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ALASKA HEALTH CARE COMMISSION

FRIDAY, OCTOBER 3, 2014

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DENA'INA CIVIC & CONVENTION CENTER

600 WEST SEVENTH AVENUE

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1 CHAIR HURLBURT: Yeah (affirmative), I think that the
2 presentation that we had and the discussions we had with the
3 HR people brought home that we're not on an island. We're not
4 out by ourselves, that a lot of folks are dealing with the
5 issue.

6 To some extent, it was a little reassuring to me that
7 they maybe weren't quite as alarmist as I've heard some of
8 them talk in other settings when Deb and I have met with them,
9 which means that we don't have time to step back and do
10 nothing, but it also means that it's not hopeless, that we can
11 work with them, work with our state agencies and address the
12 challenges that have to be addressed, the unsustainable word
13 has been used lots of times and I think that's true, but to
14 me, I think their perspective for the engines that drive our
15 state's economy and pay all of our salaries, whether we work
16 for government or healthcare providers or whatnot, is that we
17 can work to a solution with them. Bob, yeah (affirmative).

18 COMMISSIONER URATA: So one of the things that strikes me
19 is, have we heard from the other side of the, you know, the
20 people who are being paid or charging all this money, like the
21 physicians, the medical clinics that charge and the hospitals?

22 MS. ERICKSON: The specialties are particularly high?

23 COMMISSIONER URATA: Yeah (affirmative), that they speak
24 of, right.

25 MS. ERICKSON: We have not invited them to talk with us.

1 COMMISSIONER URATA: Is that something that would be a
2 good thing, or somehow let them know that this is a problem?
3 They may be part of the solution. You know, it just seems
4 like that might be something that they need to come around to,
5 you know, it's the story of the golden goose, you know,
6 killing the golden goose and -- but I don't, you know, I don't
7 know all the relationships and my understanding is a couple of
8 the cardiology clinics came together and now there's only one
9 cardiology clinic and so they have, you know, they have
10 control over prices and stuff like that and -- but anyway, I
11 think that's something that ought to be looked at, maybe in
12 the back rooms and try to figure out what the best strategy
13 would be.....

14 CHAIR HURLBURT: Yeah (affirmative), we've.....

15 COMMISSIONER URATA:to approach this kind of thing.

16 CHAIR HURLBURT: We've had.....

17 COMMISSIONER URATA: Because it's touchy.

18 CHAIR HURLBURT:more interchange with folks from
19 the hospitals on -- in several.....

20 COMMISSIONER URATA: Yeah (affirmative).

21 CHAIR HURLBURT:several different kinds of things,
22 not so much from the physicians. As we were getting started,
23 I went out and met with -- went to a board meeting for the
24 Medical Association, ASTHMA.

25 COMMISSIONER URATA: Yeah (affirmative).

1 CHAIR HURLBURT: Went to the board meeting with the
2 Alaska Physicians and Surgeons. On the ASTHMA, the Medical
3 Association, I didn't get a sense of real engagement there.
4 Their -- the dominant concern, I was kind of glad to hear it,
5 but the dominant concern was, how come all these Medicaid
6 patients are getting their travel paid to come to Anchorage
7 and we never see them in the audience -- in the office and
8 they're just going to Fred Meyer's or whatnot?

9 So I was kind of glad that there was that concern there
10 and I think the Medicaid has tried to tighten up and make sure
11 that if there's travel authorized, it's bonafide. With Alaska
12 Physicians and Surgeons, it seemed like a more engaged group.
13 Your predecessor in your seat, Noah Laufer, was on the board
14 there at the time, anyway, and that was before he was on the
15 Health Care Commission, but George Rhyneer, who was here in
16 our Wednesday meeting, was very much engaged in those kinds of
17 issues. They -- so there's been that kind of contact, but we
18 haven't had the physicians here, as much. Deb.

19 MS. ERICKSON: And it was one of the strategies that the
20 HR directors have talked about, but it wouldn't be in a public
21 forum, inviting the high-cost specialists to their meetings.

22 COMMISSIONER URATA: Right.

23 MS. ERICKSON: And you know, following that conversation
24 yesterday, I don't know if we would want to partner with them
25 to do it in a more public way. I mean -- and what they've

1 talked about doing to make the -- their concerns about some of
2 these high-cost specialties more transparent is to actually
3 just start publishing in the newspaper.....

4 COMMISSIONER URATA: Yeah (affirmative).

5 MS. ERICKSON:ads that show the price variations.
6 So it's -- I think it's a conversation that maybe we could
7 have and follow up with them. I don't know if it would --
8 could potentially, in some way, backfire or make things -- it
9 would not be an easy meeting and conversation to have, if they
10 would even come, but it.....

11 COMMISSIONER URATA: Yeah (affirmative).

12 MS. ERICKSON: But it's the specialties that they didn't
13 refer to directly here, but when they were talking about
14 medical tourism and starting to send folks out, where the
15 price variation is so high -- so anyway. Yes, Dr. Stinson.

16 COMMISSIONER STINSON: All of the surgical and cardiology
17 subspecialists I know are busy, busy, busy, but I think the
18 Director of the Alaska Physicians and Surgeons, I think it's
19 in Anchorage now.....

20 CHAIR HURLBURT: Annie now, Annie Holt.

21 COMMISSIONER STINSON: Yeah (affirmative).

22 CHAIR HURLBURT: Yeah (affirmative).

23 COMMISSIONER STINSON: We should invite her, and
24 obviously, Annie is smart, very well-schooled, knows the whole
25 story, and I think it would be interesting and she could

1 represent what those interests are and then maybe provide an
2 exchange of ideas and information, because we don't know how
3 much they know about our findings thus far. So that would be,
4 at the very least, communication.

5 CHAIR HURLBURT: Yeah (affirmative), and that would be --
6 Annie would be good because she came here fairly regularly
7 when she was at Regional and has the clinical background
8 herself.

9 MS. ERICKSON: Yes, Dave and then Representative Higgins.

10 COMMISSIONER MORGAN: I think knowing her, she will come,
11 if she's invited.

12 MS. ERICKSON: Could you all speak directly into the mic
13 just like I am right now, because.....

14 COMMISSIONER MORGAN: Okay.

15 MS. ERICKSON:folks on the phone yesterday -- poor
16 Barb dealt with frustrated webinar viewers all day,
17 complaining that they couldn't hear folks, thank you.

18 COMMISSIONER MORGAN: Okay, how's that? Okay, knowing
19 her, if she's invited, she'll come, but I think also, I would
20 like for us to invite the Alaska Healthcare Underwriters,
21 their executive director, and his name escapes me. They have
22 a whole set of centers of excellence and providers that
23 they're sending, especially electives, out to get specialty
24 work done, also. They also have set up with that, a process
25 or providers in-state to catch them when they come back in to

1 make sure that the care is continued and communicating with
2 those providers out of state, which I didn't know this whole
3 subculture was there until I went to their annual meeting two
4 years ago. So with what's happened in the last two years,
5 it's probably bigger, wider, and deeper.

6 Also, in the last issue of "HFMA," it had -- the front
7 part is on activities like Medicaid and Medicare. They had a
8 chart showing, and this is unbelievable, and I tried to find
9 it last night, and I probably left it down in Dillingham, a
10 chart of the low-cost states for -- and they do it by state,
11 but you don't do it by where the individual's address is, but
12 where they got their services.

13 They showed that Alaska had per Medicare beneficiary, was
14 one of the three lowest cost states under Medicare for
15 services, but then there was a little note at the bottom,
16 large numbers of elective hips, knees out, and those dollars
17 are shown in other states. So I think we -- I don't think
18 we've heard from the underwriters, but I think, especially
19 since they're Alaska-based, since they do healthcare and they
20 do it right -- do the underwriting of a lot of the policies,
21 like this guy here, I think it would be interesting to hear
22 what they're doing.

23 MS. ERICKSON: Sure. Yeah (affirmative), and.....

24 COMMISSIONER MORGAN: What I found interesting was they'd
25 set up a group of providers to catch these people coming back

1 to do their primary care and follow-up care in-state, like a
2 triangle, then working with who.....

3 MS. ERICKSON: Right.

4 COMMISSIONER MORGAN:the specialist that did that
5 service out of Seattle or Minnesota.

6 MS. ERICKSON: Right. So yeah (affirmative), I've got
7 down that we would include the AHU and the HR Leadership
8 Network. Representative Higgins.

9 REPRESENTATIVE HIGGINS: Yeah (affirmative), thanks. I
10 just wanted to chime in on the conversation a little bit about
11 the Medicaid. When you talk to physicians and they talk
12 about, they know patients that come in from out of the
13 villages or wherever, and they don't make their appointments
14 on travel, right now, the way the system is, is that if the
15 physician calls the Medicaid office and lets them know that,
16 Medicaid will charge that person the entire fee for travel.

17 So that will stop whatever that's happening, you know,
18 when you have no-shows at your appointments, and so you know,
19 that's in the -- you know, that's what we do today, but I, you
20 know, I want you guys to understand one thing.

21 This -- make no mistake about this either, this is about
22 money. This isn't about quality of care. This isn't about
23 what we're doing. This is about money, and the thing is this,
24 you know, the most important people we need to listen to right
25 now, is the HR and the underwriters, because the question

1 we've got to ask is this, at what point will they stop sending
2 people out of state for services, because we cannot compete
3 with the outside money for us. I mean, it's just, the nature
4 of the beast is it costs more to live here, and that's all
5 there is to it.

6 So what are they looking for? You know, that's -- that's
7 -- and that's really what it is, and so -- and they -- and I
8 understand their position, because the cost of healthcare has
9 gone up tremendously in the last years. So they're looking at
10 the bottom dollar, and if they, you know, and if they can --
11 because right now, they're looking at 30% hikes in insurance
12 costs and if you've got a lot of employees, that's a lot of
13 money.

14 So they are going to send people out, no matter what we
15 do in this state. So that's the role we have to look at. We
16 have to see and figure out how can we work on that and how do
17 we change that, and is it just a perception that we have to
18 do, is it that we have to educate our Alaskan citizens to say,
19 "No, we want our services done here. We don't want to go
20 outside."

21 I mean, that's what we have to do. I mean, I just want
22 everyone to understand, this is a money issue, and that's what
23 we have to deal with.

24 MS. ERICKSON: Yeah (affirmative), we had a really good
25 conversation at our last meeting, that unfortunately, Senator

1 Coghill was the one who kept reminding us, and what we've
2 talked about over the years in this group, is what we're
3 talking about is value. So we expect to pay some amount of
4 money here and the number that keeps coming up is, you know,
5 folks generally think that 25 to 30% more is acceptable, but
6 then at some point, if businesses just can't afford it
7 anymore, if individuals can't afford it, they're going to have
8 to go outside.

9 They're not -- I don't think they'll come to some
10 agreement that they can afford 200% more, but go ahead, Becky,
11 and then we should probably get back and let folks -- because
12 we only have about 10 more minutes for folks to reflect.

13 COMMISSIONER HULTBERG: Yeah (affirmative), I just wanted
14 to add, when companies are looking at -- and Greg just came
15 in, so he's probably the better person to make this comment,
16 anyway, but when companies are looking at these kinds of
17 medical tourism, typically, they're looking at paying for the
18 entire cost of travel for the person and someone to accompany
19 them, and they're also, a lot of times, looking at waving
20 copays and deductibles for that service.

21 So there's an outlay there of cost that ultimately ends
22 up factored in, and so I think, you know, that's part of the
23 equation is when that outlay of cost then becomes too much
24 compared to the savings. So I think there's a, you know,
25 there's a -- it's not as simple as if it's always cheaper

1 outside, people are always going to go outside. It's more --
2 because there is that cost and that inconvenience factor, that
3 there is, I think, I don't know what that delta is, but I
4 think there is a point -- there is a certain level, I think
5 that most organizations are going to be very willing to keep
6 people here and are willing to pay a premium. It's just a
7 matter of what that premium actually is, and you know, this is
8 a concerning issue for -- for our members.

9 COMMISSIONER LOUDON: Yeah (affirmative), Becky's right.
10 I think 20 years ago in Alaska, the health plans we had here
11 were all indemnity plans, \$200, \$300 deductible, maybe a \$500
12 out-of-pocket. So the consumers were protected from the true
13 cost of the procedure, so they didn't really care how much it
14 cost and they just wanted the convenience. They wanted good
15 quality, so as long as they could get the quality here, they
16 were fine.

17 What we heard yesterday from the HR managers is they're
18 all moving to the consumer-driven plans, which by intent, is
19 making people have skin in the game in purchasing healthcare.
20 So you've got a \$3,000 or \$5,000 out-of-pocket for a
21 procedure, you're going to look a lot closer at where you
22 spend your money.

23 So I think the HR people, as we see it with clients
24 across Alaska, they're now looking at, you know, the
25 difference in getting a procedure done in Alaska, you know,

1 maybe a shoulder or a knee or whatever it is, that the
2 differences in cost are dramatic. I mean, it could be
3 \$40,000, \$50,000 here versus \$10,000, \$12,000 in the states,
4 and Becky's right, the domestic medical tourism companies that
5 are putting these together are waving deductibles and out-of-
6 pockets for the plan holders, paying for them to have a
7 companion to go with them, and even with all that additional
8 expense, there's still saving a lot of money. It's a problem
9 that we really need to face.

10 MS. ERICKSON: Other reflections on yesterday? Yes,
11 Allen.

12 COMMISSIONER HIPPLER: This is Allen Hippler, Chamber of
13 Commerce. I recall when this body started requesting updates
14 on -- from the state on our implementation of the Affordable
15 Care Act and other federal issues, and at the time, it was
16 kind of a controversial issue. Several people did not agree
17 that this body should be informed about that, largely because
18 of our scope and our mission and the ability -- our ability to
19 influence all this.

20 While I really enjoy these federal updates, and I think
21 they're useful, I think that what happens is we get a good
22 presentation and then as soon as the presentation ends, we
23 start asking questions and going into debating the merits of
24 federal law, and that's kind of beyond the scope of this body,
25 and I think in the future, for ACA updates and other federal

1 issue updates, we should limit questions to our Chairman. Our
2 Chairman should be the one to ask all the questions, because -
3 - and this seems to happen almost every time, that we get drug
4 into -- well, deeper issues than really this body should be
5 focused on.

6 MS. ERICKSON: That's an interesting idea, Allen, and
7 maybe if the group agrees, what we could do is not necessarily
8 limit the ability to question to the Chairperson, but remind
9 the group that we're very focused on state policy and that
10 they should only be offering commentary and/or questions
11 related to how state policy interacts with the federal policy
12 issues that are being raised. Yes, Becky.

13 COMMISSIONER HULTBERG: I'd add it's broader than policy,
14 too, that -- I mean, the changes happening at the federal
15 level are having significant impact on providers and so it's
16 really important -- I mean, I -- I understand the point, and I
17 think the point is a good point, but at the same time, I do
18 think there's room for discussion because it's more than just
19 even the intersection of state policy. It's also how these
20 changes are affecting the delivery system.

21 CHAIR HURLBURT: Lincoln.

22 COMMISSIONER BEAN: Thank you, Ward. We're dealing with
23 a lot of this stuff in tribal healthcare, but my concern
24 sitting at the table of Alaska is that we have elders coming
25 at us and it's coming to a bottleneck. It's not just a tribal

1 issue. It's an Alaskan issue, and that has to be addressed,
2 just from the outside and the new face, young blood, fresh
3 eyes, big ears, that this is really interesting stuff.

4 Telemedicine, we've been doing that, I think after
5 listening to yesterday to Senator Coghill, that this needs to
6 be expanded and used, because we live in such a large mass of
7 the United States that it should be shared and used.

8 Medicare, I really appreciate your comments because I
9 think we can always do better. No matter what we do, it
10 always can be improved, and the IT, it's all mixed in with
11 what we do out there in the bush and I don't know how many
12 villages we have, but what we do, all -- encompasses the whole
13 entire state and all of this needs to be shared with what
14 we're doing and what you plan on doing here and making it
15 better. Thank you. That was my observation, thanks.

16 COMMISSIONER URATA: I have a request, which has nothing
17 to do with yesterday, but you know, we have this vision, the
18 highest life expectancy, the highest percentage of population
19 with access to primary care, and the lowest per capita
20 healthcare spending level, and I was wondering if we could get
21 those figures, because that's how we are going to grade
22 ourselves in our vision, and I was thinking, we should be able
23 to get data on that from 2010, which is around when we started
24 here, and maybe it could be shown to us or reported to us,
25 like once a year or something like that, just to see what the

1 vision is.

2 MS. ERICKSON: Yes, thank -- thank you.....

3 COMMISSIONER URATA: I know we haven't worked on the
4 vision for.....

5 MS. ERICKSON:for the reminder. We actually have -
6 - let me see if I can find it quickly. Yeah (affirmative), I
7 think I know where it is in this mess. What I don't have here
8 -- how do I get this thing out of the way? So Dr. Urata, we
9 do have those figures, but I haven't updated them for a while,
10 and right now, on this slide, I'm just showing where we rank,
11 but I have the data behind it, but I have not updated it for a
12 year or more, and so what I'll do is update the data and put
13 the actual data on here.

14 Right now, I'm just showing the rankings that we
15 currently -- or as of the last time I gathered this data, we
16 were 29th in the nation for life expectancy, 27th for the
17 percentage of population with access to primary care, and 49th
18 for lowest per capita healthcare spending or second for
19 highest, whichever way you want to look at it. Yeah
20 (affirmative) -- yes.

21 COMMISSIONER URATA: I was hoping that we could show it
22 on a yearly basis. So what was 2010, 2011, '12, '13, and.....

23 MS. ERICKSON: That's -- we could do kind of a report
24 card or some sort of benchmarking where.....

25 COMMISSIONER URATA: Yeah (affirmative).

1 MS. ERICKSON:we're looking at some sort of
2 baseline from when the Commission started in the first year?

3 COMMISSIONER URATA: Yeah (affirmative), so we can see on
4 a yearly basis if we're going up, down, and actually, since
5 we're not doing anything about it, it should be level or
6 something like that, but of course, once we implement some of
7 these things, we'll see a great improvement, I'm sure.

8 CHAIR HURLBURT: Any other reflections or comments?
9 Okay.

10 MS. ERICKSON: Hearing none, it would be great if we
11 could start a few minutes early, if our presenters are ready,
12 because we have a lot of great information that I think we're
13 about to hear, four really good presentations, I'm
14 anticipating, and probably not enough time for them all. So
15 if we could start a few minutes early?

16 What I'm going to do is invite all of our presenters, if
17 you don't mind, to come forward and sit at the end table and
18 what we're going to do is, as each of you present -- do your
19 presentation, we're going to ask you to come sit up here with
20 me and Dr. Hurlburt, so you can run the slides, if you want,
21 or I'll run them, but that way, the Commission won't have to
22 get ping-pong neck from watching you and trying to look at
23 your slides. So if our presenters would please come to the
24 table, and Greta, if you want to come on up to the front of
25 the table, since you're going to go -- start, and before we

1 get started, a couple of things, I wanted to mention that this
2 was something that we had put out in our annual report for
3 this current year, for the prior year, that this year, we
4 would have an update on clinical quality improvement
5 activities in this state and try to just learn a little bit
6 more about clinical quality improvement activities, generally.

7 I wanted to particularly thank ASHNHA and Becky and
8 Greta, who's with ASHNHA, and Greta, I'll have you introduce
9 yourself in just a minute, because I didn't even know where to
10 start and asked for them -- asked them for help and they,
11 essentially, put this session together, and so I'm really
12 grateful for your assistance with that, and Greta's our
13 resident expert on clinical quality improvement, at least at
14 the hospital level.

15 The other thing I wanted to mention, and I just brought
16 up -- hopefully, it's not blocking the way, our poster on our
17 core strategy related to pay for value, because most of you
18 weren't with us when we developed our recommendations around
19 payment reform and this is really our core strategy related to
20 payment reform, and what we talked about was the importance of
21 addressing the cost issue, as much as possible, through
22 improving quality and efficiency and effectiveness and with
23 clinical quality being a piece of that, not the whole picture,
24 of the improvement we're trying to drive, but how our learning
25 about payment reform was all about how -- the way our fee for

1 service system is structured, does not support this sort of
2 quality.

3 I think you'll hear a theme and have an opportunity to
4 ask some questions about that, but that's why I dragged our
5 pay for value strategy up here, because what we'll be hearing
6 and talking about this morning is directly related to that
7 core strategy and the recommendations that we currently have
8 on the books related to that, to payment reform. So with
9 that, I'm going to turn it over. Is that okay, Mr. Chair?
10 I'll go ahead and turn over to Greta to introduce yourself and
11 I'll pull your presentation up.

12 MS. WADE: Does this sound good? Yes?

13 MS. ERICKSON: Well, one of the things to -- yes, yes.

14 MS. WADE: Right here?

15 MS. ERICKSON: You're going to talk right into -- that's
16 perfect.

17 MS. WADE: Okay, great. For those of you whom I haven't
18 had the opportunity to meet, my name is Greta Wade, and I work
19 in the area of quality and patient safety at ASHNHA, the
20 Alaska State Hospital and Nursing Home Association.

21 When Deb Erickson reached out to ASHNHA to learn about
22 the Hospital Association's perspective on quality and patient
23 safety, we were enthusiastic. Becky Hultberg asked me, she's
24 our incoming CEO at the time, and she asked me if I would be
25 interested in sharing the work that our members have been

1 engaged in over the past two-and-a-half years, and I was
2 honored and thrilled by the opportunity.

3 So diligently, I took a moment to go to the Health Care
4 Commission website and to inform myself about the audience I'd
5 be speaking to today and while the honor persists, the thrill
6 wore off very quickly after reading each of your bios.

7 I've had the pleasure of working with Dr. Urata as a
8 hospice nurse in Juneau and I don't want to embarrass him, but
9 you know, in Juneau, Dr. Urata is a living legend, not just in
10 Juneau, but in Southeast Alaska, and when I was reading your
11 bios, I was realizing that probably most of you are living
12 legends of sorts, heroes in your own community, if not in the
13 larger sphere of Alaska.

