



# Alaska Health Care Commission

Meeting Discussion Guide  
October 11–12, 2012

# Employer's Role – preliminary FINDINGS

# Employer's Role – preliminary FINDINGS

# Employer's Role – preliminary FINDINGS

# Employer's Role – preliminary RECOMMENDATIONS

# Employer's Role – preliminary RECOMMENDATIONS

# Commission's Vision

By 2025 Alaskans will be the healthiest people in the nation and have access to the highest quality, most affordable health care.

We will know we have attained this vision when, compared to the other 49 states, Alaskans have:

1. The highest life expectancy
2. The highest percentage population with access to primary care
3. The lowest per capita health care spending level

# Commission Focus

## ▶ Acute Medical Sector

- Greatest component of health care spending
- No other body in place to study this sector
  - Other bodies exist for studying senior services, mental health, alcohol and substance abuse, disabled
  - New coalition addressing population health improvement and prevention
- If we try to do everything we won't accomplish anything

## ▶ Studying Costs

- Greatest barrier to access
- Threat to economy
- Threat to sustainability of health care providers

## ▶ Identifying Solutions that drive Value

- Safe, high quality (efficient and effective) care
- Affordable cost



# Health Care Transformation Strategy

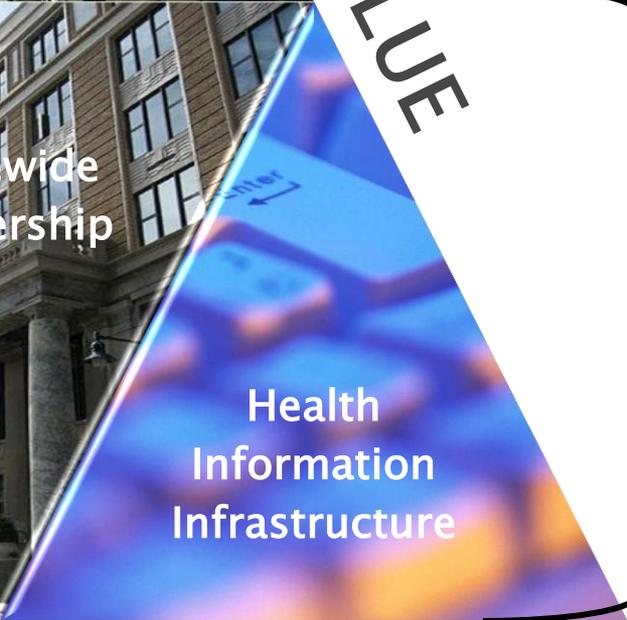
*Design Policies to Enhance the Consumer's Role in Health*

