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ALASKA HEALTH CARE COMMISSION
DENA'INA CIVIC AND CONVENTION CENTER
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1 of care and appropriate use of resources in providing care of
2 the resources that are scarce and getting scarcer.

3 What -- to get some more sense what evidence-based
4 medicine is and what it isn't and what we're talking about,
5 the term evidence-based is becoming an increasingly popular
6 term, and I think we all recognize that, and people talk about
7 an evidence-based program. We talk about evidence-based
8 public health programs, evidence-based programs in whatever
9 you're talking about, and I think, at this point, I would say
10 that, just as we heard yesterday, it's somewhat dismaying and
11 fairly startling the small proportion of articles in the peer-
12 reviewed medical literature that are really reliable in terms
13 of all of the concepts and the steps that Sheri and Mike went
14 through for us yesterday.

15 When we hear the term "evidence-based," I think we need
16 to recognize that, sometimes, that means I found an article
17 that agrees with what my bias was, and therefore, what we're
18 doing is evidence-based. And so I think that it imposes an
19 understanding more, and it imposes that the discipline really
20 demands more than that. Sometimes, it leads you to where you
21 don't think you're going to go.

22 And all of you have heard my confessions many times in
23 the past of some of the witchcraft things that I did as a
24 physician, thinking it was the right thing to do, but clearly,
25 it was not solid and was not evidence-based, and it is a

1 developing discipline.

2 You know, you think of aspirin, in so many ways, as a
3 miracle drug, as an analgesic, which means a pain reliever, an
4 antipyretic, which means it helps reduce fever, an anti-
5 inflammatory, it helps with inflammation, and now anti-
6 whatever, probably some reasonable evidence that it may reduce
7 the instances of colorectal cancers for patients that take it,
8 and is achieved on that, but it was discovered in about 1830.
9 And in 1830, there was no real discipline of evidence-based
10 analysis and even much later than that, and yet, we see it --
11 we use it a lot.

12 And so it's an evolving field, but I think that what will
13 be important for the Commission members and the other really
14 gratifyingly large group of folks who were here yesterday
15 representing clinical care, medical care in Alaska, and both
16 clinicians and non-clinicians, to not be intimidated by the
17 term "evidence-based," to recognize what it means and what it
18 doesn't mean and to have a better sense of that, and then
19 those who do have both administrative responsibilities related
20 to healthcare and programmatic or clinical responsibilities to
21 understand what the term has to offer in terms of, with the
22 scarce resources we have, how do you design your benefits, how
23 do you assure, to the extent to can, that what you pay for
24 really makes a difference so that you can go as far as you can
25 because we know there will always be unlimited needs and

1 opportunities there? And then in the clinical setting, how do
2 you foster the environment where the patient becomes involved
3 and the decisions are made that meet the patient's needs and
4 desires in an educated way?

5 So I think that Mike and Sheri did just an absolutely
6 awesome job yesterday of bringing us along to that point, and
7 they're here today. I'll turn it over to them -- if you have
8 had some thoughts over dinner last night or something that
9 came up that you want to mention -- and then we'll open it up
10 for the Commission members to have questions or comments, and
11 basically, have the first hour for that. So Mike and Sheri?

12 MR. STUART: I think, for those who weren't here
13 yesterday, the elevator short version would be that evidence-
14 based medicine is a buzz phrase, and you have to look under
15 the hood to really know what the evidence says, and you have
16 to know how to do that.

17 So if we start at the most important customer of all, the
18 patient, and work back, what we said yesterday was that
19 patients really have a set of needs, and it starts with
20 knowing what they have, why they have it, and what can be done
21 about it, but what happens, in reality, is that there is this
22 black box, and physicians and other healthcare professionals
23 are trained in their respective schools, and there is some
24 sort of belief that we all have that, because you have a badge
25 on, you know what's best for patients. This is -- I'm

1 exaggerating. I'm making this short, but it's just sort of a
2 paradigm where, if something might help somebody, the American
3 spirit is do it. Whereas, the evidence-based approach says,
4 let's be very -- let's do due diligence with the evidence
5 first and find out what the options are, what the evidence
6 says about the benefits and risks of each option, and not only
7 that, try to give patients a quantitative estimate of the
8 likelihood of achieving the outcomes that they want and then
9 allow them to make decisions based on information, so that
10 they are truly informed before they make the decision instead
11 of find out afterwards that maybe a thing or two or three or
12 four or five that they didn't know about, and they would have
13 made a different choice. And this has been established in the
14 literature repeatedly where Cochrane has done a number of
15 studies where they have found that patients make choices that
16 are frequently unexpected when they do get the information.

17 So the big question is, how do you get the information
18 rounded up and packaged for various customers? The patient
19 being number one, physicians and other healthcare
20 professionals number two. Decision-makers in healthcare in
21 all walks of life is the third category and that can be broken
22 down into many, many target groups. So the idea is the many,
23 many things that are not going to have good evidence. That
24 doesn't mean they don't work. It doesn't mean that you
25 shouldn't do them. It doesn't mean you shouldn't use other

1 considerations. It just means that you need to know the
2 details about what the evidence says about efficacy and safety
3 and this quantitative estimate of how much benefit, how much
4 risk is involved.

5 So what we do in evidence-based medicine is we pose
6 questions to the evidence or to the literatures, the way we
7 usually say it, and we try answer those questions, and it's
8 very important to get the question right. Then it's very
9 important to be able to search correctly. We didn't cover the
10 searching. It's a very big area, but somebody in every
11 healthcare group should be competent in doing search,
12 searching of the medical literature. And then once they've
13 done that, they need to critically appraise it and get rid of
14 the evidence that doesn't work or is irrelevant or is so
15 flawed that it can't be trusted. And then you package the
16 rest of it back up, and you can do that in many ways. It can
17 be a summary. It can be a messaging script. It can be a
18 systematic review. It can be many, many different things. It
19 could be a monograph. But the idea is that we need to have a
20 formal approach to how -- for us to be able to get the
21 evidence, package it, and deliver it.

22 So I think the details -- God is in the details. And you
23 have to be able to do this in a way that is both efficient and
24 that helps people. And so there are a lot of steps involved,
25 but it's not that hard. It's just that, when it's new, it

1 seems a little confusing sometimes to people, and it can be
2 organized into various approaches. And we have one approach,
3 and others have approaches that are slightly different, but in
4 fact, the principles remain the same.

5 So I think -- Sheri, do you want to add anything? That's
6 just a high level sort of outline of what we talked about
7 yesterday for a full day.

8 MS. STRITE: I do, but I want to talk about something a
9 little bit different. I want to address something Ward was
10 saying about evidence-based medicine evolving.

11 So we're always learning different things about science
12 and different approaches, and one of the case studies that we
13 gave you yesterday was the hormone replacement therapy story
14 where, in 1998, we were training people in evaluating well-
15 done observations. And then when the RCTs came about, we
16 said, oh, we were wrong.

17 So there is an evolving quality of understanding really
18 how to best approach science and what that means for clinical
19 care. And again, I'm speaking of therapeutic interventions
20 most directly. Although, screening preventions and diagnostic
21 interventions are part of this, too.

22 But as a sometimes cross country skier, I've always been
23 really happy when someone has been ahead of me making those
24 trails. And so Mike and I have the advantage of following in
25 the steps of a lot of the wonderful people that Ward had named

1 yesterday. That puts us a bit in a position of being able to
2 look at some of the legacy precepts, I guess I'd say, of
3 evidence-based medicine in a new and different way sometimes.
4 So sometimes, Mike and I are maybe -- I don't want to say
5 exactly iconoclastic, but we, sometimes, are able to look at
6 approaches in a fresh way.

7 So there are a couple things that I just want to mention
8 because what I really want to focus on is having realistic
9 expectations about what it means to do an evidence-based
10 approach.

11 One of the definitions that you will see, if you look up
12 evidence-based medicine, the most frequent one is from David
13 Sackett, who is a tremendous leader in this area, and if I --
14 I think it's Sackett's, but if not, it's someone close to that
15 time period where they talk about using the best available
16 evidence. And so you'll see that a lot and that's a term,
17 actually, that Mike and I have backed away from because
18 implicit in that is that, if you have no good evidence, no
19 reliable evidence, but you have some flawed science, that that
20 becomes your best available evidence, and we don't agree with
21 that. We think that, if you've got unreliable evidence,
22 you've got unreliable evidence. And from our perspective --
23 again just our perspective -- we always say to clinicians,
24 your judgment and experience may easily be more reliable than
25 what we saw the Professor John Ioannidis, you know, identify

1 as well-done observational studies as being only 20%
2 predictable, necessarily.

3 So our perspective is that you go out and you use an
4 evidence-based approach to find out if there is good evidence
5 out there and then utilize it. And then sometimes -- you
6 know, I mentioned yesterday, sometimes, there are going to be
7 situations where not only do we not have reliable evidence,
8 but the topic is such that we're never going to have it. And
9 so to practice medicine, people just need to do the best they
10 can and be very clear with the patients about the fact that we
11 don't have good evidence -- here are some options; here is
12 maybe what I might try -- and discuss that with the patient.

13 One of the other things, too, that I want to mention is
14 that, sometimes, people confuse having good evidence versus --
15 or not having good evidence with taking an evidence-based
16 approach. And so I want to clarify that, if one is going
17 through evidence-based steps and hasn't found reliable and
18 clinically useful knowledge, they've still done an evidence-
19 based approach, even if decisions aren't being made on
20 evidence because there is nothing there. So I hope that's --
21 you can answer that or clean that up if you want, but that's
22 what I wanted to kind help the realism around expectations
23 around it.

24 MR. STUART: No. I just wanted you to talk a little bit
25 about transparency because you were walking around it. I

1 thought you better go right to it.

2 MS. STRITE: Yes. There are several really important
3 tenets of an evidence-based practice, and I think transparency
4 is hugely key. I will use an example of clinical practice
5 guidelines where, if you're trying to develop a guideline to,
6 you know, cover, let's say, prevention and treatment of a
7 particular condition, it may be the case that you've got --
8 and I'll throw in screening, too -- really good information
9 about treatment, but not good information about screening.
10 And so in order to provide guidance, what's important is to
11 label the strength of the evidence or label whether it is, for
12 example, clinical judgment in lieu of having any good
13 evidence. And then that way, if guidelines are created that
14 way, groups are able to look at that, to use that information
15 and say, okay, this was clinical expertise. I can substitute
16 mine for that because my judgment in my situation may be
17 different and just as good. Here, we've got solid evidence
18 for this. So the transparency in the process, the
19 transparency in the documentation and in the information that
20 gets put out to providers and patients is extremely important.

21 MR. STUART: Maybe I'll just give a couple of examples.
22 We continue to be surprised by what evidence tells us, and we
23 could make a very long list, but a couple of examples.
24 Episiotomy, why did we start doing that? Well, because it
25 made sense. You have a larger birth opening, so labor and

1 delivery should be easier, but in fact, in most cases -- there
2 are exceptions, but in most cases, episiotomies are not
3 necessary. Many people in this room have dealt with Swan-Ganz
4 catheters. Why do use them? Because it made perfect sense to
5 know the pressure in the intravascular system going into the
6 heart. We know that there are complications from that, and
7 clinical outcomes are, in most cases, not improved. I could
8 on and on with the surprises that we get when things are
9 studied.

10 Yesterday, we talked about two drugs that, basically, I
11 used and my colleagues used, and we killed one of 20 people.
12 We thought we were helping them, and then they hit premature
13 ventricular VCEP or heart attack. We've had surgeries for
14 blebs in people with emphysema that did not help them, caused
15 them lots of pain and discomfort. We've had many examples of
16 drugs that get approved that, in fact, have more harms than
17 benefits in women with, for example, advanced breast cancer.
18 And I don't want to go on and on, but the point being that,
19 with thinking hard, you might come up with one answer, and
20 when you actually do good studies to actually study it through
21 a scientific method, you find that what seems to make sense is
22 wrong. So it's a step that really cannot be skipped. It's
23 almost like a moral imperative, in our opinion, to actually
24 see what the science says about an intervention. And again,
25 we're -- yesterday, we limited it to therapies, but it's the

1 same story for all types of interventions, whether diagnostic,
2 as Sheri said, or therapeutic or other.

3 MS. STRITE: And I'll just add one thing because we
4 harped on it yesterday, but I'll harp on it again. When Mike
5 talks about studying it, he talks about having valid and
6 clinically useful information. And so part of, to us, the
7 moral imperative is having people having skills to understand,
8 at least in a basic way, what that means and then to be very,
9 very aware that bias tends to favor the intervention. And so
10 it's very easy to be misled in thinking that something is
11 useful when it isn't and have the margin of benefit be less
12 than it is, or in fact, not helpful and potentially harmful.

13 CHAIR HURLBURT: So let's -- why don't we turn to the
14 Commission members now for questions and comments and
15 interaction in the context of our role as the Commission in
16 advising the Legislature, advising the Governor, and in the
17 context of (indiscernible - background noise) suggested,
18 making recommendations, taking the lead in developing a health
19 plan? Bob?

20 COMMISSIONER URATA: So I was wondering how you would
21 suggest or from your experience and what you have seen in the
22 states that you've worked with, how, you know, our state could
23 apply this to our operations in our health department and
24 private sector healthcare? Some of the things that I've --
25 you know, that are probably already existing are, you know,

1 recommendations for preventative healthcare, like pap smears,
2 mammogram, PSAs. You know, a lot of that comes from the U.S.
3 Preventive Task Force. And I think we're already involved,
4 when using evidence-based medicine, in our pharmaceutical --
5 you know, Medicaid pharmacy list of meds that we'll cover.
6 And -- but can you think of other things or have you seen
7 other areas, broad areas that we could suggest to the
8 Legislature of applying evidence-based medicine? You know,
9 we're assuming that, you know, we recommend it for all the
10 doctors, you know, at the ground level, but what would we, as
11 a Commission -- what other areas could we recommend?

12 MR. STUART: Well, that could be answered in several
13 ways, but we didn't mention this yesterday, but (indiscernible
14 - voice lowered) that's helpful to everybody in healthcare is
15 that there are these five A's. There has to be the competency
16 in the five A's of evidence-based medicine. You have to be
17 able to ask questions appropriately, acquire potentially
18 useful and relevant information, assess it, meaning critically
19 appraise it, and then you apply it in the various agencies or
20 organizations. You need to support the knowledge that's
21 needed to do the five A's. The last A is again, which is
22 updating. So even though you've done it, things change, as
23 Ward said, and you need to update the evidence by having
24 competencies in the five A's. And so it starts with having
25 those competencies.

1 And then it becomes, really, a local situation where
2 there are issues that come up that get addressed through doing
3 the five A's and that can be anything. It can be questions
4 about new technology, new drugs, new surgical procedures, new
5 diagnostic technologies, therapeutic interventions, of course,
6 and anything that touches healthcare. If there is literature
7 on it, somebody should actually take a peek at that before any
8 discussion or planning takes place. So it's a basic
9 requirement as a step one to ask the question and answer it
10 through an evidence-based process, which then gets -- it's
11 very learnable.

12 And yesterday, we showed how -- the group did a critical
13 appraisal and did very well, I might add, and then summarized
14 that in some way. Now, it doesn't have to be done in the same
15 way by every person. It just has to have the principles and
16 the concepts and the transparency there, so I can actually
17 look at what somebody came up and say, well, I'm not sure
18 you've got that right because you missed this, and I'd like to
19 look at your search terms. And this, for example, you know,
20 you need to have somebody who -- many times, it's a medical
21 librarian, but many times, it's a nurse or a physician or a
22 pharmacist who has the skills to search and then the other
23 people to do the rest of the critical appraisal and somebody
24 to do the packaging.

25 So the advice is to get the principles, concepts, methods

1 into a survivable place so that it's institutionalized and can
2 evolve as the EBM knowledge evolves, but as I said yesterday,
3 we've seen organizations that have really devoted people, and
4 they do a really good job. Those people leave; it goes away.
5 New people come in, and it might be five or six years later
6 that they reinvent the wheel. So it's got to be, somehow,
7 made semi-permanent. It doesn't mean it can't be altered and
8 updated. It's just got to be in a way so people can go read
9 what it means to be a P&T Committee member and the
10 responsibilities and the knowledge that they need to acquire,
11 and ideally -- although in most places, this doesn't exist --
12 they would have a little handbook that they could read, and
13 there are ways to get around the fact that there isn't, quote,
14 the source, but there are many places where you can put this
15 together, and you can put together your own little manual of
16 how to do the work for whatever agency you're talking about
17 with the help of the people in that agency, and it becomes a
18 team sport to develop what's already known into a useable set
19 of tools for whoever is going to be using them. Anything else
20 about advice, Sheri, to the Commission?

21 MS. STRITE: Perhaps later.

22 COMMISSIONER HARRELL: So following up on Dr. Urata's
23 comment, the DOD/VA is particularly rapid in trying to adopt
24 things. And so what I've seen is the VA, in particular, get
25 on guidelines, and started writing guidelines in the late

1 '90s, mid-'90s/late '90s and rolling those out in what is a
2 fairly large healthcare system to an advantage, but to a
3 disadvantage, too, because, based on how the guidelines were
4 written, you may be still promulgating junk.

5 But from a policy perspective, I think one of the things
6 that could be considered is an establishment out of this body,
7 a recommendation, again, of the top three to five sort of
8 places where you want to focus, so it's easy for the State to
9 define what preventative health issues they want to get after,
10 what primary and secondary issues are costing the State a lot
11 of a money in healthcare.

12 And as an informational perspective, demonstrate to the
13 medical community what the best evidence is, either by a
14 guideline or by consensus, on a particular issue. We've gone
15 back and forth on PSAs. We've gone back and forth on hormone
16 replacement therapy. What do we have that's really provable
17 that we feel good about? And highlight that to the medical
18 community, based on what the greatest expenditures are and the
19 greatest return is. And so that's something that, within the
20 DOD and VA, we're moving towards.

21 And another idea out there that would be down the road,
22 because we're all -- different entities through the state are
23 developing electronic health records, but one of the benefits
24 of being the DOD in a semi-closed system and a hierarchical
25 system is being able to push things down.

1 And so one of the things that's happening at the moment
2 is that we are creating messaging to our primary care
3 providers. So we're linking your diagnoses that are in your
4 coding in the electronic record to an actual patient. And so
5 as I, a provider, come into to see this patient, the record is
6 scanned, and if it's a diabetic and doesn't have a hemoglobin
7 Alc, the provider gets a message that says, hey, this patient
8 is diabetic, and there is no hemoglobin Alc in the appropriate
9 time, and the literature suggests that you should be doing "X"
10 as a reminder to a provider.

11 And then lastly even further than that, genetic-related
12 information is being pushed so that we understand you've got a
13 family history of the following. It would be in your best
14 interest, based on the current available information, to have
15 genetic testing for and discuss that with a patient,
16 particularly related to (indiscernible - voice lowered)
17 anticoagulants.

18 So just some ideas in terms of trying to couch a policy.
19 As I was sitting next to the Senator yesterday, he was
20 thinking, well, hey, this is really going to help me to ask
21 the right questions when we're considering bills. One of the
22 things that we can consider doing again is a finite list of
23 things that we know we need to get after because of healthcare
24 costs or because of excessive mortality/morbidity and just
25 work on educating in those small areas to get it established

1 and rooted in the community.