14 So the thought that I would be coming here today to share
15 something new with you, something that you didn't already know
16 was a bit daunting. So I want to emphasize that I am honored
17 to be here today, but our time together is really going to be
18 spent with a sharing of our observations at ASHNHA, working
19 with our members over the past two-and-a-half years.

20 MS. ERICKSON: Greta, do you want me to do the slides
21 or.....

22 MS. WADE: That will be helpful, although -- sure. So
23 the following presentation consists of three presentations
24 condensed into one. Together, we'll cover measurement --
25 measurement reporting and scoring of quality and patient

1 safety outcomes. We'll take a tour of the national initiative
2 that our members have been engaged and then we'll dive into
3 data and its rolling quality improvement.

4 So it sounds like there's been a big focus on cost in the
5 value equation and I see this presentation more as a focus on
6 quality in that equation. First, let's take a brief tour
7 through the landscape of the measurement and reporting and
8 scoring of quality and patient safety metrics. So quality and
9 patient safety metrics are simply tools that hospitals use to
10 measure their outcomes, to measure the quality of the care.

11 They consist of a numerator and a denominator, with a
12 goal of capturing a rate. For example, one metric is the rate
13 of falls per 1,000 patient days. Another would be the rate of
14 readmissions per patient discharges. So these metrics are
15 used internally for quality improvement, but of course,
16 they're also used externally for regulator purposes and then
17 they're more and more often being used by patients who are
18 shopping for high quality healthcare.

19 So for the sake of today's discussion, Alaska's acute
20 care hospitals can be divided into two groups. There are the
21 critical access hospitals, those are largely rural, with 25
22 beds or less. Nine of the critical access hospitals are co-
23 housed with long-term care facilities, and financially
24 speaking, this is how those facilities manage to keep their
25 doors open.

1 By the way, both South Peninsula Hospital and Ketchikan
2 PeaceHealth were listed recently as top 100 critical access
3 hospitals out of 1,300 critical access hospitals in Alaska by
4 the National Rural Health Care Association. So kudos to them.

5 So the other acute care group is known as the inpatient
6 perspective payment system hospitals. They have 26 beds or
7 more and for our purposes, they don't include the psych,
8 military VA or rehab facilities. These are like the, you
9 know, Providence, Fairbanks Memorial Hospital, but they also
10 include Central Peninsula Bartlett and the Yukon Kuskokwim.

11 So from a mandated reporting perspective, the demands are
12 very different from each group. As you can see here, the
13 inpatient perspective payment system hospitals, from this
14 point forward, I'll refer to them as the IPPS hospitals,
15 report on a variety of measures.

16 You can see them listed here, core measures, the National
17 Health Safety Network, and then the list follows, while the
18 critical access hospitals' mandated reporting is limited to
19 core measures.

20 A breakdown of each measure highlights the level of
21 detail this reporting requires. Some of this data is hand
22 abstracted, while others -- other data pieces come from claims
23 data. The hand-abstracted data is considered the gold
24 standard. When I say hand-abstracted, that means there is an
25 individual person who is going through the chart, whether it

1 be the physical hard chart or the electronic chart and combing
2 through their visit, looking for red flags and triggers to
3 capture the data, and there is a widely believed myth that
4 with the implementation of the electronic -- electronic
5 medical records that we are going to move into this era of
6 nimble extraction of data, you know, real-time data for
7 quality improvement, and that has not proved to be the case at
8 all.

9 It's -- there's very many electric -- electronic medical
10 records and we're just a long way from that. ASHNSA is
11 currently involved in a project, a pilot project, with the
12 National Rural Health Center and Petersburg Medical Center to
13 work on this issue, but because every -- most hospitals have a
14 different EMR, it presents a lot of challenges.

15 For mandated reporting, again, we have the gold standard
16 of data. This is it right here, The National Health Safety
17 Network. This was designed by the Center for Disease Control
18 and then it was taken over by CMS, and when I say gold
19 standard, again, hand-abstracted, rigorously defined metrics
20 relating to hospital acquired infections.

21 So when we read in the paper about, you know, MRSA
22 infection, Methicillin-resistant Staphylococcus aureus
23 infections, or catheter-associated urinary tract infections,
24 this is the data that they're looking at.

25 Of note, is that the NHS -- to report in the NHSN system,

1 it takes a great deal of investment and staff. The training -
2 - using it is like using, I don't know if any of you have used
3 the RPMS system of the old or just some really like writing
4 code in DOS. It's almost like that and it requires the staff
5 to be -- actually travel to Atlanta to get the training. So
6 of course, there's always the issue of staff turnover and the
7 huge investment to keep this going.

8 Then the acute care hospitals, with an in-patient psych
9 unit, like Bartlett, have additional reporting
10 responsibilities that include this list of measures, and
11 tribal facilities have additional metrics. They have reams of
12 additional metrics that are tied to various funding sources.

13 For the overachievers -- for the overachievers, we have
14 additional voluntary reporting opportunities and many of the
15 metrics adopted by CMS were actually vetted by these very
16 clinical professional organizations, so the National Database
17 for Nursing and Quality Improvement, again and gold standard
18 for metrics related to nursing care, the Association for
19 Health Care Research and Quality, they're, usually, these
20 metrics, when they finally get to CMS, have gone through and
21 been recommended by these professional organizations, and of
22 course, we have Leapfrog, which is driven by consumers, and
23 there is a Medicare-based quality improvement project that the
24 critical access hospitals, every critical access hospital in
25 our state has been engaged in and that's a federal program to

1 get them up to speed, because you saw in that earlier slide,
2 the disparity between the reporting mandates for the large
3 hospitals and for the CAS, the critical access hospitals, and
4 the expectation is that those demands are going to change
5 significantly and this program, essentially, is designed to
6 bring them up to speed and to get them thinking in the way of
7 using data to drive improvement and to hold themselves
8 accountable to the data, and these are the measures that the
9 critical access hospitals are looking at.

10 So we briefly covered measurement and reporting and that
11 brings us to scoring. CMS scoring of mandated data is known
12 as pay-for-performance. Under the pay-for-performance
13 umbrella are three scoring mechanisms, the value-based
14 purchasing score, the readmission score, and the hospital
15 acquired condition score.

16 Each scoring is very complex and for the sake of this
17 discussion, we elected to just highlight a few of the
18 fundamental elements. The first and foremost is that the data
19 is old. By the time it's reported and possibly makes the
20 paper, it could be up to two years old. So what the public is
21 seeing as currently released is actually old news. This
22 presents a variety of challenges, as I am sure you can
23 imagine, and one of them that I notice is that it really takes
24 the wind out of the sails of hospitals that are working on
25 quality improvement, because they're working in the present

1 and when this data comes out, it is old news and they have
2 been working to address it and improve it, and then with the
3 exception of the NHSN data that was outlined earlier that has
4 those rigorous definitions, nationally, there is broad
5 variance in interpretation of the metrics and it has been
6 surprising how broad the variance is.

7 Let me share how -- with you how this can play out. So
8 ASHNHA has this focus group. It's a quality focus group and
9 it was put together to work on the initiative that I'm going
10 to talk to you about shortly, and we all got together, all of
11 the hospitals were invited, most of them attended and we got
12 together to pick metrics that we were going to work on
13 collectively in a collaborative effort, and they were a little
14 loose, the definitions.

15 So there were a lot of questions. Well, should we --
16 we're working on readmission. Should we include the newborns?
17 What about scheduled readmissions for chemo? What about
18 observation patients? How about swing beds? There were all
19 these questions, and I thought, "You know what, let's put this
20 out to the national ListServ," which is a ListServ of 1,490
21 hospitals working on this.

22 Forty-nine hospitals responded with 16 different answers
23 about that definition. Does it mean the data is meaningless?
24 No, absolutely not. It means the data is very meaningful to
25 each hospital. Whatever it is that they are working on and

1 they are measuring, it's very meaningful to them. However,
2 when we take all that data and we put it all together, the
3 meaning is diluted, severely diluted.

4 So as a facilitator of this focus group, and you know,
5 our group really surprised me. There were a lot of leadership
6 and they all wanted to include this wide swath, you know, they
7 wanted to include everybody in the numbers, and I reminded
8 them gently, that you know, if we included everybody in the
9 numbers, our rates would look elevated compared to everyone
10 else that we were working with in the Lower 48, the 1,490
11 other hospitals, and you know what their answer was, and this
12 was so inspiring, their answer was, "Our numbers are so small
13 and if we don't know about it, we can't fix it. Let's include
14 them," and that has been the sentiment in this entire project.

15 On every set of metrics, when there was wiggle room, our
16 hospital leaders wanted to capture it all. I thought that was
17 impressive.

18 So this is just one example of variance, but the theme
19 remains the same for documentation at the point of care, and
20 even more so, for billing codes. So aggregated data is simply
21 loaded with layer upon layer of hidden variances.

22 Then you should -- I wanted to point out that the scoring
23 mechanism is based on a bell curve. So it's not like a
24 spelling test, where everybody can get 100% if they answer
25 correctly. It's based on a bell curve. There are winners and

1 there are losers. If a hospital is on the wrong side -- the
2 wrong end of the curve, up to 6% of their Medicare revenue is
3 at risk. Looking ahead, ASHNHA anticipates that the
4 commercial payers will soon follow with this model.

5 So a summary of the measurement reporting and scoring,
6 the number of metrics has increased enormously. It's a very
7 dynamic environment. The mandates are changing. It's a whole
8 job just to keep on top of the mandates because they're coming
9 out that quickly.

10 Analysis at the federal level is retrospective and too
11 retrospective. Aggregation of the data diminishes its value.
12 The increase in mandates and penalties achieved a timely goal
13 of grabbing the attention of hospital leadership. I want to
14 highlight the word timely. More data at this time, more data
15 mandates at this time will be potentially counterproductive.

16 There is plenty of data. There really is plenty of data
17 out there, but there is a scarcity of time. There's a
18 scarcity of time for staff -- and staff to be dedicated to
19 collecting the data. They need to focus now on improving the
20 data and they are eager to do so.

21 So let's talk about something a little bit more fun. We
22 live in this amazing place and in my role at ASHNHA, I derive
23 such joy and inspiration from working with people around the
24 states -- around the state and nothing makes the ASHNHA team
25 more satisfied than connecting our members to each other and

1 seeing them work together to improve the care for all
2 Alaskans, and the program that I'm about to share with you is
3 an example of exactly that.

4 So almost three years ago, ASHNHA's Board jumped at the
5 opportunity to join the -- a national initiative called the
6 Partnership for Patients. This national initiative was driven
7 by CMS and it's an alignment with the pay-for-performance
8 model that we just reviewed, the model under the Affordable
9 Care Act, and it was an effort to support the triple aim,
10 improve the patient experience, healthier population, and
11 reduce cost, again, kind of a big piece of the value equation.

12 So underneath this Partnership for Patients national
13 initiative, there were 26 hospital engagement networks and
14 ASHNHA elected to join the network associated with the
15 American Hospital Association. So under this umbrella, there
16 are 26 networks and ASHNHA chose to join the American Hospital
17 Association Network and that network is the largest in the
18 country, 1,490 hospitals, as I mentioned before.

19 It's the largest -- it claims to be the largest quality
20 and patient safety initiative of its kind in the history of
21 the United States. So it's a pretty impressive endeavor. The
22 goal of the three-year initiative is to reduce hospital-
23 acquired conditions by 20% and to reduce preventable
24 readmissions by 40%, and you might have noted by now that the
25 initiative network name, the Hospital Engagement Network,

1 resulted in a very unfortunate acronym.

2 A commitment to focus on reducing the listed hospital-
3 acquired conditions was a requirement of participation in yes,
4 the HEN, and you might recognize some of these hospital-
5 acquired conditions, but basically, this is what we've been
6 focusing on. This is what our members -- in addition to all
7 of the work that they're doing and that they, of course, have
8 many other focuses. For the sake of this initiative, they
9 have been working on these specific measures, with a highlight
10 on falls, early elective deliveries, and catheter-associated
11 urinary tract infections, as well as readmissions.

12 So on your left is a list of all the initial participants
13 and after a year, we decided to invite all of our members,
14 because Fairbanks Memorial Hospital and Providence, you know,
15 they're some of -- a couple of our largest hospitals and they
16 had a systems obligation. So Providence had its own HEN, its
17 own network and Banner has its own network. So they were
18 really obligated to those systems, but it was kind of hard to
19 have a statewide effort without them, because they're pretty
20 critical and so we just asked them, we said, "You know, would
21 you consider just working with us, sharing your data with us,
22 learning with us and being a part of this statewide quality
23 effort," and they said, "Absolutely. Absolutely," over what
24 was essentially a digital handshake, and email, they said,
25 "Here, here's our data," and I wanted to point out, this is

1 not just publically reported data.

2 This is data that they hadn't been sharing publically
3 with anybody and I really think it speaks volumes for the
4 relationship, and I'm not talking about my relationship, of
5 course, with their quality people or even our ASHNHA team's
6 relationship with the leadership team. It's really about the
7 relationship -- ASHNHA has been serving hospitals in Alaska
8 for over 60 years and while it might seem incidental, I feel
9 like that relationship was really a pivotal -- was a critical
10 element to the robust participation.

11 So then, they joined and all together, there we were, a
12 statewide quality effort. The foundation of this effort is
13 really education, education, education, education, evidence-
14 based practice, helping hospitals change policies to
15 standardize their care.

16 So we have a weekly quality call, and I'd be happy to
17 invite any or all of you to this. It's really open to the
18 public, but we started out -- it's every Tuesday at, usually
19 at 1:00, and we have a wide variety of topics and I still get
20 kind of almost teary-eyed when facilitating these calls and
21 there's a hospital from every part of the state represented,
22 and it's like, wow, that is special. Here we are. We're all
23 together, working to improve care for Alaskans.

24 We've had three quality conferences in two years, with a
25 focus on the topics you can see here. They were very well

1 attended, and then, while the conferences were really great
2 for, you know, the relationship building, we didn't really see
3 that they were resulting in outcomes, improved outcomes when
4 we looked at the data.

5 So we decided to try something different. We hired some
6 subject matter experts to come and we asked hospitals, would
7 you commit to this? Would you commit to getting a team
8 together? The team had to have a physician and pharmacist for
9 the adverse drug events, to join together in working on
10 reducing adverse drug events, for this example. Would you
11 participate in these webinars? Would you host this subject
12 matter expert in your community to spend a day with your staff
13 from frontline, all the way through leadership, and then would
14 you participate in follow-up calls and look at your data
15 together, and they said, "Yes," and we've found that this
16 model actually is more expensive.

17 Even though it's more expensive in some ways, it's a
18 really good model and hopefully, we'll be seeing more of it,
19 and then we also did that with falls. Dr. Quigley actually
20 visited, I think over the course, it was 13 acute care and
21 long-term care facilities in the state.

22 So if ASHNHA had to choose one successful program, it
23 would be the Mentors for Quality Program. This program has
24 just been phenomenal. I wish -- I don't know, how big does
25 that picture look? It's just this great mentoring program.

1 It's a structured mentoring program. It's not just, here,
2 let's meet and everybody have fun and move on. This is
3 something very different.

4 Our first cohort lasted a full year. I'd love to talk
5 about it in greater depth at a later time, but I think we knew
6 we were onto something really valuable when Mike Powers, the
7 CEO at Fairbanks Memorial Hospital, brought in the
8 professional photographer and stayed with us for the photo
9 shoot. We thought this was a really good sign, and I'll be
10 talking more about their work, as we move forward, but I --
11 we're very happy with the success of this program.

12 Here, this image just captures the essence of the
13 program. It really captures, not just the essence of that
14 program, but of this initiative in general. There you have,
15 on your right, Jen Gul, the Interim Quality Director from
16 Fairbanks Memorial Hospital, and Shelley Hjort from
17 Petersburg. So there you have a bridge connecting hospitals
18 in Alaska, something so essential to accelerate the learning,
19 taking learning from research to the bedside, and so you have
20 those -- that bridge.

21 You have those genuine smiles and behind them, very
22 importantly, you have genuine data to support the work that
23 they are doing, which brings us to data. Let's take a dive
24 into the data.

25 Here's a key for your help -- for -- to assist you when

1 you're looking at these graphs. The main thing you should
2 note is that gray represents all of the 1,490 hospitals in the
3 country, and again, they are just a quick reminder of the
4 hospitals that submitted data.

5 So first we -- catheter-associated urinary tract
6 infections, I'm not going to go into any major detail on
7 these. I know they're really, probably of interest to the
8 clinical folks, but you can see here that there has been
9 tremendous reduction in catheter-associated urinary tract
10 infections, but there is still work to do, of course. So
11 we're just moving in the right direction, and again, this is
12 the gold standard data.

13 This is the data that you're seeing on Hospital Compare,
14 but it's aggregated just for Alaska, which makes it kind of
15 nice, and it includes the critical access hospitals that are
16 not included on Hospital Compare.

17 Surgical site infections, great success, moving in the
18 right direction again. Ventilator-associated events, we
19 typically are at none, but every once in a while, we have one
20 and those numbers do represent real patients, even though
21 they're low numbers, hospitals acknowledge that those are real
22 people and real lives. We take them very seriously.

23 Central line and bloodstream infections, this is another
24 one that makes the news or has made the news in the last year.
25 We see a trend, very positive trend, and then you also see,

1 because of the right, that's just the critical access
2 hospitals, you see that this measure really is almost
3 meaningless for them. They have -- a lot of the measures
4 really don't apply to critical access hospitals. They just
5 don't insert many central lines. So if they have one
6 infection, it looks really, really bad, and then preventable
7 readmissions.

8 Again, take into consideration that our members wanted to
9 choose the widest swath for their numerators and denominators.
10 They wanted to capture all the patients. Whereas, in the
11 Lower 48, there seems to be a general trend to capture as few
12 as possible, so that you can look better compared to your
13 peers. Maybe that's a little cynical, but that seemed to be
14 the trend and so I think they're doing some impressive work
15 here.

16 Pressure ulcers, again, doing well, always room for
17 improvement. Adverse drug events, this is an issue that is of
18 great importance nationally, oversedation with opioids, and
19 our hospitals have been working very, very hard on this with
20 Dr. Steve Tremain. He's the subject matter expert in this
21 area. He's practiced internal medicine for over 30 years and
22 he has been a tremendous help, but the work that's being done
23 is really being done at the hospitals, very impressive, still
24 room to improve, but moving in the right direction. That
25 seems to be a theme. We're moving in the right direction.

1 Venous Thromboembolism, what this basically says is
2 patients are getting the treatment they need to prevent
3 pulmonary emboli or deep vein thrombosis. That's basically
4 what that's saying. So kudos to our members for that. C-
5 section rate, again, doing well, and I'd be happy to answer
6 any questions about this.

7 I'm sorry, I'm kind of whisking through it, but -- and
8 then early elective deliveries, which you're going to hear
9 more about in a bit from Fairbanks Memorial Hospital. This is
10 one of the most successful quality improvement efforts, the
11 early elective deliveries, the reduction of early elective
12 deliveries that has ever happened in the history of medicine,
13 and if -- I'm sure that Dr. Hogenson will tell us more about
14 that later, and then falls.

15 I'd mentioned that we had Dr. Quigley come here, she's
16 visited 13 hospitals, and look it, we had a trend. You can't
17 see the trend line, but we were going down up until July of
18 2013, and we have maintained. We can't -- somehow, we can't
19 get -- we haven't been able to get that to move down, and some
20 people look at it as a failure.

21 This is the good stuff. This is where we can really
22 look, work together and brainstorm and try to identify what
23 are our challenges. So this really has provided a lot of good
24 opportunity to work together, and we're still working on it.
25 Yes.

1 MR. PUCKETT: I'm not trying to be funny, but those are
2 falls just within the building, that doesn't include right
3 outside the grounds?

4 MS. WADE: If it's on the campus, it's considered a fall.
5 These were actually just patient falls, but sometimes they
6 actually include patients and employees in one bucket.

7 MR. PUCKETT: Thank you.

8 MS. WADE: Sure. So that's the data that, despite the
9 variances and despite its weaknesses, that's the data that
10 boards really like and that gets them very excited. That's
11 the data that policy-makers really like. That isn't the data
12 that inspires people working in hospitals every day. That's
13 just -- let me show you what inspires our members.

14 Petersburg Medical Center, this came out of the
15 Mentorship for Quality Program, a year -- and continuous focus
16 on falls prevention, falls with and without injury. They
17 received national attention for the creative display of data.

18 This is posted in their lobby. This is posted for
19 patients to see. This is what excites staff. This is what
20 makes nurses say, "I'm not going to have a patient fall on my
21 watch." This is what gets healthcare workers engaged.

22 Yukon-Kuskokwim Health Corporation, this is their poster
23 in their lobby. A little aside on this is that we had a
24 poster presentation at the end of the program and they sent me
25 the file. I made it into a poster for them, because you know,

1 with the -- it was easier that way and afterwards, and they
2 had a poster already in their lobby, and after the conference
3 was over, Kathy Katongan came up to me and she said, "Can I
4 take that poster back to YK with me," and I said, "Well,
5 Kathy, you know, it's the airplane and everything. You're
6 going to have to carry that. What a pain, you know, just take
7 the file back and make one when you get there," and I said,
8 "Besides, you already have one in your lobby," and she said,
9 "No, we want to put this one at the other entrance." That's
10 how eager they were to share this data with their -- with
11 their patients.

12 So this inspires patients' confidence and that hospitals
13 are acknowledging, hey, we're working on things. It also
14 inspires the staff.

15 Providence working on hand hygiene, believe me, this
16 makes -- this helps nurses, doctors, and all healthcare
17 providers improve. When you see these numbers and you're
18 working in the ICU, and your unit isn't doing very well, it
19 makes a difference. You start to do better.

20 South Peninsula Hospital, take a look at this. This is
21 posted in their lobby. This is not just, you know, the good
22 stuff. This is warts and all, and it's not just quality, it's
23 also finance. You can see under finance, they say their goal
24 for cash on hand is 45 days. How much do they have now, 34, I
25 can't see the number on my printout, but not -- they haven't -

1 - they're not at their goal. This is, again, posted in their
2 lobby.

