but
12 maybe we could give the Irish some type of a cut and then
13 bring them back here. We haven't been able to do that either,
14 you know. It doesn't even make sense, but that's one of the
15 things that people have actually talked about is re-
16 importation.

17 You know, if you think about, in 40 years, what we've
18 done simply with computers. Phenomenal. You know, 40 years
19 ago -- Dr. Hurlburt, I don't think we talked about HIPAA, but
20 we certainly -- that's one of the things that we have to worry
21 about, but we still have problems with some wonderful
22 diagnostic tools that are a result of technology, but we still
23 have many physician offices and clinics with all their medical
24 records sitting there so that the cleaning crew can take them,
25 if they want to, you know. We're worried about HIPAA, but we

1 have all these paper records lying all over all our providers'
2 offices. So that's one of the things, obviously, that we are
3 trying to address throughout the country, including Alaska.

4 You know, I don't balance a checkbook anymore. I just go
5 online, you know, but I can't get any of my medical records
6 online. You know, I can't look up a prescription that may
7 have been provided to me in the past, and we have to make sure
8 that all of that -- as a consumer, that we have access to it,
9 but also certainly if I'm seeing two different providers, that
10 they know exactly what that other provider has recommended,
11 and we're not there yet.

12 We still have a lot continuing problems. We still have a
13 lot of defensive medicine. I have been involved with enough
14 state legislatures to know that the trial lawyers and the
15 providers don't get along very well and that is a continuing
16 problem. We have a problem that just won't go away in terms
17 of rural providers.

18 I talked to the head of the Texas Medical Association
19 about why we couldn't get physicians in rural Texas, and he
20 said spouses, you know, and that's the reality that we're
21 going to have in Alaska. That's the reality that we're going
22 to have in rural America.

23 We have problems with physician patterns of practice.
24 Dartmouth has been studying this for years trying to find out,
25 why do physicians in Salt Lake City not do these tests and

1 physicians in Boston order them all the time? You know, is
2 there some type of a problem where the hospitals say, listen,
3 we make money off this, so we want you to make sure that
4 you're using this equipment or providing this type of a test?

5 You know, one of our other problems, one of our other
6 blessings is life expectancy. You know, we've seen enormous
7 growth in our life expectancy. Dr. Urata talked about
8 geriatric medicine. If you're in medicine, you're going to be
9 practicing geriatric medicine.

10 I remember talking to a male physician one time, and I
11 told him that I work in gerontology, and he said, so do I.
12 I'm a family practitioner. And certainly, we're going to see
13 more and more attention paid to geriatric medicine. You know,
14 at age 65, 29% of women can expect to live until they are 90.
15 At 65, 18% of men can expect to live until they're 90. That's
16 25 years after you are eligible for Medicare that almost a
17 third of women will be alive, about one out of five men.
18 That's a long time to have to provide some type of health
19 coverage. That's a long time for us to figure out what are
20 those health care costs going to be for some of those people.

21 You know, Dr. Hurlburt mentioned that you're going to be
22 spending quite a bit of time looking at end of life issues. A
23 lot of people in this country are more worried about end of
24 life costs than they are about end of life issues and that
25 certainly -- you know, you see different numbers, but

1 basically, I think it comes down to about 1% of our population
2 uses up about 40% of our health assets and that's something --
3 it's one thing to talk about that in the abstract. It's
4 another thing to talk about the fact that, yeah, what about
5 mother, you know, and she's at the end of her life, and I want
6 to make sure that we have the funds there, available to take
7 care of her.

8 We're not going to go back, I don't think, to -- I
9 remember Dr. Crowley. Dr. Crowley -- we used to go to his
10 office, and Dr. Crowley used to come to our bedside when we
11 were kids. We may not have the Dr. Crowleys again, but we do
12 have to do something about encouraging more people to go into
13 primary care. You know, we simply don't have the incentives
14 there, and it has to be financial incentives to get people to
15 practice. It's a tough job. It's underpaid compared to some
16 of the specialties.

17 I remember talking to one of the editors of the *Anchorage*
18 *Daily News*, and I was saying -- we were talking about primary
19 care providers and the necessity to recruit more, and I was
20 telling her, you know, we have to make it so that it's not as
21 attractive to be a dermatologist and work four days, and she
22 said, I know. My daughter is a dermatologist, and she works
23 four days a week. You know, so there have to be more
24 incentives, and if the state is working on that, I think the
25 whole country is going to have to work on that.

1 But we do have a lot more attention toward evidence-based
2 medicine. We have great work that's being done by the
3 Institute of Medicine. I think, you know, when I was looking
4 at what some of the other health care commissions are doing,
5 in Maryland, the health care commission there has an online
6 hospital pricing guide for every acute care hospital in the
7 state. They have the number of cases, the average charge per
8 case, the average charge per day for the 15 most common
9 diagnoses. And I think one of the things that we'll talk
10 about next probably is going to be, where should the
11 Commission go in the future?

12 We do need to pay a lot more attention, I think, to oral
13 health. Physical health is not going to work. It's not going
14 to be productive unless we also pay some attention to oral
15 health.

16 I think the Medicaid program here did a tremendous
17 service toward the Medicaid beneficiaries when we started
18 doing coverage for adults who were on the Medicaid program.
19 Prior to that, you would have to have to be in pain and have
20 an emergency and then they could do an extraction. That was
21 it. There was no prevention. Now about 50% of the funding
22 for adults in the Medicaid program is actually going for
23 people who need dentures, and I think we need to keep that
24 focus on oral health there.

25 I think one of the things that Alaska really has going

1 for it is collaboration. You know, I've never worked in a
2 state where the VA, and the military, and the Native health
3 system, and the private as well as the public systems, the
4 profits and the non-profits collaborate as much as they do
5 here. Part of it is because we have one degree of separation
6 and we know each other, but it's also one of our strongest
7 assets.

8 You know, obviously, the Supreme Court decision is a big
9 question, but one of the interesting things, on Monday, United
10 Healthcare said that they already going to look at what's
11 being done, some of the more popular provisions of the federal
12 program, like coverage for the under 26 for employees, and
13 they said that they are going to continue to allow that.
14 Within a couple hours, AETNA Humana said, yeah, so are we, and
15 we're going to look at some of the other more popular
16 provisions in that program. My guess is that they're going to
17 be looking at coverage for preexisting conditions, that
18 they're probably be looking at lifetime limits. Those are
19 some of the issues that, from a family standpoint, many people
20 are concerned about.

21 But the second part of the discussion really is, you
22 know, some of the good work -- and Dr. Hurlburt referred to
23 the interview that I did in the *Alaska Health Policy Review*.
24 If you look at your statute, you know, it says that you can
25 develop, adopt, and implement a statewide health care plan. I

1 don't know whether we've gone beyond talking about developing
2 and maybe adopting some parts of it, but does the Commission
3 actually want to get into the implementation and what can be
4 done there?

5 I think one of the things that the Commission certainly
6 can do, and Representative Keller, I think, would verify this
7 -- we only have three full-time health care professionals in
8 the Legislature, Senator Olson, Senator Giessel, and
9 Representative Wilson. They rely, just as they rely on other
10 lobbyists or advocates, on health professionals, people who do
11 this for a living to make some recommendations on what they
12 ought to be doing, and I think this Health Care Commission
13 could probably serve the Legislature and serve the citizens of
14 Alaska much more if you would also do more advocacy work.
15 Actually, when you've studied an issue, come up with some
16 recommendations. If you would also then say, you know,
17 Governor, this is important. We have come to consensus.
18 We've come from a lot of different areas in the health care
19 industry, but this is one of the things that we think should
20 be done. And obviously, the way Alaska works, and most states
21 work, if you get the Governor's attention, you know, it's much
22 easier to move things along, but we have some terrific
23 committees. The HESS Committees in the House and the Senate
24 are where much of our health legislation starts, and it gives
25 us an opportunity, frankly, to bring some of these issues.

1 I've listened to Representative Keller, in the sense he's
2 been on this Commission, and the information that he has
3 shared with his colleagues on the HESS Committee and from the
4 House floor, you know, you are privy to so much good
5 information and colleagues that have so much good information,
6 and it shouldn't just stay in this building. It needs to be
7 shared down in Juneau, and it needs to be shared with the
8 Governor, and I would encourage you to consider, you know,
9 what more can we do, and take our recommendations and really
10 become advocates for what we have already discovered might
11 work. Thank you.

12 CHAIR HURLBURT: Pat, thank you so much for sharing.
13 Deb?

14 COMMISSIONER ERICKSON: (Indiscernible - away from mic)

15 CHAIR HURLBURT: Yeah. Any questions? You'll see a
16 couple of nicely provocative quotes from Pat up there on the
17 screen. So any questions about what Pat said or the quotes
18 there?

19 COMMISSIONER BRANCO: I'll start one. And pretty simple.
20 In one of the areas when you were talking about the
21 advertising on TV about every prescription known to save human
22 beings, even if it's at the periphery of good medicine, you
23 referred back to, perhaps, we should move back to advertising
24 only to the prescription writers to help educate these folks.
25 That was -- and this is just an observation and then just to

1 solicit your reflection back on it. That's the way it began
2 with the detail folks from the pharmacy companies pitching
3 each provider to the point where they became *persona non grata*
4 in our hospitals because they got a little too overaggressive
5 in the gift-giving to solicit prescription writing. Do you
6 think there is a happy medium where we can invite them back to
7 help them in the education path with our physicians?

8 MR. LUBY: Yeah (affirmative). Certainly. I mean, the
9 federal government has talked about this, and I think there
10 are actually some efforts underway right now so that, if a
11 detail person shows up in your office, they have to report any
12 gifts that they may have given you. I mean, we have had
13 people go on cruises, you know, to learn about prescription
14 medications. We have had people -- my wife works with a
15 dialysis center, and she's a social worker. She doesn't
16 prescribe, but she is invited to go to dinner by the salesmen
17 from the different companies.

18 The *Atlantic* even had an article several years ago that
19 talked about the physical attributes of the detail salesmen
20 who show up in physician and hospital offices and the fact
21 that they seem to be very good looking men and women, and
22 depending on who they were talking to, you might get a female
23 rep or you might get a male rep. It's a very interesting
24 article. I'll see if I can dig it up for you because it does
25 put a spotlight on some of the problems that we have with this

1 industry, but it could be done.

2 Vermont actually tried to pass a law so that providers as
3 well as the companies would have to report every single gift
4 that they gave. It was overturned, but I think some of the
5 efforts that are being made right now are going to go in the
6 same direction. And once you put a spotlight on that and it's
7 public knowledge, those pharmaceutical companies don't want to
8 be put in a bad light so they will change some of their
9 behavior, some of it, not of all of it.

10 COMMISSIONER BRANCO: Yeah. I can't tell you the numbers
11 of docs who have walked in my office with a new \$500 golf club
12 saying, look what I just got. Well, give it back.

13 COMMISSIONER STINSON: Under the Affordable Health Care
14 Act, all of that is reportable now, and at the end of the
15 year, there is supposed to be a printout from not only the
16 companies but from all the physicians of the dollar value of
17 whatever they accept. I'm not quite sure exactly when that's
18 supposed to be implemented. It may even be active now. I'm
19 not sure. What we've done in our clinic is people can drop
20 off whatever they would like to drop off. That's it.

21 COMMISSIONER HARRELL: And clearly from the federal
22 perspective, there is precedent for this. Obviously, I'm not
23 entitled, as a physician or an officer, to accept any kind of
24 gift over a particular amount, and it all has to be
25 reportable. So there is initial angst on it, but it's

1 absolutely doable, and folks get over it and move on.

2 COMMISSIONER STINSON: I'll clarify. They can drop off
3 any information they want to drop off and that's it. No golf
4 clubs, no articles or gifts.

5 MR. LUBY: Well, you know, if you go back, you know, one
6 of the things that we heard about in the early 1990s was that,
7 you know, well, prescription drugs cost a lot because we do so
8 much research and research is expensive, and it is. But way,
9 way, many, many years ago, we went so that we were paying much
10 more money on direct-to-consumer advertising than we were on
11 research in the entire pharmaceutical industry. So we could
12 save a tremendous amount of money on our prescription drug
13 costs if we could just get rid of those ads.

14 COMMISSIONER HARRELL: You mentioned the collaborative
15 environment here, which is something that I've experienced
16 since arriving here. I'm curious of your thoughts regarding
17 the electronic health record, and particularly, sharing of
18 data, your thoughts on how you would incentivize the different
19 entities to move towards that sharing of data. We all agree
20 that we need to do it. We all agree it's in the best interest
21 of our patients, but everyone comes with competing interests.
22 So any thoughts on how you're going to actually incentive
23 different agencies to begin to share that information for the
24 benefit of patients?

25 Again coming from a federal system, it's pretty easy for

1 me. I'm mandated and so we're going to do this, and it's
2 amazing to me that I can be here at our hospital in JBER and
3 pull up a record from somebody that was just seen at
4 Lanchfield (ph) two days ago in Germany and have access to
5 everything they've got. And there are fits and starts with
6 it, but it is amazing, as we have brought that online, in
7 terms of the access of information that I have.

8 MR. LUBY: Well, I think, you know, the military and the
9 VA are really way in the lead on all of the electronic
10 technology. You know, I remember Tom Nighswander, Dr.
11 Nighswander, I was talking to him one time about this, and I
12 said, well, you know, when will we get all this to work? And
13 he said, when CMS demands it for Medicare and Medicaid. And
14 at that point, then everyone is going to have to do it and
15 then everything else will come along.

16 You know, from our standpoint, it's a consumer
17 organization. We think it's going to reduce medical errors.
18 No one is sure whether it's going to save money. I think it
19 probably would, in the long run, but it certainly -- with
20 people being as mobile as they are and seeing as many
21 providers as they do, we have to do this. You know, we're
22 causing many of our own health problems for people because
23 providers don't know what another provider may be doing.

24 COMMISSIONER BRANCO: If I could, let me add to that as
25 well. When I first began to hear of the concept of a

1 community health record, not the P self version, not the
2 Providence version, not every individual health care
3 organization's individual electronic medical record, the
4 concept of a community health record, I first heard it from
5 George Bush's administration, the concept of moving towards
6 that as a standard within our communities to share
7 information, and of course, any time that's introduced, we get
8 the "yeah, but" -- yeah, but mental health should be private;
9 it should be limited scope on who can access that. But I
10 think you're right on track with how much money could actually
11 be saved, how many lives could actually be saved. If we have
12 patients doc shopping for prescriptions, and if there is no
13 communication across the community of who is getting what,
14 other than through our pharmacies who are now active partners,
15 these are concepts that are real. They'll save lives and
16 money. I think you are right on the money.

17 MR. LUBY: Let me ask a question. Representative Keller,
18 you know, how do you think the Legislature would feel if the
19 Commission took a more activist role as an advocate, taking
20 some of your recommendations and being there to testify more
21 often?

22 COMMISSIONER KELLER: I have mixed feelings about your
23 recommendation, and the reason is that the advocacy needs to
24 be broader than the Legislature. It needs to be people, as a
25 whole. You know, people make choices out there; we all do.

1 We all, ultimately, have the responsibility for our own
2 health. When it comes to pharmaceuticals, you bring up, at
3 some point, you know, you have a stake in what pharmaceutical
4 is bought, used on your behalf. That's huge, considering the
5 gap between what I think, in my opinion, what people know, you
6 know, about their choices, you know.

7 So the trouble, I think, with going to the Legislature
8 is, often, it gets interpreted. I know this isn't the intent,
9 but it gets interpreted as, give us the money and we'll make
10 good choices for the good of the people. And so it has to be
11 well done. We have to be sure, as a Commission, together when
12 we make a recommendation that we're all here. We represent a
13 broad spectrum, and if we are, in fact, unified on it, then I
14 think we would have a huge impact. Yeah.

15 COMMISSIONER CAMPBELL: In full disclosure, I've known
16 Pat since '89 or '90, I guess, and my hair wasn't as white as
17 it is, but the fact is that Pat has lots of veracity in his
18 field throughout AARP with its almost 40 million members. He,
19 with his gerontology background, has been a huge -- he has
20 been an influence to from my hospital background and health
21 care background. So I'd just like to compliment him for his
22 years of being here.

23 Wearing the hat as Chairman of AARP back in 2000, it was
24 my idea to put these state offices around the country so that
25 they could have the kind of impact with the research, the

1 giant research that's done in the Public Policy Institute at
2 AARP, so that we could disseminate that. You can't do it from
3 Washington, D.C. You've got to have people, like him, in
4 these states being an advocate for the consumer and not just a
5 health consumer, but in all aspects of consumerism. And so I
6 just -- when we instituted these state offices, Pat was in
7 California at the time, and he came north with me, and I've
8 been very glad to have him here when we instituted this
9 office. It's been a good thing from AARP's perspective, but
10 it's also been a good thing for the information available as
11 it is instituted at the local level. Instituted is the wrong
12 word, but at least, formulated to fit each individual state.

13 And that has been the importance of Pat's role here, and
14 I just can't say too much and wish him well as he heads back
15 to Texas to quit being a long-term care giver to his mother-
16 in-law and things, like that. So I just do want to compliment
17 him on that. He has been a tremendous resource, and we look
18 forward to having his successor being the same.

19 COMMISSIONER MORGAN: I'll make this short. I think,
20 especially on that statement -- I make four trips down to the
21 Legislature during the legislative session, and I know that --
22 I think the Commission does interact with the Legislature a
23 little more, not as a group, but as individuals. I talked and
24 went office to office on two occasions on the Primary Care
25 Association trip and talked to eight legislators, and

1 virtually, every one of them would show this, our report, and
2 I know of three issues that came up from immunizations to
3 patient home funding that several legislators would go to our
4 recommendations on our pages and utilize this document to help
5 make a decision on whether to vote or to support those
6 activities.

7 So I agree with Wes. I don't think we necessarily need
8 to go down and testify as a group on every issue, but I do
9 think the people around us, the individuals around this table
10 do interact with the Legislature, and I do know, in the seven
11 legislators that I talked to and a couple of senators also and
12 the Governor's office, this document is read, and this
13 document that we produce every year is used. Would you not
14 agree, Wes?

15 COMMISSIONER KELLER: Yeah. Thank you for backfilling
16 what I should have said. I mean, that's a very important
17 document, and yes, I sure refer to it, and I refer other
18 people to it, and it is paid -- you know, attention is paid to
19 it.

20 MR. LUBY: Representative Keller raised another issue
21 though where he talked about it's not just the Legislature
22 that needs to be educated, but we have an endemic problem here
23 that we don't have any health care reporters in our mass
24 media. We used to, but the State hired Ann Potempa away from
25 the *Anchorage Daily News*, and you know, some of the

1 recommendations that you have are actually -- it's better off
2 not taking them to the Legislature. It's better off taking
3 them to the public. And one of the challenges that we have, I
4 think, in Alaska is trying to figure out, how are going to get
5 these messages across in our mass media because some of the
6 work of the Commission, you're right, should be directed
7 toward all Alaskans. It shouldn't just be directed toward our
8 policymakers and that's something, I think, we have to work on
9 because, obviously, it's not going to be in the print media.
10 It's going to have to be on television and really
11 strategizing. We made a good decision here. Now how are we
12 going to get it on Channel 2?

13 COMMISSIONER KELLER: One thing, Pat, that you brought to
14 my mind I've been sitting here thinking about, and I just want
15 to throw it on the table. Maybe it's worth something; maybe
16 not. But one of the things that makes a problem on advocacy
17 is when somebody blindsides us that doesn't have a perspective
18 and hasn't had any input, and I was thinking, I wonder if we
19 shouldn't consider having a pharmaceutical representative on
20 this Commission, somebody who works in the industry that can
21 speak for the industry, you know, and the pricing and that?
22 Just a thought.

23 CHAIR HURLBURT: Yeah. I would just respond to that a
24 little indirectly, and as we're hear a little later, one of
25 our plans is to have the study of pharmaceutical costs, the

1 what's and the why's, comparable to what we did with hospitals
2 and physicians this year, and helping us work with that, we do
3 have a very good pharmacist with the Medicaid program, Chad
4 Hope, who will work with us on that and bring that resource in
5 to us there.

6 Pat, again, thank you very much. We appreciate your
7 willingness to share with us and to share your thoughts. You
8 do credit to your profession as a lobbyist and that's not a
9 profession, as you know, same as physicians or anything else,
10 that always gets a lot of credit, but you elevate your
11 profession, and you've done well, and you've earned a lot of
12 respect here. So thank you, Pat. Deb, I'll turn it to you.

13 COMMISSIONER ERICKSON: And I would invite Pat to stay at
14 the table for a little bit, too, if you'd like to just -- if
15 you have anything to add to the continuing conversation about
16 the Commission's role. We're going to get into that just a
17 little bit more. Is that okay with you?

18 MR. LUBY: Yeah.

19 COMMISSIONER ERICKSON: You don't have to. Well, I
20 thought I would follow on Pat's comments with a little bit of
21 a discussion about what some of our limitations as a
22 Commission are, and I've included -- Pat referred to our
23 statute, and I don't normally include our full statute in the
24 copies of your notebooks, but behind tab two is a copy of the
25 bill that established the Commission in statute during 2010.

1 So you can refer to that, and we might refer to it a couple of
2 times, in a couple parts of this conversation.

3 But one of the things about the Commission that is
4 important to understand, especially for the new folks on the
5 group, is that we were established as an entity within a state
6 government agency as distinguished from a separate body
7 responsible directly to the legislators, like the Legislative
8 Blue Ribbon Task Force type thing, or there was -- there were
9 actually three bills pending when this bill passed that would
10 have established a Health Care Commission in statute.

11 One of those would have created the Commission as some
12 hybrid entity outside the Administration, the Executive
13 Branch, that would have been responsible to both the Executive
14 Branch and the Legislature directly.

15 It's important, in part, to understand that we're part of
16 the Executive Branch and we're responsible to and are governed
17 somewhat by the procedures that the governor, whoever the
18 governor happens to be at the time, assuming we're in place
19 when we have another governor come onboard at some point in
20 the future, but as an Executive Branch agency, we are
21 restricted in how we are allowed to work with the Legislature
22 by the protocols that are put in place for an Executive Branch
23 agency and how we interact with the Legislature. So I don't
24 know if that was clear enough or abstract enough to understand
25 if that makes sense.

1 Also we are established as an advisory body. We are
2 advisory to the Governor and the Legislature through our
3 annual reports. We don't have any regulatory authority. We
4 don't have an operational capacity for actually implementing
5 anything. So those are a couple of the limitations.

6 One of the things I wanted to note, too, is that, while
7 we are accountable and under kind of the authority of the
8 Governor's office, to date, since we were established, we have
9 -- this body and Dr. Hurlburt and I have not been directed in
10 any way by the Governor's office to pursue a particular path
11 or policy. They actually have been fairly hands-off as far as
12 the strategies that we've selected and what we're following,
13 for whatever that's worth. I don't think that that -- that
14 won't necessarily always be true, and it wouldn't necessarily
15 have been true, if we had taken a different path or were
16 looking at other strategies, but I could imagine that, with
17 other governors in place, that office might choose to play a
18 much more active role in helping to set the agenda for this
19 body. So far, the folks sitting around the table are the ones
20 who really have set the agenda.

21 One of the other things, too, that we've talked about as
22 a group earlier on and it's probably a good reminder for our
23 earlier members and something to help our two new members to
24 understand is that we made a decision at very first meeting
25 actually, before we were even established under law and were

1 just under Governor Palin's Executive Order during 2009, that
2 this body would not take positions on legislation, either
3 federal or state legislation.

4 The main reason was we didn't want to politicize the
5 group, but the other reason was, since we were advisory and
6 were supposed to be coming up with our policy recommendations
7 for legislators and the Governor to consider, we didn't want
8 to get pulled in lots of different directions and have our
9 resources watered down by trying to analyze and respond to any
10 piece of legislation that might relate to health or health
11 care in some way. That could easily take all of our time and
12 attention. So those were the two main reasons.

13 And also, especially for, again, our two new members, we
14 made a decision when the Affordable Care Act passed that,
15 essentially, the level of policy recommendations that this
16 body is making are already reflected in the Affordable Care
17 Act. There was so much related to how federal government was
18 going to implement -- and we're going to go into a lot more
19 detail later today on where we're at with the Affordable Care
20 Act and how much has been done to implement it by the federal
21 government and what's going on in the state -- that we could
22 get so buried in implementation details that we wouldn't do
23 anything else and that the policy was, essentially, already
24 set by Congress and that we would track what was going on with
25 implementation of those policies, but we also didn't want the

1 group to become politicized at that point, and it hasn't
2 changed.

3 About a third to 40% of the population in the U.S. loves
4 the Affordable Care Act. Another 30% to 40% hates it, and
5 everybody else continues to just be confused about what it
6 means, and there just wasn't any way we could take a position
7 in some way on that bill and not alienate half the folks in
8 the state, one way or the other.

9 So we've tried -- and my point is, we've tried to, as
10 much as possible, kind of keep this group as politically
11 neutral as possible and just focus on the issues.

12 So that being said though, I would invite both questions
13 and comments on these reflections on our role right now, but
14 also would like to invite suggestions on what we might do both
15 with working to educate the public better and also to work
16 with the Legislature a little more directly.

17 One of the things -- Dave and Representative Keller
18 mentioned that we have had opportunities to participate
19 directly with the Legislature. We provide our annual report
20 to the Legislature each year.

21 One thing that I did, in addition to the annual report,
22 just this past year -- and I hadn't included it in your
23 notebooks, but we did the little two-page flyer, just back and
24 front, hitting the main highlights and trying to provide an
25 overview, understanding that we wanted a simple summary for

1 legislative staff and legislators to refer to, understanding
2 that most of them wouldn't read a 200-page report, and a two-
3 page overview, while it's hard to capture all of the main
4 points in two pages, we wanted to provide something that they
5 could, at least, get a snapshot. So that's one of the things
6 we did different this past year.

7 The other thing you should know is that Dr. Hurlburt and
8 I have had an opportunity, both this year and last, to -- or
9 have been invited by both the Senate and the House Health and
10 Social Services Committees to present our report before those
11 committees, and we've also had opportunities to meet
12 individually with some other legislators, who play some
13 influential roles in the Legislature who aren't part of those
14 committees, to have private meetings with them to review our
15 report with them.

16 We also have, in terms of the public, made some efforts
17 to outreach to the public, both through the website, our
18 ListServ, which is up to about 750 participants -- folks now,
19 and we've had some opportunities on radio, I think once in the
20 past on TV, but a number of opportunities through radio
21 programs, call-in shows to participate and share information
22 from the Commission. We've had an opportunity to do actually
23 two call-in radio programs with Jeff. Just for the record,
24 Jeff Davis has just joined us at the table. And some of those
25 have been picked up in rural Alaska as well.

1 So I mention those just so you have that as a background.
2 I invite any suggestions from all of you what we might do more
3 or different to improve our outreach to the Legislature. And
4 just so you know, too, we have active contact and
5 participation from the Governor's office. The Governor's
6 office is well aware of the work that we're doing, and we've
7 had opportunities, at least at one point in the past, to make
8 a presentation on the Commission's report directly to the
9 Governor.

10 So again all of that being said, any
11 suggestions/recommendations on what we might do to improve
12 outreach to the Legislature or to the public are invited right
13 now. Keith?

14 COMMISSIONER CAMPBELL: Question, do you always have to
15 wait for an invitation from the Legislature to make your
16 entrees or can you just select somebody and ask for an
17 interview?

18 COMMISSIONER ERICKSON: We do not have to wait for an
19 invitation. It's a lot simpler for us if we have an
20 invitation from a legislator to come meet with them or to
21 provide information to them. We're able to do that directly
22 with no restrictions, but just with keeping legislative
23 liaisons in the Governor's office and the Commissioner of
24 Health and Social Services' office advised. If we want to
25 make outreach directly that is not initiated, essentially, we

1 need to get permission first to do that.

2 (Pause - background noise)

3 CHAIR HURLBURT: I think it's important to say that, as
4 Commissioners, you don't lose your humanity. As a
5 Commissioner, you are appointed by the Governor and that does
6 place certain restrictions on what you can do as a Governor's
7 appointee, but what you do as your own person in your job, not
8 because you've become a Commissioner, doesn't censor you.
9 This is America. We have free speech here. So I think, as an
10 official body, more so for Deb and me as state employees,
11 there are restrictions, but even as a state employee, while I
12 do need to seek permission to take initiative to talk to a
13 legislator, as an individual on my own time, I would never
14 give up that right because I am an American. So I think it's
15 -- I know we all realize that, but I think it's important to
16 say that.

17 COMMISSIONER ERICKSON: And I want to respond to that,
18 too, but first of all, for those of you are on the phone, we
19 thought we had you all on lecture mode, but we're hearing
20 somebody talking and rustling papers in the background. So if
21 you all, for now while we work with the conference operator to
22 get this fixed, if you could please mute your phones on your
23 end for folks who are listening in, thank you.

24 And then thank you, Dr. Hurlburt. I did not mean to
25 suggest -- that was really important clarification -- that you

1 all individually aren't able to work directly with
2 legislators. Really, Dr. Hurlburt and I, on behalf of the
3 Commission, have those restrictions that I was talking about
4 earlier.

5 COMMISSIONER KELLER: If I could, it occurred to me as
6 you were talking -- and I'm speaking for myself, not for the
7 Legislature here, of course. You know, in my capacity, I
8 would invite the Commission on numerous occasions to come
9 down, and part of the reason for that is that, every year or
10 every session anyway, there is a total reorganization. There
11 are new faces and whatever. So maybe we ought to be thinking
12 toward a "Challenges of Health Care in Alaska 101"
13 presentation early in the session, you know, and make it
14 available to both Health and Social Services Committees. I
15 think that would be very helpful, and I think it would be
16 well-received. It would be deeply appreciated by most
17 because, you know, the person who wins an election and ends up
18 in Health and Social Services, and you're thinking, where do I
19 go from here? You know, Medicare, Medicaid, what's the
20 difference, you know, kind of thing? I mean, we need the 101.

21 And I want to say that Commissioner Hultburg and
22 Commissioner Streur filled that role, to some degree, you
23 know, this last session. They just made us aware of the
24 State's challenge as of the largest consumers in the state of
25 health care, and their information was something that was

1 really appreciated by the Legislature.

2 COMMISSIONER ERICKSON: Thanks for that suggestion. I
3 just noted that. Other thoughts or ideas? Yes, Pat?

4 COMMISSIONER BRANCO: Mine is a question, and it's based
5 on Pat's reading of our charter to us, the word implement.
6 What is our reference to the word implement?

7 COMMISSIONER ERICKSON: I will confess that I wasn't sure
8 I remembered reading the word implement in our statute. So I
9 would have to look quickly, and if somebody can find it.....

10 MR. LUBY: It's on page two.

11 COMMISSIONER ERICKSON: Page two of the bill? So okay.
12 This is an important clarification. So the section of this
13 bill -- we're looking at SB172 from 2010. The section of the
14 bill that actually establishes the Commission and provides the
15 Commission's charge is at the bottom of page two where it
16 says, "Chapter 9, Statewide Health Care, Article 1, Alaska
17 Health Care Commission." Everything following that title at
18 the very bottom of page two and up to -- through line 29 on
19 page six is the section of what is now state law that governs
20 the establishment and work of the Health Care Commission. The
21 line to which you're referring, Pat, is actually in a
22 different part of state law, Title 18, Chapter 5 refers to the
23 duties of the Department of Health and Social Services.

24 COMMISSIONER KELLER: And that's back on page one, line
25 six.

1 COMMISSIONER ERICKSON: And what you're seeing is the
2 current law. I don't believe it's been amended since.
3 Starting on page one through line 28 on page two, those are
4 the duties of the state Department of Health and Social
5 Services as they are lined out in state law. And what the
6 legislation that established the Commission did, related to
7 the "Duties of the Department," was add a duty, but I think it
8 says "may." Yes. This is the "Duties of the Department" in
9 this Chapter. The "Department may." It's not the Department
10 shall, an important distinction. Added a new provision that
11 the Department may develop, adopt, and implement a statewide
12 health plan under AS 18.09, based on recommendations of the
13 Alaska Health Care Commission. So it's the Department's duty
14 to implement and that they may develop a plan to implement,
15 based on recommendations of the Commission.

16 If you look at the Commission's charge, I think, at the
17 top of page three, our purpose statement in the law is that
18 the Alaska -- "the Health Care Commission is established in
19 the Department of Health and Social Services. The purpose of
20 the Commission is to provide recommendations for and foster
21 the development of a statewide plan."

22 So that being said -- and something that we're going to
23 talk about next -- and maybe this is the perfect segue to
24 talking a little bit about our future because the context of
25 the future is also directly related to our role and what we're

1 doing now. Commissioner Streur, the head of the Department of
2 Health and Social Services, expects that our 2013 annual
3 report -- I clarified this with him just yesterday in
4 preparation for this meeting. The Commission will sunset, if
5 we're not extended by the Legislature, on June 30th of 2014.

6 So one of the things that I've been keeping in mind all
7 along and think about more regularly as time goes on is that
8 our calendar year 2013 report could be our final report to the
9 Legislature and the Governor, and we are going to plan as
10 though we will continue, but at the same time, if, for
11 whatever reason, the Legislature decides not to extend the
12 Commission or if they decide to and the Governor decides to
13 veto that law, the Commission might not exist into the future
14 beyond that point. So while we will continue planning for a
15 future beyond that point, at the same time, I think we should
16 be focused on having a product, at that point, that is as
17 comprehensive as possible, ties all of the great work that you
18 all will have done over the course of those four years
19 together into kind of a comprehensive package with an action
20 plan and next steps for the Governor, the Legislature, the
21 Department of Health and Social Services to move forward, in
22 case it is a final product. So we will have added some value
23 and not have a bunch of piecemeal pieces of recommendations
24 laying around.