2 COMMISSIONER CAMPBELL: I've been wondering if the
3 Commission should be addressing -- we've got a fair amount of
4 medical education. We've got a residency program within
5 nursing the school and stuff like that, and I confess I don't
6 know how much of this evidence-based training or exposure they
7 get in our educational system. And I'm wondering if we ought
8 to think about addressing that and encouraging -- if it's not
9 there, encouraging them to, at least, expose these young
10 students to this.

11 CHAIR HURLBURT: I'd like to maybe pick up on this and
12 the comment earlier and use an analogy. Many hospitals, in
13 many operating room settings have now very rigidly and firmly
14 introduced the time-out process and that's a very simple and
15 an easy thing to do in a discipline, and you need people to
16 enforce the discipline and make it a part of the culture, but
17 the time-out process is probably -- most of us know, it's --
18 you stop, and you make sure -- as a surgeon, you make sure the
19 operating room, the scrub nurse, anesthesiologist, whoever is
20 there all agree, yep, we're taking out the correct kidney or
21 operating on the correct knee because it has happened that you
22 don't do that. And so consistent with, say, some of the
23 efforts of the Institute for Healthcare Improvement and with
24 the leadership of American College of Surgeons, those kinds of
25 things have been instituted.

1 So perhaps what I'm hearing Mike say -- and maybe you can
2 comment on this, your recommendation to us and then, as the
3 Health Care Commission, our recommendations to the Legislature
4 and to the Governor are that, in the State's role as a buyer
5 of healthcare services to the tune of \$2.5 billion a year,
6 probably, with Medicaid and employees and Workman's Comp and
7 Corrections and all that, we advise that the State work to
8 incorporate the discipline of an evidence-based approach to
9 what the bureaucrats, like myself, that work for state
10 government do on behalf of the taxpayers and the Legislature
11 and the Governor to administer these programs to assure that
12 we're doing, to the best we can, the right thing in
13 determining what benefits are, how we do them, and in turn,
14 work with the providers, the vendors with which we contract,
15 hospitals, docs, whoever, to encourage that that discipline be
16 incorporated as a day-to-day, routine way of doing business.
17 Is that part of what you're saying? Yeah (affirmative),
18 Sheri?

19 MS. STRITE: So if someone is going to be a surgeon, you
20 have competency tests to determine whether or not you're
21 capable of doing that. And as Mike mentioned yesterday, there
22 is no association of evidologists, for example. I maintain
23 that anybody that's involved in healthcare decision making
24 with patients should have, at least, basic skills, but when it
25 comes to having requirements that groups have competencies in

1 there, I would just caution that there are a lot of people who
2 may think that they have solid skills in evidence-based
3 practice who, in fact, do not.

4 And so my recommendation would be to find some way to
5 have an opportunity to assess whether or not certain
6 competencies are being met. Otherwise, you run the risk of
7 having misleading information being presented as an evidence-
8 based way. And so how you do that I'm not exactly sure, but I
9 think that that needs to be considered as part of the process
10 in making that happen.

11 MR. STUART: I would just add that the theme that has
12 emerged in the last few minutes is a common one in evidence-
13 based medicine where there is a gap analysis that has to be
14 done. So you have to look at what is compared to what should
15 be, based on the evidence, and that's how you close
16 evidentiary gaps. The idea there is that there is a gap
17 almost everywhere in people's knowledge of the methodology
18 regarding how to do this, but there are also -- once you have
19 that gap closed and you have people with competencies to do
20 the work, then you need to have a priority list, just as was
21 stated, about what the priorities are and so you look at the
22 high cost/high volume items or items that have special
23 interest in Alaska or to an agency, and you make a list of the
24 priorities and find out if there is a gap.

25 And Jack Wennberg and others have shown that, in fact, if

1 you look at healthcare, there is variation, and it's
2 unjustified variation, many times, because, if people all did
3 do the evidence, they would be more similar, in many cases,
4 than different and so the variation can actually be used as a
5 way to sort of get at whether there is a gap. So there is the
6 need for the methodology, but also the priority list of where
7 there may be gaps that need to be closed, which will then
8 improve quality and reduce costs.

9 MS. STRITE: I was just going to add to what Mike said
10 that, in terms of the gaps, there may be opportunities that
11 you have where we have good evidence that's not being utilized
12 that may not, on the face of it, be necessarily a high cost
13 area, but may, in fact, be very important for healthcare
14 broadly and then, ultimately, may have very large cost
15 impacts. And I'm just thinking, for example, of blood
16 pressure management, and I believe that David Eddy has done a
17 lot of research in that area where there are huge
18 opportunities there and huge opportunities that are missed.
19 So I think the idea of developing priorities, there is
20 probably a variety of criteria to look at, but there are
21 probably some low-hanging fruit opportunities, too.

22 COMMISSIONER URATA: I'm curious; do other states have
23 sort of like a department of evidology, or like, do -- how do
24 they incorporate that in their daily lives, or you know, does
25 the department of epidemiology do that?

1 MR. STUART: We don't know the answer to that question,
2 but we do know that, at least, some states are attempting to
3 ensure that the competencies are in each agency. That's one
4 way to get at it. I would say Washington is actually making
5 an attempt to do that, but I don't know the details of other
6 states. As -- you know, through the window of looking at
7 things through the State's eyes, I don't know the answer.
8 Sheri, do you want to make a comment on that?

9 MS. STRITE: Again, as I said yesterday, our work with
10 states is so episodic and generally training and generally
11 training for certain groups, largely pharmacy and
12 therapeutics, although a few other departments as well, like
13 in Washington State Corrections and Labor and Industry. So we
14 don't get to see kind of the end product of what happens with
15 various states. But I would say that Mike and I have had an
16 opportunity to look at a number of things that have come out
17 DERP, and I know a lot of states utilize that information, and
18 I think that that presents a great opportunity and then you
19 can concentrate your efforts on other areas that they haven't
20 covered, perhaps.

21 MR. STUART: Which brings up a thought regarding getting
22 to know someone in an evidence-based practice center. You
23 should have a colleague or two or three or more that you can
24 call and say, you know, we're just wondering how you handled
25 this. And I mean, it's just obvious that colleagues can be

1 very, very helpful, if they've already done what you're
2 planning to do, but I think what you're going to find is that,
3 on your own, you will as well or better than most places, as
4 long as the methodology is solid and you've got people who
5 know that methodology. Then it becomes creative in terms of
6 what you do as a state.

7 CHAIR HURLBURT: Sheri mentioned Labor and Industry. And
8 Allen, I'll get to you in a second. And I wanted to mention
9 Mike Monagle was here yesterday, and well, maybe most of us
10 know Mike. Mike's the Director of the Division where
11 Workman's Comp sits. And as you know, Workman's Comp costs
12 are the highest in Alaska of anywhere. The percentage of
13 their medical care costs are higher than any other state, and
14 they have been looking at the use of evidence-based practices
15 and have some publications from their national association.
16 And in an experience -- and I think it was Wisconsin; I'm not
17 sure -- that have really tried to apply this, they found
18 rather startlingly, from a state where the cost is much less
19 than ours now, that they reduced the cost by about two-thirds
20 -- reduced it by about two-thirds and assured the quality of
21 care that was being provided and increased the number of folks
22 being able to get back to work by two-thirds, you know, just
23 really astounding numbers, but real benefit to people, to
24 getting people back to work through the use of resources,
25 through this approach, through the Labor and Industries type

1 area. So it's fairly broad. Allen, you had a question or
2 comment.

3 COMMISSIONER HIPPLER: I have a question. I'm the layman
4 here. I don't -- from the outside looking in, it seems, to
5 me, as if evidence-based medicine could have a -- well, for
6 individual studies, there is an intervention bias. There can
7 be an intervention bias. It seems as if there could be a flaw
8 in evidence-based medicine of a bias toward recently
9 introduced therapies because there is one study that comes out
10 that points toward, for example, hormone replacement therapy
11 might be good for women around the age of 60. Well, maybe
12 there hasn't been -- maybe for years, there won't be thorough
13 studies to study that issue, but in the meantime, there is
14 some evidence saying that that's worthwhile. So it strikes me
15 as maybe difficult to evaluate that and say, from an evidence-
16 based perspective, we're going to say yes, this is a good idea
17 or no, this is not.

18 Furthermore, there is -- I can't remember exactly which
19 slide, but one of your slides was saying that one of the worst
20 guides are guidelines, experts coming up with guidelines.
21 Well, for evidence-based medicine --for example, for the State
22 of Alaska Medical Plan, someone has to come up with guidelines
23 saying the State of Alaska will or will not pay for hormone
24 replacement therapy for a woman of the age of 65, but it would
25 have to be a team of experts coming up with these guidelines,

1 which your data seems to suggest is very unreliable.

2 So I'm concerned from the perspective of the outside
3 looking in, but as a citizen of the state of Alaska, how the
4 State of Alaska's healthcare plan could save money using
5 evidence-based medicine without using experts to tell us what
6 guidelines to use. Thank you.

7 COMMISSIONER HARRELL: So you make an incredibly good
8 point, and cardiologists -- and since I am one, I can defame
9 them -- are excellent at that. The newest drug that comes
10 along garners a lot of attention, but to allay some anxiety,
11 Dr. Hurlburt started out this morning talking about aspirin.
12 There are therapies that have longevity that do have good
13 evidence, that do provide good mortality/morbidity benefit,
14 that can be instituted with good evidence.

15 And regarding guidelines, although it's true, if you get
16 20 cardiologists in the room, you're going to get 20 opinions,
17 and they're all going to be pushing exactly in opposite
18 directions, there are still reputable guidelines that have
19 qualified evidence in an appropriate manner in terms of the
20 level of evidence, quality of evidence, and the benefit of
21 particular medications or therapies that can be trusted that
22 aren't necessarily subject to whimsey. So I want to allay
23 some of the anxiety, although it's a valid point.

24 MS. STRITE: So to truly do an evidence-based process on
25 a topic, you follow a protocol that's an evidence-based

1 method. And so what you do is you do a systematic search to
2 round up, you know, as best you can, all of the available
3 evidence on a particular question. And then you take that
4 pile of evidence and then you review that to find out what
5 science supports.

6 So I just want to make sure that it's clear that it's not
7 a matter of picking up the latest journal and then seeing the
8 latest article on something. Some of the best evidence that's
9 out there may be 50 years old.

10 One of the issues, in fact, is that, as our understanding
11 of good science has evolved, it is going to be true that for
12 many older interventions there is going to be less rigor in
13 terms of study design, potentially, or reporting. And so
14 that's something to be aware of, and you deal with it the best
15 you can, but what you do is you try to get at, do we have good
16 science, what is it telling us, what are its limitations, and
17 then you throw that into the room with experts and others and
18 various considerations, make decisions, and then you make sure
19 you label, to be very transparent, where your outcomes are
20 coming from, whether they're based on very high quality
21 science, if they're based on weaker science and clinical
22 judgment, cost issues, whatever. Is that helpful?

23 CHAIR HURLBURT: And I think that it's evolving that
24 there are organizations that develop guidelines, do analyses
25 that generally have taken a good evidence-based approach, and

1 I would say the U.S. Preventive Services Task Force, the
2 Institute of Medicine -- and if you look at their material,
3 you see that rigor and the process that they've gone through.
4 And when you look at the specialty societies, as Colonel
5 Harrell pointed out with his union, that they've come out with
6 all kinds of recommendations, but we may be improving.

7 To me, it was quite remarkable, about a month, when the
8 American Urological Association, the union for the urologists,
9 came out and said no, we just don't do routine PSAs on
10 everybody. You need a discussion between the provider and the
11 patient of the upsides and the downsides of doing a screening
12 PSA. That was clearly not in their best economic interest to
13 do that, but that, clearly, was where the science has been.

14 Now that's what Group Health was doing 20 -- 15 years
15 ago, at least, saying we won't say yes, we won't say no,
16 partly because the realities of population demand, but we
17 should have a discussion with an informed patient being a part
18 of making that decision.

19 So I think we're seeing some progress like that, but part
20 of why I started out saying what I did that, just because it's
21 a guideline, just because it has a (indiscernible - voice
22 lowered) on it doesn't mean it's solid, and we need, at least,
23 some skepticism, but some knowledge of the ability to
24 understand what does make it credible.

25 MR. STUART: Back to this intervention bias, the --

1 people who live in the evidence-based medicine world know
2 this, but it's very common for a poorly done study to be the
3 first study on something.

4 Let's take chondroitin for DJD of the knee. Initially,
5 the studies were very impressive in the results section, like
6 chondroitin really helps my patients. More studies, same
7 thing. But when you look at those studies, they're very
8 poorly done. So as time goes on, you see the studies become
9 better. You see them becoming larger, and at the end of the
10 day, you see that the good studies show no benefit whatsoever.
11 And this happens repeatedly because of what you've said, is
12 that people will do a study that is not well done, and yet,
13 people who are reading that study will pay attention to the
14 results and start doing it without waiting for a confirmatory
15 study, without waiting for a third study, without waiting for
16 a study that's well-designed, well-conducted.

17 And so we see this with -- chondroitin is just one of
18 many. Knee lavage and debridement for DJD, the reason that
19 was a rather large issue was because orthopods wanted very
20 much to help people and help them with a step in between a
21 total knee replacement and taking a non-steroidal anti-
22 inflammatory drug. So they came up with, well, why don't we
23 just wash the knee out and get the debris out of the knee
24 because there is this catalytic function in the laboratory of
25 cartilage that's floating around that ends up making more

1 cartilage damage. So if we just get that out of there, it
2 makes perfect sense. And then, of course, when a sham study
3 was done where they really didn't -- where one group didn't
4 really get that and the other did, we saw that it does not
5 work.

6 And there are also things, like pulmonary emboli, where
7 you squeeze somebody's leg for a long time with a tourniquet,
8 it doesn't do well, many times, and blood clots form, and we
9 get complications that we didn't tell the patient, in detail,
10 about or we didn't give them the other risks of infection, et
11 cetera.

12 So things get done because of this imperative to do
13 something instead of wait for enough evidence to say it's been
14 shown. So it's not that it's wrong to do something without
15 evidence. It's just that you need to look at the evidence and
16 be very transparent about the fact that we don't really have
17 good evidence, but we're going to do this anyway because of
18 this.

19 But you're going to have to always deal with this
20 imperative to take action, and frequently, historically, it's
21 because of poor studies, small studies being done first, and
22 people applying the results of that study when that study is
23 "as if." It's so flawed that it's as if there was no study.
24 So when we see a Grade U study for efficacy, a study that's
25 poorly done, we say it's as if there is no evidence. Because

1 that is so poorly done, it's -- there is no way we can rely on
2 it.

3 CHAIR HURLBURT: Any other comments or questions? But
4 maybe we can start to transition -- yeah (affirmative), Keith,
5 please?

6 COMMISSIONER CAMPBELL: I remember a time when members of
7 medical staff came in waving a study about me purchasing a
8 machine to freeze the lining of the stomach so that it did
9 away with the ulcer. And I'm at a place at the end of the
10 road, and you know, no real reason to do something like that.
11 So I pled bankruptcy and didn't buy it, but it wasn't very
12 many months or years -- it was a very small period of time
13 where this was proven absolutely terrible, but there are
14 thousands of those machines sitting around in hospital
15 basements, I'm sure, and you know, it's just -- but they were
16 expensive as anything, but it was the new thing. But I
17 remember that study waved in front of my face.

18 MR. STUART: And that brings up this issue of low-hanging
19 fruit, and it could be approached many ways. My daughter was
20 working in a healthcare system, and she pointed out that the
21 implantable cardioverters were priced in a range that some
22 were five -- you could probably tell us, Colonel, but
23 probably, as I recall -- this was years ago -- five to ten
24 times the cost of others. And when she looked at the
25 evidence, there was no evidence that one was better than the

1 other, and yet, the cardiologists had definite preferences.
2 And she pointed out that, if they would agree to limit the
3 list to three -- and they could pick those, but not the
4 highest cost; they didn't have to pick the lowest, but not the
5 highest -- and just stick with that for six months, they could
6 back to their usual way, and they saved \$2 million a year, and
7 they -- basically, cardiologists were very happy because they
8 weren't coerced. They were just included, and they agreed
9 when they saw the end. Well, I guess I don't know why I like
10 this one better. And it turns out that there are very strong
11 relationships between the vendors who go into the operating
12 room and some of the physicians that helped them develop a
13 preference. And so these preferences lead to millions of
14 dollars for one, little intervention. And as we said
15 yesterday, a couple million here, a couple million there, no
16 evidence, it's a problem.

17 CHAIR HURLBURT: Yes, Senator Coghill?

18 SENATOR COGHILL: So I'm not a doctor and so some of this
19 goes way over my head, except for when it comes to the cost.
20 But one of the things that plagues me -- and I've been
21 listening intently for the last day-and-a-half trying to apply
22 it to some of the public policy issues we have to deal with.

23 For example, let's just take diabetes in Alaska. We know
24 that it's costing a lot. And so we look for ways for studying
25 prevention strategies, management strategies, and some of the

1 dramatic costs of not dealing with this well. So I've been
2 trying to think of ways to apply some of the principles that
3 you're asking, as things come rushing at me for some of the
4 proposed answers. How do I evaluate a prevention strategy,
5 for example?

6 So as I'm looking at some of the tools we have here, some
7 of the healthcare planning we have to do with some of those
8 huge kind of public health issues that are really kicking the
9 feet out from under us -- and so have you taken a look at, in
10 these kind of strategies, applying it to kind of the
11 prevention strategies? Because that's one of the biggest
12 question marks we get in the Legislature is, how do we prove a
13 prevention strategy that sounds really good, but doesn't
14 really have an evidence-based capacity to it, at least, when
15 it comes to us?

16 MR. STUART: No. I can't really address that the way I
17 would like to. I would say, since you mentioned diabetes, you
18 can take any condition and look at the history of what's gone
19 on. In the area of diabetes, we have hemoglobin A1cs that we
20 say have to be less than seven. And then we see that we have
21 more hypoglycemia when we get these hemoglobin A1cs at target.
22 And we don't see the evidence for cardiovascular benefits
23 either. So are we really helping people to get their
24 hemoglobin A1cs that low? It doesn't appear, to many of us,
25 that we are. So you have to question that.

1 If you look at intensive care units where tight glycemc
2 control is utilized and you do studies where you divide the
3 group into those who get usual glycemc control in the ICU and
4 compare that to tight control, what you find is that, in a
5 neurosurgical ICU, the mortality rate, either way, is going to
6 be very high, and there is no real advantage to tight control.

7 In some surgical patients -- and the initial big study
8 was done in a surgical ICU, and it was a poorly done study.
9 It was stopped early, which we didn't talk about yesterday,
10 but that creates a huge problem because of chance findings,
11 and the benefits are not really there. It's just the -- they
12 looked at the data at the right time, and there was a
13 significant difference between the groups, but it's now
14 falling out of favor.