3 That is such a big change for our hospitals in the last
4 couple of years, seeing them have the willingness to share, to
5 have -- to walk the talk of transparency. It's really an
6 exciting time, and this is my favorite, Bartlett Regional
7 Hospital. It doesn't have to be fancy. This is in the ICU.
8 Dr. Urata, does this look familiar?

9 COMMISSIONER URATA: I thought it was blue.

10 MS. WADE: Well, it might be. So this number six from --
11 they had six months without a catheter-associated urinary
12 tract infection when I took this picture. This number went up
13 to 18 months. Their infection preventionist has spoken all
14 over the country about their work, Kim Vermedal. This
15 inspired -- inspires providers.

16 In fact, one night, they finally did have one in April,
17 but a couple of months before that -- a couple of months
18 before that, one of the doctors called the infection
19 preventionist at her home after-hours and said, "Gosh, Kim,
20 you know, I feel so bad that I think that we have a patient
21 with a catheter-associated urinary tract infection and I feel
22 so bad because it's my patient," and it turned out it wasn't,
23 because the patient had it when they came in, when they did an
24 objective review of the data, but that level of engagement, to
25 have a physician calling, that's pretty spectacular.

1 Okay, I'm sorry. So a summary of our collective efforts
2 -- effort, this effort was voluntary, supported by education,
3 a real focus on evidence-based medicine, driven by data. The
4 successes, I think I've already covered. The challenges, lag
5 and payment reform is stunting the QI progress. It really is.
6 That's a whole other presentation, and then, of course, the
7 all-Alaska ever present problem of the depth and stability of
8 workforce.

9 So in summary, I just wanted to close with a personal
10 story. This picture was taken by my great-grandfather. It's
11 a picture of a ship that my great-grandmother took from
12 Skagway, her home, to the Lower 48, to Oregon, to give birth
13 to her first born child. So at that time in Skagway, the
14 doctor thought, because of her advanced maternal age of 30,
15 and other medical, you know, complications, they thought, "You
16 know, it's better for you to leave Skagway and give birth down
17 in the Lower 48," and there she went, had her first child.

18 Now remember, this is at the turn of the century, the
19 turn of the 20th century, the height of the gold rush. This
20 is when -- and Skagway probably had more infrastructure at
21 that time than they have now. They thought it was better for
22 her to leave Alaska and go to the Lower 48, and she did.

23 My grandmother, as she got older, she wasn't a bitter
24 person. She was a very delightful person, but there was this
25 little kernel of resentment that she had been conceived in

1 Skagway, lived her whole life in Skagway, but darn it, she was
2 born in Oregon, and that just bothered her, but let's fast-
3 forward to 1970.

4 The cover of the "Anchorage Daily Times," Dr. VonHippel,
5 some of you might remember him, he performed a surgery that
6 had only been performed twice before. At that time, that was
7 life-saving surgery. It was a slow news day, because it was
8 on the front page, and I have been telling people for 42
9 years, because my mom just sent me this clipping, but I had
10 been telling people for 42 years, that I was the first person
11 who had the procedure done at Providence, but in fact, I was
12 the third, so -- but look, between 1900 and 1970, look how far
13 we've come, look how far we've come.

14 I know we get bogged down on the cost issues. We get
15 bogged down a lot, but take a step back, look how far we've
16 come. Hospitals, doctors, and nurses in 1970 were revered.
17 They were revered by the public, because they were healing
18 people. They were saving lives and they were allowing people
19 to stay in Alaska for their care, but what's on the front page
20 today?

21 Now, I'm not comparing the "Globe" to the "Alaska Daily
22 Times," because that would be an insult to the "Times," but
23 this illustrates a point and this is a really important point.
24 One CEO recently went from one of our larger hospitals --
25 recently lamented, "Gosh, our communities see hospitals as a

1 part of the problem," and you could see a collective nod by
2 our colleagues, acknowledging that, yes, the public sees us as
3 a part of the problem.

4 The public's asking, "What happened? What went wrong,"
5 and what are hospitals doing to improve things, and in our --
6 at ASHNHA, our observation is that hospitals are in a period
7 of deep reflection on the state of healthcare delivery. They
8 really are.

9 We all know that the answer to this question is, no, you
10 know, of course, doctors and healthcare providers today are
11 not less empathetic, less skillful or less trained, less
12 knowledgeable or less passionate. That is not what we are
13 seeing, but we would all agree that the answer to the question
14 is not that each person out there needs to continue doing the
15 very best job. That's what we've been doing. We can't just
16 keep thinking that if everybody just does the best job, that
17 we're going to get through this transition.

18 Hospitals recognize that it is critical to standardize
19 our care, to improve the use of evidence-based medicine, to
20 accelerate that transition from the research to the bedside,
21 to use data to hold ourselves accountable and to inspire us.

22 So what we are seeing from the frontlines to leadership
23 is a genuine willingness and the engagement necessary to
24 improve care, and with that, I'd like to close. Thank you.
25 Do you have any questions? Are there time for questions or

1 no?

2 MS. ERICKSON: Quickly.

3 MS. WADE: Okay, sorry.

4 CHAIR HURLBURT: I have a question. One of the things
5 that the Health Care Commission is trying to foster is more
6 transparency related to value, meaning related to cost and
7 relating to outcomes and several states, as you know, have
8 implemented an all-payer claims database, which gathers -- can
9 gather both kinds of information. Generally, it has not been
10 used a lot. New Hampshire is probably the state where it's
11 been most used, but with the data that you have there, the
12 hospitals are using it in some of the illustrations you had,
13 to show their demonstration to quality to the public, to show
14 their staff that this is important and we want to get those
15 numbers going in the right direction, but -- and our
16 situations where there's competition, it's limited, but for
17 example, in Anchorage, where both Regional and Prov are in the
18 system, can the individual who's going to have a knee
19 arthroplasty go online and look at the data by hospital and
20 say, "Is Regional doing better or is Prov doing better," and
21 that's going to be a part of my decision of where I'm going to
22 have my surgery. Is your system at that level yet so there
23 can be public or employer or payer access to those kinds of
24 comparative quality data?

25 MS. WADE: Well, there -- on Hospital Compare, you could

1 look at surgical site infections. So yes, and they are all
2 listed on -- but the breakdown as to the particular surgery,
3 no, and our data, really at this point, has been used as an
4 ASHNHA collaborative and we haven't released it to the public.
5 Although, we are not opposed to doing so, and I don't think
6 our members would be opposed to doing so. I mean, I can't
7 speak on behalf of them, of course, at this -- you know, we'd
8 have to ask our Board, but I think they have a lot to
9 celebrate and to share. I don't know if that answers your
10 question.

11 CHAIR HURLBURT: Yes.

12 MS. WADE: Okay.

13 CHAIR HURLBURT: Thank you. We're not there yet.

14 MS. WADE: Okay, yeah (affirmative), yeah (affirmative).

15 REPRESENTATIVE HIGGINS: Just a quick question, so when
16 you were talking about the data is two years old, so in June,
17 when the Alaska Dispatch put out that article that we have
18 four hospitals that have issues with quality on the ranking
19 system, is that -- what you're saying is that's two-year-old
20 data, I mean.....

21 MS. WADE: Some of the data is two years old. Yes, it is
22 that old.

23 REPRESENTATIVE HIGGINS: So then in essence, then, how
24 does a hospital change that? I mean, there's nothing they can
25 do about it for two more years or what? I mean, that's.....

1 MS. WADE: Well, this is -- this is -- the crux of it is
2 the hospitals knew about it two years ago. The hospitals have
3 been working on it. The trend is obvious after four data
4 points, so after four months, and they're working on it, but
5 once it happens, you know, and if you're -- it's -- then it's
6 published two years later. So the hospitals are working on
7 it, and it's not really affecting the hospitals and how
8 they're working on it, what it affects is the relationship
9 that the hospitals have with the public, because the public
10 doesn't understand that the data is two years old.

11 COMMISSIONER URATA: Doesn't that website get updated on
12 a quarterly basis?

13 MS. WADE: With two-year-old data.

14 COMMISSIONER URATA: Yeah (affirmative).

15 MS. WADE: Yes.

16 UNIDENTIFIED SPEAKER: So (indiscernible - too far from
17 microphone).

18 MS. WADE: And it's also, you know, it's more complicated
19 than that, like as far as readmissions, for example, four of
20 our hospitals are being penalized for readmissions. What they
21 don't explain is that score is very specifically based on
22 patients who are 65 years and older, who had either heart
23 failure, pneumonia, or a heart attack. That's the group. I
24 mean, not to say those people aren't incredibly important, but
25 it could be just one patient with one of those issues. So

1 that's just one of the weaknesses of the data.

2 MS. ERICKSON: Thank you. Thank you very much, Greta,
3 and Dr., is it Hogenson or Hogenson, very good. Yeah
4 (affirmative), come on up and I'll put your presentation up,
5 and Dr. Tierney, do you want to come sit at the table with
6 Greta and Matt? If we have time to engage in more of a
7 conversation -- but we're just switching out here and if you
8 all -- actually, yeah (affirmative), come as close over as
9 possible. Do you want me to run the slides for you?

10 DR. HOGENSON: No. Push the button.

11 MS. ERICKSON: You'll push the button?

12 DR. HOGENSON: I kind of use my slides. I just talk off
13 of them.

14 MS. ERICKSON: So if you guys just want to introduce
15 yourselves and try to speak directly into the mic as much as
16 possible.

17 DR. HOGENSON: Yeah (affirmative).

18 MS. ERICKSON: Otherwise, folks won't be able to hear you
19 on the phone, because we have a lot of folks on the webinar.

20 DR. HOGENSON: Go right in?

21 MS. ERICKSON: Yeah (affirmative), go ahead.

22 DR. HOGENSON: Okay. Yeah (affirmative), I'm Dr. Ellie
23 Hogenson, and this is Jackie Collins. We're from Fairbanks
24 Memorial Hospital. I'm an OB/GYN and was a Department Chair
25 at the time of this -- an initiative that I'm going to be

1 speaking about.

2 This is Jackie Collins, who is the Director of Women's
3 Services at our hospital. So I'll be talking about our no-
4 cost intervention to improve delivery outcomes, which is the
5 elimination of early term elective deliveries. As you saw,
6 that was one of the initiatives of ASHNHA, and so first, I'll
7 explain a little bit of the problem, just so you can
8 understand why we care about these early term elective
9 deliveries and why we'd like to make them rare and then
10 describe how the initiative was -- Jackie will describe how
11 the initiative was rolled out at Fairbanks Memorial.

12 So first, a little bit of terminology, when I was in
13 residency, there were only three buckets into which we could
14 drop deliveries. Delivery before 37 weeks was called preterm.
15 Between 37 and 42 weeks was term, and 42 weeks was post-term.

16 Those were definitions that had been used for decades,
17 but we had long realized that the complications experienced by
18 babies that were born at 24 weeks were very different than
19 those born at 36 weeks, even though they are both preterm, and
20 we were coming to realize that there were more differences
21 between babies born at 37 weeks, as opposed to the due date at
22 40 weeks.

23 So in 2008, 2009 is what this -- yeah (affirmative),
24 2008/2009, new nomenclature was introduced and now has become
25 widely used to give more buckets to drop the deliveries into -

1 - which -- so that the complications in each bucket are
2 similar. So now, we have our -- we have our preterm and we
3 have our -- the orange arrow, actually of preterm is late
4 preterm and then we have term, which is 37 to 42 weeks, but
5 then we have early term, which is the 37 to 39-week mark. So
6 we have late preterm, early term that we've added, and then
7 we're really thinking about 39 weeks to 42 weeks being the new
8 term, where we really would like babies delivered if there's
9 no complications.

10 So part of the problem with monitoring when babies are
11 delivered is trying to come up with guidelines for dating a
12 delivery. Not every pregnant women presents right at the
13 beginning of their pregnancy, and so the American College of
14 OB/GYN, ACOG, has come up with a set of guidelines that we
15 follow for making sure that when we're thinking about
16 performing a delivery, that there's a reasonable, a guestimate
17 that the baby is well developed and will do well, and this
18 just talks about the different ways of doing it, that we have
19 fetal heart tones documented.

20 Very few people are using a fetoscope. This is really
21 probably for countries that use the ACOG guidelines outside
22 the U.S. That's the old -- they listen on the mom's belly,
23 basically with this big bell-shaped device or by 30 weeks by
24 Doppler. That it's been 36 weeks since a positive pregnancy
25 test, and of course, a lot of our moms are getting ultrasound

1 measurements in the early part of the pregnancy so that we can
2 really know when this baby is going to be ready to come out.

3 There's also amniocentesis, that's where we put a needle
4 into the belly, take out a little bit of fluid and measure for
5 some fetal lung maturity. This is still included in the
6 guidelines for assessing that, although, there's some
7 difficulty with that test. There is some risk associated.
8 It's an expensive test and it doesn't always -- is not always
9 reliable.

10 So when we look at our ultrasound, if it's done early in
11 pregnancy, it can give you a one-week window. If it's in the
12 second trimester, it can be within 10 days of when we really
13 think the due date was and then basically, useless if it's
14 done in the third trimester.

15 So we've long known that there might be some problems
16 with delivering babies electively too early. There -- this
17 gets away from the medically-indicated deliveries. You know,
18 we're always -- in obstetrics, it's always that balance. Is
19 the baby better in, baby better out, and we knew that, you
20 know, there were definitely complications of prematurity that
21 even creep into this kind of early term window between 37 and
22 39 weeks, and even since 1979, the ACOG has cautioned against
23 deliveries before 39 weeks, but it wasn't a very strongly
24 worded statement.

25 They also said that just because you do an amniocentesis

1 and get a positive result that the lungs are mature, doesn't
2 necessarily mean that baby should come out, because there's
3 still going to be some complications with the baby being born
4 a little bit early.

5 So what are these risks that we're worried about and why
6 do we care? Well, like I said, the old data really did show
7 that there was an increased risk of NICU admission, increased
8 risk of retained fluid in the lungs. That's called TTN,
9 increased risk of respiratory distress syndrome, where the
10 lungs are immaturely developed. There's an increased use of
11 ventilators, increased risk that the newborn will develop
12 infection because of immature immune system, and then there's
13 the -- just risks of feeding problems, jaundice, trying to
14 keep warm. These are all problems when you're looking at
15 earlier deliveries between 37 and 39 weeks, and then, kind of
16 the bombshell hit.

17 There was a big study that was sponsored by NIH, the
18 National Institute of Child and Health and Human Development,
19 an arm of NIH, that was published in "New England Journal" in
20 2009, and this was wide in its scope and kind of got
21 everybody's eyes open to this problem.

22 This was 13,000 elective C-sections at a multi-center
23 study for -- so 19 high-volume facilities, and the data was
24 pretty stark that they came up with. So they divided the
25 different adverse outcomes into the buckets at 37 weeks, 38

1 weeks, then 39 weeks and I think you can see the data really
2 speaks.

3 So the first column is any adverse outcome or death. So
4 that's the composite. Then there's adverse respiratory
5 outcome, which is only one part of the equation, and then
6 that's divided into respiratory distress syndrome or the
7 retained fluid, the TTN, and then there's just all-comers
8 admission to the NICU, and then there's infection, and when
9 you look at this, as far as odds ratio or what's the chance
10 that a baby will have one of these conditions, I think it
11 becomes even a little bit more startling.

12 Like if you look at the rate of respiratory distress
13 syndrome, that's the third column over, you can see that a
14 baby born at 37 weeks has a four-time chance of developing
15 that pretty severe lung condition than a baby that's born at
16 39 weeks.

17 So like I said, this got everybody's eyes kind of awake
18 and we're coming to more of an understanding that of the
19 timing of delivery, and this is when we can control it,
20 obviously, you know, sometimes, mom will develop a condition
21 where it's just too dangerous for her to stay pregnant or
22 baby's developing a condition, maybe it's not growing well or
23 it has a placental abruption, where it's just not safe for the
24 baby to stay in, but we're just talking about for otherwise
25 healthy pregnancies, that the baby outcomes at 37 and 38 weeks

1 are actually -- may be even worse than going beyond your due
2 date, for which we long recognized there were some
3 complications, and that the best outcomes are usually at 39
4 and 40 weeks, across a range of measures.

5 So we're coming up with kind of U-shaped idea about the
6 timing of delivery, where really, the lowest risks for
7 admission to the NICU, of course an important measure, not
8 just for, you know, baby's health, but also for cost of
9 deliveries, is best at the 39th/40th week.

10 This is the rate of the -- that severe lung condition,
11 the respiratory distress syndrome. Again, 49 -- or 39 and 40
12 weeks, seem to be this kind of golden window for babies, and
13 even when we're talking about the brain development of the
14 babies, too, we're noticing this same U-shaped curve holds.

15 There's actually quite a lot of brain development that
16 happens in those last few weeks of pregnancy, especially, look
17 at the third point down there, there's a five-fold increase in
18 the myelinated white matter. So these neurons get a little
19 protective sheath of myelin that happens between 35 and 41
20 weeks. So we're coming to this understanding that the brain's
21 somehow protected maybe from the stresses of labor, kind of
22 the longer we wait in pregnancy and that's actually shown out
23 by a very similar U-shaped curve, where cerebral palsy, which
24 is -- often times can be a problem with the immature brain
25 response to low oxygen delivery or other problems like that,

1 also shows this U-shaped curve, where it seems to be this
2 magic window between 39 and 41 weeks, in this case where
3 babies tend to do a little better.

4 So with all this data, how are we doing at preventing
5 this fairly, you know, preventable, I guess, complication of
6 deliveries, some of these preventable complications of
7 deliveries? Well, when this NICHD study came out, we were
8 doing pretty bad. Of these elective C-sections, actually,
9 over 1/3 of them were performed less than 39 weeks. So this
10 is not -- this took C-sections that were done because of any
11 kind of complication or problem. So these were just -- they
12 had decided to do these C-sections early, and interestingly,
13 the risk factors for being born early or for having your
14 delivery early were not our traditional risk factors for
15 preterm labor.

16 The moms tended to be older. They tended to be
17 caucasian, married, tended to -- interesting, I found -- I
18 don't know why, but tended to have a normal grown baby. LGA
19 is OB/GYN speak for a large baby, large for a gestational age
20 fetus, so they tended to be babies that were well born or well
21 grown, and then the moms tended to have private insurance.

22 So why is this done? Well, there's a lot of pressures on
23 moms and doctors at the end of the pregnancy. Of course,
24 being, you know, eight/nine months pregnant is not
25 comfortable. It's hard not to be able to tie your shoes, you

1 know. Some, you know, people were trying to avoid larger
2 babies. They said, "Well, this baby, if we let it go, it's
3 just going to be too big," so -- but you don't know that it's
4 going to be that, and then there's always scheduling, you
5 know.

6 Here in Alaska, we hear, "Well, before the end of the
7 year, then I can get a PFD or a break on the taxes," or
8 whatever. We get that. One difficult one that we don't,
9 luckily, have to deal with quite so often is deployments, you
10 know, we -- often times would have to try to time deliveries
11 around those, so -- and then maybe some factors relevant here
12 in Alaska, is the history of fast labor, that you live in Tok,
13 you know, so and then there was a belief if people weren't
14 looking at the data that, well, we have a healthy baby now,
15 why not just get it out now before there's, you know,
16 possibility for problems down the line, so -- which isn't now
17 borne out in the bigger data sets that we have, so and the
18 state of Alaska has actually looked at this.

19 How much of a problem was it for our state? So in the
20 epidemiology bulletin, published -- I think this was a few --
21 this was from 2012, they looked at our data between 2005 and
22 2010, and this is Medicaid data, because that's data set they
23 had access to, so likely, this is an under-reporting, since
24 like we saw from the NICHD data, this tended to be less of a
25 problem with people with public insurance, as opposed to

1 private, and we were doing better than the national data
2 showed, but we still had early term and non-medically
3 indicated early term births.

4 So the black bars is really what we want to be able to
5 affect. So of our Medicaid data, about 26% of the births were
6 early term and about 4% were non-medically indicated. Like I
7 said, that's likely an under-reporting, but the interesting
8 thing is that elective deliveries less than 39 weeks really
9 depended on the facility. Less than one percent in some
10 facilities to 17% in others. So what's our solution? I'll
11 give it over to Jackie and she'll talk about what we did at
12 Fairbanks Memorial.

13 MS. COLLINS: I'll let you continue to drive there.
14 Okay, so at Fairbanks Memorial, the first thing we did was we
15 developed a clinical practice and we actually did it system-
16 wide with all the banner hospitals, but in that clinical
17 practice, the big piece of it was education, you know,
18 education to the providers, education to the staff, and
19 education to the patients, as well, because I mean, a lot of
20 the patients really do want to be delivered early because they
21 didn't understand that, you know, there were issues.

22 So that took our PR Department, they did a couple of
23 articles in the newspaper and tried to get the word out to the
24 local Fairbanks community that, you know, we were no longer
25 going to do any kind of elective deliveries before 39 weeks.

1 We developed a hospital policy and then we developed a
2 scheduling kind of a protocol, so that anybody, when the
3 physicians were calling into schedule a C-section or a
4 delivery, induction, you know, we had strict protocol. If the
5 case did not meet criteria, we did not schedule it, but -- and
6 then the other big piece was having a physician champion that
7 went to their colleagues, and you know, agreed that this was
8 the right thing to do, and then you guys already saw a picture
9 of Jen Gul, but she was happily collecting all the data for
10 us, so that we could trend and chart our outcomes.

11 So the first thing that we did was we gathered the
12 baseline data for, you know, the patients that we were
13 inducing less than 39 weeks and then we came up with an
14 implementation list, so in other words, the indications that
15 Dr. Hogenson was talking about that were diagnoses that maybe
16 the patient did need to be delivered before 39 weeks and then
17 the other part was that we identified Dr. Hogenson, at the
18 time was the Department Chair, who 100% accepted it, so that
19 she could speak to it and just let the other physicians know,
20 like this is the clinical practice that we're doing and if we
21 have anybody that wants to deliver -- 39 weeks, if it's not on
22 this list, we're, you know, going to scrutinize it and look at
23 it. It wasn't saying that they couldn't deliver somebody that
24 had a diagnosis that wasn't on the list, but we, at least,
25 wanted to make sure that it was a medical reason.