25 And also there are a number of other planning efforts

1 coming together that are statewide in nature, and we'll be
2 learning about those more at our next meeting in August, but
3 I'm having ongoing conversations with folks working on those
4 about how those will tie into -- because one of the other
5 duties in our statute laid out here is that the Commission
6 also is expected to kind of be the coordinating body for
7 health planning in the state. We're not taking a real active
8 role in going to every organization that's conducting health
9 planning and trying to direct, in some way, what they're
10 doing. We will, more and more, be pulling pieces in together
11 and looking at the framework that we're putting together as
12 kind of an umbrella framework for all of those pieces. So
13 that will be another component of that 2013 annual report will
14 be tying all of those pieces together, but we'll get into more
15 details related to that at our next meeting.

16 Does anybody have anything more to add on this
17 conversation or any questions about, in general, our future
18 plans? Hearing none, thank you very much, Pat, again, and
19 congratulations on your retirement. We're all very sad to see
20 you leave. We echo, again, what Keith said earlier about how
21 much you have been appreciated.

22 Moving into the next part of our agenda, we'll talk a
23 little bit more about our plans. I think we've talked about
24 our plans for beyond. I need to get my PowerPoint
25 presentation back, but we're going to talk a little bit about

1 our plans for this year right now. So the agenda -- and for
2 our new members, for the benefit of our new members, one of
3 the things that -- well, maybe I'll just talk about process
4 for a second in terms of coming to our development of our
5 annual report, the overall process.

6 We've identified how -- at the beginning, we identified a
7 vision for the future. That's something that we're going to
8 revisit here in just a minute, but we did that, actually, at
9 the beginning of the Commission established by Governor Palin,
10 and this new Commission established under the statute we just
11 looked at, essentially, just adopted that without any change,
12 that original vision statement. But what we did was we
13 identified vision in the future up front and decided that we
14 would spend time, each year, studying the current condition of
15 the system and trying to understand better why we haven't
16 attained that vision yet and then also, at the same time,
17 spend some time studying strategies for how we think we can
18 help move the system towards that, so we're understanding the
19 baseline and current conditions better, looking at strategies
20 for trying to attain the future.

21 So that's just very generally what our process has been.
22 So in our reports, we have some components where we're just
23 studying and trying to explain the current condition. For
24 example, one of the things we did this past year was study a
25 comparison of pricing and reimbursement levels for hospital

1 and physician services between Alaska and a number of other
2 states as just -- this is a current condition. We didn't make
3 any recommendations directly related to that study, but used
4 it as learning.

5 So one of the other things that we do then in preparation
6 for the coming year, we'll put out for public comment, and we
7 invite public comment throughout the year, but we will try to
8 have drafted findings from our current -- the studies we'll do
9 this year as well as recommendations based on strategies we've
10 studied, try to have those drafted by the end of October and
11 share those for public comment during the month of November
12 and then we'll come together for a one-day meeting in early
13 December to consider all of the public comment, do a little
14 bit of wordsmithing and finalize all of the findings and
15 recommendations that will go into our annual report to the
16 Governor and the Legislature each year. So I just wanted to
17 make sure that you understood, just really generally, how our
18 process will work.

19 One of the things that we do in addition to identifying
20 findings and recommendations, based on our studies throughout
21 the year, is we will identify what we thought was significant
22 to study for the -- to continue studying, just to identify new
23 studies for the coming year, other strategies we want to study
24 for the coming year. We'll do that in advance of the public
25 comment period in November and so we're, essentially, setting,

1 at the end of the calendar, with public input, our agenda for
2 what we're going to study in the next calendar year.

3 And looking at the slide that I have on the screen here
4 right now, this agenda that we have for 2010 [sic], our
5 current calendar year, is something that we decided several
6 months ago and included in our 2012 report.

7 Each year, we spend some time in each of our meetings, we
8 spend some time looking back to our previous recommendations
9 and learning about how -- what activities are happening
10 related to implementation of those recommendations, and there
11 is just a summary of those, the major areas of those on this
12 slide right now. For the benefit of folks on the phone,
13 applying evidence-based medicine, strengthening primary care,
14 improving the State's trauma system, increasing price and
15 quality transparency, paying for value, developing a
16 sustainable workforce, developing the health information
17 infrastructure, and supporting prevention, particularly around
18 what the Commission identified as the top population health
19 concerns, obesity, immunization, and behavioral health issues.
20 We have more detailed recommendations related to each of those
21 areas. We'll spend some time learning about the status of
22 those at each of our meetings.

23 For this year, continuing study of the current system,
24 we'll do some more price and reimbursement analysis around
25 pharmaceuticals, and we will include step-down care as part of

1 that as well. Learning about the behavioral health system, we
2 did at our last meeting. The current malpractice environment
3 we did at our last meeting as well. And at each of our
4 meetings, we spend time looking at current status of
5 implementation at both the federal and state level of the
6 Affordable Care Act. And related to studies and learning
7 about potential strategies where we might actually develop
8 some recommendations, the four areas we had identified for
9 this year were the use of technology to facilitate access to
10 care and that's what we're spending all of our time tomorrow
11 focused on. Enhancing the employer's role in health and
12 health care, we'll have a focus in October at our October
13 meeting on that. Improving quality and choice in end-of-life
14 care we'll be doing in August. And reducing government
15 regulation is something that will be kind of sprinkled
16 throughout all of these meetings. We started talking about
17 that at our last meeting, and we are trying to focus on, in
18 each of these areas, as well as if it comes up in any other
19 area, if there is a particular barrier, especially around the
20 state, we're going to have a lot less impact on any federal
21 laws or regulations impacting the health system, but around
22 state, if we are identifying something. For example, one of
23 the things -- I know we have Deborah Stovern in our audience
24 today, who is the Director of the State Medical Board, and
25 she's going to be on a panel tomorrow. One issue that we want

1 to learn a little bit more about is physician licensure, more
2 broadly provider licensure. Are there issues around licensure
3 rules in the state that are either helpful or are causing a
4 problem that we might want to make recommendations about
5 breaking down barriers around? So just as an example.

6 So that's our agenda for 2012. Yes, Emily?

7 COMMISSIONER ENNIS: Deb, I know we heard a report on
8 long-term care several meetings ago, and we understood that
9 there is a task force or workgroup developing more
10 information, recommendations, findings on long-term care needs
11 in our state. Do we anticipate that we will have that
12 additional information in 2012 or is that something that's
13 going to be a 2013 information and report?

14 COMMISSIONER ERICKSON: Thanks for bringing that up. We
15 wrote a general description in our 2011 report on what we
16 learned about the long-term care system -- or actually, it
17 might have been our 2010 report. No. It was 2011. And we
18 noted in there -- this was an area for study, so we didn't
19 develop any recommendations around it, but we noted in there
20 the work that -- a coalition had come together representing
21 broad stakeholders who were going to be moving forward with
22 developing -- working towards development of a long-term care
23 and that the Commission would track that. I don't know if
24 this is true, so maybe I shouldn't say it, but I believe that
25 that group hasn't been able to get a whole lot of traction. I

1 don't know if that's true, but there is going to be -- while
2 we're going to be looking more at quality of clinical care in
3 our end-of-life care discussions, it's too interrelated with
4 the issues of long-term care, and what I'd like to do is
5 invite an update. I'm hesitating a little bit because, if we
6 get too far off into the whole long-term care system, it's
7 going to dilute our focus on the end-of-life care discussions
8 that we need to be having. At the same time, we can't
9 completely divorce ourselves from that. So I want to invite a
10 presentation as part of that session and our learning at our
11 August meeting to get an update, which is what the Commission
12 said we would do. We would just update ourselves on the
13 status of the long-term care planning, not try to take it
14 over, and make that part of that discussion. So I'm glad you
15 brought that up. Thank you. Pat?

16 COMMISSIONER BRANCO: Debbie, just a quick piece and that
17 is part of my charter and representation on the Commission is
18 the Alaska State Hospital and Nursing Home Association, so
19 long-term care is part of my advocacy, but it isn't a
20 separately carved out piece of the Commission's agenda yet.

21 COMMISSIONER ERICKSON: Yeah. The group does need an
22 update on the status of that planning effort, if it's
23 happening, and we'll have to figure out how to distinguish
24 when we're looking at the importance of the continuum of care
25 for long-term care services and looking at ensuring quality at

1 end-of-life and for the seriously ill, so that will be an
2 interesting tension and dance for us, but we can, at least,
3 learn about the status. Any other questions?

4 The next slide I have up -- and I apologize for those of
5 you on the phone. Any of the presentations that we will have
6 from guest speakers today and tomorrow, to the extent I had
7 them by the close of business yesterday, they are all posted
8 on our website, but I have a PowerPoint that I'm just using
9 kind of as a discussion guide for the purposes of the
10 Commission today and that's not on our website. So as I'm
11 referring to slides right now, those of you on the phone won't
12 be able to see them. I'm trying to describe them in a little
13 more detail. Any other presentations that we'll have later
14 today are all on our website.

15 So just a little more detail about our plans for the rest
16 of the year. We're focused more on access issues today, and
17 while we normally are really strict about the agenda that we
18 set and keeping our sessions at our Commission meetings
19 limited to those, one presentation that we're going to spend
20 the last half of our morning on today that might be a little
21 bit more of a stretch -- I'm thinking of it more as government
22 barriers or not, but this was too exciting not to focus on
23 with the Commission and make sure the Commission was learning
24 about it and profiling it in our report -- is the fantastic
25 work that the VA, the Indian Health Service, the Health

1 Resources and Services Administration at the federal level,
2 the tribal health system, and I know the State's Primary Care
3 Association is really interested in moving forward in this,
4 our new Service and Resource Sharing Agreements between all of
5 these different systems, which is -- I don't know that I've
6 ever seen anything quite like it. I think it's pretty
7 fantastic, and it's going to do a lot to improve access to
8 care for veterans in rural Alaska throughout the state, not
9 just rural Alaska. And so we'll have a two-hour presentation
10 about that, thinking about it as an opportunity for overcoming
11 barriers that government regulations and rules and programs
12 might create for themselves and how these programs are
13 breaking down those barriers.

14 COMMISSIONER MORGAN: One slide change. We were -- I've
15 asked Fran, who has been very involved in this for a couple of
16 years from Yukon-Kuskokwim who is in the audience, will be
17 joining us at the table, if that's okay with the body. She
18 has a lot of experience, and she's also a veteran, so.....

19 COMMISSIONER ERICKSON: Well, then we can't say no.

20 COMMISSIONER MORGAN: That's right. And by the way, I
21 would like to put it in the record that today is the birthday
22 of the United States Army. It's 236 years of age today. It's
23 Flag Day under the old process. And since me and Fran, we're
24 both former Army guys, I just had to throw that in.

25 COMMISSIONER ERICKSON: As long as that's okay with our

1 Air Force guy.

2 COMMISSIONER HARRELL: (Indiscernible - away from mic)

3 COMMISSIONER ERICKSON: Very good. We don't need to sing
4 Happy Birthday. Thank you. And Fran is most welcome to join
5 the panel at our 10:15 session. So those are our plans for
6 today. I'm really excited about the plans that are coming
7 together for our last two big meetings of the year. I should
8 have put our December meeting on this slide, too. So we'll
9 make sure I add that, and I will post this PowerPoint to our
10 website when we're done at the end of this week, for those of
11 you on the phone.

12 So our meeting in August, we will be meeting at
13 Providence for that meeting. Our focus will be more on
14 clinical quality. We -- the speaker who we have lined up --
15 now one of the other things that I wanted to apologize to all
16 of you -- you all received a book in the mail from me a couple
17 of months ago maybe now, at least a month ago, and I asked you
18 to read it for this meeting and that was in preparation for
19 our end-of-life care session, and I was hoping to have that
20 scheduled for this meeting. The book, for those of you in the
21 audience, is *The Best Care Possible*. It's the latest book out
22 by Dr. Ira Byock, who is a national leader in the area of
23 palliative medicine, and I was trying to get him, Dr. Byock,
24 to come make a presentation for the Commission, but I think,
25 especially with this -- that book was just released. I mean,

1 it was hot-off-the-presses when I got it and mailed it to all
2 of you. I think, with his speaking schedule related to that,
3 plus they're in the process at Dartmouth of doubling the size
4 of his palliative care program, that he didn't have an opening
5 in his speaking schedule for, at least, 12 months.

6 But I am not disappointed with the speaker we've been
7 able to line. Dr. Hurlburt and I had an opportunity to spend
8 an hour on the phone with Dr. Ritchie, Christine Ritchie, who
9 had been the head of a regional palliative care center,
10 national level regional based out of Alabama, and she just
11 moved to San Francisco and is with the School of Medicine at
12 University of California at San Francisco right now. But she
13 is another nationally-known speaker in the area of palliative
14 care, and I hear wonderful things about her and have had great
15 interaction with her. I think she'll be our featured kind of
16 keynote speaker at our meeting in August.

17 And I want to refer you to your notebooks. This is not a
18 handout, for folks in the room. Most of the things in the
19 notebooks are posted in the Web and available to the folks
20 sitting in the room on the back table, but some of the stuff
21 that's pretty drafty yet I did not include for the -- as a
22 handout for the public. But I have a page and a half or so, a
23 kind of overview description of our plans for the session
24 around end-of-life care, and also the draft agenda for August
25 is starting to come together. So I wanted you to have a

1 chance to look at that. So behind tab two, the third document
2 back is maybe the easiest thing to look at, quickly together.

3 I normally do not like large panels, and we might break
4 this panel up a bit. So you see our plans for Thursday,
5 August 16th are to start and to spend the first half of that
6 morning with a presentation and then a conversation with Dr.
7 Ritchie and then to spend the second half of the morning with
8 a panel of groups of folks, both representing the health care
9 industry, the parts of the health care industry that might
10 touch, most directly, folks who are seriously or terminally
11 ill.

12 Dr. Rust, who is the director of the only palliative care
13 program we have in our state based out of Providence here in
14 Anchorage, will lead us off. We're looking at potentially
15 having a couple of different hospice directors, and sometimes
16 -- Dr. Urata, I can't remember if you mentioned during your
17 introduction that you also are and have been for, at least, 25
18 years or maybe since its inception the Medical Director,
19 volunteer Medical Director for Hospice of Juneau; is that
20 correct?

21 COMMISSIONER URATA: Yes, since 1987, and we started out
22 as a volunteer hospice, but expanded into Medicare certified
23 home care and then now a Medicare hospice program.

24 COMMISSIONER ERICKSON: So we -- sometimes, I will ask
25 Commission members to actually sit on these reactor panels, if

1 they are the absolute best person to represent the particular
2 issue or their sector. So I may or may not drag you onto this
3 panel, but I think we have lots of opportunities to invite
4 other directors of hospices and administrators to the table,
5 and you're going to have lots of opportunity to provide input
6 during the course of the conversation that day. Pat?

7 COMMISSIONER URATA: Whatever you wish.

8 COMMISSIONER BRANCO: And not to request panel
9 participation for myself, but just to correct the record,
10 there is a second active formal palliative care program in the
11 state of Alaska and that's in my house, in Ketchikan.

12 COMMISSIONER ERICKSON: Well, see and that's why we have
13 these learning sessions is to learn stuff, like that. I don't
14 know if the palliative care community in Anchorage knows that.

15 COMMISSIONER BRANCO: No. And of the Juneau.

16 COMMISSIONER URATA: Can I kind of make a little
17 distinction?

18 COMMISSIONER ERICKSON: Yes.

19 COMMISSIONER URATA: You know, there are two things. One
20 is hospice, and one is palliative care. And palliative care
21 is -- well, hospice is palliative care for those at the end-
22 of-life, the people who are dying from cancer or age. And our
23 hospice is not in the hospital. A lot of times, palliative
24 care programs are in the hospital and deal with patients with
25 pain from whatever reason. They could be young people. They

1 could be older people. They could have different types of
2 medical diagnoses. So a lot of the palliative care programs
3 deal with a broader age group in a hospital setting whereas
4 many of the hospices could be in the hospital or at home. And
5 in Juneau, ours is a home-based hospice program. So I just
6 want to clarify that distinction.

7 COMMISSIONER ERICKSON: Thanks for that clarification. I
8 think that's a real important distinction and something that
9 our learning at this meeting will help us to clarify. That's
10 why we've invited both to participate and why I really would
11 like to have both a Medicare-certified hospice representative
12 and a volunteer hospice, so we can understand the distinction
13 between those two different types of hospices, not just
14 between hospice and palliative care because I think it might
15 be important for us to understand, and I think it will also be
16 important us to understand, too, Pat, how connected, or not,
17 the palliative care and the hospice communities are across
18 Alaska, how isolated or connected they might and if it would
19 be helpful to make them less isolated -- help them to be less
20 isolated in some way, if they are.

21 COMMISSIONER BRANCO: Happy to contribute. And we have
22 both volunteer hospice, as Dr. Urata described, home-based,
23 and the palliative care is hospital-based.

24 COMMISSIONER ERICKSON: So related to the book, you are
25 only getting two books that are required reading this year,

1 I'm pretty sure. I don't think we're going to load you up
2 with any more. So if you haven't read Dr. Byock's book yet,
3 you have an extra two months to read it.

4 Dr. Hurlburt had pointed out this other document that's
5 in the plastic wrap that you all have at your seats right now,
6 when you're not here, and this was something that Dr. Urata
7 shared. He just sent me a copy, and I was blown away when --
8 I thought you were sending me some brochure from some national
9 group, the End-of-Life Foundation. This is a little Juneau-
10 based foundation, the End-of-Life Foundation. And this
11 guidebook, when you have a chance to open it and look at it,
12 is just absolutely fantastic. I've never seen anything like
13 it in terms of a resource for families and individuals to use
14 to help plan for their families for end-of-life. It's
15 absolutely beautiful, very well done, and it just seems like a
16 huge gift to me, and I've shared it with some other folks
17 involved with hospice who haven't seen anything like this and
18 certainly not of that quality. So to understand that a small
19 handful of folks sitting down in Juneau would come up with
20 something that's such a great resource, I think it was
21 something that you all would need to, at least, see. We may
22 or may not want to develop some recommendations related to
23 that sort of resource and supporting families in making plans
24 for end-of-life and guiding decisions related to that. I'm
25 sure that will be part of our conversation in August, but

1 that's why you have that document there. Unfortunately, I
2 didn't have enough to share with the audience, and as far as I
3 know, Dr. Urata, it's not available in PDF form
4 electronically. So I can't post it to the Web, but again,
5 we'll talk about availability of this resource to the broader
6 public when we meet in August. So that's just something.
7 It's more reading, but even though it's about planning for
8 your death, I promise you will enjoy reading this guidebook.

9 So does anybody have any questions or comments or
10 suggestions actually related to our August plans?

11 So then for October, it will be more of our focus on the
12 employer's role in health and health care. It's the other
13 book you have at your place, *The Company That Solved Health*
14 *Care*. And following on Pat Luby's comments to us this
15 morning, the suggestion that Pat made was that, at one point,
16 his experience in Texas where there were community business
17 councils on health and his recommendation that the business
18 community needed to be more engaged as a purchaser in
19 improving health and health care in the state, that's
20 something the Commission discussed a little bit last year and
21 put on our agenda for this year.

22 So this book, *The Company That Solved Health Care*, was
23 written by an individual. John Torinus was the CEO of a
24 Midwest, I think, Wisconsin manufacturing firm who, earlier in
25 the 2000s, was frustrated with the fact that his employee

1 health benefits costs were going up 15% or more each year, and
2 he couldn't stomach that anymore. At the same time, he
3 couldn't bring himself to just discontinue that benefit for
4 his employees. So he started experimenting with different
5 strategies to try to control costs of health care for his
6 employees, and some worked; some didn't work. But over time,
7 putting together the pieces that did work, he was able to
8 demonstrate a return on investment for his company in
9 investing being a little more strategic about both supporting
10 employee wellness as well as around design of the health
11 benefits and how to provide care.

12 So we are very fortunate we are going to actually be able
13 to bring the author of this book to Alaska to make a
14 presentation to the Commission. I have the contract in place
15 with him now, so we're set. We'll be holding this meeting at
16 the Marriott because we're going to be partnering with
17 Commonwealth North, and Commonwealth North, if you're not
18 familiar with them, is a bipartisan policy body -- member
19 policy body. Most members are participants in the business
20 community. They hold forums on various policy issues
21 throughout the year. It'll just be a luncheon forum where
22 they will have as many as 100 people or so, again mostly from
23 the business community, show up for those. So we're
24 partnering with them for Mr. Torinus' speech to the
25 Commission. It's actually going to be a Commonwealth North

1 event, and we'll have -- depending on room availability, right
2 now, we're planning on 150, but I was going to see if we could
3 have even more folks from the business community join us for
4 that presentation. So we're working to schedule that as a
5 luncheon for 150 business leaders that you all will be able to
6 participate in with Commonwealth North.

7 Something else related -- and then we'll -- similar to
8 what we have been doing with the featured speaker is following
9 kind of a reactor panel. We'll have a panel following,
10 profiling some of the things that are happening in Alaska and
11 reflections from other leaders about what they think the
12 opportunities and what the challenges for the business
13 community are in helping to improve employee health and also
14 contain health care costs and kind of drive improvement in
15 health care in the state.

16 One of the things that I wanted to make sure that we were
17 doing as part of that conversation -- and these are actually
18 recommendations from members of the non-health care business
19 community who I've been trying to reach out to over the last
20 couple of months -- a suggestion that we not just invite them
21 to our table, but that we go out to them and ask them what
22 they know about health care, what their concerns are, what
23 they're doing right now. So we'll be working on some sort of
24 activity to either reach out through round tables, again going
25 out to them and compiling information from that, but I was

1 recently able to connect with someone who has experience
2 working in an employee health management program who is
3 currently in the Master's of Public Health program for UAA,
4 and for her Master's thesis, is planning on doing research
5 directly with the non-health care business community, going
6 out to them and asking those very questions, and her research
7 project is going to be implemented in the next month or so.
8 And so I've offered -- made an executive decision -- to be
9 kind of the executive sponsor. She needed a sponsor of some
10 organization that said they would use her research. So the
11 Commission is going to sponsor her work from the survey and
12 the outreach she's going to be doing. We'll bring that
13 learning back, just to complement the learning that we'll be
14 doing in these other ways. So I wanted to share that with
15 you, too. I'm real excited about that.

16 Then I mentioned earlier, we will be spending at that
17 meeting also in October trying to firm up recommendations that
18 have come from all of these four areas and putting those out
19 for public comment during November, and we'll also hold a
20 final one-day meeting in this room on December 10th to
21 consider public comments.

22 In the interest of time, I'm going to move on to our
23 Vision Statement revision, and I'm just going to put this out
24 on the table. Since you didn't have it in advance of the
25 meeting, you may or may not want to make a decision right now

1 or table it for our next meeting. But in these conversations
2 that I've been having business leaders, pretty consistently
3 hearing back from them that they don't quite get our Vision
4 Statement, but that they think that the work that we're doing
5 is critically important to them. And so one suggestion I've
6 had -- and I will confess that I've never been that enamored
7 with our Vision Statement. It actually came out of one
8 brainstorming session, and it just was -- these were the main
9 issues that came up. In brainstorming, it got lumped together
10 into a Vision Statement, and we never really refined it. But
11 so what I've been hearing -- our current Vision Statement is,
12 "Alaska's health care system produces improved health status,
13 provides value for Alaskans' health care dollar, delivers
14 consumer and provider satisfaction, and is sustainable." And
15 what I've heard back is, well, that's not very simple. We
16 can't remember it. We don't really understand it. It's not
17 very compelling. It's not visionary, especially from an
18 entrepreneur standpoint where they're thinking not about what
19 I can do today, but what does the future really -- what should
20 the future hold? It's not -- it would be helpful if it was a
21 little more time specific and we could understand what it will
22 look like when we attain it.

23 So those were the complaints I've heard about our Vision
24 Statement, and based on that, I've actually played with a
25 rewrite. Again, this is based on what I've been hearing from

1 business leaders of what they think would be compelling and
2 bouncing it off a few other people.

3 To make it time specific, "By 2025, Alaskans will be the
4 healthiest people in the nation and have access to the highest
5 quality, most affordable health care." And this is, again,
6 what I've been hearing reflected back. We want to know that
7 we're the healthiest people and that we have the most
8 affordable and highest quality health care. Why can't you
9 just say that? Why can't that just be your vision? And if we
10 know we're going to measure it, we have an end point that
11 we're shooting for. And if you can tell us how we're going to
12 know with just two or three high level measures, so we will
13 know we've attained this vision when compared to the other 49
14 states, and these are all measurable, that Alaskans have the
15 highest life expectancy measured in years of healthy life, the
16 highest percentage population with access to primary care --
17 one of our features of importance of access that we've talked
18 about -- and that we have the lowest per capita health care
19 spending level. Now whether that's attainable or not our
20 entrepreneur friends would say, it needs to be a reach. It
21 needs to be a vision. So I'm going to stop talking for a few
22 minutes and invite some feedback on this proposed draft new
23 Vision Statement.

24 COMMISSIONER BRANCO: Deb, have you tested it with any of
25 your business community cohorts?

1 COMMISSIONER ERICKSON: Just limited informally, yes.

2 COMMISSIONER BRANCO: What was the initial reaction?

3 COMMISSIONER ERICKSON: Very positive.

4 COMMISSIONER BRANCO: I'm an opponent of wordsmithing by
5 committee and having random thoughts thrown up on a piece of
6 paper. I think is an exceptional start, and if we're
7 reasonably satisfied with it, I think we ought to press it,
8 and if time changes the direction of it and we revise the
9 vision over time, I think that's acceptable, but I think this
10 is a real commendable start.

11 COMMISSIONER ERICKSON: Keith?

12 COMMISSIONER CAMPBELL: Let's take an informal poll
13 quickly of our audience.

14 COMMISSIONER ERICKSON: We could do that. I don't know
15 if folks can see it on the screen very well or if it would
16 help if I read it again, but we could ask for a show of hands
17 from the audience. Dr. Urata, first.

18 COMMISSIONER URATA: You know, I think having a lot of -
19 - the highest percentage population with access to primary
20 care is good, but we also need to have a balance that we have
21 an adequate amount of specialists to take care of those who
22 can't be taken care of by primary care. I mean, I could live
23 with this, but you know, I don't want to make my specialist
24 colleagues upset either.

25 COMMISSIONER ERICKSON: You're too nice. With deference

1 to Dr. Stinson.....

2 COMMISSIONER URATA: Well, you know, I.....

3 COMMISSIONER ERICKSON: Let me just mention -- and
4 Colonel Harrell -- too, this is the highest level. One of the
5 other things that we're not going to get into today -- it's on
6 the agenda, just to note -- is that we have been shooting for
7 coming up with a set of measures, and we will, that are more
8 detailed that will fall below those and be more directly
9 related to our goals, and we're going to hold off on doing
10 that for now because one of the other statewide efforts is a
11 way to help measure if we're making progress. So we're not
12 going to use only those three measures, but those will be the
13 kind of top outcome measures as far as attaining our vision,
14 and we'll have another set of measures for measuring whether
15 we've attained our goals or not, and we're going to partner
16 with the group that's working on a statewide health
17 improvement plan, developing a Healthy Alaskans 2020 plan, to
18 come up with those measures, and plus, the federal government
19 just came out with a website that they're using to measure
20 health system improvement, and we'll make sure we're aligned
21 with those as well, but in response to your question. Yes,
22 Colonel Harrell?

23 COMMISSIONER HARRELL: Well, first of all, I appreciate
24 the deference to specialists; however, I'll tell you, within
25 our circles and our discussion, one of the phrases that we're

1 using more and more is moving from health care to health
2 because health is what we're after, and so when you're after,
3 I think the emphasis is primary care and preventative
4 medicine, not specialty care. So then I would vote that
5 number two there is completely appropriate because health is
6 what we're after, not better health care. We're after health
7 for the population.

8 COMMISSIONER ERICKSON: Dr. Stinson?

9 COMMISSIONER STINSON: I agree with that, plus it's a
10 measurable standard to look at. Number one I have a little
11 bit of a problem with when it says, "measured in years of
12 healthy life." I think, if you want to go highest life
13 expectancy, that's a standard that would be measurable. When
14 you try to put a qualitative factor on if someone lives an
15 additional ten years and they're diabetic and have progressive
16 amputations, I'm not sure that we need to get down to that
17 kind of data, but.....

18 COMMISSIONER ERICKSON: We could have a debate with our
19 public health epidemiologist about whether and how we measure
20 that. My one thought was I, sometime in the past few months,
21 saw a report that Americans are living one year longer now
22 than we were, and I can't remember how many years, what the
23 comparison was, but we were living one year longer, but we had
24 two years more of disability affected in some way or poor
25 quality life. And so if we're living longer but we have

1 shorter years of quality living, that's why I was making the
2 distinction, but I think that's real important to think about
3 that, and we want to keep it as simple and as measurable and
4 comparable as possible. And so I'll follow up on that. Yes,
5 Dr. Urata?

6 COMMISSIONER URATA: I might make a suggestion that we
7 compare ourselves with other nations that lead in the life
8 expectancy. In Japan, I think the life expectancy for women
9 is in the low 80s, 83 or something like that, and men are 81.
10 In the United States, we're still in the high 70s, I believe.
11 And perhaps one way to easily measure is to look at our life
12 expectancy in our state for men and women and compare it to
13 countries with the best in that category.

14 I think a lot of people, like the World Health
15 Organization, look at life expectancy of a measure of the
16 health care system in that country, and the United States
17 usually is around 37th or 32nd in terms of life expectancy,
18 and we also have a -- we lag behind other countries in infant
19 mortality, and perhaps that would be something to look at and
20 consider.

21 COMMISSIONER ERICKSON: Jeff?

22 COMMISSIONER DAVIS: Thank you, Deb, and apologies to the
23 group and the audience. Somehow the power went off at my
24 house in the middle of the night, and luckily, my four-year
25 old son woke up early enough that I got here because,

1 otherwise, I'd probably still be sleeping after getting home
2 from Seattle late last night. A blinking alarm clock is not a
3 good thing to wake up to.

4 Anyway, moving on, I really like the statement. It's
5 certainly an audacious vision, and we could probably spend
6 time -- and I appreciate all the comments -- in working on the
7 measures, but if we get anywhere close to obtaining that, that
8 would be amazing and wonderful. So I think these measures are
9 close enough, and we'll know if we've gotten aware close to
10 obtaining our vision by 2025.

11 COMMISSIONER ERICKSON: Should we go back to Keith's
12 suggestion that we poll the audience? Colonel Harrell?

13 COMMISSIONER HARRELL: Sorry about that. Just one more
14 comment in favor. As you digest the three and you couple one
15 and two and then you pair it with three, then you get to value
16 and that's also important. So you've got a clear preventative
17 focus in one and two and then, when you bring in the cost
18 feature in three, you start making commentary about favor, and
19 I think, again, that has merit.

20 COMMISSIONER ERICKSON: Does anybody have any concerns
21 about this statement? Maybe we let the audience participate
22 through our public comment period later, if everybody's
23 feeling positively about this, at this point.

24 CHAIR HURLBURT: Yeah. It's a little curmudgeonly
25 compared to what we've all been saying. I think it's a

1 wonderful aspiration. I think that it's impossible. I think
2 that comparing our average life expectancy to Japan's, the
3 horse is already out of the barn for 2025. We have four times
4 the obesity rate that Japan has. We have already decided
5 what's going to happen in 2025, and it would be a huge success
6 if the disparity between the United States and Japan does not
7 widen over the next 13 years. So that's a little bit
8 curmudgeonly, but I think it's the reality. Sorry.

9 COMMISSIONER DAVIS: So Dr. Hurlburt, I agree and so I
10 would say -- suggest to be more specific. I think Dr.
11 Stinson's recommendation about healthy life. That's very
12 hard, and I think if we just keep it simple. And if we got
13 close to number one in the 50 states, that would be an amazing
14 accomplishment. So keep it simple and drive for it.

15 COMMISSIONER ERICKSON: Well, would somebody like to make
16 a motion to adopt this now?

17 COMMISSIONER HIPPLER: (Indiscernible - away from mic)

18 COMMISSIONER ERICKSON: Sorry. Allen?

19 COMMISSIONER HIPPLER: I didn't have a question. You had
20 asked if anyone had objections to it. I agree with Dr.
21 Hurlburt. I think it's completely unattainable. A goal
22 should be attainable. We could make it relative to ourselves
23 at this current time or some time in the past. Maybe that's
24 attainable.

25 COMMISSIONER ERICKSON: Well, now just to clarify, this

1 isn't a goal; it's a vision.

2 COMMISSIONER HARRELL: Right. And so the commentary
3 there would be, of course, the philosophical difference. A
4 vision can be unattainable because you're setting a bar out
5 there, which drives behavior. So the fact that it's
6 attainable or not, at least in my opinion, would be
7 irrelevant. It's where you are driving towards.

8 COMMISSIONER ERICKSON: Dr. Urata?

9 COMMISSIONER URATA: Yeah. I agree with Dr. Harrell that
10 it's a Vision Statement, and the American Heart Association
11 developed Vision Statement in the year 2000 that we would
12 reduce mortality rates from heart attack and strokes by 25% in
13 the next ten years, and everybody thought that that was going
14 to be really difficult, but in fact, it did occur. Strokes
15 and heart attacks, by 2010, had been reduced by 25% through
16 public health, work research, cardiology, and there were a
17 whole bunch of factors that went into that. And what we call
18 this Vision Statement is a BHAG and that's B for big, H for
19 hairy, and A is audacious, and G is goal. And I guess, in
20 this sense, we could kind of reduce the word goal in terms of
21 its meaning, but it's a BHAG and that's what we want. That's
22 what I would recommend.

23 COMMISSIONER ERICKSON: And I haven't put up here,
24 actually, our four more specific goals related to access,
25 cost, quality, and population health improvement, and I

1 wouldn't suggest that those change, and we can put this
2 together in a package. Does somebody want to make a motion to
3 accept this with, I was hearing, a possibility of revising
4 that first measure?