**Build the Foundation**

- Statewide Leadership
- Sustainable Workforce
- Health Info Infrastructure

*Through*

- Innovations in Patient-Centered Care
- Support for Healthy Lifestyles



ACCESS

VALUE

HEALTH

**To Achieve Goals of**

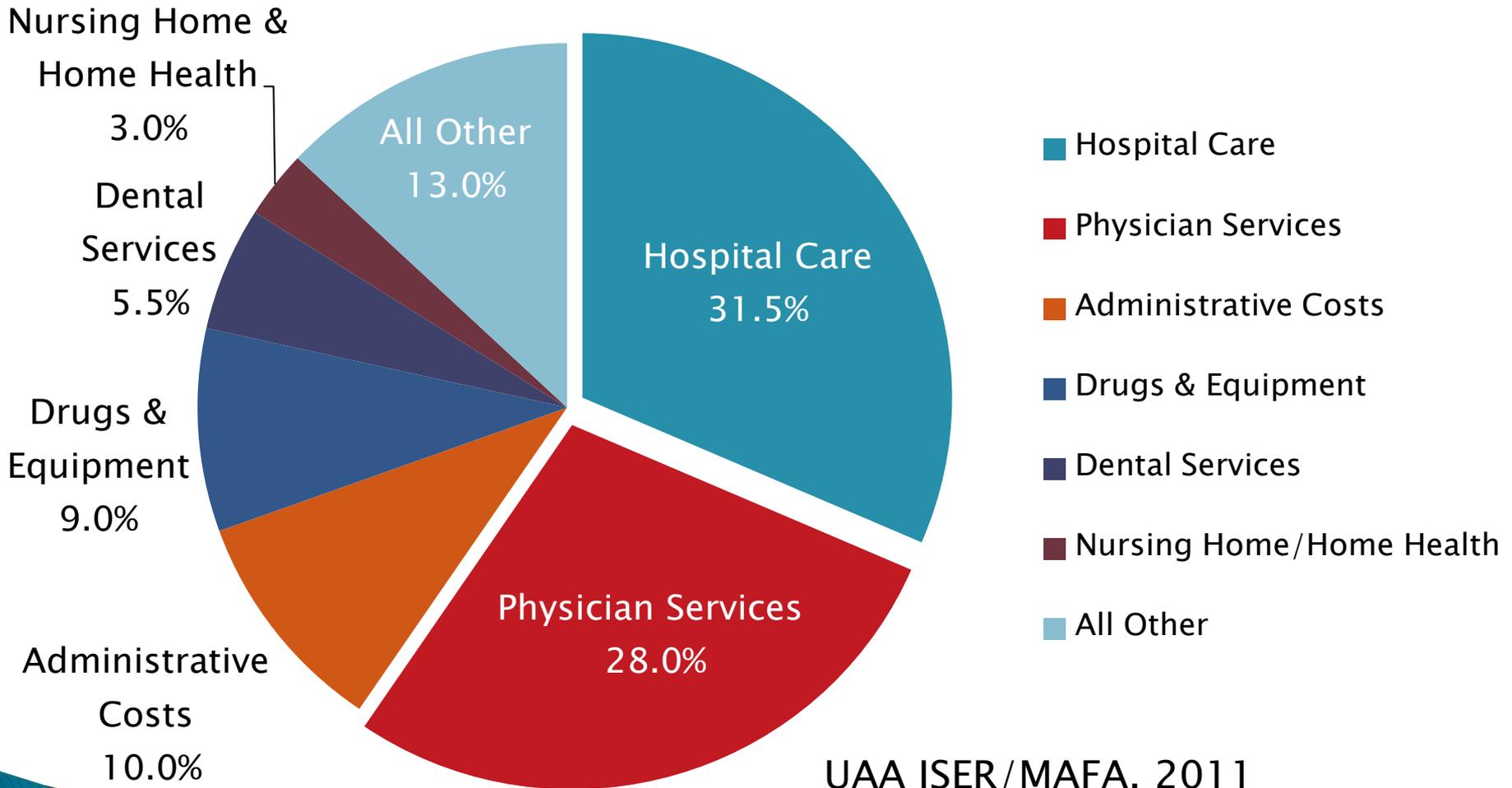
- Increased Value
  - Decreased Cost
  - Increased Quality
- Improved Access
- Healthy Alaskans

Foundation for Transformed System

# Analyses of Current System (To-Date)

- ▶ **Description of Alaska's health care system (2009)**
  - General Overview of Non-Acute Medical Sectors:
    - Long Term Care System (2011)
    - Behavioral Health System (2012)
  
- ▶ **Discussion of current health care challenges (2009)**
  - Unsustainable costs
  - Inadequate insurance coverage
  - Logistical challenges
  - Fragmentation and duplication
  - Workforce shortages and maldistribution
  - Health status, health risk behaviors and changing demographics
  - Use of health information technology
  - Urban Medicare access problem
  
- ▶ **Affordable Care Act Overview & Impact (2010)**
  
- ▶ **Impact of Alaska's Medical Malpractice Reforms (2012)**
  
- ▶ **Health Care Spending & Cost Drivers in Alaska (2011)**
  
- ▶ **Actuarial Analysis of Medical Price Differentials**
  - Physician services (2011)
  - Hospital services (2011)
  - Durable Medical Equipment (2011)
  - Pharmaceuticals (2012)