1 Then we were implementing the criteria for establishing
2 the age greater than 39 weeks, so in other words, we were all
3 looking at the same thing, like the early ultrasound, or you
4 know, because there's several different ways that you can
5 decide how the patient -- at what gestation the patient's at,
6 you know, when the baby's due. So we all looked -- made sure
7 that everybody was looking at the same criteria for that.

8 So this is as simple as it was. There aren't very many
9 diagnoses to deliver a baby less than 39 weeks, but this is
10 it, and we taped it up to our little glass thing right by the
11 telephone and we took one down to the OR for scheduling C-
12 sections and everybody got the message that if it's not on
13 that list and if they're less than 39 weeks, they need to
14 either call myself or Dr. Hogenson.

15 So we developed the hard stop. So all cases that did not
16 meet the criteria, you know, we definitely said, "No, they
17 can't be delivered." We got administration buy-in. That was
18 a huge thing. We also didn't want -- did not want the nurses
19 to become the policemen of this. So having medical
20 leadership, you know, physician champion was very important,
21 and then to ensure success of the program, we just continued
22 moving forward. So we did regular reviews of the data and
23 just made sure that we were having the outcomes that we
24 wanted.

25 DR. HOGENSON: So this is -- this is a project that has

1 been implemented other places and actually has had some
2 dramatic results. So we are hoping for the same at our little
3 facility.

4 There was a big Ohio push for this and they reduced their
5 inappropriate early term deliveries from 25% to less than 5%.
6 So this is where they were hovering before and then they
7 implemented this similar kind of hard stop policy and really
8 got their numbers down in a hurry, so and this was ours.

9 We were able to have very similar -- so this was a random
10 sample. This wasn't counting all the -- we actually have much
11 better ways of tracking deliveries now than we did in 2010,
12 but did an audit of charts and found 13 out of 103 that were
13 born, elective early term deliveries, and got it down in a
14 hurry in 2011, and we've been now, 0%, we've had zero for over
15 1,000 days, so -- so yeah (affirmative), just in summary, this
16 is a problem with a solution.

17 It's worked well. We -- we had education for staff and
18 physicians and really had pretty much across the board buy-in
19 by physicians and certainly by the staff, who don't love to
20 run elective inductions anyway, but yeah (affirmative), so the
21 data's consistent. There are adverse consequences for these
22 neonates with the elective deliveries before 39 weeks and
23 these hard stop policies -- the nice thing is, that a patient,
24 you know, very uncomfortable, and they do get very
25 uncomfortable at the end of delivery or their mother-in-law's

1 in town, or you know, they come into my office, they say,
2 "Boy, I really need the baby born," you know, or it's aunt
3 Millie's, you know, birthday and that special day, aunt
4 Millie, you know, I mean, these things come up. I can say,
5 "The hospital won't even let me schedule this delivery for
6 you. I just can't do it," you know, and that's kind of a
7 powerful thing to say and we have the discussion, and it will
8 be better for your baby, anyway, to wait, but you know, but
9 their sister's baby was born at 36 weeks was fine, and so you
10 know, it's really a nice, powerful thing to say, "The hospital
11 won't even schedule it," so -- and one thing I was going to
12 just -- in preparing for this, I was wondering how many other
13 hospitals had implemented similar hard stop policies, and
14 pretty much they all had.

15 I called up the nine hospitals in Alaska that had over
16 150 deliveries per year and this is not including military
17 facilities, but -- and seven out of nine of them had
18 implemented a hard stop policy. One of them that wasn't
19 included in the seven, they say, "We don't do any elective
20 inductions," so yeah (affirmative), so it's been widely
21 adopted throughout Alaska, which is, I'm sure, a very good
22 thing, so.....

23 COMMISSIONER LOUDON: I'm just curious whether you also
24 tracked the qualitative measures associated with this, so
25 reduction in NICU admissions or bad outcomes on the babies?

1 MS. COLLINS: We actually do track that, but I don't know
2 if the data, and unfortunately, we don't have the quality
3 person, but I don't think we necessarily put it with that.
4 Although, it would be very easy to do, you know, to track --
5 because we do track how many NICU admissions we have per
6 birth. So it would be very easy to look back and see it, but
7 I don't have that number.

8 COMMISSIONER LOUDON: Yeah (affirmative), it just seems
9 to me, it would be a lot more powerful information, I mean,
10 you made the decision to reduce those because of the outcomes
11 that you expected. You should be able to go back and say,
12 "Yeah (affirmative), and we also had these quality
13 improvements also," would be pretty telling for other people.

14 MS. COLLINS: And I think you're right, because I know a
15 lot of the hospitals that have implemented this, they say that
16 their NICU is actually -- I know some of the banner hospitals
17 say that their NICUs really aren't getting the volumes that
18 they used to have. So I think you're absolutely right.
19 That's good data to have.

20 CHAIR HURLBURT: I have a comment and then a specific
21 question, and I'd to thank you for this. I first came to
22 Alaska as a doc in 1961 to Kanakanak and our current outcomes,
23 as you all are aware, and as we actually mentioned here
24 yesterday related to newborn neonatal outcomes are the best in
25 the United States, and I can't ever remember anything

1 medically where we were the best in the United States, and
2 it's due to what you all have done and a lot of others and I
3 think, you know, if you live to 150, you have contributed
4 something unique in doing this and the others engaged in it,
5 and I'd just like to thank you for it.

6 I believe -- my understanding from talking with March of
7 Dimes folks and I didn't see it on the list that Valley
8 Hospital has a hard stop program now, as well, but the last I
9 had heard, our biggest hospital, Prov, had not adopted it.

10 DR. HOGENSON: They have now.

11 CHAIR HURLBURT: And what.....

12 MS. COLLINS: At least that's what labor and delivery
13 seemed to think.

14 CHAIR HURLBURT: Yeah (affirmative), and I'm putting you
15 on the spot, and it's -- I'm totally comfortable for you to
16 answer -- I am totally comfortable that the hospital director
17 there would be absolutely totally supportive of doing it, so
18 probably it's a matter of getting the docs onboard.

19 Why have they not, and what might we, perhaps, do to
20 encourage that, bring some moral suasion, because it has been
21 a very important thing for our newborns and for the future of
22 Alaska.

23 MS. COLLINS: Do you want me to answer? Well, I'll at
24 least start the answer anyway. For myself, I know that the
25 biggest thing at Fairbanks Memorial was having that physician

1 champion and having the right one, because I think that when
2 we first started implementing it, it was a change of practice
3 and I mean, like Dr. Hogenson said, a lot of times, the
4 physicians are getting pressured from the patient.

5 It's not so much that they want to do it, but I think
6 that having, for myself, having Dr. Hogenson in place, because
7 the staff would come to me and then, I'd usually call Dr.
8 Hogenson and she wasn't afraid to call the physician out on it
9 and just say, "You know, this is a practice that we've
10 implemented and we need to, you know, stick with it. Is there
11 really, you know, a good reason for it," and usually, there
12 wasn't, and then being able to blame the hospital, I think,
13 was always a good thing, too, just being able to say, "Really,
14 this -- the hospital, you know, it's a hard stop with the
15 hospital. We aren't going to schedule it." So I -- and it
16 just changed the culture slowly.

17 DR. HOGENSON: I think the education of the staff and the
18 medical staff is really important, because you know, in our
19 experience, I mean, how many -- how many 37-weekers have I see
20 with respiratory distress syndrome, you know, two maybe, you
21 know, and I've seen a few, you know, at 38, 39 weeks, you
22 know, and so you don't have that, you know, it's really needed
23 be data in aggregate, because you know, you can get into a
24 situation, "Well, that doesn't, you know, I haven't seen that
25 and that doesn't seem to be, you know, like it's dangerous at

1 all to deliver these babies at 37, 38 weeks," but so I think -
2 - I think some education is really important and now, it's
3 actually -- ACOG's come out with a pretty firmly worded
4 statement against it, you know, and so I think that really
5 gets, you know, an OB/GYN's attention for sure, and then, like
6 I didn't actually anticipate the benefit of having that power
7 like Jackie was saying, to say, "You know, hey, this is the
8 hospital policy, and you know, let's wait," and so I think the
9 docs want to do the best thing. They just may not know, you
10 know, that it is important.

11 MS. ERICKSON: Thank you both very much. I'll keep
12 things moving. I'll ask you to introduce yourself.

13 MR. EISENHOWER: I will do that, and thank you for
14 getting the slides up here. My name is Matt Eisenhower. I'm
15 the Program Director in Ketchikan. I sometimes feel like
16 Ketchikan is almost in a different state than the rest of
17 Alaska.

18 A lot of the things that we deal with are a little bit
19 unique, even within the scope of Alaska, as well as other
20 parts of Alaska. So I am just infatuated with the
21 information. I sat through a lot of the sessions yesterday
22 and a lot of the topics that I'm going to be talking about,
23 you dealt with, as far as reduction of payments, trying to
24 figure out better ways to partner with business folks, to help
25 them understand how to take care of their patients better, and

1 I've given this presentation or similar presentations in a lot
2 of different venues and have been very fortunate to be the
3 spokesperson for a lot of things that we're doing.

4 So I want to kind of abbreviate my presentation and then
5 hopefully, lead to some dialog. I think that might be a
6 little bit better for our time here, but just as a little bit
7 of a background, you know, I don't know how many military
8 folks are here, but airborne pathfinders are folks who are
9 kind of dropped in deep in a situation ahead of the normal
10 airborne divisions, and they're small, nimble type of groups
11 that are designed to find unique paths, in the old days, when
12 you actually had to walk places, but even now with helicopters
13 and things in the military, these pathfinders find unique
14 nimble ways to get places that the big Army is going, and very
15 much, I feel like the innovation program that CMS is doing is
16 like that pathfinder, where we're trying to get at little
17 groups of people into places and explore, and some of the
18 things that we're learning are very intriguing.

19 So a little bit of background of the program, CMS, as
20 part of the Affordable Care Act, implemented a group of CMS
21 called the Health Care Innovation Award. It's known as HCIA.
22 Maybe you've seen that in some of the news releases, and the
23 first round of HCIA awards were 107 sites.

24 We were the only site selected in the state of Alaska and
25 it was around the triple aim, in that we wanted to increase

1 care to have better outcomes and ultimately, to reduce per
2 capita costs, and I think that's been the theme here and
3 that's one of the things that I really want to focus on.

4 So I'm going to give you some result first. I'm going to
5 work the presentation backwards, give you some of the results
6 first, and then talk a little bit about some of the things
7 that we're doing with the team that will hopefully, spur some
8 conversation, and the truth of the matter is, is that, you
9 know, the per capita costs, I'm a data -- data nerd and I like
10 to talk about numbers and things, and I'll try to limit that,
11 but obviously, when we're looking at the per capita costs, I
12 was intrigued by the HR representatives yesterday, because I
13 think they're sniffing in the right direction.

14 I'm not convinced they're completely there yet, but the
15 truth of the matter is, is that we've got an 80/20 or not
16 quite the 80/20 rule going on. In most settings, about 80% of
17 our costs are associated with about 5% of our population. In
18 some cases, it's lower than that. In some cases, it's higher
19 than that.

20 So when we look at actually reducing costs, it's follow
21 the dollars. Follow the dollars to those high utilizers, and
22 I think those conversations have been in place, but
23 incidently, if we have time, I think there are things that our
24 healthcare providers can partner with our business
25 communities, and we're exploring this in Ketchikan with Vigor,

1 one of our ship-building organizations there and the
2 healthcare or the -- the school system to try to find ways to
3 help them understand how to deal with those high cost patients
4 and how we can add value to that on the preventative side,
5 specifically in the clinic setting, versus the hospital
6 setting, and as a side note, I'm giving you lots of precursors
7 that will hopefully, get the brain juices flowing.

8 Obviously, in our country, since EMTALA was implemented,
9 I think, in the mid '80's, the easiest access to care for most
10 people, and EMTALA is the law that requires emergency rooms to
11 see patients and give care, since that has been implemented,
12 the easiest path to care has been on the treatment side in our
13 country and not the prevention side, and the truth of the
14 matter is, is our incentives of payments have followed that,
15 that the treatment is really where people go to first, instead
16 of the prevention side, and when I worked for the medical
17 device industry, we used to joke about the fact of the matter
18 that the money's in the treatment, not the cure.

19 If we deal with the cure, then there's not a whole lot of
20 money, and obviously, we joked about it. We didn't really
21 mean it. At least, I didn't, maybe others did, but so with
22 that as a backdrop, let me give you a little bit of what's
23 going on within the innovation program and just give you some
24 of the results of review that I think may be of value, and
25 I'll go through some of these quicker and dive deeper if I see

1 some heads nodding, but at the end of the day, the most
2 important thing that we're looking at doing is reducing these
3 payments to our hospital.

4 It's not a great business model. When I'm working with
5 our CFO and trying to convince them that reducing our revenue
6 by 15 to 25% is what we're after, but I'll explain why that's
7 an important thing. The other thing that we're seeing is this
8 reduction in 30-day all-cause readmission rate, which is kind
9 of the gold standard for making sure that we don't have people
10 back in the hospital unnecessarily, and I assume in this
11 group, we understand what that means, but I'll just say it
12 again, that a readmission rate is someone who has been in the
13 hospital for whatever they might be in for, maybe a knee
14 replacement or congestive heart failure, and then when they're
15 discharged, for whatever reason, within that first 30 days,
16 they wind up back in the hospital.

17 Most people believe that generally speaking, and with
18 some exceptions, that's not a good thing. It means they left
19 the hospital. They didn't get the care that they needed. So
20 that 30-day readmission rate is an important measurement.
21 We've seen a 27% reduction in a way that we do the
22 intervention, and I'll explain that in just a second, which is
23 very compelling, and then finally, some improved clinical
24 outcomes that I could bore you for the next six hours on some
25 of those things, but so reduction of payment, let me start

1 with a little bit of the way CMS asks us to measure this.

2 I think a theme that we've heard the last couple of days
3 is sometimes sexy sophistication can get in the way of simple
4 sound solutions. I tell that to our staff a lot, that often
5 times these sophisticated sexy things that frankly, people
6 like to talk about, often times get in the way of just some
7 good old fashioned Alaska solutions that don't take a whole
8 lot of things going on, but the equation that CMS has asked us
9 to think about is looking at this per capita reduction.

10 There's a very simple solution and it works very well in
11 Ketchikan, because we're isolated, is that they just look at
12 our total CMS, and so it's the Medicaid/Medicare dollars that
13 are paid out to our facility, PeaceHealth, and then we simply
14 divide that by the total encounters, and this could be
15 anything from stitches to surgery.

16 It's just these encounters are averaged out, and that
17 gives us this per beneficiary, per encounter average number.
18 So some of the baseline that we looked at was fiscal year '12,
19 and you can see there in that highlighted section, it was \$536
20 per encounter in 2012.

21 Most of our implementation started about midyear fiscal
22 year '13, and we started to see a reduction of \$457 per
23 encounter and then, obviously, in 2014, we're still finalizing
24 these numbers, but it looks like, it will probably be better
25 than actually that \$418 an encounter. So that's a 22%

1 reduction in the way CMS likes us to measure that.

2 Now, not all of this can be attributed to the primary
3 care intervention that I'll talk about, but I want you to see
4 that reduction is taking place.

5 The second method is just historical total dollars,
6 again, a very simple way of looking at this, is we looked at
7 our total, and these are CMS dollars. I've looked at both CMS
8 and private payers, but I'm just going to put up CMS dollars.
9 They're pretty comparable, just for the point of the --
10 illustrating the point.

11 You can see that fiscal year '12, we were just over \$11
12 million dollars net reduced and fiscal year '13, to 10.4, and
13 then the projected fiscal year '14, actually, I think it's,
14 again, better than that, will be 9.4 million. So that's a
15 reduction of 15% or about \$2.2 million over the course of that
16 18 months of intervention, and just to put that, as far as a
17 return on investment of this program, with the actual
18 intervention done, if you separate the administrative costs,
19 over that period, there was probably about \$500,000 to
20 \$600,000 of invention -- intervention done to result in that
21 \$2.2 million reduction.

22 Again, I don't want to over -- take the credit for this.
23 I think there were other things at play that most facilities
24 have realized, but clearly, there's a direct correlation.

25 So reduction of payments, that's, again, there's some

1 things that can be looked at that more closely, but I just
2 wanted to put that up as a cursory piece of evidence.

3 The second one, and I just put a note up there, this is
4 all done in the concept of the climate that our encounters
5 have actually increased in our setting, which as a
6 statistician knows that if you increase the amount of
7 encounters, certain types of encounters that are less
8 expensive, obviously, it's going to help you.

9 So the second piece I just wanted to talk about was the
10 reduction -- well, let me -- I'm going to skip through that.
11 That parses out the difference of clinic-based payments and
12 hospital-based payments. You can see that the large majority
13 of our win is in the hospital side, but let me talk about the
14 readmission rates, because I think this is probably, for me as
15 a clinician, the most interesting piece of what we've seen,
16 and you'll see, these are our -- I'll just populate the whole
17 screen and you can look at different things.

18 So if you look at the blue lines, we've got two
19 population groups. It's a wonderful research protocol,
20 because we have a control group in Ketchikan. So our
21 hospital, obviously, we see patients, not only from Ketchikan,
22 but from the lower Southeast and we've got about 13,000 people
23 on the island and about 20,000 people in our footprint of our
24 care.

25 About 40% of those patients that are in our hospitals are

1 PeaceHealth Medical Group, meaning the clinic. So the primary
2 care providers are PeaceHealth folks. The rest are other
3 providers, other primary care providers, either Native Health
4 or some other areas of the Southeast.

5 So it presented itself, as a research nerd, as a
6 wonderful control group, because basically what we did, is we
7 did some intervention on transition of care, when patients
8 leave the hospital, on the PeaceHealth Medical Group side, but
9 we allowed to remain the typical care that happens for the
10 other patients, the other 60%, and so those are non-
11 PeaceHealth Medical Group patients, so if you see on that
12 graph -- you see some -- a thick line and a thin line.

13 The thin line are the actual numbers by month and you see
14 in blue, those are the non-PeaceHealth Medical Group patients.
15 So those are patients that come to the hospital, have their
16 treatment and then they are discharged and then they have
17 traditional care, which in our case was no care, unless there
18 was a PCP that was particularly interested in them, but
19 generally speaking, when they left the hospital, there was
20 almost no intervention.

21 So we implemented, in early 2012, this transition of care
22 protocol that I'm willing to share, but I don't think we have
23 the time, but what I want you to see is that the control group
24 of the blue, you can see, you know, we had a seasonal rise up
25 to about 10% into September and October, and you can see the

1 numerator and denominator numbers there in the blue on the
2 bottom, and then that compared to the red, which was the
3 PeaceHealth Medical Group patients in which we did the
4 intervention and I'm not sure that I could have created a
5 better slide for my undergrad statistics class to see, that's
6 a polynomial trend of three months that you see, and you can
7 see that increasing spread.

8 It was at about this time in February and March that we
9 actually made a decision within our inpatient side, we felt
10 that there was an ethical problem with us continuing down this
11 path, because we felt that we had statistically significant
12 evidence to suggest that what we were providing those patients
13 should be extended, to the best of our ability, to all
14 patients, and so the interesting thing is, is beyond March or
15 in late February, early March, our charge nurses on the
16 inpatient side began to make some phone call follow-ups, and
17 although the intervention isn't exactly what we're doing with
18 our team, it's similar and we've, incidentally, seen that
19 trend line begin to smush a little bit, but both of those
20 lines, both of those readmission rates have decreased.

21 If we look at some folks, we use Premier, which does some
22 statistics and expected type of readmission rates and things
23 of that nature, with our colleagues and the type of hospital
24 that we're at in Ketchikan, we should be at about 8.5, I think
25 it's 8.87, is the predicted 30-day readmission rate.

1 You can see that, you know, now, we're well below that in
2 the four, five, and 6% range. So that's a very, very
3 compelling argument, I think, for some of the work that we're
4 doing, and why I give you those two data points, as Mr.
5 Loudon, I hope I'm pronouncing your name -- I think your point
6 for the previous presentation was very important because if we
7 only look at readmission rates and we don't connect that with
8 actual savings, I think we've only done, you know, half of the
9 job.

10 So the readmission rates, our theory is, is we'll reduce
11 our costs and they do, indeed, at least what we've seen on the
12 first section, so -- and then I'm going to skip through this,
13 but these are some of the health maintenance things that we've
14 looked at, hemoglobin A1c, obviously for diabetics, and
15 emergency room clinic referrals that used to -- we used to not
16 have the capacity in the clinic and so we've seen some
17 hypertension work and those are the follow-up things, but let
18 me talk a little bit about the operations of what we're doing
19 and maybe this will spur some conversations.

20 We have three primary care coordinators, one LPN, and two
21 nurses, and without getting into the minutia of what they do,
22 I can tell you this, that the secret in the sauce, at least
23 according to my opinion, is that we've allowed care
24 coordinators to draw on two sets of expertise, the clinical
25 side, which is the nursing, as well as the social work side,

1 and then we have a team together, but both of those types of
2 hurdles to care, these care coordinators will work, and the
3 way this looks is, is the staff is embedded in our primary
4 care setting, so they're right alongside their PCP doctors and
5 other nurses.

6 It's very much a medical home type of a model, and they
7 are charged with dealing with the expensive patients and
8 they've learned, and we've taught them to look for those, you
9 know, five to 7% of the high risk patients, whether they're
10 being discharged from the hospital, whether they're part of
11 the big three bundle that we talk about with cardiac, cancer,
12 and diabetes, and they're given the responsibility to make
13 sure that those patients do not have hurdles to care on the
14 prevention side, because we know that if they have hurdles to
15 care on the prevention side, they will wind up being on the
16 expensive side, which is the treatment and the inpatient side
17 of things.

18 So again, a simple concept, but I think it's a little bit
19 foreign to the way some clinics are set up and frankly, the
20 reason, and this is the point of conversation, is that we are
21 not incentivized on the primary care side to do a lot of what
22 we all know needs to be done.

23 Most of the incentivization is still in the treatment
24 side, and I think with this Board, I think from, you know,
25 recognizing we have got a variety of expertise, but your

1 mission is to make sure there our policy at a state level, you
2 know, is -- continues to move that forward.