5 COMMISSIONER URATA: So moved.

6 COMMISSIONER ERICKSON: With the revision to the first
7 measure, healthy life expectancy?

8 COMMISSIONER URATA: Yes.

9 CHAIR HURLBURT: Is there a second to the motion?

10 COMMISSIONER BRANCO: Second.

11 CHAIR HURLBURT: Pat, thank you. Any discussion? Is
12 there a call for the question? All those in favor, raise your
13 hand. Opposed the same. It's unanimous. Thank you. Deb?

14 COMMISSIONER ERICKSON: Thank you, all, very much. We're
15 going to break in just two minutes. I already mentioned the
16 points about measuring health system improvement.

17 One of the things, I wanted to apologize for not getting
18 your notebooks to you in advance. The notebook pieces for our
19 next two meetings are already coming together and so you will
20 -- and for our two new members, normally, you would get your
21 notebook, at least, a week in advance of the meeting for some
22 pre-reading and preparation. But I've started drafting,
23 because I don't want to wait for all of the pieces to come at
24 the very end of the year this time, papers on the issues that
25 we learned about at the last meeting. And so in your

1 discussion guide, there are just a few of the highlights
2 related. We'll have one related to malpractice reform, one on
3 health insurance regulation and what we've learned from Linda,
4 we want to capture now that she's retired, and one related to
5 the behavioral health system, and I want to run that draft by
6 our panelists and presenters on that session, too, before I
7 even share it with you all to get their feedback. But I
8 pulled out some of the highlights, and especially at the end
9 of that meeting after the presentation on the behavioral
10 health system, we identified some preliminary findings. You
11 have in your notebook behind tab two -- I think it's the last
12 couple -- the last couple of pages -- or the last page of that
13 document is all of the bullets from the slides from that
14 brainstorming session, but what I did was I took and
15 categorized those first and then I kind of crafted them into
16 some more general Finding Statements, some along the lines of
17 challenges and others opportunities. And so if you have any
18 thoughts about what is captured there, we can follow up later
19 on those, but that's what's come out of that last discussion
20 and what will be captured in the first draft of that kind of
21 overview discussion paper, description paper.

22 I think we are done with this presentation for now. It's
23 time to take a break. We'll reconvene at 10:15 with the
24 presentations on the new sharing agreements between the VA,
25 the tribal health system, and we also have another project

1 related to veterans' access for behavioral health services in
2 Southeast Alaska. We'll have a presentation before lunch.
3 Any final questions or comments on the morning before we stop
4 for a break? Very good. Thank you.

5 10:02:03

6 (Off record)

7 (On record)

8 10:18:27

9 CHAIR HURLBURT: Thank you. I think we're ready to go
10 ahead and start on our next session. As Myra was just saying,
11 this is a fun thing to talk about. These are some of the neat
12 things going on here in Alaska. Part of it certainly reflects
13 outside interests in what's being done here, but a part of it
14 reflects just basic Alaska. As Colonel Harrell was saying,
15 it's notable coming here how well folks work together, and
16 I've probably said the same thing to this group before, but
17 when I came back and I came into this job, the weekend before
18 I really started, we had a young child, a ten-year old from
19 Fairbanks, who died with H1N1, and at that point, we were
20 saying, is it 1919 or what? But what was so dramatic was how
21 everybody was working together on that. So that's one of the
22 nice things. It's part of having not many people in a really
23 big state, but probably partly because of what Alaskans are
24 like and that's going to be a good thing.

25 The contrast I gave is that we were Outside in the Puget

1 Sound area, and I worked in one of the emergency preparedness
2 groups there, and what was startling, to me, in those days in
3 Fort Lawton and Bremerton and Everett Naval Air Station and a
4 number of large military installations there, they thought
5 they could do all this emergency preparedness totally
6 excluding DOD, which is such an incredible resource anywhere
7 you are, but that is not Alaska, fortunately for us.

8 So what we're going to hear about first is an effort
9 going on with the Veterans Affairs, with the Indian Health
10 Service, and the Alaska tribal health system here. There has
11 been a formal Memorandum of Agreement, and the effort is
12 reaching out where there are so many veterans, reflecting the
13 reality of Alaska, but in isolated situations, maybe a
14 disproportionate number. We have probably the largest number
15 of veterans and retirees in the state and the country and a
16 lot in rural areas because the rural areas are, often, largely
17 Alaska Native people and historically have been a very
18 patriotic group of people. A lot of them have been in the
19 military services, going back to the Second World War days and
20 probably before certainly and since then. So there are a lot
21 of folks out there that are entitled to benefits, but for
22 practical, financial reasons, there has not been a physical VA
23 presence there. So we want to talk about that the panel that
24 we have -- and I'll just introduce them all now and then maybe
25 turn it over to -- Dave is first on the list, unless you have

1 a different plan than -- to Myra. Okay.

2 Dave Morgan, who is with SouthCentral Foundation and has
3 had a number of experiences here in Alaska worked with APIA in
4 the past. So he's had experience with rural Alaska with
5 primary health care centers around the state. He will be here
6 on the panel.

7 Myra Munson, who has a long history in the state here as
8 an attorney, has been very much related to what we do here in
9 her role when she was Commissioner of Health and Social
10 Services for the state of Alaska. In more recent years, her
11 primary focus has been working providing legal support and
12 advocacy with the tribal health system, both here -- largely
13 here in Alaska, but also a lot on a national basis through her
14 firm.

15 And then Susan Yeager will be the third one. Susan is
16 with the VA health care system here, but again, a person whom
17 I first got to know when she was the Administrative Officer in
18 Barrow and a person who intimately and very well knows the
19 challenges of providing rural health care in Alaska. Susan
20 was not able to be here on the phone because she out doing her
21 job and implementing this agreement that we have here now.
22 Deb?

23 COMMISSIONER ERICKSON: She is on the phone.

24 CHAIR HURLBURT: I'm sorry. I thought.....

25 COMMISSIONER ERICKSON: And then Fran is here.

1 CHAIR HURLBURT: I meant to say that, if I didn't. Thank
2 you, Deb. So Susan is joining us on the phone, but not here
3 physically. And then Fran Liptrot, who is the Executive
4 Director for Revenue Management, and would be, I guess,
5 David's counterpart with YKHC, again the largest of the tribal
6 health programs in Alaska that provides services to the
7 25,000-plus folks in southwestern Alaska there. They have
8 done a number of innovative things, been a very, very
9 progressive organization providing health care in that part of
10 the country. So we'll have these four folks with us, and I'll
11 turn it over to Myra with that.

12 MS. MUNSON: Thank you. Susan Yeager, who is on the
13 phone -- we're very sorry she couldn't be here because lots of
14 people get credit for this activity, an enormous number, and
15 I'll mention others of them later, but I want Susan to speak
16 first because no one, in my opinion, gets more credit than
17 Susan does for this being possible. It really is her role in
18 helping to initiate, to get off the ground, the coalescence of
19 people from the Veterans Administration here, Veterans
20 Affairs, and tribal system that brought together that led to
21 the 13th Workgroup being formed, and from that, the
22 opportunity to work on a Sharing Agreement, and her efforts
23 through all that process to try to work with tribal health
24 programs and then to now work -- well, first, to work on
25 enrollment of veterans, which is a tremendous issue and unmet

1 need. So she is working on that. And then now to implement
2 these agreements is really just extraordinary. So Susan, you
3 get to go first.

4 MS. YEAGER: Boy. Geesh. Well, thank you for that --
5 thank you very much for that introduction, and I am very sorry
6 I couldn't be there today. I'd certainly like to see Dr.
7 Hurlburt. I haven't seen you in a while. I, too, left Alaska
8 and then just came back a year ago. So I am down in Homer
9 right now with a team from the VA that we're doing our
10 outreach, just to bring a combination of VA staff from the
11 health care side of the VA, the benefits side, and then the
12 Memorial Affairs side. So we always bring the whole group of
13 people so that, when a veteran comes, whatever their question
14 is, there is someone here to answer it, and it's transparent,
15 our different division of VA.

16 But as I said, I'm Susan Yeager, and I'm very happy to
17 have had this job now at the VA for the Rural Health
18 Coordinator. It's really great to be able to come back to
19 Alaska to try to help set up this program. The VA set it up,
20 and Alex Spector hired me about -- a while ago as a result of
21 feedback that the VA was receiving that the VA needed to get
22 out more and contact veterans and health care organizations to
23 explain what benefits are available to veterans and to help
24 those veterans overcome the barrier, the hurdle of the
25 government bureaucracy and all that paperwork. So this is

1 what we've been trying to do.

2 And one of the major pushes, as Myra had said, is the
3 foundation for the VA to provide health care services is this
4 enrollment process. So just a minute about it, and I won't
5 take up too much time because I know we have slides that we'll
6 be going through, but the enrollment process -- the VA cannot
7 pay for any health care or provide any health care until that
8 veteran is determined to be eligible for the services, and to
9 be eligible, they must enroll, meaning fill out a 1010-EZ
10 form. So we've really been pushing that, and it's all the
11 more important now as we implement our Sharing Agreements with
12 the Native health organizations, which, I would say, with all
13 the work that Myra has done and Dave and Paul and others, a
14 dozen on our ad hoc group, the 13th Workgroup, we're really
15 supportive of, Mr. Lincoln Bean and Lanie Fox from the Native
16 Health Board, that's been our major effort.

17 So by the end of this week, we expect to have 20 signed
18 and awarded contracts or Sharing Agreements with Native
19 organizations and everyday getting one or two questions about
20 adding new ones. And so the VA then in response to the
21 feedback to get out there, we've been busy working to get out
22 and touch veterans and get to them and actually sit with them
23 and help them fill out the paperwork. And down here, for
24 example, we were in Kenai yesterday.

25 Part of our training, our focus now is two-fold: one,

1 face-to-face with veterans, and two, provide training,
2 education, and working with the business office
3 representatives from the Native organizations where we have
4 Sharing Agreements. And so just to say, on June 29th, we'll
5 have a training at Anchorage in our VA clinic for Native
6 organization business people who are interested in -- and
7 really anyone who is interested in how to, under the Sharing
8 Agreement, bill us and how to process claims and how to
9 partner in the enrollment part, including things such as co-
10 pays and third-party recovery and pharmacy reimbursements, and
11 still, care coordination.

12 The VA sees itself really as a health care provider, and
13 in Alaska, it's different because we don't have as much
14 infrastructure. We do have our inpatient facility under our
15 Joint Venture with JBER and Elmendorf and so that's our
16 inpatient facility in Anchorage, but around the rest of the
17 state, we're very lacking in infrastructure, all the more
18 reason that we, the VA, partner with organizations for the
19 access to care. So with many of the issues that, I think,
20 Myra is supposed to talk about, the reasons that led up to
21 having this agreement, I just am fortunate to be here at the
22 right time, really, when I see many of the pieces of the
23 puzzle were coming together. So I was very lucky to be here
24 at this moment in time.

25 So basically, you know, just a thing to remember; these

1 agreements, as Myra might mention, we're the first in the
2 country to have these. Within Alaska, folks -- we kind of
3 have a big state, but a small population. We all pretty much
4 know each other and can work together here. So we're kind of
5 leading the nation now, which can be good or bad, in these
6 agreements, and it's really about access to health care for
7 the VA and for rural veterans. And there are certainly many
8 other issues involved, but of the roughly 77,000 veterans in
9 Alaska, of that number, for the VA, in a year, we're seeing
10 15,805 veterans, for example, in FY11. And so we know there
11 is a large number of veterans who are not connected to the VA.

12 In the Native population, which is information we're
13 starting to gain, we know very little about those Native
14 veterans because most of them, we believe, have not applied
15 for VA. So that enrollment piece is critical to understand
16 who the veterans are, where they are, and how we could better
17 serve them.

18 So our recent statistics, which were very rough until we
19 get some experience, it looks like we have about 9,200 Native
20 veterans in Alaska, and we have some projections by borough,
21 and of that number then, only 6% of those Native veterans are
22 actually using VA services either directly or through our fee-
23 basis program and that's a program where we buy health care,
24 under which we pay for these agreements. So that's a big gap
25 between the rest of the population in Alaska where 20% of the

1 overall veteran population are seen, in way or another, by the
2 VA in a given year. So we realize we have a tremendous gap in
3 access and that's what these agreements are helping us to
4 correct.

5 I think, you know, having said that, I think I'll stop
6 right now, and as we go along, if there are questions for the
7 VA, I'd be happy to answer. I just want to say that we're
8 very grateful, from the VA's perspective, to have such great
9 partners and support from Alaska, from the Native side, from
10 Myra, and others to get these agreements done in pretty much
11 what we consider record time.

12 So it just reminds me of a design build project where
13 we're sort of "as we go." We're currently, right now, just
14 developing our internal pathways in our organization, so that
15 we internally can process these agreements and so a lot of
16 it's brand new for us and then our training of our staff, and
17 as I mentioned, the organizations come June 29th.

18 We will have an electronic version of our member
19 guidebook completed by next week, which we'll be able to
20 provide electronically to any of the Native organizations that
21 have the agreement. And just FYI, we do have and have had in
22 Alaska for many years a vendor guidebook that explains how the
23 private sector can interact with the VA to obtain
24 authorization for the VA to buy that care, reimbursement care.

25 So I'm very grateful to be a part of this and that's it

1 for me for now.

2 MS. MUNSON: Thanks, Susan. If we could move the slide,
3 all of you -- and again, and we can stop here. I think Susan
4 introduced the notion of what the high percentage of veterans
5 is, and this slide presentation starts with some very basic
6 information before we get into the substance.

7 Some of this came as really a complete surprise to me
8 when I was asked to be involved on behalf of some of our
9 clients to try to help move forward the reimbursement piece of
10 all the other work that was going on. I really had no idea.
11 I knew there were a lot of veterans in Alaska. I knew my son
12 had served and my ex-husband, and you know, lots of the people
13 -- two of the people beside me. Fran and David both have
14 served. But I had no idea that it was one out of four Alaska
15 men were veterans and that, you know, this is -- a third,
16 again, is high as in the Lower 48. It's consistent, but high,
17 even among tribes all over the United States. Everywhere you
18 go in Indian Country throughout the United States, veterans
19 are revered, and they have a higher percentage of veterans,
20 but nowhere more than in Alaska, as far as I know.

21 It also was a surprise, to me, that Alaska women were
22 more likely to be veterans, with 4% as opposed to one in the
23 United States. I mean, that's really an amazing statistic,
24 and it's an important thing as we begin -- a week ago, there
25 were meetings in which tribal representatives were together,

1 and part of the conversation was -- we started on May 4th, the
2 first day the agreements were signed -- you've got to start
3 with enrollment, and it means patient registration. People
4 have to start not only asking, are you on Medicaid, but also,
5 are you a veteran, and they have to remember not to impose a
6 preconception about that. They have to ask every young woman
7 and older woman, too, are you a veteran, not just men who may
8 be coming through their program. So these are -- it set an
9 important backdrop to our discussion. Next slide.

10 This is, I think -- you get two maps in this
11 presentation, but I think this is, really, the key to this
12 discussion, and similar things have -- if you look at around
13 the country -- and I mention the rest of the country because
14 there is a national backdrop to this agreement, although
15 months and months and months would have gone by more if Alaska
16 had not taken the lead. So there is just so much credit to be
17 given to the VA in Alaska, but the VA in Alaska, other than
18 the facility it has here, has services in Fairbanks, Juneau,
19 Kenai, and some in Wasilla. It doesn't show up on that map,
20 five locations in our enormous state.

21 If you turn to the next map, this is a map of the tribal
22 health system and not truly complete because it picks up
23 mostly larger clinics, but the Alaska tribal health system has
24 a presence in every community in which there are Alaska
25 Natives, virtually every community. The tiniest villages may

1 have only a community health aide, but they have, at least, a
2 community health aide and that community health aide is
3 connected, increasingly, technologically very connected, but
4 in the old days, by CB radios, but now with very high-powered
5 telehealth tools, in many cases, but they're connected to a
6 sub-regional or regional hospital, and they're all connected
7 to the Alaska Native Medical Center here in Anchorage. So
8 they're connected to a very sophisticated health care system
9 that they can access to make sure that the people in that
10 community have health care and that's the health care that
11 everyone wants for every veteran in Alaska and that's what we
12 think is achieved under these agreements. Let's turn to the
13 next slide.

14 I'm a lawyer. You've got to have something about legal
15 authority; I mean, what can I say? But I think it's helpful
16 to understand this, in this case. The VA has always had
17 authority for Sharing Agreements and that authority is
18 identified there as 38 U.S.C. § 8153, and there have been
19 agreements between VA and tribes in the past at tribal health
20 programs for certain services, limited, lots of
21 preauthorization, but the impetus for really a paradigm shift
22 in the relationship came after the passage of the Indian
23 Health Care Improvement Act amendments.

24 The Indian Health Care Improvement Act is one of the two
25 laws that provide basic authority for Indian health programs

1 and identify a number of things. The amendments were an
2 astonishingly tedious 11-year process, but they actually got
3 adopted in the Affordable Care Act. Among those amendments --
4 I know -- I'm going to get you there. Among those amendments
5 is a provision that says that Indian health programs have --
6 my grammar is a little problematic, but anyway, Indian health
7 programs have a right to be reimbursed by VA and DOD where
8 services are provided through an Indian Health program to
9 beneficiaries eligible for services from either such
10 department and that, of course, includes the Department of
11 Defense. We have not yet tackled agreements with the
12 Department of Defense. In Anchorage, they're very much part
13 of the partnership, a little bit more so in some agreements in
14 other parts of the state, but we'll be talking to DOD soon, at
15 least that's.....

16 COMMISSIONER HARRELL: I would just add we just recently
17 had a visit from the Assistant Secretary of Defense for Health
18 Affairs, Dr. Woods, and Dr. Petzel, and they're both aware of
19 our desire to, locally here, participate, and they gained a
20 tremendous amount of insight during their joint visit.

21 MS. MUNSON: Terrific. Clearly, the impetus is with
22 veterans because they're out in the communities with the
23 active members. They're serving where they get their health
24 care principally, so DOD was not the first target in terms of
25 working on these agreements, and their members were not the

1 folks who are most in need of having the expanded services.

2 And the other provision here that I didn't read is,
3 notwithstanding any other provision of law. This is really --
4 this, combined with other provisions -- and I didn't bore you
5 with all the other cites that there could have been there --
6 of the Health Care Improvement Act that speak to a Memorandum
7 of Understanding between IHS, Indian Health Service, and the
8 Veterans Administration or Veterans Affairs Department, and
9 Payor of Last Resort provisions. Work is continuing on those.
10 The Memorandum of Understanding went into place; it was
11 renewed a year ago. And issues about the Payor of Last Resort
12 and what that actually means are still being resolved between
13 the two departments, and the Department of Justice is
14 assisting them to understand what it means. We heard,
15 informally, that there might be some conclusion of that, but
16 nobody has shared anything with the tribes. So we don't know
17 yet.

18 When we began our work in this process, we kind of
19 stepped past all this, but I want to point out -- I saw Bob
20 Urata's eyebrows go up when I mentioned that the amendments to
21 the Affordable Care Act authorized 1645. That's where that
22 occurred. When we entered into this agreement, we started out
23 having -- in the legal authority provision of the agreement,
24 it had a citation to both of these provisions.

25 At some point, VA said, you know, if you want the 1645

1 provision, you can have it, but if you don't, we don't care.
2 We're relying on our Sharing Agreement authority. And I got a
3 little heat for this later on from some folks, but I said,
4 thinking, Affordable Care Act, Supreme Court; yeah, 8153 is
5 just fine. So this agreement relies exclusively on the 8153
6 provision. If, at some point -- well, at the end of the
7 month, we'll know. My guess is the next round of
8 modifications on these agreements -- and there will be many as
9 the years go by, just tuning them up -- we'll probably add the
10 citation to the Indian Health Care Improvement Act as well,
11 but while it was still in flux waiting for this decision, we
12 decided we would not create any ripple about these agreements.
13 These agreements stand, regardless of what the Supreme Court
14 does. They are not reliant on the actions related to the
15 Affordable Care Act. So we appreciate the VA's interest in
16 using their own authority. We're happy with that today.
17 Let's go to the next slide.

18 I mentioned, when I started, and I think Susan mentioned,
19 that there had been a 13th Workgroup. So nationally, the VA
20 had 12 workgroups working on various issues associated with
21 Indian services. After a visit by Secretary Shinseki and
22 others to Alaska and with the work that had been going on
23 among tribes with Susan, a 13th Workgroup was formed. I
24 wasn't a member of it. I didn't attend any of those meetings.
25 But the important piece of this is how high up the support for

1 it was, that it came out of this initiative from the Secretary
2 that he wanted work being done. It was a recognition that
3 there was a unique environment in Alaska and not only that the
4 situation and services were unique, but also that it was sort
5 of a unique energy that's been referred to here about the
6 ability to get things done, for people to work together. So a
7 lot of credit goes to the Undersecretary for Health and all
8 the participants in that.

9 The group was sponsored by the Alaska Native Health
10 Board, the advocacy arm for the tribal health programs, and
11 chaired by Mr. Lincoln Bean. The charter was approved, and
12 they met first in September of 2011. They were co-facilitated
13 in Alaska, with Native representatives, by Libby Watanabe from
14 SEARHC, SouthEast Alaska Regional Health Consortium. The IHS
15 Area Director, Chris Mandregan, participated, and near the
16 end, his Executive Officer, Leslie Dye, also participated, and
17 the VA was represented principally through their Rural System
18 Program Coordinator, Susan Yeager. That workgroup was very
19 active, meeting very regularly, and working on issues, like
20 enrollment, expanding information, and so on. Let's go to the
21 next slide.

22 Talking about what folks were trying to accomplish, and
23 they focused on increasing access, including veterans'
24 benefits and cemetery administration. So the 13th Workgroup
25 has focused not exclusively on health, but principally. It

1 began work on endorsing and supporting the Tribal Veteran
2 Representative training and support program, that network, and
3 I've heard Lincoln Bean, Chairman Bean speak a number of times
4 now about how just moving it was when TVR training came out to
5 Kake, where he is from, and the entire village turned. I
6 mean, all these veterans came, and one-by-one, they came and
7 talked to folks. They took part in -- people took part in
8 training. There is sort of this really unmet need among
9 Alaska Native veterans for recognition of their service and
10 for an interaction with Veterans Affairs, who they are so
11 remote from most of the time.

12 So this Tribal Veterans Representative program is an
13 incredibly important piece. The principal people being
14 trained are veterans, but not exclusively. Many of the people
15 trained are volunteers, but in addition, some employees of
16 tribal health programs and other tribal organizations are
17 obtaining training, so that there is a vehicle for veterans,
18 Native and non-Native, in every village to be able to have
19 access. So the goal of having that access to every village is
20 far from complete, but it is improving dramatically everyday,
21 and as Susan said, she's in Homer now working on that.

22 Also the endorsement of ongoing training for Native
23 health organizations to understand the VA process for
24 authorization (indiscernible - voice lowered) VA. We talked a
25 lot at negotiations about VA has its own culture; tribal

1 health programs and the people being served have their own
2 culture. Bringing these two together is not an inconsiderable
3 task and so work is occurring on an ongoing basis to do that,
4 and the agreements will help because they define some of the
5 provisions that make it easier for people on both sides to
6 understand what they need to do.

7 COMMISSIONER MORGAN: Can I make a comment?

8 MS. MUNSON: Yeah, please.

9 COMMISSIONER MORGAN: Fran might speak better at this,
10 but the TVR program, I think -- it's a three-day training.
11 The TVR, the reps help veterans in each of the organizations
12 that signed on -- help them find out if they have benefits,
13 and if they don't, help them get those health benefits, and
14 it's not limited to tribal. It's -- a lot of these villages,
15 especially in my experience at Eastern Aleutian Tribes and
16 Chugachmuit, they're usually the only game in town. They see
17 everybody anyway, and I believe 40, Fran, have been trained,
18 and they're going to try to get to 100 by the spring; is that
19 -- you have the most trained people now, I think.

20 MS. LIPROT: Thank you. I just want to speak in
21 reference to the Tribal Veteran Representative training
22 overall. We definitely want to thank Susan. She has brought
23 in many experts, even from the Lower 48, to help expand this.

24 One of the things in working with the tribal organization
25 I'm currently with is that we found that there are numerous

1 individuals that are veterans out there, but they're unaware
2 of their benefits. They're unaware of the access to care that
3 they are entitled to from the service in which they've
4 provided to us. And the TVRs -- YK currently has six TVRs.
5 We've actually increased that. We were one of the first pilot
6 programs also that worked in conjunction with the VA to have a
7 VA TVR, themselves, placed out in our area because we wanted
8 to expand it. We've incorporated it within our outreach
9 program of identifying those individuals, assisting them in
10 enrolling and screening and trying to acquire their benefits.

11 And one of the biggest opportunities which we've found
12 was that opportunity of 94% of all Native veterans is
13 something that we're reaching for as a goal. So we're not
14 doing it just from a corporation. We are using volunteers.
15 We're also providing additional training to other businesses
16 within our area, so they can start going through.

17 So there is quite a bit of training involved, but there
18 is a lot of reward that's coming to fruition for the veterans
19 for the communities themselves. So Susan is doing an
20 outstanding job, and as we're going through this, we're
21 wanting there to be a lot of self-support from the tribal
22 perspective, so we can offer this not only to Native veterans
23 but to all veterans in our areas.

24 MS. MUNSON: Thanks. You can tell I have -- since we
25 began this process and the first agreements were signed in

1 May, we've had a number of presentations everywhere. Every
2 time the Tribal Veteran Representative discussion starts, it
3 consumes the presentation because, in many respects, it's the
4 most exciting piece of this because it is linking those
5 veterans with the benefits to which they're entitled, once
6 enrolled, wherever they go. If they leave that village and go
7 someplace else, they now have access to veterans health
8 without having to go through that first step, and I'm assured
9 that that first step is not so complicated, but I have a son
10 who is a veteran, and I think all of us know that the Veterans
11 Health Administration is an overwhelmed system in many, many,
12 many parts of the United States. It's underfunded for the
13 demand, particularly with the return of veterans after ten
14 years of continuing warfare.

15 So it's a challenge for any veteran to get in that
16 system, and getting past that first place, that first
17 enrollment is a critical step, and so this is an exciting part
18 of the agreement, and in many respects, these Sharing
19 Agreements created an impetus for the tribal health programs
20 to become an active part of the process of achieving
21 enrollment, and in that, it's an extremely important part of
22 the Sharing Agreement, in and of itself, although it makes up
23 a very small part of the detail. Let's move on.

24 Among the goals that the 13th Workgroup had were to
25 improve coordination of care, including co-management, and

1 there was discussion about supporting development of Sharing
2 Agreements and establishing a workgroup to develop a Sharing
3 Agreement. Let's go to the next slide. We'll get into the
4 Sharing Agreement, itself.

5 In February, there was a 13th Workgroup meeting occurring
6 in Juneau at the same time the Alaska Native Health Board was
7 holding its meetings and the Mega Meeting with the State was
8 occurring, all these meetings happening, so lots of key
9 players there. And VA had a number of people at that meeting.
10 Four of our clients -- and I feel obliged to mention their
11 support -- SouthCentral Foundation, Alaska Native Tribal
12 Health Consortium, Yukon-Kuskokwim Health Corporation, and
13 SouthEast Alaska Regional Health Corporation, so four very
14 large players in this issue and with some greater resources
15 asked if I would go to that meeting and see if the 13th
16 Workgroup was ready to get down to brass tacks about a Sharing
17 Agreement, and I know a lot about tribal health and virtually
18 nothing about veterans health, although I've learned a whole
19 bunch recently, but I can write an agreement about any darned
20 thing, you know, just any darned thing. Somebody can put some
21 information in front of me and tell me what you want; it can
22 make sense or not. I don't really care. I can get an
23 agreement written. And so they sent me to these meetings to
24 see if I couldn't, you know, get an agreement written.

25 We met in February. The 13th Workgroup members were very

1 supportive. They wanted to be sure that, if I was coming in
2 to help, I was really going to help and that I understood what
3 veterans really needed, that it was going to maintain the
4 right focus, that it wasn't either just some lawyer coming in
5 to help or going to ignore the specific needs of veterans as
6 we work on these agreements and with enough assurance, and the
7 fact that nothing would go in the agreements that the actual
8 tribal representatives and VA hadn't agreed to, that, you
9 know, I really only write what I'm told to write.

10 So they formed an ad hoc agreement, and VA was extremely
11 supportive. The task was to negotiate a Sharing and
12 Reimbursement Agreement and to get it done as quickly as we
13 could. VA met with our ad hoc committee in March for a two-
14 day meeting and brought Headquarters representatives to be
15 here for the agreement in addition to a whole long list of
16 people who came from VA locally to participate in that
17 discussion. The Area IHS was represented with the Executive
18 Officer, and the tribal representatives were there, including
19 Chairman Bean. So Fran, and David, and me, and others from
20 the tribal health systems, including Brent Simcoski from
21 Ketchikan Indian Community, came. So small and large
22 programs, hospital-based and non-hospital-based programs,
23 urban and rural were all represented on the ad hoc committee
24 from the tribal side.

25 It was a really amazing meeting in terms of the

1 willingness of the VA and tribal representatives to find
2 common ground, and we began, really -- it was interesting. We
3 kept trying to talk about -- you know, somebody would want to
4 talk about this detail or that and what we did is we stepped
5 away and we took ourselves to Barrow. So we went to the
6 furthest north place we could metaphorically. We stayed in a
7 small conference at one of SouthCentral's conference rooms,
8 but we went up to Barrow, and we talked about how would a
9 veteran get care in Barrow. Let's talk about, what the rules
10 would be for that veteran in Barrow, for a Native veteran, for
11 a non-Native veteran; what is it that we're trying to
12 accomplish? And we would talk detail for a few minutes and
13 then we would step back and then we'd talk detail for a few
14 minutes and then we'd come back to our principle. And in the
15 process, by the end of the first day, we really had an
16 agreement in principle. We really understood what we were
17 trying to accomplish and how to get at what needed to be in
18 there.

19 It then took from -- that was March. It took me about
20 three or four weeks to get a draft written and then it was a
21 marathon of teleconferences, and the last -- well, not the
22 last teleconference, by any means, but the last really big
23 teleconference of trying to work it out occurred -- I was
24 actually in D.C. Susan was, I don't know, someplace in
25 Alaska. Other folks were in meetings in someplace in the

1 Lower 48. People were scattered all over working on details.
2 And the lead attorney for the Chief of Staff for the Veterans
3 Administration working for Veterans Affairs, working on this -
4 - and I said, well, you know, I'm in D.C. Shall I just come
5 over tomorrow?

6 We spent ten hours with three of their attorneys and
7 myself and people dropping in, an assistant to the Secretary,
8 making sure we stayed on track and we worked through the
9 details. I have never worked on any agreement anywhere with a
10 federal agency and had a higher level of interest and support
11 and willingness to not roll over, by any means, but to stay
12 focused on what the objection was and to meet a timeline. We
13 had all agreed we wanted this done before a national Indian
14 meeting, a Self-Governance Conference, at the beginning of
15 May. We wanted these agreements done before that meeting
16 happened, and we hit that target. So the first agreements
17 were signed -- 14 agreements were signed by May 5th. The
18 first one was signed May 4th, actually, at an Alaska Native
19 Health Board meeting, Gene Peltola from Yukon-Kuskokwim Health
20 Corporation was there, and he made darn sure he got the very
21 first one.

22 COMMISSIONER MORGAN: But we were second.

23 MS. MUNSON: Yes. Then it was a competition, but by the
24 end of the day, by the end of the fifth, 14 of them had been
25 signed by the tribal representatives, and it took a few more

1 days. This really was, you know, sort of a national effort.

2 The Contracting Officer for VA here is in Spokane, I
3 think, or somewhere in Washington, and he was amazing. He was
4 -- I find myself in shock every time I say that. I've never
5 said this about a Contracting Officer for anybody, even the
6 ones who worked for me when I was Commissioner. You know,
7 they're just, by nature, nit-picky, hard-to-work-with sorts of
8 folks, and they work on their own timeline. He was amazing.
9 He facilitated everything we needed to do and was there in his
10 office until midnight working on agreements, making sure they
11 all got entered and could be signed.

12 Mr. Spector, from the VA here, was home with his wife who
13 had surgery and made a special trip to come into the office to
14 sign agreements, so that they would not only have a VA
15 Contracting Officer -- it was really the only absolutely
16 necessary signature for VA -- but that they would have his --
17 the (indiscernible - voice lowered), really, of the Secretary
18 there through his offices of signing them, the effort. And
19 Susan just ferried things around and helped facilitate.

20 I can say that, when I say it was the highest levels, we
21 had some of the agreements signed by the tribal representative
22 already when, on this second day of this sort of marathon of
23 signatures at the very end of finalizing these agreements, I
24 got an email from Dennis Holith (ph), the attorney in D.C. I'd
25 been working with, and it's said his boss had actually kind of

1 read the agreement and had a few little edits, and I'm
2 thinking, a few little edits from the Chief of Staff; this is
3 not what I want to hear when I wake up in the morning, having,
4 you know, 14 of these signed already from -- they were purely
5 editorial. I mean, they were nice. They cleaned up some, you
6 know, commas and a couple of words, but they were purely
7 editorial. I wrote back and said I would make those changes
8 in a heartbeat, just to encourage him because I'd never had a
9 Chief of Staff of anybody actually read anything at that level
10 and take it serious enough to make some edits and be that
11 engaged. I really can't -- you know, I can't overstate how
12 engaged they were. Let's move on.

13 Veteran outreach occurring here in McGrath. Here are the
14 principles that guided this. The VA has committed to meeting
15 health care needs of all eligible veterans and has special
16 expertise in the care of veterans, but very few facilities in
17 Alaska and relatively very few facilities that really get
18 rural America, the most rural places in the United States.