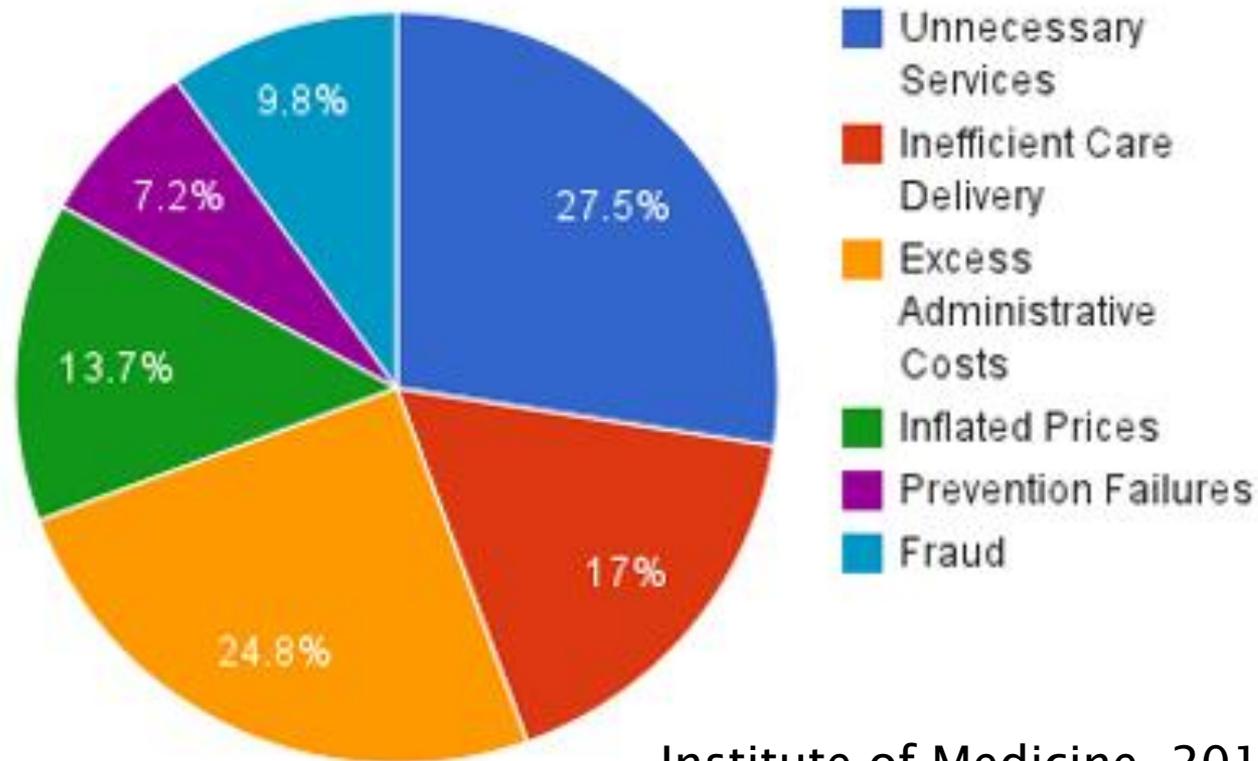
# What do Alaska's Health Care Dollars Buy?



UAA ISER/MAFA, 2011

*Alaska's Health-Care Bill: \$7.5 Billion and Climbing, August 2011*

# Sources of \$750 Billion Annual Waste in U.S. Health Care System



Institute of Medicine, 2012

*Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, September 6, 2012*

# Commission Solutions (To-Date)

- I. Ensure the best available evidence is used for making decisions *(apply Evidence-Based Medicine principles)*
- II. Enhance quality and efficiency of care on the front-end *(focus on patient-centered primary care and trauma system)*
- III. Increase price and quality transparency *(strengthen Hospital Discharge Data and consider All-Payer Claims Database)*
- IV. Pay for value *(consolidate and use state purchasing power; implement payment reform – begin with PCMH)*
- V. Build the foundation of a sustainable health care system *(strengthen health info infrastructure; sustainable workforce)*
- VI. Focus on prevention *(foster healthy lifestyles, address obesity and immunization rates, implement behavioral health screening and service integration)*

# Additional Solutions Studied this Year

- vii. Enhance the employer's role in health and health care
- viii. Improve patient choice and clinical quality in end-of-life care
- ix. Use technology to facilitate access to appropriate evidence-based care
- x. Reduce government regulation that hampers innovation and increases cost

# Malpractice Reform – Highlights

- ▶ Costs associated with medical liability are generally considered to be one driver of health care costs
- ▶ Alaska’s malpractice environment is relatively stable, supported by:
  - 1997 Alaska Tort Reform Act
  - 2005 Alaska Medical Injury Compensation Reform Act
  - Alaska Civil Rule 82
- ▶ Clinicians in two of Alaska’s three delivery systems – DoD/VA and Tribal Health System – are covered under the Federal Tort Claims Act
- ▶ Alaska’s malpractice reforms to-date appear to have made an impact on the cost of medical liability coverage.
  - In 1996 medical professional liability rates for physicians in Alaska were approximately two times those in northern California (considered the “gold standard” in liability reform)
  - Today, in 2012, Alaska’s medical liability costs are in line with those in northern California.
- ▶ Cost savings associated with defensive medicine practices are more difficult to identify, as there are other contributors to these practices beyond the threat of litigation, e.g., physician training and culture, fee-for-service reimbursement structures, and financing mechanisms that insulate patients from the cost of health care services.