15 We got a call from endocrinologist in Indiana who said
16 our guidelines group is telling us that we need to do tight
17 glycemc control in the ICU. Could you look into this? And
18 so we said yeah (affirmative), but this is going to take some
19 time because there is a lot of literature. And what we found
20 was that there really is not evidence for tight control, but
21 if you think about what happens in hospitals, nurses -- alarms
22 go off. Nurses are quite nervous because they don't want to
23 see the hypoglycemia, yet they want to have tight control.
24 But there was never any evidence that substantial that that
25 tight control in the ICU was doing anybody any good.

1 And so I think you just have to keep looking everywhere
2 for the low-hanging fruit, and in diabetes, I think it's the
3 same story. There are many things that are done in diabetes,
4 but as David Eddy said, why don't you just make sure
5 everybody's blood pressure is well taken care of in diabetes,
6 and you will save many more lives than trying to get their
7 hemoglobin A1cs down below seven.

8 So I think that, really, it's more just looking around
9 for the gaps, the low-hanging fruit, things that are high
10 volume/high cost and then thinking very carefully about
11 whether you really want to maybe change recommendations about
12 care.

13 Now, I'm not saying that it's easy without a dedicated
14 epidemiologist, but you have many people. I talked to your state
15 epidemiologist yesterday, who is a very bright fellow who
16 knows a lot. He read the first 27 pages because he was going
17 to be late for the meeting, and this is the kind of sort of
18 devotion to doing the right thing that we just love to see.
19 And these people are everywhere in every state. You just need
20 to support them in doing the work, but you have to actually
21 help them by supporting them and maybe sort of start with the
22 first thing we want you to do is find the areas, like the
23 diabetes, and what is in them that should be changed because
24 we just sort of have an inertia problem that starts with bad
25 science and somebody's belief, and we just keep doing it.

1 CHAIR HURLBURT: Sheri?

2 MS. STRITE: So one of the things that you said -- or
3 what are some of the questions that you might ask when faced
4 with things like looking at programs, one of the cautions that
5 I just want to make -- that's what I spend my life doing, I
6 guess, is making cautions -- is, if you have -- let's say
7 you're looking at another state that has implemented a
8 program. I'd be careful about conclusions that may be drawn,
9 if they say we improved patient outcomes in mortality or "X"
10 and such. Perhaps they did, but just be aware, from some of
11 the things that we were saying yesterday, that there may be
12 some confounding things that explain that, other than that's
13 actually true.

14 And so one of the things that I've been learning from
15 Mike's answer here is that what you really do is dismantle the
16 various components maybe in a program and find ways to look at
17 those things individually. And then again if you've got
18 something that has to do with therapy prevention screening or
19 diagnostic intervention -- diagnostic is a little bit more
20 complicated, but at least, with those three, you want
21 randomized control trials that are valid that give you solid
22 evidence, you know, or then you make clinical judgments around
23 that. So I think taking those elements apart and then
24 determining what's best for your culture is probably a helpful
25 way to kind of question some of those things.

1 COMMISSIONER ERICKSON: I just want to follow-up on this
2 though, too, because I think one of the questions -- and you
3 can correct me if I'm wrong, Senator Coghill -- is -- what I
4 heard is that you were interested in understanding how you
5 could apply critical appraisal to more population-based
6 primary prevention program ideas. So if you have the State
7 Division of Public Health, for example, coming and suggesting
8 that they need funding for obesity prevention, can you -- I
9 mean, you can't do a randomized control trial study on policy,
10 like maybe take tobacco, increasing tobacco taxes. So we're
11 talking about a more generalized population strategy and how
12 you apply this methodology, I think, is what you were asking;
13 is that correct?

14 SENATOR COGHILL: Yeah (affirmative). When we deal with
15 prevention issues, whether it's smoking, obesity, some of the
16 diabetic issues, which really are huge cost-drivers, and when
17 I have somebody like Mr. Hurlburt coming before me, I want to
18 what evidence can you bring me that shows this benefit. And
19 so then I'm going to be asking those questions. But in the
20 prevention area, it's experimental, as far as I can see, at
21 this point. And so do we ask them to bring us some studies?
22 Because I can tell you -- and you talk about action -- the
23 Legislature wants to do something. We want a headline, number
24 one, but we also want to do something good for our
25 communities. So those two things probably go hand-in-hand, to

1 some degree. But sometimes, the doing something might be
2 taking valuable resources and putting them in a wrong place.
3 So we're kind of trying to figure out how to get those
4 questions.

5 So yes, the broader public health issue as well as, as
6 the Doctor knows, working with rapid action, like our EMS
7 people, having those protocols done. Certainly, we have
8 national people that are telling us what to do, but we need to
9 know, are they coming at us with good studies? So we'll be
10 asking those questions, too.

11 But I appreciate the set of questions you've brought
12 before us and the way to think through some of those things.
13 I'll be taking it very seriously. But some of them, because
14 they're broader public health questions, are hard to get
15 drilled down to the detail that you're talking about.

16 MS. STRITE: So does everyone remember what we said
17 yesterday is the best answer to all of this? It depends. And
18 I'm sure Mike is better informed in this than I am, but there
19 are instances in which, for public health policy, people can
20 do randomized control trials.

21 And for example, at Group Health where I worked in what
22 was the then the Center for Health Studies, there were
23 randomized control trials looking, for example, at the effect
24 on co-pays, and you know, that provided us with some useful
25 information. And so I think it depends.

1 Again, you want to identify, you know, what is the
2 question that you're trying to address? So kind of leading
3 back to yesterday, just because it's simple for me to think in
4 these terms, if I have a question about a therapy and cause
5 and effect, I know that I want a randomized control trial.
6 When you're dealing with, does this pill, or you know, does
7 this procedure cause this outcome, that's complex to do. And
8 then when you start thinking about very complex things, like
9 you're talking about programs, you have a much harder time to
10 figure out what actually is going to be good evidence, if any,
11 and how you approach that. So those become very complex, and
12 I think you try to do the best you can, breaking things apart
13 to see maybe where you can have some information that informs
14 you. And then a lot of things, at the end of the day, are
15 going to be, just as we're always living, in a guess.

16 SENATOR COGHILL: And Doctor, one of the things I'll be
17 doing -- so for those of you who get to bring me requests and
18 answers, I'll be asking them, how did you arrive at this
19 conclusion? And I'll probably apply that a little more
20 seriously when it comes to, you want money for what or you
21 want to put this into law why? And so those are some of the
22 questions, but as we try to fulfill our role as Commission
23 members, somewhere along the line, we also have to be able to
24 apply that to a planning process that says, this is the best
25 way to do health planning in Alaska. So I'll be watching

1 that, too.

2 CHAIR HURLBURT: I think that kind of is a good segue.
3 Sheri and Mike can be with us until ten and then they're going
4 to need to leave because they've got a plane heading back
5 south, but if we could -- for the rest of the time they're
6 with us, if we could maybe transition over.

7 You all have the pink sheet, 2010 Findings and
8 Recommendations, and those were the recommendations of the
9 Commission related to evidence-based medicine back with the
10 2010 ones. We've come back to this now and spent virtually
11 all of this meeting addressing that. So if we could look at
12 that, maybe transition a little so that the conversation now
13 is among the Commission members, but with the advantage of
14 Mike and Sheri still being here, that we can turn to as
15 consultants to us, but kind of look at where we are, how we
16 want to fulfill the mandate and the charge that we have that
17 will both enable the Legislature and the Governor to do their
18 jobs better, but also to provide guidance and suggestions to
19 them for their consideration. Yes, Val, please?

20 COMMISSIONER DAVIDSON: Just the first one under "Finding
21 A," now that I've learned all about this great, valuable tool,
22 I'm wondering about the validity of that statement and whether
23 the research that we found that came up with that statement is
24 actually verifiable.

25 MS. STRITE: It might be low, and we'd be happy to give

1 you some -- I'm not sure where this statement came from, but
2 we would be happy to give you some references that we have
3 that provide some comparable information. Yeah (affirmative).
4 There are quite a few, actually.

5 COMMISSIONER ERICKSON: You're referring to Finding A?
6 Yeah (affirmative). The Institute of Medicine report that
7 came out just this past year identified 30% as a conservative
8 estimate (indiscernible - simultaneous speaking).

9 MR. STUART: Yes. And so has the VA come up with a
10 similar number and so has Rand. Other groups have, the
11 Institute of Medicine, as you mentioned. So we don't really
12 know the exact number. We know that it's a lot. There are a
13 lot of -- there is a lot of overuse. And Senator Coghill
14 brought up an issue that I just -- I have to respond to.

15 You're going to have people bring you bad evidence and
16 tell you it's good evidence. He's gone, but the -- the fact
17 is.....

18 MS. STRITE: He's going out, hunting the evidence.

19 MR. STUART: He's going out for the evidence. Well,
20 maybe I'll hold this until he gets back because I think he's
21 going to have people coming to him.

22 Let me just tell you a story about what happens with.....

23 MS. STRITE: Do you just want to wait until he comes
24 back?

25 MR. STUART: Well, okay. I'll hold all of it until he

1 comes back; yeah (affirmative).

2 MS. STRITE: And then I can interject here just something
3 that Deb showed me. I'm looking at the Core Strategies for
4 Healthcare Transformation, and she was listening very closely
5 to something I said earlier. Ensure the best available is
6 used for making decisions. That statement is good, and
7 probably, I would like to volunteer to maybe make a little
8 suggestion, when I get back home, to find some ways to qualify
9 that a little bit so that it doesn't -- or that -- what do I
10 want to say? That it appropriately excludes evidence that
11 isn't good enough.

12 COMMISSIONER URATA: I was going to suggest that we add
13 the words "critically appraised evidence-based medicine."
14 Would that make all those phrases too long? But that's what
15 we want is critically appraised.

16 MR. STUART: Well, what you want is critically appraised
17 evidence. So the correct statement would be "critically
18 appraised evidence."

19 COMMISSIONER URATA: So then we would not be able to just
20 simply add those two words to wherever it says "evidence-
21 based?" Yeah (affirmative), under Finding B. And then there
22 is "evidence-based" throughout this document that I was
23 thinking, somehow, we should add "critically appraised." And
24 maybe we should put down, in parentheses, "critically
25 appraised evidence" after the words "evidence-based" because

1 that takes it another step further towards making it right.

2 MS. STRITE: So technically, to me, evidence-based
3 practice includes critical appraisal, but not everyone is
4 thinking that way. So I like your idea. And so maybe it's
5 just a matter of having something that's definitional that
6 says, to us, evidence-based medicine means the following, and
7 you add things, like transparency as well, to that.

8 And we, Mike and I, spend a lot of time trying to really
9 carefully craft statements, and when I get home, I know I can
10 pull up some things that we can put before you that may help
11 you with that.

12 COMMISSIONER URATA: (Indiscernible - away from mic.)
13 Excuse me. Bob Urata. We have "transparency" in another area
14 of some of our core suggestions.

15 (Pause - Senator Coghill returns to room)

16 COMMISSIONER URATA: I just would like to throw out --
17 well, I'm kind of hesitant, but I'll just throw it out, just
18 for discussion. Do people think we need an evidentiologist
19 (ph) as part of this?

20 MR. STUART: Evidologist.

21 COMMISSIONER URATA: Evidologist. I can't even pronounce
22 it correctly. Is that somebody completely different than an
23 epidemiologist? Is this something that we should put in as a
24 consideration as one of our recommendations?

25 COMMISSIONER MORGAN: The comment I wanted to make, I

1 just happened to get -- I get notices. As a professional
2 joiner-upper, you know, I get stuff from the State, the Feds,
3 you know, name it, and I noticed that our Commissioner for
4 Administration is hiring a Quality Improvement individual, and
5 bang, that struck me.

6 And I looked at the job description. It's a director
7 level. And I think we have pretty much got one-third of their
8 job description. It's basically to evaluate programs,
9 methodologies, to review peer review, to come up with the best
10 quality, to improve quality with the strategy of also
11 maximizing cost containment. I mean, it had a lot of the same
12 buzz words in it.

13 I was hoping, even though I had -- they're starting to
14 call them emergencies back at my job, just, you know, Morgan's
15 (indiscernible - voice lowered), but I had to go back, but I
16 was hoping to catch her, the Commissioner, just to ask her
17 what her -- just because it says that doesn't necessarily mean
18 that's what they're going to do.

19 The organization I belong to has a lot of Quality
20 Improvement Specialists to help do stuff, and part of that is
21 that of what we're going through.

22 And then my professional organization, HFMA, and this --
23 I got it last night. I go home -- light reading -- and they
24 called it big data, but it, basically, has what you're talking
25 about, except trying to bring statistical systems in line with

1 this methodology so that you could start healthcare
2 organizations that can do some of this work to see, if they do
3 this, what happens kind of stuff with standards and metrics.

4 In my own mind, I was -- I'll add this. It almost seems
5 like, sometimes as a Commission, we're kind of trying to find
6 a magic bullet for a lot of this stuff. And I've been in a
7 lot of different circumstances and a lot of different
8 organizations over my 30-year career, and I've come -- you
9 know, I came to the meeting, listened, and read everything,
10 and it almost seems, to me, that the best we can do is make
11 recommendations to the Governor and the Legislature of this is
12 what needs to be in it. These are the standards that need to
13 be used to review it. And there is some stuff out there, and
14 there are some things we can do. But on the other hand, I
15 think our colleague from the Chamber is, for a guy looking
16 outside in -- that's why I always like Allen to say those
17 things. Sometimes, a guy outside can see things we can't --
18 that maybe we need to take a lot of this with a grain of salt
19 and make sure that what we're getting is what they've been
20 talking about.

21 And I think Senator Coghill, and I'm willing to bet, Wes
22 Keller will tell you these two days have helped them because,
23 at least, it gives them the criteria and how to read this
24 stuff, at least, to hit the major, big flaws in this --- you
25 know, this will reduce costs by a third for knee injuries, if

1 you do this. And at least, we can recommend this is how you
2 take a shot at evaluating it. And it's tons of this stuff. I
3 mean, we have piles and piles of studies, and you probably --
4 all of us do.

5 And I sit here and ponder how we're going to do it.
6 We'll have to prioritize, like Deb said, but bottom line is,
7 when the finance guys are even talking about this stuff and
8 healthcare financial management, you know, basically, they're
9 taking the approach of the role of the purchasers in value
10 improvement -- catch word -- managing value in uncertain
11 times, and basically when you read it, a lot of it is this
12 stuff, basically, but bringing in data systems, how to set
13 what you've been taught -- probably Seminar 9 of how the
14 systems that record the data that you're measuring whatever
15 you're measuring with the baseline to see if there is an
16 effect, whether good, bad or indifferent. And maybe that's
17 where we're going to go here. I don't see us evaluating
18 stuff, just coming up with some concepts to use when you are
19 evaluating, I think. Whatever that's worth.

20 CHAIR HURLBURT: In response partly to what Bob says,
21 that probably the more practical and potentially useful thing
22 would be for us to make the recommendation that the approach
23 be used, as you described it, rather than specifically saying
24 that we build it with state employees, for several reasons.

25 There is a limited amount of expertise in Alaska. There

1 is also a pretty determined focus, really, at both, in the
2 Governor's office and in the Legislature, because of reduced
3 throughput, you know, oil prices that are sometimes below our
4 target and so on, to be very sensitive to the number of state
5 employees that we have.

6 And I think that the Department of Administration, in
7 their approach to the \$600 or \$700 million that they are
8 responsible for, for active employees and retirees both,
9 administered by the Department or through a union trust, that,
10 with Commissioner Hultberg's leadership, they are really
11 taking a very, in a positive way, progressive type approach in
12 looking at that. They've never really had any medical input
13 before, and both Alex Malter (ph) and I are now working very
14 closely with them, and it is just -- it's totally gratifying.
15 They are so open in wanting that support.

16 And I think that, if Commissioner Hultberg has identified
17 the Quality Assurance position, as she's building within the
18 staff she has and making those priorities -- she was going to
19 be here, but for Alaska Airlines' mechanical problem
20 yesterday. But I think they're open to that.

21 We had Emily Cotter, in leaving yesterday, said, I'm
22 going to go back, and I'm going to set up some luncheon
23 seminars with the Commissioner to really talk about what we
24 talked about.

25 So I think that, as the leaders -- and like Jim Puckett

1 and his Division, who was here yesterday -- as they understand
2 that, we need understanding in-house, but it may not be
3 practical or realistic to build our own structure to do it,
4 but we can obtain it.

5 Now in Medicaid, we had Margaret Brodie, who is the
6 Director of Health Care Services Division, here yesterday,
7 doesn't have a clinical background, but I think that having
8 her exposed to that will be invaluable. I would say, probably
9 realistically, Medicaid has not been quite as open yet to some
10 of these newer concepts as Administration is for the employees
11 and retirees, but I think the interest is there, and we're
12 coming along.

13 So I think our role would be to recommend that's the way
14 we need to do business, and then with the practicalities of
15 being Alaska, budget situations, employment ceilings, and so
16 on, then let the State figure out the best way to get there,
17 but making sure it's done in that context. Val, did you have
18 another comment?

19 COMMISSIONER DAVIDSON: I guess what I heard -- one of
20 the things that I heard Dave say was, to the extent that
21 people are being hired, we should hire -- or if they don't
22 have this capability to begin with, then we should train them
23 and make sure that they have that capability, which I think is
24 different than what's there. And I think what we're saying is
25 that we're recommending that this approach be used as a part

1 of doing business in whatever the position the person may be
2 in, whether they are in a private hospital, whether they're in
3 a public facility, whether they are within the Alaska
4 Department of Health and Social Services, or wherever.

5 MS. STRITE: And I just want to build on several of the
6 comments here and say I would be very cautious about making
7 recommendations naming some kind of profession because you're
8 going to miss the mark. There are a lot of people who have
9 outstanding evidology skills who've never heard that term. So
10 it's not like there is a band of people with that sort of name
11 emblazoned on them. It's a fairly new term that only a few
12 people know, and we use it because it kind of collects up some
13 things nicely that we do.

14 People that are trained out of the quality improvement
15 shoot, infrequently, have any of this knowledge or experience.
16 Mike and I sort of liken folks that have more process
17 experience, which tends to be where quality assurance often
18 lies, in terms of looking at how efficiently and did you get
19 the instruments to the operating table as compared to whether
20 you should have done the operation in the first place.

21 And so by focusing on what activities you expect, what
22 processes you want to recommend, focus on that and don't try
23 to label, we need an epidemiologist or anything like that
24 because there a lot of people that can fulfill what you need.
25 Some people that, maybe from their titles or educational

1 backgrounds, you might guess they can, but actually can't, but
2 could be trained to do so.

3 COMMISSIONER KELLER: This is slightly different. I'm
4 going to -- just for discussion, I'd like to say that we make
5 a recommendation that we promote, somehow, patient access to
6 the evidence. You know, I'm saying like DynaMed and UpToDate,
7 and I just -- you know, I was reading our recommendations, and
8 these are very professional and provider-oriented. And so I -
9 - just a little story, just a test.

10 Right now, I have a recommendation that I have this
11 surgery, right? So I -- this is the back of my mind, and I'm
12 thinking about it. So I went to DynaMed, and it lets you get
13 on for a day, and I did some, you know, research on what this
14 recommendation is all about. Well, the bottom line is that
15 the recommendation I have is inconsistent or limited evidence,
16 you know. So I'm just saying, from a patient's perspective
17 from the outside, you know, coming at this, this is a valuable
18 thing, even though I had to use the glossary and I had to use
19 the links to get there, you know. And I still don't --
20 probably, there is a lot of stuff I don't understand.