19 Tribal health programs are found throughout the State,
20 including virtually all villages, and have cultural expertise
21 in serving Alaska Native veterans.

22 All Alaska veterans should have maximum access to health
23 care services with minimum travel. We really focused, as we
24 talked about this, on the importance of recognizing that you
25 can't have a medical home if somebody has to get on an

1 airplane and fly for, you know, hundreds of miles and hundreds
2 of dollars, maybe a thousand dollars or more, to get to the
3 place you get health care, that you have to have a medical
4 home to have a good health care system.

5 Those first two pieces we talked a lot about because some
6 of the VA representatives who were there were understandably
7 supportive of, and in some ways, defensive for their own
8 system. As Susan said, they're a direct health care delivery
9 system principally, not a purchaser of health care. In the
10 same way, the tribal health programs are. They buy a lot of
11 health care, too, but they, principally, are health care
12 providers. And the VA said, but we know a lot about serving
13 veterans, and from the Tribal Health Representatives, what we
14 said is yes; you do know a lot about serving veterans, and we
15 want to make use of your expertise. So outside of this
16 agreement, there are other discussions about sharing,
17 training, and other kinds of expertise that's so important,
18 but our comment was about the tribal health programs. You may
19 know lots about veterans, but before they were a veteran, they
20 were an Alaska Native. And we know about being an Alaska
21 Native in the tribal health system, and when they come to the
22 tribal health system, they're surrounded by people who are
23 Alaska Natives themselves, increasingly even among the
24 professionals, but certainly in every other role and that what
25 we want to do is bring those things together for every Alaska

1 Native veteran, so that they get the benefit of people who are
2 culturally competent in their own community and for the older
3 veterans, for the elder veterans who speak their language.
4 It's less of an issue for younger veterans, but for the elder
5 veterans, the language barrier is still a very real issue for
6 them. But we do respect the expertise of the VA and so we
7 want all of those pieces to come together.

8 The fourth of these points is that it's critical that
9 tribal health programs can serve non-beneficiaries, but
10 they're not required to do so. The Health Care Improvement
11 Act has always permitted certain tribal health organizations
12 to serve non-beneficiaries, but in those amendments -- and
13 this could change; it would not affect most of these settings
14 -- the rules under which tribal programs can serve non-
15 veterans were changed. They were easier to accomplish,
16 truthfully, and that meant that, in all those places out in
17 rural Alaska, all those places were already serving non-
18 Natives, where, you know, in more regional centers, they can
19 serve non-Natives. Some of them hadn't because there are
20 other health providers. So those tribal health programs that
21 do serve non-Natives will be able to continue that service,
22 which means that, if you're in Barrow where the Samuel
23 Simmonds Hospital and the Arctic Slope Native Association is
24 the principal health provider -- the Borough provides some
25 limited services, but the Native organization is the principal

1 provider -- every veteran in that community can get access to
2 care, not just the Native veterans, and that was an important
3 principle throughout the agreement, and it meant that
4 everything we did -- and that's why we chose Barrow, in some
5 ways -- in the discussion was here's how it will work for a
6 Native veteran; here's how it works for a non-Native veteran
7 because there are some differences in the rules that will
8 apply.

9 And the Alaska Native veteran -- this is true, of course,
10 of other veterans, but a non-Native veteran can't choose to
11 use a tribal health program, unless the tribal health program
12 has authorized services to non-Natives, but all Alaska Native
13 veterans have a choice, of course, to go to the VA, to come to
14 the tribal health program. It was important that it be stated
15 clearly that they get to choose where they get their health
16 care. They can make that choice at any time. Let's move on.

17 The parties to the agreement are each individual tribal
18 health program and the Department of Veterans Affairs. The
19 agreement was negotiated as a model. The tribal health system
20 is very integrated in terms of the work that they do to be
21 efficient, and it's very common for them to assign somebody or
22 a committee and say, go forth and work out the best deal you
23 can; bring it back. But each one, ultimately, reserves the
24 right to negotiate their own terms and to decide for
25 themselves whether to participate or not. So each of these

1 agreements is an agreement, specifically, between the VA and
2 that particular tribal health program. If you look at any one
3 agreement, it will look very much like all the others, but not
4 necessarily identical to those others, and over time, they
5 could shift a little bit to deal with individual
6 circumstances.

7 In the Lower 48, while we were in the middle of
8 negotiating, IHS and VA had actually completed a draft model
9 agreement and were seeking Tribal Consultation about it. That
10 consultation ended about two weeks -- on May 25th, about three
11 weeks after this, and Alaska tribal programs did comment on
12 it, both supporting some provisions of it and commenting on
13 some that we thought were not particularly good in the
14 national model. Among those things, as they were looking at
15 it, at least, the language of it suggested that there be an
16 IHS/VA agreement and then tribes could sort of tack on, and we
17 said no; this is a VA tribal agreement. This is a government-
18 to-government, or in this case, tribal organization-to-
19 government relationship that is being protected. Moving on.

20 Which veterans are covered? All of them. Tribal health
21 programs will be reimbursed for services provided to eligible
22 veterans, if the eligible veteran is an Alaska Native veteran
23 who will have no preauthorization requirements. Any tribal
24 health program who provides a service to an eligible Native
25 veteran will be paid for having provided that service, if the

1 veteran was eligible. And I've learned -- I think the VA
2 folks began to be concerned about whether I was just a little
3 slow. We were sitting in that meeting, and I kept saying,
4 well, let's lay out who is eligible for what. I like
5 precision in agreements. It seems a sensible thing to do.
6 They said no; it's complicated. I said, yeah, yeah, yeah;
7 that's what everybody always says about their program. It's
8 always too complicated. That's all about control, I'm
9 thinking, you know, and they say, no, no, really.

10 So we get talking about dental benefits. This is the
11 place at which I finally conceded. We were talking about
12 dental benefits, and they're into it, quarreling with
13 themselves, truthfully, about whether the full dental benefits
14 were available among other categories, only to veterans who --
15 among POWs if they'd served, if they'd been a POW for so many
16 days or weeks or months or whatever or any time as a POW, and
17 then they finally resolved it, that the rules had changed and
18 anyone who was ever a Prison of War is eligible for full
19 dental benefits. And then were some other categories that
20 were, but everybody else isn't at all, except under these
21 other circumstances. I finally threw up hands and said, okay;
22 I got it.

23 And David's got a booklet. This booklet is, apparently,
24 always out of date. It's already out of date, but there are
25 eight categories, and under them, there are subcategories of

1 eligibility for certain services, but what was also
2 interesting is that those services -- and it was important
3 that we keep our eye on the ball because those services are
4 really the tiniest edge of the system.

5 The basic Medical Services Benefits package that's
6 available to any veteran who is eligible to get direct service
7 who is eligible to enroll, honorably discharged, is really a
8 robust system. Whether it's always available or not is a
9 different question, but it's really -- it's very robust, but
10 what is clear is that, as veterans have come back from each
11 campaign and they've had advocates in Congress and as the
12 circumstances have changed, they've advocated for and gotten,
13 in some cases, silos of benefits. There is just a recent
14 change in eligibility for veterans coming back from Iraq and
15 Afghanistan. So it's a constantly moving target of
16 eligibility. Income plays a role. So there are many factors,
17 but the core is the same. So the first task is to get
18 enrolled. The second is to find out what you're eligible for,
19 but most of the services a tribal program could provide the
20 veteran will be eligible for.

21 Non-Alaska veterans, there does have to be
22 preauthorization. VA is a direct service provider, of course,
23 and so there does have to be some. However, in all locations,
24 what VA agreed to, because of its strong commitment to serving
25 veterans wherever they live, making sure they can get access

1 to service, what VA agreed to in Alaska is that any veteran
2 who lives outside a community where VA has a direct location -
3 - Anchorage, Wasilla, Kenai, Juneau, and Fairbanks, if you're
4 outside of those areas, VA has agreed that it will, as a
5 preliminary matter, give a block preauthorization for a 12-
6 month period for six medical and four behavioral visits. We
7 had initially proposed three. They said -- they went back to
8 their behavioral health person and said no; it needs to be
9 four, if we're going to have an adequate evaluation and begin
10 service, if that's needed for that veteran. Of course, all of
11 these have to be medically necessary, but they will grant it
12 without having to first define that the veteran has a specific
13 medical need. They want those veterans to be able to get
14 health services when they need them and know up front without
15 the delays that they'll have access to that care. If then the
16 veteran is determined to have additional medical needs that
17 require more services, then the tribal health provider will
18 have to obtain additional authorization for that.

19 Inside an area where VA has facilities, any care would
20 have to be specifically preauthorized, and we would anticipate
21 VA would not authorize that care to the non-Native veteran,
22 unless it needed to buy it someplace anyway and the tribal
23 health program were a good place to provide it. There are
24 certain services, of course, that ANMC offers that are not --
25 they're more readily available there than they are anywhere

1 else. For instance, there are examples of that around the
2 system. And we know that the tribal health programs in the
3 other areas will begin to develop more expertise about
4 veterans' services as they're seeing and working with their
5 own Native veterans, appreciating them as veterans, not merely
6 as Alaska Native only. Let's go to the next slide.

7 What's covered? I mentioned it's any health service for
8 which the eligible veteran is eligible under VA statutes and
9 regulations, and the health medical benefits package -- this
10 is a statutory package -- it's basic care, outpatient medical,
11 surgical, mental health, substance abuse. I won't read the
12 whole thing to you because you have it in the slide, but it's
13 really extensive, and we were particularly pleased that it
14 included home health and hospice and extended care services,
15 including adult daycare and respite, travel, preventive care,
16 health education, and there are more restrictions, as I said,
17 for dental, for certain travel. There are other services,
18 including long-term care. And so understanding the breadth of
19 this package was very important and the tribal health system,
20 in varying degrees, provides virtually everything on this
21 list. Not every program provides it in every location, but
22 some programs have it. Some tribal health programs have it in
23 their locations.

24 There are some special terms. Let's move on. The other
25 things that were really remarkable about this agreement are

1 that VA has agreed it will reimburse for the services of
2 Certified Community Health Aides, and I think probably all of
3 you have had some introduction to the Community Health Aide
4 program, but I'll give you the two-minute version.

5 Community Health Aides are, essentially, community
6 members who become trained to provide health care services
7 through local and university and other kinds of training
8 programs. The start of the program over 50 years ago with the
9 people we refer to generally as Community Health Aides
10 provides basic medical services and has had an absolutely
11 indescribable impact on health status in rural Alaska by being
12 able to provide preventive care and also, through their
13 connection to the regional centers, their ability to intervene
14 in really complex situations as well and to provide health
15 care. They've just simply changed the face of health care in
16 rural Alaska. It's also a model that's considered in other
17 parts of the world as one to be considered because of this
18 networking, training, supervision.

19 Health Aides must be employed by a tribal health program.
20 They must be supervised by a physician, or for the behavioral
21 health, by a licensed mental health provider, behavioral
22 health provider, and for the dental health aides, by a
23 licensed dentist. They go through preceptorships. They're
24 constantly monitored and evaluated.

25 So VA, when looking at this, thinking about if we really

1 want services available throughout the state in the location
2 where the veteran lives, then we have to include the health
3 aides because they are the only health provider, principally,
4 for medical care, but also behavioral health services. Often,
5 they're the only behavioral health provider in the small
6 villages, and increasingly with dental health aide therapists
7 and dental health aides, they're able to actually provide
8 dental care as well out in those areas. So this was very
9 important.

10 Reimbursement is going to be based on the IHS-published
11 Medicaid Inpatient and Outpatient Encounter rates. This made
12 the agreement easy to administer. It ensured that the tribal
13 health programs were recovering the cost of care. The
14 published encounter rates are a cost-based rate. The costs
15 are evaluated annually. The rates for Alaska are an aggregate
16 from tribal health programs in Alaska, so they're very Alaska-
17 specific. There are some instances where there are certain
18 services that are not included in the calculated encounter
19 rate, and those would be paid on the VA Professional Fee
20 Schedule, and I think probably most of you know the VA fee
21 schedule. We discussed briefly Medicaid. They had offered
22 the VA Professional Fee Schedule. We compared them. The VA
23 schedule is a much closer reflection of the cost of providing
24 professional health services than the Medicaid schedule, and I
25 suspect that physicians may find it still too low, but it's

1 certainly better than the Medicaid or Medicare. It's
2 certainly better than Medicare rates.

3 The tribal health program -- well, let me start with
4 something that it doesn't say in here. VA, we're told -- no
5 reason to believe otherwise -- must charge co-pays for
6 veterans. It's a condition of their services. There are lots
7 of exceptions. They get to a certain amount and then they
8 quit having to pay. They're low enough income they don't have
9 to pay. They have met certain service condition requirements;
10 they don't have to pay. There are a number of exceptions, but
11 the core rule is that there must be a co-pay.

12 The tribal health programs made it clear that it was
13 simply unacceptable for any Alaska Native veteran who comes to
14 an Alaska Native health program to get a bill for receiving
15 services, even for a nominal co-pay. That simply was not
16 acceptable. The premise of tribal health services is that the
17 United States owes a duty to every Alaska Native and American
18 Indian to provide them health care at no expense and that duty
19 is reflected in law and treaties and statutes and must be
20 respected.

21 So we worked on a model for how to achieve this because
22 we have to achieve -- the VA, obviously, has to comply with
23 its laws. The tribal health system simply was not going to
24 have any veteran, any Alaska Native veteran receive a bill for
25 getting services from them, and they would get the bill

1 because VA pays providers the full amount that provider would
2 get paid and then it bills the veteran for the co-pay. It
3 does not withhold the co-pay from the provider bill and that
4 is, in part, I understand, because determining what is owed
5 for co-pays sometimes takes longer than they want to hold up
6 payment to providers because there are a number of conditions
7 that apply to that co-pay. It's not a quick, every-single-
8 time calculation.

9 So what we worked out, we -- initially, they were going
10 to pay an amount adjusted by taking out the co-pay for the
11 Native veterans. Again because of timeliness issues and their
12 information systems, they simply couldn't do that. What we
13 finally agreed on is that they will do a reconciliation, so on
14 a periodic basis. How frequently will depend on the size of
15 the health program, the frequency of activity. They will send
16 a bill back to the tribal health program, which will then
17 write a check back to VA for the co-pays for those veterans
18 because no Alaska Native veteran is going to get charged for
19 getting services in an Alaska Native program.

20 We could not, in the time we gave ourselves, work out all
21 the details and so we are still working on what the
22 reimbursement structure and payment would be for home care,
23 nursing home care, residential, mental, health, and substance
24 abuse treatment, hospice. All of those are services that are
25 provided some places in the tribal health system. A number of

1 them have elements of home care. SouthCentral is a certified
2 home health agency. Many have personal care attendant
3 programs or some equivalent kind of program that provides home
4 care services that fit within the service that VA pays for
5 that will allow veterans to be able to remain in their own
6 homes longer with a higher quality of life, better health
7 status.

8 Norton Sound and Maniilaq have nursing homes. Norton
9 Sound has had one for decades. Maniilaq has had one off and
10 on. It's reopened as a beautiful new facility. And Yukon-
11 Kuskokwim Health Corporation is opening, within the year, a
12 new nursing home and will have hospice. Many of the programs
13 provide palliative care, if not a formal hospice program. So
14 they will be able to provide these services, and in the next
15 few weeks, we'll have finished agreeing on the rate structure
16 for those things. Let's turn to the next slide, and I'm going
17 to turn this over to David soon.

18 We have remaining challenges, and getting the agreement
19 was the critical first step. It lays out all the processes,
20 talks about how bills are to be done. We had to jerry-rig how
21 the forms that are used to submit claims are done, so that
22 there would be a (indiscernible - recording interference) for
23 the tribal health program that the person was Native or not
24 because, you know, race and ethnicity and tribal membership
25 are not allowable things to consider in most environments. So

1 we had to figure out -- what we did is we said, well, in every
2 claim, there is a place that you put who all the other payers
3 might be and that's important in this case because VA
4 subrogates, and it will go after other payers. If there are
5 other insurers, it will go to them to get reimbursed for some
6 of the payment it made to the tribal health system, but it's
7 an unlimited -- it doesn't have a limit on the number of lines
8 because there could be -- you know, we don't know how many
9 payers there might be.

10 What we agreed is the last line in the payer section in
11 every case where it's an Alaska Native veteran will say IHS,
12 not because IHS is a payer. It's because that was an easy way
13 to show that the person was Native. If VA sees that, then it
14 processes this in terms of co-payments and preauthorization as
15 if this is a Native veteran, and without that, it processes it
16 as if it's a non-Native veteran, and it won't pay if there
17 isn't preauthorization, and it will, of course, bill for the
18 co-payment. So lots of sort of working through the details to
19 make these two systems come together occurred.

20 We have to learn how each other's systems really work,
21 and in aid of that, the agreement provides a 60-day transition
22 period. So we're in that right now. Claims are accruing.
23 Services are being provided, but no claims will be filed until
24 60 days after the first agreement in order to work out some
25 details. So meetings are occurring at the end of this month

1 and will continue in this period. We'll work on fine-tuning
2 some of the rate agreements on some of these pieces and maybe
3 mods if we find some things we thought we would work won't
4 work, to be sure that, when the first claims are filed, they
5 actually can process properly and that there aren't system
6 failures.

7 Coordinating care is really important, and the agreement
8 provides for the responsibility of the tribal health system to
9 determine who is Alaska Native and not for it to define the
10 services that it provides, so that the VA can know what they
11 can expect to be able to receive from that program in the
12 various locations. The VA is responsible for determining
13 enrollment, making enrollment occur, for determining and
14 verifying eligibility for particular services, and for
15 ensuring that veteran gets access to care outside the tribal
16 health system process. So if a veteran is in a village and
17 needs to be in a regional center to get the level of care they
18 need, VA provides travel. So this would be a way to
19 coordinate care. VA could pay for the travel, if the veteran
20 is eligible for it. So how those coordination pieces will
21 work is really important because, in the tribal health system,
22 the tribal health program tends to coordinate that care. So
23 they will act as a conduit over to the VA system, and VA will
24 have people who are specially trained to be sure they
25 understand how to handle that kind of coordination and also to

1 hand off veterans into the VA system or to other providers
2 when the tribal system simply can't meet their needs to be
3 sure that the veteran then doesn't get sort of caught up in
4 the bureaucracy and get lost when they need additional care
5 that only VA could provide.

6 Sharing expertise. As we said, we hope that what
7 develops out of this is more relationship and that, in
8 addition to all the work going on in enrollment, the
9 implementation of these agreements, that a third category of
10 work occurs, and it really is occurring now in the behavioral
11 health arena that you'll be hearing more about and that is to
12 share expertise, so sharing expertise with the veterans health
13 providers about working with Alaska Natives, them sharing
14 information about working with veterans, particularly those
15 who may have served in combat and have special needs resulting
16 from that, but in any way, sharing expertise that the two
17 systems have, and the ultimate goal, of course, is making the
18 systems seamless for veterans so that every Alaska veteran,
19 and particularly, every Alaska Native veteran who is being
20 served in both systems has complete access in a seamless way
21 that does not -- where they don't go along, hit a bump, and
22 stop. So that's our Sharing Agreement. Dave is going to talk
23 about the future for some other folks.

24 COMMISSIONER MORGAN: That was a great outreach. We
25 immediately -- as Pope Pius said, the most zealot supporter is

1 a newly converted. As soon as we signed and got trained, we
2 started having outreach meetings in rural Alaska and McGrath
3 and Nilavena and that's actually a volunteer who is a Vietnam
4 Veteran who is on the Advisory Board. You can use Advisory
5 Board members, and Yukon-Kuskokwim did. Go ahead and through
6 the next slide.

7 I think what we all have to remember is I think the
8 numbers I gave you are the best estimates, except for the
9 first column. I think they're low. I think, yeah, there is
10 probably 77,000-78,000 veterans that we know of that could get
11 services, that are registered. We know that there are only
12 28,000 that have actually enrolled and got health care
13 benefits, and we know about 15,800 have actually used
14 services, but when you look at the tribal side, and I think,
15 in the rural areas for non-tribal, it's way low. If they
16 don't register, if they don't get into the system, you don't
17 know -- you know, you know what you know, but sometimes you
18 don't know what you don't know. And just from the seven or
19 eight years that I have been out in the rural parts of Alaska
20 -- and Fran has 56 rural clinics in your.....

21 MS. LIPROT: Sorry. We have 58 rural clinics, and it's
22 very important that we're able to provide those services to
23 the individuals living in those areas. And David, if you
24 wouldn't mind, when you finish, I'll speak a little bit on
25 that.

1 COMMISSIONER MORGAN: Absolutely. Interrupt me at any
2 time. I came in, in the last six months, basically, to
3 provide concierge services. My trick was to put them in a
4 very small room, provide them a lot of food, but only have one
5 bathroom and that's how I helped my contribution -- and some
6 math, a little math.

7 You must remember that we have a lot of tribal programs
8 who have a lot of tribal rural clinics and even urban clinics.
9 Many of those have community health centers, especially in the
10 rural areas, because, since they're the sole provider, they
11 see a lot of non-tribal individuals. So they need the extra
12 capacity and to provide a sliding fee scale and to work with,
13 sometimes, the local boroughs. At Eastern Aleutian Tribes, we
14 were the tribal -- the seven health clinics in the Aleutians.
15 We were the community health center in all seven clinics, and
16 we were under contract as a borough health department, except
17 for animal control. Nobody likes seeing health aides dealing
18 with rabid animals.

19 So with the completion of this, being the visionaries
20 that me and Fran are, now that this agreement is going into an
21 operational phase, in my mind, working with the chairman of
22 the Primary Care Association board and the Governmental
23 Affairs Department at the Primary Care Association -- go ahead
24 and flip the next one, if you can.

25 Basically, the Primary Care Association has been around a

1 while, has 50 members. Go ahead and flip the next one.

2 But what you find is, virtually, these are the programs,
3 but a slight majority of the programs are tribal run and
4 operated, and about 11, depending on -- it seems like numbers
5 change about every hour, and we're talking about 142 clinic
6 delivery sites. About 60% are tribal. SouthCentral has two.
7 You have 58. Then the non-tribal, like Anchorage Neighborhood
8 Health, and there are non-tribal community health centers in
9 the state. As you can see, they see a lot of people, and they
10 provide a lot resources. There is nothing to prohibit having
11 a contract relationship with those non-tribal clinics. Hey,
12 if you're going to go for two-thirds, go for the whole deal
13 until someone says you can't. Flip it.

14 So what have we got right now outside the agreement?
15 Basically, about 11 CHC programs with about 27 clinic delivery
16 sites. And so what we're going into in the next phase -- and
17 we have some Primary Care Association staff here -- is to
18 start where we were last November, but these folks have
19 already done the real heavy lift. In my mind, you just take
20 the tribal part out of that, and you know, kind of move some
21 things around and negotiate a few other things. Go ahead.
22 I'm going to try to get through this fast.

23 So basically, what I'm going to propose to the board --
24 and I've talked to the chair of the board already -- is this
25 very rough schedule. I have recommended that -- why go

1 through training another lawyer? Go ahead and bring -- Myra
2 has done work for the Primary Care Association and to build
3 that relationship. Nothing has happened yet, but the momentum
4 is there. Most of the board, most of the members are tribal
5 who have already signed agreements. It's just a simple --
6 it's a different relationship, but there is nothing to keep us
7 from developing a relationship.

8 In my mind -- my father says I have one of the finest
9 minds of the 17th Century. In my mind, what I'd like to see
10 is an all 142 or 44 or 48, whatever the number is today,
11 primary clinics that a veteran, tribal or non-tribal, can find
12 out what their benefits are, and at least, get primary care,
13 get hooked into the system, or if they're not, to help them
14 get into the system and they can get the benefits that they've
15 earned, whatever those are. The basic benefits are robust,
16 but we're also going to have these other services.

17 Now I'm speaking for myself, at this point. I think,
18 especially in the urban areas, and for a lot of our returning
19 veterans, I think substance abuse, behavioral health, suicide
20 prevention, which the tribes do a lot stuff in there, primary
21 care -- it never made sense, to me, when I lived in Sand Point
22 that, if I had to come into the VA center, I had to fly in,
23 get a blood test, a couple other things, and sometimes fly out
24 or hang out for a few days and get my services. It makes a
25 whole lot of sense, to me, to go to the nearest primary

1 clinic, tribal clinic, whatever clinic, get those prelims done
2 by professionals, share that information.

3 Now remember, the original system in tribal health RPMS
4 was invented by DOD. So we are sort of, as we say in
5 Kentucky, kissing cousins, you know. So we have a lot of
6 relationships anyway. But more important after that surgery
7 or day surgery, I envision, through care coordination, that I
8 would go back to Sand Point, and if I needed a couple of weeks
9 of infusion therapy or antibiotic therapy or whatever therapy,
10 that the care coordination between the VA and the local tribe
11 or community health center or tribal community health center
12 or FQHC or whatever then could pick up the ball, report back,
13 and provide those services at home. And it's not a big -- to
14 me, it's one of the reasons I kind of hung around, if you want
15 to know the truth. This was something that I had always
16 wanted to see happen and be involved in. I will say the
17 Indian Health Board, the individuals that Myra has mentioned,
18 has been working on this for years, and Fran. I came in, in
19 February. I was dispatched, sort of like Myra, from
20 SouthCentral because, basically, my boss, Lee Olson, said, who
21 is a veteran? Everybody looked at me. So I was dispatched
22 down to help and to provide whatever we could do to make this
23 thing move along and get done, whatever it was going to be.
24 And Fran, you've been involved since the beginning, right, for
25 the last two years or something?

1 MS. LIPROT: Initially, I was involved when Senator
2 Begich had the Department of Veterans Affairs come here and do
3 tours to explore the area. It is a great opportunity, as
4 David was just saying, particularly from the rural perspective
5 because we have veterans that are both Native and non-Native
6 that are there that we do service. We want to encourage a
7 medical home for the veterans, particularly being able to
8 provide preventative care, kind of decreasing the chronic
9 long-term illnesses that can arrive there, also to allow
10 transparency within the coordination of care. So those are
11 the things in which we're partnering, from the tribal
12 perspective, along with the VA, and I think those are things
13 that are soon coming to fruition even more so.

14 MS. MUNSON: I think that's it for us.

15 COMMISSIONER ERICKSON: We're going to have time for
16 question and answer and discussion with the Commission, but I
17 want to do a quick time check. We are over time, but I think
18 we will be able to -- which is okay, but we have flexibility
19 in the afternoon. And Dr. Hurlburt, so far from all of the
20 folks in the audience in the room, we only have two people
21 signed up to testify during our public comment period. Dr.
22 Stinson had something he'd like to share during that period.
23 We don't know how many people we have on the phone, but
24 usually, we don't have more than two or three. Should we
25 postpone Tracy's presentation until 1 o'clock and assume we'll

1 be done with the public hearing at 1 o'clock rather than at
2 12:30? She has the flexibility to do that for us and then I
3 think we have some time flexibility in our afternoon agenda
4 anyway.

5 CHAIR HURLBURT: That sounds good to me.

6 COMMISSIONER ERICKSON: If that's okay with you?

7 CHAIR HURLBURT: Sure.

8 COMMISSIONER ERICKSON: And Tracy?

9 MS. SPEIER: I'll do whatever it takes to make things
10 work for you guys.

11 COMMISSIONER ERICKSON: You are awesome. Okay; 1 o'clock
12 for your presentation then. Thank you. So Dr. Hurlburt, I'll
13 turn back over to you to moderate the Q&A.

14 COMMISSIONER CAMPBELL: Recognizing horrendous travel
15 costs for medical services in this state, have you calculated
16 or estimated what the savings in travel costs by using these
17 clinics versus traveling to the VA center here in Anchorage?

18 MS. MUNSON: We haven't, and it's going to be an
19 interesting question because, whose travel costs? Virtually
20 no Alaska Native veterans have been using -- the VA has paid
21 for virtually no travel expenses for Alaska Native veterans,
22 to put it in the affirmative, because those Alaska Native
23 veterans weren't enrolled. So there are no savings there.

24 In the tribal health system, there will be savings
25 because, as veterans enroll and are eligible for a VA travel

1 benefit, VA will pick up that travel benefit rather than the
2 tribal health system paying it, and some veterans, because
3 that's available, will be able to have travel that would not
4 have been able to afford it and it wasn't affordable for the
5 tribal health system. So I don't think we have any idea what
6 the savings is.

7 This is an agreement which, up front, I should say, I
8 think you won't start with the short-term savings because this
9 is going to be a significant new expense for the Veterans
10 Administration to absorb. What it's doing is it's avoiding
11 the need for new facilities, long-term, if those veterans are
12 going to get the services they're entitled to, and secondly,
13 ensuring long-term better health status, as Fran pointed out,
14 so that we're not expending resources later, but we're not
15 going to see travel savings, I think.

16 CHAIR HURLBURT: Yes?

17 MS. LIPTRON: Thank you. As Myra was just saying, we
18 haven't calculated the cost in regard to travel, but from both
19 VA and also from the tribal entities, we have been sharing
20 that cost. In addition to it, we're looking at being a cost
21 initiative savings, based upon the ability to share resources.
22 So you're adding in additional providers of care in various
23 disciplines that are there; whereas, the VA possibly has been
24 able to send those veterans outside of Alaska for those
25 particular services, where some of them are now available

1 through ANMC, through SouthCentral and other tribal
2 facilities.

3 CHAIR HURLBURT: Pat?

4 COMMISSIONER BRANCO: Myra, a question for you, and it's
5 on slide 14, if we can go back. I just have a disconnect when
6 it says, which veterans are eligible, and the opening line is
7 all of them, but then it says, "eligible veterans only if" and
8 the two categories are Native. So I missed something in the
9 translation there.

10 MS. MUNSON: Sorry. The second category under there,
11 they're all eligible. The non-Native veteran, if the care had
12 been preauthorized. So if, for instance -- in Ketchikan, for
13 instance, if the Ketchikan Indian Community serves non-Native
14 veterans -- and I actually don't know if it serves non-Natives
15 at all. If it were to and that veteran -- the VA has
16 authorized them to provide that service, then they could
17 provide that service, and they are one of the places -- if
18 they're outside of an area where VA has a facility, then it
19 would be possible.

20 To give a different example, in the Copper River Area,
21 Copper River Native Association has a program. There are no
22 VA facilities nearby. They do serve non-Natives, and they
23 will -- any veteran would be able to obtain the services that
24 Copper River Native Association provides, which are,
25 principally, Community Health Aide services, and they have a

1 mid-level provider who provides direct services, and they have
2 a dentist. So they would be able to provide them.

3 COMMISSIONER BRANCO: I think I'm particularly dense
4 today because I just don't see it in the language there.

5 MS. MUNSON: It may not be there. I may have just left -
6 - you know, I mean, the level of detail -- these are slides.
7 I think that the point is, for the non-Alaska Native veteran,
8 the care has to be preauthorized, and I think, on a some other
9 slide, under the principles, every tribal health program
10 determines for itself whether it will serve non-Native
11 veterans, serves non-Natives.

12 COMMISSIONER BRANCO: But that's talking about non-Alaska
13 Native veterans; that's my point. It's not non-Native
14 veterans; that's non-Alaska Native veterans. The two
15 categories are Native.

16 MS. MUNSON: Well, let me try again. The two categories
17 are Native and non-Native.

18 COMMISSIONER BRANCO: Then it's just a slide issue.

19 MS. MUNSON: Well, isn't that what it says?

20 COMMISSIONER BRANCO: No.

21 UNIDENTIFIED FEMALE: It says non-Alaska Native.

22 COMMISSIONER BRANCO: Non-Alaska Native.

23 MS. MUNSON: Oh, somebody took out Alaska. Oh, I see.
24 It's non-Alaska Native, Alaska Native being a term of art,
25 referring to -- she just changed that word, but it said -- it

1 wasn't -- I apologize. Let me try again. This is -- what we
2 usually do -- and I was trying to avoid acronyms. Usually,
3 early on in the first slide, it would have Alaska Native and
4 American Indian and then it would have had an acronym, ANAI,
5 and everywhere then it would have been non-ANAI. Instead, I
6 used Alaska Native, which is a term of art, not Alaska as
7 opposed to non-Alaska Native. If we were referring to an
8 Indian person outside Alaska, it would have said American
9 Indian.

10 COMMISSIONER BRANCO: Now I'm so much smarter; thank you.

11 MS. MUNSON: Sorry about that.

12 COMMISSIONER MORGAN: I just want it on the record that I
13 didn't write that.

14 MS. MUNSON: Oh, I wrote it.

15 MS. YEAGER: This is Susan. I'm still here from the VA.
16 I just wanted to mention someone in Copper River, for example,
17 where we were the veterans eligible for travel, you know, when
18 we do a cost benefit, part of the decision is -- because care
19 close to home is one of our principles, but we would look at
20 cost of traveling that person compared to the cost of, you
21 know, buying the care in the community. So that's part of the
22 decision we make, too, in what -- you know, where to spend
23 that money.

24 COMMISSIONER CAMPBELL: I've seen this 77,000 total
25 veterans in the state, and I wonder how you get counted. I'm

1 a veteran, and I've never used anything in this state. I
2 used, you know, my educational one years ago and things like
3 that. How do you do that?

4 MS. YEAGER: This comes -- the 77,000 number basically
5 comes from the -- where the -- the census, when they go around
6 and they do the census. So that's from the census taker
7 process, but we, the VA, don't know much about -- we don't
8 know anything else about those veterans, unless they enroll
9 with us by filling out that 1010-EZ, and even if they're
10 signed up for veterans' benefits, like compensation, we still
11 don't know about them in health care.

12 MS. MUNSON: Go ahead, Fran.

13 MS. LIPROT: Thank you. In addition to that, that's
14 just the ones, as Susan was saying, that have been identified
15 through the federal census population, but we have a very
16 strong suspicion that there are even additional veterans out
17 there that haven't disclosed that information.

