

Erickson, Deborah L (HSS)

From: Pamela [p1111@mtaonline.net]
Sent: Thursday, November 08, 2012 6:19 PM
To: Erickson, Deborah L (HSS)
Subject: 8 nov 12

I read your report and am excited that the State of Alaska is working toward a healthier future.

I couldn't see anything in the report about Alaska's plans for insurance exchanges to decrease the increasing costs of monthly premiums.

My husband and I are now paying \$3200.00 EACH MONTH for coverage with a high deductible and 15-20 % increases projected for 2013. I no longer have full-time employees because I can't afford their premiums. I have 5 part-time staffers now.

Pamela S Hill MD

Erickson, Deborah L (HSS)

From: Sewell, Robert G (HSS)
Sent: Wednesday, November 14, 2012 1:07 PM
To: Erickson, Deborah L (HSS)
Cc: Craft, Kathryn L (HSS); Carr, Patricia A (HSS); Millard, Mark A (HSS)
Subject: P-0030 - AHCC - AK Health Care Commission draft 2012 recommendations Look fine - RGS

Hello Deborah,

The AHCC doc/recs for 2012 looks fine.
Thanks for sharing, I have nothing to add.

The Report covers the broad sweep of HC issues in Alaska.
I'm heartened to see that "support-for-service" remains a key aspect.

With my regard,
Robert

Robert Sewell, MA, Ph.D., Health Program Manager
Health Planning and Systems Development, Alaska DHSS
(907) 465-4065 phone
E-mail: robert.sewell@alaska.gov



Supporting Health-care Access through Loan Repayment
<http://www.hss.state.ak.us/dph/healthplanning/sharp/>

From: Craft, Kathryn L (HSS)
Sent: Wednesday, November 14, 2012 12:48 PM
To: Craft, Kathryn L (HSS)
Subject: Alaska Health Care Commission draft 2012 recommendations

Hello. The Health Care Commission has released its draft 2012 recommendations for public comment. See the link below if you are interested. Kathy

<http://hss.state.ak.us/healthcommission/2012commissionreport.htm>

The Alaska Health Care Commission last week released its draft 2012 recommendations report for public comment. The commission, established in December 2008 by then-Gov. Sarah Palin, is tasked with "fostering the development of a

Erickson, Deborah L (HSS)

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From: Williard, Mary E [mewilliard@anthc.org]
Sent: Wednesday, November 14, 2012 4:01 PM
To: Erickson, Deborah L (HSS)
Subject: Comment on: Alaska Health Care Commission 2012 Draft

1. I have looked through the Alaska Health Care Commission 2012 Draft for Public Comment. There is only one mention of "dental" in the entire document which is on page nine, second paragraph, in which it is mentioned that 5.5% of the money spent in the state for healthcare is going to dental services. If I search for the word "oral," the only findings that will come up are "Behavioral." It is concerning to me that a document that is looking at the state of health and health care delivery in the State of Alaska, that oral health has been completely ignored. Dental caries (cavities) are the number one disease of childhood, more common than asthma.
- 2.
3. On the CDC's website (See link below) you can quickly pull up a document which states:
4. "Although dental caries are largely preventable, they remain the most common chronic disease of children aged 6 to 11 years and adolescents aged 12 to 19 years. Tooth decay is four times more common than asthma among adolescents aged 14 to 17 years (1). Dental caries also affects adults, with 9 out of 10 over the age of 20 having some degree of tooth-root decay (2). 1. Centers for Disease Control and Prevention and the American Dental Association. Fluoridation: nature's way to prevent tooth decay. Available at http://www.cdc.gov/Fluoridation/pdf/natures_way.pdf [PDF - 117 kb]
5. 2. Dye BA, Tan S, Smith V, Lewis BG, Barker LK, Thornton-Evans G, et al. (2007), Trends in oral health status, United States, 1988-1994 and 1999-2004. National Center for Health Statistics. Vital Health Stat 11(248). "

http://www.cdc.gov/healthywater/hygiene/disease/dental_caries.html

In Alaska we have documented some of the highest rates of decay anywhere in the US. To ignore dental health care in this document is irresponsible. It is clearly the trend in medical and dental fields to increase collaboration and increase our focus on oral health as a basic component of overall health. Access to oral health care in Alaska is good if you are insured, have additional expendable income and live in a larger urban hub. However, a substantial portion of our population lacks access to even basic dental care on a consistent basis. The Alaska Native Tribal Health Consortium has recognized the importance of oral health and the difficulties Alaska Native people have in accessing dental services by committing to an innovative dental health aide initiative which is leading the entire country in the use of dental mid-level providers known as dental therapists. I respectfully and strongly urge the commission to consider adding information about oral health care to this document.

Mary E. Williard, DDS
Director, Department of Oral Health Promotion
Director, DHAT Educational Program
Alaska Native Tribal Health Consortium
Division of Community Health Services
University of Washington DENTEX Training Center
4200 Lake Otis Parkway, Suite 204
Anchorage, AK 99508
Desk: 907-729-5602
Cell: 907-382-2188
Fax: 907-729-5610
email: mewilliard@anthc.org
website: <http://anthc.org/chs/chap/dhs/>
UW website: <http://depts.washington.edu/dentexak/>
DHAT training is ANTHCsmile on facebook and twitter

Erickson, Deborah L (HSS)

From: HealthCare Considerations [hcc@gci.net]
Sent: Thursday, November 15, 2012 4:06 PM
To: Erickson, Deborah L (HSS)
Cc: Parnell, Sean R (GOV); Puckett, Jim P (DOA); linda.hall@alaska.gov; Hultberg, Becky (DOA); Barnhill, Michael A (DOA)
Subject: Written comment on 2012 Draft Findings and Recommendations
Categories: Red Category

Dear Ms. Erickson and members of the Alaska Health Care Commission,

Thank you for your dedication and efforts to reduce costs and improve efficiency in the Alaska health care system. You are to be commended and as a 40 year resident, I am encouraged that this work will be fruitful.

My comment is regarding the effect of costs of procedures in Alaska on the health care purchaser (medical consumer). As previous Benefits Manager for the State of Alaska, Division of Retirement and Benefits, as well as Manager of the Aetna customer service office in Juneau for the AlaskaCare Health Plans, and a Certified Medical Assistant working in various practice settings, I have intimate knowledge of the challenges we face in educating the Alaskan consumer of their role in the process of health care purchasing and delivery. One way cost reduction and efficiency can be achieved is to educate the Alaskan consumer about how the current health care delivery system works, the price mechanisms that go along with a medical purchase, and getting over the unrealistic expectation that most costs will be absorbed by their health plan(s), creating insurmountable challenges to employers who provide health plans to their workers.

I do not intend this to be a commercial, but I just can't remain silent when the answer is so obvious. I developed a product to address just this issue. It is an educational program called "Manage Your Health Care Dollars – with the HEAL System". Taking all the things throughout my career that were resounding questions from medical consumers this education was developed to teach them to effectively maneuver the health care delivery system and give them many tools to make informed decisions about purchasing health care realistically, so they can "fish" for themselves rather than be hand fed a fish whenever they need one, so to speak.

The HEAL System was piloted over a period of 10 years and is now available in the marketplace. Commissioner Hultberg and Deputy Commissioner Barnhill were approached in July of this year and given a HEAL System to review. It is my express belief that if people knew what questions to ask, knew the basics of health care economics, and knew who to contact for what type of situation, as well as how to understand the charge and reimbursement differences of health care encounters, we could begin to see a paradigm shift by our purchasers of health care without intense individual involvement. The financial remedy for the people and families would drive their shift in thinking about health care purchases. I am happy to discuss this product with you and provide one to you if you would like (free of charge, of course).

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My entire career (please see my [Linkedin account](#) or visit my [Web site](#) for my full biography) I have answered the same questions from purchasers throughout the nation time and time again. Now we have a product to address these questions on a large scale. It would be a waste not to use it to advance the Commission's goals of reduced costs and improved quality of care for Alaskans in every corner of our great state.

I can be contacted via any of the methods below and I would be pleased to share any information with you that you desire in regards to this product and how it can transform "patients" and their families into "informed medical consumers". Thanks for your time and I appreciate the Commission's work very much.

My kindest regards also to the others addressed in this email.
Be well,
Freda

HEALTHCARE CONSIDERATIONS



Freda Miller, CMA (AAMA), CPC, PCS
www.healthcareconsiderations.com
907-209-5715

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From: Alaska Department of Health and Social Services [mailto:AlaskaDHSS@public.govdelivery.com]
Sent: Sunday, November 11, 2012 6:24 PM
To: hcc@gcl.net
Subject: Alaska DHSS Weekly Digest Bulletin

Message 1

From: Alaska Health Care Commission <AlaskaDHSS@public.govdelivery.com>
Date: 11/06/2012
Subject: 2012 Draft Available for Public Comment

Dear Alaska Health Care System Stakeholder:

The Alaska Health Care Commission's 2012 draft findings and recommendations are now available for public comment. Written comments will be accepted through **Friday, November 30**. You may access the draft on the Commission's web site at:

Xxxxx

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Erickson, Deborah L (HSS)

From: Jennifer Meyer [jameyer2@alaska.edu]
Sent: Thursday, November 15, 2012 4:31 PM
To: Erickson, Deborah L (HSS)
Subject: public comment on commission report and white paper on CNA training
Attachments: UA CNA barriers to training white paper April 2012.pdf

Hi Deb,
Just a few thoughts about the 2012 commission report.

1. I was glad to see the emphasis on broadband needs in rural areas. In terms of being able to communicate or learn online high speed is vital...We are desperate for high speed in rural areas for UAF students. GCI has high costs but the university is looking into this since we can't grow elearning without it.

2. About telehealth. I am concerned that this is viewed as the 'solution' for medicine and psychiatric patients in rural or AN populations etc. These machines are already in most clinics and sit in the closets for a variety of reasons, they are cumbersome, intimidating, don't work etc. I worked for years in the public health center in Bethel and we had one that sat in a closet as well.

Something like skype (which is free) and could be on a laptop or iphone (mobile) would be great (if we had high speed), say positioned in a room where the team and patient could be observed, the person or persons on the device could offer suggestions or ask questions of a patient in real time etc. It seems like mobility would be key.

I would kindly suggest wording along the lines of how telehealth could 'compliment' the current health care delivery system, (not replace or duplicate it). What I am getting at here is the awareness that we don't further disenfranchise the tribal system by creating more dependencies on 'non-local experts'. I realize this is a fine line to walk, but it seems important.

3. I appreciated the emphasis on career pathways/tracks and growing health care professionals in AK. I also wanted to share with you the UA Health Programs White Paper on barriers to delivery of CNA training programs. This is a good example of how antiquated federal requirements and their interpretation by the Alaska board of nursing have made it near impossible to offer CNA training in rural areas - which tends to effect Alaska Native students that might be interested in a career in nursing. Bethel is opening a 16-32 bed long term care facility next year so the pressure to prepare the workforce to care for these elders is at a critical point. I'll attach white paper for your review. ASHNHA and the Alaska Health Workforce Coalition have taken this issue on, and there has small forward progress since April. Please let Sheila or I know if you have any questions.

Thanks again and have a great week,
Jennifer

--
Jennifer Meyer RN, MPH, CPH

Assistant Professor of Allied Health
University of Alaska Fairbanks
CRCD Kuskokwim Campus
iameyer2@alaska.edu

For more information about e-learning and community-based Allied Health Programs, please contact me directly or visit: www.uaf.edu/crcdhealth, the Center for Distance Education at www.distance.uaf.edu, the Kuskokwim campus at www.bethel.uaf.edu, or other local campuses via this link: <http://www.uaf.edu/rural/campuses/>.