21 We have that in the recommendation about promoting
22 informed discussions with our doctor, but I would like -- I'm
23 thinking that we ought to have a specific, separate
24 recommendation that this is accessible to the patients.

25 MR. STUART: Well, I was going to make a comment earlier

1 in response to something Senator Coghill said, but I looked,
2 and he was not. So I will do it now.

3 The idea of people coming to you, when you've asked them
4 to bring the evidence, made me smile a little bit because I've
5 seen so much in the way of what's called real world data
6 that's brought to people. Let me give you two quick stories.

7 One is a new drug for glaucoma. This is just a
8 hypothetical. It has been approved by the FDA. A group --
9 and this new drug has the advantage that there are fewer
10 respiratory problems in people with COPD. So it is marketed,
11 based on randomized control trials that are well done, that
12 the hospital admission rate is going to be lower with the new
13 drug. So an industrious quality improvement person says I
14 think I'll just take a look at our data and see how we're
15 doing with this new drug, and lo and behold, the data shows
16 that there are higher rates of admission with the new drug.

17 And so you have to be able to sort of understand why the
18 randomized control trials show one thing and the real world
19 data shows another, and the answer is, in epidemiology, there
20 is this thing called compounding by indication. And what
21 happens in situation, like this, very frequently -- it's
22 happened with many drugs and many interventions -- is that the
23 database is reflecting a different problem in that, if all the
24 pulmonologists know that there are fewer respiratory problems
25 with this new glaucoma drug, then they will put all their

1 highest risk patients on the new drug. So yes; they will be
2 admitted to the hospital because they're higher risk patients,
3 not because the drug didn't work. But the evidence that will
4 be brought to you, in many cases, will be like that. It will
5 be very tempting to go with this database study when, in fact,
6 database studies are observational studies, and they have
7 about a 20% chance of telling you the truth.

8 So it's going to be -- so in an earlier statement, David
9 asked about, should we have an evidologist? And our answer is
10 yes; you should. It would be like a hospital not having a
11 cardiologist.

12 MS. STRITE: I would say someone with evidology
13 skills.....

14 MR. STUART: Yes.

15 MS. STRITE:since I suggest avoiding the
16 professional title.

17 MR. STUART: Yes. Yes. But I'm just saying that the
18 problem is that, when you ask people to bring evidence, unless
19 you are really skilled at evaluating that, you will frequently
20 jump the wrong way because the evidence is going to lead you
21 down the wrong path, and I think you have to be extremely
22 cautious because there is more misleading evidence than there
23 is good evidence.

24 CHAIR HURLBURT: So let me ask you -- I'm testifying
25 before the Legislature and advocating for one of my passions,

1 what I think the number one public health problem is,
2 overweight and obesity, facing our society and facing our
3 state. And we've seen some successes in the school district
4 in Anchorage, in the school district in MatSu, statistically
5 significant reductions in overweight and obesity in the
6 schools when we did various things. And so Senator Coghill
7 says, thank you very much, Dr. Hurlburt, what is your evidence
8 for what you're requesting? And then I come back with an
9 observational study, and as you said your course, he'll say,
10 well, that's not very strong. And I can't come up with a
11 randomized control trial where we give one group unlimited Big
12 Macs and the other arugula for the next six months. So how do
13 I deal with that?

14 MS. STRITE: But you attended our course, so you know,
15 too, there are concerns with observational studies.

16 MR. STUART: And also Senator Coghill does know this now
17 and so he has been enlightened. He's been pulled out of
18 Plato's cave, and he is not allowed to go back in.

19 MS. STRITE: And for some things, you're never going to
20 have good evidence. And so you make some choices, and
21 sometimes, you do things because they make sense to do. We
22 just say, you know, look for good evidence first, and then if
23 you don't have it, do whatever the heck you want.

24 COMMISSIONER URATA: Well, I wanted to get back to
25 Representative Keller's recommendation; is that all right? I

1 would agree with it. I don't think that we have it anywhere
2 else in our other recommendations, and I think that part of
3 the importance of the future of healthcare is for people to
4 understand their own health and help maintain their own
5 health, and they need good evidence for that. It should be on
6 a website somewhere, but I don't know how, if the State would
7 pay for DynaMed for all the citizens of Alaska or something
8 like that, but we have to figure out a way so that they would
9 have easy and free access, I guess.

10 COMMISSIONER HIPPLER: Certainly, more information about
11 quality would be helpful because nobody really cares about
12 price. They care about value. So it makes the transparency
13 of price more meaningful.

14 COMMISSIONER DAVIDSON: So I'm guessing -- I'm wondering
15 about the impact of -- sometimes, having more information
16 available isn't necessarily so helpful. So for example, all
17 of the people who show up in the doctor's office because
18 they've seen that great, new ad on TV for this wonder drug
19 that's going to make sure that they never have to watch what
20 they eat, they never have to exercise, and they can pretty
21 much lay around and be perfectly healthy. And also with
22 WebMD, I mean, we have a whole group of people who come in and
23 say, I know exactly what I have. These are my symptoms. This
24 is what I'm experiencing. I've done all the research on the
25 Web. I demand that you give me this particular drug. So I

1 think we should -- there is always a tendency of -- it's
2 ironic because, yesterday, we talked about the challenge is
3 we're over-prescribing, we're doing all of this because there
4 is more information available, and at the same time, we're
5 also advocating that more information be available in another
6 forum and maybe they're balance each other out, but I think we
7 have recognize that our history has shown -- again, that's not
8 research, totally anecdotal and observational.....

9 MS. STRITE: It's evidence.

10 COMMISSIONER DAVIDSON:that anytime we do provide
11 that information, the exact opposite may happen, which is sort
12 of an unintended consequence of having more information out
13 there.

14 MS. STRITE: And so my suggestion would be try to help
15 people understand that there is differential in terms of
16 quality of that evidence, as you can.

17 When you look at DynaMed, my guess is that you're going
18 to find that that would potentially decrease use, not
19 encourage overuse. Our concern with UpToDate is that, at
20 least from what we've seen -- and it may have changed since
21 we've studied it -- is that there are specialists presenting
22 kind of every which way you can do something. So they're
23 demonstrating they know a lot and a lot can be done, and our,
24 at least, older experience with that is that it tends to
25 promote overuse.

1 So I think that part of what would be useful in your
2 recommendation is to have something that is a starting point
3 for patients that gives them some background into variation of
4 quality of information that they get, so that they become
5 somewhat educated in these concepts that we've been talking
6 about over the, you know, day-plus and then help lead them to
7 information that's going to be more useful for them and more
8 in line with evidence-based practice.

9 CHAIR HURLBURT: In terms of the Recommendations section
10 where, I think, Recommendation E, we probably have now, but
11 the rest of it is not as specific. I'm sorry?

12 COMMISSIONER URATA: (Indiscernible - away from mic)

13 CHAIR HURLBURT: Okay. Yeah (affirmative). Yeah
14 (affirmative). That's not the clinical part so much. It's
15 the public health information that kind of comes over the
16 chronic disease section with the data there. That's not so
17 much the clinical aspect.

18 But in terms of recommendations, Deb is -- are there any
19 areas that you see now as omissions, based on our
20 conversations here and previously, or they still look pretty
21 cogent?

22 COMMISSIONER ERICKSON: I was going to ask the Commission
23 members and our consultants that question. And you're correct
24 that Recommendation E, the very last one, was more specific to
25 public health information. So it was -- you know, we've been

1 tracking the development by the Division of Public Health, the
2 web-based system for some of the public health data. So are
3 you suggesting that.....

4 CHAIR HURLBURT: And that was up and working and getting
5 pretty good use and then it was down for a while, but I think
6 it's back up now.

7 COMMISSIONER HURLBURT: Part of it. Yeah (affirmative).
8 It's not fully operational yet. The hospital discharge data
9 is going to be added to it, but that's the sort of thing --
10 behavioral risk factor, surveillance data. So that's what
11 Recommendation E is about. So are you suggesting that we
12 should add a new one or modify that existing one?

13 CHAIR HURLBURT: I guess I'm looking for that kind of
14 input, and since you probably, totally internalize these more
15 than anybody else, that's why I was picking on you there, but
16 I think the question really is for everybody.

17 COMMISSIONER URATA: I'd recommend an "F" for
18 individuals.

19 COMMISSIONER KELLER: I just wanted to ask Allen, were
20 you saying that transparency -- maybe we ought to mention it
21 in this, and you know, tie it, is that what you were thinking?
22 Because I was thinking in that context. It's interesting.

23 This procedure that I'm referring to, you know, I just
24 thought, hey, I'm going to use this as a test case because
25 it's been around for a year now. You know, it's real slow, no

1 big deal, but the cost is another aspect of this that is
2 really fascinating. You cannot find the value very easily of
3 any given procedure, and I have been looking out of state and
4 trying to make comparisons, even though, theoretically, it
5 makes no difference to me because my insurance will pay, but
6 it's -- you know, I think that was a good suggestion.

7 CHAIR HURLBURT: It was interesting, to me, and a little
8 disappointing in that August 9th meeting that the Senior
9 Medical Director from Premera, in responding to a question in
10 that regard, said yes, we're really working on getting out
11 what the co-pays and deductibles and all that are, and that's
12 really what people care about, and I think that that's
13 probably true sometimes. But I think more and more people
14 really much more enlightened in that and are concerned
15 globally; what's the whole cost?

16 And when we heard last October from John Torinus about
17 his company, certainly, the successes that they have seen
18 there in Wisconsin are related to getting that transparency
19 and aligning the interests of the employer and the employee in
20 providing that.

21 In terms of the comment about should the State provide
22 DynaMed for all the citizens, at least, my gut reaction would
23 be that's probably not realistic, number one, having no idea
24 what it would cost, and I think we do -- we have talked a lot
25 about the State sponsoring transparency so that payers,

1 providers, patients, consumers can obtain quality and cost
2 information, but in terms of access to that kind of
3 information, you know, maybe you're better, if an individual
4 is not going to pay for it themselves, then you can probably
5 get a better price with a whole lot of people. But maybe it
6 would be more appropriate for the State to do it for the
7 State's employees and retirees perhaps as an employer, but for
8 Alaska Airlines to do it for their employees or for Premera to
9 do it for their enrollees, but that, if it's a useful tool so
10 that you get more enlightened patients, more enlightened
11 consumers, you'll end up with better quality care, better
12 decisions being made, and based on the experience, time and
13 time again, like the number of stories that Mike and Sheri can
14 share from Group Health, reduced costs. Yeah (affirmative),
15 Keith?

16 COMMISSIONER CAMPBELL: It seems to me that, if you go
17 down that road, you've got to incorporate some sort of a broad
18 public education on how to use this sort of stuff, and I don't
19 know how. I'd have to think about how you would design that,
20 but that would certainly have a cost to someone.

21 CHAIR HURLBURT: Yeah (affirmative). It would be, and
22 yet if I put on a hat, say, as a Chief Medical Officer with
23 large health plan, I would say that that's a part of our
24 responsibility. If we have the financial risk for the care
25 and the accountability for the quality of the care that's

1 being provided, that would be up to us to figure that out.
2 Yeah (affirmative)?

3 COMMISSIONER ENNIS: While I wholeheartedly support
4 helping patients become more educated and having access to
5 information, I do realize that there are a large number of
6 patients who simply aren't going to have access, take the time
7 or really understand the information they might receive. And
8 a growing number of patients in our society, the elderly, are
9 going to see their physicians or healthcare practitioner as
10 the expert and really are not going to question or want more
11 additional information, and because of that, I feel that it's
12 very important for us to consider how we can provide
13 assistance to our physicians and our healthcare practitioners
14 in gaining access to this information.

15 I heard Dr. Urata say yesterday that, although he tries
16 to spend enough time reading journals and looking at the
17 literature, it's very time-consuming and now we've learned
18 that, perhaps, only one percent of those are going to be
19 accurate. I think that, even just from my thinking, is
20 somewhat frustrating and overwhelming.

21 So how can our state help our healthcare practitioners
22 have better access, easy access, and is it establishing a
23 position or a department or program that can be an essential
24 go-point is a question I have. Thank you.

25 CHAIR HURLBURT: Well, and I think, to some extent, there

1 is a philosophical issue there. We've talked about the All-
2 Payer Claims Database, and we've talked about the Hospital
3 Discharge Database and making that available to consumers, to
4 employers, to other payers. And I think that our -- the
5 approach we've taken, as a Commission and our political bias
6 as a state, has been that it's one thing to look at the State
7 as a payer, whether it's for Medicaid or as retirees and
8 employees, and it's another thing to look at what should the
9 State do in terms of a regulatory capacity.

10 Now, we will have regulations, but generally, we're
11 sensitive, in our state, to trying to make sure that the
12 regulations that we have are really necessary.

13 So for example, Mike gave the example yesterday of
14 President Clinton had his CABG done in the three percent
15 place, but -- and he didn't go to a one percent place, but the
16 question was -- and of course, all providers will always say
17 you don't understand my patients are sicker, but that may be
18 the reality. It may be that he went to the place that was
19 really getting the toughest cases to do and that, on the
20 surface, we might say he didn't use the data that New York
21 State gets and publishes. Well, I think New York State is
22 doing that. It didn't appear that the former president used
23 that information in making his choice, and what we've heard
24 from the Freedman Group about the All-Payer Claims Database is
25 it doesn't sound like it's been taken on, which is

1 disappointing to me, and been used a lot yet where it's been
2 put into practice. There is enthusiasm, like Colorado.
3 That's the newest state, I guess, still. There is still a lot
4 of optimism there that it will be used, but there is that
5 dichotomy and a balance we need to have.

6 We are sensitive here to not just expanding the role of
7 the State as a regulatory agency, beyond what we need to do.
8 We're not Neanderthals, and we don't say, you know, that there
9 isn't valid role for that, but we're also sensitive to what
10 should the State do and what should others do. And I think
11 that's something that we wrestle with, and I'm not trying to
12 give an answer to what you're saying, but just saying yeah
13 (affirmative), that's a valid issue, and we need to come up
14 with what is our recommendation in that regard. Yeah
15 (affirmative), Colonel?

16 COMMISSIONER HARRELL: I actually wanted to second
17 Emily's point because I've sat and listened. Generally, I
18 mean, you all know, in the military, we tend to be "let's go."
19 You know, let's be very proactive. But within the DOD -- and
20 see, I've got a double whammy, but the DOD/VA has probably one
21 of the better activated populations. We have very engaged
22 patients. They're energetic about their care. And I still
23 find, anecdotally, a significant minority that takes advantage
24 of that. And so I would share your concern about a lot of
25 finances and energy put towards making these pieces of

1 information available to the populace at large; however, the
2 education that they are out there, the education of, hey, you
3 need to engage your healthcare provider would be of some
4 value, I think, but I would actually urge restraint because I
5 think we would be marching down a road with significant
6 financial investment that would, more than likely, end up
7 having minimal return just, based again, on seeing our
8 population that's very motivated, and still, a few of them
9 actually take advantage of information that's made available
10 to them.

11 CHAIR HURLBURT: I think, when an individual is in the
12 healthcare setting, they are open to that kind of thing and
13 then the healthcare setting needs to do the education. I
14 think that's one of the reasons why, you know, I just delight
15 whenever I go over to Southcentral, the clinic. They've got
16 education stuff going on all the time there, and I think
17 that's good for a system to do.

18 When you look at the -- and I've got a graph of the array
19 of the rate of TRPs (ph) that are done on men -- and there is
20 a big display, and if you make it horizontal, the number of
21 the rate that's being done -- the number of locations doing
22 that rate or the number of facilities, it kind of spreads out
23 and comes down.

24 Well, take the example of Group Health as a staff model
25 institution, and there, in that array, they were fairly low, a

1 relatively low number of the rate of TRPs being done. They
2 then instituted -- and I think it was the late '90s; I'm not
3 sure -- enhancing the educational effort, and they bought some
4 audiovisual equipment and some interactive audiovisual
5 equipment. And so if the urologist talked with the man and
6 he's having some obstructive problems or whatever and the
7 discussion is, should you have the TRP, that interchange
8 happened. And then when they had more time to have the video,
9 they even dropped way lower, where the patient saw the
10 downsides of impotence and incontinence and so on. But it
11 took place by the healthcare system in the healthcare setting.

12 Now, it's easier for Group Health to set up in the
13 urology service with a half-a-dozen urologists doing that for
14 TRPs than it would be for Bob, as he's saying. You know,
15 should we refer you to the urologist for surgery or not? But
16 it seems like within that setting is when people are open to
17 it. And then that's a part of the educational responsibility
18 on the part of the system, to me.

19 And I think, you know, you guys, the VA and DOD, would be
20 just like I described for Southcentral. You're probably
21 fairly exemplary in doing that. Allen?

22 COMMISSIONER HIPPLER: I do have questions about comment
23 D, but before our guests leave, I would like to ask them a
24 question.

25 In your experience, what kind of data can be given to a

1 consumer of healthcare to help drive their decision making
2 for, say, very, very expensive elective therapies? That is to
3 say, is there anything that, as an insurer or an employer, we
4 have proof that, if you give this information to employees,
5 they have better health outcomes? Thank you.

6 MR. STUART: Well, I don't know all the evidence to
7 answer that question; however, as I mentioned yesterday,
8 Cochrane has tried very hard to study the association between
9 decisions made by patients and the information that they
10 receive, and it is pretty clear that the decisions will change
11 depending upon how the information is packaged, the quality of
12 the information, and people do -- patients, just like
13 healthcare providers, do understand this. It's really not a
14 difficult problem, once they're in the situation where they
15 need to make a decision, but as you've pointed out, it's an
16 uphill battle to make -- to create a system when all the
17 vectors are pointing against you. So we've got economic
18 survival. You've got people's professional careers. You've
19 got all kinds of things at stake. You have journals that may
20 not be able to publish every two weeks.

21 So there are so many vectors that are pushing against a
22 truly evidence-based decision making process for our country
23 or our state, that it really has to focus, as Ward said, on
24 the people who are really facing the decision at that time.

25 So I don't think there is much question that the

1 information to people who are in the situation where they have
2 to make a decision will affect their decision, but it's quite
3 likely they're not going to get the right information. And we
4 spent, well, a number of -- we spent a lot of time with
5 Healthwise seeing how they try to understand.

6 Does everybody know what Healthwise is? It's actually a
7 Boise, Idaho company that specializes in packaging information
8 for patients, and they're very skilled at their work, and
9 they're very devoted, and I think that they're being -- well,
10 they're in use by Group Health and many other organizations to
11 try to fill the role that you're talking about, and I think
12 that what the ideal -- I mean, they've talked to us about the
13 ideal way to package information for patients, and we've
14 actually done some examples for them and sent them to them,
15 what, about ten conditions we did. I don't remember how many
16 we did.

17 But the answer is that everything gets watered down too
18 much, and they're not like the messaging scripts we showed
19 yesterday with quantitative information, but those messaging
20 scripts that I showed were only just one example that can be
21 used. I don't know that anybody has the answer. I think that
22 it's a difficult problem, but there is no question, in my
23 mind, that there is a need for the right information to make
24 the right decision. It's -- again, God is in the details, and
25 it's going to vary, depending upon how you approach it, and I

1 don't -- without seeing a more developed picture about how you
2 expect to go, I don't feel I can answer that question as well
3 as I'd like. Do you want to say something about this?