18 A lot of the providers, both tribal and non-tribal, are
19 implementing even more identifying methods from the time of
20 the patient access into their health care system through also
21 using what we described as the TVR, the Tribal Veteran
22 Representatives, by going out through outreaching. So we're
23 not querying just those individuals that we have; we're asking
24 about the entire family, so we can start branching out and
25 expanding even more so.

1 What we have discovered, particularly in the Delta area,
2 is that there are quite a few veterans that are from previous
3 Korean wars, the previous wars prior to the 9/11, and we're
4 seeing that a lot of them have never enrolled, that they have
5 never -- not only that, a lot of their families have never
6 pursued their burial benefits that are out there. So we're
7 looking at it to provide their health care and their overall
8 benefits. So we are screening those individuals as a family
9 unit.

10 COMMISSIONER CAMPBELL: I'd just as soon wait on the
11 burial benefits for a while. Thanks.

12 COMMISSIONER MORGAN: I, personally, since I turned 60
13 while this was going on, took umbrage at the questions and
14 training on burial benefits and getting your gravestones.

15 MS. LIPROT: You have ten years on me, David.

16 CHAIR HURLBURT: So I'm not sure I -- Susan, you may be
17 the better one to answer this or Colonel Harrell might know.
18 For a veteran who has not served through retirement time, for
19 somebody who was in two, three, four, five, or six years,
20 something like that, what are the limitations around
21 eligibility for various kinds of health care benefits?

22 MS. YEAGER: Colonel Harrell, do you want me to address
23 that from the VA or would you like to go first?

24 COMMISSIONER HARRELL: You can start, and I'll add.

25 MS. YEAGER: Well, it's interesting because the --

1 throughout the time -- throughout history, through
2 legislation, there are different eligibilities that are kind
3 of identified by different time periods. Basically right now,
4 if someone served for 24 months and was discharged in a
5 category other than dishonorable, they could be eligible for
6 health care benefits. If they become -- have something they
7 get -- so we can have some veterans -- we have some veterans
8 that are retired military, so they are retired and a veteran
9 and also Native. So some of our veterans have three
10 eligibilities for health care.

11 So for a person that's retired from the military --
12 they're a veteran -- they can become service-connected, you
13 know, for something whether they were in the military a very
14 short time or retired. If something occurred during that
15 military experience that was injury or illness, they could
16 become service-connected and compensated for that, which would
17 then lead to higher level health care eligibility. So it's
18 really more about that individual veteran and what happened to
19 them while they were in active duty to determine their
20 eligibility. That includes -- someone could retire from the
21 military and never have anything -- you know, any health
22 issues occur. They may not be service-connected at all, but
23 they would have their retired health care benefits for
24 TRICARE. So they do -- we have overlapping eligibilities for,
25 you know, in some cases, the same person.

1 CHAIR HURLBURT: Colonel Harrell?

2 COMMISSIONER HARRELL: I mean, succinctly, outside of the
3 retirement, it is going to boil down to the period of time
4 that you served in, which conflicts you served in that sets up
5 the eligibility and then a service-connected medical
6 condition. So you can be coned down to a single condition
7 that you would then be eligible for care for, based on that
8 book that he's looking at right now, the *Overall Health Care*
9 *Benefits Overview*, and the different priorities. So the key
10 would be service-connected illness. If you haven't retired,
11 it's service-connected illness and/or the period of time that
12 you served, based on which regulations were in force at the
13 time.

14 MS. MUNSON: Could I.....

15 MS. YEAGER: What Colonel Harrell is mentioning is that,
16 if someone -- and in different campaigns. For example, for
17 soldiers now who are getting out and becoming veterans from
18 Iraq, Afghanistan, and Operation New Dawn, they have a five-
19 year window of presumed eligibility for any health care that
20 could be related to their service without co-pay and so that's
21 kind of a special unique -- first time I've seen it happen
22 from the VA for this current campaign. Other people may have
23 gotten out of the military after serving, and there are
24 different, you know, years, but generally now after 24 months,
25 they may not be service-connected at all. They're probably

1 non-service-connected. If they meet the income thresholds,
2 roughly a single person below \$30,000 a year income, then they
3 become a priority and eligible for the whole health care
4 package. So it's through the service-connected disability or
5 through income needs test.

6 CHAIR HURLBURT: Thank you.

7 MS. YEAGER: Do you see what Myra means now?

8 MS. MUNSON: I mean, it really is complicated. The
9 interesting thing about this agreement is that what has been
10 agreed upon is that any veteran will be able to get basic
11 health services at any tribal location. Those health services
12 that require special eligibility to obtain, they'll only get
13 if they meet the specific eligibility for that service.
14 That's the only circumstance in which the tribal health
15 program will be paid for it, but if that veteran appears at
16 any tribal health program, the Native veteran gets basic
17 health services, primary care, including behavioral health at
18 a tribal health program, VA will pay for that benefit under
19 the agreement.

20 MS. YEAGER: There is generally eight priority groups,
21 just to let you know, and that's why that whole enrollment is
22 so critical, that 1010-EZ form that can even be filled out
23 online now, but that's the first step because that will then,
24 through the records for their discharge, et cetera, will
25 designate them their priority group, and the VA now is seeing

1 veterans all the way from priority 1 through 8-D, which there
2 are eight priority groups and then the subsets. So 1 through
3 8D are eligible for health care. Some of those, depending on
4 their level of service-connectedness or income, may have a co-
5 pay.

6 CHAIR HURLBURT: Thank you, Susan. Any other questions
7 or comments? Pat?

8 COMMISSIONER BRANCO: I just read the book, and I found
9 out I'm a Priority-2 veteran. Wow.

10 MS. YEAGER: Eligible for health care.

11 MS. MUNSON: Susan can fix that. You can enroll, 1010-
12 EZ.

13 MS. LIPROT: And it is online.

14 MS. MUNSON: And it's online. But it's actually a fairly
15 serious thing. I just want to make one last pitch for
16 enrollment. For a variety of reasons, every veteran really
17 should be enrolled, partly, if for no other reason, than it
18 allows the Veterans Affairs Department to know where the
19 veterans are and to anticipate and to make sure that you and
20 your family can get benefits when the time comes and that
21 should be true of everyone who has a veteran in their family.

22 MS. YEAGER: And also even though some of the veterans
23 say, well, I'm not service-connected and I make more than
24 \$30,000 as a single person or more, if you have dependents,
25 they say, well, why should I bother, and we used to say to

1 them because, right now, the VA knows nothing about you.
2 Please enroll. We don't know what the future will hold in
3 terms of your individual situation or in terms of the
4 decisions that do change in terms of which veteran groups are
5 eligible, and they usually -- if you're already in the system,
6 then you can be -- you're sort of grandfathered in or you are
7 eligible to -- you might not have been eligible before.
8 Recently, they just raised that income threshold for those
9 non-service-connected veterans. So we encourage everyone, not
10 knowing what the future may bring.

11 COMMISSIONER ERICKSON: I have a question for, well,
12 actually, the whole panel, but I'm thinking about Myra. I'm
13 just wondering -- you had mentioned that this was a day some
14 of you were working towards for ten years. I was talking to a
15 former staffer of Senator Stevens who said, eight years ago,
16 they were pushing really hard for this. I'm assuming -- you
17 referenced several times the significance of the very top
18 leadership of these federal agencies working to make this
19 happen now, but I was wondering, what were the barriers before
20 and how were you able to overcome them, just as learning for
21 the Commission from our perspective of overcoming governmental
22 barriers?

23 MS. MUNSON: Serendipity is probably as much a factor in
24 how it came together right now than anything, but tribal
25 health programs, tribes have been advocating for VA to pay --

1 and Indian Health Service -- for VA to pay for health services
2 they provide to veterans from the beginning of time probably,
3 everybody looking around for a payer.

4 Truthfully, the way the conversation used to go is that
5 IHS said, well, we have regulations that say we're the Payor
6 of Last Resort, and VA's response was, well, we have a
7 statute. We're the Payor of Last Resort. And after getting
8 the amendments to the Indian Health Care Improvement Act in
9 March 2010, we said, we have a statute that says,
10 notwithstanding any other law, we're the Payor of Last Resort.
11 That set up the statutory framework in which this could occur.

12 I think though that, more important, was that the
13 leadership at the Administration, at Health and Human
14 Services, and with Secretary Sebelius and Director Roubideaux
15 from IHS, with Secretary Shinseki, it really was their
16 commitment to be sure that veterans were getting services,
17 that all of the provisions of the Health Care Improvement Act
18 that had been adopted in other provisions of the Affordable
19 Care Act were actually implemented. These discussions were
20 not easy between IHS and VA. Tribes were not happy they
21 weren't concluded at the table in those conversations from the
22 beginning, and I truthfully believe it would have gone better
23 and faster between IHS and VA had tribes been at the table.
24 They went to the White House many times. Many of the issues
25 that were resolved in the national agreement came from

1 leadership from the White House, saying we are going to find a
2 way. We have to respect the needs of both agencies and their
3 challenges, but there is going to be a way we're going to get
4 this done and that led to the national draft.

5 In Alaska specifically, I don't know that we would have
6 gotten there if there had not been that level of
7 administration support for the -- federal administration
8 support, the statutory provisions and so on, but the specific
9 how we got it in Alaska is because people were working
10 together face-to-face and understanding. And you know,
11 Senator Begich included, I think in the Affordable Care Act, a
12 provision requiring a study about sharing arrangements of all
13 the kinds of federally-funded activity. That work was done
14 two years ago. A team came up, including representatives of
15 the Secretary of Health and Human Services and Veterans
16 Administration and DOD and others, and they looked at every
17 federally-funded kind of health activity in the state. We
18 wrote a -- the tribal health programs wrote, you know, a book
19 and sent it in, in comment on all of that in terms of the
20 importance of that kind of sharing and that these
21 relationships were important, and I think, at each stage, our
22 delegation was important in bringing the right people
23 together. At bottom, it was absolutely the commitment to be
24 sure that veterans get services. What gave them support and a
25 little bit of impetus were having new statutory provisions to

1 say we've got to do something. Exactly what -- and then the
2 personal relationships that had developed, the energy that
3 Susan brought, the right timing, you know.

4 Since you asked, I want to comment about one thing. I
5 pointed out that we took from February to May. I think I just
6 read the front of a novel, a quotation. I'm now going to get
7 it wrong, but basically, it's about crisis, and in every
8 crisis, there is -- you know, something bad has happened, but
9 there is an opportunity. Sometimes, you create a crisis if
10 you don't have one or you create the appearance of one. VA
11 and IHS' negotiations -- and we're talking among ourselves
12 here. VA and IHS' negotiations were painful. They didn't get
13 along particularly well. Their cultures are different. It
14 was not an easy discussion.

15 When we met in Alaska and we started the discussion, we
16 went into the meeting saying we're not negotiating about big
17 principles in terms of -- you know, or interpretation of the
18 law. That's challenging for a lawyer, but I don't care what
19 it says about Payor of Last Resort. The bottom line is I want
20 there to be an agreement. That's what my clients have said
21 they need. That's what, evidently, we needed. So we went in
22 and we said, we're going to set aside the things we can't
23 agree on. We'll get an agreement on everything we can. There
24 are provisions here. We think the VA owes tribes for the last
25 two years of services, since the law went into effect. We

1 said, we're not going to fight about that. VA agreed, but we
2 want a reservation in the agreement that says we haven't given
3 up any statutory rights as to any claims for that last two
4 years. They said fine; we don't know if you have any rights.
5 We're not conceding you have any rights. We're not conceding
6 we'll ever pay you anything, and given how few were enrolled,
7 that may be right, but nonetheless, what we went in saying is
8 we want an agreement. They came and said we want an
9 agreement. And then we, in the first day of the meeting,
10 said, you know, there is a national meeting coming up here May
11 8th, and there is a panel, and IHS and VA are talking.
12 Wouldn't it be nice if we had an agreement in Alaska and we
13 could go to that meeting and you could be on the panel saying,
14 we have an agreement? And in fact, Susan and I got on the
15 panel, and we presented the Alaska agreement. It created a
16 timeline that had a real point and that pressured everybody
17 working together to hit that.

18 So I'm a big fan of setting a deadline and having an
19 external -- not merely one that we've all agreed we want to
20 hit, but having some external event that you've sort of
21 created. This is when we're going to announce it, as a way to
22 get it done, and I think it made a huge difference here in
23 terms of -- once people got it in their mind that we could --
24 I mean, there was no legal pressure to do it. If it hadn't
25 happened, it's not like the world would have ended, but

1 everybody got it in their mind they were going to present this
2 agreement on May 8th or May 9th at this conference in New
3 Orleans in front of tribes from all around the United States,
4 and once it was in everyone's mind, it became a big deal, and
5 everybody's job was to get it done by then, and the
6 Contracting Officer stayed up, and the Chief of Staff was
7 reading agreements, and I was on teleconferences from
8 everywhere every night, it seemed like. We all had our
9 assignment to get it done.

10 CHAIR HURLBURT: Bob? Last question.

11 COMMISSIONER URATA: This kind of goes to another level,
12 but I was wondering if you could briefly tell me how Medicare
13 or Medicaid gets involved with these silos, and are the VA and
14 tribal health able to get compensated by yet another federal
15 program?

16 MS. MUNSON: Tribal health programs are able to be
17 compensated by both Medicaid -- Indian Health Service and
18 tribal programs are able to be compensated by both Medicaid
19 and Medicare, but only under special provisions that were
20 enacted in the Indian Health Care Improvement Act in 1976
21 because the basic rule is one federal program cannot bill
22 another federal program for health care services.

23 VA, I believe, has a couple of pilot projects with
24 Medicare or Medicaid in which it does do some billing. I'm
25 not particularly familiar with them, and I don't even know if

1 they're still active, but I believe there has been some
2 limited activity. However, what has happened in -- what
3 happens under these agreements is VA can bill all other
4 payers. So the way this is going to play, Alaska Medicaid
5 will actually be one of the beneficiaries for this of this
6 agreement because, as a veteran receives services, the non-
7 Native veteran -- the Native veteran, it was all federal money
8 anyway coming through the 100% federal matching percentage.

9 For the non-Native veteran, if VA pays the tribal health
10 program, it can't turn around and bill Medicaid, and it
11 doesn't bill Medicare. So it only bills private insurance
12 companies. So this will put some more pressure on the
13 Veterans Administration budget, although it will also show up
14 in their statistics as services. So their funding sort of
15 aligns to that, and it will relieve the State Medicaid
16 program.

17 MS. YEAGER: And that's an important point that, you
18 know, the VA does not bill Medicare or Medicaid. The veteran
19 -- from our perspective, if we are authorizing, or in this
20 case, if the Native veteran is eligible, then we directly pay
21 that bill from the VA budget, and as Myra said, we do --
22 certain cases of certain categories of veterans can go for
23 third-party reimbursement from private insurance, but we do
24 not bill the other, not (indiscernible - voice lowered).
25 There are some situations between VA and DOD under some other

1 arrangements, but it's very different than that.

2 MS. MUNSON: I should say one of the reasons that we use
3 the encounter rates that are set is those encounter rates are
4 an enormously efficient way to bill for health services. You
5 do the aggregate cost -- the process for the aggregate cost
6 report. The rate is published. The billing goes out. The
7 payment comes in. It avoids a lot of the hassles for billing,
8 and these limitations on billing -- one federal agency billing
9 another, in part, are saving health care dollars that would be
10 spent on administering claims.

11 COMMISSIONER URATA: So there is no double reimbursement
12 for individuals?

13 MS. LIPROT: Excuse me. No. There is no double
14 reimbursement for the individuals under those various
15 government programs. It does indirectly provide a savings to
16 the State because we've found that numerous of the veterans
17 were not using their benefits. They were not enrolled. They
18 were using their Medicaid eligibility, which was coming from
19 the State itself.

20 MS. MUNSON: There is no circumstance in which the
21 payment from one of these programs could result in a tribal
22 health program or any provider receiving payment from multiple
23 payment sources. They're not permitted to accept more than
24 they were ultimately allowed to receive.

25 The question is, who ultimately paid for it? So in some

1 cases, if the veteran had private insurance, the provider gets
2 paid. VA will be reimbursed from the insurance company for
3 whatever it's responsible for. So VA's cost has been reduced.
4 If the veteran was eligible for Medicaid or Medicare, those
5 programs have achieved savings because they didn't get the
6 bill; VA paid the bill. The individual may be a beneficiary
7 of Medicaid, VA Medicare, and private insurance. The private
8 insurance always has to meet its obligations because they were
9 paid for as a separate benefit. The other agencies, only one
10 of them will ultimately pay.

11 CHAIR HURLBURT: I think we probably better break for
12 lunch now. Thank you so much for coming and sharing with us.
13 I see David already moved to his Commissioner seat because
14 what I'm going to say next. But at 12:30, we'll have the
15 public comment period. Then at 1 o'clock, Tracy Speier will
16 be sharing with us. The lunch is here. I think there is
17 enough lunch for everybody, but if the folks in the audience
18 could let the Commissioners go first, so that we can get done
19 and be ready for our 12:30 time.

20 MS. YEAGER: Thank you very much, Dr. Hurlburt.

21 CHAIR HURLBURT: Thank you, Susan. Look forward to
22 seeing you.

23 12:03:11

24 (Off record)

25 (On record)

1 12:32:33

2 CHAIR HURLBURT: I think -- are we off of mute for the
3 folks on the phone?

4 COMMISSIONER ERICKSON: Yes.

5 CHAIR HURLBURT: Can we get an idea of folks that are
6 online who would like to testify? Is Patricia Atkinson from
7 SEARHC on? We'll come back in a little bit. We'll go ahead
8 here. We have one person signed up here -- two people.

9 COMMISSIONER ERICKSON: Elizabeth Ripley, and I can't
10 read that name. Ms. Burrell.

11 CHAIR HURLBURT: Elizabeth Ripley, could you come
12 forward, please, and identify yourself and who you represent
13 and take probably three or four minutes? Just press the
14 silver button.

15 MS. RIPLEY: Dr. Hurlburt, members of the Commission,
16 thank you for the opportunity to speak with you today. My
17 name is Elizabeth Ripley. I am the Executive Director of the
18 Mat-Su Health Foundation.

19 And first, I wanted to thank you for your 2011 report
20 recommendations and finding regarding the sharing and access
21 of data at the borough and community level. Because you
22 shined a light on this issue, the State has found the
23 leadership and the resources to populate and start to bring
24 IBIS online. IBIS is the Indicator-Based Information System
25 for public health, and I know there is a handout out here

1 about it from Dr. Fenaughty. So anyway, I really appreciate
2 that very much. We're excited about where that's going.

3 Today, I'm representing the Mat-Su Health Foundation,
4 which is a 501(c)(3). It's actually a non-profit hospital in
5 the eyes of the IRS, and we share ownership of the Mat-Su
6 Regional Medical Center with an equity partner. But I'm also
7 representing a coalition of aging and disability providers
8 from across Mat-Su, and this coalition has come together to
9 create a Mat-Su-based aging and disability resource center.

10 My comments to you today will focus on the needs of the
11 fastest growing age demographic in Mat-Su and across the state
12 of Alaska, that of senior citizens. As you are aware, Alaska
13 has one of the highest rates of senior citizen population
14 growth in the nation, and in Mat-Su, the Alaska Department of
15 Labor is projecting the 65 to 74 year old aged cohort to grow
16 by 159% and the 75 to 84 year old age cohort by 247% by 2030.
17 The Alaska Commission on Aging reports Mat-Su's senior growth
18 rate at 11.6%, which includes a net gain from a senior in-
19 migration rate that is almost double its senior out-migration
20 rate. There are only two places in the state of Alaska where
21 the in-migration is greater than the out-migration and Mat-Su
22 is one of them.

23 In 2010, 17.6% of senior households in Mat-Su qualified
24 for Medicaid, slightly lower than the statewide figure of
25 17.9%. And while the percentage of households qualified for

1 Medicaid statewide will decrease by 2015 by about 0.2%, the
2 actual number of households will increase by 3,379 households,
3 or 34%. Growth of Medicaid-qualified households in Mat-Su by
4 2015 is projected to be slightly over 38%, and this will have
5 dramatic financial consequences for the State.

6 Mat-Su's gap population, which encompasses those
7 households above the Medicaid threshold but below the median
8 income, is projected to grow 60.9% to 2,174 households by
9 2015, and these individuals are typically at greatest risk
10 because they do not qualify for state support, but likely lack
11 sufficient income to pay privately for senior services.

12 So in 2011, the Mat-Su Health Foundation collaborated
13 with the Alaska Mental Health Trust Authority, the Denali
14 Commission, Rasmussen Foundation, and United Way of Mat-Su to
15 commission a Mat-Su Regional Plan for the delivery of senior
16 services, and I'd be glad to come back at a future date and
17 present the findings of this regional, which can really be a
18 template for regional planning across the state. It has been
19 presented to the Alaska Commission on Aging, to the
20 Commissioner of Health and Social Services, and other parties,
21 and it makes a series of recommendations for the both state
22 and at the local level, which we are actively engaged in
23 implementing.

24 One example of a state level recommendation in our plan
25 is for the State to proactively evolve a fully functioning

1 aging and disability resource center model to encompass all
2 three primary functions of the program, which are information
3 referral, access, and assistance.

4 The State would need to dramatically increase ADRC
5 funding to both achieve this fully functioning model at
6 existing sites and to expand to other areas of Alaska,
7 including Mat-Su. ADRCs are viewed as a key element in the
8 process of expanding access to services for older adults and
9 disability populations, while containing Medicaid cost growth,
10 improving the efficiency of the system with more streamlined
11 allocation of resources, and increasing consumer satisfaction
12 with person-centered, self-directed care aimed to maintain
13 their independence. So that's just one example of a finding
14 in the plan.

15 Foremost, we encourage the state elected and appointed
16 leadership to take a proactive stance on senior issues and to
17 make a State of Alaska long-term care plan an immediate
18 priority.

19 In the interest of decreasing the Medicaid cost growth,
20 only a proactive and thoughtful approach will be able to
21 contain costs, which will still increase, due to the high rate
22 of senior population growth.

23 Alaska has the resources and the brain trust to address
24 these complex issues and ensure that seniors live out their
25 remaining years with dignity. We need a high level leadership

1 commitment to address these issues in a coordinated and
2 meaningful way. Thank you.

3 CHAIR HURLBURT: Thank you, Elizabeth. Larry?

4 COMMISSIONER STINSON: What kind of funding are you
5 looking for, for the State? Is this for a pilot project or to
6 implement something that you have underway?

7 MS. RIPLEY: Well, we've been, I think, really successful
8 in our advocacy in that the State did use our regional plan
9 when they recently adopted their Aging and Disability Resource
10 Center plan for the State. We asked that -- because Mat-Su is
11 lumped into Region V, which covers Kenai, Cordova, Valdez, and
12 Mat-Su, and Kenai has the ADRC serving Region V, and they were
13 using Mat-Su's robust numbers to get their funding and
14 providing no service to Mat-Su. So we were able to make a
15 case for, hopefully, carving out funding with respect to ADRCs
16 to, at least, have two sections of funding for Region V, so
17 that Mat-Su with its, you know, robust senior growth could get
18 some services.

19 In the state plan, they have done that. They have used
20 our -- they've actually used our financial modeling. They've
21 used our numbers. They've carved Mat-Su out. What we don't
22 have is the funding appropriated. So you know, I think -- but
23 as we have delved into this and as we've learned more about
24 it, we have come to recognize that the bigger problem is the
25 lack of a state long-term care plan, but this is a piece of

1 that plan, and our regional plan actually looked at the entire
2 continuum of care for the needs of seniors and folks with
3 disability across the entire continuum for Mat-Su. And so if
4 I was to present just the demand analysis across the
5 continuum, it just kind of, you know, knocks you off your feet
6 because -- and Mat-Su is really uniquely positioned in that we
7 have a very healthy private sector and that private sector has
8 really stepped up and been able to develop the services across
9 the continuum of care where there is reimbursement. Where
10 there is no reimbursement, there is no care.

11 So another finding of the plan is that there is no
12 reimbursement in Alaska for memory-assisted care and so you
13 have Alzheimer's patients -- and I know, from my long tenure
14 with the hospital, that assisted livings drop their combative
15 Alzheimer's patients off in the ER, and we have them as
16 inpatients because there is nowhere else to send them. That's
17 not an appropriate use of the system. It's very costly, but
18 because we have not developed a workforce that can address
19 those Alzheimer's and memory-assisted patients and the
20 facilities, then we don't have them. So you know, the plan
21 really goes into a lot of different pieces across the
22 continuum. This ADRC is one piece.

23 We know that there is a federal grant that the State
24 right now is eligible to apply for that would be able to
25 expand ADRC funding, and they have to make that decision and

1 apply by mid-July. So there are some opportunities here, but
2 again, what is the State's long-term plan. How does that
3 funding fit into it? I think, you know, as we've come to,
4 again, delve into this one particular issue, it really is like
5 opening a can of worms.

6 And you know, I sat next to a representative last week at
7 the Blood Bank 50th Anniversary who said to me, we've known
8 about this problem for ten years. So it really is -- you
9 know, our window here is now. It's not to put it off. It's
10 now and so we just would really encourage the Commission to
11 shine a light, like you did on the data issue, on the need for
12 a state long-term care plan that does prioritize and does look
13 at this allocation of resources and is fair, looking at the
14 different population centers in the state, like Mat-Su.

15 CHAIR HURLBURT: Any other questions or comments? Keith?

16 COMMISSIONER CAMPBELL: You're talking long-term care.
17 That's a pretty wide continuum. Are all facets of long-term
18 care in this state -- and I should know the answer -- are they
19 all under the Department of Health or are they scattered
20 through other departments of the state government, the
21 administration or granting or whatever?

22 MS. RIPLEY: Well, I'm not sure that I know the answer to
23 that. However, the plan does point out that there silos
24 within the state system of senior services and that that, just
25 the sheer bureaucracy created by the many different silos of

1 administering the different programs is problematic. I know
2 our regional plan points that out, but there can be
3 efficiencies if it was better consolidated. But I can't speak
4 to if they're all in the Division of Health and Social
5 Services, but maybe someone else can.

6 CHAIR HURLBURT: I'm not aware of others outside; are
7 you, Deb?

8 COMMISSIONER ERICKSON: Well, yeah. I'm not sure if
9 there is something outside the Department that I'm not aware
10 of, but I do know that, at one point, some programs, like both
11 the Older Alaskans Commission and the Pioneer Homes, were in
12 the Department of Administration and were transferred into the
13 Department of Health and Social Services a few years back.

14 COMMISSIONER KELLER: I think, mostly in Health and
15 Social Services -- we've got the Commissioner here, but I
16 think the Department of Admin probably deals some with it, you
17 know, but I think that's the only two places. But the silos
18 are definitely there. They're there, you know, and I'll say
19 this right in front of the Commissioner, they tend to be there
20 right in the Department, you know, but you know, we see it,
21 you know, as legislators, but I know that it's a priority of
22 the existing Commissioner to get them working together to get
23 the different silos working together.

24 CHAIR HURLBURT: Thank you very much.

25 MS. RIPLEY: Thank you.

1 CHAIR HURLBURT: We have one other person here in the
2 room, in the audience with us, Ms. Burrell, also from Mat-Su.
3 If you could come up and identify yourself again and who you
4 represent, please?

5 MS. BURRELL: Hey, Dr. Hurlburt. I haven't seen you in a
6 while. You're looking good on those TV commercials though.

7 CHAIR HURLBURT: (Indiscernible - voice lowered)

8 MS. BURRELL: I'm Pauline Burrell. I'm the Director of
9 Case Management at Mat-Su Regional Medical Center. It was
10 pretty fabulous I got to follow Elizabeth Ripley. Woo-hoo.
11 So she already gave you the demographics of us, but I'm here
12 to talk about what the needs of our community are, and the
13 community -- what I see and what we see in the community is we
14 really need a nursing home or a skilled nursing facility in
15 our area.

16 So Mat-Su Regional Medical Center is a 73-bed hospital.
17 We have an intensive care unit, a step-down unit, med/surg
18 unit. We do obstetrics, and we do have four swing beds, which
19 are kind of like skilled nursing home beds, and I'll explain
20 that more as we go on.

21 So I'm going to give you some demographics of our
22 hospital and what our inpatient admissions look like. As you
23 can see, I gave you some 2010, 2011, and 2012 numbers. We had
24 a slight decrease in inpatient admissions from 2010 to 2011,
25 and you can see where we're currently at, at 2012, but we did

1 implement InterQual criteria in 2011, which InterQual criteria
2 kind of changes the status of where you place your patients.

3 So you can see, on the bottom of page two, our
4 observation patients, which are patients that are there less
5 than 23 hours. They climb significantly between 2010, 2011,
6 and you can see where we're at already for 2012. So it's just
7 putting the patients in the appropriate level of care.

8 So our average daily census at our facility is about in
9 the 40s. So when we discharge patients out, I put a home on
10 this slide because we all want to go home. Not everybody has
11 a home, but we all want to go home. Not everybody has running
12 water. Not everybody has facilities, but most people would
13 like to go home, but not everybody can go home because they're
14 ill.

15 So we do discharge patients out to the long-term care
16 hospital, which is St. Elias, but you have to meet a certain
17 criteria in order to get there. You have to be quite ill. So
18 most of the patients that are transferred there out of our
19 facility come out of our ACU, straight to St. Elias, and they
20 do a fabulous job with patients, but they have to meet a
21 certain criteria in order to get there.

22 Inpatient Rehab. As you can see, we're kind of status
23 quo there, eight, six -- oh, we got seven in this year, so
24 we've been really working hard, but you have to be able to do
25 rehab three hours in order to get into an inpatient rehab

1 facility. So not all patients who are ill or chronically ill,
2 have had a stroke, not all of them are quite ready to do three
3 hours all at once. So that doesn't work for everybody.

4 Skilled Nursing Facilities. We call our Skilled Nursing
5 Facilities, which is PEC and which is Providence Extended Care
6 and Prestige. We call. We beg. We fax, just like everybody
7 else -- and because those are the only facilities we have.

8 What did you say?

9 UNIDENTIFIED MALE: (Indiscernible - away from mic)

10 MS. BURRELL: No. I don't lie. But as you can see, we
11 don't get a lot of our patients into the nursing home. We did
12 call this morning to see what their bed status is. Providence
13 Extended Care had two openings, one male, one female, and
14 Prestige had two rehab, Medicare rehab beds available, and
15 we're hoping to steal, at least, one today, if we're lucky, if
16 we meet their criteria.

17 And Swing Beds. We do have four swing beds in our
18 facility, and these swing beds are kind of like rehab beds or
19 they're a bed that patients go to when they are no longer
20 acute. They need a certain period of time, and maybe they're
21 going to go back and have surgery again. So they're kind of a
22 short-term kind of nursing home, but we have a waiting list in
23 our facility to get into these four beds. We've had -- like
24 Providence has called us in the past and asked if they could
25 have one of our swing beds for one of their patients, and I

1 didn't have an empty swing bed at that time. If I would have,
2 I would have traded them a psych bed for a swing bed, but I
3 couldn't. So that's the way it is. So they're full all the
4 time.

5 Now these next two slides are a little flipped here.
6 Sorry about that. Assisted Living. As you can see, we
7 discharge quite a few patients into Assisted Living, and the
8 reason why we do that is because we have no other place to put
9 them. They're not safe enough to go home. We don't have a
10 nursing bed to put them in and so we apply for general relief
11 funding for patients to get into assisted living. Some of
12 them qualify for waivers. Some of them don't qualify for
13 anything, and some of them privately pay between \$5,000 to
14 \$6,000 to get into an assisted living. And we also -- when a
15 patient goes home into an assisted living facility, we do
16 provide or connect them in with home health or equipment or
17 whatever else they need. And also not everybody -- the people
18 who don't qualify for assisted living -- so if there is like a
19 husband and wife -- so for him to go into the assisted living,
20 he would take all the income. So some of these patients go
21 home and so they go home, and we try and do everything to make
22 sure it's a safe discharge, and we put home health and
23 therapies, and you know, we try and connect the families in,
24 but you know, there is that possibility those patients will
25 readmit. And we do send patients home with hospice. Not all

1 assisted livings take hospice, so that is also an issue.

2 So I went ahead and put some of our readmission rates on
3 here, so you can see that we've had between -- on our good
4 months -- like 5% -- woo-hoo -- and our bad months, we've had
5 over 8% readmissions in our hospital, and in 2012, it's
6 looking similar. We had a good month in April. I don't think
7 I looked back at May. So I haven't had a chance to verify the
8 May numbers, so I didn't want to put them on there.

9 So we would love a nursing home, if anybody wants to
10 build one out in our area. It would just be a safer
11 transition. So patients who are -- like Medicare patients who
12 come into our hospital who may have broken something, need a
13 couple weeks of rehab, you know, they could go to a nursing
14 home, get the skill and the care they need and then they could
15 have a safe discharge home. It's cost-effective. It reduces
16 readmissions, and people like to stay within their community.
17 Right now, our assisted living beds, we filled them up. We
18 have three available assisted living beds in our area, and you
19 know, assisted living facilities, they get to choose what kind
20 of payment -- everybody will pick those private pay patients
21 who have to pay \$5,000 or \$6,000 a month, but the ones who get
22 paid -- general relief is, like, \$2,100-\$2,200. Those are a
23 little bit harder to find beds like that.

24 So it's just the right thing to do for the Alaskan
25 people, and I heard you were going to build me a nursing home,

1 Dr. Hurlburt. It's my dream. And what's your dream?

2 CHAIR HURLBURT: You can't do it until September,
3 Pauline. Thank you, Pauline. Any questions or comments?
4 Jeff?

5 COMMISSIONER DAVIS: Thank you for that. I'll just ask
6 what's probably an obvious question with an obvious answer,
7 but if there's all this need, then why hasn't someone stepped
8 in and created that -- filled that business opportunity with -
9 - by building a nursing home?