# Health Insurance Regulation – Highlights

- ▶ Regulation of the private insurance market is a state government function
- ▶ State of Alaska insurance laws and regulations apply only to the private insurance market. Excluded are:
  - Public insurance programs (Medicare and Medicaid)
  - Federal and tribal health care delivery systems (DOD, VA, Indian Health Service, Tribal Health System)
  - Self-insured employer plans protected under ERISA
- ▶ Only 15% of Alaskans are members of private insurance market health plans regulated by the State of Alaska.

# Behavioral Health System – Highlights

## Challenges:

- Population health concerns
  - Suicide
  - Alcohol & Substance Abuse
  - Depression
- Systems serving different populations (mental health, substance abuse, developmental disabilities, seniors) are not integrated.
- Community/social supports (e.g., housing and employment) are not integrated with service delivery system
- Service gaps, e.g.,
  - Alcohol & substance abuse treatment
  - Short-term crisis care
  - Long-term care for patients with behavioral disorders
  - Early intervention for children
- Workforce shortages
- Anticipated increased demand for services due to the Affordable Care Act
- Data sharing barriers

# Behavioral Health System – Highlights

## Opportunities:

- State integration of mental health and substance abuse programs and regulations
- Integration of behavioral health and primary care; Patient-Centered Medical Homes
- Move towards acuity-based rate setting
- Analysis of delivery system structure and organization
- Telebehavioral health system development
- Health Information Exchange

# End-of-Life Care: FINDINGS concepts

## ▶ Note that

- Discussion starts with ethical and spiritual dimension of the issue – conversations and decisions regarding this topic must focus on our common humanity and shared respect.
- Alaskan patients who are seriously or terminally ill sometimes feel that they are treated more like a battlefield than person.
- Palliative care starting earlier in the disease process, ideally at diagnosis, could increase the value equation in health care – increasing patient satisfaction, quality of care, outcomes; and decreasing costs.
- Cost savings within the health care system do not always accrue to the investing/subsidizing organizations, e.g., hospitals providing and subsidizing home health.

# End-of-Life Care: FINDINGS concepts

- ▶ Define Palliative Care and Hospice, and include
  - distinction between the two;
  - a note that hospice is not about slowing or hastening death, but providing compassionate care to ease death;
  - a note that if palliative care starts at the time of diagnosis it doesn't matter that the timing of death is unknown;
  - distinction between the hospice Medicare plan benefit, and hospice as a concept.
  
- ▶ Describe how reimbursement for hospice services works. Also explain that palliative care as a service is not reimbursed (physician services are reimbursable but other team members' services are not (e.g., social workers, pharmacists, chaplains, etc.)).

# End-of-Life Care: FINDINGS concepts

- ▶ Emphasize the four areas of care that palliative care and hospice address:
  - Spiritual health
  - Social health
  - Psychological health
  - Physical health
- ▶ Note that pain control with the other supports at end of life is essential
- ▶ Describe MOST/POLST
- ▶ Describe Alaska's existing Comfort One Program

# End-of-Life Care: RECOMMENDATIONS

## I. Education

- Public Education Campaign regarding the importance of (and including tools for) end-of-life planning. Include education regarding what palliative care and hospice are.
- Provider Education
  - Include CME in end-of-life care, palliative care and pain management in state Medical Board requirements for physician license renewal, and also in all other professional licensed provider license renewal requirements.
  - Include community-based service providers and care in training and education efforts
- End-of-Life Resources for Alaskans (general public and providers) on common website

# End-of-Life Care: RECOMMENDATIONS

## II. Standardization

### o Protocols & Systems

- POLST/MOST – Should there be new legislation? Consider Montana state law as an example. Alaska Comfort One program legislation was modeled on Montana’s Comfort One. Montana has since replaced Comfort One with POLST.
- Secure electronic registry (*Need to specify for what – DNR? Comfort One? MOST?*)
  - Align with the new Health Information Exchange
  - Include mechanism for patients to keep copies of the form with them

### o Palliative Care Formulary.....

- *Are we suggesting a state government mandated or even suggested formulary?*
- *Or are we suggesting that practice guidelines and best practices could be shared on-line (on the End-of-Life Resources site)?*

# End-of-Life Care: RECOMMENDATIONS

## III. Incentives

- Can/should palliative care and hospice be better reimbursed by State of Alaska health insurance plans (Medicaid and state employee and retiree health plans)? In what ways?
  - Include/address in patient-centered medical home pilot projects, and in other care coordination/care management initiatives.
  - Are ACOs/ HMO models the only way to address the hospital hospice subsidization issue?