The Alaska Health Summit is one of many efforts of the Alaska Public Health Association to promote the advancement of public health and improve the quality of life for all Alaskans. Please visit <http://www.alaskapublichealth.org/> for more information.





Erickson, Deborah L (HSS)

From: Gordon Wrobel [gordonwrobel@mac.com]
Sent: Friday, November 16, 2012 8:03 PM
To: Erickson, Deborah L (HSS)
Subject: Health Care Recommendations

Below please find my comments on the 2012 Health Care Commission recommendations report.

I found the report to be overly truncated. This left me wondering what data were used to support which recommendations. This is an important social issue that deserve in-depth consideration. Despite this shortcoming the report elevates one of my primary concerns. There is a significant lack of infrastructure to support the development of modern efficient and effective services. Without access to state-of-the-art technology any system that is built will be antiquated before it is implemented. I find it amazing that within 100 miles of the capitol of this state that it took 20 minutes to download this report. Telemedicine has transformative potential if the infrastructure is available to support such a system of service delivery. I live in a rural (aka, frontier) community that relies on remote services for all but basic health intervention services. Emergency services are often used when an effective triage would have prevented expensive emergency transportation.

I also found the report to be particularly lacking in emphasis on behavioral health. Perhaps this area of need was considered in the discussion but behavioral health in the finale report was particularly absent. Again, developing service centered in the major population centers will do little to impact the significant needs that exist in the rural/remote settings. The needs are significant and the services inadequate.

Regards,
Gordon Wrobel, Ph.D.

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Erickson, Deborah L (HSS)

From: Michael Humphrey [Michaelh@thewilsonagency.com]
Sent: Monday, November 19, 2012 11:31 AM
To: Erickson, Deborah L (HSS)
Subject: 2012 report

Deb

I read the draft 2012 report and it captures the committee discussions.

You sure put together a great report.

Mike

Michael Humphrey | Senior Benefit Advisor | The Wilson Agency, LLC
3000 A Street #400 | Anchorage, AK 99503
P: 907.277.1616 | F: 907.274.7011 | Michaelh@thewilsonagency.com | www.thewilsonagency.com

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Erickson, Deborah L (HSS)

From: _____
Sent: Friday, November 23, 2012 9:12 AM
To: Erickson, Deborah L (HSS)
Subject: Brain Health

Hello Ms. Erickson:

I'm writing to comment on the recent Alaska Health report. In particular, Brain Health. Alaska, as is known, almost leads the nation in TBI. I'm a recent TBI victim. I suffered two falls on Fairbanks icy streets in March 2012 & April 2012, and experienced concussions. The last fall, I have no memory of that harmful event. And short-term memory continues to be an issue; along with severe headaches.

We (TBI patients) need professional health Brain Care that really knows concussions. Although, I admit that this "hidden disability" is very difficult to diagnosis and treat. In my visits to the Indian Health Service system it has taken time to convince them what I'm experiencing (short-term memory issues & severe headaches). I can of understand, because many persons abuse pain medication, and this causes problems for those of us, like myself, both respect & fear pain medications.

Respect it because it takes away the severe headaches, and fear it because of the potential for addiction. No one should have to live in pain, because of other "bad apples" who ruin it for persons with no history of abuse, but need professional health care.

Please keep your efficient work going, because the radar says that its not looking good for big decreases in TBI accidents. Thanks to Access Alaska, and its TBI peer group, I now understand what it means to experience a concussion. And not have it explained somewhat limited on NLF cable news. And my Care Provider, _____ of CAIHC, has been most helpful and my advocate. As has been doctors in their Eagle group.

The role of a Neurologist should be explained more thoroughly, and she/he can do to help persons with a TBI to recover.

Keep-up the latest work and keep out to the public--we rely on you for our health.

cordially,

I found out of this report only through Alaska Brainwork network.

Erickson, Deborah L (HSS)

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From: Serrano, Jacquelyn L [Jacquelyn.Serrano@providence.org]
Sent: Friday, November 23, 2012 5:06 PM
To: Erickson, Deborah L (HSS)
Subject: Healthcare Commission Draft Report

I reviewed the 2012 report and have a few comments:

First is that the vision goals are quite lofty. It would be helpful to know where we stand now as a state in each of those areas. (Access to care, cost of care and life expectancy).

Regarding the supply and distribution of healthcare providers:
I agree that more family medicine residency programs could play a role in getting more primary care doctors to places in need. However, I do not feel that adding an internal medicine residence program would help much. As it stands now our family medicine residents are choosing to practice in Anchorage as hospitalists or to become locum tenens physicians rather than choose to permanently go to a rural area where their services are needed. We need to give them more incentive to go and live and work in the rural communities. An internal medicine residency program would likely have similar issues with graduates choosing to work in the Anchorage area where we have plenty of doctors already.

End of Life Care
I am very supportive of the idea to do away with the comfort one system and go to a POLST/MOST system. Palliative care and hospice are wonderful ways to provide excellent and compassionate care to individuals with life-threatening illnesses. A public campaign to dispel some of the myths regarding hospice and palliative medicine would be great.

Thanks.

Jacquelyn L. Serrano, MD, MPH
Family Physician
Faculty, Alaska Family Medicine Residency Program

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Erickson, Deborah L (HSS)

From: Pat Olsen [<mailto:olsen99615@hotmail.com>]
Sent: Wednesday, November 28, 2012 7:08 PM
To: Erickson, Deborah L (HSS)
Subject: Public Comment Draft 2012

With implementation of the Affordable Care Act, Alaskans will face more challenges in the area of health care. It is anyone's guess how it will affect delivery of health care services, health insurance and all associated costs. What will not change, however, is the fact that we need to attract qualified health care providers. Having "...a positive malpractice environment in the state" and the creation of the Alaska Health Workforce Coalition are two findings which address the need for healthcare providers in this draft report. The malpractice statement is anecdotal and there are no reports of facts that have been gathered by the Workforce Coalition. Admittedly it has not been in existence long but are there any facts to report? How many workers are there in various fields? What workers are needed? What data has been collected? If any of this information exists, it should be in this report. If there aren't, can there be something more specific about what is being done?

Under B. Health Care System Foundation- Health Workforce - a number of recommendations from previous years were summarized. Many begin with the word "support." How has the Commission supported educational loan repayment and the other recommendations? Has WWAMI been expanded?

Under C.1 Use telehealth technology to facilitate access to and quality of care the recommendations are excellent. Alaskans can cut provider costs substantially with this service. The sooner the Department of Health and Social Services can begin work on this, the better. We can be a leader in this area and cut costs of health care delivery.

Under C.3 Enhance the employer's role in health and health care – both recommendations are excellent. We need to be informed consumers. I am still not sure I understand the usual and customary scenario on page 11, but a database like the one described would provide consumers with the facts they need to make an informed choice.

I especially like the second recommendation. Employers need to engage their employees in this important and seriously expensive benefit.

I would like to see included in the recommendations, a state provided database on available health care coverage for Alaskans to purchase since our state has opted out of the state health insurance exchange.

Everyone deserves quality, affordable health care. Thank you for continuing this important work.

Respectfully,

Pat Olsen

Kodiak

Erickson, Deborah L (HSS)

From: Grace Snider [grace@alaskabraininjury.net]
Sent: Thursday, November 29, 2012 9:00 AM
To: Erickson, Deborah L (HSS)
Subject: Public Comment

This came to us after our announcement; you might have already received it.

November 2012

To Whom It May Concern,

This letter is a response to the request emailed on 11/21/12 "to share the need for traumatic brain injury prevention efforts and services." The email was entitled "Alaska Health Care Commission seeks your input." As a patient who has been dealing with TBI and physical injuries from a car crash for almost a year, I can say without a doubt that in my opinion, there is a severe need for information dissemination.

With injuries such as TBI, The Brain Injury Network and the Alaska Healthcare Commission realize there is a need for a multi-disciplinary approach to treatment. However, how is a patient supposed to know that these services are needed? Unfortunately, although I've seen many specialists, nobody has talked to me about multiple treatment options that might be helpful – even if they know about different options. I have had to research this myself, which has been especially difficult in my condition.

Every specialist I've seen has claimed that the greatest healing happens within six months of the initial trauma, and then after one year healing may be severely diminished. Not having access to knowledge about different treatments as soon as possible is almost certainly harmful to the healing process.

A list of office names is not sufficient when there is no explanation about the office specialties included with the list. The networks that are available are either not known or not disbursed to patients by providers; I learned about the Traumatic Brain Injury Network through friends rather than providers. If there were a way for patients to learn about different multi-disciplinary treatment options and networks that could assist with healing as soon as the initial injury occurred, then patients might have different avenues to pursue. They would not go ten months or longer (as I did) before finding out about multiple treatments that could have helped them all along. In conclusion: **As a patient, I have a responsibility to seek treatment... but how can I seek treatment when I do not know what treatments exist?**

Please consider this letter my contribution and input about health care in this state currently. It is meant as a response to the emailed request for information from a patient point of

view. Please feel free to use any information here if it is useful. Please maintain my confidentiality and anonymity at all times currently and in the future without an end date.

Thank you for your time reading this letter. Best of luck with your goal "to have Alaskans "be the healthiest people in the nation and have access to the highest quality, most affordable health care" by 2025." I sincerely hope that your goal is achieved and becomes a reality.

Sincerely,

Anonymous

TBI patient 2012

Grace Snider
Resource Navigation Program Director

Alaska Brain Injury Network
3745 Community Park Loop, Suite 140
Anchorage, AK 99508
Work Phone: (907) 274-2824
Toll Free: (888) 574-2824
Cell Phone: (907)-250-0900
Fax: (907) 274-2826

www.alaskabraininjury.net

The ABIN mission is to educate, plan, coordinate, and advocate for a comprehensive service delivery system for the survivors of traumatic brain injury (TBI) and their families.

Erickson, Deborah L (HSS)

From: Nighswander, Thomas [<mailto:tnighswa@anthc.org>]
Sent: Thursday, November 29, 2012 10:57 AM
To: Erickson, Deborah L (HSS)
Subject: Transforming Health Care in Alaska-end of life care

Debra, would you include the following in the Public Comments:

Commissioners,

You have made timely recommendations on training in end of life care and also on pain management.

Both issues have been raised in preparation for a major curriculum reform that is just beginning in the Alaska WWAMI Program as part of the larger reform of the medical school curriculum of the School of Medicine of the University of Washington.

I have been assigned to participate on the Primary Care working committee that will address education and training issues through all 4 years of medical education.

I will use these recommendations to place emphasis on both of these issues. I must say I think I will be "preaching to the choir". Both are critical to the future of health care in the USA, and both have inadequate recognition in our curriculum.