4 MS. STRITE: There certainly is an impact on patient
5 decision making in terms of how information is packaged and
6 then how it's presented and that's going to sound kind of
7 obvious, but one of the slides that we didn't show yesterday,
8 we talked about absolute risk reduction, relative risk
9 reduction and number-needed-to-treat, and there was some
10 research done on looking at patient acceptance rates of
11 treatment. We'll see how well I do this by memory. But when
12 patients were presented with that information in relative risk
13 terms for -- I think it was a statin. I think they were high
14 risk patients.

15 MR. STUART: It was a statin.

16 MS. STRITE: Eighty-eight percent of patients --
17 impressionistically, 88% of patients accepted the treatment.
18 When it was presented as absolute risk reduction, that figure
19 dropped to, I think, 34% of patients accepted the treatment.
20 When it was presented as number-needed-to-treat, which
21 sometimes is a challenging concept for patients to understand
22 -- so we actually like the number out of 100 that will benefit
23 -- I think that number dropped to 24%. So patients clearly, I
24 think, benefit from and react to quantitative information, and
25 we certainly have some tools and guidance that we'd be happy

1 to share with you that give you some ideas for ways to think
2 about how it can be packaged and what should be conveyed to
3 patients.

4 MR. STUART: It would be a very easy step to have a
5 conversation with one of the medical directors at Healthwise
6 as a consultant, a phone call. They're extremely wonderful,
7 nice people there, and they want to help, and they really
8 spend everyday -- many, many of them -- trying to figure out
9 how to do this so that patients can make the decisions that
10 are in their best interest. So I would, personally, give
11 Marty -- what's Marty's last name?

12 MS. STRITE: I'm happy to.....

13 MR. STUART: Yeah (affirmative). Sheri can take care of
14 that, but if somebody wanted to have a chat with them, they
15 would be, as part of sort of a due diligence information
16 gathering, brainstorming beginning, they would certainly be
17 able to provide some very useful input, I believe.

18 MS. STRITE: And I'll just mention that they're a non-
19 profit, very dedicated, wonderful people, so not that for-
20 profit is necessarily bad.

21 CHAIR HURLBURT: I think the State has used their book.
22 When was it, when we were with Premera? I know, in the past,
23 with one of the TPA vendors that we've had, that they've used
24 their books. So we've had some contact up here. Yeah
25 (affirmative), Deb used them.

1 MS. STRITE: And again as we stressed yesterday, in all
2 of the resources that we're talking about, there is variation,
3 too. And so anything that is provided to consumers to educate
4 them should have some cautionary notes like that.

5 COMMISSIONER ERICKSON: I think we're ready to wrap up,
6 and I'll summarize and make a couple suggestions, but Allen,
7 you said you had one question about Recommendation D that you
8 wanted to bring up.

9 COMMISSIONER HIPPLER: Yes, but we can wait for guests to
10 leave.

11 COMMISSIONER ERICKSON: Okay, but I think we'll probably
12 be -- well, we can talk about it as part of our next
13 discussion, I suppose, except that's getting into a little bit
14 too much detail.

15 COMMISSIONER CAMPBELL: I think Allen suggested a
16 Recommendation F to kind of bifurcate that recommendation
17 between the public and the private information. I don't have
18 any words for you, but that's -- I think that was his
19 suggestion.

20 COMMISSIONER ERICKSON: And I had wordsmithed that, and
21 I've just been looking, again, at this set of recommendations
22 that we have currently on the books here, and the first one is
23 to -- a general statement that the Legislature and the
24 Governor should encourage and support state health programs to
25 apply it, and as we've discussed, we can -- I can get some

1 follow-up suggestions from Sheri about how to wordsmith this a
2 little bit, so we make sure -- we did use the words "high
3 grade evidence," but maybe bring in the critical appraisal
4 terminology into that, so we can improve that recommendation.

5 So the first one is about encourage and support the in-
6 state health programs. The second is about -- Recommendation
7 B -- coordinate, that state health programs coordinate
8 development. The third is that providers and consumers,
9 stakeholders be involved in some way in that development.

10 And then we have these next two, which aren't directly
11 related. This Recommendation D about patient compliance, it
12 was more -- I think the private community represented at the
13 table when we were having this conversation was concerned,
14 generally -- if it's fair for me to read into this -- about
15 state health programs starting to develop new provider payment
16 methodologies and benefit designs and how patient compliance
17 and their responsibility for it and how they're going to get
18 paid get tied to patient outcomes. It was a concern about
19 that, and it wasn't as much, I don't think, directly related,
20 just like Recommendation E, to the evidence-based medicine
21 recommendation.

22 So what I've heard come out of this discussion this
23 morning then that we might -- I haven't heard anything, I
24 don't believe -- so correct me if I'm wrong -- that would, you
25 know, beyond clarifying, lead to any more substantive

1 changes to those first three recommendations, A, B, C, that it
2 be encouraged and supported, coordinated, and involve
3 stakeholders.

4 So what I've heard then that we might to this body of
5 recommendations is a recommendation that we support physicians
6 and clinicians to have better access to this information and
7 this skill and that we support patients to do so. So we don't
8 have something that, I mean, we can wordsmith, but if those --
9 if you agree, in concept, that we're doing that, I think we
10 can have a continuing conversation to clean up the wording,
11 without doing wordsmithing now, about that and then talk about
12 if we need to add a little bit more information with
13 recommendations about how to do it, or at least, be mindful of
14 what Ward was referring to earlier, and I added a third, is
15 the role of government. Government, as a payer, can implement
16 this for the patient population that they're responsible for,
17 the employees who are in their health plans. Government, as a
18 regulator, I haven't heard us going there yet with these
19 evidence-based medicine recommendations, but also government
20 as an information gatherer and information provider is more
21 about what we might be talking about here, but then we've also
22 talked about -- well, maybe I'll even add it -- government as
23 a supporter of educational programs.

24 And just as an example, when we were discussing end-of-
25 life care, one of the recommendations we made that is already

1 playing out in the system -- we haven't had an opportunity to
2 talk about it and learn about it together, but one of the
3 recommendations you all made was that palliative care, end-of-
4 life care issues be incorporated into educational programs and
5 curriculum for clinicians, and we have had conversations with
6 folks who are working on redesign of the WWAMI curriculum for
7 primary care providers, specifically, and we have staff here
8 who were involved in that, who have taken that message there,
9 and they've also shared it with heads of all the clinical
10 training programs at the university system.

11 So it's just another example of maybe how we can -- might
12 want to make a recommendation or elaborate on a recommendation
13 related to clinician training programs.

14 CHAIR HURLBURT: So the State pays \$50,000 a student per
15 year for the WWAMI program and \$50,000 a year for the family
16 medicine residents, and I was just really delighted to see
17 Bill Hogan here yesterday, as the Dean of School Health
18 Sciences at UAA here. So with the State putting that kind of
19 money -- and then are you suggesting maybe it would be an
20 appropriate recommendation, on our part, to say that one of
21 the expectations that state government has is that an
22 understanding and ability to use the concepts of -- that have
23 been presented related to evidence-based medicine would be one
24 of the expectations the State has in their various schools of
25 health sciences, whether it's nursing or.....

1 COMMISSIONER URATA: So I talked to a medical student
2 yesterday who said that they did get some training in
3 evidence-based medicine, but I don't know the details of what
4 that means, if there was critical appraisal being done or not,
5 but through the University of Washington. Maybe you folks
6 know. But it may already exist, so -- you know, but I think
7 it's okay to make sure.

8 MS. STRITE: Well, again as I was saying earlier, there
9 is, often times, a qualitative difference in terms of people's
10 understanding of what that means. So I'll embarrass people in
11 my state and just mention that I know of some people,
12 personally, for example, at Oregon State University and Oregon
13 Health and Science University that understand these principles
14 and have brought them into training, and yet, Mike and I did a
15 training program last year, and they encouraged one of the
16 residents, who is a pharmacy resident, who is one of the
17 graduates of that school, and at the end of two days with us,
18 she said, I got nothing like this, and she was an extremely
19 bright, extremely interesting woman, and I was literally
20 shocked. And so I followed up with a couple of people, and
21 they said, well, you know, some people are teaching bits and
22 parts.

23 And so even for a place to say they have programs, I
24 think, if you have an opportunity to evaluate what that really
25 means, what's really being done, what competencies really are

1 happening, I think that's very important. Evidence-based
2 medicine is something everybody wants to say they're
3 practicing, and a lot of people don't really know what that
4 means because they haven't gotten a good opportunity to get
5 quality training in that, too. So again, I know I keep saying
6 big variation.

7 CHAIR HURLBURT: We probably should go ahead and take our
8 break now because Mike and Sheri need to catch an airplane.
9 Thank you very much.

10 MR. STUART: Thank you very much. We really appreciate
11 being here.

12 MS. STRITE: We're very, very honored to be here.

13 CHAIR HURLBURT: We'll come back in about ten or 12
14 minutes maybe.

15 10:06:29

16 (Off record)

17 (On record)

18 10:19:44

19 CHAIR HURLBURT: I think if we could take out from your
20 books the section Stakeholder Meeting 8-9-2013 with the
21 meeting notes that Deb took there.

22 (Pause)

23 CHAIR HURLBURT: So Deb is going to amaze us all again by
24 kind of leading this section and being our scribe.

25 COMMISSIONER HIPPLER: Mr. Chairman? Mr. Chairman, a

1 quick question. The additional recommendation proposed by Dr.
2 Urata, are we moving past that or where are we at with that?

3 COMMISSIONER ERICKSON: So we didn't have a motion about
4 this specific recommendation, the proposed new F, the
5 recommendation that the State implement a web-based system for
6 making information on critical appraisal of evidence-based
7 medicine available for patients in the general public. I
8 ended up generalizing that a bit more around these two
9 potential new recommendations and suggested that I could do
10 some wordsmithing and bring them back to the next meeting.

11 One is about support for patients in the general public,
12 and the other about support for physicians and clinicians.

13 COMMISSIONER URATA: And I think that Dr. Hurlburt's
14 subsequent discussion should be kept in mind that, you know,
15 perhaps the insurance companies should actually pay for that
16 and not necessarily the State of Alaska, but some sort of web-
17 based information, evidence-based information should be
18 available for patients when they need it. And so it doesn't
19 necessarily have to be a state-run program, but you know,
20 somebody ought to have that available for patients. I think
21 many of them don't even know it exists.

22 COMMISSIONER KELLER: On that point, you know, and if I'm
23 remembering right, Blue Cross said that they were putting cost
24 information online and then Aetna followed up and said the
25 same thing. I went to both sites, and I've got to admit that

1 I didn't spend eight hours at it. I mean, I might have missed
2 it, but what they were -- like the Blue Cross site, it was a
3 statement that they're doing it. You know, I didn't -- there
4 was no useable database of information about specific
5 procedures that I could find. I might have missed it, and I
6 couldn't find it on Aetna either. So just -- I mean, we may
7 be a long ways away here.

8 COMMISSIONER URATA: One thing just came to mind when he
9 said that. You know, if we have the insurance companies do
10 it, they might do their own, and it might be pretty biased.
11 You know, that's part of the thing. So -- but if they did
12 DynaMed, you know, then maybe it wouldn't be so biased. But
13 you know, it's something to look into.

14 CHAIR HURLBURT: Allen, did you have -- either in regard
15 to the DynaMed type of information or in terms of the point F
16 that you mentioned, did you have some wording on a
17 recommendation that you wanted to make?

18 COMMISSIONER HIPPLER: No. I wanted to talk about the
19 proposed finding, but if that finding has been withdrawn or
20 not talked about anymore, I don't have anything to say.

21 CHAIR HURLBURT: Okay. Thank you. Deb?

22 COMMISSIONER ERICKSON: Just to quickly revisit, what
23 we're going to do right now, for the next hour, is review the
24 feedback that we received at the Stakeholder's Meeting on the
25 9th, and I have included, in your handouts -- I think Dr.

1 Hurlburt was just pointing out -- the meeting notes from that
2 meeting. So it looks like this. You should have it. It says
3 Stakeholder Meeting at the top. You've got it. And I have
4 put -- what I've done is I've gone through those and have
5 treated this similar, just in terms of process, to the way
6 that we've worked with comments received during our written,
7 formal comment periods when we've circulated our draft reports
8 and during the month of November, and I'm treating this
9 similarly to how we've done our December meetings in the past
10 where I've tried to summarize and paraphrase the comments in a
11 series of slides in the meeting discussion. And so we'll go
12 through each section, and you all can share your thoughts in
13 response, and we can have a conversation about points that
14 you're interested in having a conversation about.

15 But just to start off the discussion again, what prompted
16 Commissioner Streur to convene that group a couple of weeks
17 ago of stakeholders is a plan to kind of try to move to the
18 next step of taking the Commission's recommendations to date
19 and putting together a statewide health plan, based on these
20 recommendations.

21 And I think something that we should all be thinking
22 about together as we move forward, too, is what the
23 Commission's role has been shaping up to be related to the
24 official state health planning and coordinating body under our
25 statute as well as developing recommendations for state

1 government and how those get implemented.

2 And so I just put an outline and shared this at our last
3 meeting about how we've had this role related to developing
4 visions and priorities and core strategies and more specific
5 policy recommendations and also spending some time studying
6 the current system has all been providing the framework for a
7 state health plan and that, beyond that now, we might have
8 more of a convening and a coordinating role in working with
9 the state agencies that might be implementing various aspects
10 of those recommendations and coming to us, not us going to
11 them and telling them how we think they should do it, but
12 asking them to come to us to share with us what their action
13 plans for implementation are.

14 And so that's kind of the next steps, but then also the
15 healthcare system stakeholders' engagement is important, and
16 I'm imagining what that will be, will be similar to what we
17 might be doing with state agencies. And I think what happened
18 at this last meeting was a good example. We have a few pages
19 of feedback on what we have done to date, but there has been -
20 - I mean, all of that has been very open and transparent all
21 along, and there have been opportunities to comment on those
22 recommendations as they were in draft form in the past.

23 But I think what we might be more interested in the
24 future is also hearing from stakeholder organizations what
25 actions and initiatives that they're implementing that relate

1 to our core strategies.

2 And I'm just thinking about some of the comments I heard
3 related to evidence-based medicine and some of the concerns I
4 think I heard this morning, it will be interesting -- it would
5 be interesting to bring together the different insurance
6 companies, along with the TPA for the state health plan. And
7 one of the insurance industry reps, who was in the room
8 yesterday, was sharing with me something that -- a new
9 initiative that they're working on related to evidence-based
10 medicine.

11 One of my thoughts was we have all of these different
12 insurance plans coming up with their own strategy. How are
13 the poor providers going to deal with this? But perhaps,
14 that, again, could be part of Commission's role going forward
15 is convening these folks along with the people and the
16 providers who are subjected to all of these great new programs
17 and ideas and be a place for monitoring progress and see how
18 it's going and if it's working or not and if the principles
19 that we've been learning about are actually being applied or
20 not, and then ultimately, most importantly, are we able to
21 determine, in some way, whether we're having the positive
22 outcomes as a result. Yes, Keith?

23 COMMISSIONER CAMPBELL: If we could get them together in
24 one room to do something like that, I think it would be fine
25 because maybe we could encourage them not to build in too many

1 individual biases. It's bound to happen, if they do their own
2 without any coordination whatsoever.

3 COMMISSIONER URATA: How do they differentiate themselves
4 from each other as they try to compete for the marketplace?
5 I'd just leave them alone. And if they want to get together,
6 they can do that, I mean, but.....

7 COMMISSIONER ERICKSON: So moving on, this is -- I just
8 pulled in a slide that we shared at that stakeholder meeting,
9 and I think the only person here who had to miss that meeting
10 was Dr. Urata. Is that right? So everybody else around the
11 table, at this point, was able to be with us that day.

12 So we're working the Department of Health and Social
13 Services and also with these other programs, who now have
14 become real interested in the work of the Commission and
15 engaged in sharing information with us and learning with us,
16 as evidenced by the Department of Administration's engagement
17 the last couple of days and also the Worker's Comp program, so
18 not just Department of Health and Social Services, but we'll
19 be ramping up coordination with them over the next year. And
20 then assuming the Commission survives its sunset date, we
21 could have a role in monitoring, evaluating, and refreshing
22 the plan over time.

23 So starting then -- what I did -- I moved up, just
24 because it was about process -- and then we'll go into the
25 vision and the various areas. What I've put here on slide 14

1 is just a summary of what, in your longer handout of the
2 meeting notes from the Stakeholder Meeting, is on page three.
3 So just in case you want to check back to make sure I've been
4 accurate and honest in summarizing and paraphrasing the points
5 that were raised by the folks in the meeting, you could do a
6 double check there.

7 But I picked up two major questions related to the health
8 plan process. Well, actually three. Two were about process,
9 and one was a little more substantive. One was a question
10 about what are the roles of other planning bodies in other
11 statewide plans in the statewide health plan that we're
12 facilitating the development of here. Another question was,
13 what is the role of stakeholders, including providers? And
14 the third wasn't as much a question as an observation, is a
15 feeling, generally, that, from all of the core strategies and
16 more specific recommendations made to date, insurance coverage
17 isn't addressed as a means of increasing access.

18 I'll open it up for you all to comment and discuss. I
19 just wanted to note that I think we are forming the answer to
20 those first two questions. I've been working most closely
21 with the Healthy Alaskans initiative. That's why they've been
22 coming here around the prevention part of our strategy.
23 Generally, what the Commissioner has shared as his vision --
24 and he's supposed to be here, so if you want to ask him more
25 about that when he gets here at 11:00 -- is that he's seeing

1 the work that we're doing as providing kind of an umbrella
2 that we're not going to duplicate or redo or revise work that
3 other statewide planning groups are doing, but we're maybe
4 providing a home for linking and identifying and trying to
5 prevent duplication for some of those initiatives, like the
6 behavioral health boards, for example, and any planning work
7 that they're doing, the Older Alaskans Commission and the
8 planning work that they do for seniors.

9 Another good example is the Workforce Coalition. We
10 identified, early on -- you know, our first year, we came up
11 with some specific recommendations related to workforce at the
12 same time the Statewide Workforce Coalition was developing.
13 We've identified that as a group that's kind of taken the lead
14 for that. It's not that we're automatically adopting every
15 recommendation that they come up with, but we're not going to
16 duplicate their effort and acknowledge them as the Statewide
17 Workforce Development Coalition.

18 And the role of stakeholders, I think, we addressed
19 earlier, to the extent that we have our processes open and
20 public as possible and opportunities to comment on drafts,
21 that there is an opportunity for engagement there.

22 So anyway, that's my thought on those. I'll just open it
23 up for comments, discussion. And I guess maybe it would be
24 helpful, too, what I'm imagining we'll do is something very
25 similar for those of you -- most, but not all, of you have

1 been part of our kind of fifth annual meeting, our December
2 meeting where all we do is get together to review comments
3 received on our draft Findings and Recommendations that we
4 circulate in November, and I've tried to summarize and
5 paraphrase them in slides, and we'll go through, but we don't
6 need to discuss every single point. It's up to you all to
7 identify what you think is something that you might want to
8 question or emphasize and if you want to do something with it
9 or not. So I'm just going to open it up. Is the process
10 clear before we move, what we're doing over the next hour?
11 Okay. Heads nodding.