## IV. Infrastructure

- Use telemedicine as a tool for delivering palliative care to rural and underserved populations, and to create a “virtual hospice” for underserved communities.

# Telehealth – Preliminary Findings

- ▶ Telemedicine is an important mechanism for improving access to and quality of care.
- ▶ Alaskan health care providers have been pioneers and global leaders in developing telemedicine solutions to geographical barriers. For example
  - 1925 – The original Iditarod – transport of diphtheria anti-toxin from Anchorage to Nome by dog-sled facilitated by Morse code messages relayed via telegraph lines
  - 1960s – Radio communication between village CHAs and regional clinicians
  - 1970s – White Mountain satellite station
  - 1990s – telemedicine carts, teleradiology
  - 2012 – eICU, telestroke, home monitoring, tele-behavioral health

# Telehealth – Preliminary Findings

- ▶ **Barriers** exist to expanded development and use of telemedicine technologies
  - Silos exist between health care sectors and between payers – there is not a collaborative approach to identifying barriers and designing solutions.
  - Savings achieved through the use of telemedicine do not always accrue to the providers who must invest in the technological infrastructure.
  - Reimbursement has been restructured somewhat to support funding of “presenting” site providers, but there is evidence these reimbursement opportunities are not fully utilized by providers. Questions remain:
    - Are existing reimbursement mechanisms fully utilized, and if not, why? (e.g., Clinician documentation? Coder training? Other billing issues?)
    - Can new reimbursement mechanisms be justified? Are costs and savings clearly identified and documented?
  - Information technology and telecommunication systems continue to develop rapidly. Are there technological barriers today? Is bandwidth a problem in some rural communities still? Or are there network access problems? Or both?
  - Clinician licensure requirements for out-of-state providers to serve Alaskan patients via telehealth --- is this a barrier? If so, does the patient-protection function outweigh the telehealth needs?

# Telehealth – Preliminary Findings

- ▶ **Opportunities** exist and new developments are underway to expand development and use of telehealth. For example,
  - Health Information Exchange
    - Direct Secure Messaging
    - Provider Directory under development
  - ConnectAK Program
    - On-going effort to map broadband access and expand high-speed internet capacity statewide

# Telehealth – Preliminary Recommendations

*Consider in context of current  
Commission recommendations  
regarding telehealth/telemedicine  
(from 2009)*

# Telehealth – Preliminary Recommendations

1. The State of Alaska should study the costs and benefits of a common centralized network service for facilitating communication, video-consultation, scheduling, etc. between providers
  - *Stewart Ferguson and Paul Cartland have developed a slightly more specific recommendation for the Commission to consider*

# Telehealth – Preliminary Recommendations

2. The AHCC recommends the SOA develop pilot telehealth projects to foster collaborative relationships between delivery systems and sectors, and between payers and providers, and to facilitate solutions to current access barriers.
  - Focus on behavioral health and primary care
  - Focus on specific diagnoses and conditions for which clinical improvement, costs and cost savings can be documented
  - Require an evaluation plan and baseline measurements before starting a pilot study
    - Evaluation plan must have measurable objectives and outcomes
    - All pilot study partners must agree on the metrics

# Planning 2013 Agenda

# Commission's Future

- ▶ Sunsets June 30, 2014 (subject to extension)
  - Treating 06/30/14 as a transition point
  - CY 2013 Annual Report (due 01/15/14) = “final” product
    - Consolidated findings, recommendations, implementation status from 2009 – 2013
    - Suggested Action Plan & Next Steps
    - Align with and provide framework for other health plans
      - Public Health Improvement Plan – Healthy Alaskans 2020
      - State Health Information Technology Plan
      - Etc.