3 So I would be an advocate for making sure that we will
4 reinvest on the primary care side of things, and then also
5 recognize that some of the traditional things that we've done
6 in the past are expanding and let me -- and with one quick
7 story that will maybe illuminate this and then we can have
8 some conversation surrounding it and we can go in a lot of
9 different directions, but my grandfather was an old country
10 doctor.

11 It sounds like we've got a grandparents theme today, but
12 he was an old country doctor in southern New Jersey, and just
13 to give you a piece of his legacy, he was one of the first
14 doctors at Jefferson Medical Center in Philadelphia who gave
15 penicillin. So that kind of explains the stretch of his
16 tenure. I can't imagine practicing medicine without
17 penicillin, just as -- it's just a foreign world, but he was
18 in southern New Jersey and I used to spend a lot of time with
19 him.

20 That was at a time when I wanted to be a doctor and I
21 think I realized that the medicine that he was practicing, I
22 probably wouldn't be able to practice in my lifetime. So I
23 took a different path, but I used to work with him a lot and
24 his EMR consisted of a three-by-five card, that he would write
25 his notes on in the clinic and he would give it to me and I

1 would go file it in the filing cabinets and the extent of his
2 kind of data collection and quality was, at the end of the
3 day, he would have me file these cards and he'd say, "Matt,
4 go, you know, look at Ms. Erickson and see what her blood
5 pressure was the last time, you know, she was in, compared to
6 what it is today and we'll talk about it after dinner," and so
7 that was my exposure to quality with a three-by-five card,
8 which incidentally, worked pretty dag-gone well for him, and
9 then, you know, obviously, prior to to HIPAA compliance and
10 things, that I was able to do it, but the point being is that
11 often times, he would have a patient come in.

12 They would need a medication and literally, right next
13 door was the pharmacy and he would call Ted or whatever his
14 name was in the pharmacy and tell him what he needed and the
15 hurdles to care for that patient were not significant. They'd
16 walk into the office. They'd see my grandfather, talk to my
17 grandmother, talk with me, go get their meds. I can remember
18 many, many times, if there were people without means that
19 needed help, that it was just taken care of.

20 Nowadays, a patient walks into a typical clinic setting
21 and has to go through a lot of steps, from a financial side to
22 understanding their insurance, to understanding their copay,
23 to meeting people they maybe never have met before, as a nurse
24 and a provider, and then when the provider gives them a plan
25 to maybe go get a mammogram, they don't know, you know, who to

1 call or how to make that happen, and there's these -- all
2 these hurdles to care, that frankly, I think the medical
3 community is not used to understanding how to handle, and many
4 folks will say, "We're clinicians. We're not social workers,"
5 and we throw up our hands and we wonder why these patients
6 aren't getting the preventative care and they wind up getting
7 expensive treatment, which I'm convinced can be impacted.

8 So my little slice of the pie would be to recommend that
9 this care coordination that we've been able to implement, that
10 uses social work, as well as nursing skills and just help them
11 understand, help the staff understand, you know, what your
12 main goal is, is to focus on these spot fires and to make sure
13 that they're handled well, with grace and humanity, and help
14 them with things to get the treatment to care.

15 So with that, I've got lots of things that I can share
16 with you, as far as cost of service, what I would estimate
17 that we could do for that, but I would just open it up for
18 questions and comments at this point.

19 CHAIR HURLBURT: I'll start out, we thank you very much.
20 I think that this is an example of what has to happen to get a
21 handle of the challenges that we face, and being led by those
22 on the provider side, such as yourself, we will make less
23 mistakes.

24 You showed that the cost per encounter went down. You
25 did say the numbers of encounters went up and our economic

1 model, medical care is so unique, that we can control the
2 number of encounters to manipulate it, but you showed that the
3 total dollars went down, which is the bottom line. Your
4 paycheck says PeaceHealth on it?

5 MR. EISENHOWER: Correct.

6 CHAIR HURLBURT: PeaceHealth is not for profit, but like
7 the good sisters always say, "No money, no mission." Why is
8 PeaceHealth doing something to reduce your revenue? I think
9 it has to be done in the country.

10 MR. EISENHOWER: Sure.

11 CHAIR HURLBURT: I think it's commendable, but it's maybe
12 a chance for an op-ed piece to why are you doing that?

13 MR. EISENHOWER: Well, I appreciate the observation,
14 because it's a terrible way to run a business because we're
15 without this grant funding, we would be paying for services
16 that are reducing our income. That's not a great way to be
17 like, having a pizza shop with somebody standing out front
18 saying, "You know, I think you should only have one pizza a
19 week," and you know, that's -- and you pay the person to stand
20 out there to say, "One pizza a week," and then you reduce your
21 pizzas that you're selling. It's -- that's the analogy that
22 we're in.

23 The quick answer is, is we believe this is the future and
24 we want to be the leaders in understanding it and -- but we
25 are clearly, you know, everybody is going from one canoe to

1 another canoe and paying for value, instead of paying for
2 service, and frankly, right now, we've got one foot in one
3 canoe and one foot in the other, and you know how that feels.
4 It can be very uneasy, but the reason is, is that we did have
5 the luxury of this funding and we also wanted to understand
6 the future.

7 I can tell you, though, it's very clear for us now that
8 if we could even have a simple shared savings model that we
9 could go to the state and say, "We are going to save you X-
10 amount of dollars on your Medicaid population. Will you share
11 us half of that?" I estimate about 50 to 60% of that shared
12 savings. We give the 40% back to the state and we keep our
13 60%, and we could run a program like this. I've just heard
14 varying views as to whether that would be received well.

15 COMMISSIONER HULTBERG: I just want to underscore that,
16 because I think that is such a critical point and one of the
17 reasons I -- we thought that the work that PeaceHealth was
18 doing was really worth highlighting for this Commission,
19 because we talk a lot in this Commission about healthcare
20 costs and we have payers talking about the burden of
21 healthcare costs, but what is going to -- what's it's -- what
22 will be required in order for us to move from one canoe to
23 another, and that is sitting down with payers and talking
24 about these unique -- these unique payment arrangements that
25 can support this work, because clearly, it's worth work --

1 it's work worth doing, but we can't be having conversations,
2 which is healthcare is too expensive, and you know,
3 ultimately, it's going to -- you know, the math is going to
4 kill our economy, on the one hand, and providers, on the other
5 hand saying, "But you're paying me for this. You're paying me
6 for this. I don't know how else, you know, I don't know how
7 else to operate because I'm -- I don't know how else you're
8 going to pay me."

9 It's got -- those two have to merge and there has to be
10 some real intentional conversations about how do we move from
11 volume to value, and so that is what I hope this group gets
12 out of this, is that there are solutions, but there's
13 solutions that are going to have to involve the payers sitting
14 down with the providers saying, "How can we make this
15 transition in a way that keep this work going and keeps this
16 facility open and doing great work, and at the same time,
17 realizes savings for the payer?"

18 MR. EISENHOWER: And thank you, Becky, for that. I would
19 add, too, that the layer that we saw yesterday is get the
20 employers involved. That's what we have seen, because
21 frankly, in our setting, the private payers are along for the
22 ride. As long as we're working on public dollars, they're
23 experiencing, and we're not -- we're not going to parse out
24 who we're giving this care to, whether it's a public or a
25 private payer, but if we engage the business folks and say,

1 "Help us help you. Help us get a shared risk," and especially
2 when it comes to medical tourism, that's what we're after. I
3 mean, you know, Ketchikan has been affected by medical tourism
4 for probably farther than or longer than much of Alaska, just
5 because of proximity to Seattle, but if we can go to them and
6 say, "Look, we will help you reduce your cost of expensive
7 patients by preventative care, if you hang with us and do your
8 knee replacements and your shoulder work here in our
9 community, which will allow us to keep our doors open," that's
10 a conversation that I think, you know, has to happen at a
11 local level, and frankly, I think our hospitals need to
12 understand that business model differently than maybe they've
13 never understood before, but again, we're more of an op-ed,
14 but so.....

15 COMMISSIONER URATA: So I have a couple of questions.
16 First of all, are most of your providers under contract and
17 are salaried?

18 MR. EISENHOWER: They're under salary, not under
19 contract. So they're PeaceHealth -- if you mean separate
20 contract, they're PeaceHealth employees.

21 COMMISSIONER URATA: Okay.

22 MR. EISENHOWER: When you say, "Most of them," I'd say,
23 obviously, with PeaceHealth, but we have private folks, as
24 well.

25 COMMISSIONER URATA: Okay, so most of them are not fee

1 for service?

2 MR. EISENHOWER: Correct.

3 COMMISSIONER URATA: Okay, and then the other thing is,
4 you know, I think, you know, all this planning and such, comes
5 back to making a point I was trying to make yesterday, which
6 was, you know, waste. Eliminating waste in our current system
7 is an important part and there's a lot of savings in there. I
8 think what some people have said like 34% of the cost of
9 healthcare in America is due to waste, because we're paying
10 for waste, and one of the things that you have done is
11 eliminated one of the key wasteful things that occur, which is
12 patients coming back 30 days after a discharge, which is very
13 wasteful.

14 So I think if we pay attention to those things and work
15 on those things through quality improvement, which is the
16 catch word that we're using today, is very important. It
17 increases the value if you increase the quality, and so I
18 applaud you for that, but you know, the one point here is we
19 need to look at payment reform, and you know, I'm not so sure
20 that everybody being on a salary is a good thing for, you
21 know, for providers and that would be a big change.

22 If we were to accomplish this, that would be a very big
23 change and I would say that many of them need to be at this
24 table if we go down that road.

25 MR. EISENHOWER: Yeah (affirmative), we do -- to answer

1 your question directly, we do incentivize our providers by
2 their quality outcomes. It's very small. It's, you know, in
3 the neighborhood of 3% to 5%. It's growing, but it will be
4 probably be larger than that.

5 COMMISSIONER URATA: Yeah (affirmative), but I think
6 that's the way to do it, incentivize them for quality or
7 outcomes or.....

8 MR. EISENHOWER: But there's.....

9 COMMISSIONER URATA: And not for the number of people
10 they see or.....

11 MR. EISENHOWER: Exactly and.....

12 COMMISSIONER URATA:the number of tests they do.

13 MR. EISENHOWER: Right.

14 COMMISSIONER URATA: Or you know, I mean, it goes on and
15 on and on. Our current system is -- why our current system
16 doesn't work.

17 MR. EISENHOWER: And there are simple solutions, I think,
18 to what you're recommending in the sense that, and just for
19 folks in the group that may understand how this works, I'll
20 give you a great example of someone that goes in the hospital
21 for congestive heart failure and they're released, you know,
22 depending on the research that you look at, about 90% of those
23 patients who are readmitted within 90 or within 30 days, are
24 readmitted for one reason and one reason alone, is they didn't
25 understand their medications, and it really comes down to, "Do

1 I take the blue, you know, blue pill in the morning and the
2 two pink pills at night?"

3 That's really what it comes down to. So the investment
4 in that education and prevention will reduce that readmission,
5 which that readmission alone is probably somewhere in the
6 neighborhood of, you know, \$15,000, just to restabilize them,
7 and that's an important point, I think, of what you're after,
8 as far as reducing those unnecessary readmissions and frankly,
9 waste.

10 COMMISSIONER URATA: Well, just one more, if you'd
11 indulge me, sorry, Becky. So one of these days, I'd like to
12 hear the story of how you got all these doctors to sign on.

13 MR. EISENHOWER: That's a longer conversation, for sure.

14 COMMISSIONER URATA: I know, but that's part of the big
15 picture for the future, I think, is how.....

16 MR. EISENHOWER: Yes.

17 COMMISSIONER URATA:are you going to get them at --
18 docs to sign on to something like that?

19 MS. ERICKSON: Susan had her hand up, Becky another one,
20 but we really need to get to Dr. Tierney's presentation, too,
21 but I want all of our presenters to come sit up at the table
22 with Greta and see if we can continue this conversation a
23 little bit. We're running short on time, but it's an
24 important conversation. So quickly, Susan.

25 COMMISSIONER YEAGER: Just quickly, Matt, you'd mention

1 that -- you showed a reduction of your revenue. How did you
2 reconcile that with continuing your operations?

3 MR. EISENHOWER: Well, the mission of PeaceHealth, like I
4 reference earlier, is to carry on, and in order to carry on,
5 you need some margins. Frankly, again, a piece of this is
6 because of the grant funding, was able to -- but we've had to
7 really cut some corners and -- not cut some corners, but cut
8 some -- cut some staff in some areas and reduce expenses.
9 That's the way nonprofits work.

10 We recognize that this is a longer conversation, but some
11 of the things that we've been able to do is shift, because our
12 utilization is being lowered, we've been able to shift some of
13 our costs related to those utilizations, but that's the very
14 short and simple answer.

15 UNIDENTIFIED SPEAKER: Actually, I have some that's
16 similar to that, is you talk about a reduction in revenue, did
17 you also have a corresponding increase in margin on the
18 revenue that you did have?

19 MR. EISENHOWER: That's another way of expressing exactly
20 what I said.

21 UNIDENTIFIED SPEAKER: Okay, that's what I was curious
22 about.

23 MR. EISENHOWER: So when we reduce our utilization in
24 certain areas, we've been able to reduce the cost associated
25 with, you know, giving those types of care, which then is a

1 margin for us.

2 MS. ERICKSON: Dr. Tierney, do you want to come up?
3 Becky if you had (indiscernible - too far from microphone).

4 DR. TIERNEY: Okay.

5 MS. ERICKSON: So if you could speak directly into the --
6 do you want me to run the slides for you?

7 DR. TIERNEY: No, I can run them. Yeah (affirmative),
8 great, thanks. Okay, good show. Well, my name is Steve
9 Tierney. I'm a family physician. I've been in Alaska a
10 little over 20 years. I have been with Southcentral
11 Foundation for the entire time, even since I was a baby doc,
12 right out of residency.

13 I have been their Medical Director for Quality
14 Improvement for 15 years, and have gone through a number of
15 transitions, as we have sort of evolved over time, from a more
16 older school model in the '90's, to our current place that we
17 exist now, and I'd like to say we're still evolving from, but
18 you know, hopefully, I'll sort of echo some of the things that
19 Matt and Greta and some others have said, because I think we
20 have the same message, that 80% of our energy and effort is
21 spent on a very small percent of the people, but who are they
22 and what are we doing about it, and I think that's the
23 important thing that we have to link to.

24 One of the things that we like to think about is what's
25 happened to healthcare, and this is the thing that I use.

1 This is from my friend Atul Gawande's article in the "New
2 Yorker," where he talks about the healthcare cost conundrum.

3 We've gotten really good at being a business and really
4 good at finding out, if you're going to pay me per encounter,
5 I know, I'll just have twice as many encounters. Brilliant.
6 Will anyone get better? Well, hopefully, but you know, I will
7 and I'll feel better at the end of the day.

8 Well, you've set yourself up for a problem, because
9 anybody who's followed a market bubble knows that sometimes
10 good money isn't necessarily good business. So if I have a
11 restaurant and I have 10 tables and I hire 30 serving staff,
12 I'm going to charge an awful lot to pay for the food. So the
13 meal I sell you is going to be very, very expensive in order
14 to accommodate this very bloated, very wasteful and sort of
15 overaggressive staff.

16 What I've prepared for is, essentially, every
17 eventuality. What I've staffed for is way too much than I
18 need and our estimate is that the waste built into healthcare
19 in nonmedical service is actually about 50%, not 30, yeah
20 (affirmative), and so I mean, the opportunity is huge, but
21 think about this.

22 We all know Blockbuster. Blockbuster was brilliant.
23 They said, "Our house, our rules, our hours, our inventory,
24 and we're going to make a fortune," and by the way, if you
25 bring that disc back a couple of days late, because it was in

1 the cushions of the couch, then you know we paid three dollars
2 for it, but we're going to charge you 30. I mean, how did
3 that sit with you as a customer, not so good, until Netflix
4 came up and said, "Late fees, forget about it. The DVD's, why
5 do you even need them? Why even buy a DVD player? You've
6 just got to replace it. Why don't you just stream it online,
7 watch it whenever you want?"

8 What they thought about was value and what happened --
9 and you saw what happened to Blockbuster. As soon as somebody
10 came up with a value-based equation and offered a high quality
11 service at a reasonable price, they were dead tech walking and
12 I think that's what we're looking at in healthcare, is we've
13 taken advantage to a point at which we're about to hit a
14 market bubble and it's going to do to us, if we're not careful
15 and not thoughtful, as Matt is already, you know, thinking of
16 the future, is we're going to be in trouble.

17 So what happened to us years ago is we had to rethink our
18 philosophy. You know, when we said, "We're going to take over
19 from the federal government, who do we want to be when we grow
20 up? You know, do we want to get really good at doing what we
21 already do? Do we want to do it faster? Do we want to do it
22 better?"

23 The pain question, if we do fantastic on that and ask
24 every person with pain, "Have we added value," "But Doctor,
25 I'm just here for my school physical." "Yes, but are you in

1 pain?" "Well, yeah (affirmative), but I just need this form
2 filled out." "But does it hurt, you know?" "No." "I -- but
3 I have to answer this pain question because we currently have
4 a quality improvement project going on the pain questionnaire
5 with every single visit and our staff's very committed to
6 this."

7 So what we realized is about half the work we were doing,
8 added no value, but we were improving it, and we were psyched
9 and those lines were going up. We had posters everywhere. It
10 was fantastic and we started to say, "No one's actually gotten
11 better, except for us," at what, and we didn't know. We
12 really didn't know, and we started to say, "Maybe we're not
13 thinking about a process, maybe we're thinking about an
14 outcome. Maybe we should start thinking about a population.
15 Maybe we should think about a service and not really just a
16 product," you know.

17 So we look at the practice of change as sort of a macro
18 economy. So if you think of the health system as its own sort
19 of organism and it has different functions. It has heart,
20 lung, liver, brain, kidney, you know, whatever. Every time
21 you adjust one of those things, it affects all the others.

22 So whenever somebody has a bright idea that says, "I have
23 a project. We need to do this," but what's going to happen as
24 a result is you're going to start doing more check boxes and
25 more surveys and stop talking to people. Well, that's a

1 problem, because kind of what I really want you to do is talk
2 to people, but you can't do it if you're face is stuck in the
3 computer screen, checking through a checklist for a box that
4 we've already found when we ask some of these questions or do
5 some of these screeners adds no value.

6 So what are we doing and why, and who are we applying it
7 to? So if we look at ourselves as change agents and look at
8 all interventions to the health system, no matter what they
9 are, and they seem little, it's just one thing. It's just one
10 question. What's the big deal? Come on.

11 When you add 100 of those together, you now don't do very
12 much talking to people at all, and what does that do to your
13 outcome? Your process is fantastic, but your outcome, not so
14 much, and your costs, well, now you've got three servers for
15 one table, because that's what you're starting to pay for.

16 So we started to say, "Well, let's look at this as every
17 intervention is like a drug, only use it if that's the only
18 thing that you can do," because it's going to add cost. It
19 may add waste and it may cause harm, because sometimes when we
20 do things, they don't do what we intend.

21 There's three events that can happen with any medical
22 intervention. You can get better. You can stay the same.
23 You can get worse. Two of those things are not good.

24 UNIDENTIFIED SPEAKER: That's what Woody Hayes said, too,
25 about passing.

1 DR. TIERNEY: Yeah (affirmative), right, you can drop it.
2 You can turn -- right. So it means, you've got to be careful,
3 you know, careful what you wish for. So you know, and I'll
4 echo the same thing that Matt said, you know, of course, we
5 don't need to say it again, you know, 10% of the population
6 consumes -- and of course, depending upon who you read, you
7 know, but in other words, a very small group of people, you
8 know, consume a very large amount of the healthcare resources.

9 What's really interesting is as we followed this over the
10 last decade, that group doesn't stay static. People have
11 rough patches and they get better, and they have rough patches
12 and they get better. Now some have more rough patches, but
13 the truth is, you're not labeled once you have become one of
14 the top 10%, you know, that's not a forever condition. So we
15 need to appreciate that, because we don't want to add waste
16 and continue to layer on extra stuff for you forever, if we
17 started when you were 25, but we've got to think about this.

18 U.S. healthcare or U.S. companies all add -- so when we
19 hire somebody, we add 30% to their salary for their pay and
20 benefits package. Every single company in the U.S. does this.
21 So when Airbus competes with Boeing, Airbus pays this much.
22 Boeing pays 30%. Boeing is starting a fight with Airbus with
23 one hand tied behind its back.

24 So if we don't get our heads around this, if we don't
25 start doing better with value, this is a problem, not just for

1 healthcare, it's a problem for the country. So we really need
2 to think about this seriously and work on this.

3 So here's what we have done, is you know, and Greta
4 reflected this, you know, very nicely. You're working with
5 data. You've got to have data. You've got to understand
6 where you're going and where you want to go to, but you can't
7 do it with two-year-old stuff and do it in the way that you
8 want.

9 So what we said years ago, and this is my other role, I'm
10 the Chief Medical Information Officer for Southcentral. So I
11 manage the data structure. So we said, "We need to get really
12 good at being good." So we rebuilt our data system. So what
13 we have, and everybody has this, this is every single person
14 in Anchorage who's registered with our system, based on their
15 9-digit Zip Code. This is literally their house.

16 I can layer on top of this in almost real time and update
17 this every 24 hours, where all my diabetics live on top of
18 that, what their level of control is, how recently they've
19 been tested. I can also layer on top of that how much we
20 charge for every last one of them with charge tables and
21 refresh this every 24 hours. I can also layer what their
22 socioeconomic context is.

23 Think about this, Zillow can tell you what the average
24 house price, income, school, crime rates, you know, home size,
25 family size, age, gender, I mean, this stuff's publically

1 available. I don't even need to ask a questionnaire. Why
2 would I spend staff time asking you how much you make, where
3 you live, how big's your house, and all this stuff? It's
4 free. All I've got to do is pull it into my data
5 infrastructure.