12 So questions or comments related to the process, the
13 feedback we got on the process generally? Bob?

14 COMMISSIONER URATA: Under -- you know, I missed that
15 meeting, but under number one, what is the role of other
16 planning bodies and other statewide plans, that question is --
17 are we supposed to look at other statewide plans and see how
18 they are working and then suggest how we should work or is
19 that why that question is there?

20 COMMISSIONER ERICKSON: I did not -- I think it was a
21 more general question. I don't think it was a suggestion.
22 And one of the things that I did not include in your notebooks
23 this time -- I've included it a couple times in the past. The
24 only thing we've done so far in this coordination role is
25 compiled an inventory of all of the statewide bodies that have

1 some sort of health-related planning role. That's a pretty
2 long list, but we have that inventory. A much longer list is
3 an inventory of all of the statewide plans and reports that
4 address health in some way and that's a much longer list. I
5 think I have those posted on our website, but that's all we've
6 done so far. And we have not, in the past, asked the
7 Commission members to go review those specific reports for the
8 most part. Well, not for the most. All of them are related
9 to specific topics or issues. So we have a statewide HIV
10 plan, for example. That's getting at a little bit too
11 detailed of a level for this group to have the time or the
12 resources to review and address.

13 So far, our coordination role has not provided -- has not
14 been to go into that level of detail. I think this question
15 was more about there are these other groups and programs
16 involved in statewide health-related planning in some way, and
17 they want to understand what part they're going to play, and
18 if the Department of Health and Social Services is putting
19 together a statewide health plan, what is their role in that?

20 COMMISSIONER URATA: Well, it seems, to me, that it ought
21 to be up to the Commissioner or the Governor to determine, you
22 know, what role we should play, depending on, you know, the
23 overall plan and where we might fit into that plan. I'm not
24 so sure that we should actually include ourselves in a plan,
25 necessarily. Although, you know, it seems reasonable to have

1 some sort of a committee that coordinates.

2 COMMISSIONER ERICKSON: Well, actually under the statute,
3 it's our responsibility to do that. So that's where -- so
4 that's what -- if you look -- I know. So if you look at slide
5 ten, the bill that established the Commission in statute.....

6 COMMISSIONER URATA: (Indiscernible - away from mic)

7 COMMISSIONER ERICKSON: Yeah (affirmative). So the
8 Commission shall serve as the state health planning and
9 coordinating body as part of our charge under our statute.

10 And the second bullet is not in the Commission's section
11 of statute. It's in the Department's section of statute, and
12 it's authorization for the Department, and specifically -- I
13 put in italics -- the Department -- at that part of statute,
14 the Department of Health and Social may develop, adopt, and
15 implement a statewide health plan, based on the
16 recommendations of the Commission. Does that help?

17 COMMISSIONER URATA: Yes.

18 COMMISSIONER ERICKSON: Val?

19 COMMISSIONER DAVIDSON: So what is our process for
20 hearing periodically from those other statewide planning
21 bodies, to this process? So for example, the behavioral
22 health -- all of the other groups that are meeting and making
23 recommendations, what is our process for input here?

24 COMMISSIONER ERICKSON: We don't have that process in
25 place right now, so that's part of the evolution of the role

1 of our Commission, right now, is moving forward. Should we
2 have -- I mean, it's more of a process piece. Do we want to
3 have them come and report to us what they're doing under this
4 coordination role? Or so far what we've done is acknowledged
5 that there are these other statewide bodies responsible for
6 this piece of the puzzle, and we're not going to duplicate it.
7 So that's what it's been so far. Whether it's going to evolve
8 to convening them as part of these meetings to report to us
9 and discuss it, I don't know if that's what you're suggesting.
10 Val and then Bob?

11 COMMISSIONER DAVIDSON: I think it would make sense to
12 hear what the recommendations are. I mean, it would be -- so
13 for example, the last day-and-a-half, we've heard from these
14 incredible experts. Whereas if we treated them like the
15 others, we would say, well, we're going to let them do that
16 work, and we'll take their -- I mean, we should -- if we have
17 -- if those folks are being charged and considerable state
18 dollars are being spent to be able to provide those
19 recommendations, we probably ought to take a little time to
20 hear what those recommendations are, in the same way that
21 we've made those opportunities for others that we have
22 consulted with to provide that information to us.

23 COMMISSIONER URATA: So another way of looking at it then
24 is that we have a set of goals. Then we have to develop an
25 action plan with that and then we need to figure out who is

1 going to implement the action plan. Do we need legislative
2 action for some of those action plans or is this something
3 that the Commissioners can just implement, if we communicate
4 that this is an important thing, and you know, negotiate or
5 however you get those implemented into the culture and plan
6 for the state? And then we need to do monitoring.

7 So we have a set of goals. We have to develop an action
8 to implement those goals and then monitor, and we, you know,
9 have got to figure out who is going to implement that. I
10 mean, this is sort of like -- you know, you get something from
11 the Legislature, and you have to implement it and develop
12 rules around. Is that -- am I going way over in terms of our
13 goals for what we've done? And then, of course, there are
14 some goals that really don't apply, but I mean, it seems like
15 we have to develop that kind of a thing.

16 COMMISSIONER ERICKSON: It depends on who you mean by
17 "we."

18 COMMISSIONER URATA: You.

19 COMMISSIONER ERICKSON: Thanks. No. So the way that the
20 process is going right now is that we have laid out these
21 eight core strategies with more specific policy
22 recommendations, but they're still general policy
23 recommendations. But what we've been trying to avoid doing
24 all along is suggesting to state government exactly how they
25 should be doing it and getting at an operational level. We

1 don't have enough information about budget, staffing, other
2 federal regulatory requirements that they might be operating
3 under, those sorts of things.

4 So the next step in the process in coordination that
5 we've identified is that these organizations come to us, that
6 these state agencies come to us and say these are the action
7 steps that we are taking. So that's the action step part of
8 the plan. We're not telling them what action steps to
9 implement. They come to us and say these are the action steps
10 we're taking to implement this particular core strategy.

11 Senator Coghill and then Allen?

12 SENATOR COGHILL: So in the next steps, should we then
13 ponder, you know, the -- should we take a look at the list of
14 those who are doing health planning -- do an evaluation based
15 on, you know, price, quality, access under the various
16 different things that we've been looking at and then develop
17 some questions that we asked them to come answer, is that what
18 you're thinking?

19 COMMISSIONER ERICKSON: I don't think so, generally.
20 What you're suggesting is more of a monitoring role, that the
21 Commission have a monitoring role over all state health plans
22 and all aspects of it.

23 SENATOR COGHILL: I wasn't so much thinking about
24 monitoring, Deb. I was thinking about asking them, how are
25 you implementing quality decisions, based on your health

1 planning, to help us understand are we even on the right track
2 or can we partner by making recommendations? So that's kind
3 of what I was thinking. Do we ask them questions to come talk
4 to us about or do we share with them our goals and then what?
5 So that's what I'm wondering. If we do collaboration, it has
6 to be based around some questions, and certainly, these core
7 strategies become our major questions, right?

8 COMMISSIONER ERICKSON: Exactly. So that's what I was
9 really imagining, to Val's earlier question, was that these
10 other statewide planning bodies' relationships to the
11 Commission would be very similar to what we're working on with
12 the state agencies themselves. It's not that it's just an
13 open -- every activity we're going to review and discuss
14 together and have questions about, but ask them to come sit at
15 the table and share with us what activities and
16 recommendations they have that align with the eight core
17 strategies and then ask those questions of them. So Val?
18 Allen had had his hand up, and Bob his hand up now.

19 COMMISSIONER DAVIDSON: I think, if we want to remain
20 true to what our charge is, a more open-ended question to
21 those who are coming to present would be, we are charged with
22 developing a statewide health plan; based upon your expertise
23 in this particular area, what are the things that you
24 recommend that the Commission take up to be able to include in
25 our health plan and why? Because I think, if we limit that

1 and if we narrow that, we're going to miss a lot of
2 opportunity. The quality of the answer that we get will be
3 completely based upon the quality of the question that we ask.
4 I think we've heard that in the last couple of days.

5 COMMISSIONER ERICKSON: Allen and then Bob?

6 COMMISSIONER HIPPLER: Mrs. Erickson, I'm sorry to do
7 this to you. I know you just went over this 15 minutes ago.
8 I'm a little confused about what we're doing this second, and
9 I don't understand how it's related to the Stakeholder Meeting
10 we had a couple of weeks ago. I'm sorry. I just don't
11 understand.

12 COMMISSIONER ERICKSON: Please don't apologize. It's
13 okay. It's important to clarify process. What we're doing is
14 reviewing the comments received at the stakeholder meeting and
15 discussing those comments. And so the specific comment
16 received at the Stakeholder Meeting that we're discussing
17 right now is, what is the role of other planning bodies in
18 statewide plans in relation to the work of the Commission and
19 the Department's effort to develop a statewide health plan?
20 Does that make sense?

21 COMMISSIONER HIPPLER: So page three?

22 COMMISSIONER ERICKSON: So it's on page three of the more
23 detailed meetings notes, at the bottom of page three, the
24 questions related to the state health plan process and what I
25 have up on the screen on slide 14. Does that make sense?

1 COMMISSIONER HIPPLER: So we didn't -- I don't recall any
2 feedback or much feedback on that question at the Stakeholder
3 Meeting. This was a question posed to us that we're supposed
4 to answer now?

5 COMMISSIONER ERICKSON: We don't need to answer this
6 question right now, but we're just gathering the response of
7 the Commission members to this particular feedback point. So
8 we're not going to make any decisions about this, necessarily,
9 unless somebody wants to make a motion. But for now, so far,
10 since there is nothing in particular that folks seem inclined
11 to actually make a specific motion about, what I would say is
12 this information-gathering your thoughts as we -- and "we"
13 being Dr. Hurlburt and I -- go back and continue working with
14 Commissioner Streur and Commissioner Hultberg and others and
15 also having conversations with other statewide planning
16 bodies, continue to just evolve what the role of the
17 Commission is going to be and how the process is going to
18 work, also understanding that you have very limited staff and
19 resources and time, yourself, for this work. We need to keep
20 that in context, too. Yes, Dr. Urata?

21 COMMISSIONER URATA: Well, maybe I'm ahead of the way
22 things work, but you know, if we go through all of these core
23 strategies and just say who would be responsible for doing
24 them, is that something that could be done to make -- as a
25 step towards getting this implemented?

1 COMMISSIONER ERICKSON: I don't.....

2 COMMISSIONER URATA: Kind of like "ensure the best
3 available evidence," well, who does that? Well, it's public
4 health or something like that, a department. "Increase price
5 and quality transparency," I don't know, is there is a
6 department in your -- is there somebody who you have in mind
7 to do that or pay for value?

8 COMMISSIONER ERICKSON: So I don't think that's something
9 that the Commission has -- that's getting too operational
10 again. What we're going -- what we're going to do is go back
11 and start documenting what we're learning in conversations in
12 between meetings from them what they're doing, and if they're
13 -- and then going forward in the future, we'll start inviting
14 them to the table. So just -- I'll be doing the work of
15 compiling information about who is doing what and documenting
16 those and action steps that they have identified.

17 COMMISSIONER URATA: Well, I'm looking at it from a point
18 of monitoring, so that we can go the next step, like, how is
19 the person who is looking at Pay-for-Value doing, and can we
20 get a report from then.....

21 COMMISSIONER ERICKSON: Right. Exactly.

22 COMMISSIONER URATA:or when will they be able to
23 give us a report, that sort of thing.

24 COMMISSIONER ERICKSON: Right. Right.

25 COMMISSIONER URATA: So have you identified folks who

1 would be responsible for doing these eight core strategies?

2 COMMISSIONER ERICKSON: Not in writing, but I have a good
3 idea.

4 COMMISSIONER URATA: Okay. Am I getting ahead of.....

5 COMMISSIONER ERICKSON: No. Unh-unh (negative). Yes,
6 Val?

7 COMMISSIONER DAVIDSON: So I'm a little -- I guess I'm
8 confused. So having the -- are we going to now have other
9 statewide planning bodies come and report their
10 recommendations to us or do we need a formal motion to make
11 that happen? I don't recall we needed a formal motion to be
12 able to get all of these other folks who came to present to
13 us, so.....

14 COMMISSIONER ERICKSON: Well, the reason these other
15 folks were coming to present to us is we're identifying -- we
16 have an agenda that you all set for a year, and we circulate
17 that for response as a draft and then that's voted on. So
18 what we voted on at the end of last calendar year was we were
19 going to spend more time this year studying evidence-based
20 medicine. And so Ward and I identified who we thought would
21 be the best consultants for helping the Commission to do that,
22 and we brought them to do that.

23 COMMISSIONER DAVIDSON: I guess what I'm wondering is, I
24 think we should caution ourselves. We seem to have a love for
25 consultants, which I think is, on the one hand, really

1 helpful, but I think we should also look from within, within
2 our own state, these other folks, these other planning bodies,
3 these other commissions that have been established by the
4 Governor, assuming -- I assume are doing great work in moving
5 forward recommendations. And as we're considering those other
6 things, in addition to these outside consultants, we should
7 also look within and see what recommendations that our own,
8 internal folks have come up, and perhaps, there will be some
9 balance there or maybe they're all singing the same song, but
10 I think that we often say every time -- and I've heard -- I
11 don't know that there is a person with exception who said
12 this, Alaska is different, and I think that we should probably
13 make the best of those resources that the State has spent to
14 be able to invite those folks to come and present, so we may
15 have the opportunity to hear what the recommendations are.

16 COMMISSIONER ERICKSON: Why don't I suggest, so we can
17 move on because we've got a lot of other slides to cover
18 related to feedback, that, for now, what I'm going to do is
19 include them, the other statewide planning bodies along with
20 the state agencies -- and they're part of state agencies, all
21 the ones I'm thinking off of the top of my head, either an
22 initiative of or an actual body within the Department of
23 Health and Social Services, for example -- that we incorporate
24 them in the action plan that we're going to start documenting,
25 and then out of that process, it should identify -- there

1 might be something bubble up that we need to have a specific
2 presentation on as we review that. Yes, Representative
3 Keller?

4 COMMISSIONER KELLER: Question, what do you mean
5 "incorporate?" Does that mean we have to go in and look at
6 their mission statement and everything and evaluate what
7 they're doing? I mean, they're still -- we invite them as
8 they fit our need as we go along trying to accomplish our
9 mission, not that we would come here -- and okay.

10 COMMISSIONER ERICKSON: Right.

11 COMMISSIONER URATA: So one of the things is, do we have
12 -- you know, I think, if we're going to monitor, we have a
13 duty to measure, as well, outcomes, and you know, I think one
14 of the ways to measure is, you know, if our vision is coming
15 to reality, but that's going to take ten years or so. But the
16 other thing is, how do we measure cost savings in all of these
17 recommendations? Because I think a lot of these
18 recommendations come from our feeling, evidence-based or not,
19 that they would save money and lives.

20 COMMISSIONER ERICKSON: You don't want an answer to that
21 question now, right? I'm just capturing it as a question.

22 COMMISSIONER URATA: Well, I was wondering how -- we have
23 to.....

24 COMMISSIONER ERICKSON: I think that says part of the
25 conversation is.....

1 COMMISSIONER URATA: Yeah (affirmative). We need to make
2 sure.....

3 COMMISSIONER ERICKSON: As Senator Coghill was
4 suggesting, that we'll have a set of core questions that we'll
5 ask as these programs bring their action steps.

6 COMMISSIONER URATA: Yeah (affirmative). We can't forget
7 about measurements.....

8 COMMISSIONER ERICKSON: Right. Right.

9 COMMISSIONER URATA: to see if it's working or not.

10 COMMISSIONER ERICKSON: Exactly.

11 SENATOR COGHILL: I think just embedded within what are
12 the alignments -- as we go forward the rest of the year, I
13 mean, part of it is identifying alignments, as you said. So
14 embedded in that should be, how do we identify a congruity
15 that's going to be embedded in their plan? So I will
16 definitely be thinking about those things.

17 COMMISSIONER ERICKSON: Other discussion about the
18 planning process feedback before we move on?

19 COMMISSIONER DAVIDSON: Did we address the third one,
20 transparency?

21 COMMISSIONER ERICKSON: We did not.

22 COMMISSIONER DAVIDSON: So on page -- at the bottom of
23 page five and the top of page six, one of the things that we
24 are specifically charged with doing is evaluating the increase
25 in number of insurance options for healthcare services. And

1 so I would recommend that we spend some time looking at the
2 impact of insurance or the lack of insurance for covered
3 Alaskans and the impact that it has on access to care.

4 COMMISSIONER URATA: Question?

5 COMMISSIONER ERICKSON: Yes?

6 COMMISSIONER URATA: Isn't the Accountable Care Act
7 supposed to help with some of that -- the Affordable Care Act,
8 excuse me?

9 COMMISSIONER ERICKSON: It's supposed to, but that's our
10 next agenda item.

11 COMMISSIONER URATA: Okay.

12 COMMISSIONER ERICKSON: So what I would suggest that we
13 do is put this in -- start our draft 2014 calendar year agenda
14 and put this on the list for the 2014. I've got one thumbs-
15 up. I've got two thumbs-up. So this is starting, just like
16 last -- this time last year, we started putting together and
17 started solidifying more at our October meeting and put it out
18 for public comment these are the issues. Like, evidence-based
19 medicine was one. Continued employer engagement activities
20 was another that we were going to study this year. So
21 insurance coverage would be one of the things that we'll study
22 during 2014. Does that make sense? Okay. Should we move on
23 now?

24 A vision statement. How much time do we have? Time has
25 gotten really short, and Commissioner Streur and Josh have

1 joined us. We were going to go until 11:15 with this
2 discussion, but we got through one slide out of several.

3 So let's talk about vision statement and then give you a
4 chance to review, quickly, the other slides you have in your
5 handout, too. And I guess what I would suggest is let's talk
6 about vision statement next, but then if there are any
7 comments related to any of those core strategies that you
8 particularly wanted to address, let's try to do that quickly,
9 too, and move on, so we can have the Commissioner and Josh
10 come join us.

11 COMMISSIONER HIPPLER: So at this time, are we supposed
12 to be determining whether or not this slide accurately
13 captures comments that we got or are we supposed to comment on
14 these?

15 COMMISSIONER ERICKSON: You're supposed to comment on the
16 comments we received, but you have an opportunity to call me
17 on the carpet, if you think I've mischaracterized something,
18 but our process isn't for you to comment on how I've captured
19 the comments. It's to respond to the Stakeholder comments.
20 If you think that I've mischaracterized them, then call me on
21 it.

22 COMMISSIONER DAVIDSON: So I also heard a couple of
23 people notice that dental care or oral healthcare wasn't
24 specifically included, and some folks consider that a part of
25 primary care, and other folks don't.

1 COMMISSIONER ERICKSON: I will add that to this bullet.
2 Other comments or response or would you like to move on?
3 Allen?