Thomas Nighswander, MD MPH
Assistant Clinical Dean, Alaska WWAMI Program
Clinical Professor of Family Medicine
School of Medicine, University of Washington

Erickson, Deborah L (HSS)

From: William H Hogan [<mailto:whhogan@uaa.alaska.edu>]
Sent: Thursday, November 29, 2012 12:38 PM
To: Erickson, Deborah L (HSS); 'Nighswander, Thomas'
Cc: William H Hogan
Subject: RE: Electronic version

Deb, I did discuss the end-of-life care recommendation with the College of Health Leadership Team this morning. They are in full support of this recommendation. I also encouraged them to review the Commission's draft and comment as they see fit. Thanks, Bill

Erickson, Deborah L (HSS)

From: Deborah [debgid@earthlink.net]
Sent: Thursday, November 29, 2012 4:41 PM
To: Erickson, Deborah L (HSS)
Subject: Health Care Commission Public Comment

Dear Commissioners:

As a Clinical Neuropsychologist who has practiced in Alaska in public and private settings for a total of 11 years since I first came here in 1988, I have observed a serious absence of post-acute services for individuals with brain disorders and a dearth of prevention efforts and education regarding their needs. The incidence of individuals identified with brain injury is 28% higher than that of other states, and so called "mild" traumatic brain injuries with *major* consequences are typically overlooked and not included in such figures. Despite these data, resources for traumatic brain injuries and other acquired brain disorders (strokes, seizures, dementias) in our state are dramatically absent.

Clinical Neuropsychology practice uses scientifically developed, evidence based methods to assess the cognitive, emotional and psychosocial functioning of individuals with brain disorders and to measure their progress through recovery. Unfortunately, in my practice in Alaska, I am very frequently unable to find resources for the individuals with brain disorders I've identified as clearly needing specific resources.

Cognitive, speech, occupational and psychosocial therapies are essential to foster recovery from brain disorders, especially early after their onset. Structured living and teaching environments are critical to provide support and management and to guide the development of adaptive behaviors. These resources are woefully limited or nonexistent in our state. Individuals are typically turned back out into the communities to struggle with impaired functioning in multiple areas of their lives and often to incur additional brain injuries and devastating social, vocational and economic consequences.

Compounding the limitations to care for brain disordered individuals is the lack of information about the consequences of brain disorders on the full spectrum of physical to behavioral health. In brain disorders the physical impact is not separable from the cognitive, emotional and behavioral effects. Relatedly, one in three individuals in Alaska who seeks behavioral health services has an already identified brain injury. Yet behavioral health providers are often lacking in knowledge about the impact of brain disorders on the individual's presentation and needs for care. Conversely, persons who focus on the physical or medical aspects of brain disorders typically are unaware of their neurobehavioral consequences.

As the Alaska Health Care Commission has stated: *The health care continuum is the full array of physical and behavioral health services, from prevention to treatment to rehabilitation and maintenance, required to support optimum health of a population.* The health challenges of individuals with brain disorders require this full spectrum of physical to behavioral health services. Nonetheless, in Alaska, services for them are not provided throughout this spectrum. Furthermore, the education of caregivers has been insufficient to foster appropriate care, and the public has not been well educated about the consequences of brain disorders or supported in their prevention.

As a health care provider who has devoted a lifelong career to the identification, treatment and prevention of brain disorders, I ask the Commission to carefully attend to this dramatically

underserved and needy population. On behalf of the individuals I serve, I request services across the continuum of care from physical to behavioral and acute to chronic needs. Specifically, I request the Commission to consider:

- Long term rehabilitation programs and facilities
- Increased rehabilitative therapies (cognitive, speech, occupational, psychosocial)
- Improved education for caregivers about the spectrum of impairments in brain disorders
- Education and prevention efforts for the public

Respectfully submitted,

Deborah A. Glendon, Ph.D.
Clinical Neuropsychologist

Erickson, Deborah L (HSS)

From: Donna Stephens [<mailto:donna@hospiceofanchorage.org>]

Sent: Thursday, November 29, 2012 8:11 PM

To: Erickson, Deborah L (HSS)

Subject: Public Comment for 2012 Finding and Recommendations of the Alaska Health Commission

Dear Deborah,

I commend the Alaska Health Care Commission for the foresight to study end-of-life care to improve choice, quality and value in the health care system in Alaska. The recommendations proposed in the draft are excellent starting points for improvement in dealing with the complex issues facing Alaskans in dying, death and bereavement.

My comments below are focused on Findings C 2. Improve patient choice and quality in end-of-life care.

A key concept is that all end-of-life (and palliative) care needs to be patient and family-centered care. Individuals rarely cope with serious or life-ending diseases by themselves. The challenges are usually immense for the family as a whole and often negatively affect the health of the family system and in many cases cause severe financial strain or even bankruptcy.

Dying, death, and bereavement are distinct and overlapping, elements of the end-of-life journey.

Suggested wording change: Hospice care is palliative care for **individuals approaching the end of life and support for family and caregivers through the dying and grieving process.** Hospice is neither about slowing nor hastening death, but about providing compassionate care to ease **dying, death and bereavement.**

"Hospice began as a movement in the 1970s ..." add - **Most hospice care is provided in the home setting.**

Add, **Nationally,** in front of "There are now" **examples of** "hospice organizations and insurance benefits that support ..."

Suggested wording change to "Some Hospice organizations": **Alaska Regulations provide for licensing full-service hospices (which are essentially Medicare certified hospices) and volunteer hospices. Volunteer hospices are limited to services they can provide and are prohibited from seeking reimbursement for care.**

Suggested wording change -" Medicare, Medicaid ... require clinician documentation" **of life expectancy of six months or less,** "and does not allow...."

Research demonstrates ... add,

Decreases adverse health outcome for survivors. (Christakis & Iwashya, 2003)

Alaska established the Comfort One Program...to help health care providers, add, **the Medical Examiner and First Responders.**

Thank you and the Commissioners for an outstanding start in understanding and recommendations for improving a complicated piece of the health system that impacts all of us.

Donna Stephens, RN, MEd, FT, CTS

Executive Director

Hospice of Anchorage

2612 E Northern Lights Blvd

Anchorage AK 99508-4119

907-561-5322 x 206

907-229-0721 (cell)

907-561-0334 (fax)

www.hospiceofanchorage.org

Erickson, Deborah L (HSS)

From: Gary Miller [gmiller_juneauak@hotmail.com]
Sent: Thursday, November 29, 2012 8:28 PM
To: Erickson, Deborah L (HSS); bcurata@gci.net
Cc: New RPEA_State_EB
Subject: AK Health Care Commission

**Response from Gary Miller
to
State of Alaska Health Care Commission
Transforming Health Care in Alaska 2012**

I received a copy of the Alaska Health Care Commission, Transforming Health Care In Alaska 2012. Here are my comments.

On page 9, paragraph 2, there is a statement 9% of health care costs in Alaska are "...9% for prescriptions and equipment..."

Prescriptions for seniors are very much higher than for the general public. An email dated March 2, 2010 from Lisa Tourtellot from Retirement and Benefits stated the following concerning the health care costs for PERS and TRS retirees:

- "In calendar year 2008, the retiree plan paid:
- Total medical claims - \$219.76M
- Total Drugs - \$115.35M
- Generic Fill Rate 57.1% as compared to 2007 which was 52.6%"

Prescription drugs cost for the state's retirees was 52%. On August 12, 2011, Administration Commission Hultberg wrote to Retired Public Employees of Alaska that for FY2010 the total cost for drugs rose to \$130,937,137 (about a 14%) increase. I can supply a copy of the email and letter if you would like to see them.

Here is my suggestion. Federal bill S.319, "Pharmaceutical Market Access and Drug Safety Act of 2011" is a bipartisan bill with the following sponsor and cosponsors.

Sponsor Snowe

Republican cosponsors are Brown, Collins, Grassley, McCain and Vitter.

Independent cosponsor is Sanders

Democratic cosponsors are Begich, Bingaman, Boxer Conrad, Johnson,

Klobucher, Kohl, Leahy, Levin, McCaskill, Nelson, Shaheen, Kerry, Stabenow, and Whitehouse.

"...the Congressional Budget Office has found that the cost of prescription drugs are between 35 to 55 percent less in other highly-developed countries than in the United States;" The cost savings to American would be huge. Senator Murkowski should be pushed to become a cosponsor.

You may not be aware of this, but while the Veteran's Administration is allowed to go out to bid for prescription drugs, Medicare and Medicaid are specifically prohibited from doing the same thanks to Congress. Our three federal legislators should change this. With our country's fiscal crisis Congress should reverse this and give the U.S. citizens a break instead of the drug companies.

One of the major causes of poor health in Alaska is smoking. A person can buy tobacco at the age of 19 but not buy alcohol until they are 21. Tobacco kills more people than alcohol and illegal drugs combined. The age for smoking in Alaska should be raised to 21 and sold only in liquor stores. At some of the food stores in Juneau it is very easy to buy tobacco because it is stored near a checkout stand. It should be more difficult to purchase and not near to a customer who may be trying to quit and does not need the temptation.

When I entered Safeway today the first think I encountered was shopping carts and then cakes, doughnuts, cookies etc. When I got to the checkout line and had to wait I had an array of candy and soda at hand's length. I think that stores should be prohibited from having bakery goods within a certain distance from an entrance and prohibited from having candy, soda etc. by the checkout stand. My wife and I are raising our grandson and there is always a battle to keep him away from the candy at the checkout stand. How many parents give in to their kids at the checkout line to reduce conflicts with their kids while waiting in the line?

When I worked at the Department of Labor about 20 years ago, the department was paying \$20,000 per year for a room for smokers to go to for smoking. When I requested that showers be installed (a onetime cost) so that I could ride my bike to work or exercise during lunch I was told the department could not afford it. In Juneau, there are several buildings that could easily install showers for people who want to walk or bike to work or exercise before work, after work or during their lunch hours. When parents get home from work to their kids and house chores, exercise is the first thing to go when they run out of time.

For a few years when I worked at the Department of Labor, we had public health nurses coming to our office once or twice per year to take blood pressures. It was a good time to pass out literature explaining the health risks of obesity, smoking, drinking etc. Free flu shots at work would reduce illness that keep people away from work and out of the doctor's offices and hospital. As you know, preventative measures pay off.

The federal building in Juneau has a nurse on staff every day. People can go to her for free. She can detect when a person needs to go to a doctor and when they don't. She can also give advice on a healthy life style. The federal building has an exercise area and showers. They save money in the long run because of these. In places like Juneau, a few public health nurses strategically placed who could be seen for free could save the state money and encourage public employees to live healthier life styles. Who is there to do that now?

We have people in Juneau who would like to live in their own homes instead of moving into a long term care facility. Home health care could allow more people to stay at home if they had someone to come to their home a few hours per day to help them. Long term care facilities are very expensive.

My last suggestion will never happen but I am going to propose it anyway. Medical school should be completely paid for by government. After four years of college, four years of medical school and two years of internship, doctors have staggering school debts to pay. Add to that a wife, children, a home, liability insurance, an office, staff, setting money aside for retirement, and living expenses, a doctor has to charge a large amount of money. We have hundreds of billions of dollars to kill people in Iraq, Afghanistan, Pakistan and Libya. It makes sense to me to pay student medical school bills.

Thank you.

Gary Miller
20135 Cohen Dr
Juneau, AK 99801-8211
789-3757
gmillier_juneauak@hotmail.com



**Comments on the Alaska Health Care Commission 2012 Draft Plan
Alaska State Hospital and Nursing Home Association
November 27, 2012**

Thank you for giving us the opportunity to comment on the draft 2010-2014 Strategic Plan update. Enclosed are some comments on the Strategic Plan 2010-2014: Transforming Health Care in Alaska 2012. We are focusing our comments on the Challenges Prioritized for Study in 2013 and on the Recommendations in the plan.

Current Health System Challenges Prioritized for Study in 2013 – Page 12

- **Cost of Skilled Nursing Facility Care in Alaska** – Complete actuarial analysis comparing pricing and reimbursement levels for acute medical services in Alaska with comparison states and identifying drivers of cost differentials:
 - Skills Nursing Facility (SNF) care as the last component of acute medical services.
- **Federal Reform:** Continue to track Affordable Care Act implementation activities in Alaska.