6 So now, I know who you are, where you live, what you've
7 got, how it's doing, and what your context is, because when I
8 go to adjust this system, I've got to know you, because if you
9 live in the hillside in a 5,000 square-foot house with a
10 three-car garage, my game for your diabetes is an entirely
11 different game than if you're down in Muldoon in a trailer in
12 one of those things off Muldoon Drive. If you've ever driven
13 through that neighborhood, it's like the third world. If
14 you're not taking your insulin, just giving you more diabetic
15 education is not going to fix that. It will waste and it will
16 be two encounters I can charge for, but it's not going to
17 change your Alc.

18 I can also now, start to hot map this. So now, I have a
19 polyvarian analysis. I can look at where am I bleeding to
20 death? Who am I spending huge amounts of money on? Where do
21 they live, and how am I doing clinically, because if I'm
22 paying \$100,000 for Alcs of 13, I've got a problem. I'm not
23 doing process anymore. I quit doing pain questions and quit
24 watching that graph go up, because I don't care.

25 I care. I do care, if I paid 100k for a Alc of 13 and

1 two hospital admissions in the last 12 months. I really care
2 about that. The pain question, you had.....

3 COMMISSIONER MORGAN: A disclaimer, I work for
4 Southcentral, for 14 years, okay, before anybody sends an
5 email, because there's a lot of emails sent about me. This is
6 probably a softball question, but when you boil all this down,
7 whether it's Medicaid, Medicare, Southcentral is basically an
8 ACO, because we had a previous speaker that actually showed
9 how they were foregoing revenue in certain payer groups to do
10 things and they, of course, they adjusted their budget, of
11 course, but they also had a grant, but being an ACO with
12 50,000 patients, I haven't been there in three or four.....

13 DR. TIERNEY: Sixty-five.

14 COMMISSIONER MORGAN: Sixty-five -- you, okay, 50,000
15 come a lot.

16 DR. TIERNEY: Yeah (affirmative).

17 COMMISSIONER MORGAN: Sixty-five that kind of visit every
18 once in a while, you can justify this and I know we took -- I
19 know that you guys, when I was there, were taking some hits,
20 especially in Medicaid to do certain things, because you
21 looked at it as if the whole population, all of that, and it
22 was almost like, to me, and I'm -- this is me, my -- it would
23 like R&D kind of, you took the hit, but the overall savings
24 was more than the hit in reimbursement.

25 Do you think that being a tribal system, that has at

1 least the minimal numbers to get into show sizeable savings,
2 as an ACO, do you think -- is that what we're really
3 describing? I worked for -- my first job was in a staff model
4 HMO. It was co-op and it was very rude to metric, but we had
5 a guy that sort of did what you're talking about now in that
6 HMO and that was in 1985. It was a little pencil and paper,
7 sometimes, but it kind of looked like that, not as cool, you
8 know, this is almost like a sci-fi moving in a way, you know.
9 The.....

10 DR. TIERNEY: What.....

11 COMMISSIONER MORGAN: The -- the aliens have invaded in
12 these areas, kind of thing, but.....

13 DR. TIERNEY: Yeah (affirmative). What I can say is, for
14 us, our philosophic incentive was we, essentially the tribal
15 organization, were taking care of ourselves. So for us, we
16 had a moral imperative that was above and beyond just what the
17 price was.

18 However, as we progressed, we began to realize, "My God,
19 you know, if we can figure out how to increase margin, while
20 decreasing revenue," and that's, I think, the golden ticket
21 you've already hit on, is you've got to stay alive, but you
22 don't have to do it on revenue -- on the back of revenue
23 alone.

24 If you do it on margin, well, then, if I've got half the
25 staff, twice the value and twice the margin, I'm still living

1 large. I'm good with that, but I've got to remember, I can't
2 have three servers per table. I'm going to have to lean up a
3 little bit and I've got to think about my process, and I've
4 got to think about where I can apply it in a lean, smart,
5 real-time way.

6 So here's some of the other infrastructure we've built.
7 So basically, we have a web-based tool, where -- and I was,
8 you know, sharing this a little bit before, when I train my
9 provider staff for one hour, I lose 600 visits. Training is
10 very expensive. Data is very cheap, the way to change
11 people's behavior.

12 So we have refreshed, every seven days, in the clear for
13 every single employee, from the CEO to the janitor, they can
14 see how every single provider's performance is doing. It's
15 available on the web. It's refreshed every seven days. You
16 can split it out. You can look at how everyone's doing.

17 We have variance projections, because as an improvement
18 person, I'm more interested in variance than I am in the mean.
19 Everything will regress to a mean. I've got to find out who's
20 hitting us out of the park and who I need to talk to, because
21 I don't want to train them all. I want to learn from the ones
22 that got it and I want to teach the ones that don't.

23 We use, you know, action lists. So if I tell you you're
24 not doing well. I also owe you the courtesy of telling you
25 who you need to fix, because we've got to have a lean, tight

1 process. We're going to track how any individual provider's
2 going to do over time and what's interesting, is if you talk
3 to them and show them the data, it's actually very interesting
4 with no training at all. They're pretty darn smart. They'll
5 start figuring it out, especially if they know everybody's
6 looking at it.

7 We have score cards for every one of our teams, because
8 this is a team sport, and we refresh this every seven days,
9 but it tells you in every chronic condition, how you're doing
10 and links to an action list and links to your historical
11 trends.

12 We have a corporate score card, because we need to align
13 from the board, the CEO, the VPs, and the frontline staff,
14 because everybody's got to be headed in the same direction.
15 When Peyton Manning gets under center and he says, "Omaha"
16 something, something, everybody's got to know what he's
17 talking about, but if the board's going this way, the CEO's
18 going that way, the front staff are going that way, you're not
19 going to get it done.

20 So this is a team sport and we're only successful, and we
21 can only be lean if we're in each other's heads to such a
22 degree where I know, 15 steps, go left. That's what I got to
23 know, and if you do that well, and if you build an
24 infrastructure that supports all this, here's what happens to
25 your costs.

1 This is the cost trends for the United States healthcare
2 since 1999. This is cost trends for Southcentral Foundation
3 over that same period of time. After we took over ownership
4 from the, you know, fed.

5 What we have shown is, I'll bet it's more than half of
6 what we can take out of the waste. Now, we're talking about a
7 game that if we do this well, we have saved the bacon for
8 American business. We have addressed the market bubble for
9 healthcare and the value for the produce won't even compare
10 between Netflix and Blockbuster.

11 What does that mean? What does that mean in an
12 environment, as Matt suggests, with medical tourism? If
13 you've got it going on, and you have a high quality product
14 for low cost and you're a Blockbuster versus Netflix, where
15 are you going to take your business, and who's going to line
16 up to ask you how you did it?

17 So our game now, 20 years later, is this is an important
18 message. It has more to do than just with us, in Alaska, that
19 has an impact that's potentially gigantic, and for us, it was
20 so important that we've actually formed an institute to say we
21 need to be able to train our own people and anybody else that
22 needs to learn this, because this is a message that's really,
23 really important.

24 CHAIR HURLBURT: What are on, particularly on the
25 Southcentral numbers, you show that the downward and then

1 level trend, where everything else is going up, is that on a
2 per capital cost per year of service, per capital cost?

3 DR. TIERNEY: Yes. Yes. Yeah (affirmative), so what we
4 did is we compared apples to apples, based on what was there.
5 Now, I would have done it a little differently, because costs
6 are really slippery. Costs will regress you to a mean rather
7 quickly. What do you charge for each Band-Aid, each gauze
8 pad, each, you know, you know, alcohol swab? It's really kind
9 of hard.

10 Charges are dirtier, but I'm a big Nate Silver fan.
11 Trend is far more important than absolute value. So what you
12 want to do is you've got to figure out what's happening with
13 your top 10% and charge is going to be a much more sensitive
14 benchmark about what you do week per week, because I can't
15 know two years ago how we did. I've got to know now.

16 Charge will do that for me. Cost won't, because what
17 you'll do is bury the high users into that mean and they'll
18 hide them from you, because the ones I really want to kill --
19 I want to knock it out of the park on, is these folks that are
20 really, really struggling, because that's where we've got to
21 have our best effort.

22 COMMISSIONER MORGAN: Do you have an up-to-date chart?

23 DR. TIERNEY: Yes, I do. I'm sorry, you know, I pushed
24 all the folks in finance and they just freaked out. I'm like,
25 "I'm giving a talk, come on, give me a break here, you guys,"

1 but no, but we have more up-to-date stuff. Actually, we're in
2 the process of sort of reforming all of this, because this is
3 interesting, but I want charge -- I want per person and I want
4 daily trends, because this has to be live feed.

5 This has to be like the stock market. This has to be
6 like your E-trade app, buy, sell, hold. I've got to know
7 every day how I'm doing, because that's how I'm going to make
8 real change.

9 This is the funny thing -- okay, well, let me roll
10 through the last three, Dave. So you hear healthcare in this
11 sort of desperate mode of, "Please, God, help me do
12 something," you know, so you'll hear somebody, "Well, that's
13 the best practice. You should do that." "Yes, absolutely,
14 sure. No, I get it," so you know, but you look at this sort
15 of, you know, these things don't really even belong in the
16 same ballpark.

17 So if somebody says to you, "It's a best practice to keep
18 your car full of gas because in Alaska, when it gets cold, you
19 get, you know, vapor formed if you have an empty gas tank."
20 "So right, so you're saying I should put gas in my car and
21 keep it kind of full all the time, at least above half?"
22 "Yes, that's a best practice. You should do it." "But what
23 if my car's electric?" "Gees, okay, I hadn't thought about
24 that," but it means that adopting best practices, cutting and
25 pasting, is really -- teaches me that people are so damn

1 desperate to do anything that they'll just say, "Yeah
2 (affirmative), sure, I'll start doing that. I don't know if
3 it makes any sense at all, but uh-huh (affirmative)."

4 How do we get smarter and sharper and leaner about
5 applying fixes that make sense. If I'm a Mac guy, do not
6 install Windows. It's not going to work, even though it's a
7 best practice to have the latest edition of Windows on your
8 Windows computer, but think about it. This is all contextual,
9 so -- or more training. More training kills me.

10 Providers are pretty darn smart. Their IQ is generally
11 fairly high. You stick some numbers in front of them, they'll
12 figure out how to change it. Training, they just eat the
13 doughnuts and they leave, and it cost me 600 appointments.
14 I'm bleeding to death here and you guys just ate some
15 doughnuts. How about you go to work? I'll let you know how
16 it's going or I'll put it up on the data wall.

17 I have my 10 tips for redesign. I won't read them all,
18 but my number one is, the only thing worse than no plan at all
19 and that's a bad plan. It means bad plans burn money. They
20 burn energy. They burn time. They distract your focus. You
21 know, they don't do what you want and so just adopting best
22 practices just because, is not always a good plan. It's a bad
23 plan. So if you're not sure what to do, don't do anything.

24 The first measure, never try to navigate by running as
25 fast as you can in any given direction. Get your GPS, figure

1 out what you've got, figure out where you are, and figure out
2 where you want to be.

3 Now, you start, but very often in healthcare, we just
4 start doing stuff, because somebody said, "That's the best
5 practice. You ought to do it," and if there's anything that
6 you just want to see the veins stand out in my neck with our
7 team is, "Well, I found a form. We should do it, because it's
8 a best practice." No, we're not doing that.

9 So we want to think about healthcare as a means of the
10 future. What is healthcare? Well, today, in today's world,
11 you call. You make an appointment. You show up. They check
12 you in. You do this stuff, but really, is that what we want?
13 In a lean progressive model that leverages tech, that
14 leverages, you know, the way people communicate, is it really,
15 you know, electronic portals?

16 Is it really GIS analysis? Is it really email? Is it
17 text? Is it, you know, Face Time? Is it Skype? I mean, how
18 do we communicate and who, you know, if this is a team sport
19 and I have five members of the team, a social worker, a case
20 manager, a physician, a medical assistant, a pharmacist, you
21 know, how do we interact collectively, but in a synergistic
22 way, not siloed separate way, and so what our next rendition
23 of the future is managing a medical home is not good access.

24 It's not just visits. It's managing a social network
25 that's continuously connected 24/7, 365 with live feed data,

1 all the time, to tell you how you're doing and how it's going
2 and how you can make it better, and that's it.

3 COMMISSIONER MORGAN: A clarification, your -- the
4 charges, this is a question, not a statement. Your charges at
5 Southcentral do reflect, I think, that's a better word, I
6 think, the actual cost for that charge, because I just happen
7 to know a guy that did a lot of that work.

8 DR. TIERNEY: Yeah (affirmative).

9 COMMISSIONER MORGAN: So charges can be used as a
10 management tool, if they're not pulled from ingenics or some
11 place every two years for the northwest, you know what.....

12 DR. TIERNEY: Sure.

13 COMMISSIONER MORGAN: Would you speak to that just for a
14 few minutes, of actually using -- if your charges reflect true
15 costs, how that then creates this real -- speeds up the real
16 time look?

17 DR. TIERNEY: Well, what you want to do, is you want to
18 get as close to the event as possible, because you also --
19 when somebody says, "You did better. You did worse. You did
20 the same," there's a lot of stuff going on. Sometimes that
21 meant you were 10 docs short. You had a cataclysmic event,
22 you know, you were installing an EHR. You know, there are
23 other things that happen to affect your performance.

24 Two years ago, can anybody remember exactly what was
25 going on? Well, the answer is, probably not. So what you

1 need is close to real time, but charge is really a more
2 sensitive reflection of the weekly business behavior that you
3 have per individual person.

4 Now, it's dirty, in that it doesn't talk about all of
5 your costs. When you talk about improvement, what you want to
6 do is find out for this person, that day, that time, that
7 quarter, did we do better, worse, or the same? So I think
8 what it does is allow you a view of -- and I think it
9 approximates costs well enough that it gives you what you
10 want, which is, did I do better for this human being, which is
11 what I want to know, you know. Did I do well by this person
12 or not?

13 MS. ERICKSON: Well, thank you very much. Is it a really
14 quick question, because we're behind time and we need to wrap
15 up.

16 COMMISSIONER URATA: Okay. What kind of computer system
17 do you have, because it sounds like you have a very robust
18 computer system and was it something you made yourself or.....

19 DR. TIERNEY: Yes.

20 COMMISSIONER URATA: Or is it available on the market?

21 DR. TIERNEY: No, and I'll tell you, I have searched for
22 more than a decade for the market to buy a plug and play tool
23 to do this sort of data analysis. It doesn't exist. So what
24 you'll find is almost all the electronic records are really
25 good at making money for you and they will document every

1 single charge that you do during the confines of office
2 visits.

3 They don't think about the population. They don't think
4 about they system. So what we had to do, is we had to build -
5 - and we built it in sequel server. So what we did was pool
6 all of lab data in, all of our electronic record data in,
7 vaccinations, charge, you know, that stuff, so we pool it in a
8 central repository, and then we'll add the GIS, you know,
9 socioeconomic demographic stuff on top of that, but we can
10 apply it, because we have everybody's nine-digit Zip Code and
11 unique, you know, master patient index ID. So we can do it,
12 but we had to pull it all off of our legacy systems and build
13 it in a central spot.

14 Now, what I can tell you is it's still not as good as
15 what I want. So we're about to actually embark with Cerner,
16 who's our EHR partner, to say, "I want that, but I want it to
17 connect with the HIE. I want it to connect with Seattle
18 Children's. I want it to connect with our, you know, core
19 system, and everybody else, because if you've got Percocet, if
20 you've got a vaccination, if you got a mammogram, I need to
21 know when I speak to you today, but I don't care where you got
22 it. I just need to know that you did.

23 MS. ERICKSON: I think just to follow up on that, I
24 remember Dr. Eby telling us, at one point a few years ago,
25 that Southcentral Foundation made a point of investing 10%

1 into data, 10% into staff development.

2 DR. TIERNEY: Yeah (affirmative).

3 MS. ERICKSON: Which is significant. Thank you very,
4 very much for your time and for your expertise and for
5 everybody's expertise. This was even better. I thought it
6 was going to be great. I think it was an even better series
7 of presentations that I'd anticipated and before I let you go
8 on break, and we're going to have a real short break,
9 Commissioner Streur joined us a little while ago this morning
10 and he's next up.

11 I want to ask you to do one thing, at some point during
12 your break, is to pull out, it should be behind Tab 4, it was
13 maybe in your packet of extra handouts, the letter that I gave
14 to the Medicaid Reform Advisory Group on September 16th, and
15 embedded in this letter is a series of diagrams and Dr. Urata,
16 it might look familiar to you.

17 I mentioned, at one point, the book that you had
18 suggested by Dr. Cutler had some diagrams that I think he had
19 borrowed without crediting the payment reform expert who we
20 brought to our -- to the Commission a few years ago, and so I
21 think those diagrams will look very familiar to you. I just
22 pulled diagrams right into this letter, because I couldn't
23 think of a way to simply convey in words what we've been
24 hearing this morning, about how we pay for care now and how we
25 can change it to improve care through the way we pay, and I

1 will confess, I tried really hard, because I recognize I have
2 a lot of power in my role with this group, I try real hard not
3 to sway the conversation at all and I bit my tongue yesterday.

4 The one thing that made me really, really sad yesterday,
5 was that payment reform didn't end up on our list of six,
6 because this is the way we're going to drive this sort of
7 improvement in the system is through changing the way we pay
8 for the system so it recognizes and supports this type of
9 quality improvement.

10 On that note, if it's okay with Dr. Hurlburt, why don't
11 we take a break and come back in 10 minutes?

12 10:43:09

13 (Off record)

14 (On record)

15 10:57:15

16 CHAIR HURLBURT: Deb was -- why don't we go ahead and
17 start, maybe with the second bullet there, Medicaid Reform
18 Advisory Group, Federal Health Care Reform updates?
19 Commissioner Streur is with us again, as he is every time. We
20 really appreciate you coming, Bill and Josh, and I guess
21 Lori's on the agenda, but she was here yesterday, but maybe
22 not coming. So we'll turn it over to you, Bill or Josh.

23 COMMISSIONER STREUR: Do you want me to take over?

24 CHAIR HURLBURT: Yeah (affirmative), well, on the update
25 on the Medicaid Advisory Reform Group.

1 COMMISSIONER STREUR: Yeah (affirmative), well, there's a
2 few items I want to cover before we move into this and since I
3 have the power of the mic, I'm not going to ask for permission
4 if that's.....

5 CHAIR HURLBURT: Anything, yes.

6 COMMISSIONER STREUR: But a few things that I really want
7 to touch on and one of them is that we have moved the
8 Department over the last three years to results-based
9 accountability. Results-based budgeting, missions and
10 measures, a lot of different descriptors for that, and I'm
11 particularly proud because this year, we have developed our
12 entire budget around results-based accountability, and what it
13 effectively has done is taken us from the silos of individual
14 divisions and taking a look at those divisions' contributions
15 to our core services and how they fit in, where they fit in,
16 which of our core services they align with, and then it
17 cascades down to their own core services, and so what we've
18 done is -- instead of having the vertical silos in each
19 division, we're now going across by core services.

20 So if an individual is in there, you see the range of
21 services that are available for him or her, and it's been an
22 interesting transition in that we started it out with the
23 directors and they were reluctant enthusiasts, at the very
24 best, when we started out, because here's another one of those
25 schemes that some character who has never worked in the field

1 has come up with and it's a buzz word. It's a fad, and so the
2 first year was kind of hard sledding.

3 We were not only pushing the rope, we were pushing it up
4 hill. So it was a real challenge, and then the second year,
5 lights started coming on and then the last year, the lights
6 have come on and it's interesting because I was noting to some
7 noting to some of the people this last week that I get on an
8 elevator now and somebody who I don't really know who they
9 are, we have 3,600 employees and they'll come up to me and
10 they'll say, "Commissioner, you don't know me, but," and they
11 start talking about results-based accountability, because --
12 and the big thing they say about it is people are recognizing
13 now what it is I bring to the table, and they're working
14 across division.

15 You may see somebody from Senior and Disability Services
16 sitting with somebody in Public Assistance or sitting with
17 somebody in Behavioral Health, and they're talking about
18 cases. They're talking about ways to maximize the effort that
19 they do.

20 So anyway, what we did was we -- in this last year, we've
21 taken our budget and said, "Okay, where does what you do in
22 your division contribute to the core service and how much is
23 that contribution," and we've taken the entire budget and
24 broken it out by core service, and so when we go into the
25 Legislature now, not only will I be able to tell them what

1 division I'm taking the money out of, but I'll be telling them
2 what they're losing in terms of units of service, in terms of
3 widgets, take your pick, and what they're using in -- losing
4 in quality and -- of care, whatever that care may be, to an
5 individual family or a child, and I think it's going to be
6 powerful.

7 We're the first department to come anywhere close and
8 we'll see how things go, so -- but we'll keep you updated on
9 that. I hope, maybe in the coming months, we can do a 20-
10 minute presentation of what it is we really do. Tara Horton,
11 who's kind of my core champion leader, and I have been out,
12 I'm not going to say proselytizing, but advertising, take your
13 pick, of what it is that we're doing. So please stay tuned on
14 this because it's been very meaningful and both Deb and Dr.
15 Hurlburt have participated in parts of it and so it's very
16 good to get, very good to move forward on.

17 The next thing I want to talk about briefly is budget.
18 We submitted our budget. I think you all know that we're
19 looking at a tighter budget than we've ever had before, right
20 now. Oil, this morning, was about \$92 a barrel. The budget
21 is based on 105 and 550,000 barrels of output a day. Take
22 that 550,000 a day, although, we're not even pumping that, and
23 you put that \$15 or \$13 reduction and we're talking eight
24 million dollars a day of lost revenue.

25 So it adds up very quickly and so I went into our budget

1 process this year saying, "Guys and gals, we need to budget as
2 closely as we can." We have the last four years. Our largest
3 budget increase over the last four years, including Medicaid,
4 was about 3.2%. Two years ago, it was about 2%. Last year,
5 it was one and change. This year, we're just slightly below
6 one percent increase in our budget, and it's still a lot of
7 money, when you're talking a \$2.7 billion annual budget, one
8 percent is still more than a decimal point for -- in
9 government.

10 In fact, it's more than budgets of many of the other
11 departments, so -- but the important thing is that the
12 Department has responded and I think effectively in that we're
13 not seeing a substantial reduction in access or level of care
14 through that, and part of it has been the provider community
15 stepping up, part of it is better management, part of it is
16 better tracking, but it's a variety of things that everybody
17 has worked together to make this happen, and we went through
18 Medicaid reform about four years ago, now.