10 MS. BURRELL: Well, I keep hoping somebody is, and I've
11 heard a little bit of interest out there. So if the interest
12 comes through, I'm hoping you guys would approve our
13 Certificate of Need out in our area, if somebody actually does
14 do that.

15 COMMISSIONER BRANCO: A question quick. Do have an
16 assessment of bed need for the.....

17 MS. BURRELL: I could fill up a wing today for you.

18 COMMISSIONER BRANCO: How big is a wing?

19 MS. BURRELL: I don't know. I'm just saying we.....

20 COMMISSIONER BRANCO: 20-25?

21 MS. BURRELL: Oh, I would say a minimum. I mean, we are
22 pretty full, and like I said, we put everybody into assisted
23 living, but if we had an opportunity to put people in the
24 right level of care -- and at some point, maybe they would
25 need to go into an assisted living, but it's better for the

1 people to be able to go to a nursing home, get the care they
2 need, go home, if that's what they would like to do. So you
3 know.....

4 COMMISSIONER MORGAN: I guess I'll ask the question
5 again. It doesn't sound like a Certificate of Need is the
6 barrier. What is the barrier? If we have -- I know the
7 answer, but I'm going to ask it anyway. I never ask a
8 question, if I don't know the answer, usually. What is --
9 it's not Certificate of Need. It's not because there is not a
10 bunch of patients. What is the reason or three reasons why
11 there isn't a nursing home in the Valley?

12 MS. BURRELL: I just need somebody to build it. I don't
13 know what the barrier is. I'm just saying that I know there
14 is the funding issue to get a nursing home built.

15 COMMISSIONER MORGAN: I think -- I'm only guessing, but I
16 think the real problem is, basically, coming up with a --
17 building, from my experience, is usually not the problem.
18 Between the Rasmussen Foundation to -- somebody has money to
19 build things. It's operating and sustainability. Clue, okay?

20 So I think we all know the real problem. I'm just trying
21 to get somebody, other than a Commission member, to say it,
22 but I guess I'll have to. It's basically there is -- the --
23 so few people have long-term insurance, and of course, the
24 Glass Act out of the Affordable Care, was the first thing that
25 went out of the -- you know, it was pooled, which was long-

1 term care insurance for everybody. We'd all be paying in for
2 two years and then start the process, but basically, there is
3 just not the type of dollars of reimbursement or payments to
4 make one be sustainable to meet the standards, which are
5 reasonable. I mean, does any -- I mean, hopefully, somebody
6 will jump up and say, David, you're wrong and here's why, but
7 I think that's the problem, but hey, what the heck?

8 MS. BURRELL: I guess I disagree. I'll step up. So --
9 because I actually worked at Central Peninsula Hospital, and
10 I've worked in the QIO and so I've traveled a lot, but I can
11 tell you, from working at Central Peninsula Hospital,
12 Heritage, which is the nursing home that was connected to the
13 hospital, was quite profitable, and they were full all the
14 time. So -- and people from Providence, you know, in
15 Anchorage would send people back home there. So their
16 facility was full all the time. So my hope is, if we were to
17 build something or somebody was not -- not the hospital,
18 because I've already hit the administration up over and over
19 again, but if somebody was to build one, I'm thinking it would
20 be full, and hopefully, it would be profitable. So that's my
21 hope. I'm not saying you would make millions from it, but I'm
22 hoping you would make money.

23 COMMISSIONER MORGAN: Really? I mean, if -- I guess it's
24 -- I can't get my mind around it. You have a tremendous
25 number of patients, reimbursement or operating dollars. If

1 you had one, you would be like Morgan Stanley. I mean, you
2 could sustain it, make it make money. You could make money.
3 Then I'm just very confused. I usually -- in the United
4 States' economy when you have a need, you can make money at
5 doing it, whether it's building, to the chagrin of your
6 previous guy, widgets to baseball bats to health care, then I
7 can't figure out why some entrepreneur or organization doesn't
8 build one. I mean, you're saying it's simply everybody has
9 chosen not to do it.

10 MS. BURRELL: Well, I'm not saying they haven't chosen
11 it. I'm saying that I'm hoping it's coming down the pike and
12 you'll hear about it. I'm dreaming; I know.

13 CHAIR HURLBURT: Maybe one last comment, Bob. We've got
14 one or two other folks. Go ahead.

15 COMMISSIONER URATA: Well, why doesn't your hospital tack
16 one on? You know, Wrangell has a long-term care center and
17 that's what keeps them alive. They only usually have two
18 acute patients, and you know, 15 long-term care patients, and
19 in fact, in Juneau, we have to send patients to Wrangell or
20 Petersburg or Sitka because we don't have long-term care beds
21 open in our community. So some of our community elderly end
22 up having to go there for subacute rehab, you know, under the
23 Medicare program and then they come back to Juneau, once they
24 get over their hip -- you know, get rehab. And so we've been
25 trying to get more beds added, but if we add beds in Juneau

1 and they don't get some of our patients, then those hospitals
2 could suffer. But in your situation, you know, it seems like
3 there is adequate population to support one, and maybe your
4 hospital should look at just tacking it on.

5 MS. BURRELL: I'll let our CEO know you said that.
6 Thanks. Thanks, Dr. Urata. Hey, that's just not in their
7 strategic plan sort of thing, but thank you for that comment.
8 I'll let them know.

9 CHAIR HURLBURT: Thank you, Pauline.

10 MS. BURRELL: Thank you.

11 CHAIR HURLBURT: Anybody online? Patricia Atkinson? Not
12 online. Karen, come on up. Yeah. Maybe quickly because
13 we've obligated the rest of the time. We have one more.....

14 MS. PERDUE: I wanted to update the Commission on the
15 recommendation -- two recommendations that you made in your
16 report.

17 Karen Perdue, CEO of the Alaska State Hospital and
18 Nursing Home Association. On data, discharge data and other
19 activities, you remember that the Alaska State Hospital and
20 Nursing Home Association entered a partnership probably a
21 decade ago with the Department to collect hospital discharge
22 data and that process, I would say, has gone up and down in
23 terms of its success and participation. Your committee -- the
24 Commission recommended that we renew our efforts, and we have
25 been putting a lot of shoe leather into that process.

1 Elmendorf, I believe, is coming on very soon, and we have
2 attracted a couple of other hospitals that are interested.
3 And then also we have done a couple of other things.

4 We have formed a data committee of knowledgeable type
5 people in our industry to look at this because what we have
6 found is that the value added for the data is not absolutely
7 known to everyone who is either submitting or is in charge of
8 getting it submitted. You know, there are three different
9 reasons that we've identified for the data.

10 One would be market strategic planning for facilities.
11 Another would be industry representation and trends. The
12 third would be public health planning. And I think that the
13 feedback loop on the second two are not robust. In other
14 words, they are not a lot of resources available to use and
15 analyze the data so that those who are reporting see its
16 value.

17 That then leads to the question of strategic use of the
18 data for market analysis, and frankly, in the SouthCentral
19 area, that's a problem right now. We have not been able to
20 get Mat-Su Hospital Regional Medical Center to participate,
21 nor has the State, and that is a big hole in the Southcentral
22 market numbers. And so I think this is the problem that our
23 other hospitals are starting to identify as a key issue.

24 We also have a lot of conversions of EHR systems going on
25 all across hospitals and that is creating a barrier as people

1 convert to submitting data, both inpatient and outpatient.
2 Some very small hospitals are not participating yet, but they
3 say they will when they finish their conversion.

4 We've hired Garth Hamlin (ph), who is a long-term CFO and
5 known to Dr. Urata very well, to help us with this because he
6 has been a long-term champion of discharge data out of Juneau,
7 and he has been looking at trying to figure out ways that
8 would make the data submission less painful. In other words,
9 are we already collecting it?

10 So I won't go into a lot more detail, but just to say you
11 can see that we're doing a lot of shoe leather on this issue.
12 I would say that the Executive Committee met and talked, you
13 know, for over an hour on the issue of data and raised a lot
14 of important questions, some of which I've shared with you,
15 but probably the most important thing is, I think, our
16 industry has decided that, if we look a decade out, a
17 discharge data system just for hospitals is not going to be
18 enough, and I think the Commission dealt with this in your
19 report when you talked about an All-Payer claims system or
20 some other system that then started to compile information and
21 make data and transparency available not from the provider or
22 site-specific place where the patient is cared for, but across
23 the industry.

24 So we're very interested, and we're very tooled-up now to
25 participate in any process the Commission might have. I've

1 talked, to some degree, with my counterparts across the
2 country who are involved in doing some of this planning. It's
3 a big job. Big, big job. Needs a lot of good resources and a
4 lot of good brainpower on it, if we're going to do it right.

5 So I just wanted to give you an update, let you know that
6 we're available to participate in data discussions. They can
7 be dry. They can be boring, but in the long run, it might be
8 one of the most lasting things that the Commission could do
9 would be to create this platform that providers would be
10 comfortable with and also consumers would be comfortable with
11 and policy analysts could be comfortable with. Thank you.

12 CHAIR HURLBURT: Thank you very much, Karen. I think we
13 probably should move on. Dr. Larry Stinson offered to share
14 an update on the information on Washington State's experience
15 with legislation related to pain management. We've heard some
16 from before. Larry?

17 COMMISSIONER STINSON: We've talked previously about
18 outcome studies, about review of different things that could
19 help health care while, at the same time, reducing costs, but
20 actually improving outcomes without any additional cost to do
21 so.

22 Washington State passed an opioid drug law now two years
23 ago. We have the preliminary data, and it's in this article.
24 And actually, I have much more in-depth data, too, but this
25 kind of outlines the results. They performed a cutoff at 120

1 milligram equivalent of morphine per day, and if anybody
2 really wants to know what that means, I will be glad to go
3 into detail to tell what that is. That's a fair amount of
4 narcotic medication. I mean, the two most common reasons why
5 somebody sees a health care provider is, depending on your age
6 group, an upper respiratory infection or pain. So it's one of
7 those two reasons why you see somebody.

8 And then when you're giving that much medication, you
9 better have a really, really good reason because, as you go
10 through this article, it will show you that the reason why
11 that was picked as the cutoff for Washington State, you begin
12 to have a nine-fold increase in risk of death, including
13 cardiac death, respiratory death, and they didn't even get
14 into it in this article, but the number of ER visits goes way
15 up. Domestic violence goes way up. Behavioral health issues
16 increase substantially. It's a fairly good marker across the
17 board, and this has actually been used nationally because
18 other states are already now passing similar laws, including
19 Florida just did so, and Florida needed to because that was
20 the state with actually the worst problem with opioid abuse in
21 the country.

22 This goes into, I think, sufficient detail. It drops
23 health care costs considerably. It drops death rates
24 considerably. Gary Franklin is the head of Worker's Comp in
25 Washington State, and for those of you who don't know him,

1 he's a very interesting, very smart gentleman, but very
2 strongly opinionated about a lot of things and is always
3 looking for some way to improve care. It has dropped the
4 Worker's Comp costs in Washington State significantly, and
5 he's so cynical he didn't expect anything to be able to drop
6 the Worker's Comp costs while improving care and outcomes.

7 So there is still more data that's being compiled. The
8 University of Washington is taking the lead by proactively
9 recording data on every patient visit in the University of
10 Washington system and through their emergency rooms. This is
11 all being recorded and cataloged. And I've seen some of the
12 preliminary data, but there is going to be a publication
13 that's going to go into this in more detail. So I can't
14 really talk about it, but this is significant.

15 And if you want to talk about something that other states
16 are doing and have already tested, that could potentially be a
17 significant benefit for Alaska. Even if our total numbers of
18 people who are taking that amount of medication or more per
19 day aren't that substantial, because of the indirect costs
20 related to that group of people, it makes the costs of the
21 medications pale by comparison, plus the loss of life.

22 So this is something I'm going to continue to follow, and
23 when the other data is publishable, I will be glad to share
24 that with the Commission, but this is something that the State
25 of Alaska, I think, should consider because it's already been

1 test-labbed in other states and it works. Thank you.

2 CHAIR HURLBURT: Thank you, Larry. The inappropriate use
3 of legally controlled substances now kills more people than
4 automobile accidents in the United States. So it's a national
5 problem. It's a Washington problem. It's Alaska's problem.

6 Let's -- if we can go ahead now and go back to our
7 earlier session, Tracy Speier is going to come and talk with
8 us a little about another VA-related project, Behavioral
9 Health Access Project. Welcome, Tracy. If you could identify
10 yourself and then go ahead with your presentation?

11 MS. SPEIER: Thank you. I'll wait until you can get it
12 up on the screen; how's that?

13 So this presentation works nicely from the presentation
14 that was given this morning, and just realize before I get
15 started, it is in transition, and it has gone through a lot of
16 transition.

17 My name is Tracy Speier, and I work for the section of
18 Health Planning and Systems Development here at the State of
19 Alaska, Department of Health and Social Services.

20 I am here to talk to you today about the Rural Veterans
21 Health Access Program. It is a national pilot project funded
22 by Public Law 112-74. Next slide, please.

23 Section 1820 of the Social Security Act. The funding is
24 through the Health Resources Services Administration, Office
25 of Rural Health Policy, Office of the Advancement of

1 Telemedicine. There are only three projects of this sort in
2 the country, based on the rate of veterans in all of the
3 states, and Alaska, Montana, and Virginia have the highest
4 rates of veterans in the country per state.

5 The funding cycle of this particular project is September
6 1, 2010 through August 31, 2013. Public Law 112-74, during
7 the passing of the federal budget last year, they realized
8 that all three of the funded programs were not compliant with
9 the initial congressional intentions of the funding, and so as
10 of January of this year, all three projects were mandated to
11 revise their scope of work halfway through the project.

12 I just happened to start the day that we got notification
13 of that change of scope of work. So needless to say, since
14 day two of being on the job, we met with the VA and started an
15 intensive revision of the scope of work. Next slide, please.

16 This brings me to the presentation of my outline. First,
17 I'm going to go over the language of Public Law 112-74. I'm
18 going to talk about the accomplishments in the first year of
19 the project, the first year-and-a-half before I came onboard
20 because it really set the foundation. Despite the change of
21 scope of work, it set the foundation for the project and where
22 we're heading today.

23 You heard a lot about the parallel efforts that were also
24 going on and continue to go on of which, when I changed the
25 scope of work, it was sort of like playing the game of Twister

1 in terms of all the different circles I had to work around in
2 terms of developing a revised scope of work.

3 Then I'm going to talk about a Preliminary System Gap
4 Analysis that I did of telebehavioral health care in Southeast
5 Alaska, and I'll summarize with the revised goals and
6 objectives of the project.

7 First, Public Law 112-74 mandated that funds for this
8 project be used to purchase and implement telehealth services,
9 including pilot and demonstration projects on the use of
10 electronic health records to coordinate care for veterans in
11 rural areas. Next slide, please.

12 The critical piece of Public Law 112-74 is that the first
13 year-and-a-half of this project was highly collaborative with
14 the VA and what the VA was doing. However, because the
15 initial reaction or the purpose of the funding was to develop
16 telebehavioral health services, that's where the change of
17 focus came in, but leading up to those changes, my predecessor
18 develops the core networking involved in this particular
19 project.

20 In the first year, the project focused on three regions
21 of the state, the northern region, the southeast region, and
22 the southcentral region, and it was based on which areas of
23 the state the VA focused on as well. However, with the change
24 of scope, we are now focusing on the southeast region, and
25 I'll get into that in a bit.

1 My predecessor also created a core steering team of key
2 people, both internal and external of the state, and had
3 monthly meetings, and also helped facilitate the beginning of
4 the training of behavioral health providers throughout the
5 state on issues, like Post-Traumatic Stress.

6 Then through collaboration with the VA and also my
7 predecessor, it was decided that information on veteran
8 enrollment was needed because a lot of clinical providers
9 didn't have the information about enrollment for veterans. So
10 they created this enrollment door hangar for a clinical
11 setting. We have distributed those in many areas of the state
12 and continue to do so, and I've already distributed two today
13 at the table.

14 So as you heard a lot this morning, another parallel
15 effort was the MOA between the VA. I won't get into that
16 because you heard about that already. And also the VA is
17 working on a project with SEARHC and the telehealth
18 coordinator position. You heard also about their Tribal
19 Veteran Representative training and also the increase in VA
20 vendorizing.

21 The 13th Workgroup was critical in terms of the direction
22 that this project took, primarily because this project is
23 complementary to what the 13th Workgroup is doing, but it's
24 focusing on areas that the VA is not working on right now.

25 So when I worked with Susan Yeager on trying to develop

1 something for this project that wasn't duplicative, I wanted
2 to focus on something that would help accelerate the efforts
3 for the non-tribal system and what the VA is trying to do.

4 Next slide, please.

5 So as explained earlier, those were the three. Increased
6 access, improved coordination, and increased availability of
7 services in accordance with the law is a summary of what the
8 13th Workgroup focused on or is focusing on right now. And of
9 the area of the 12 areas that the 13th Workgroup identified
10 what they wanted to accomplish, these are the three areas that
11 this particular project is working on that the 13th Workgroup
12 also has in their scope of work, but this project can help
13 accelerate that process.

14 So we're going to improve health care through telehealth
15 technology and enhance access by developing and implementing
16 new models of care using technology and also increase
17 capability and improved quality of health through workforce
18 development. Next slide, please.

19 This is where the work really started to happen on my
20 end. Being new to the project and not knowing anything about
21 telehealth and not being a veteran myself, but having lots of
22 experience developing models of care in rural Alaska, the
23 first task I had to do is wrap my mind around all the
24 telehealth players in the state as they related to this
25 particular project. I'll go over that in just a second.

1 Then the second piece that I had to do, in order to
2 identify where we could do a pilot project and what
3 telebehavioral health systems exist and where there are gaps,
4 we decided, in order to not duplicate what was already
5 happening between the tribal health system and the VA, to
6 focus on the part of rural Alaska that had a mixture of tribal
7 systems and non-tribal systems, and Southeast Alaska just
8 happens to have the highest number of mix of different types
9 of those systems.

10 So we went into Southeast Alaska, and I started the
11 System Gap Analysis, an entire huge spreadsheet that I created
12 and that I was very excited about, and everybody looked at me
13 and make it simpler.

14 So we looked at all the different types of facilities in
15 Southeast Alaska, whether they were tribal, community health
16 centers, critical access hospitals, public health nursing, and
17 the type of equipment that they had. We also looked at
18 whether they were currently -- the Department of Military and
19 Affairs is helping me right now look at who is a VA vendor and
20 who is not and then we also looked at gaps in telebehavioral
21 health.

22 So the next slide is an overview, and this mind map was
23 just to help me understand all the telehealth systems. I
24 separated it between the federal health care system and the
25 non-federal health care system, primarily because I could not

1 duplicate efforts that were already happening within the
2 federal health care system. So in order to do that, I also
3 had to understand how all the other systems worked together,
4 the bridge lines.

5 COMMISSIONER ERICKSON: Can I interrupt for just a
6 second? I just wanted to point out, for folks in the room,
7 that that slide that's really hard to look at is a slide in
8 your handout, is a separate, behind your handout, enlarged
9 printout of it, and the other slide that's difficult to look
10 at as a slide is the map, and when we get to the map, there is
11 a printout of the map in your notebooks, and both the mind map
12 and the map of Southeast Alaska are on the back table for
13 folks in the room, too, as a separate handout.

14 MS. SPEIER: Thank you. And the key thing about this is
15 one of the key factors of trying to develop an electronic
16 health record system that's compatible is to get all the
17 different systems to communicate. One of the things
18 identified was that there is all of these different types of
19 electronic health records or databases out there. AeHN is
20 working on that. And again to avoid duplication, I didn't
21 want to go there, but it became an issue because it's a
22 mandate in this grant that we actually utilize electronic
23 health records.

24 So through that, I also had to develop collaboration with
25 our internal state Health Information Technology and find out

1 where they were and where AeHN is, and how to fit in what
2 they're doing into this project, so it would be complementary
3 without duplication.

4 So the next slide -- I guess there is -- can you go one
5 more slide forward? There you go. The next slide actually is
6 the telebehavioral Health System Gap Analysis that I did in
7 Southeast Alaska, and I really have to give credit to SEARHC
8 for assisting me with this. They spent an entire afternoon
9 with me identifying what they do, and the whole goal was not
10 only to identify where there are gaps, but where there are
11 systems already that have telebehavioral health networks that
12 may need other telebehavioral or updates.

13 In doing the System Gap Analysis, it became very clear
14 very quickly that the area served by Wrangell Behavioral
15 Health Services or Alaska Island Care -- I'm mixing those
16 acronyms up; I'm sorry -- Alaska Island Care Services was
17 really the area that needed to be the pilot. So I called the
18 Director of Alaska Island Care Services and asked if he would
19 be interested in doing this. Of course, when somebody offers
20 I'll do all your work and I'll pay all your equipment, it's
21 really hard to say no. So they are onboard, and we are in the
22 process of working with them on the collaboration. If you
23 could go back to the previous slide, please?

24 So with those agreements in place and a preliminary
25 System Gap Analysis, I started looking at assessments of

1 connectivity and equipment costs. I'm working right now with
2 a couple of private communication companies in terms of what
3 is available out there and also determining what type of
4 equipment would be most efficient, given the technology and
5 capabilities of connectivity. Two slides forward.

6 So the summary of costs of equipment, if you notice, were
7 really at a tipping point with telebehavioral health
8 capabilities right now, and future technology is much less
9 expensive than what the technology is out there right now.
10 However, we're not quite there in terms of connectivity, but
11 we're getting there. And so it's sort of like I'm between a
12 rock and a hard place, in a sense. Do we buy the more
13 expensive technology that may be obsolete in three to five
14 years or do we hold off to make sure all the upgrades are
15 needed and then try to invest in the new technology, given
16 this is a pilot project? We're working all that out right now
17 with Wrangell and also Alaska Communications Systems. We're
18 testing the systems out there through a company in
19 Pennsylvania. I mean, it's fascinating, to me, how all these
20 technology is working, given I'm on a learning curve on it
21 all. Next slide, please.

22 So with all of that in place, we also have been
23 conducting weekly and bi-weekly meetings with different
24 stakeholders involved in this particular projects, and we've
25 developed all the linkages and scope of work agreements of

1 different partners within the project. Next slide.

2 So in summary, goal one, which is mandated by public law,
3 is to implement a demonstration project that provides access
4 to and increases the delivery of quality mental health
5 services and other health care services to veterans in remote
6 communities in Southeast. We're going to do that through --
7 next slide -- the development and deployment of a telehealth
8 network. We're also going to do it through the use of
9 electronic health information exchange, and I wanted to talk a
10 little bit about this because we're not really there
11 technologically yet in Alaska to actually integrate electronic
12 health records. We actually are trying to implement a pilot
13 project of what AeHN is trying to develop a pilot project for
14 in the urban area. We just got approval from that from the VA
15 two weeks ago to move forward with that. So it's kind of in a
16 holding pattern right now because we have to actually get
17 approval from the Central Office of VA in Washington, D.C. for
18 the VA to participate in this, but they have to get approval
19 to do it the urban pilot as well. So they're just going to
20 present it as an urban rural pilot. And of course, the other
21 piece of this is we're going to provide a lot of intensive
22 training to providers around the state.

23 So objective one of goal one I've sort of covered and
24 that's to develop the telebehavioral health network and
25 increase telebehavioral health capabilities, and Objective B

1 is what I just discussed in terms of the "Ax the Fax"
2 campaign. It's not duplicative right now, in the sense that
3 this project is going to be the first behavioral health
4 services project that is part of AeHN's project, and I think
5 you're going to hear about all of that this afternoon or
6 tomorrow sometime. So that will tie in.

7 And then Objective C of the project right now is to
8 increase behavioral health services provided to veterans by
9 increasing knowledge among health providers about military
10 culture, screening for VA status, Post-Traumatic Stress, TBI,
11 and other health issues common among veterans, including
12 substance abuse, depression.

13 And then Objective D is to establish online, on-demand,
14 VA approved training for distance delivery education
15 statewide.

16 Objective E of the project is to then, once all the
17 training for the providers is online, we're going to do
18 outreach to care providers that the training is available, and
19 this is also to address the high turnover rate among providers
20 in rural Alaska and also to increase the knowledge of the
21 providers in rural Alaska, given the variety of veterans that
22 are out there.

23 Goal 2 has two parts. The first part is to increase the
24 number of veterans enrolled in VA benefits within the
25 demonstration area. I did not want to duplicate what the VA

1 was already doing with their outreach efforts. So one of the
2 things that I discussed with the Department of Military and
3 Veterans Affairs within our state office is to take the
4 concept of this clinical pamphlet that's being primarily used
5 in a clinical setting, and through the Department of Veterans
6 Affairs, they said that the returning Vets from the Gulf wars
7 weren't showing up in clinics, like the Vietnam Vets were.
8 They're self-medicating. And of course, I had a flashback
9 from previous public health days of when I was the first
10 responder to the first cluster of AIDS in rural Alaska, and I
11 said, well, let's go where the veterans are and do outreach in
12 drinking establishments, grocery stores, things like that. So
13 we're expanding this to make a poster with little tear-off
14 cards on it with information, and we're going to connect them
15 to the Tribal Veteran Representatives. So we're going to
16 connect those different systems without duplicating services.
17 That's Objective A.

18 And then Objective B is we're working with Department of
19 Behavioral Health to train behavioral health providers that
20 are grantees of the State to screen for veteran status, to
21 document that in AK AIMS and also to document any referral
22 processes that the behavioral health providers offer the
23 veterans and that is either to TVRs or to other clinical
24 services. And we already have baseline data on that, that
25 we've pulled together.

1 Goal 2b is to increase the number of non-tribal health
2 care facilities in Southeast that are VA approved vendors.
3 Now if you notice how this is working is what's already
4 happening between the tribal system and the VA we're trying to
5 complement by trying to accelerate what they're planning to do
6 with the non-tribal systems.

7 And then Objective A of this is to also work with APCA
8 and ASHNA and other VA to provide the resources to encourage
9 other non-tribal health organizations in becoming vendors.
10 The goal of this, even though our demonstration area is in
11 Southeast, is to connect other providers statewide through
12 videoconferencing equipment.

13 Then Goal 3 is to identify where and how existing
14 networks can be improved, expanded, and linked to increase
15 services that meet the mental health needs of rural veterans
16 living in selected demonstration areas. An example of that
17 already is a female veteran has been identified in Sitka. She
18 receives part of her behavioral health care by a provider in
19 Sitka that is not trained in military culture, but is trained
20 to identify some of the traumatic brain injury issues that she
21 has, and the Sitka Community Hospital already has
22 videoconferencing equipment, but they're not using it for
23 telehealth purposes. So rather than trying to go in and build
24 a whole new system for veterans in Sitka who are non-veterans
25 [sic], we're just simply trying to get a link between the

1 Sitka Hospital, connect the equipment because, right now, the
2 VA is spending traveling this Vet up to Anchorage for service
3 care. So I think it's a win-win at no expense really to
4 anybody.

5 So Goal 3 -- next slide, please -- and also Objective A
6 is to establish and maintain the Core Steering Committee.
7 That has expanded to include all key stakeholders involved in
8 this grant at this point, and Objective B is to secure any
9 necessary working agreements between the Core Steering Team as
10 well as other players who become part of the project.

11 And Goal 4 is to consult -- is also mandated by the
12 grant. It's to consult with the area hospital associations
13 and primary care associations and any other key stakeholders
14 that are not affiliated with IHS or the tribal health system
15 to provide technical assistance and input in terms of how the
16 project should be implemented.

17 And then finally, Goal 4 is the execution and upgrade of
18 the equipment and to test it throughout the state.

19 Current status of the project is that we submitted the
20 revised scope of work two weeks ago, and we're waiting to hear
21 back from that. We've secured all of the necessary
22 collaborations internally as well as externally that we need
23 at this point to keep moving forward, and we have started the
24 system development for the online and in-person education for
25 health providers around the state.

1 And the final slide is the informational campaign to
2 increase VA benefits through distribution of information to
3 drinking establishments around the state, homeless shelters,
4 substance abuse clinics, and of course, grocery stores. And
5 that's all I have to say. The final slide is just thank you
6 for allowing me to present.

7 CHAIR HURLBURT: Thank you, Tracy.

8 COMMISSIONER URATA: Have you thought of going to
9 hospitals and clinics to sign people up, too?

10 MS. SPEIER: We have, and we're going to be -- in fact, I
11 just talked with Karen here. The enrollment -- the piece with
12 the enrollment is the dance between the duplication between
13 what the VA is doing. And so the next goal is to actually tie
14 in the hospitals to see what equipment they have, what
15 equipment they need, and also how to increase these
16 assessments for veterans and then doing the referrals into the
17 TVRs.

18 CHAIR HURLBURT: Larry?

19 COMMISSIONER STINSON: I hate to bring up something that
20 may sound kind of silly in a way, but I've seen it used over
21 and over again at the fair. Everybody shows up all over the
22 state at the fair, and there are, like, three entrances, and
23 if you had "are you a veteran," I.....

24 MS. SPEIER: That's a great idea.

25 COMMISSIONER STINSON: I've seen that work over and over

1 again for different constituencies.

2 COMMISSIONER BRANCO: Like Dr. Urata's point, using the
3 hospitals, our ER is the threshold where we're encountering
4 great numbers of folks, and it seems the perfect forum for
5 getting them the information for benefits they may be eligible
6 for, including the behavioral elements.

7 MS. SPEIER: And some of what has been discussed already
8 is the idea of, when a veteran is identified in the ER room,
9 identifying if they are a veteran, getting them referred and
10 who to connect them to in terms of enrollment, but also who to
11 connect them to in terms of community health services, and
12 part of what I've been working with on a continuum of care is
13 everything from API to -- and you can see that on the map that
14 I made of equipment that is there. Acute psychiatric care for
15 emergency interventions, that's going to be part of the
16 training for providers. It's going to be open to emergency
17 room providers as well. But all the way through the continuum
18 of home care whether it's primary care through monitoring
19 (indiscernible - voice lowered), or with the newer technology,
20 you can actually go in with an iPad and meet with someone
21 regarding behavioral health. And so that's part of all of
22 what's being explored through this.

23 Just yesterday through a presentation we had, one thing
24 that has not been identified as part of the continuum of care
25 and where there are risk factors for veterans is the

1 Department of Corrections, in the sense that, when there is
2 acute crisis, I've heard feedback. It hasn't been confirmed,
3 but I did try to address it in February, was how many veterans
4 are being sent to the Department of Corrections, if there is
5 no other place for them to go in terms of acute care. I tried
6 to call the Department of Corrections. They did not know how
7 many veterans they actually have housed within the Department
8 of Corrections, and they currently don't provide a lot of
9 transitional services for veterans when they're released into
10 the communities. So that's a whole piece that hasn't even
11 been part of this.

12 COMMISSIONER BRANCO: One more quick follow up on that.
13 That's one place where we've made some progress in Ketchikan.
14 We include the Department of Corrections in our Behavioral
15 Health Action Group. I don't know who said the Big Hairy
16 Audacious Goal. That was you, wasn't it? We have BHAG,
17 Behavioral Health Action Group, in Ketchikan as well. But the
18 Department of Corrections believes the.....

19 MS. SPEIER: Always be careful of your acronyms,
20 especially in public health.

21 COMMISSIONER BRANCO: It was purposeful. Anyway, that is
22 one of our areas of focus, and they're great attendees in
23 helping to identify all the populations we served, but they
24 may be a good vehicle for that.

25 MS. SPEIER: Yeah. And one of the issues is some of the

1 behavior associated with Post-Traumatic Stress can be
2 misinterpreted as -- I'm going to put this in quotations --
3 "criminal behavior" and so, is the Department screening some
4 of these folks for veteran status, and are they in
5 consultation with the VA in terms of treatment if they are
6 incarcerated? These are all issues that are unanswered at
7 this point, but I have experience with all these different
8 fields. So I have some of the answers already.

9 COMMISSIONER BRANCO: And how many are related to PTSD
10 and all the cross connections there?

11 MS. SPEIER: Correct. Well, thank you very much.

12 CHAIR HURLBURT: Tracy, thank you. Why don't we take a
13 ten-minute break? And then we'll have one again about an hour
14 after that. Ready for a quick break.

15 1:36:43

16 (Off record)

17 (On record)

18 1:50:05

19 COMMISSIONER ERICKSON: We're go ahead and get started,
20 whether folks are at the table or not. So if you're not at
21 the table and are talking, take it out to the hall, please.

22 CHAIR HURLBURT: The next hour, we want to talk about --
23 and the Commission members have all received this document.
24 This was our 2011 Findings and Recommendations that went to
25 the Governor's office and went to the Legislature, and we have

1 portions of this, at least, that we want to talk about, just
2 to kind of update the Commission on where we stand on that.
3 And then we will finish that with an update on federal health
4 care reform on where we are, just our regular update that we
5 do at each of our Commission meetings. So the first is
6 transparency and payment reform. Deb?

7 COMMISSIONER ERICKSON: So actually, this is -- Karen's
8 testimony, just now, is a good segue to this. We have just
9 some preliminary recommendations in our 2011 report related to
10 both price and quality transparency and payment reform, and
11 one of the things that the Commission learned, as we were
12 studying those two issues this past year, is the importance of
13 having a good data infrastructure in place for supporting
14 planning and decision making around payment reform as well as
15 providing the information for any sort of public reporting on
16 both price and quality transparency, and the Commission had
17 learned, just for the benefit of our new members, about All-
18 Payer Claims Databases, which are databases -- again, Karen
19 just referenced this -- of claims data compiled from multiple
20 payers, private insurance, Medicaid, Medicare into a data
21 warehouse. And we had decided that, initially, we were going
22 to recommend that the State have an All-Payer Claims Database,
23 but then decided that, first, what we really needed was to
24 make sure we could make the business use case, that we're
25 doing a feasibility study to make sure it's feasible to create

1 and actually sustain a database, an All-Payer Claims Database,
2 and also to look at other opportunities for getting at the
3 same goal, if there are other ways to go about it.