ASHNHA Comments:

Cost of Skilled Nursing Facility Care in Alaska

We appreciate the effort to learn about the conditions of Alaska health care system in 2013. However, we oppose a study focused on SNF only or even a subcomponent of SNF.

This is the third time we have commented on the wisdom and design of this study.

In December 2011 we commented on the narrowness of the study. The Commission voted not to pursue it. In August 2012 when an RFP was released by the Health Care Commission for *A Pricing and Reimbursement Study for Skilled Nursing Facility Care*, we registered our deep concern over the concept, methodology and rapid procurement timeframe (two weeks). The RFP was withdrawn. We now find ourselves commenting again on the specter that this will be a major activity of the Commission's workplan in 2013.

Attached please find extensive comments and documentation that we submitted to the Department in August regarding this matter. **Attachment 1**

As we understand it and read in the August 2012 RFP, the study focused solely on the cost of skilled nursing facility (SNF) care in Alaska. We focus on the RFP because it provides the only tangible scope of work related to the Commission's thinking on what would be the work product of this study. This approach makes limited sense to us for the following reasons:

- The study is not a comprehensive programmatic look at LTC costs and cost drivers in

Alaska, but instead focuses on SNF care only. SNF care accounts for 2% of the clients in Alaska LTC settings.

- DHSS issued another RFP to accomplish *Long Term Care Strategic Planning* on November 5th of this year for \$50,000. We think this is a worthwhile endeavor and a comprehensive approach. This RFP is being undertaken in part due to recommendations of the Health Care Commission. Wouldn't this be adequate to advance the discussion on the future of LTC in the nursing home or hospital setting?
- SNF services represent 20% of LTC expenditures (\$87 million) and are relatively flat in growth- community based services represent 80% (\$323.6 million) and have grown dramatically. (Dollars are State managed LTC expenditures)
- Pioneer Homes which are licensed as assisted living would not be in the study, but they provide over 450 beds and are supported by the State at the level of approx. \$60 million.
- We understand that an additional clarification of the study would be "SNF services in an acute care setting or those paid by Medicare." As we understand it, this would certainly represent a fraction of the services provided and might only focus on one hospital or a few settings. As the Hospital and Nursing Home Association we would need more information to determine what kind of services would be captured in such a study if it did not include SNF LTC care as commonly defined by licensure and rate setting. Is it the number of days that defines this service? Is it the setting? Is it the payment source? Is it the diagnosis of the patient?
- Comparable cost information is available from other states (see attachment).
- Medicaid pays for approximately 85% of SNF services in Alaska and the cost/rate information is repositied in the Department of Health and Social Services. Detailed cost reports are submitted and audited that outline the cost components or "drivers". This information is publically available. (see attached)
- Medicare accounts for another 5-10% of SNF payment . Facilities are paid on a prospective basis. All of private pay and other sources account for the remainder. Most often a flat dollar maximum is paid per day by third party payers.
- The RFP shows a lack of clarity or understanding regarding how rates are determined for the vast majority of SNF care, especially considering the fact the Department sets the market rate for this service. The RFP called for *an analysis of a range of billed and allowed charges, as well as the mean and the 50th and 80th percentile*. Virtually all SNF rates are set in a cost based reimbursement system, or a flat per diem rate.

If the Commission is going to undertake further study in this area a study of the cost of all major components of the LTC system including community based would be more useful.

ASHNHA Comments:

Federal Reform

We recommend the Health Care Commission take a more active role in federal health reform activities in Alaska. Simply tracking the activities is no longer enough. Now that the Supreme Court has ruled on the Affordable Care Act and the election has occurred, we believe the Health Care Commission could take a more active role in informing the public of the decisions and actions ahead.

Under the *Summary of Prior Year Findings* (page 8) the Commission has determined that “Health insurance coverage in Alaska is inadequate.” There are two provisions in the ACA focused on improving insurance coverage – Medicaid Expansion and Health Insurance Exchange. We would like to see the Commission include a recommendation that Alaska fully explore and ultimately support the Medicaid Expansion and work in partnership with the Federal government to develop a health insurance exchange that will support Alaskan’s in purchasing health insurance through an exchange that addresses the unique health care environment in Alaska. The challenges of designing an exchange that will fit our market are considerable and we need local Alaska

As implementation of the Affordable Care Act continues, we recommend the Health Care Commission identify the implementation activities that are aligned with the Commission’s vision and goals and enthusiastically support these activities.

Summary of Solutions Recommended To Date – Page 13

V. Support the foundation of a sustainable health care system

Ensure there is an appropriate supply and distribution of health care workers. Create the information infrastructure required for maintaining and sharing electronic health information and for conducting health care analytics to support improved clinical decisions, personal health choices, and public health.

ASHNHA Comments:

ASHNHA very much supports the commission’s efforts to advocate for an appropriate supply and distribution of health care workers. ASHNHA is a participant in the Alaska Healthcare Coalition, a partnership to address healthcare workforce needs.

2012 Commission Recommendations:

Health Workforce - Page 14:

In the short time since their formation the Alaska Health Workforce Coalition has made significant progress, leveraged through an impressive partnering effort and pooling of resources rarely seen between public and private sectors. The coalition identified a series of goals and strategies for

strengthening the workforce and published the Alaska Health Workforce Plan in 2010, and during 2011 developed an "Action Agenda" to focus efforts on specific high-priority occupational and system improvement issues. The commission applauds the efforts of the coalition, and will continue tracking their work over the coming year. Of particular importance to the commission are the coalition's systemic change initiatives focused on improving workforce data to support needs-based planning and resource allocation, and on government policy barriers to and supports for workforce development.

ASHNHA comments:

ASHNHA and its members are key partners within the coalition and continue to work to identify areas for increasing the supply of healthcare workers at the appropriate training levels.

Use telehealth technology to facilitate access to and quality of care - Page 16-17:

Recommendation

1. The Alaska Health Care Commission recommends the Department of Health & Social Services direct the Statewide Health Information Exchange entity to perform a business use analysis for offering a statewide brokered telehealth service

ASHNHA Comments:

While we agree with the concept of this recommendation we are not sure if the Alaska e-Health Network (AeHN) is the right entity to take on this role at this time. We believe it is important to get the health information exchange operating and sustainable. We are concerned that adding new duties and new broad scope of work to AeHN could distract from the primary and frankly gargantuan role of bringing up and sustaining a health exchange.

The AeHN Board should be consulted on the wisdom of performing a business use analysis. ASHNHA has a seat on the Board and is not aware that the Board has been consulted in the development of this recommendation.

Enhance the employer's role in health and health care - Page 21-22:

Commission Recommendation:

1. The Alaska Health Care Commission recommends the Department of Health & Social Services investigate and the legislature support implementation of a mechanism for providing the public with information on prices for health care services offered in the state, including information on how quality and outcomes compare, so Alaskans can make informed choices as engaged consumers.
 - To support this strategy the Commission is currently studying the business use case for a statewide All-Payer Claims Database for Alaska, and investigating health care price and quality transparency legislation enacted in other states.

ASHNHA Comments:

ASHNHA has been following the All Payer Claims Database (APCD) feasibility study with intrigued



interest. Hospitals and nursing homes are committed to increased price and quality transparency. New activities and mandates are being implemented every year that increase the public's knowledge of all aspects of hospital and nursing home care.

The APCD would consolidate virtually all the financial and utilization data of a \$7 billion dollar industry into one large bucket, potentially operated by government. It is absolutely essential that providers, among others, understand and agree on the purposes and generally on the operating principles of the data base.

Our comments are based on the assumption that the feasibility study will recommend moving forward with some sort of APCD in Alaska. We want to ensure that the process of moving forward allows hospitals and nursing homes and other health providers to be at the table and part of the process in a meaningful way. The purposes of the APCD need further definition and the customers of an APCD are more than the public consumers. The APCD needs to work for providers in order for it to have a positive impact in Alaska and for it to be used for clinical or quality improvement. We want real and significant input into the process separate from the Health Care Commission's comment process. We believe a formal stakeholder group will need to be formed to determine the next steps for an APCD.

ASHNHA provided comments into the APCD feasibility study. Those comments are included as part of this document as to be part of the public record on our thoughts on the APCD feasibility. See Attachment 2.

Commission Recommendation:

2. The Alaska Health Care Commission recommends the State of Alaska, as a major employer in the state, play a leadership role for all Alaskan employers by continuing to develop and share strategies already underway to improve employee health and productivity and increase health care value. The Commission recommends the Department of Administration take a comprehensive approach by including all the essential elements of a successful employee health management program: Price sensitivity, price and quality transparency, pro-active primary care, and healthy life-style support for employees.
 - To support this strategy the Commission will continue to engage the business community and public employers in learning about opportunities for increasing value in health care and improving health outcomes.

ASHNHA Comments:

We agree that the State of Alaska is a major employer, however health care is also a major employer in Alaska and health care needs to be viewed not only as a driver of costs but as a major employer capable of playing a leadership role in developing strategies.

We urge the Commission to be mindful of the complexity and fragility of the health care system in Alaska especially in rural areas and be mindful of potential unintended consequences.

Strategies under Consideration for Study in 2013 - Page 23:

- **Design policies to enhance the consumer's role in health and health care - A) Innovate to improve quality, affordability and access to care:**
 - **Price & Quality Transparency:** Consider final report from the Commission's All-Payer Claims Database consultants, inventory of transparency legislation from other states, and additional strategies for providing health care price and quality transparency.

- **Design policies to enhance the consumer's role in health and health care - B) Support Healthy Lifestyles**

- **Build the foundation of a sustainable health system**
 - Statewide Leadership**
 - Identify indicators for measuring statewide health care delivery system improvement
 - Sustainable, Innovative Health Workforce**
 - Track developments in Alaska related to previous recommendations
 - Health Information Infrastructure**
 - Track developments in Alaska related to previous recommendations

ASHNHA Comments:**Price and Quality Transparency**

To reiterate our comment on the All Payer Claims Database, we believe a stakeholder group separate from the Commission is needed to determine the next steps after the feasibility study is completed.

Build the foundation of a sustainable health system

ASHNHA very much desires to work with the commission to build the foundation of a sustainable health system. Each of the areas identified are critical to that foundation, and ASHNHA is working on several initiatives to address the goals.

No other specific comments on the strategies under consideration for 2013.

Thank you for the opportunity to comment.

Attachments:

Attachment 1: Skilled Nursing Facility Comments & Documentation from August 2012

Attachment 2: All Payers Claims Database – Comments from Sept 2012

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Alaska Native Tribal Health Consortium

Administration • 4000 Ambassador Drive • Anchorage, Alaska 99508 • Phone: (907) 729-1900 • Fax: (907) 729-1901 • www.anthc.org

via e-mail: deborah.erickson@alaska.gov

November 30, 2012

Deborah Erickson, Executive Director
Alaska Health Care Commission
3601 C Street, Ste. 902
Anchorage, AK 99503-5923

Dear Ms. Erickson:

The Alaska Native Tribal Health Consortium (ANTHC) appreciates the opportunity to provide written comments on the draft report by the State of Alaska, Alaska Health Care Commission, "Transforming Health Care in Alaska, 2012 Report / 2010-2014 Strategic Plan" (Commission Report).¹

The Alaska Native Tribal Health Consortium is a statewide tribal health organization that serves all 229 tribes and over 139,000 American Indians and Alaska Natives (AI/ANs) in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AI/ANs in Alaska.