19 Man, time -- five years ago, now, time flies, and we came
20 up with seven key initiatives, some of which got us a lot of
21 money, some of which cost us a little bit of money, but
22 overall, it was a good experiment, and we're now engaged in
23 Medicaid Reform Advisory Group, that probably has the same
24 mixed reviews, whether you're on the provider side, the
25 recipient side or the payer side, in terms of the Department,

1 and what I'd like to do is turn it over to Josh to kind of
2 give an overview of where we are with the MRAG, Medicaid
3 Reform Advisory Group, that we affectionately call the MRAG.

4 MR. APPLEBEE: I keep telling the Commissioner he's got
5 to stop using the phrase MRAG, but it's the best we've got
6 right now. Good morning, thanks for inviting me. As many of
7 you know, the Medicaid Reform Advisory Group began meeting
8 earlier this year and what we started to do, and I'm sure many
9 of the people at this table can appreciate this, is we started
10 flooding them with information, just reports, what other
11 states are doing, here's data, information, until finally,
12 they stopped and they said, "Okay, enough of this. Let's get
13 to the point of what are the items that can happen in the
14 state and let's take a look at those."

15 So we came up with a list of reform items, about 23 of
16 them, we brought to the Advisory Group, and it was at that
17 point, the Advisory Group really surprised -- surprised me,
18 and I think surprised several people, and they said, "Look,
19 some of these items, the Department just needs to be doing
20 anyway. They don't need our official recommendation. They
21 don't need any special wand waving, just go forth and do some
22 of these things."

23 So they were able to call out some of those items,
24 saying, "Just go do these. These make sense. These are
25 something that you should be doing already," and they whittled

1 down that list and they sent us back a smaller list of about
2 11 to 14 that said, "We want more information on this. We
3 want more information on these individual items and we want
4 you go to spend some time, give us an idea of the effects,
5 some timelines, and to begin to look at some costs on what is
6 going to happen if these," we called them innovations, and to
7 be fair, that's a misnomer, really nothing new under the sun,
8 but how it interfaces with the Alaska healthcare system is
9 really the difference there, and we brought those items back
10 before the Advisory Group and went through item-by-item, going
11 -- talking about the pluses and the minuses and the Advisory
12 Group said, "Yes, we like these. No, we don't like that."

13 I do love the one that said, "Boy, we'd really like to do
14 this, but our MMI system can't run the data, so we're going to
15 move this off the table until we get to a point where we can
16 actually track some results."

17 We're at a point now where they've taken votes on several
18 of these items and they've sent it back to the Division to
19 really buff out those items, to get as best a handle on, you
20 know, what are the potential costs? Are there potential
21 savings? What sort of effects would those have, not just
22 within the Department, but on the provider side, on the
23 recipient side, and it's those more robust items that we want
24 to bring back before the Advisory Group to make sure that's
25 the recommendations that they want to put forth and recommend

1 to Governor Parnell, "This is what we think you should do."

2 I think one of the things that we're missing in the
3 process that absolutely needs to happen before we issue a
4 final report, is to get some very detailed and substantive
5 feedback from the people that these recommendation would
6 affect.

7 So I do believe that between now and the final report,
8 there's going to have to be a time set that says, "We need to
9 hear from providers. We need to hear from recipients. We
10 need to hear from the advocacy groups. We need to hear from
11 you, more than just -- we're waiting to hear more than just,
12 'We kind of like what you're doing, but we're waiting to see
13 something.' We need to hear some comments of, 'This is great.
14 We like this direction,' or, 'You've got to stop this. This
15 isn't going to,'" I mean, some -- we need to get substantive
16 feedback and we've enjoyed the feedback that we've gotten so
17 far, but there really needs to be more of that, I think, as we
18 move forward and I think the other thing that I'd like to
19 stress about this process that sometimes doesn't get stressed
20 enough, is that this is not an end in and of itself.

21 This is not a, we're going to go to the bag. We're going
22 to pull out the three silver bullets. We're going to
23 recommend them to the Governor and we're done. I think people
24 need to remember that Medicaid reform doesn't really end.
25 It's taken us 40-plus years to develop this program. It's

1 going to be reformed and developed over the next 40 years and
2 beyond.

3 So this is, as the Commissioner stated, with the last
4 iteration of Medicaid reform, this is another step in that
5 process. The conversations need to continue. The analysis
6 needs to continue and as we move forward, the reforms need to
7 continue.

8 Our next meeting is currently scheduled for October 29th.
9 It's currently scheduled to be held at the Frontier Building.
10 We've been having some of our meetings at the crime lab, and I
11 don't know, for those of you that have been there, we've had
12 some A/V issues over there. Although, it's a pretty nice
13 little classroom, I think it won't serve our needs going
14 forward.

15 For those of you that were able to listen to the radio
16 earlier this week, the Commissioner and I were on Talk of
17 Alaska with Annie Feidt talking about Medicaid reform. Becky
18 Hultberg was kind enough to call in from Juneau, despite being
19 on her deathbed, and I think that went really well.

20 I think we had some interesting call-ins. I believe that
21 the issue of where Medicaid is today is something that could
22 be broadcast a little bit broader. I think your average
23 person doesn't really know where we are or where it fits in
24 the state budget, or you know, I think people are very much
25 busy in making sure that their lives are the best they could

1 be, that they don't look at it from the larger scale, but I --
2 the need for Medicaid reform, I think that message needs to --
3 needs to get farther out and just beyond the sound bites and
4 the campaign slogans, which I hope will be over in the next 32
5 days, but I brought the -- the innovations and the motions are
6 all available on the website.

7 We have a link directly off the main page of Health and
8 Social Services. In addition to that, if anybody has ideas,
9 anybody has feedback, and they want it to -- they want to
10 submit it via email, our email address is very simple. It's
11 medicaid.reform@alaska.gov.

12 So please, if someone asks you, "Hey, we heard there's
13 this Medicaid Reform Group out there," have them write
14 something. Have them email it in, please. I can't stress
15 that enough. I think that's what I have.

16 COMMISSIONER STREUR: I want to stress that this is not
17 the end. Josh used the term three silver bullets. We're not
18 going to take those three silver bullets and shoot, but it's
19 to come up with ideas and then spend time with affected
20 providers, affected recipients, and coming up with a solution
21 as to how. This is merely a what. It may be that through the
22 process, after the group is disbanded that it doesn't work,
23 and it may be that, you know, there's a next step that comes.

24 We don't know what that is, but you know, I look at the
25 cost of healthcare -- Becky and I used to agree on everything.

1 We tend not to agree on much anymore, and one of us changed,
2 and I'm not going to go where that was, but anyway, seriously,
3 it's -- we have to change Medicaid.

4 Medicaid in Alaska is the most expensive Medicaid program
5 in the nation on a per person basis. Healthcare in Alaska is
6 the most expensive healthcare in the nation on a per person
7 basis. United States is the most expensive healthcare in the
8 world. Arguably, Alaska is the most expensive healthcare in
9 the world, and I honestly believe that we can do something
10 about it.

11 When I look at shared incentives for savings, one of the
12 challenges I have -- I got your attention there, didn't I, but
13 shared incentives for savings, it's where do we start, because
14 is that 100% what 100% should be or are we going to begin
15 skimming fat off before we start to improve the delivery of
16 healthcare, and so it has to be cautiously done. It has to be
17 cautiously tracked.

18 The idea of the pilot, and I'm a former PeaceHealth
19 employee, so I watch you guys closely, the idea of the pilot
20 really excited me when it came about and it's -- some of that
21 stuff is what we need to do, but it's going to take a lot of
22 deep dives like that.

23 It's going to take a look at the system and what are
24 better ways to provide the system. It's going to take more
25 primary care driven. I would love to have had an incentive or

1 one of the incentive -- or initiatives be that we're going to
2 move toward a total primary care driven system in Medicaid.

3 In other words, every Medicaid recipient will have an
4 identified primary care provider, a medical home, if you will.
5 I hate to use that phrase because it's gotten so adulterated,
6 as to what a medical home looks like, but the old primary care
7 case management that we used to know. The old -- well, I grew
8 up with one doctor and for years and years and years. Our
9 family had one doctor for years and years and years, and you
10 know, now, it's hither, thither and yon, you know, a warm
11 body, and we chase them down, but I don't know what the
12 answers are going to be.

13 I just know that we have to change this. I kid around
14 with Becky and I disagreeing, but I think one of the areas is
15 that, you know, Becky and others in the room, would like to
16 say Medicaid expansion. You know, and truth be known, I'd
17 like to see Medicaid expansion, but I have to know that we can
18 pay for it.

19 When I do the numbers, it's in five years, it's a \$200
20 million burden on the state, a \$200 million burden in terms of
21 just straight general fund dollars, and how are we going to
22 cover that, because I see the revenue, I brought it up
23 earlier, I see the revenue not going up, but going down.

24 I hear that before we see the benefits of SB21, we're
25 going to probably have another two years of declining revenue

1 and how do we justify that? If I can find \$200 million in
2 savings in a streamline, more up-to-date, better managed,
3 better driven system, it makes it a lot easy to argue than to
4 say, "I don't have any magic bullets and we need to do this."

5 So the MRAG, as I said, is a first step. We will present
6 this to the Governor. The Governor will consider it. The
7 Governor will deal with the lobbying that's already begun of
8 him, over some of our initiatives, innovations, and you know,
9 we'll see where that goes, but I think it is something that
10 needs to occur.

11 It may not have been the best of the best, but it's at
12 least an attempt. The provider community, I continue to
13 encourage them to, I've used this phrase a lot, be bold, you
14 know, come out there, but don't come out there always shooting
15 at what's out there, but come out there with better mouse
16 traps, come out there with a PeaceHealth model, come out there
17 with a Nuka model that can be spread statewide or can be
18 implemented on an increasing basis from year-to-year.

19 I don't know what those initiatives are or those
20 innovations are, but that, to me, is the direction that the
21 Governor wanted to go with this and I think we need to
22 continue to work toward it, whether -- no matter who's
23 Governor, so and it's not a four-year task. It's going to be
24 a long time coming, because we've had -- Josh mentioned four
25 years of providing Medicaid. We've had 40 years to adulterate

1 what was a great idea when it happened.

2 So the final thing I want to covers is an update on Xerox
3 and I'm sorry, Doctor, as you know, we've filed an
4 administrative claim against Xerox. That administrative claim
5 will be handled through the Office of Administrative Hearings.
6 The reason we went through the Office of Administrative
7 Hearings was for expediency.

8 Superior Court, we're talking two years, potentially.
9 Administrative hearings, we're talking four to six months.
10 That doesn't mean that it can't proceed to Superior Court and
11 there's a good chance that it will, but the bottom line, the
12 only thing that I am interested in is getting a working MMIS
13 system for the state of Alaska, and one that can pay
14 accurately and timely, and I'm going to just pull out all the
15 stops to make that happen.

16 Mediation didn't work. We thought we had a settlement.
17 They said they wanted to go home over the weekend and consider
18 it. They came back and said, "We want a do over," and so
19 mediation failed, and you know, it was what they had agreed
20 to, they went home and slept on and they had buyer's remorse
21 and said, "We don't want to do this anymore."

22 So right, wrong, or indifferent, it didn't work, and you
23 know, maybe we had a role in it, maybe they had a role in it.
24 It doesn't matter, it didn't work. So we're continuing to
25 move it forward. We're continuing to work with them on a

1 corrective action plan. They have not quit working. They
2 have not reduced anything.

3 There's not going to be a change in the relationship, in
4 terms of the operational aspects and we're continuing to keep
5 the pressure on them on the developmental aspects to make --
6 to get this system to work. We, again, have about \$150
7 million. We dropped it down a little bit in advances out
8 there, but we've robusted it back up because some of the
9 providers that wanted to get us paid back early had second
10 thoughts and said, "Well, can we get the advance back," and
11 we're reissuing those advances to try to ease that pain as
12 much as we can.

13 I got a call this week from an association saying, "We've
14 avoided getting advances from you, but a lot of us have burned
15 through our reserves and we really need to come up now and get
16 an advance," and I ask you to continue being patient, but once
17 again, I ask you to continue to keep the pressure on, because
18 keeping the pressure on us helps us through the administrative
19 claiming process, as well.

20 I have a \$46 million lien out there against them right
21 now in liquidated damages. So we're talking real money,
22 so.....

23 UNIDENTIFIED SPEAKER: Yes, sir, Representative.

24 REPRESENTATIVE HIGGINS: Commissioner Streur, I know
25 we've had a lot of conversations on this. Can you clarify for

1 us, the corrective action? I mean, the boat -- if it's
2 sinking, we need to get off and maybe look for another boat,
3 or I mean, what timeline are we looking at? I mean, that's
4 what people keep asking me. What are we -- what timeline, is
5 it one-year out, correction action, two years out, or can we
6 even correct it? That's -- and I don't know. I don't know
7 the answer to that.

8 COMMISSIONER STREUR: I don't know the answer to that. I
9 can give you what I believe is a very good guess. One of the
10 things that came out of mediation was that they believe that
11 they can correct this issue within 120 days, that they can
12 have a working system that pays claims at 90% -- 90% of all
13 clean claims in 30 days.

14 REPRESENTATIVE HIGGINS: Don't take this the wrong way,
15 but I heard that 120 days ago.

16 COMMISSIONER STREUR: You heard that in your hearing six
17 months ago. Yes, sir, you did.

18 REPRESENTATIVE HIGGINS: Yes.

19 COMMISSIONER STREUR: The difference is that we -- the --
20 we've had the discussion with them about the corrective action
21 plan. I -- in May or in April, I submitted a letter to them.
22 March 24, I submitted a letter to them telling them that they
23 needed to develop a corrective action plan.

24 They sent me a one-page letter saying, "We're going to
25 fix this," saying, "We're 100% with you. We're going to do

1 the best that we can," and I'm paraphrasing and minimizing it
2 a little bit, but -- and I said, "No, we're going to tell you
3 to do a do-over on this one, because you're going to have to
4 come along better than that."

5 They came back to us another 30 days later and flew up
6 here with a bunch of their senior people and they presented a
7 PowerPoint to me that was not a corrective action plan. It
8 was a listing of the problems that we had identified to them
9 and a timeline when they would be fixed, but no cookbook as to
10 how they were going to get there.

11 They are now submitting that. We have some early
12 iterations for various parts of it and it's looking much more
13 meaningful. So I do think that we're moving. We're paying
14 claims at about 60% right now. We've got 30% to go. We were
15 around probably 36 to 40% during the time of the hearings that
16 you held and but we still have accuracy problems.

17 We still have incorrect denials, incorrect suspensions,
18 and then either paying too much or too little. So we still
19 have issues and it's moving forward.

20 In terms of when do we climb off the boat? I continue to
21 look at options and I continue to talk to potential innovative
22 ways to address that. How about questions about MRAG? No?
23 Anyone?

24 COMMISSIONER HULTBERG: Back to MMIS, I just had and
25 observation and a question, sorry, I can't get away from this

1 one yet, but observation from, at least our -- from the
2 hospital and nursing home sector, is long-term care is paying
3 very -- is paying much better, almost current, and that was
4 not the case six months ago, so a significant improvement on
5 the long-term care side, not -- mixed feedback on the acute
6 care side, still a lot -- still big back logs, but paying
7 currently better, but not -- but back logs have not been
8 cleared and -- which kind of, you know, I have one facility
9 still hasn't been paid for an MRI since September of last year
10 or August of last year.

11 So you know, some pretty big, you know, big outstanding
12 things that are yet to be resolved, which kind of leads me to
13 my question about your one percent or less than one percent
14 budget increase. How are you forecasting Medicaid expenses
15 for the next fiscal year, when you're basically missing a
16 year's worth of data?

17 COMMISSIONER STREUR: We aren't -- to answer the
18 question, we aren't missing a year's worth of data, and some
19 of it is through extrapolation. Some of it is through
20 historical, and looking at the growth historically each year
21 and where we've had reductions in claims, and part of it is in
22 total claim count.

23 Total claim count, we, at least, have the total number of
24 claims submitted. That is accurate out of the system. We
25 don't know where some of them went, but we do have the claim

1 count, and the claim count began to decrease, first in '12,
2 then in '13, then in '14.

3 Now, as we're in '15, '14 numbers, we've been able to
4 mostly reconstruct by now and as we're in '15, we're
5 projecting forward on it.

6 COMMISSIONER HULTBERG: I guess I just note that in the
7 past, and I won't get any more detailed than this, because
8 probably no one else is -- just very few are interested in
9 this level of detail, but what some of the facilities have
10 shown on their books for accounts receivable has been very
11 different than what the Department and Xerox have believed or
12 asked any accounts receivable. So at some point, connecting
13 with some of the CFOs -- I would just -- that's what I
14 suggest, is try to get a temperature check of really what they
15 have still sitting out there on their books, because I don't
16 think the two numbers are in the ballpark.

17 COMMISSIONER STREUR: To address that, Margaret has begun
18 that process.

19 CHAIR HURLBURT: Yes.

20 COMMISSIONER MORGAN: And it's not about MMIS. It's
21 about MRAG. To bring us back to that part on the Advisory
22 Group, this is probably an easy -- a more of a softball
23 question, but what are the -- and I've attended two of the
24 meetings and listened to two of the meetings.

25 So I do appreciate and like the spirit and the free

1 wheeling activities going on. It's been very interesting to
2 watch and listen to. Out of all of this, what do you think
3 are the three things, the three ideas, the three concepts,
4 whatever, that actually, in the short-run, you think you --
5 that could have a shot of actually having an impact of being
6 implemented?

7 COMMISSIONER STREUR: The first one would be payment
8 reform, and I don't know what that looks like. The second one
9 would be greater patient responsibility. In other words, if
10 there's ability to pay, we need to make sure that they're
11 engaged in some level of payment.

12 The third one, without looking at the list, I'm -- I'd
13 say, "Why can't we all get along," but that's not one of them,
14 so.....

15 COMMISSIONER MORGAN: Sure, I'll accept that.

16 REPRESENTATIVE HIGGINS: You know, as being part of the
17 group, my number one would not be payment reform, but would be
18 case management. That, I think, would be number one.

19 COMMISSIONER STREUR: That's what Josh just.....

20 REPRESENTATIVE HIGGINS: And that would be saving us more
21 than anything else, is that. If we can implement that, I
22 think we're on the right track.

23 COMMISSIONER STREUR: And you know, we are engaged in
24 several different pilots right now in that, and that was --
25 Josh just slid that one across in front of me as being the

1 third one I should have put in there, but I think we need to
2 look at everything that we're doing.

3 CHAIR HURLBURT: Thank you very much, Josh, Commissioner,
4 for coming, as always.

5 MR. APPLEBEE: Thank you.

6 CHAIR HURLBURT: So we're -- we want to move into the
7 wrap-up for this meeting, talk about the next steps, and as
8 always, there'll be the question of what went right, what
9 didn't go so well for this meeting, and what can we learn from
10 that, so any comments on that.

11 MS. ERICKSON: Can -- I'm sorry.....

12 CHAIR HURLBURT: Do you want to just.....

13 MS. ERICKSON: Is it okay if we wait a little bit,
14 because we're not -- we have another half hour.

15 CHAIR HURLBURT: Okay.

16 MS. ERICKSON: And so before -- I don't.....

17 CHAIR HURLBURT: You want to go back to the
18 Wednesday.....

19 MS. ERICKSON: Well, I'm.....

20 CHAIR HURLBURT: Go ahead.

21 MS. ERICKSON: Yeah (affirmative), yeah (affirmative),
22 there was one more update on there, plus -- on our agenda. So
23 I was going to do that, and I also was going to provide a
24 handout. Let me make sure we have a couple of extra copies up
25 here, before I give them all away.

1 Lori stopped in and she had an assignment for the
2 Governor's Office she had to get done and I told her -- she
3 didn't really have anything to add from the conversation we
4 had yesterday, but she did, I think it was Allen who had asked
5 her a question at one point about covered lives, and she has
6 provided a very informative, detailed table.

7 It's from 2012 premium data, but it shows the numbers of
8 the amount of premiums and the numbers of covered lives for
9 the top 10, I think, insurance companies by individual, small
10 group, and large group markets. So I don't know if that
11 answered your question, Allen, but I thought everybody would
12 find that informative and we'll scan a copy and put it on our
13 website for this meeting, too.

14 I don't know if we have -- if extra copies end up at the
15 end of the table, anybody in the public wants to -- in the
16 audience right now wants to pick up a copy, then feel free to
17 help yourself, but we'll scan it and put it on the website,
18 too.

19 COMMISSIONER HIPPLER: Thank you.

20 MS. ERICKSON: You're welcome. We'll thank Lori for you,
21 and I did just want to take a couple of minutes to wrap up on
22 the Medicaid Reform group. I had told those of you who were
23 with us at our last meeting in August, I had let you know that
24 I was planning on writing this letter, just at least to
25 identify where some initiatives that Medicaid could undertake

1 that would align with our eight core strategies, and so on the
2 back of the letter that I pointed to you earlier, is a list of
3 initiatives, but I, essentially, walked through with the
4 Committee really quickly with these diagrams, in part because
5 of the conversation around payment reform.

6 We had learned so much earlier, the Commission had, about
7 payment reform, I thought it would be helpful to just help
8 provide some context for that, but then also share the
9 Commission's core strategies and some suggestions. So I just
10 wanted to follow up with that.

11 We just heard that public comment is being invited on the
12 initiatives that are out. I did not print and provide a copy
13 of the larger packet that Josh was just referring to, but
14 that's available on the Medicaid Reform Advisory Group's
15 website, if you wanted to look at that, and certainly, any of
16 you, individually, or working with your -- the groups you
17 represent, have that opportunity to respond and I think I'll
18 probably follow up with Dr. Hurlburt afterwards to see if
19 there's something more that we might do to contribute to that.

20 So if -- do any of you have any other thoughts or
21 questions about Medicaid reform in the context of the work
22 that the Commission's doing?