# Analyses of Current System (To-Date)

- ▶ **Description of Alaska's health care system (2009)**
  - General Overview of Non-Acute Medical Sectors:
    - Long Term Care System (2011)
    - Behavioral Health System (2012)
  
- ▶ **Discussion of current health care challenges (2009)**
  - Unsustainable costs
  - Inadequate insurance coverage
  - Logistical challenges
  - Fragmentation and duplication
  - Workforce shortages and maldistribution
  - Health status, health risk behaviors and changing demographics
  - Use of health information technology
  - Urban Medicare access problem
  
- ▶ **Affordable Care Act Overview & Impact (2010)**
  
- ▶ **Impact of Alaska's Medical Malpractice Reforms (2012)**
  
- ▶ **Health Care Spending & Cost Drivers in Alaska (2011)**
  
- ▶ **Actuarial Analysis of Medical Price Differentials**
  - Physician services (2011)
  - Hospital services (2011)
  - Durable Medical Equipment (2011)
  - Pharmaceuticals (2012)

# Commission Solutions (To-Date)

- I. Ensure the best available evidence is used for making decisions *(apply Evidence-Based Medicine principles)*
- II. Enhance quality and efficiency of care on the front-end *(focus on patient-centered primary care and trauma system)*
- III. Increase price and quality transparency *(strengthen Hospital Discharge Data and consider All-Payer Claims Database)*
- IV. Pay for value *(consolidate and use state purchasing power; implement payment reform – begin with PCMH)*
- V. Build the foundation of a sustainable health care system *(strengthen health info infrastructure; sustainable workforce)*
- VI. Focus on prevention *(foster healthy lifestyles, address obesity and immunization rates, implement behavioral health screening and service integration)*

# Additional Solutions Studied this Year

- vii. Enhance the employer's role in health and health care
- viii. Improve patient choice and clinical quality in end-of-life care
- ix. Use technology to facilitate access to appropriate evidence-based care
- x. Reduce government regulation that hampers innovation and increases cost

# Commission's 2012 Agenda

- ▶ Track Prior-Year Recommendations
  - Apply evidence-based medicine
  - Strengthen primary care
  - Improve trauma system
  - Increase price and quality transparency
  - Pay for value
  - Develop sustainable workforce
  - Develop health information infrastructure
  - Support prevention (obesity, immunizations, and behavioral health)
  
- ▶ Continue study of current system
  - Pharmaceutical costs
  - Behavioral health care
  - Malpractice environment
  - Federal health care reform (track implementation)
  
- ▶ Develop new recommendations
  - Use technology to facilitate access
  - Enhance the employer's role in health and health care
  - Improve quality and choice in end-of-life care
  - Reduce government regulation

# Proposed Commission Plans for 2013

## **I. Continue Analysis of Strategies to Improve Value:**

- Employer's Role
- Evidence-Based Medicine
- Transparency
- End-of-Life Care

## **II. Continue Study of Current Conditions:**

- Complete acute medical care actuarial analysis with final component – SNF care.
- Continue tracking implementation of 2009–2012 recommendations
- Continue tracking implementation of PPACA
- Track development of Healthy Alaskans 2020

## **III. Prepare Consolidated “Final” Plan:**

- Update and refine findings and recommendations made 2009–2012
- Incorporate 2013 recommendations
- Consolidate into a “final” plan for attaining 2025 vision.

# Proposed Commission Agenda for 2013

- ▶ **Employers' Role:** Continue engagement with the business community and employers regarding evolving business models that are addressing employee wellness and health care as a business strategy.
  - Answer the question – “What can and should state government do to support new business strategies?” (e.g., additional education; transparency initiatives; consumer protection legislation; State government leadership; etc.)
- ▶ **Transparency:** Refine and finalize a complete set of recommendations for legislation to support increased transparency, including but not limited to APCD and hospital discharge data.

# Proposed Commission Agenda for 2013

- ▶ **Evidence-Based Medicine:** Deeper dive into how the application of high grade evidence can be better utilized by patients, clinicians, and payers to improve value.
- ▶ **End-of-Life Care:** Continue exploration of improving patient/family choice and clinical quality through evolution of Alaska's Comfort One law to POLST.
- ▶ **Continued Study of Current Conditions:**
  - Complete acute medical care actuarial analysis with final component: SNF care
  - Continue tracking implementation of 2009-2012 Commission recommendations
  - Continue tracking implementation of PPACA
  - Track development of Healthy Alaskans 2020

# Next Steps

- ▶ **October 26:** Teleconference to finalize draft for public comment
- ▶ **November:**
  - Public comment period
  - Set 2013 Meeting Schedule
- ▶ **December 10:** Meeting to consider public comments and finalize 2012 recommendations and 2013 agenda.