The Alaska Health Care Commission (Commission) was established in 2010 to foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the State, including a strategy for improving the health of Alaskans. The Commission Report serves as both an annual report and a multi-year strategic plan and is the vehicle used by the Commission to formally communicate recommendations to the Governor and State Legislature. The ANTHC offers one additional recommendation to be included in the Commission Report.

In Part I, Section B of the draft Report, "The Commission's Vision for Transformation of Alaska's Health Care System," the Commission identifies three benchmarks for knowing when its vision has been achieved. ANTHC recommends a fourth benchmark be added to be sure that small sub-populations within the State (including AI/ANs) do not get left behind as the vision is pursued. The fourth benchmark could read: "4. All populations in the state are represented on an equivalent basis to the total population in life expectancy, access, and health care spending.

In Part II, Section A of the draft Report, "Understanding Alaska's Health Care System Challenges, Summary of Prior Year Findings," a list of findings from prior years is provided. One finding identified is "Health insurance coverage in Alaska is inadequate."

¹ http://hss.state.ak.us/healthcommission/docs/2012_Public_Comment_Draft_FINAL11-5-2012.pdf

Given that this finding is one of a total of only eight prior year findings, and given that the Inadequacy of health insurance coverage negatively impacts most if not all of the other seven findings, ANTHC urges the Commission to include a recommendation to take action on this finding.

The ANTHC recommends the inclusion of the following paragraph under Part II at the end of section E (page 12). This section identifies the prioritized study to take place in 2013.

"Medicaid Expansion: Implement the option available to the State of Alaska to expand the State of Alaska's Medicaid program to cover adults without dependent children with income up to 138 percent of the federal poverty level and evaluate the impact, including costs and benefits over the first three years while the Federal match is highest."²

On June 28, 2012, the U.S. Supreme Court ruled that the core Medicaid expansion provisions of the Patient Protection and Affordable Care Act (Affordable Care Act) are to be available to states without the threat of loss of funding for a state's current Medicaid program if the state fails to exercise the expansion.³ As a result, the decision to expand eligibility under the State of Alaska's Medicaid program is solely a decision for the State of Alaska and its residents to make. The core Medicaid expansion provisions of the Affordable Care Act enable States to extend eligibility to adults without dependent children with family income at or below 138 percent of the federal poverty level.

The option would be effective January 1, 2014, consistent with the Governor's FY2013 proposed budget. In the Governor's budget, it is noted under the Department of Health and Social Services section --

"Although no significant changes are anticipated for FY2013, HCS [Health Care Services] will increase its attention to the 2014 Patient Protection and Affordable Care Act (PPACA) expansion of Medicaid that would open Medicaid eligibility to a majority of chronic and acute medical assistance (CAMA) recipients."⁴

We are aware that the Department of Health and Social Services will soon receive a "a cost study of the Alaska Medicaid system expansion as outlined in the federal health care reform act and made optional by the US Supreme Court in June of 2012."⁵ We anticipate based on our own initial research that it will reveal some costs, but that they are substantially exceeded by the revenue particularly during the first three years while the Federal Medical Assistance Percentage is 100 percent for the new eligibles. We

² The Affordable Care Act intended to require state programs to provide Medicaid coverage by 2014 to adults with incomes up to 133 percent of the federal poverty level (or 138 percent when factoring in the five percent income disregard.) § 1396a(a)(10)(A)(i)(VIII) and § 1396c.

³ National Federation of Independent Business *et al.* v. Sebelius, Secretary of Health and Human Services, *et al.*, June 28, 2012.

⁴ State of Alaska, FY2013 Governor's Operating Budget, Department of Health and Social Services Catastrophic and Chronic Illness Assistance (AS 47.08), Component Budget Summary.

⁵ [http://notes3.state.ak.us/pp/pubnotic.nsf/0/0b696db937495ad189257a8d007e5575/\\$FILE/RFP+2013-0600-15281++Medicaid+Cost+Study.pdf](http://notes3.state.ak.us/pp/pubnotic.nsf/0/0b696db937495ad189257a8d007e5575/$FILE/RFP+2013-0600-15281++Medicaid+Cost+Study.pdf)

also anticipate that the next revenue to the State will actually be higher if it accepts the Medicaid option than it will be if it simply has to absorb an increased enrollment of current eligibles who have not yet enrolled without the benefit of the higher FMAP for the newly eligible population.

We encourage, though, a more complete analysis of the costs as well as the savings to the State of Alaska budget as well as a comprehensive analysis of the benefits to the overall physical and financial health of the State's residents and businesses over the initial years in order to assure that unreasonable burdens are not added to the State budget.

In contrast to federal law prior to passage of the Affordable Care Act, expansion of Medicaid eligibility to adults without dependent children with income up to 138% of the federal poverty level is permitted without the State needing to request "waiver" approval from the federal Department of Health and Human Services and without the need to identify offsets to the new federal spending, as the new federal spending was fully financed in the Affordable Care Act. The new expansion option would be funded in large part by the Federal government, with a permanent heightened federal Medicaid match rate of 90%, and even higher federal match rates in the initial years, including the permanent 100 percent FMAP for services provided to American Indians and Alaska Natives through the tribal health system.

To fully assess the impact of exercising the Medicaid expansion option for Alaska, it is necessary to identify and analyze a range of direct and indirect impacts on Alaska residents, health care providers, and businesses, as well as on the budget of the State of Alaska itself, but the opportunity to provide coverage at Federal expense beginning January 1, 2014 should not be delayed. The studies can follow and the option can be reconsidered if it proves to be impractical or to fail to achieve the anticipated General Fund spending offsets, potential additional revenues to the State, improvements in the physical and financial health of State residents, and growth in the State's economy.

We understand that the timing of this recommendation is awkward given the study that the Department has not yet received and other work being done to evaluate the option. Given the urgency of this issue, though, it believes timely review of the studies and serious timely consideration of this recommendation need to occur so that we as a State do not delay in our efforts to move forward with initiatives that will further achievement of the Commission's vision, goals, and values regarding the physical and financial health of Alaska's residents.

Sincerely,

Valerie Davidson
Senior Director of Legal & Intergovernmental Affairs



THE STATE
of **ALASKA**
GOVERNOR SEAN PARNELL

Department of
Health and Social Services

ALASKA MENTAL HEALTH BOARD
ADVISORY BOARD ON ALCOHOLISM
AND DRUG ABUSE

431 North Franklin Street, Suite 200
Juneau, Alaska 99801
Main: 907.465.8920
Fax: 907.465.4410

November 27, 2012

Deborah Erickson, Executive Director
Alaska Health Care Commission
3601 C Street, Suite 902
Anchorage, Alaska 99503-5923

BY EMAIL ONLY

Re: Comment on Health Care Commission 2012 Report and Findings

Ms. Erickson,

Thank you for the opportunity for the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse to provide public comment on the report of proposed findings made by the Alaska Health Care Commission. We appreciate the hard work and careful consideration of commissioners during the past year, and offer our comments in support of their ongoing endeavors to improve the health care system for Alaskans.

We appreciated the commissioners' interest in learning more about Alaska's behavioral health system at the March 9, 2012 meeting. The information shared by major providers in Anchorage and Southeast Alaska, Division of Behavioral Health Director Melissa Stone, Ron Adler from Alaska Psychiatric Institute, Jeff Jessee from the Alaska Mental Health Trust Authority, and our executive director was entirely relevant to the themes of consumer action, healthy lifestyles, and innovative practices described in the Commission's health care transformation strategy – and more importantly, to the definition of "Health and Healing." Thus, we are disappointed that none of that information is incorporated into the draft report. We feel this is a missed opportunity for further integration of behavioral health into health care transformation efforts.

We are very concerned that the Commission's definition of "Health and Healing" (page 5) neglects to include mental health. Neither "emotional health" nor "intellectual health" can be considered to be the same as or a proxy for mental health. Mental health involves thinking, behavior, and mood; mental health disorders are health conditions that result in impaired thinking, reduced functioning, and distress.¹ Mental health disorders can result from neurological or physiological causes, disease or injury, life experiences like trauma, developmental disorders, substance abuse, other causes, or a complex web of multiple causes. Mental health disorders, whether mild or moderate or severe, often result on physical ailments and are often accompanied by other chronic health conditions. Substance use disorders, while often arising from different circumstances, lead to similar impairments of thinking and functioning and

¹ Definition provided by the Substance Abuse and Mental Health Services Administration Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health, available online at <http://promoteacceptance.samhsa.gov/publications/thefacts.aspx>.

occur in high incidence with other chronic health conditions.. To describe “optimal health” without reference to mental health or freedom from addiction leaves out a integral part of Alaskans’ overall health and wellness.

The description of Alaska’s health care system (page 6) omits the public health care system. A substantial number of Alaskans receive their health care from Alaska Psychiatric Institute (a public hospital that served 1,157 unduplicated patients in FY12) and the Department of Corrections (3,663 offenders were in correctional institutions served by Inmate Health Care in 2011). Omission of these public health care providers is significant because our constituency is uniquely served by Alaska Psychiatric Institute, and is overly represented in the corrections system.²

We appreciate and support the Commission’s emphasis on tele-health resources as a means of increasing access to care. The Commission recommends “focus on increasing access to behavioral health and primary care services” through tele-health (page 17). Currently, only professional services are reimbursed, not equipment and infrastructure.³ A community behavioral health services provider or mental health physician clinic is reimbursed for facilitating the tele-behavioral health session only if it provides the equipment, establishes the electronic connection, and remains available throughout the session to ensure the connection is maintained.⁴ The practical result is that only tele-behavioral health delivered at the community behavioral health center or mental health physician clinic is reimbursed, limiting access for many individuals. Thus, efforts to expand access will require thoughtful review and update of the regulatory framework for these services.

We support the Commission’s recommendation for a “secure electronic registry” for advance medical directives (page 20) – specifically to include advance psychiatric directives – to ensure that Alaskans are able to exercise self-determination when it comes to health emergencies. Psychiatric advance directives are underutilized in Alaska, due in part to the fact that there is no safe and secure way to store them while at the same time ensuring access by hospitals and other mental health emergency services providers.

In the discussion of employers’ role in health and health care (page 21 et seq.), we note the absence of discussion of behavioral health and the importance of access to behavioral health services through health benefit programs. The Commission states that “essential elements of employee health management programs . . . include: . . . [a] pro-active primary care emphasis.” **We submit that access to a robust array of behavioral health care services is equally essential to employee health benefit programs.** In fact, a recent study of the costs of alcohol and drug abuse in 2010 to Alaska’s employers found an annual cost of \$673.2 million in lost productivity (costs due to an inability to contribute to the economy through employment earnings and household services).⁵

² *A Study of Trust Beneficiaries in the Alaska Department of Corrections*, Hornby Zellar Associates, Inc. (2007), available at www.mhtrust.org.

³ 7 AAC 110.635(b).

⁴ 7 AAC 135.290

⁵ *The Economic Costs of Alcohol and Other Drug Abuse in Alaska, 2012 Update*, McDowell Group (2012), available at <http://www.hss.state.ak.us/abada/>.

AMHB and ABADA Comment, draft Health Care Commission Report 2012
November 30, 2012
Page 3

Employee assistance programs (EAP) – health benefit programs providing substance use disorder counseling and other services to help reduce the adverse impact of behavioral health disorders on employee work performance and wellness – are an effective way in which employers can support employees’ health and lifestyle choices. We encourage the Commission to include behavioral health program benefits, and specifically EAPs, in Recommendation 2 related to “enhancing the employer’s role in health and health care” (page 22). We also encourage the Commission, in its consideration of health care system transformation strategies in the coming year, to include meaningful discussion about parity and EAPs (page 23).