4 COMMISSIONER HIPPLER: I do recall the comment calling
5 into question the desire to reach the lowest per capita cost
6 for healthcare. I just respectfully disagree with the
7 commenter. I think it's a -- although I also question our
8 ability, I think it's a worthy desire.

9 COMMISSIONER DAVIDSON: I think what you have captured
10 there is accurate. There are both pros and cons.

11 COMMISSIONER ERICKSON: Should we move on to evidence-
12 based medicine? So the comments we received, folks felt as
13 though we were aligned. There were a couple of comments about
14 the importance of patient education and communication. We
15 spent a considerable amount of time this morning, earlier this
16 morning talking about that, and a point that we don't always
17 have the sufficient evidence available for making decisions.
18 So everything we've learned the last day-and-a-quarter have
19 borne that out. I'm going to move on, unless I see some
20 indication of interest in discussing the comments.

21 For increasing transparency, there was a suggestion that
22 a government role could be to mandate healthcare providers
23 provide a sticker price, like government requires car dealers
24 to do, that all sectors of the healthcare industry be
25 included, not just a couple of different types of providers or

1 different parts of the sector. I think this was specifically
2 related to our recommendation related to data systems. We
3 have a couple of recommendations under transparency related to
4 two specific data systems, All-Payer Claims Database and
5 Hospital Discharge Data, and a concern to make sure that we
6 are addressing privacy and security concerns, who owns the
7 data, the purpose for the data, the uses of the data, those
8 sorts of things.

9 Importance of measuring and the difficulty in doing that,
10 and the challenges that rural Alaskans have, and while they
11 might have -- if they have more transparency, they still not
12 have as much choice as folks in urban areas and folks with
13 more financial means. Any questions or discussions around
14 those comments? Yes, Allen?

15 COMMISSIONER HIPPLER: Well, first of all, I don't like
16 government mandates about prices. I don't like that idea, and
17 I think it's impractical. If we're going to use the analogy
18 of cars, imagine if you're car broke down, and you took it to
19 a mechanic, and before the mechanic could actually start
20 working on it and get into your car and figure out exactly
21 what the problem was, he had to give you a sticker price.
22 Well, I mean, that wouldn't be very useful because he would
23 say, well, you know, it's probably this, but it might be this
24 or this or this.

25 Similarly with a medical professional, even in elective

1 surgeries where you know a week in advance what you're going
2 to do, there could be complications.

3 COMMISSIONER ERICKSON: Other comments? Pay-for-Value.
4 Did you have something, Dave?

5 COMMISSIONER MORGAN: Well, from my experience in three
6 states, one with information posted with quality measures and
7 two without, at least, having -- you, at least, have an idea
8 of what a Toyota Camry will be, and whether you get certain
9 electives in it will change the price. And yeah
10 (affirmative), it is true that you may go in for a hernia
11 operation, and suddenly, you know, you have a complication.

12 From what I've heard, especially from the healthcare
13 insurance underwriters who have been doing a lot of work on
14 this and have their own, little system so they can make
15 rational decisions on how to measure risk, I don't think it --
16 I think it would be helpful for everyone to, at least, get an
17 idea of the relative comparison between providers or between
18 hospitals or surgery centers or whatever what they are
19 charging or what it's costing. If nothing else -- and the one
20 I saw in Kentucky actually has a statement saying, barring any
21 -- you know, like a disclaimer of complications or problems,
22 and usually, describing that group of surgeries. They don't
23 do all of them. They basically do the top 30 diagnoses or
24 surgeries or whatever.

25 So though I loathe -- and trying -- I don't think we

1 should ever become a rate review state because I've worked in
2 that situation, too, in Indiana under Governor Brown, who is
3 an M.D., by the way. I think all of us, from insurance
4 companies to people paying for it, ought to, at least, have an
5 idea of what the charges are or what the costs are or
6 something to get a relative value in making a decision,
7 especially on the most used diagnoses, like babies. You know,
8 where would you like to have your child between the three
9 hospitals? Or if you're getting a hip replacement, which some
10 of us may get to experience here pretty soon, is it better to
11 go to Portland so you can make -- to be able to compare
12 prices? It also helps, at least, bring some market forces
13 into this, not a whole lot, but some.

14 So I kind of take the middle ground on this. I know you
15 expect me to be very militant, but I have to -- I'll take the
16 middle ground. We've got to have something to measure and
17 compare with, even if it's only the major diagnoses or
18 surgeries, or you know, not on all 5,000, but on the top 30 or
19 something.

20 COMMISSIONER ERICKSON: Senator Coghill?

21 SENATOR COGHILL: Just a comment. I agree that it was
22 the stakeholder feedback, and I think the takeaway for us is
23 people are interested in price transparency to the highest
24 degree they can get. So I think we should move on.

25 COMMISSIONER ERICKSON: Pay-for-Value. I'm not going to

1 take the time to review these in detail. I'll just let you
2 read them and see if there is one to want to respond to, just
3 in the interest of time. If there is no comment on payment
4 reform -- yes, Keith?

5 COMMISSIONER CAMPBELL: I'm struck by the "Benefit
6 managers need to be reconsidered." I don't recall how much
7 savings that they -- the person brought forward, if any, other
8 than just a general statement about benefit managers and this
9 potential savings or that sort of thing. I seem to recall
10 that there are these manager companies that are rife with
11 games that they play with states and (indiscernible - voice
12 lowered) and places like that. So I don't know how solid that
13 statement is for real benefit. I don't think we got that
14 answered, quite frankly.

15 COMMISSIONER DAVIDSON: And I don't see it on the notes.

16 COMMISSIONER ERICKSON: It might be one of the ones I
17 pulled forward. We're not going to review the many pages -- I
18 noticed we have just a couple of pages on feedback, but the --
19 we have many pages, lots of good information about what others
20 are doing that align with the Commission's eight core
21 strategies, but there were a few points thrown out during the
22 sharing time, I think, when folks had an opportunity to think
23 a little bit more, that they threw out that was more of a
24 comment, not sharing a contribution. And so I put, in italics
25 at the beginning of those bullets, starting on page four, so

1 about -- just to see, for one example, about halfway down
2 under evidence-based medicine, I put, in italics at the
3 beginning, consider under feedback. It was a point that
4 somebody was sharing that wasn't, "This is something we're
5 doing to contribute to this;" it was more of a general
6 comment, and I moved it to -- I included it on the slide --
7 all of these points on these slides. Does that make sense?

8 COMMISSIONER HIPPLER: I believe that specific comment
9 was received in writing by Dr. Kiessling, and he
10 (indiscernible - simultaneous speaking).

11 COMMISSIONER ERICKSON: No. It's at the bottom of page
12 four. It was under the Pay-for-Value discussion, and it was -
13 - yes. It was Dr. Kiessling, but he did share it with the
14 whole group during the discussion. It just got captured under
15 Contributions rather than under General Comment.

16 COMMISSIONER KELLER: If I could at some point, maybe
17 2014, I'd sure like to explore this a little bit more. He
18 isn't the only source of persons that have brought that to my
19 attention as something we ought to be paying attention to, and
20 the information I have, which may be dead wrong, is that this
21 could be very significant financial issue to examine.

22 COMMISSIONER ERICKSON: So I just put that on our
23 tentative draft agenda for 2014 to look at pharmacy benefit
24 managers.

25 Engaging Employers. Again, this was one that was put --

1 suggested during the contributions, but it would be useful to
2 provide employers with data and information about what others
3 are paying and doing.

4 I'm moving on to Strategy V about primary care, the
5 comment, again, about making sure we're including behavioral
6 health when we mention primary care and the comment, again,
7 about insurance coverage. Somebody thought we should be
8 emphasizing all services all services, not just primary care,
9 and a comment that it's a means, not an end. Any additional
10 discussion or questions or comments about the comments
11 received in that area?

12 COMMISSIONER DAVIDSON: I thought I heard an emphasis on
13 providing care as close to home as possible through utilizing
14 technology, like telemedicine.

15 COMMISSIONER ERICKSON: I'm just going to go ahead and
16 add that in here. I'm remembering that coming up in the
17 discussion specific to end-of-life care, but it certainly is
18 generalizable to all areas.

19 COMMISSIONER DAVIDSON: (Indiscernible - away from mic)

20 COMMISSIONER ERICKSON: The contributions of what the
21 tribal health system is already doing?

22 COMMISSIONER DAVIDSON: I'm sorry. I think I was
23 speaking to the opportunity to provide care as close to home
24 as possible by whatever means are available. So for example,
25 there is telemedicine. There is also the VA agreement where

1 they're using facilities that are already there in local
2 communities rather than building additional facilities out
3 there where facilities already exist.

4 COMMISSIONER ERICKSON: Other comments? We'll move on,
5 while I'm dealing with technology, to Strategy VI. Does
6 anybody have any comments about that in response to feedback
7 from the stakeholders? Ready to move on to Strategy VII?

8 Focus on prevention. Just a point about this, I included
9 in the additional handouts you got this morning -- and I did
10 not make copies available for the public because it's not
11 officially released yet -- the current, and what I think is
12 final now, set of objectives and 25 core indicators from the
13 Healthy Alaskans 2020 Initiative, and this is directly related
14 to our prevention and one area that we might look at, as we
15 move forward, as that initiative, playing the role of
16 addressing population-based prevention. And so we'll have an
17 ongoing conversation about that, but they wanted to share with
18 you their current set of indicators. And one thing that will
19 come out next month is the preliminary set of targets that
20 have been developed by that group now and that's part of your
21 handout in that packet. Dave's holding it up, in blue and
22 gold. Did anybody have any feedback on the feedback in this
23 area? Okay.

24 Moving on to building the foundation, our last area.
25 Then we can invite the Commissioner up to the table. Yes,

1 Val?

2 COMMISSIONER DAVIDSON: So I don't know that this point
3 was raised, but it is one of our -- one of the things that
4 we're charged with doing is known health risks, including
5 unsafe water and sanitation systems.

6 COMMISSIONER ERICKSON: Could I suggest I add that bullet
7 under Strategy VII rather than Strategy VIII?

8 COMMISSIONER DAVIDSON: Yes. That's fine.

9 COMMISSIONER ERICKSON: Because it -- and I'm going to
10 add it to that slide, and just a note about that, too, there
11 is an indicator in the 25 indicators that speaks directly to
12 that goal.

13 COMMISSIONER DAVIDSON: Thanks.

14 COMMISSIONER ERICKSON: Any other final feedback before
15 we move on to our next agenda item? Again, feedback on the
16 feedback received a couple weeks ago?

17 Hearing none, I'm going to invite Commissioner Streur and
18 Josh to the table and refer you to another presentation that
19 was in your packet, and this will be posted on the Web after
20 noon, I think, today. Or no; it is on the Web already, and
21 there are copies in the back of the room, and it's just our
22 usual update showing. And I've provided a summary of some
23 significant implementation activities and changes related to
24 the Affordable Care Act at the beginning of the presentation.
25 I hadn't done that at our last meeting, so it's showing as a -

1 - what I've done is provided a series of slides summarizing
2 major changes and updates since March, not just since June,
3 which is normally what we would have. And I think what I'll
4 do is just go through some highlights real quickly and then
5 turn it over to the Commissioner and Josh to correct me. Does
6 that sound like a good plan, just take five minutes to do
7 that?

8 And I'm starting on slide two, and it's this presentation
9 that you have in your packet, the Federal Health Care Reform
10 Overview and Update. So right now, as of just this past
11 month, there are 27 states. I'll just highlight what Alaska
12 is doing. Alaska is one of 27 states that will participate in
13 the federally-facilitated exchange, and there currently are 23
14 states that have decided, so far, to expand their Medicaid
15 program in the coming year.

16 A couple of notes about the Insurance Exchange itself.
17 As Dr. Hurlburt mentioned earlier, Bret would have been with
18 us today, but he's actually on an airplane on his way to a
19 National Association of Insurance Commissioners meeting right
20 now. But one of the things that he shared with me the other
21 day was the actual number of plans that his division reviewed
22 and approved, based on the rate filings that they received.
23 And he shared, at our last meeting, that they had had rate
24 filings from Premera and from Moto Health and so those have
25 been approved.

1 It's something, I think, is important for folks to
2 understand, and it's real confusing for everybody, not just
3 the average person on the street, I think, is understanding
4 the difference in the roles and responsibilities of the state
5 government versus federal government.

6 Our state has been recognized by the federal government
7 as being a federally-recognized rate review state. And so
8 essentially, the Feds are, essentially, blessing the State's
9 process for their own purposes, not for our purposes, if that
10 makes sense. The state has the same relationship with the
11 insurers as they always have. They have to -- the insurers
12 have to file their rates and plans with state government for
13 the state government to approve for sale in Alaska. They did
14 that. Then it's the responsibility of the insurance companies
15 then to submit application to the federal government to
16 participate in selling their plans on the federally-
17 facilitated insurance exchange. And so that relationship is
18 between the insurance companies and the federal government,
19 and we don't know what the outcome of that has been or even,
20 necessarily, we don't have documentation of any sort that
21 they've went ahead and applied to sell their plans on the
22 Exchange. We're just assuming that, at this point. We will
23 find out. The date I've heard from the federal government is
24 that they'll announce on September 4th information on the
25 plans that will be sold and that they will release on October

1 1st the actual rate information for those plans that will be
2 sold on the federally-facilitated exchange.

3 There have been a number of federal grant awards made and
4 a number in this state specific to supporting enrollment
5 assistance for the Insurance Exchange, and it was just
6 announced last week that the Tribal Health Consortium and
7 United Way received a grant of \$300,000 each to support the
8 Navigator program here, and the community health centers in
9 this state received a total of \$1.8 million dollars to support
10 outreach and enrollment earlier this summer.

11 A number of provisions have been postponed. I assume
12 you've heard about, at least, one of these in the popular
13 media, the employer mandates have been postponed for one year,
14 but there have been a couple of other provisions postponed as
15 well.

16 The Long Term Care Commission has been meeting. This was
17 the body that was formed when the CLASS Act Title VIII of the
18 Affordable Care Act was repealed with the fiscal cliff deal
19 and that was the provision that created or would have created
20 a federal Long Term Insurance program. So they eliminated
21 that when they decided it couldn't be actuarially sound the
22 way it was designed in law and created a commission to
23 redesign it, and their final report is due to Congress in
24 September.

25 And there have been a whole series of regulations. I'm

1 not going to go over these, even generally, but you might be
2 interested to review those at your leisure, just the bullet
3 points about them. There are several slides, just to get a
4 sense of the scope and the volume, and I even pulled in the
5 number of pages. It is beyond me to understand how providers
6 -- I probably shouldn't add commentary -- deal with this, one
7 set of regulations that came out in April in draft that, I'm
8 imagining, they're all having to review and figure out how to
9 address and nearly 1,500 pages dealing with Medicare payment
10 policies. It boggles my mind just to read that bullet, let
11 alone think about 1,500 pages and all of the financial and
12 legal folks who have to deal with that, but it's where we are.

13 So with that, I will turn the mic over to Commissioner
14 Streur. Welcome. Thank you for joining us, and Josh.

15 COMMISSIONER STREUR: Thank you for the opportunity
16 today. I'm going to probably say very little today because,
17 part of it is, I just got off the Kenai River last night about
18 2 o'clock in the afternoon, and after having my butt
19 thoroughly whipped the day before by Representative Keller,
20 and it was a great three days on the river. My freezer is now
21 full or almost full. So it was a good time and a good time by
22 all, but getting back in gear is not the easiest thing that
23 there is to do.

24 I need to clarify a few points and a bit of a disclaimer.
25 Annie Feight (ph) talked to me very briefly. APRN talked to

1 me very briefly about the Arkansas Plan. I indicated a bit of
2 fascination with it. I did not indicate that the State of
3 Alaska was pursuing an iteration of that and so I just want to
4 clarify that that was not my intent, that we were pursuing
5 that direction or even looking in that direction.

6 The fascination with it is that it's a concept I had
7 discussed very early on with CMS, and it didn't go anywhere.
8 Wisconsin also discussed it with CMS, didn't go anywhere. And
9 then suddenly, it pops up in Arkansas as -- and it was a
10 surprise (indiscernible - voice lowered) when Governor Beebe
11 announced that that's what he was going to do in the Medicaid
12 expansion, but he has submitted a Medicaid waiver to allow for
13 that to happen. However, it has not been approved and so we
14 will continue to watch it. Basically, it puts everybody in
15 the Medicaid expansion group into an insurance plan, and the
16 Feds pay the insurance premiums for that. If the money goes
17 away, funding goes away because it's all federal money. And
18 that's a big step, a big step for the State of Alaska to look
19 at expanding the Medicaid population and then saying no more
20 money; it's gone.

21 Representative Keller, Senator Coghill, and others would
22 not be very popular with a large proportion of the population
23 when that switch was flipped, and hopefully, I'd be gone by
24 then so my successor could do this double speak on it.

25 Another thing. Deb's slide talked about 24 states do

1 plan to expand. Of those 24 states, there are several states
2 who -- I'm sorry -- 23 plan to expand. Several of those
3 states either it's passed the Legislature or the Governor has
4 introduced it as what he wants to do, and it has not been
5 approved by, in one case or two cases, the Governor's office,
6 and in another two cases, by the Legislature. So that doesn't
7 mean there is agreement in those states.

8 It says 24 states, including Alaska do not plan to expand
9 at this point in time. Alaska is undecided. We have not said
10 we are not expanding. We said we're undecided. The Governor
11 has said in his release of his budget on December 15 will be
12 the next time he talks about Medicaid expansion. There has
13 been no decision made and then it still has to go through the
14 Legislature. Some believe it still has to go through the
15 Legislature; others don't. So I have always put us in the
16 undecided category and would appreciate that that -- because I
17 believe that is where we are right now.

18 Susan Johnson had -- Susan Johnson, the Regional HHS
19 Director from Seattle, was up here, had a press conference
20 last week talking about why we need to do all these good
21 things, and suddenly, we have a flurry of activity in the
22 Department and a new set of questions, a new set of issues.
23 Where are you going? What are you doing? The Health
24 Insurance Exchange has come up. And I believe, in my heart of
25 hearts, that our decision on the Health Insurance Exchange was

1 the right decision.

2 Josh is going to talk about where some of the other
3 states are and the challenges that are out there. And you
4 know, the fact that we would have to assume the ongoing cost
5 of operating the Exchange beginning in 2015, I only see one
6 source of revenue for that and that's going to be the
7 insurance premiums of the individual insurance carriers. So
8 somebody has to pay for it, and it's not going to fall out of
9 the sky. I do not believe -- although there are smarter
10 people than me in here -- on that process, I don't believe
11 that it's going to be very popular with our Legislature to
12 pick up the cost of that, so that premiums don't go up, but
13 that is also another consideration that could happen. In that
14 case, it would have to be all of General Fund to pay for that.

15 So I'm going to stop with my part right now. Josh has a
16 lot to cover, so I'll turn it over to him.

17 MR. APPLEBEE: Thanks for inviting us, once again. I try
18 not to bring the same set of notes to each meeting.
19 Hopefully, I bring something new.

20 I did want to make a couple comments in regards to the --
21 of what's happening in Arkansas. As they're working their way
22 to getting their private option plan approved, they're running
23 into some very interesting challenges.