4 And so the suggestion was, and we made a recommendation
5 actually, that the Commission, in this year, conduct the
6 feasibility study. We were concerned, if we recommended that
7 some other part of state government do it, that it might not
8 ever happen.

9 So we do have an RFP out on the street right now for a
10 consultant to conduct this study for us, and there is a copy
11 of the RFP in your notebook, if you're interested, but we
12 specified in there the goals that we would look towards
13 attaining through either an All-Payer Claims Database or some
14 other data system, and we want to make sure that, when the
15 consultant comes onboard, they're not only working with
16 various stakeholders to make sure that we can make the
17 business use case, but we're also coordinating with other
18 related new developments in the Health Information Exchange,
19 as that's continuing to be developed, the health insurance,
20 the health benefits exchange, if there is some opportunity or
21 not for aligning with one, if the State of Alaska decides to
22 create one, and also with the hospital discharge database.

23 So we anticipate having the contract awarded sometime
24 later in July, and I will keep you apprised of that. Does
25 anybody have any questions before we -- about the plans for

1 the feasibility study for the All-Payer Claims Database?
2 Keith?

3 COMMISSIONER CAMPBELL: Time for completion, or did I
4 miss that, of the study?

5 COMMISSIONER ERICKSON: That will be negotiable, but I'm
6 looking at November, at the latest, and hoping to have all the
7 preliminary information from them for our October meeting.
8 Any other questions?

9 Josh Applebee is the Deputy Director for Health Policy
10 for the Department of Health and Social Services, and he's in
11 charge of a couple of major initiatives very much related to
12 the Commission's interest right now, and he's going to update
13 us on the first of those. I asked him to just kind of sit at
14 the table with us for the rest of this time block on our
15 agenda because the Affordable Care Act update is another thing
16 he'll help me out with.

17 But first of all, the Department of Health and Social
18 Services Patient-Centered Medical Home Initiative, Josh is
19 going to fill us in on where we're at with that.

20 MR. APPLEBEE: Thanks. Hello, everyone. Again, I think
21 Deb just wants to keep me here, so that she can throw things
22 my way.

23 On the patient-centered medical homes, the Department has
24 contracted with Public Consulting Group, PCG, to assist the
25 State in developing a strategy to advance patient-centered

1 medical homes and a model for that for the Medicaid program,
2 based on state needs, stakeholder input, and demonstrated best
3 practices. The project kickoff on the 26th of April at the
4 Alaska Rural Health Conference was where the numerous follow
5 up discussions with individual stakeholders were completed.
6 PCG has conducted an environmental scan to identify and
7 analyze factors likely to effect successful implementation and
8 sustainability of medical homes in Alaska. Additional
9 stakeholder meetings completed through May have focused on
10 examining other patient-centered medical home initiatives
11 through the completion of a structured provider questionnaire.

12 As you know, there are several patient-centered medical
13 home programs being developed and being implemented. We
14 wanted to make sure that the Department's pilot programs work
15 in conjunction with them, so we're not repeating or
16 reinventing the wheel, but building on previous successes, and
17 hopefully, building towards future successes.

18 Based on the environmental scan and ongoing dialogue with
19 stakeholders, our consultants will construct a broad-based
20 provider self-assessment to evaluate the readiness that
21 providers measured against standards for practice --
22 participation in a pilot project.

23 The assessment will be based on the research done by PCG
24 of the best practices from accrediting organizations and from
25 other state initiatives. The provider assessment, we expect

1 to be completed and distributed in early July, following
2 feedback from stakeholder groups. So it's currently in
3 development, and we hope to get it out before the 4th, but
4 probably just after the 4th.

5 The Resulting Gap Analysis, to be completed by the end of
6 July, on the readiness and capacity of provider organizations
7 and their ability to implement patient-centered medical homes
8 in Alaska will be used to create the final standards to be
9 incorporated into an application to solicit participating
10 pilot patient-centered medical homes. The application is
11 expected to be issued sometime in the middle of August, with
12 pilot site selection completed towards the end of August.

13 Concurrently, baseline recipient utilization and cost
14 trends to service will be developed by PCG to establish a
15 basis for evaluating the impact of the model on Medicaid
16 expenditures and the quality of care. So hopefully, we'll be
17 able to design measures that we can actually design points of
18 measure to determine whether or not we're doing what we should
19 do and getting the results that we hope to get.

20 The contract will go through 2013. So not only will they
21 be here in the development process, the selection process, but
22 also, as we get these patient-centered medical homes up and
23 running, in the evaluation process as well. So hopefully, at
24 the end of it, we will have -- we will be well on our way with
25 data coming in to know whether or not we're moving in the

1 right direction or if we need to change direction at that
2 point.

3 So it's a lot of build up, and there is a lot of work to
4 do still. July and August are going to be pretty busy, but
5 it's kind of exciting to be involved with something that's
6 actually going to get in the nitty-gritty of helping reduce
7 the increase in health care costs.

8 COMMISSIONER BRANCO: I've just been learning a bit more.
9 I've always viewed the patient-centered home model to be a
10 really valuable tool in addressing individual care and
11 reducing costs and that opportunity, but I'm learning
12 something new is I sort of accidentally got into the business
13 of employing physicians lately and primary care, in
14 particular, because reimbursement is really challenging and so
15 they've come knocking on the door saying, could we find a job
16 with you?

17 One of the things that you do first is figure out a way
18 to pay physicians for the work they do, and the traditional
19 old productivity measure is RVUs, the resource-based Relative
20 Value Units. And no physician likes to be turned into a
21 widget producer and that's the thing, but the shift has become
22 panels of patients for the physicians, and it starts to lead
23 much more into this patient-centered care, patient-centered
24 home model, and to the public health perspective, the
25 management of populations of patients and starting to derive

1 the real benefits of both cost-effectiveness, but also
2 changing the behavior and wellness of an entire population.
3 So I think this is just in time, and it really should be a
4 promising future for us and for the State.

5 MR. APPLEBEE: Certainly hope so.

6 COMMISSIONER HARRELL: So not having been here for any
7 prior discussion, I'm curious if you have made any contact
8 with the Department of Defense or the VA regarding patient-
9 centered medical home. We've rolled out patient-centered
10 medical home to 74 treatment facilities across multiple
11 markets in multiple sizes over the last two-and-a-half years.
12 So we have a decent amount of experience within the DOD
13 regarding what metrics are appropriate to follow and then the
14 VA has a very similar model with PAK teams.

15 So as you're constructing what you're doing and trying
16 not to recreate the wheel, and more importantly, trying to
17 avoid some pitfalls, it may benefit you to reach out and to
18 talk to the Air Force Medical Operations Agency in San Antonio
19 that's responsible for the rollout of the program across the
20 Air Force Medical Service and then certainly here locally at
21 JBER with Mr. Spector and myself to give you some insight and
22 give you points of contact, if you desire.

23 MR. APPLEBEE: Absolutely. And if you don't mind, I'll
24 be happy to make sure that our consultants at PCG get a chance
25 to spend some time with you on the phone and do exactly that.

1 I think that's exactly what we need to do. So if you don't
2 mind if I put them in contact with you?

3 COMMISSIONER HARRELL: Okay.

4 MR. APPLEBEE: Thank you.

5 COMMISSIONER ERICKSON: Other questions for Josh on the
6 patient-centered medical homes? Well, let's move on. Thank
7 you, Josh. If you don't mind staying here for our federal
8 reform update -- and I promise not to throw anything your way.
9 I'll end up hitting another Commissioner anyway.

10 Dr. Hurlburt is going to update us on trauma system
11 improvement and two of the three areas of prevention. We're
12 not covering everything in our 2011 report in this meeting.
13 We're breaking things up, and we'll do different points at
14 different meetings. But immunizations and obesity under
15 prevention?

16 CHAIR HURLBURT: Thank you, Deb. Trauma systems, what
17 we're talking about is mainly the hospital component of trauma
18 systems. Trauma systems are much broader. It includes the
19 prehospital component, your first responders, your EMTs,
20 ambulance services, and so on. This is what I'm talking about
21 as the hospital component.

22 In 2008, as we've heard in the past, the Department
23 hosted a consultation visit by the Committee on Trauma of the
24 American College of Surgeons in which they basically said
25 Alaska has a disaster on its hands with the lack of

1 compliance, with conformity, with the hospital trauma system
2 that the rest of the country has adopted, where hospitals are
3 designated and certified at an appropriate level for managing
4 trauma, with the findings that Alaska is the only state
5 without a Level I or Level II trauma center and Anchorage is
6 the largest city in the United States without a Level I or
7 Level II trauma center.

8 Now it's inappropriate for Anchorage or for Alaska, in my
9 bias, to have a Level I trauma center, and we really do have
10 one in Harborview, where we have limited numbers of patients
11 that go there to that facility that serves Washington, Alaska,
12 Idaho, Montana, in many ways, as a Level I center. But what
13 was true in 2008 remains true today. However, Representative
14 Coghill, now Senator Coghill, became very engaged in this
15 issue, became very knowledgeable about it, and became a real
16 champion because of a family occurrence that happened with a
17 person in his family, and championed some incentives.

18 One way some states have dealt with this issue -- by way
19 of a stick, by way of mandating it, that, if society grants
20 you a hospital, a franchise, a part of our requirement is that
21 you meet these standards. Our preference here is to try to do
22 it with a carrot. And so he championed the Trauma Bill, which
23 did pass the Legislature and was signed by the Governor, a
24 couple of years ago.

25 We had had five hospitals in the state that had been

1 designated and certified beginning about four years ago now.
2 ANMC was certified as a Level II trauma facility. The reason
3 I said what I did earlier is that ANMC does, indeed, take some
4 non-Native trauma patients, but they don't have the capacity
5 to serve the whole city or the state as a Level II trauma
6 facility. And then we had the two hospitals in Sitka, Mount
7 Edgecumbe and Sitka Community, and Bethel and Nome that were
8 certified as a Level IV.

9 With the availability of the funding through the Trauma
10 Bill -- and the Trauma Bill awards a certain amount of
11 dollars. The higher your level of certification the greater
12 amount of dollars. It awards the dollars to a hospital which
13 has become certified. So it can't be used in the process of
14 working up to that, but it awards that money for certain
15 approved functions, and it's had a dramatically positive
16 impact.

17 We now have the current designated trauma centers. Level
18 II is still ANMC. Level IV is now YKHC in Bethel, Sitka
19 Community, Mount Edgecumbe, Norton Sound, and the newly-
20 designated Kanakanak Hospital, Providence Seward, Providence
21 Valdez, and JBER Hospital, and as Colonel Harrell was saying
22 this morning, they're looking at potentially going to a Level
23 III. There are other hospitals around the state looking at
24 this, so this has been a favorable development. We still have
25 a ways to go, a year or a little more to go maybe.

1 Both Regional and Providence in Anchorage had a
2 consultation from the Committee on Trauma. The report -- they
3 had the consultation, so the report went to them. I would
4 say, just my assessment in the past, that Providence
5 Anchorage, which has the most comprehensive set of services,
6 the largest hospital in the state, in the past, the
7 Administration has not been real supportive of doing this, but
8 I feel the Administration is very much onboard now.

9 The stumbling blocks are the physicians, particularly
10 orthopedists and general surgeons, like me, that have been not
11 willing to or have not seen the rationality of meeting the
12 standards set by my union, by the American College of Surgeons
13 Committee on Trauma, as far as being available for call. So
14 that's still a work in progress, and Dr. Monsager, the CEO of
15 Providence, continues to work with the medical staff there and
16 continues to work on it. So we're seeing good progress, but
17 still a work-in-progress there. Any questions on that?

18 The next item is Immunizations. In terms of young
19 children, in terms of two-year olds -- and we measure 19 to 35
20 months on that -- Alaska had the distinction of being number
21 49 among the states in terms of our immunization rates. So
22 we've had a focus on that. We're now about number 42, not
23 very good. We had hoped, by this time, to be about midrange
24 among the states, and we've not gotten there, but we have seen
25 some improvement.

1 In recent years, meaning quite a few recent years, while
2 Senator Stevens was wielding his large club on our behalf in
3 the Senate, Alaska was funded to buy vaccines for all kids,
4 whether Premera insured them, whether they had no insurance,
5 whether they were Alaska Native, whether they were Medicaid
6 eligible or whatever, and we were uniquely blessed in that
7 regard. He was, as you know, very much interested in a number
8 of health issues. And then when he was defeated, that funding
9 began to be reduced. And so we are now funded by the Feds the
10 same way other states are funded, namely the Vaccines for
11 Children program, which provides for kids on Medicaid and all
12 Native Americans, all Alaska Native kids, which is about --
13 which comprises about half of our kids there. We figure about
14 25% of the kids in the state have good health insurance that
15 will pay for their immunizations and so that leaves about
16 another 25% that have not been insured.

17 Now one of the principles of insurance is herd immunity.
18 So it's not just if you get your measles vaccine or your
19 whooping cough vaccine that you have a good level of
20 protection. Generally, never quite 100%, but generally pretty
21 good with today's vaccines. If those in your community are
22 also protected, you have what we call herd immunity, and the
23 whole community is protected. So Jeff, for example,
24 obviously, is interested in his kids that have Premera
25 insurance being immunized because, if they get their whooping

1 cough immunization, they don't become one of the 2,000
2 Washingtonians who have whooping cough and now spreading into
3 Oregon and Idaho, which means it's going to come. It was in
4 California a couple of years ago. He's not only interested in
5 those for whom he is responsible. He's interested in the rest
6 of the kids, too, because, as the other kids get protected, it
7 protects his enrollees. So all of us involved are interested
8 in that.

9 There was also what was called 317 federal funding and
10 that, with the public health dollars in the federal budget
11 going down over the last three or four years -- fairly steep
12 downward curve in federal public health dollars and grants --
13 that money has been going away and so all states have had a
14 problem. The State of Alaska, the Territory of Alaska has
15 never put money into immunizations, but championed by Senator
16 Cathy Giessel, it picked up. Representative Keller was very
17 helpful in the House. Representative Herron was, in seeing
18 the importance of this. And the Governor's office -- the
19 Governor put in \$700,000 into his budget for immunizations for
20 the uninsured kids and the uninsured and underinsured adults
21 for things like the flu vaccine, pneumococcal vaccine, and so
22 on, and for all the kids, what's required to go to school.

23 We tried to look at it in a cost-effectiveness way. The
24 Legislature added another \$4.5 million. This was absolutely
25 unprecedented. Never happened before, but the legislators

1 really felt this was something we need to do for Alaska. So
2 there is a significant amount of money there, not enough to
3 cover everything, but almost everything, including the most
4 important ones.

5 When you look at vaccines, some of them, like the measles
6 vaccine, mumps vaccine, they have a positive return on
7 investment. In other words, you save more money than what you
8 spend to get to vaccine. Some others are looked at in terms
9 of what is your investment per quality-adjusted life year.
10 That's a concept of saving a healthy person for a year. And
11 so the priority will be for those that are the most cost-
12 effective, and the money will be used as far as we can go. We
13 want to get our immunization rates. We want to be better than
14 number 42 among the states, and we should be. We think we can
15 be, but the more vaccine we use of the cheaper vaccines, the
16 most cost-effective ones, like the measles, mumps, rubella,
17 and so on, the less there is for some of the ones that are
18 really good and that people ought to use, like the shingles
19 vaccine, the (indiscernible - voice lowered) vaccine for older
20 adults, it's something that folks ought to get, and it --
21 again, not 100%, but very significantly effective and protects
22 you from something that makes your life awful.

23 So there has been some really good news. Now the budget
24 appropriation was for three years and then with the
25 expectation that that gives the Department three years to

1 figure out how can we cover these kids in other ways. Other
2 states have been hurting more than we have. Other states have
3 been ahead of us because they didn't have the tail of the
4 declining coverage from what we used to get with Senator
5 Stevens' efforts.

6 Washington State was able to get more kids covered by
7 delegating private practices, like a qualified health center.
8 The Feds have blown the whistle on that and said hey, that's
9 not the intent. And so Washington State is going to use that.

10 We've been having a number of meetings looking at this.
11 Jeff and I are going to be meeting with Senator Giessel later
12 this month. She is very serious about the three years. She's
13 a nurse practitioner, as most everybody here knows, I'm sure,
14 and is very committed to this. We're taking it seriously.

15 My assessment, at this point, is -- and it was partly the
16 reason for my questions about the VA earlier -- I think that
17 this 25% of our population that doesn't have coverage, we're
18 probably going to need to whittle away at. We have done
19 things, like getting our public health nursing centers, and
20 this is approvable by the Feds, getting them designated as
21 delegates of an FQHC through the Anchorage Neighborhood
22 Community Health Center and that we've been able to do.

23 We will be able to do that with some private practices in
24 remote areas where there are not -- there is not other health
25 care available. Probably that won't work for places like

1 Anchorage or Juneau or some of our more urban areas. But some
2 of things that have happened related to that, we need to get
3 our immunization rates up. They are improving, not as fast as
4 we would like to see, but that's good news. Any questions
5 about that?

6 The next thing I want to talk about is obesity. And
7 there was a publication that recently came out from an
8 organization that was new, to me, called the Bipartisan Policy
9 Center. It's a fairly new entity, looking at a number of
10 things. They have four co-chairs, and they're interesting.
11 The co-chairs are two former Secretaries of Agriculture, two
12 former Secretaries of Health and Human Services, two from the
13 Clinton Administration, two from the George W. Bush
14 Administration, and interestingly, one of the ones from
15 President Bush's Administration was Mike Leavitt, former
16 Governor of Utah, former Secretary of Health and Human
17 Services, and the designated Chair for the Transition
18 Committee, should Governor Romney win the presidential
19 election, so a guy that potentially has some influence there.

20 But what I want to do -- on the slide that you see there
21 is Chair of the Health Care Commission giving a grade to the
22 State's Director of the Division of Public Health as far as
23 how successful we've been and our level of effort, being able
24 to convince folks that obesity and overweight is a public
25 health problem, and I think I have to give the Director of

1 Public Health a big fat "F" on this. My predecessors didn't
2 do any better, and Dick Monsager, Jay Butler tried. We have
3 not been able to successfully convince enough of our leaders
4 that this is a public health problem. There was a request in
5 Governor Palin's budget, but the Legislature did not support
6 that.

7 The issue that I see is that the perception is the
8 problems of overweight and obesity are the result of poor
9 individual choices, and one of the legislators whom I have
10 immense respect for, a very able person, a very able numbers
11 person said, you know, they just have to push themselves away
12 from the table and that's true. That's absolutely true
13 because they are decisions each of us make individually.

14 But when you look at what is public health, public health
15 looks at the population and what's killing us and what's
16 making us sick, what's disabling us, and when you look at
17 that, historically -- TB did that. It was a great public
18 health threat. Bad water did that. Communicable diseases did
19 that, and we don't see measles here now.

20 At the beginning of my practice here, I saw kids die
21 every time we had measles come in. In my early years in
22 practice, I saw kids on iron lungs. We don't see that now
23 because of polio vaccine. That's a basic public health
24 function.

25 Tobacco. When I was young, it was cool. Everybody

1 smoked. It was good for your T-zone, was one of the ways the
2 tobacco company advertised, and we've had a huge societal
3 change. And in Alaska, our smoking rates were like
4 Mississippi's and Kentucky's and North Carolina's, the tobacco
5 growing states. They were really high, and we still have some
6 big challenges here. Alaska Native adults still smoke.
7 They've dropped below 40%, but still really, really common.
8 So some wonderful successes.

9 When our Governor was the Chair of the Senate Finance
10 Committee, he was -- he took a leading role in locking in a
11 significant amount of the tobacco settlement money and of our
12 tobacco taxes for anti-smoking efforts, and we spent a little
13 over \$10 million a year on that now. Our adolescents, our 14
14 to 17-year olds, now smoke at less than 15%, and we're about
15 number seven among the states. That is an immense success at
16 seeing that. There's still a lot of work to do, but we
17 accepted this was a public health problem, and we have not for
18 nutrition and obesity.

19 I have two other slides that I want to do what you're not
20 supposed to do with slides; I want to read them. And as I
21 said to somebody yesterday, if -- a lot of people go to
22 churches where they use creeds, and I would almost say we
23 ought to read this like the Apostles' Creed or the Nicene
24 Creed or something, but this is from this report that I just
25 showed you that came out, bipartisan report, and these are

1 just excerpts from the first page, but the medical
2 complications of overweight and obesity cost us more than
3 tobacco does now. For Alaska, direct medical costs are over
4 half-a-billion dollars a year. Total costs for Alaska around
5 a billion dollars a year in indirect costs and killing lots of
6 people.

7 So let me just read these little four short excerpts:
8 "Our nation is in the midst of a public health crisis so
9 profound that it is undermining our national well-being, our
10 economic competitiveness and even our long-term national
11 security. Fully two-thirds of Americans are overweight and
12 obese. In short, obesity is the most urgent public health
13 problem in America today. It is a primary reason why life
14 expectancy in large parts of the United States is already
15 several years lower than in other advanced countries around
16 the world."

17 We talked about that earlier. Not only that, as was said
18 in the *White House Report*, taken from other sources, kids
19 being born now may be the first generation of Americans to not
20 live as long as their parents since we founded the country.
21 Next slide there.

22 "More broadly, the costs of obesity and chronic disease
23 have become a major drag on our economy. Escalating health
24 care costs are the main driver of our spiraling national debt,
25 and obesity-related illness comprises an increasingly large

1 share of our massive health costs. The obesity crisis is,
2 therefore, not just a health crisis, but a major contributor
3 to our fiscal crisis."

4 And finally, "but for our nation as a whole, the impacts
5 of America's obesity epidemic jeopardize our global
6 competitiveness and national security directly undermining our
7 ability to cut the federal debt, prepare and sustain a highly
8 productive workforce, maintain our military strength, and
9 compete effectively in the global economy."

10 Twenty-five percent of potential military recruits are
11 not eligible because of overweight and obesity. And so I
12 think this reflects the reality. It's starkly stated, but the
13 job of the Director of Public Health is -- that's the public
14 health person, and it's to sell the leadership in the state
15 that it is a public health problem. The Commission has been
16 very supportive in that area, but I would have to give the
17 Director of Public Health a failing grade. So that's the end
18 of my report.

19 COMMISSIONER ERICKSON: Any questions for Dr. Hurlburt?
20 Comments on whether he is being a little bit too hard on the
21 Director of Public Health?

22 CHAIR HURLBURT: I don't think so. Pat?

23 COMMISSIONER ERICKSON: He doesn't think so. Go ahead,
24 Pat.

25 COMMISSIONER BRANCO: One of the things you talked about

1 last year was the elimination of sugar drinks in, I think, the
2 Mat-Su School District. These are the pathways. The
3 individual pushing myself away from the table is key to my
4 obesity issue, but from the public health concerns, these are
5 the avenues that we need to find to help you to elevate your
6 grade to a D- or a D. We need to find these pathways that we
7 can help influence a larger population to accomplish this and
8 so let us know what we can do to help as well.

9 CHAIR HURLBURT: We have two successes, Mat-Su, which we
10 reported on last year, and Anchorage now, where their school
11 board, Carol Comeau and the others, have gotten onboard, and
12 we've actually seen a very small downward trend in average
13 BMI, not a lot, but where this ever-increasing onward/upward
14 slope of adolescents weighing about ten pounds more every
15 decade in the state. We have seen in those two school
16 districts a bending of the trend. Whether it will persist or
17 not we don't know, but the school boards have been on the
18 school superintendents, the borough assemblies, and they've
19 gotten more PE. They've gotten sugar-sweetened beverages out
20 of the schools. They've improved the school diets there. So
21 there are some small successes, but it shows that we can do
22 it. I think we do -- we need to change our culture. We need
23 to educate the public on it. Thank you.

24 COMMISSIONER BRANCO: Well, that certainly warrants a D-
25 at least.

1 COMMISSIONER HARRELL: So a question, particularly in
2 light of this book that we're going to be looking at in the
3 near future. State incentivizing the private sector and
4 business towards a healthier lifestyle for less obesity. So
5 for my job, it's easier. I don't maintain my fitness
6 standards I lose my job. So you can't do that in the private
7 sector from the state perspective, but are there are ways to
8 incentivize the private sector, the corporate world to move
9 towards that, potentially through insurance mechanisms or
10 other things that could help it begin to shift?

11 CHAIR HURLBURT: Well, I think we see some of that
12 happening. I don't think we're going to see the State -- and
13 I, frankly, wouldn't advocate for putting money into
14 incentivizing people to do that. I think the public health
15 function is to educate the public there, but in the October
16 meeting where we focus on what business is doing, we will hear
17 about things that enlightened employers, like Department of
18 Defense, have been doing because it's the right thing to do,
19 but also it's the prudent thing to do from a financial
20 standpoint. And I think that most of employers, whether small
21 business or big business, they're good people. They want to
22 do the right thing for their employees, but the way the
23 insurance premiums are going up, it becomes more and more
24 challenging for them to pay those premiums and so they're
25 looking at ways -- how can we reduce this ever-escalating

1 curve? And one of them is to prevent the disease.

2 COMMISSIONER MORGAN: I actually sat in at a conference
3 that he was at, and I read the book several months ago the
4 health insurance underwriters have utilized. In fact, they
5 gave me five of those books when we went over to their
6 conference.

7 I think what you will find is he kind of attacks it, and
8 the more successful organizations, like UPS, Safeway,
9 Southwest Airlines, Cummings Engine Company, approach it from
10 both directions. In their wellness programs, they actually
11 give incentives of more benefits or financial incentives to
12 meet certain metrics. No one is forced to do it. It's sort
13 of the carrot cake kind of thing.

14 He also looked at how he was spending his dollars, and
15 utilizing the Wisconsin systems, you could see what -- how
16 health care -- how much it costs, how much they charge you,
17 and looking at his claims data from insurance companies, he
18 started basically, for especially chronic care, making his
19 own. He didn't know what he had created because it was 15
20 years ago, but it was a medical home. He basically found
21 contractors that had high quality and worked with the patient
22 to reduce the expenditures. He was looking at readmission
23 rates and medicine that worked that had provable metrics. He
24 approached it as if he was producing widgets, as we economists
25 say.

1 So what's interesting about what he did and the
2 successful companies that are operating now is they sort of
3 didn't say hey, what it costs is not my problem, like what Pat
4 was talking about earlier, and there is really nothing I can
5 do about Dave Morgan. He's 20 pounds overweight. You know,
6 what are you going to do? They gave -- where they made
7 strides and benefits here because of better outcomes here,
8 they kind of shared the wealth. Instead of making people do
9 stuff, they -- you know, we all make -- we're all economists.
10 We just don't know it. We will, a lot of times, choose what
11 benefits me from it. There are some people that simply say,
12 hey, I want to be 25 pounds overweight; I don't care. But the
13 point is, whether it's a HEDIS standard or whatever, if you
14 hit a certain percentile of a metric, you will bring costs
15 down and you will improve health care and that's basically
16 what that book does. He just didn't know what he was -- the
17 name of what he was doing when he did it. He's a very
18 interesting guy, really. When he comes up, you should -- I
19 think I would have conversations with him, especially our
20 insurance and Chamber of Commerce friends, for sure, and Wes,
21 too.

22 COMMISSIONER HARRELL: That's actually where I was headed
23 with my commentary in terms of incentivizing, not so much the,
24 you know, cash bonus or things like that, but thinking about
25 the insurance commission, thinking about other tax-based

1 incentives for corporations that meet targets in terms of
2 reducing health care costs. That seems, to me, that's
3 something that the State could have interest in potentially
4 doing because it overall increases the health of the
5 population that way. I just don't know if that's a mechanism
6 at this Commission's disposal to recommend or not.

7 COMMISSIONER ERICKSON: Allen and then Dr. Urata?

8 COMMISSIONER HIPPLER: Thank you. There are a couple of
9 comments. I'll speak to the business factor a little bit.
10 There has been a lot of comment about, you know, business
11 needs to get involved, and from the perspective of business,
12 there is -- one problem is the dilution of benefit and
13 concentration of costs. So if I, as a business, invest money
14 into encouraging my employees to become more healthy, I don't
15 necessarily benefit from that. I get all the costs from it,
16 but I don't benefit. Rather Blue Cross Blue Shield benefits,
17 or more properly, Blue Cross' other customers benefit because
18 the whole group benefits as costs go down. I don't see the
19 direct benefit to that. So there is an issue there, and maybe
20 Jeff can help me work through that, but there is that issue
21 there.

22 The other thing I just -- I have to say this, even though
23 I know we're in a world where we all pay for each other's
24 health care problems, but it's not something I like to hear,
25 that the State government feels that it's the responsibility

1 of state government to tell me not to overeat, and I know
2 we're already there and we're already doing it, but it's still
3 something that makes me uncomfortable and that I don't
4 necessarily like. So I thought I'd make that comment. Thank
5 you.

6 COMMISSIONER ERICKSON: Dr. Urata?

7 COMMISSIONER URATA: Well, this might make you mad,
8 Allen, but you know, one of our battles with tobacco was
9 working on children in the school systems and educating them
10 at a young age, so that they would not start, so trying to
11 make it so that it was uncool to start smoking. And I think
12 that was an effort of multiple groups of people.

13 So I think, with this obesity problem, one of the things
14 that we've talked about a lot in the American Heart
15 Association is, you know, how do we educate young people not
16 to become obese, just like we try to educate young people not
17 to start smoking because, once you start smoking, you never
18 quit and that's one of the reasons why the tobacco industry
19 focused on children, teenagers, to make it look cool to smoke.

20 Now you know, I don't necessarily think that anybody is
21 advertising people that look overweight and obese as looking
22 cool, but you know, super-sizing everything is a cool thing to
23 do on advertisement.

24 The other thing that comes to mind, and I'm not
25 necessarily advocating this, but you know, when Alaska

1 increased the tobacco tax a dollar per pack, it reduced the
2 number of teenagers starting smoking something like 17%. And
3 so you know, when you hit teenagers' pocketbooks, it affects
4 their behavior sometimes, but -- so anyway, my point is, you
5 know, we've got to educate children so they don't get into
6 bad, unhealthy habits because, once they start unhealthy
7 habits, it's hard to stop.

8 COMMISSIONER ERICKSON: Jeff?

9 COMMISSIONER DAVIS: Thank you. Just a couple of things.
10 I'm not sure I would give Ward an "F" either, even if you give
11 yourself that. I think there is a different perspective,
12 which is that there are some hopeful signs out there. It may
13 not be that our leadership has, you know, wholly embraced the
14 need to attack this as a public health issue, but from my
15 perspective working with our clients, this is not a surprise
16 to a lot of them. In fact, there is a really good study,
17 which I'll share with Deb, and if she thinks appropriate, will
18 share it around, by a major international consulting firm that
19 looked at employers and those who were not engaged in trying
20 to -- well, let me back up.

21 Employers are starting to recognize that health is a
22 business strategy, pure and simple. Safeway was mentioned as
23 an example. Safeway said, well, we're in a low margin
24 business. We can't control the costs of a whole bunch of
25 things, but if we can help to influence the costs of health

1 care, then (indiscernible - voice lowered) goes right to the
2 bottom line. So it was a business strategy, and if we can do
3 it better than the next guy, now it's a competitive advantage.
4 So a lot of businesses are recognizing that. And so you kind
5 of go from this, well, it's the right thing to do, which it is
6 the right thing to do to -- it's the right thing to do for the
7 business, and the impacts are absenteeism, presenteeism,
8 health care, worker's comp, you know, you can go through, and
9 it's been studied, and you can see that.

10 So in the study of five million people, they saw
11 employers that weren't engaged, didn't view it as the business
12 strategy. There are trends. Their year-over-year increases
13 were 12% to 15%, if I'm remembering correctly. There was a
14 middle group who was moderately engaged, and their year-over-
15 year increases in health care costs were, you know, half that.
16 Then there was a group that was in this range, the 2% to 3%.
17 And so at least for those employers, they believe that there
18 was an immediate payback for their investment in their health
19 care trend, but also in those other things.

20 To your point, yes. If you were in a pooled -- in an
21 insurance pool, it doesn't directly (indiscernible - voice
22 lowered) to you, the benefit of those reduced costs, but it
23 does (indiscernible - voice lowered) to the pool. So it's
24 kind of a different strategy, and you know, it's incumbent
25 upon us to try to work the pool to get the costs down.

1 But all of that being said, where the hope is that there
2 is just so much more interest now in health as a business
3 strategy and the workplace as a place to have impact on that,
4 and it's starting to have an effect. We're seeing a lot of
5 our clients who, again, see that immediate impact.

6 And just one other thing. There are actually health --
7 or wellness actuaries in the world, and they would argue that
8 there are, you know, three things. Well, there are four
9 things: how much you eat, how much you move, how much you --
10 what you put in your mouth, and how much you sleep. Those
11 four things have a direct impact on your health care costs,
12 and it's an immediate impact. A meaningful reduction in BMI
13 through natural means has, within several months, an impact on
14 health care spending by someone who was previously overweight.

15 So it's an interesting area. I agree with Dr. Hurlburt.
16 I agree with Allen. It makes a little queasy, but if you do
17 think about things, like vaccines and water and smoking, you
18 know, we kind of are down that road of saying what we do
19 individually does impact us collectively, and this one's got
20 some really negative consequences. Thank you.

21 COMMISSIONER ERICKSON: I think it's time to move on.
22 Just to kind of wrap up that segment of the conversation
23 though, as a reminder, the Commission's 2011 recommendation
24 related to obesity and overweight was that the State invest in
25 programs that are evidence-based, and I think one of the

1 challenges, or you know, the concerns that Allen was raising
2 and the sorts of things that some other states and cities are
3 doing that feel too much like a heavy hand of the government
4 telling me how much soda pop I can drink, but then there are
5 other things in the public world where, for example, we're
6 spending public funds in schools, and can we redirect those
7 funds so that the kids are supported to be more nutritionally
8 healthy and physically active and redirect existing public
9 funds and policies to make it easier for folks.