We again thank you for the opportunity to comment on this draft report. It has been a pleasure working with you and the Commission this year as issues related to behavioral health were explored, and we look forward to our continued participation in the this process.

Sincerely,



J. Kate Burkhart
Executive Director

- cc: Michael Kerosky, Chairman, Advisory Board on Alcoholism and Drug Abuse
- Dan Meddleton, outgoing Chairman, Alaska Mental Health Board
- Joe Dingman, incoming Chairman, Alaska Mental Health Board
- Tom Chard, Executive Director, Alaska Behavioral Health Association
- Denise Daniello, Executive Director, Alaska Commission on Aging



3701 E Tudor Rd. Suite 208
Anchorage, AK 9950
907.274.0827
www.aknurse.org

November 30, 2012
Comments of the Alaska Nurses Association
State of Alaska Health Care Commission
2012 Strategic Plan Update

Dear Ms. Erickson;

The Alaska Nurses Association would like to thank you for this opportunity to comment on the Commission's 2012 draft findings and recommendations. In general we are in agreement with the report but would like to express some specific concerns.

It is not exactly clear where this concern belongs, but a concern of nurses who work with adolescents is what happens to young adults when they transition out of health care designed for children into the adult health care system. There are two components to this concern. One is transitioning young adults from pediatric providers to adult providers and the other relates to insurance coverage. What happens to children with chronic illnesses when they are no longer eligible for Medicaid or Denali Kidcare or are no longer eligible for their parent's insurance? Will their preexisting conditions prohibit them from being able to acquire insurance on their own? Some of this is addressed by federal legislation, however your report mentions that only 15% of Alaskans are members of private insurance market health plans regulated by the State of Alaska.

We want to thank the Commission for promoting the use of best available evidence in making decisions (pg 13). This not only applies to making decisions that are made about providing health care to individuals but also applies to making decisions about how health care is delivered. It is our experience that there are many schemes developed about using unlicensed personnel to replace registered nurses for cost cutting purposes without first testing whether these plans will provide safe patient care. When considering the quality of care provided and efficiency of care delivery, many times these plans are not as cost saving as first thought.

It has long been a goal of the nursing profession to focus on prevention as a way to keep the population healthy (pg. 13). As everyone knows, services designed to promote wellness aren't always reimbursed or well funded. In recent years there has been a drastic decrease in funding for public health nursing services which are largely designed to promote prevention of illness or injury.

Under the Health Workforce section (pg. 14) there is mention of increasing the supply of primary care physicians. In Alaska, Advanced Nurse Practitioners are involved in providing primary

care to many Alaskans. We think that there should be increased funding to educate these providers as well as MDs.

In regards to health information infrastructure (pg. 15), Registered Nurses are very involved in the use of electronic health records as well as telemedicine. As use of these tools increases there needs to a way to monitor problems that arise and make sure that all health care providers are properly trained to utilize these tools. There are many legal and ethical issues that are arising as the use of these tools increases.

In regards to licensure of out-of-state clinicians serving patients in Alaska (pg. 16), we have not heard of any registered nurses from outside of Alaska who have had difficulty being licensed in the state. We whole hardly agree with your statement on this page.

We want to commend the Commission for including a section on patient choice and quality end-of-life care. Registered nurses have for many years been leaders in developing and providing hospice and palliative care. One patient once commented that you can tell when your end is near because the doctor transfers your care to a nurse.

Since nurses have been leaders in developing and providing these types of services we have some difficulty labeling a statewide program POLST, or Physician Orders of Life-Sustaining Treatment. Since advance practice nurses are often involved in providing these orders we think it would be more appropriate to call these Health Care Provider Orders... Related to this at the bottom of page 19 you refer to terminally ill people who wish to not receive life-saving measures. If measures really are life saving we think patients would want them. A more appropriate term might be life prolonging.

The Alaska Nurses Association was very involved in getting the Alaska Five Wishes bill passed by the state legislature. We are very much in support of actively promoting the use of this and other tools by individuals who want to express their desires regarding end of life care. The Association has also supported legislation to establish a secure electronic registry where these documents may be stored and accessed by healthcare providers when needed.

On page 23 there is mention of evidence based medicine. We would like for you to use the term evidence based healthcare. There are many types of healthcare providers in the state and there has been research done in each profession that helps identify good practices.

In closing we want to inform the commission that nurses have long been concerned about the quality of care provided to the patients we serve. The American Nurses Association has developed a national database of nursing quality indicators, a magnet recognition program of hospitals who provide outstanding nursing care, and professional standards of nursing care.

We appreciate the work the Commission has done and hope that you involve registered nurses in your future discussions of these important healthcare issues.

Patricia Senner MS, RN, ANP



THE STATE
of ALASKA
GOVERNOR SEAN PARNELL

Department of Health & Social Services

GOVERNOR'S COUNCIL ON DISABILITIES
& SPECIAL EDUCATION
Millie Ryan, Executive Director

3601 C Street, Suite 740
Anchorage, Alaska 99503-5924
Main: 907.269.8990
Toll Free: 1.888.269.8990
Fax: 907.269.8995

November 30, 2012

Deborah Erickson, Executive Director
Alaska Health Care Commission
3601 C Street, Ste. 902
Anchorage, AK 99503-5923

To the Members of the Alaska Health Care Commission:

We are writing you to respond to the Alaska Health Care Commission's 2012 draft finding and recommendation statements currently available for public comment.

We are glad to see the Commission working to represent all stakeholders with the worthy goal of improving the health of all Alaskans through transformation of our existing health care system.

As a representative of two stakeholder groups—the State of Alaska's Health and Disability Program Committee and the Governor's Council on Disabilities and Special Education—we are very aware of the importance of good health care systems for Alaskans, particularly those experiencing disability.

It is well documented that children and adults with developmental disabilities experience poorer health and more difficulty finding and paying for health care, as compared to other populations. The extraordinarily high dispensing fees for Medicaid recipients in Alaska—one of your 2012 findings—dismays but does not surprise us.

Your recommendations for 2012, particularly those around telehealth technology, could have a substantial positive impact on the health and well-being of our constituents. We encourage you to seek substantial feedback from Alaskans with disabilities and their families when shaping these recommendations.

We also hope that you will ensure that Alaska's communities experiencing disability are involved in your discussions around proposed strategies for 2012. We saw no specific acknowledgement of the critical impact that quality health care has on Individuals experiencing disability, particularly in your strategies around enhancing consumers' roles in health and health care.

The Governor's Council on Disabilities and Special Education (GCDSE) considers health a central priority for its constituents, and would be happy to provide additional information on the special needs of Alaskans with developmental disabilities.

In addition, a recent grant from the Centers for Disease Control and Prevention (July 2012) has allowed us to expand this focus into the creation of the State's Health & Disability Program Committee. This program is housed within the Section of Women's, Children's, and Family Health, with support from the GCDSE and other Sections.

If we can provide any additional information on our program's activities or ways in which we might be able to further support the Commission's important work, I hope you'll be in touch.

Sincerely,



Millie Ryan
Executive Director
Governor's Council on Disabilities and Special Education

40

Erickson, Deborah L (HSS)

From: Jim Freeburg [Jim.Freeburg@nmss.org]
Sent: Friday, November 30, 2012 4:09 PM
To: Erickson, Deborah L (HSS)
Cc: Doug Toelle; Antonia Fowler
Subject: Comments on the 2012 draft report
Attachments: National MS Society Comments to the Health Care Commission.pdf

Hi Deborah,
Please find comments attached on the 2012 draft.

Thanks.

Jim Freeburg
Advocacy Director

National Multiple Sclerosis Society

Greater Northwest Chapter, Seattle Office
192 Nickerson St, Suite 100
Seattle, WA 98109

tel +1 206 284 4254 ext 40237
tel +1 800 344 4867 press 2 then ext 40237
fax +1 206 284 4972

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www.MSnorthwest.org



National
Multiple Sclerosis
Society

November 30, 2012

Dear Alaska Health Care Commission,

On behalf of the National Multiple Sclerosis Society, Greater Northwest Chapter and the Alaska MS Center, please accept these comments on your 2012 draft findings and recommendations. We represent over 1100 people living with multiple sclerosis (MS) in Alaska - a population with significant health care needs. While we represent a relatively small population, we believe our concerns are shared by other chronic disease populations who experience many of the same challenges and as such, deserve full consideration by the Commission. We are grateful for the efforts of the Commission to address the quality, accessibility, and availability of health care for all citizens and hope that these comments may contribute to that goal.

Improving access to health care for people living with MS in rural areas is a priority of the National MS Society. Individuals with MS in less urban areas report having less access to specialty care (i.e. neurologists), less satisfaction with their health care, and lower physical health related quality of life. As such, we are working hard to improve access to specialized MS care in rural areas, expand the number of MS health care practitioners, and increase the quality of MS health care services.

The Commission's recommendation to "use telehealth technology to facilitate access to and quality of care" is in direct alignment with our strategic initiative to increase access to MS care in rural areas. Telemedicine has been shown to be successful in managing symptoms of MS such as depression and falls and has been shown to increase physical activity and improve quality of life. Telemedicine has also shown great promise in reducing costs for patients with complex chronic conditions, making MS a health condition deserving of more consideration for telemedicine. Therefore, we would like to commend the work of the commission and offer support for the recommendations.

In addition, we encourage you to continue investigating reimbursement and licensing issues. With the increase of consolidations and affiliations within multi-state provider systems, we anticipate there being additional opportunities for health care providers outside of Alaska to serve people in Alaska via telemedicine. Individuals with less common conditions, such as MS, who need access to specialists, may significantly benefit from these arrangements, but it may be too early to determine if licensing laws are a barrier to telemedicine. We encourage you to continue to monitor this issue in the years ahead.

We also want to address the Commission's recommendations regarding the role of the employer in health care. As indicated in your report, pro-active management of a chronic condition like MS avoids more costly care later and allows employees to stay employed. However, "consumer-driven" health plans that place more risk on the individual have been shown to discourage individuals from seeking necessary care and put much needed treatments out of reach for many people with a chronic condition. Co-Insurance is a particularly harmful practice to people living with MS, especially when applied to pharmaceutical benefits. Employers who choose these options should be warned of their potential negative side effects on people living with chronic conditions and consider alternatives that don't harm employees with a chronic disease. Continued attention to these needs of employed individuals with chronic conditions is crucial to keeping down the costs of the state's safety net and deserves recognition within your findings.

Lastly, we appreciate the strategies under consideration for study in 2013. We encourage the practice of evidence-based medicine but have some concern over its application to uncommon

conditions such as MS where research is very limited. Off label use to treat symptoms of MS is a commonly accepted and successful practice within the treatment of MS and other chronic conditions. When studying recommendations regarding evidence-based medicine, the Commission should consider patient protections, like a standardized appeals process and respect for the patient-provider relationship. If the Commission chooses to study this area further, we would appreciate you taking into account a strong patient perspective and we would be happy to work with you in this regard to ensure it is represented in your findings.

Thank you for the opportunity to comment on your 2012 report. We look forward to working with you to improve the lives of people living with MS in Alaska.