24 I can say that I read, yesterday, that they've finished
25 their draft regulation, draft waiver plan, and they expect to

1 hear back from HHS on October 1. I'm pretty sure that HHS has
2 other things to do between now and October 1, but that's when
3 they hope to hear back. But one of the problems that they're
4 running into is their electronic portal for the federal
5 exchange with this private option. They've discovered that
6 they can't have one entry point, that they're actually going
7 to have to create separate exchanges for their new Medicaid.

8 So in the state of Arkansas to get this waiver approved,
9 they're actually going to have to set up two exchanges. And
10 so I just couldn't imagine the logistics of that.

11 COMMISSIONER DAVIDSON: Would that have been true if
12 they'd done just the standard Medicaid expansion?

13 MR. APPLEBEE: I don't know. I would think that it's --
14 this additional -- because they need to separate out this
15 group specifically, they almost have to redirect them to a
16 specific, new doorway. So I think maybe your answer would be
17 no, it wouldn't, if they did a straight expansion, but they
18 didn't address that. But it's interesting that they're
19 finding these problems as they go through.

20 The Commissioner mentioned several other states --
21 Tennessee, Nebraska -- have all gone down the road of looking
22 at the private option to see if will work in their state, and
23 in the case of Tennessee, for example -- and I think I
24 mentioned this in the last meeting -- they said, well, we'd
25 like to do the private option, but we'd like to do it a little

1 differently. We think that people who can afford to pay more
2 should have some higher co-pays and share in their costs a
3 little bit more, and HHS said no. So it's interesting that
4 the Arkansas Plan with very minimal co-pays gets to the stage
5 of send us a plan, and the Tennessee idea with higher co-pays
6 gets denied at the outset. So that's just a quick comment
7 about Arkansas, what's happening there.

8 In terms of the marketplaces, I'm sure many of you read
9 the Governor's commentary that was published in both the
10 Anchorage and Fairbanks papers earlier this month. The
11 official press release went out on the 14th, but I think it
12 was published the weekend before.

13 Some interesting things of note that I'd like to bring
14 up, it really comes down to the cost of the development of the
15 Exchange. Colorado spending over \$109 million, Oregon well
16 above \$200 million, and the state of Washington up over \$150
17 million, just in development costs.

18 There was a Letter to the Editor today. Someone said,
19 Alaska is all about self-sufficiency. We should have done our
20 own exchange and taken all the federal money. And I kind of
21 thought to myself, is taking all the federal money really
22 self-sufficiency?

23 And so states, like Colorado -- Colorado, because they
24 came late to the game, their exchange funding was actually
25 subject to the sequester. So they took a ten percent cut in

1 the first round of the sequester. Oregon, in their plan to go
2 through 2014, has found out that they're about \$16 million
3 short in operational costs. So they're going back to the
4 federal government for an additional \$16 million, just so they
5 can make it through the end of next year.

6 In the state of Georgia, they're finding out that there
7 are some problems with getting everything up-to-speed in terms
8 of their system. They've asked for an emergency extension,
9 and they're also finding that there are insurance companies --
10 Aetna comes to mind in the states of Connecticut and Maryland
11 -- that have actually applied to be a part of the exchange and
12 have since pulled back. We saw that they didn't even apply up
13 here, and I don't think that they applied down in Washington.
14 I know they didn't apply in California because I think they're
15 waiting to see how it all pans out.

16 There has been a lot of talk, of late, about the federal
17 data hub, and I think I've mentioned it in my last several
18 updates about how we've been struggling to get updates from
19 the federal government about how we're going to link to the
20 federal data hub, how we're going to get information to and
21 from, and one of the big issues, when it comes to that sort of
22 level of information -- people's tax information,
23 identification information, date of birth, Social Security
24 number -- would be security.

25 The federal data hub has failed all of their security,

1 major security hurdles so far. And so they've reset their
2 timelines, and they've set up a new certification date for
3 security and that's September 30th. So the federal hub is
4 going to have to certify that they are security compliant the
5 day before they go live. I don't know how that's going to
6 work, and I've always said that this is -- some of these
7 timelines have created significant problems, not just for the
8 states that are developing the marketplaces, but for the
9 federal marketplace also. I mean, it's a monumental task, but
10 data security is going to be critical, and if we can't get
11 interlinks between the federal data services hub and the
12 federal marketplace, I think we're going to really have
13 issues.

14 I know that there are current bills being drafted and/or
15 dropped in Congress to postpone everything until we know that
16 that data link is secure. But it's also created problems in
17 the Oregon Exchange. The Oregon Exchange now has released a
18 statement saying we don't know if we can move forward because
19 we don't know if the federal data hub is going to be there.
20 We don't know if the security link is going to be there. I
21 think you find that in Washington State and another state-
22 based exchange is going to have the same problem. If they
23 can't connect to the federal data hub securely, certified
24 securely, that running the exchange on a state level is going
25 to be incredibly problematic.

1 The last comment that I'd like to talk about is the
2 exchange in Washington State. They've recently approved --
3 they've made the approval for some of their health plans for
4 companies, to be sold inside the Exchange and then they turned
5 down five other companies. They turned down Moto Health,
6 Kaiser Foundation Health Plan of the Northwest, and three
7 current Medicaid plans. And it's creating a situation where
8 some counties will have limited choice and other counties --
9 your larger, urban counties, for example, will have a choice
10 of everybody throughout the exchange. So it's an interesting
11 dynamic between, oh, these plans didn't comply with state and
12 federal law and these other ones did, but these plans that
13 were rejected are currently serving Medicaid patients, and
14 these -- anyway, so it's really interesting how it's
15 developing. They're currently going back and forth trying to
16 resolve their issues, but I think it really shows, again, the
17 difficulty in trying to push this so quickly to reach October
18 1.

19 I got a question. Probably three weeks ago, someone
20 called my office and said, what happens if, come October 1, it
21 doesn't work? And the answer was pretty simple. The answer
22 is, well, nothing. People aren't required to have insurance
23 until January 1st. So if it doesn't work on October 1 but
24 works on October 2 or October 3, we have to remember that
25 people have until the end of the year to get the coverage to

1 begin January 1. So there is a lot of room in there, but it
2 is going to be an interesting time in the 41 days until
3 October 1. I think that's about right, right, 41 days. I
4 know some people actually have that counter on their desktop.

5 COMMISSIONER URATA: (Indiscernible - away from mic)

6 MR. APPLEBEE: I'm sure that there is no NAIC meeting
7 that will keep the Director of Insurance from showing up at
8 that meeting. But in his absence, I will have to say that
9 Bret Kolb and his staff are doing a really good job
10 interfacing with the federal government and making sure that
11 the Alaska companies and the people in Alaska to be covered
12 are, indeed, protected and that the plans fall within what the
13 state of Alaska laws require. And so I think they've been
14 doing an excellent job.

15 And one of the reasons that he sends a large group of his
16 staff to the NAIC meetings is because the data transfer and
17 the information that they'll gather at those meetings will be
18 critical when they come back. And so I don't really begrudge
19 him too much for not being here.

20 COMMISSIONER DAVIDSON: So I guess, I think that the
21 balance is that our state did have the opportunity to be in
22 the driver's seat for the exchange, and we chose not to be.
23 And there are benefits, but there are also costs with that
24 decision. I think one of the benefits is we don't have the
25 expense of, apparently, what other states are experiencing

1 where they're having to put in additional resources, but the
2 cost to our state is we are no longer in the driver's seat of
3 that system. So that's a challenge. I mean, with every
4 decision we make, there are tradeoffs. There are good
5 outcomes, and there are unfortunate outcomes.

6 I think that, if we look realistically about the
7 implementation of large data systems, whether we're talking
8 about the federal marketplace data system or we're talking
9 about our own MMIS implementation, we can recognize that there
10 are challenges with implementing those large data systems. So
11 it doesn't surprise me that there are challenges with
12 implementing a brand new program when we haven't been able to
13 make -- to implement our own MMIS system for -- I lost track
14 of how many years it's taken to be able to do that, but there
15 are challenges with every system as we implement it, and I
16 think we should be fair and balanced when we're trying to
17 describe the challenges that we have with integrating any kind
18 of new program into our state.

19 MR. APPLEBEE: Well, I think that's exactly right, and I
20 think -- to begin with, I think the decision to go forward
21 with the federally-facilitated marketplace was the correct
22 one. Several states with the population size of Alaska or
23 thereabouts all made the same decision, regardless of party
24 and political beliefs, because it really just was an issue of
25 the small population can't sustain those sort of costs, and I

1 think Director Kolb and his group have been doing such good
2 work in making sure that that connection is going to be there,
3 that we do what we need to do to make the federal marketplace
4 as effective for Alaskans as possible. And so it's like I
5 mentioned before; I don't think the world ends on October 1 if
6 the system doesn't work, but I think it's such a -- it is a
7 monumental task, and I really am in awe that -- well,
8 actually, I'd like to be the one selling coffee in Washington
9 right now.

10 COMMISSIONER MORGAN: I guess my -- I kind of fall on the
11 other side of Val on this one, which doesn't surprise her.
12 I've actually attended a couple and listened into the Finance
13 Committee in their monthly review of the Health and Human
14 Services budget, and to no surprise to anybody, especially
15 Commissioner Streur and Josh, their main concern was
16 controlling costs and the expansion of the Department. It's
17 now bigger.

18 I remember Commissioner Streur saying you have three
19 sections or departments inside your division that are bigger
20 than the next-sized division in state government.

21 And my question goes to, when I was there listening to
22 the Governor giving his reasons why to tread water for a year
23 on Medicaid expansion, the sequester, and the debate over the
24 budget had an impact, and lo and behold, guess what? That's
25 when I turn on my MSNBC this morning, an hour-and-a-half of

1 it, an hour of it was talking about another possible sequester
2 and possibly even a shutdown again.

3 So for us that are old enough to remember 1995, or too
4 old to, I guess my question -- I'm leading -- I'm getting
5 there -- is, it was one of the main points of the decision,
6 besides the risk and the issues and almost the same issues as
7 the exchange or marketplace in a small population supporting
8 another program and the cost -- Medicaid expansion isn't free.
9 There is -- he has to come up with \$20 or \$30 million,
10 probably, a year to do it that's not supported. But if --
11 this is a big if, but if we go into the same process of more
12 sequester, possible budget shutdown, which throws that onto
13 the state -- you know, you've got to finance all this stuff --
14 do you think that would be a precursor to another year of
15 treading water on Medicaid expansion, if there is a lot of
16 uncertainty over the federal budget, just like we had when the
17 decision was being formulated the last time?

18 MR. APPLEBEE: Well, the first thing I can say is that
19 Medicaid funds are not subject to sequester. I mean, that's
20 clear. But in terms of how that affects the decision moving
21 forward, I don't know. I think there is still a lot of time
22 between now and the Governor's next decision point, and I
23 think that momentary budget arguments for position shouldn't
24 affect long-term plans. But other than that, it's difficult
25 to say that, you know, whatever is happening in Washington

1 today and how high the rhetoric gets and how that's going to
2 affect the Governor's decision several weeks from now, I don't
3 know.

4 COMMISSIONER STREUR: I might take a little different
5 tact on Medicaid funds not being subject to sequester because
6 the 100% match, I think, is always vulnerable.

7 As we know, when Congress was getting ready to go on
8 their last recess and they all wanted to get home, they
9 suddenly found money for the FAA, and they took it out of
10 places we didn't think they were going to take it out of,
11 including DOD, including public health, including vaccination
12 programs for kids, and foster care subsidies. So you know, I
13 think it's always difficult to predict what they're going to
14 do, and I think anything is up for discussion.

15 The other thing is that what is subject to sequester is
16 2015 insurance exchange's marketplace funding because they are
17 funded by the federal government for operations through 2015.
18 And as Oregon has found out, they don't mind dipping into it,
19 particularly with expansions.

20 But you know, part of my thing is philosophy, too, and
21 this is the conservative coming out. When I see \$250 million
22 being spent on developing an exchange in Oregon, which has 2.5
23 million people, I have a difficult time with that, and it's --
24 you take and you multiply that across the 16 states, somewhere
25 between \$91 million, I think, and the 250 -- Oregon is at the

1 top of the heap right now, but Washington is breathing down
2 their neck, from what we understand -- and it's got to be a
3 considerable expense that, you know, is on the back of the
4 rest of what we do.

5 So I'm going to sit back and watch for the next three
6 months to see where it goes. And we do need to have something
7 in front of the Governor. We do need to present options. We
8 do need to take the study that we did and show where we can
9 save or where we can't save or where it's going to cost, show
10 the risk, but also show the benefit and that's what we will
11 have in front of him well prior to him presenting his budget
12 in December.

13 SENATOR COGHILL: Commissioner and Josh, thanks for
14 coming. One of the issues that we deal with, as a Commission,
15 and we're trying to figure out how to do planning or including
16 planning is going to be some of healthcare access issues, and
17 certainly, Medicaid is a big driver, in many ways. So you're
18 going to have payment reforms. You're going to have penalty
19 reforms, readmit reforms. So have you had a chance to kind of
20 quantify what that's going to do to access to healthcare in a
21 Medicaid world?

22 COMMISSIONER STREUR: Senator Coghill, yeah
23 (affirmative), we have, and we get to it once-a-month for
24 three days with 12 of my good friends from House Finance
25 Subcommittee. And it's an ongoing process, and it is the

1 concentration of what they are looking at, as a group. You
2 know, show us what you've got, show us why you have it, and
3 show us where we can save. And so we've done a couple of deep
4 dives.

5 Senator Kelly sent me a rather protracted letter
6 requesting a lot of information. I think we just sent him
7 over 50 pages of information in response to that letter,
8 talking about where we can save money -- Medicaid, where we
9 can save money in the public assistance programs, you know,
10 where the low-hanging fruit is, and where the untouchables
11 are, who is affected by these things, and what it means going
12 forward.

13 SENATOR COGHILL: Part of what we have to deal with is we
14 want increased access, and it looks -- it just looks, to me,
15 like it might be counteractive. And so probably, I'll wait
16 until I get to the legislative session and look at the answers
17 you gin up for the Legislature, but we are interested in
18 saving money, but I think the Medicaid expansion, at least,
19 indicates that there might be the ability to increase access
20 for certain people, but we're also going to put pressure down
21 on the delivery of healthcare services. So I don't know that
22 they're going to actually receive it because I don't know that
23 they'll be there to be paid for. I guess, kind of what I was
24 looking at is how -- what that impact is.

25 COMMISSIONER STREUR: So is that like we're putting more

1 air in the balloon, but we're not going to let balloon get any
2 bigger? Thank you, sir.

3 COMMISSIONER CAMPBELL: You're talking about the
4 exchanges and the costs of setting them up and things like
5 that, and this is going to take several months to shake out,
6 but ultimately, probably, the State will have to, in some
7 form, get into one of these exchanges. Do you think the buy-
8 in is going to be exorbitant or do you have a feel for that,
9 or if after these exchanges are developed, will the buy-in
10 price be lower than the developmental costs appear to be
11 happening right now?

12 COMMISSIONER STREUR: That's one of the unknown
13 questions, unknown -- that's one of the questions with an
14 unknown answer. We don't know what the federally-facilitated
15 exchange is going to cost because, in 2015, the states are
16 going to have -- they're going to be billed, in some way. We
17 don't know how yet, and we don't know what it's going to be.
18 But when I look at an exchange that goes across 20-some
19 states, I have to believe it's going to be cheaper on a per
20 state basis than the one-offs of the 16 states that are
21 developing it, I think.

22 MR. APPLEBEE: Just one last thing. The Admin Reg Review
23 Committee of the Legislature has been having hearings through
24 the summer regarding the Affordable Care Act, and their next
25 meeting is the 27th of August up in Fairbanks, and it's via

1 teleconference. If you want to dial in, it starts at 10:00
2 a.m. So just wanted to let you know.

3 CHAIR HURLBURT: Thank you very much, Commissioner and
4 Josh, for coming. We appreciate every time you come and
5 update on that.

6 We're going to wrap up. Can we start with any feedback
7 on the meeting? I think it well-received yesterday, but on
8 process, on our topic, how well we addressed it, any comments?
9 Maybe particularly negative ones? We had a lot of positive
10 ones, but any negative ones would be constructive.

11 COMMISSIONER ERICKSON: How about suggestions for
12 improvement?

13 CHAIR HURLBURT: I think this part where we just limit to
14 the Commissioners, so thank you.

15 COMMISSIONER URATA: I would just say that I was hoping
16 for more suggestions or focus on what would work for
17 statewide, and I think I kind of got a little bit, but perhaps
18 more examples of how states could better utilize this skill.

19 CHAIR HURLBURT: Senator Coghill?

20 SENATOR COGHILL: I'll agree with that. I got a little
21 frustrated because I kept trying to think of our vision
22 statement, our charge, and the issue that we were dealt with
23 on evidence-based really drilled down deep into specific
24 issues, and I kept trying to translate that. So it might have
25 been better if we would have given them a little higher level

1 target, although I think what they were showing were the
2 principles, but we really needed to glean a way to translate
3 that to our vision statement. So I worked hard at that. I
4 don't know that I arrived, but I'm going to continue. I'm
5 going to use their website. So I think that was a valuable
6 tool. I rehearsed the questions last night, trying to think
7 what could I ask them this morning, and I still kind of came
8 up a little more empty than I should have. So I think that
9 was a little disconnect.

10 CHAIR HURLBURT: Others? Okay. Deb, do you want to.....

11 COMMISSIONER ERICKSON: Sure. I'll just wrap us up real
12 quickly. Before I mention our next steps though, I wanted to
13 recognize and thank Flora for helping us. Thank you, Flora.
14 I gave Barb permission to take leave this week because she was
15 delivering her son -- that's probably the only reason I would
16 have given her, delivering her son to his freshman orientation
17 in college down south, and I was afraid she was going to kill
18 him, if she didn't get him kicked out of the house this week,
19 for those of you've had teenage sons. So Barb is out for just
20 the week, and Flora has just been wonderful to help us out.
21 And also thanks, Sonya and Ryan, for helping us out with our
22 other technical issues. Appreciate it very much.

23 And just a note that our next meeting is October 10th and
24 11th, and we'll be in Anchorage. I have our usual facility
25 reserved, but we're -- left on our agenda for this year is

1 additional work around employers' engagement in health and
2 healthcare and so that agenda will focus on that topic, in
3 part. And so stay tuned for that, and let me know if you have
4 any questions. Does anybody have any final questions or
5 comments before we sign off? Yes, Val?

6 COMMISSIONER DAVIDSON: Have we set our November meeting
7 date yet?

8 COMMISSIONER ERICKSON: We have a December meeting date.
9 Our -- it is December 6th. Yeah (affirmative). It's on slide
10 26. Yeah (affirmative). Other final questions or comments
11 before we adjourn? Are you ready to adjourn? Mr. Chair, do
12 you want to gavel us out?

13 CHAIR HURLBURT: Motion to adjourn?

14 COMMISSIONER URATA: Second.

15 CHAIR HURLBURT: Thank you all for being here. We're
16 dismissed.

17 11:58:09

18 (Off record)

19 **END OF PROCEEDINGS**

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