10 So those are the sorts of programs that we discussed,
11 that we thought the State should support. We had funds from
12 the federal government, at one point, that we have no longer
13 is my understanding. We've had some support from individual
14 legislators supporting, through capital appropriations,
15 special projects, but I think, other than that, the state
16 funds are dwindling fast and that's the sense of urgency where
17 we haven't made any progress in getting more political support
18 for investment in obesity prevention and overweight. So we'll
19 continue to track that and maybe make a little more time on a
20 future agenda to see if we want to revisit that recommendation
21 again this year and see if there is something we do to
22 strengthen it a little bit.

23 Moving on quickly, we've either touched on already or are
24 going to revisit pretty soon, but I had captured for you all
25 in this slide and provided copies of the actual legislation in

1 your notebook -- it's in tab, behind tab four behind the
2 purple sheet -- copies of the legislation from this past
3 legislative session directly related to -- and this is only
4 legislation that passed. So I've left off anything that was
5 proposed that died at the end of this session, that didn't
6 pass. But just very quickly, we're going to hear from Paul
7 Cartland as the Department's Health Information Technology
8 Coordinator a little bit later this afternoon, but there were
9 a number of capital appropriations related to Health
10 Information Technology that are real significant this year.
11 Those were all listed here, and I've included a copy of SB160,
12 just the pages where these appropriations occur, in case you
13 are interested in a little more detail.

14 Also very significant related to earlier Workforce
15 Development recommendations, the Commission had made one of
16 those, that the State have a loan repayment and financial
17 incentive program for recruitment and retention of health
18 professions where there are shortages, and the Commission
19 specifically had suggested that those resources, government
20 resources should be targeted at primary care. This
21 legislation doesn't necessarily go that step further, but it
22 did pass. House Bill 78 was signed into law in May and
23 appropriated funds to the operating budget to support a state
24 loan repayment program. There is a copy of HB78 in the fiscal
25 note in your notebooks.

1 There also was a capital appropriation to continue
2 supporting patient-centered medical home implementation, and
3 the Department is going to be working on how to target those
4 funds. The capital appropriation in a prior year was
5 specified for the state Primary Care Association. This one is
6 not, but it still is for federally-funded community health
7 centers. So we'll track what's happening with that, along
8 with the pilot program that the Department is developing.

9 The Trauma Care Fund was recapitalized, \$2 million
10 appropriated to that fund. There is a copy of that bill in
11 your packet.

12 And then finally, Dr. Hurlburt's reference to House Bill
13 310, which established for the three-year program, the state
14 immunization program and the fiscal note that accompanies
15 that, and you have a copy of that. So there were a number of
16 real positive developments. We can be a little concerned
17 about or very concerned about obesity and overweight and other
18 things related to the Commission's recommendations; there have
19 been some real positive developments.

20 I had asked Jeff to -- I don't know if this -- this is
21 not directly related to any of our recommendations. Maybe
22 this is a good segue into the Affordable Care Act, and we'll
23 go through that just real quickly, but there was another bill
24 that passed House Bill 218, which addressed reinsurance for
25 the high risk pool. Jeff, could you update us a little bit or

1 brief us a little bit on what that means for the State?

2 COMMISSIONER DAVIS: Sure, Deb. I'll try not to make it
3 too complicated. It's a little esoteric, but this is a really
4 important thing. It's a little tiny statutory change that
5 changes the law under which the high risk pool, the Alaska
6 Comprehensive Health Insurance Association operates.

7 And first, I should say that this was a -- this was a
8 group effort. It took a village to make this happen.
9 Representative Keller was very important in that. Senator
10 Ellis was very important in getting that to happen. Lots of
11 other people pitched in to make this happen, particularly
12 Marilyn Kasmar, from the High Risk Pool Board, and Cecil
13 Bykerk, our Executive Director, did fantastic work.

14 So what does this all mean? The way the high risk pool
15 works today is, if you are unable to get individual insurance
16 because of a medical condition, you can go into the high risk
17 pool, or if you have a number of specified conditions, you can
18 go in the high risk pool. You pay a premium, and you receive
19 your insurance administered by the pool.

20 The pool is expected to run a deficit. To give
21 illustration to that, there are 500 people in the pool. We
22 expect the deficit in this coming year to be \$12 million for
23 those 500 people, so claims costs and administration, over and
24 above their premiums that they are paying, which are 125% of
25 market. So that's a lot of money and paying for some really

1 expensive stuff.

2 But who the high risk pool covers? And then that deficit
3 is allocated out to the insurance companies, based on their
4 market share, and basically, becomes a tax on obtaining health
5 insurance. And then beyond that, Representative Rokeburg,
6 several years ago, was able to get legislation passed that
7 provided a 50% premium tax credit. So in effect, general
8 funds paying half of that overage, and this assessment to the
9 insured population is paying the other half.

10 So we have a couple of things coming down that were
11 created by the Affordable Care Act. One was guarantee issue
12 for children under 19 and that was not specifically in the
13 Act, but it was deemed to be in there, and it was pretty much
14 direction to carriers that they had to provide guarantee issue
15 coverage to children under 19. The response by many carriers
16 was that they no longer would sell child-only policies. They
17 would only sell family policies, and what that created in
18 Alaska was that there is no availability of child-only
19 policies today. That's a problem.

20 Further, in 2014, there will be guarantee issue.
21 Assuming the Supreme Court upholds the law and it goes
22 forward, there will be guarantee issue for the entire
23 population, and there are significant concerns about how you
24 effectively spread that risk to a large enough population that
25 it doesn't -- the burden doesn't fall too heavily in one

1 place.

2 So in the early part of this year with the help of
3 Director Hall and others, we pulled together a group to look
4 at the long-term role of the high risk pool in 2014 and
5 beyond, and one of the things that was identified is that the
6 high risk pool -- this mechanism, which is, in my view,
7 effective public policy, could be extended to address both of
8 those situations, the under 19 and the financial risks from
9 guarantee issue, come 2014. But they would require a change
10 to the operating statute under which ACHIA operates. So that
11 change passed at the 11th-and-a-half hour of the legislative
12 session. Again, thanks to many, many people, including
13 Director Hall, which I should have mentioned earlier. That's
14 the problem. You start thanking by name, you're always going
15 to leave someone out. So there were lots of people who made
16 that happen.

17 And now that the Governor has passed it, the regulations
18 that are -- what the law does is it allows the Division of
19 Insurance -- and the high risk pool operates under the
20 Division of Insurance auspices -- to write regulations that
21 allow it to expand the populations that can be covered and
22 reinsured, if you will, through this pool. So the concept is
23 that ACHIA gets used as an invisible high risk pool, with the
24 first application being to children under 19. And our
25 actuaries have said, as soon as the regulations are in place,

1 we'll start selling child-only policies because the financial
2 risk has been eliminated. So it would be voluntary for other
3 carriers to do that. Hopefully, they will, but we really
4 don't care if they do or not. We'll do it and fill that need.

5 But the way the concept works is someone, let's say a
6 child under 19, comes. They have a preexisting condition. We
7 sell them a policy. They become a member, a covered insured,
8 just like anyone else. But then in the background, there is
9 an analysis of that person's health conditions and/or claims.
10 There is a specified period of time that will be specified in
11 the regulation that the carrier can make a decision to
12 invisibly cede that life to the high risk pool, say okay, high
13 risk pool, I'm giving you the life; I'm giving you the
14 premium, but I'm also giving you the claims. In other words,
15 they'll be reimbursed for their claims.

16 So for the children under 19, what that will allow
17 between now and 2014 is for that risk to be spread to the rest
18 of the insured market, like it is for the 500 that are in the
19 pool today.

20 Come 2014, again if the law stands as it is, it would
21 give the ability for that same thing to happen with other
22 guarantee issue business. Kind of the economic comparative
23 behind this is, if -- and this concept was developed by our
24 actuaries, I'll say. Give them credit for that, and they
25 presented this to the Division of Insurance in Oregon and the

1 Legislature, and it was passed in Oregon and implemented in
2 Oregon and has been working successfully down there. Not a
3 lot that we adopt from the People's Republic of Oregon, but
4 this one made sense, having been born and raised there.

5 So where was I going with that? I got lost in my own
6 narrative. Yeah, People's Republic of Oregon; there we go.

7 Anyway, so come 2014, this concept can be applied to the
8 broader market. Oh, and as our actuaries were doing the
9 analysis that they brought to this in looking at ACHIA,
10 without a mechanism like this, due to guarantee issue and
11 adverse selection, the rates for the anticipated 20,000 people
12 in the individual market in Alaska would double. Well,
13 actually, they'd only go by 98%, just based on this one
14 factor. So the market would implode, just because of the
15 expense. And so you wouldn't have access for anyone, really,
16 in a practical sense.

17 By using the invisible high risk pool and the ability to
18 see -- and oh, by the way, the Affordable Care Act gives the
19 ability to assess not just the insured populations, but self-
20 insured populations in 2014, '15, and '16, spreading the risk
21 to 50% of Alaskans rather than 15. That impact on the
22 individual market and that impact on any one group, it gets
23 minimized.

24 So the bottom line is that, with this small statutory
25 change and the regulations that have been submitted for legal

1 review, Alaska will have access for children under 19, as soon
2 as those regulations are in place, and has the mechanism in
3 place for a financially viable individual market come 2014,
4 should the law continue to be implemented.

5 So believe it or not, that was the short version. It's
6 complicated, but otherwise, it doesn't mean anything. So
7 thank you.

8 COMMISSIONER ERICKSON: Very good. Thanks. Any
9 questions for Jeff about that? Allen?

10 COMMISSIONER HIPPLER: So at some point in the future,
11 you will be able to write these high risk policies and spread
12 the costs to self-insured businesses; is that what you're
13 telling me?

14 COMMISSIONER DAVIS: Yes.

15 COMMISSIONER HIPPLER: And then we're all going to say
16 businesses should get more involved in lowering health care
17 costs?

18 COMMISSIONER DAVIS: Yes. It's one of those things that
19 you play the hand you're dealt, and this is the hand that's
20 been dealt by the Affordable Care Act, and there would not be
21 access. There would be a sustainable individual market
22 without a reinsurance mechanism. The law gives the states the
23 ability to establish a reinsurance mechanism. This is one
24 that has been shown to work and to be as fair, by any measure
25 I can come up with, as anything anyone has come up with.

1 COMMISSIONER HIPPLER: Then you're even more weakening
2 the abilities of these employers to encourage their employees
3 to be healthy and stay fit because, again, you're spreading
4 all the costs to these businesses? You.

5 COMMISSIONER DAVIS: Yeah. Right. I have very broad
6 shoulders for that. No. I don't disagree with your premise.
7 It's just how much -- you know, is it going to be 1% to 2% on
8 everybody or is it 98% on the group, the individuals who are
9 trying to buy plans? And then you have another 20,000
10 uninsured and then that burden falls on you because providers
11 have to raise their rates to cover for the uninsured. I mean,
12 somebody has got to pay for it somewhere or it just collapses,
13 but I don't disagree with your premise, Allen.

14 COMMISSIONER CAMPBELL: So with the invisible high risk
15 pool and your explanation, it seems that the State is always
16 going to be a 50% partner in this whole thing or did I hear
17 you wrong?

18 COMMISSIONER DAVIS: That's a technicality that I don't
19 know. I have not seen the draft regulations. We'll have to
20 see what came out of that, and actually, we'll have to go back
21 and look at the statute, the change that Representative
22 Rokeburg was able to effect. So I'm not sure of the answer to
23 that, Keith, but that may be correct; it may not. I don't
24 know, but it's a very good question.

25 COMMISSIONER ERICKSON: We are a little bit behind time.

1 And so instead of going through the Affordable Care Act update
2 PowerPoint presentation, I am going to refer you all to that.
3 Any of the updates made in the past three months are in green
4 font. It's available for folks in the room on the back table.
5 It's also on the Commission's website, and those of you around
6 the table, in your notebooks behind tab four behind the yellow
7 piece of paper, is a copy of this presentation. So if you see
8 anything in green font in here that you have questions about,
9 want to know more about, I'm just looking through it quickly.

10 One of the highlights is there were a number of new
11 grants awarded to community health centers around the state
12 for capital infrastructure development. One was for capacity
13 expansion in Fairbanks, and a number of other community health
14 centers received facility improvement funds. That's one
15 specific significant development in the state, just in the
16 past two or three months, related to the Affordable Care Act
17 implementation.

18 But we had invited Josh, specifically, to update us a
19 little bit on the status of the State's analysis of the
20 development of Health Insurance Exchange. So Josh, if you
21 could do that right now, and then we will take just a five-
22 minute break while we set up the PowerPoint presentation for
23 Dr. Fenaughty.

24 COMMISSIONER HIPPLER: Excuse me, Mr. Chairman? As we
25 discussed earlier, may I be excused? Thank you.

1 MR. APPLEBEE: Thanks, Deb. My presentation on the
2 Health Insurance Exchange is pretty quick. We are eagerly
3 awaiting the final report from our consultant group on the
4 roadmap of developing a state-based exchange, and like many
5 other states, we are waiting for the Supreme Court and their
6 decision on the Affordable Care Act. It's anticipated that it
7 will be delivered before the end of the month. Traditionally,
8 that's when it will be delivered.

9 So we will get our final report from our consultants by
10 the end of the month. We'll have the Supreme Court decision
11 by the end of the month, and at that point, all of that
12 information will be delivered up the chain to the
13 Commissioner, to the Governor to decide how Alaska will move
14 forward, given those two major pieces of information.

15 So Alaska, in addition to being a plaintiff in the
16 Supreme Court case, is amongst several states -- you know, 17
17 have basically documented, saying that they're not doing
18 anything but waiting for the Supreme Court, but I have a
19 sense, from all the meetings that I've gone to, is many more
20 states have throttled back their progression on exchange
21 development because we just don't know what's going to come
22 out of the Supreme Court.

23 And so certainly by the next time this Commission meets,
24 we'll have a more complete update. We'll, certainly, by that
25 point, should have a report available for everybody. And then

1 from there, we'll know what direction the State is going to
2 move forward in terms of insurance exchange.

3 COMMISSIONER ERICKSON: Any questions for Josh? Let's
4 take just a five-minute break, if you could make it very
5 quick. Please don't get sucked into any other conversations.
6 We're going to reconvene here very quickly, as soon as we can
7 get the computer set up.

8 2:58:13

9 (Off record)

10 (On record)

11 3:03:18

12 COMMISSIONER ERICKSON: I need Ward to pound his gavel.
13 There you go. Now we've got people's attention. Most of you,
14 but not all of you, have had the pleasure of having a previous
15 presentation. Dr. Fenaughty has presented to us a number of
16 times in the past, the Commission, including on obesity
17 prevention.

18 But following actually on one of our commenters during
19 the public comment period, Elizabeth Ripley thanked the
20 Commission for bringing attention to the need for more
21 publicly available and useable data on public health issues,
22 and since the Commission made that recommendation, since that
23 time, the Division of Public Health has developed now this new
24 data system that Dr. Fenaughty is going to be sharing with us
25 to update us on the status of implementation there. And I'm

1 remembering that Colonel Friedrichs and Pat Branco both were
2 the ones pounding the table particularly hard about their
3 frustration that they put lots of data into the Department and
4 never see it come back out again. So this is an effort to
5 move in that direction.

6 MS. FENAUGHTY: Well, hi, everybody. Good to see you
7 again. I feel like I come back to see friends every few
8 months, and I appreciate the opportunity to do some updating
9 here. And I think, as Deb said, this is, to me, a great
10 example of hearing a need. There was also already some work
11 in progress, but I think there is just a little bit more of a
12 catalyst to move things forward, and I really appreciate your
13 role in that.

14 So I'm going to update you on what we're calling now The
15 Informed Alaskans Initiative, and it's really made up of two
16 pieces. They're both web-based data dissemination systems, so
17 ways of getting public health data out to the public.

18 The two pieces are InstantAtlas, which I don't know that
19 I've said very much about when I've talked to you before,
20 which is a data visualization system, basically maps, like
21 maps, and this launched last week. Yay! So we're very
22 excited about that.

23 The other piece is what you have heard me talk about
24 before, which is IBIS, the Indicator-Based Information System
25 for Public Health. This is really more of a query system. So

1 on the fly, as you are looking for specific information, for
2 specific years, for specific groups, hit go, and you get the
3 result, as well as indicator profiles, which have a little bit
4 more text and narrative with them as far as interpretation.
5 And at this point, we're thinking of launching -- we're hoping
6 to launch later this summer or in the fall.

7 So really, what I'm going to spend most of my time
8 talking about is InstantAtlas, which is now out there. It is
9 an interactive web-based system. This was an application that
10 exists that we just needed, really, to tailor for Alaska, and
11 it combines statistics and map data to do these things.

12 Improve data visualization. People can look at numbers,
13 and they don't really grab you, but if you can look at a map
14 with different colors on it and you see your region and you're
15 doing worse or better, that's really powerful. Enhanced
16 communication. Use it as a tool that you can use with your
17 partners and really focus on a specific project. And engage
18 people in making more informed decisions.

19 So why we chose InstantAtlas as a software, it has that
20 map element. It's not truly a GIS, but in terms of
21 visualization, you see the map and you see it broken into
22 regions. It's interactive, and as you'll see, I'll do a demo.
23 There are a number of pieces that all interact together, and
24 it's multi-mode. So in addition to the maps -- that works for
25 some people; some people want to see a chart. Just let me see

1 the chart, and other people want to see a table. So you have
2 all those options.

3 The cons. It's not really a con, but just really to keep
4 in mind, no software is going to get over the fact that, in
5 some of our regions of Alaska, if you go down to really fine
6 granularity, you don't have enough numbers to really present.
7 So this isn't going to fix that. I don't really what could,
8 but just to keep that in mind.

9 So right now, the data that is included are the BRFSS,
10 and you may all not know what that is. It's the Behavioral
11 Risk Factor Surveillance System. It's basically our statewide
12 data self-report, phone-based on adult risk behaviors in
13 Alaska.

14 And so our plan was to show the feasibility of this with
15 the BRFSS data and then move from there. Maybe we'll see
16 vital stats on here, maybe the hospital discharge data. It
17 really can go in any number of directions.

18 So real quickly, there are four templates of displaying
19 the data. I'm going to go over each one of these in more
20 detail. One shows a single map. One shows two maps, so two
21 variables at the same time. An area profile is a way of
22 looking at a single region, but with lots of different
23 variables all at the same time. And then the HTML profiles.
24 For accessibility reasons, we needed to be able to present in
25 a tabular way for those who are visually impaired and not able

1 to read maps. So that's what that is.

2 So in a little bit more detail, the single map -- and
3 I'll go over all these pieces more in the demo, but as you'll
4 see in the right-hand corner up top, there is an actual map,
5 and there is Alaska. Below it is a bar chart, so you can see
6 how different regions compare on that particular indicator.
7 And then on the left, you're going to be able to see, over
8 time, how are we doing. So those are the main components.

9 A double map let's you look at two things at the same
10 time. So it could be two variables you think are related.
11 Maybe I want to look at obesity rates by region as well as
12 maybe heart disease rates, and you can look at those two, and
13 it would show you actually what the connection is between the
14 two.

15 This is the Area Profile. For a single region, it
16 presents any -- and this example is the Gulf Coast, but it
17 presents a whole array of indicators that you select, and it
18 displays them in what's called a spine chart. Basically, on
19 the right, it shows how different is this region on this
20 variable from the Alaska main overall. So you can see where
21 you are kind of off the main. And this is what data tables
22 look like, if you're not able to look at the maps.

23 So we have four different regional breakouts that are
24 available currently. The first is what we call the six Public
25 Health Regions. These are also labor market regions, and as

1 you can see, they are Anchorage/Mat-Su, Gulf Coast, Interior,
2 Northern, Southeast, and Southwest.

3 We can also break it into what are called Metro or
4 Micropolitan Statistical Areas. It's a little bit different.
5 We only have a couple of metropolitan statistical areas, a few
6 micro, and then everything else is rural.

7 We have the 27 borough and census areas. Now of course,
8 you are looking much more granular, so we look at multiple
9 years together to be able to look at those maps.

10 We also included, for our tribal partners, 12 Tribal
11 Health Regions, displaying Alaska Native data only. They
12 requested this. So working ANTHC epicenter, we were able to
13 add this component.

14 The basic pieces you get, you'll get one or two maps,
15 depending on which template. You get a data table for each
16 map, a bar chart. I believe pie charts are in the future.
17 The time series. A scatter plot, if you are looking at the
18 double map and that spine chart.

19 So this is currently what was launched last week. Twenty
20 years of BRFSS data we have now have. We've been collecting
21 it since 1991; 46 unique geographical units across those four
22 different kinds of regional breakouts I just talked about. We
23 have, currently, 132 health risk factors from the BRFSS, and
24 those are broken up into 29 what we're calling themes.
25 They're just buckets of risk factors. So you take all that

1 and do the math, and you basically have over 200,000 different
2 data points.

3 So now I'm going to show you a demo, and I understand
4 we've been rated "F" in obesity, so I chose that as an
5 example. I don't take it personally. It's all right.

6 So for my example -- I know I'm looking at the BRFSS.
7 Those are the data we have right now. I wanted to look at the
8 public health regions. I wanted to look at the single map,
9 and as you'll see, you can look at crude rates or age-adjusted
10 rates. I really just want to look at the crude rates.

11 So now this will work perfectly. Can you all see that
12 pretty well? I wonder if I can -- is that better?

13 COMMISSIONER ERICKSON: Yes.

14 MS. FENAUGHTY: Let me go up one more. There we go. So
15 this is Informed Alaskans. I'm very excited about the fact
16 we're getting all these out. I will make some caveats. We
17 are not web designers. You will see lots of words. We are
18 working on that. We want this to be very user-friendly, and
19 we're not quite where we want that to be, but we really wanted
20 to get it out there and have it be usable. So I appreciate
21 any feedback along those lines.

22 So the first thing that I'm going to do is scroll down.
23 We have where it kind of walks you through some steps that are
24 way too far down to get to, and the first thing that I need to
25 do is go over here on the left and pick which regions I want

1 to do, and I said I wanted to do the public health regions.
2 So on the left-hand navigation here, I pull those up. And now
3 I have a choice of the kind of template I want to look at.
4 Single map, which is what I said I wanted to do, and within
5 that, I could do crude or age-adjusted rates. I'll say I want
6 to do crude rates, and here we go.

7 Now by default, it pulls up an indicator that may be not
8 what you want. This happens to be physical limitation days,
9 but just to show you a little bit of what you're looking at
10 here. So in the right-hand top corner is the map, and we use
11 Google maps, so that's what that is. As I scroll down on the
12 left-hand, you'll see the trend. So that's the Alaska mean.
13 That's the whole state mean. And then down here at the bottom
14 are what those six regions look like on that indicator, but as
15 I said, that's not -- we want to look at obesity and so we
16 need to select that. So I'm going to scroll up here, and
17 right here, it says, select risk factor. Click that, and you
18 see this whole drop down menu organized into those themes.

19 So if you weren't very familiar with BRFSS data, you
20 might have to do a little playing around to see the variable
21 you are looking for. I happen to know we want a risk factor,
22 and it's down because I'm zoomed out here. Overweight and
23 obesity. That opens up, and I could look at neither
24 overweight nor obese. I could look at just overweight. I
25 want to look at obese, so I click on that one. And now it has

1 all the different years. I just want to look at the most
2 recent, and there it is.

3 So if you see, you're looking at a map that really looks
4 all the same color, so we can fix that. And then over here,
5 you're looking at the trend from '91 up to 2010. This one
6 happens to have, if you hover over here, the Healthy People
7 and the Healthy Alaskan 2010 indicators. And it's all
8 connected. So for example, I'm just hovering on the map, and
9 I'm highlighting the Interior region. It tells me that the
10 rate of obesity there is 27.1. At the same time, it's put
11 that line on the trend so I can compare the trend in just that
12 region versus the Alaska State trend, and at the same time,
13 it's highlighted -- you can see, this bar chart below -- which
14 of those, because they are in order of lowest to highest, that
15 particular region. So all those are connected.

16 Each of these three components can be zoomed, maximized.
17 So let's say I want to look at the map a little more closely,
18 and let me see. You have some choices. This is a hybrid map.
19 If you just wanted to look at a regular old map-map, you could
20 do that. I kind of like having the background. You could
21 look at the satellite image. There is even one that has the
22 terrain in it. So the hybrid has all those together. And of
23 course, you can zoom. So we're going to zoom this one up a
24 little bit.

25 So those are your regions. They're all one color. So

1 what that tells me, however they broke up obesity, everybody
2 is showing up in the same bucket, which is not what I want.
3 So let me -- I'm going to have to reduce this zoom a little
4 bit, so I can get to everything here. And now my map totally
5 went away. Sorry about this.

6 (Pause)

7 MS. FENAUGHTY: I'm just going to close it out and start
8 up again, which is good because I can tell you how to get
9 here. Just go to Google and type "Informed Alaskans." That's
10 what I do. That way, you don't have to remember the URL. So
11 I'm going to quickly get back to where we were. We had public
12 health regions. Here is our map. And then I pick obesity.

13 So what I wanted to show you is how you can change the
14 legend. Right now, the legend is off. If we turn the legend
15 on, you'll see what it's doing is, by default, it picked equal
16 intervals for these. If we go to settings, which is this
17 little blue pen, I don't want equal intervals. I want to do
18 broken into quantiles, and all of sudden, we have a range of
19 colors on our map. That's -- it defaults it to five. I could
20 say I want it in four categories. You can also do natural
21 breaks. There are a number of ways to break it up, and as you
22 can see, you can change the color. I can do them greens. I
23 can do them blues. Whatever makes sense and helps you make
24 you the point you want to make.

25 Over here at the bottom is a little animated time trend.

1 So what that does is shows you, over time with the map
2 changing, how the prevalence of, in this case, obesity changed
3 over time. So you can see if there were significant changes
4 in one region versus another. And at the same time, the bar
5 charts are changing.

6 You'll notice, on the bar charts, there are error bars,
7 so you can see if there is really a difference between the
8 regions or not. And if I wanted to click -- so right now, the
9 trend is showing you the Alaska mean. If I wanted to see what
10 that looked like, I hover here, and I have the Interior. And
11 if I just hold control, I can add as many trends to that as I
12 want. So it's just giving a lot of different ways to look at
13 information.

14 Now I'm going to show you another example really quickly
15 with a double map. Let's say I want to do with this census
16 area borough data. This is only age-adjusted rates because
17 you're doing a comparison, so you would want to be age-
18 adjusted. And again by default, it's going to grab two
19 variables. Let's see what it got. It is gender. That's not
20 terribly interesting. So let's pick a different variable
21 here. Let's say we want to look at cancer, and this is self-
22 reported cancer. And you'll see they are three-year averages
23 because these are smaller areas, and the other thing we want
24 to look at -- how about smoking? Current smoker.

25 So you have your maps showing those two breakouts. The

1 table at the top shows you, for your "X" variable -- in this
2 case, it's cancer -- what the rates are for all those census
3 areas, and it scrolls down. You can see you can't show it all
4 in one. And then the "Y" is the smoking rate. And then what
5 this nice little regression basically shows you -- it's an
6 ecological analysis, so it's not individuals, but for a region
7 -- for example, if we hover here, that's Northwest Arctic, and
8 they are pretty low down on cancer, but pretty high up in
9 smoking, which looks strange.

10 COMMISSIONER MORGAN: What I think you're showing is they
11 smoke, they smoke, they smoke. Then they get a cancer. Then
12 they leave.

13 MS. FENAUGHTY: And they're not in the survey.

14 COMMISSIONER MORGAN: And they go to Anchorage or Seattle
15 or the Mayo Clinic or the big dirt nap, one of those.

16 MS. FENAUGHTY: So it's -- there is a lot here to play
17 with. You can download the data. Right now, we can't
18 download the maps. You can do a screen shot of the maps
19 because they are Google maps. There is an issue with that
20 that we're working out, but we're in the process of doing
21 trainings, and as I said, refining the web presence so it's a
22 little more user-friendly.

23 So the next steps, we want to get up through 2011. The
24 2011 BRFSS data is coming out. We're moving forward with our
25 technical assistance. These are -- you know, if anyone is

1 interested, there is one next Wednesday. Charles Utermohle
2 has been doing his kind of dog-and-pony show and walking folks
3 through this. His information is here. And like I said, just
4 go out, get people you work with just to try it, just to go
5 out there and see what's useful.

6 What we hope to do -- our next big step is going to be
7 with IBIS. So as far as this fiscal year, we've been working
8 on it internally quite a bit. I demo'd it at the Health
9 Summit. Right now, we have a number of these indicator
10 profiles ready. We've not been able to launch them because of
11 security plan issues, which we're moving forward with. There
12 are no big obstacles. It's just taken longer than we thought,
13 and we've got 31 of the BRFSS indicators in there.

14 The Query System, again, it's really pretty ready, just
15 ready to move past the security issue with BRFSS variables as
16 well as the YRBS, which is the Youth Risk Behavior Survey. So
17 we'll have youth data on there for all those years.

18 Then we hope, by December, we'll actually have it tested
19 and on the Internet, internally first and then out, and we'll
20 have -- expand the Indicator Profiles up to about 75. And
21 then you can see the listing there of where we are and where
22 we hope to be, including Cancer Registry data, Trauma
23 Registry. Those are probably the next ones slated, and of
24 course, we'll be including the Healthy People, which we know,
25 and the Healthy Alaskans 2020, which will be in development.

1 So that's what I have, and I'll take any of your
2 questions.

3 COMMISSIONER MORGAN: If I brought up diabetes on here,
4 because I saw it there, you basically use the diagnostic code
5 for diabetes; is that correct?

6 MS. FENAUGHTY: Right now, it's -- because it's the
7 Behavioral Risk Factor Survey System, this self-reported. So
8 for diabetes, what it would be is an individual saying my
9 provider told me I have diabetes. We're hoping to move
10 forward with hospital discharge data, if that's possible.
11 That would be a very different way of looking at that.

12 COMMISSIONER MORGAN: But if, say down the road, we have
13 a -- under the medical home process -- I'm not saying this
14 exact data site, but if you had a medical home and you're
15 reporting -- you know, sell it, like a service, like Facebook,
16 I guess, you know, have your own encrypted as a provider, and
17 you're reporting and you based it on diagnostic codes, then
18 you would actually have, for those that want to do it,
19 providers that wanted to do it or specialty groups or even
20 hospitals or medical homes, then basically you have sort of
21 the beginnings of a possible database that they could work on
22 to start planning out action plans or metrics for different
23 diagnostic groups; is that possible, Ward?

24 CHAIR HURLBURT: I guess, why would you want to do that
25 rather than just go to an All-Payer Claims Database?

1 COMMISSIONER MORGAN: Ditto. I was just -- it's sort of
2 an evolution, kind of.

3 COMMISSIONER ERICKSON: Well, and I think what the
4 question I had for Andrea is, what's next in terms of looking
5 at additional databases? So including the BRFSS data was just
6 a first step, and there is an opportunity to include as many
7 databases as we would like in this system, if I understand
8 correctly. So if and when the State develops an All-Payer
9 Claims Database, that database -- information from that
10 database could be added to this system, but could you explain
11 that a little bit more, Andrea, and are there plans to add
12 additional databases any time soon, what the next steps
13 related to that might be?

14 MS. FENAUGHTY: Sure. Yeah. With the IBIS, in
15 particular, it's extremely flexible, and for those of you who
16 have heard me talk before, Utah has, I think, 35 different
17 data sources currently, including Medicaid claims and their
18 hospital data. So it's really robust, and those templates
19 exist for us to be able to use. It's a matter of we really
20 wanted to start with BRFSS, which we house, so we have control
21 over it, test it out, get the bugs worked out, and then, as
22 long as we have folks willing to work with us in terms of the
23 data that they have and make sure we're putting it out there
24 in the right way, yeah, there is absolutely room for that.

25 So like I said, Vital Statistics, Cancer Registry, and

1 Trauma Registry are the ones that we've got next on our
2 horizon, but that's open to change.

3 COMMISSIONER BRANCO: I was just thinking of one other
4 data source, too, or two, actually, census data to get the
5 robust demographics information that we would use, and the
6 second piece is tiger data, which is geographic data, so that
7 the natural boundaries that are built in, which we can get
8 from Google Maps, but actually on a database level rather than
9 just a mapping level. The barriers that existed may drive and
10 influence disease patterns, et cetera.

11 MS. FENAUGHTY: That's it. All right. Great. Thank
12 you.

13 COMMISSIONER ERICKSON: We had one more presentation we
14 were going to hear this afternoon and that is from Paul
15 Cartland, who is the State's Health Information Technology
16 Coordinator, and he was going to update us on the status of
17 the Health Information Exchange, not to be confused with the
18 Health Insurance Exchange, as well as the EHR Incentive
19 Program and the some other initiatives related to Health
20 Information Technology. He's in another meeting and wasn't
21 going to be able to be here until a little bit later. I'm
22 wondering if we shouldn't just adjourn. You have his
23 presentation with the updates, and we could invite him -- he's
24 going to be here tomorrow morning for our -- to help respond
25 to the presentations related to telehealth. So if we have

1 time tomorrow morning, which we probably won't, we could ask
2 him to update us, but for now, maybe what we should do, Dr.
3 Hurlburt, is -- we could just adjourn for the day and invite
4 questions later for Paul and invite him back to a future
5 meeting to update us on the status of the Health Information
6 Exchange.

7 CHAIR HURLBURT: Any objections? None. Thank you all
8 very much then, and we'll see you in the morning.

9 3:30:26

10 (Off record)

11 **SESSION RECESSED**

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