Sincerely,

Doug Toelle
Alaska Leadership Board member
National MS Society, Greater Northwest Chapter
Advocacy Director, Access Alaska

Jim Freeburg
Advocacy Director
National MS Society, Greater Northwest Chapter

Antonia Fowler
Executive Director
Alaska MS Center

Erickson, Deborah L (HSS)

From: Maesha Champion-Read [alaskanmaesha@gmail.com]
Sent: Friday, November 30, 2012 4:30 PM
To: Erickson, Deborah L (HSS)
Subject: Health Care Commission's 2012 Recommendations

Hello, my name is Maesha and I am offering comment on the commission's health care recommendations. I have been a licensed clinical social worker in Anchorage for many years and in the field of human services since 1987. A service we are missing in the State of Alaska is services and treatment for people with brain injuries. Alaska has a high rate of Traumatic Brain Injury (TBI) and no facility to treat acute or chronic problems. Please consider the vital opportunity of address this problem. Many people with TBIs end up in API or sent out of state, far away from family and friends and the environment in which they will ultimately return. Desperately needed is acute and post-acute rehabilitation, long term care and housing option.

Thank you so much for allowing this opportunity to give input.

Sincerely, Maesha Champion-Read, LCSW,#376

Erickson, Deborah L (HSS)

From: Byron Perkins [bperkins@christianhealth.org]
Sent: Friday, November 30, 2012 5:05 PM
To: Alaska Health Care Commission; Erickson, Deborah L (HSS); Byperkins00@yahoo.com; Brenda Moore
Cc: Sutton, Robert; rflood@pnwu.edu; Robyn Madson; Isoriano@gci.net
Subject: RE: 2012 Draft Available for Public Comment
Attachments: Testimony-Alaska Health Care Commission 2012 Draft Finding.docx

Thank you for the opportunity to provide written testimony to the Alaska Health Care Commission's 2012 Draft Findings and Recommendations. The public testimony is included in the attached document. Dr. Perkins

From: Alaska Health Care Commission [mailto:AlaskaDHSS@public.govdelivery.com]
Sent: Tuesday, November 06, 2012 2:30 PM
To: Byron Perkins
Subject: 2012 Draft Available for Public Comment

Dear Alaska Health Care System Stakeholder:

The Alaska Health Care Commission's 2012 draft findings and recommendations are now available for public comment. Written comments will be accepted through **Friday, November 30**. You may access the draft on the Commission's web site at:

Xxxx

Thank you for your interest in improving health and health care in Alaska.

Sincerely,

*Deborah Erickson, Executive Director
Alaska Health Care Commission
3601 C Street, Ste. 902
Anchorage, AK 99503-5923
(907) 334-2474
(907) 269-0060 (fax)
deborah.erickson@alaska.gov
http://hss.state.ak.us/healthcommission*

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Alaska Health Care Commission 2012 Draft Finding & Recommendation Statements

Written Public Testimony, November 30, 2012

Byron Perkins, DO, Alaska Area Director, Pacific Northwest University of Health Sciences, College of Osteopathic Medicine, Yakima, WA

Thank you for the opportunity to respond and comment on the 2012 findings and recommendations of the Alaska Health Care Commission. Let me commend the Commission for the excellent work done to date. The progress from the initial report of the Alaska Physician Supply Task Force in 2006, through the establishment of the Commission and the results of their activity is measurable, and represents significant strides forward in the health care environment in Alaska.

I want to comment on the current 2012 draft findings, P. 13-14, (Part III: Alaska Health Care System Transformation Strategies B: Health Care System foundation; Health Workforce (2009), Alaska Health Workforce Plan(2010) and Action Agenda (2011)

Summary:

- **Make health workforce development a priority and support coordinated planning**
- **Strengthen the pipeline of future health care workers**
- **Increase the supply of primary care physicians**

The Alaska Osteopathic Medical Association (AKOMA) and the osteopathic medical community at large broadly support these goals, and have specific recommendations for consideration in the 2012 Draft. *The Hill's "Healthwatch"* blog reported on Nov. 20 that the United States will need about 52,000 new primary care doctors by 2025, during which time period the population is expected to increase by 15.2%, according to research published in the *Annals of Family Medicine*. The Osteopathic profession has historically produced disproportionately higher percentages of primary care physicians, who have traditionally chosen to serve in rural and often underserved communities. The data on Licensed Osteopathic physicians in Alaska support these findings. There are some communities in Alaska where medical care is delivered solely by the resident osteopathic physician in that community¹. Even in Urban communities, the ratio of Osteopathic Primary Care Physician to Specialist approximates 50%. The Osteopathic profession is uniquely situated and prepared to assist in the goal to increase the supply of primary care physicians in Alaska.

In the APSTF 2006 Report, Page 57, (Recommendations: Section VI, B. Goals and Strategy Recommendations. D: Assist Alaskan students to attend medical school by: i) reactivating and funding the use of the WICHE with a service obligation attached, and ii) evaluating the possibility of seats for Alaskans in the planned osteopathic school at the Pacific Northwest University of the Health Sciences) the task force recommended reactivating the WICHE program for funding Osteopathic Medical Education, and to explore a working relationship with the Pacific Northwest University of Health Sciences, College of Osteopathic Medicine to educate and train Alaska Students.

1. R. Andreassen, DO, Delta Junction; T. Huntington, DO Galena

Pacific Northwest University of Health Sciences educates and trains health care professionals with osteopathic values and conducts research to provide quality care to communities of the Pacific Northwest, particularly rural and underserved populations. It is my privilege to report that PNWU-COM graduated its first class in 2012, and there were 5 Alaska residents represented. The University has funded 2 Alaska Regional Deans, one in Fairbanks, and one in Anchorage, to coordinate 3rd & 4th year Clinical training experiences for Alaska students in Alaska. There are currently 23 Alaska residents matriculated at PNWU, and there are 12 students in clinical rotations in Alaska. I serve as the Alaska Area Director for PNWU, and we are prepared to discuss methods and opportunities to expand the role of the University in providing educational opportunities for additional Alaska Students.

In addition to the opportunity afforded by PNWU, Alaska students have traditionally opted to attend Osteopathic Medical Schools around the country. Many of those students express a desire to return to Alaska upon completion of their Post Graduate training. A cursory review of the Alaska State medical Association Directory shows Osteopathic Physicians representing a broad number of Osteopathic Medical Institutions, including but not limited to, Des Moines University, College of Osteopathic Medicine; AT Still University, College of Osteopathic Medicine; Midwestern University/Chicago College of Osteopathic Medicine; Philadelphia College of Osteopathic Medicine; Kansas City University of Medicine & Biosciences; New England University College of Osteopathic Medicine; Western University College of Osteopathic Medicine of the Pacific; NOVA Southeastern College of Osteopathic Medicine; Touro University College of Osteopathic Medicine; University of North Texas, College of Osteopathic Medicine. Western University recently opened a satellite campus in Lebanon, OR, and their first class of 100 was enrolled in August 2011. AT Still University has branch campus's for 10 students each in Portland, OR and Seattle, WA. The expansion of Osteopathic Universities in the Northwest in the past decade represents significant increase in the opportunity for Alaska students to obtain a quality medical education, in an environment that fosters primary care and service in rural communities. With the development of additional Post-Graduate Residency Training sites in the Pacific Northwest and Alaska, the likelihood of physicians training in the Northwest and returning to their home state is greatly enhanced. We support the development of additional Residency training programs in the State.

The expansion of the WWAMI program to 20 class size has already produced results. Without a doubt, the economic advantage and attendant prestige of attending WWAMI is a significant incentive for Alaska students. It is the Alaska Medical School. While we support the draft recommendations to increase the class size in WWAMI (pg 14) as resources allow, we request further consideration of developing additional medical training options in Osteopathic medical schools. Furthermore, wherever efforts are made to expand training opportunities for WWAMI and allopathic students, similar consideration should be afforded osteopathic medical students as well. The Alaska Family Practice Residency is a dually accredited program for MD's & DO's, where physicians train side by side in an integrated learning system. The opportunity for allopathic and osteopathic medical students to train similarly in their clinical rotations will afford a broader experience with cross pollination of both.

One of the significant barriers to Osteopathic medical education is the significant costs of a private education. Despite the increased costs, many Alaska students selectively choose to pursue an osteopathic medical education, because they want to be osteopathic physicians. The WICHE program already exists, but is not currently open to osteopathic medical students. Efforts to expand financial assistance to Alaska students, whether by scholarship, loan assistance, loan repayment, tuition assistance via WICHE, or a totally new approach contracting directly with osteopathic medical schools to assist Alaska students are strongly encouraged and supported.

From the FY 2013 Budget overview for Dept. of Health and Social Services, the target to increase the ratio of active licensed healthcare providers in Alaska in proportion to the population growth has not been met. The ratio of active physicians to Alaska residents decreased slightly, with 1 physician per 424 residents as of July 1, 2011, as compared to 1 per 405 residents during 2010. There are currently many Alaska students in the medical education pipeline attending Osteopathic medical schools, and completing Post-graduate residency programs around the country. Recruitment activities directed at this cohort of students can have an immediate near term impact on addressing the current physician shortage in the state. We believe that Osteopathic physicians are well qualified and suited to serve the needs of our diverse state. Osteopathic physicians are serving with distinction in many communities around our state, and the evidence speaks for itself. We stand prepared to fill the gaps wherever they are found, and to do our part in addressing the health care needs of our great state.

Thank you for the opportunity to present this testimony on behalf of Pacific Northwest University of Health Sciences, College of Osteopathic Medicine, and the Alaska Osteopathic Medical Association

Byron Perkins, DO, Medical Director
Cornerstone Clinic: Medical & Counseling Center
Alaska Area Director, Pacific Northwest University of Health Sciences, College of Osteopathic Medicine

Erickson, Deborah L (HSS)

From: Randi Sweet [rsweet@ak.org]
Sent: Friday, November 30, 2012 6:09 PM
To: Erickson, Deborah L (HSS)
Subject: AK Health Care Commission 2012 Findings & Recommendations Public Comment DRAFT

Deb - please find below some ideas regarding the AK Health Care Commission 2012 Findings & Recommendations Public Comment DRAFT

2012 Report

- **Consider Including current information on**
 1. *Alaska's life expectancy in years and national ranking*
 2. *Alaska's percentage of population with access to primary care and national ranking*
 3. *Alaska's per capita health care spending level and national ranking*

- **Consider including a scorecard to show elements of the Alaska health care system and associated costs to show trends from year to year.** The scorecard may also provide a systems view of the impact of implementing new models of care, i.e., Patient Centered Medical Home and Health Information Exchange. Primary Care utilization and cost may go up, but specialty and hospital care utilization and cost may go down.

2013 AK Health Care Commission Activities

DESIGN POLICIES TO ENHANCE THE CONSUMER'S ROLE IN HEALTH AND HEALTH CARE – B) SUPPORT HEALTHY LIFESTYLES

- **Consider studying the community's role in community members' health and health care - possible elements**
 - o Community needs assessments, health improvement plans and action teams
 - o Under the Affordable Care Act, nonprofit hospitals provide money to communities to support health improvement efforts, what is their perspective on how this is working?
 - o This might also be an opportunity for the AK Health Care Commission to go to communities working on these projects and hold meetings to get public comment.

On page 13, the report includes

Focus on prevention

Create the conditions that support and engage Alaskans to exercise personal responsibility for living healthy lifestyles. High priorities include reducing obesity rates, increasing immunization rates, and improving behavioral health status.

- **Consider studying evidence based practices on how to engage individuals in their health and wellness.**
 - o Identify ways in which to engage Alaskans in the health and economic impact of healthylifestyles.
 - o Identify/recommend policies to support this engagement.
 - o Evaluate a permanent fund dividend for health and wellness.

Best regards,

Randi

Randi Sweet, MBA
Director, Community Action
United Way of Anchorage
701 West 8th Avenue, Sulte 230
Anchorage, AK 99501



THE STATE
of **ALASKA**

GOVERNOR SPAN PARNELL

Department of
Health and Social Services

ALASKA COMMISSION ON AGING

P.O. Box 110693
Juneau, Alaska 99811-0693
Main: 907.465.3250
Fax: 907.465.1398

November 30, 2012

Deborah Erickson, Executive Director
Alaska Health Care Commission
3601 C Street, Suite 902
Anchorage, AK 99503-S293

Dear Ms. Erickson:

The Alaska Commission on Aging (ACoA) is pleased to provide public comment on the Transforming Health Care in Alaska 2012 draft report of findings and recommendations prepared by the Alaska Health Care Commission (AHCC). We support the intent of AHCC's proposed recommendations to promote the health and well-being of Alaskans through a focus on utilizing telehealth technology to facilitate access to quality care, improving patient choice and end-of-life care, and promoting the employer's role in health and health care. We appreciate the dedication and commitment by the AHCC to improve Alaska's health care system through a focus on prevention, affordable health care, and increased access to primary care. These goals are of critical importance to older Alaskans in their efforts to remain healthy and productively engaged with their families and communities.

The ACoA, a governor-appointed commission under the Alaska Department of Health and Social Services, serves to ensure the dignity and independence of all older Alaskans by addressing their needs through planning services, educating Alaskans about senior issues and concerns, and advocating for the needs of all Alaskan seniors through interagency cooperation. ACoA believes all older Alaskans should have the opportunity to meaningfully participate in communities that value their contributions and to have access to services which maintain their health and independence so that they may enjoy a high quality of life and live safely at home.

Alaska continues to be the state with the fastest growing older adult population (persons age 65 years and older) in the nation. This demographic transition will continue with the aging of baby boomers (persons born between 1946 and 1964) and the marked increase in the number of older people living to advanced ages (persons age 85 and older). As a result, Alaska's senior population will require strengthening of primary health care services, behavioral health care services designed to meet the needs of older adults, and additional long-term support services across the continuum of care in rural and urban communities. These services will require increased infrastructure and workforce to support them.

Access to primary health care for seniors insured by Medicare was identified as a top concern by Alaskan seniors who responded to ACoA's senior surveys in 2011 and 2005. Alaska's growing senior population



will require improved access to primary care (particularly for seniors who live in the Railbelt and Anchorage where low Medicare reimbursement payments are often not accepted by doctors) and an increase in health care professionals (due to growing vacancy rates by retiring providers and increased demand from a growing senior population). ACoA believes that we should continue efforts to build Alaska's health care workforce for primary care, geriatric medicine, and behavioral health care to meet the rising demand for these services.

The ACoA appreciates and supports AHCC's recommendations to improve collaboration between the Alaska Federal Health Care Partnership with public and private insurance programs to increase access to telehealth technologies for all Alaskans. Telehealth offers opportunities to improve access to primary care, behavioral health care, and support for self-management of chronic diseases that can reduce use of high-cost health care and improve wellness for seniors and Alaskans of all ages. In addition, use of telehealth technologies may improve safety and provide better protection for seniors with Alzheimer's disease and related dementia from accidents occurring in the home, falls, and for those who wander unattended from life-threatening consequences.

The ACoA is very concerned about the negative impact of behavioral health issues on the well-being of older adults and that behavioral health issues were not adequately addressed in the AHCC recommendations. Depression, alcohol and substance misuse are not a normal part of aging, yet these conditions greatly impact the lives of many older Alaskans. Barriers to behavioral health treatment exist and include under-diagnosis, social stigma and the presence of other health conditions. These conditions are common, costly and detrimental to the overall health of seniors. They often co-occur with other chronic diseases, such as diabetes, and can be implicated in injuries related to falls and accidents. Strategies to further integrate behavioral health into primary care are critically needed to improve health and wellness across the life span. ACoA recommends that AHCC's final recommendations include a focus on the importance of behavioral health to overall health to promote health care transformation efforts in Alaska.

The Patient-Centered Medical Home (PCMH) is an evidence-based model to provide person-centered medical and behavioral health care to address total health care needs. While medical home practices would receive additional reimbursement for providing these services to high-need Medicare and Medicaid beneficiaries, it is expected that patients would receive a higher level of care with greater improvements in preventative care and reduced risk of complications. Given the relatively low Medicare reimbursement rates for primary care providers, higher reimbursement rates for PCMH providers could help to increase the number of primary care physicians willing to accept Medicare patients. Moreover, seniors in need of behavioral health care who do not seek services through a community mental health provider, would benefit from screening and treatment offered in the primary care setting where they visit their doctor on a regular basis. We recommend that the AHCC final recommendations include greater emphasis on strategies to implement the PCMH model.

ACoA supports AHCC's recommendations to improve patient choice and end-of-life care. Older people of advanced age require an array of palliative and end-of-life care services including intensive health care, personal care, chore service, caregiver support, skilled nursing care, and hospice care. Elderly people living in rural Alaska want to spend their remaining days in their own homes and communities surrounded by family and friends, not in an urban-based facility where the people, food, and language are unfamiliar. ACoA supports AHCC's recommendation to investigate evolving the State's Comfort One program to a POLST/MOST (Physician Orders for Life-Sustaining Treatment/Medical Orders for Scope of Treatment) program to provide persons diagnosed with a serious illness or injury an opportunity to

communicate their wishes for treatment and care. The ACoA also supports the AHCC's recommendation to establish a secure electronic registry for advanced health care directives to protect Alaskans' end of life health care preferences and allow authorized providers immediate access to this information.

Under the discussion of employer's role in health and health care, the ACoA recommends that the State be a leader in preparing its own employees for a successful retirement. As part of retirement counseling, soon-to-be retired Alaska State employees should be advised on Medicare enrollment, strategies for healthy aging, and other information to help retirees achieve a successful retirement. We also recommend that the State track primary care access for seniors insured by Medicare to determine the extent of this problem statewide.

Lastly, we want to take this opportunity to encourage your consideration of Alzheimer's disease and related dementia (ADRD) as an emerging public health problem that affects thousands of older Alaskans and their families. Due largely to the aging of the State's population, the estimated number of Alaskans (age 65 and older) with ADRD is projected to nearly triple by 2030 (more than 6,000 currently to more than 17,000) in addition to younger persons with early onset Alzheimer's disease. While deaths from heart disease, cancer, diabetes and other diseases are declining in Alaska, the number of deaths from Alzheimer's disease is on the rise. Mortality rates related to Alzheimer's disease increased 23% from 2000 to 2010. Associated health care costs continue to climb.

This year, ACoA conducted a series of community forums around the State to gather input from family caregivers, providers and public members about the needs of persons with ADRD and their caregivers. We are in the process of conducting an ADRD family caregiver survey to gather information about the nature of caregiver relationships, amount and types of caregiving provided, special needs of caregivers, and service gaps. In 2013, Alaska's Behavioral Risk Factor Surveillance Survey (BRFSS) will include a module on cognitive impairment to collect information on the prevalence and impact of Alzheimer's disease in Alaska. Findings from the forums and surveys will be used to develop policy recommendations for Alaska's State Plan for Persons with ADRD to promote awareness, improve services, and reduce the burden on Alaska's budget and caregivers related to ADRD. This plan will be developed by a steering committee comprised of state agencies and other stakeholders. We invite the AHCC to be part of this important planning effort by identifying a representative to serve on the steering committee.

The ACoA thanks you for this opportunity to provide comment on the AHCC draft report. We commend the AHCC on your good work to improve Alaska's health care system and look forward to our continued collaboration.

Sincerely,

Denise Daniello, Executive Director
Alaska Commission on Aging

Cc: Paula Pawlowski, ACoA Chair
Kate Burkhart, Executive Director, Alaska Mental Health Board and Advisory Board on Alcoholism & Drug Abuse

Erickson, Deborah L (HSS)

From: Mira Mullen [miram@searhc.org]
Sent: Thursday, November 29, 2012 3:11 PM
To: Erickson, Deborah L (HSS)
Subject: Alaska Health Care Commission 2012 Draft for Public Comment

RE: Alaska Health Care Commission 2012 Draft for Public Comment

With regards to the 'draft' upon review, I am a Licensed Professional Counselor (LPC) in the State of Alaska serving clientele in the Integrated Medical and Behavioral Health medical clinic setting, and formerly practicing in the States of New Mexico and Arizona, respectively; I have spent several years in hospital work in Nome, and now several years or so in Juneau in outpatient medical care settings. My specializations are in holistic health, wellness, cross cultural populations, disabilities, head injury, and trauma. I have approximately 20 years in my profession and I had the following concerns:

1. **Strength of Current Draft:** very well written; succinct and knowledgeable; accessible to the general public at large upon review and in content. High quality in simplicity of outlook and clarity of written thematic material. Length is quite nice, not too long, not too short, an easy read. Much thought has been given to the content and development of the draft.
2. **Potential for Improvement of Text/ Theoretic Philosophy of the Draft currently:**
 - a. **Development of Wellness/ Holistic Health Components:** There appears to be an absence of a 'middle ground', i.e. the clients/ patients we serve need to have ways to recognize and engage in that ground which instructs them to gain self-care skills, inherent to both wellness and to holistic health. **Articulation of this key value** is important, as is a mindful approach to developing goals and objectives in this area in the peoples and populations of Alaska that we serve. With more ownership, there is more accountability and trending towards lessening of overall health problems developing.
 - b. **Cost Effectiveness of Integrative Medical Model:** Likewise, with more ownership by the clientele in the system in holistic areas, such as incentives/ rewards for engagement in wellness education, healthy nutrition, exercise, utilization of less intrusive modalities (i.e. chiropractic, naturopathic, Traditional Chinese Medicine, massage, etc.). Incentives of this sort are already in some health insurance plans in terms of discounts for preventative checks, and participation in exercise or nutrition counseling. It is quite possible to cut costs by roughly 1/2 via the utilization of a more Integrative Medicine model). Reference: www.bravewell.org (a consortium of 52 medical schools, the United States Military, and corporations researching cost effectiveness of Integrative Medicine).
3. **Awareness of a Need for Increased Awareness of Persons with Disabilities/ Switching the Paradigm to Persons to posit these individual as 'Differently-Abled', Valid Contributors to the Society and Community:**
 - a. **Articulation:** Again, an increase in awareness reflected in the way the draft is articulated is acutely important in the evolving medical/ health care model and culture of acceptance of persons that are differently-able in the State of Alaska.
 - b. **An Example/ Traumatic Brain Injury (TBI):** We have one of the highest rates of Traumatic Brain Injury in the nation, and since the year 2000 approximately 220,000 soldiers have returned to the United States with traumatic brain injuries. Incorporating persons with different needs/ abilities, and consciously promoting a philosophy of acceptance and integration into the community is an imperative. This necessitates articulating, researching, and planning goals and objectives, short and long term to ensure this happens. Ultimately it is a vast cost savings medically and in social services, as it improves the level of functioning of these individuals, and lightens the drain on social service agencies.

Thank you for the excellent job your team did in creating the draft. It is exciting to see this high quality draft emerge and to have an opportunity to contribute to the review with comments as a professional with several decades of experience

In the health care field. Please keep up the good work. Your endeavor is incredibly valuable to the development of an efficient and evolving health care system in Alaska.

Mira Mullen, MA, LPC – NCC
Juneau, Alaska

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