23 Okay, one other thing I was going to update you on and
24 I'll just do that real quickly, we were putting off to the end
25 yesterday morning, any sort of follow up or just discussion

1 about the event that we had on Wednesday with the health
2 policy elders, and I didn't want to spend too much time on
3 that, but it went very well, I thought, and we'll invite the
4 participants who were able to either be there directly
5 participating or observing, because a few of you around the
6 table right now had quite a bit of real positive feedback from
7 folks who were in the room, and even our stenographer is one
8 of them, came up to the facilitator and I at one point on a
9 break and she was just so excited about the conversation she
10 was hearing, and wanted to know what this group was and what
11 we were doing and what this was all about.

12 So there was a lot of enthusiasm from the folks who were
13 just sitting in and I was really particularly fascinated
14 listening to -- we had broken the group up into three
15 different table, one kind of reflecting back on what the
16 issues were, health issues of the day and how the solutions
17 were being informed around the '60's, around the '70's, and
18 around the '80's.

19 We had three different tables, and it was really
20 fascinating to hear the different cultures and systems and
21 issues and structures that were in place during those
22 different decades and how that was informing the decision-
23 making at the time.

24 So we'll have a video from that event and we also have --
25 will have transcripts from that, and I'll share it with you

1 and we'll see how it weaves into our broader project, which is
2 the health and healthcare in Alaska in 2014, and I'll just
3 remind you, and we have newer members who might not know, we
4 are in the process of pulling together current information on
5 the health status of the population and also on our healthcare
6 delivery system in the state and have a series of reports that
7 we're going to -- we're writing kind of an umbrella report and
8 we're acknowledging, recognizing that this is the 60-year
9 anniversary of the Parran Report, which is an earlier survey
10 of health status and healthcare in the state, with this new
11 initiative to pull this current information together.

12 So I'll send you some links. The public health
13 presentation we had yesterday was related to part of that and
14 I mentioned that report just was distributed to the public,
15 released yesterday, and so I'll be adding that to our website
16 and I'll send you that link, along with a little additional
17 information, but I just wanted to give you an update on that
18 project, as well.

19 It was something that -- I'll just mention Senator
20 Coghill, at an earlier meeting, had suggested that he thought
21 it would be really helpful to take a summary of the summaries
22 that we're going to have to share. We'll have a number of new
23 Legislature -- legislators, a new Legislature coming in here
24 in January, and he had also suggested that we try to move our
25 winter meeting earlier and try to schedule some additional

1 brown bags or evening sessions to bring more legislators in,
2 rather than what we've been doing in the past is making
3 presentations periodically, just to the HSS committees, and he
4 thought we could engage a broader audience of legislators if
5 we started earlier in the session and provided some additional
6 opportunities.

7 So we'll be figuring that out. I'll work with, now
8 Representative Higgins and his staff, and Senator Coghill and
9 his staff, to figure that out. I'll send these dates out to
10 you. I still need to work something out with Commissioner
11 Streur, but Barb and I have been, already looking into
12 facilities in Juneau, knowing we had to do that early, and
13 preliminarily, the dates we're looking at are February 4th and
14 5th.

15 We need to resolve a conflict with the Commissioner
16 Streur's leadership team might have with that, but I'll send
17 those dates out, just to check with all of you to see if those
18 dates can work for you or not and see if we can for sure get a
19 quorum there, and again, our winter meeting, we made a
20 decision this last winter to always hold our winter meetings
21 in Juneau.

22 So any questions about those plans related to next steps?
23 Seeing none, hearing none, I also wanted to follow up on just
24 what our next steps are going to be related to the exercise
25 yesterday and we will be putting out for public comment, the

1 six areas that you've identified that you want to work on
2 together as a group and to that list that identifies
3 specifically what that action might look like, I think we need
4 to work on refining that.

5 I'd like to include in the public comment, also, these
6 lists of ideas of what we might potentially do as a group to
7 see -- we might get some additional ideas that -- to help
8 inform our work plan for next year. So I'm going to circulate
9 that out back to you all in the next -- probably sometime next
10 week, and I would like to work over email with you all to
11 refine it as much as possible and to get your ideas into it,
12 before I included it at the end of this month in the public
13 comment document. So keep an eye out for that, and that will
14 be a follow-up activity for all of you to contribute to over
15 the next few weeks.

16 That, along with the fraud and abuse findings and
17 recommendations, we'll put out for public comment in early
18 November. Some other documents that we've produced, that we
19 have in draft right now, that I'm thinking about including,
20 include the all-payer claims database, legislative -- key
21 legislative elements paper. Not all of you have seen that,
22 but the -- for those of you who are brand new to the
23 Commission, we -- the Commission made a recommendation after
24 two years of study that the state should have an all-payer
25 claims database.

1 There was at least one legislator, particularly
2 interested in starting to draft legislation and asking for
3 help and I wanted to work with the Commission and also make it
4 a little more public process to outline some guidelines of
5 what would be included in legislation, and we have that in
6 draft and I've shared it with the Commission earlier this year
7 for feedback, and was planning on including it with the rest
8 of our documents for public comment to see what sort of
9 feedback we get from the public on that.

10 That is all that's coming to mind for me about next
11 steps. Does anybody have any questions for me about next
12 steps or anything I just mentioned? Okay, then given that,
13 I'll turn it back over.

14 CHAIR HURLBURT: Okay, I just have a comment, I guess I
15 double-tasked a little while you were talking there, but
16 taking the information that Lori gave us here on the
17 commercial insurance, and this, of course, does not cover the
18 ERISA business, which would be another significant chunk of
19 business, but this total commercial comprehensive health
20 insurance market is less than 2/3 of the size of the business
21 that the state has for active employees and retirees, less
22 than 1/3 of Medicaid.

23 So again, it emphasizes that the healthcare costs are a
24 humongous part of the state's budget and the state, as a
25 payer, as opposed to a regulator, the state, as a payer, has

1 both the opportunity and the need to really impact the market
2 here.

3 This was -- I hadn't seen these particular numbers before
4 and that was very interesting, again, just in identifying,
5 particularly in our state, and in all states, government is
6 huge, and of course, the federal government is huge, but in
7 our state, where we are so diverse and we do have a lot of
8 government employees here, it's big in the market.

9 So to go back to the question I had, just our feedback
10 cycle on this meeting, what went well, what didn't go so well?

11 MS. ERICKSON: Let me pose the questions for that. The
12 first question is, what would you have liked -- what would you
13 like to do different for next time? Anything that was done at
14 this meeting, that you would like to see some improvement in
15 or do differently next time?

16 COMMISSIONER YEAGER: This is Susan, on reflection, what
17 I think would have been more helpful for me being -- this is
18 my second meeting, to have heard all of that broad input about
19 the reality of healthcare in Alaska on a broader scale than
20 the federal government.

21 I do believe it might have made a difference in our
22 voting for our priority areas. So having -- I feel like I've
23 gained a lot of knowledge just in the last day-and-a-half with
24 the speakers, what might have changed, then in the voting, it
25 might have been good to have the voting after we had that

1 additional knowledge, maybe a little bit different perspective
2 now than I had yesterday.

3 MS. ERICKSON: Other suggestions for improvement? Yes,
4 Lincoln.

5 COMMISSIONER BEAN: I really appreciate you folks putting
6 up with me for being in the learning curve, but when the
7 Commissioner speaks, we all listen. For me, it's really
8 important to have his comments written and so I can read it
9 and digest it and take it home and read it some more. So if
10 we can have copies for this guy who is just learning, and
11 maybe it's in here, I don't know, but this is what I look for.
12 Thank you.

13 MS. ERICKSON: Lincoln, we keep written transcripts of
14 all of our meetings. So you'll have everything that he said
15 exactly in writing, eventually, through those transcripts. Is
16 that -- will that meet your needs or are you looking for.....

17 COMMISSIONER BEAN: That will (indiscernible - speaking
18 simultaneously). No, that will work.

19 MS. ERICKSON: Okay, thank you. I'll make sure -- I'll
20 remind you again, I'll need to remind myself regularly, but
21 you have to help me remember that we have brand new members
22 that I need to remember to go back and tell you about process,
23 periodically, and maybe communicate it a little more than I
24 have with this group, more recently. I try not to spam the
25 group. I've been sending you lots of emails with homework, I

1 know, but when those transcripts are posted, I'll let you know
2 that they're online.

3 We usually don't get them for about a month afterwards,
4 but we've -- Barb and I have been nagging our transcriptionist
5 company a lot to get them as early as possible lately. So
6 I'll make sure you get that link. Any other suggestions for
7 improvement for next time?

8 If there are none, what was it about this meeting that
9 you liked the most?

10 COMMISSIONER STINSON: It was nice to hear from the
11 different companies and from their human resource people,
12 because if the school district or the oil patch has to start
13 trading workers for healthcare, that really brings it home and
14 will have a lasting, persistent effect on the state.

15 COMMISSIONER URATA: I liked the process of picking the
16 three or four top things that we're going to work on this
17 year, but I hope that we don't forget about the others,
18 because they are equally important, and then I enjoyed the
19 information on quality, especially the part of Southcentral.
20 Although, I'm not quite sure how that can be implemented in my
21 neck of the woods.

22 CHAIR HURLBURT: Jim.

23 MR. PUCKETT: The manner in which Mr. Holt guided us
24 through taking the 17 or 18 that we had down to just six, I
25 appreciated it. I enjoyed it and it was very effective

1 directing the collective wealth and knowledge of the group,
2 and then the Southcentral Foundation presentation was very
3 intriguing and very thought-provoking.

4 COMMISSIONER MORGAN: I, personally, liked how we went
5 through and picked, not to discount the other ones, which I
6 don't think we will, I think we will follow up on them, but to
7 be able to laser in on three to six, to be able to do some
8 stuff, especially with the Legislature, and I would hope that
9 we would be more engaged in that interaction. I know it's
10 tough to do that way.

11 I, personally, though enjoyed seeing -- they are -- in
12 the 15 years I was at Southcentral and went through this
13 process that they're going to, they didn't try to do all of
14 this on one year, too. It was Tioga. It was Demming, in that
15 they did these marginally each year, getting better each day,
16 adding, creating, and in the six months that I haven't been
17 there, I can see better stuff already.

18 You can actually see it. Maybe when you're there day-to-
19 day, and a side bar in this, he -- Dr. Tierney, who I went
20 over and talked to before when we were kind of assisting in
21 getting him, when I worked there in the Finance Division, we
22 really hated the guy, and I'll tell you why.

23 Everything he says is true. You'd get a call wanting to
24 know how come you haven't updated the costs and the charges,
25 when you'd just done it at the close of the -- two months ago,

1 at the close of the year. Finance people like to do things
2 yearly or quarterly. This guy wanted it in 15 -- every 15
3 minutes.

4 Now that I'm over here and watching it, you know, that
5 stuff's really cool. I understand and that stuff, but when
6 you work in that, it's pretty tough. My personal opinion is
7 it is doable in Juneau or Bristol Bay, because the really
8 tough stuff of coming up with what you saw of the concepts and
9 what you've got to do to get there is done, and my advice, if
10 I was a hospital administrator or a primary care clinic that
11 wanted to do this kind of business informatics, is every year
12 for a week, and I'm going -- if Bill was still here, I'd
13 suggest sending a couple of his guys for a week, there's an
14 institute, but I'll tell you how dumb I was, we were all sort
15 of -- upper management was required to go take the institute,
16 which is five days, five-and-a-half days, and there are people
17 coming in from Scotland.

18 I remember, I was in a class with a guy from Scotland to
19 do this, but they had me do it twice. That's how dumb -- how
20 much trouble I had with it. So my suggestion, it's in June.
21 I'd send an email or a letter to Dr. Eby. They'll probably
22 comp you, so you don't pay, but I'd get a seat and just go to
23 the institute and that will show you how to get there,
24 honestly.

25 CHAIR HURLBURT: What's the institute?

1 COMMISSIONER MORGAN: The Nuka Institute.

2 CHAIR HURLBURT: Nuka.

3 COMMISSIONER MORGAN: That's what he was showing you.
4 Nuka is just a word for show. He was showing you what they've
5 developed and how they got there, but he didn't show you the
6 things underneath it to do it and since they've already done
7 it, they love sharing it. Believe me, Dr. Eby and Dr. Tierney
8 love to do this stuff. They'll share it with anybody.

9 As a finance guy, I said, "Why aren't you charging to
10 show these people how to do this stuff," but luckily, they
11 never paid any attention to me on that point, but I would -- I
12 would suggest in Medicaid to send a couple of people and just
13 to go through it to see what -- that's the future of what
14 you're going to have to deal with if you go in to negotiate
15 bundled rates.

16 I mean, how would you like to be Commissioner Streur and
17 John and a couple of other people sitting in the room and when
18 Southcentral, and I can say this, because I was caring a
19 briefcase, you've got Eby, Tierney, Lee Olson, a couple of
20 guys like me, and two or three other people going into the
21 room and you're going to negotiate a bundled rate with this
22 guy.

23 He can tell you down to what color shoes these patients
24 have, but in Medicaid, we have just some general, sketchy
25 information, and so to be competitive, whether you're an

1 underwriter or a Medicaid, or work for the Department of
2 Administration, what you saw is what's coming for those health
3 districts, nonprofits, hospitals. I wish Becky was still
4 here. She -- this might be one thing we do agree on. This is
5 what's coming if you're going to play and do the things that
6 we want to see happen, as a Commission.

7 MS. ERICKSON: And to your point, Dave, the -- it's one
8 of the reasons why one of the Commission's recommendations
9 related to payment reform includes the data development piece
10 and the -- an appropriate role for the state to be to develop
11 that.

12 COMMISSIONER MORGAN: My suggestion is as many -- as many
13 of us as I can, that we can, should go over and try to take
14 the Nuka class, just so you can really see the stuff, if you
15 have time.

16 MS. ERICKSON: Yeah (affirmative), a full week is a lot
17 to ask from folks.

18 COMMISSIONER MORGAN: Yeah (affirmative), but I bet you
19 they'd let you in for a couple of days, right.

20 MS. ERICKSON: So yeah (affirmative), Greg.

21 COMMISSIONER LOUDON: Yeah (affirmative), I just have a
22 request for a follow-up in that I really found the quality
23 information interesting and compelling, specifically in
24 Fairbanks, what they've been able to do with the early births.

25 I would ask for a follow-up from them, if we can, and

1 from any of the other groups that presented on outcomes that
2 were achieved, really, you know, the results of how the
3 prenatals did or admissions to NICU, and the business case for
4 it, because I think that if we could find, you know, we talked
5 about in Ketchikan with the lowered revenue, but increased
6 margin on that, that's a very compelling business case for
7 payers to take to providers or for providers, internally to
8 start discussing changes in payment methodology or even how
9 they bill.

10 MS. ERICKSON: I think I might need to follow up with you
11 to get more specific questions, and then we'll ask if it's
12 something that they can provide.

13 CHAIR HURLBURT: I think, in general, because now, we're
14 talking about negotiating between payers and providers, and I
15 think, in general, we are very unsophisticated in Alaska about
16 -- on both sides of that equation there, that a payer should
17 be keeping track of their data and say, if you're going to
18 negotiate with a hospital and the hospital says, "I need more
19 rates. I'm losing money."

20 If a payer keeps track of your "variance days,"
21 unnecessary days in the hospital, you can say to the hospital,
22 "Well, we can show you how you can do better financially on
23 what you're doing now, by tightening up," by doing some of the
24 things that Matt talked about.

25 Likewise, providers, I think, you know, probably

1 hospitals are more sophisticated than individual
2 practitioners, but we're pretty far on the left side of the
3 curve, and I think what you're suggesting, David, is this is a
4 way to get some knowledge, to get a little more
5 sophistication, because negotiations in the long run will
6 never work if it's a win/lose. It's got to come up with a
7 win/win, and that's not just pie in the sky. That's
8 realistic. It's got to work for both sides, and we're not
9 very good at it up here, but that will be one of the things
10 that we can get at.

11 MS. ERICKSON: And I want to go back to something Susan
12 said, now, though, and remind you that the six items that we
13 identified yesterday, I know we had a real formal process and
14 it might feel final, but we were just identifying
15 preliminarily the things we want to focus on and that's going
16 out for public comment, and this is what we've done every
17 year.

18 This has been our process. We didn't use this exact same
19 process every year, but we've put together a list of --
20 throughout the year, each year, of the issues about the
21 current system that we wanted to study more, just in terms of
22 study, and not necessarily developing recommendations around,
23 and then also, solutions that we want to study, strategies we
24 wanted to study for recommendation, put those out for public
25 comment and the group, I mean, there's always -- there's been

1 at least one thing that's changed.

2 I would suggest there's no reason why now, in the two
3 minutes left in the meeting, if there's something that you
4 thought was essential, based on your learning this morning
5 that you wish was on the list, there's no reason why you can't
6 make a motion to add it right now, and then too, there's no
7 reason why you can't change the list and we would actually
8 expect you to very thoughtfully consider any additional
9 information you get between now and our December meeting,
10 along with the public comments and you'll have an opportunity
11 to revise the list again, at our December meeting. Yes,
12 Emily.

13 COMMISSIONER ENNIS: While I'm not necessarily asking to
14 have this added to the list, I feel compelled to recommend,
15 once again, that we consider the importance of care management
16 and the primary care patient home model.

17 When looking at our core strategies, that topic came up
18 in five out of the eight of our core strategies,
19 recommendations about primary care development and -- which
20 includes care or case management, was recommended in five out
21 of the eight core strategies, and repeatedly yesterday and
22 today, we heard recommendations about care management from
23 many of our speakers, particularly, finally, with Commissioner
24 Streur, as an essential component of, you know, cost
25 containment, reducing medical costs. So I'll just, once

1 again, make a brief pitch for that, what I feel to be a very
2 important recommendation.

3 COMMISSIONER YEAGER: Well, I don't know if we're going
4 to -- I do after -- I feel that -- I guess I would -- I'm not
5 sure all the form, but I would make a motion that we do add
6 payer reform as one of our top priorities for -- to focus on
7 and further develop and put out for public comment.

8 COMMISSIONER URATA: Can I point out that under Item 3,
9 Pay for Value, includes payment reform and start PCMH, or you
10 know, primary care home, which also include what you were
11 saying, care management, and so that might be a -- to put
12 those two together and just say pay for value, and that would
13 include both areas, and then we could tease it out later with
14 care management, payment reform.

15 COMMISSIONER BEAN: I'll second that motion, so we can
16 move forward with it.

17 MS. ERICKSON: Yeah (affirmative), seconded, and with a
18 friendly amendment, and I didn't quite catch the friendly
19 amendment.

20 COMMISSIONER URATA: Say three, Roman numeral III, Pay
21 for Value, which includes care management, primary care
22 medical home, and payment reform.

23 COMMISSIONER YEAGER: So I would accept a friendly
24 amendment to include -- to also add the -- just go to -- amend
25 it for pay for value, to include the case management.

1 CHAIR HURLBURT: So we have a motion and a second
2 and.....

3 MS. ERICKSON: Any discussion?

4 CHAIR HURLBURT: Any further discussion? Yes, Allen.

5 COMMISSIONER HIPPLER: Mr. Chairman, could we have the
6 motion restated, please?

7 CHAIR HURLBURT: Susan.

8 COMMISSIONER URATA: Yeah (affirmative), it was moved and
9 seconded to include pay for value, as one of the core
10 strategies and policy recommendations that we present to the
11 public for comment, and under pay for value is implementing
12 payment reform, comma, start with PCMH, next is support
13 payment reform with data, and then the last was convene a
14 state of Alaska-led multi-payer collaborative. I wonder if
15 that's what ought to be included in that, too? I guess we
16 just leave it all together.

17 CHAIR HURLBURT: So the -- Allen.

18 MS. ERICKSON: I'm typing right now to get to Allen's
19 concern, I think.

20 COMMISSIONER HIPPLER: So Mr. Chairman, our other three
21 principle and another three priority recommendations are
22 subcategories of our larger areas. For example, under focus
23 on prevention, we forwarded a priority regarding opioids. We
24 didn't adopt focus on prevention as one of our top three. We
25 adopted opioids.

1 This pay for value is an area with subheadings including,
2 patient-centered medical home, supporting payment reform with
3 data, and convening a state of Alaska-led multi-payer
4 collaborative.

5 MS. ERICKSON: So Allen's concern is that the suggested
6 amendment actually adds three from our original list of 27,
7 then our shorter list of 15, instead of one, and look, if I
8 could make a suggestion, just the first step, if you did just
9 the first one, I think it gets at -- it's facilitating
10 starting the process of payment reform and starting with
11 primary care and patient-centered medical home case management
12 care coordination piece. So you -- it's one way you could
13 take the three back down to one, and at least have it on your
14 agenda for the next couple of years.

15 COMMISSIONER URATA: So then I should withdraw my motion?

16 COMMISSIONER HIPPLER: It would be if we're following
17 Robert's Rules of Order, certainly, but we, as long as there's
18 agreement, it's -- in an informal setting like this, it's
19 appropriate for the maker of the motion to restate her motion,
20 perhaps.

21 COMMISSIONER YEAGER: I'll try.

22 CHAIR HURLBURT: Why don't we see, maybe have Greg and
23 then have (indiscernible - speaking simultaneously).

24 COMMISSIONER LOUDON: Yeah (affirmative), have further
25 discussion on it before.....

1 COMMISSIONER YEAGER: I could withdraw and start over
2 again.

3 COMMISSIONER LOUDON: Within that category, pay for
4 value, I had some items ranked a one and some that were ranked
5 a five, just weren't that important to me. I'm very
6 interested in payment reform, but when I went through -- and
7 I'm brand new, so I'm not trying to cast dispersions on any
8 work that was done, but when I read through the findings and
9 the recommendations associated with these headings, you know,
10 I looked at the importance and the impactability and some of
11 them looked like they were too big, that we were not going to
12 get there.

13 So within this category, number three, support payment
14 reform with data, was one of my highest ranked things. I was
15 very interested in that. I think we need to have data before
16 we can have payment reform, so just my two cents. I'm
17 interested in the subject. I just don't know that we were --
18 the way that it was presented, the finding, it was not
19 something that I was supportive of.

20 COMMISSIONER ENNIS: I was just going to make a comment
21 about implementing patient-centered medical home that in order
22 to do that, there will be need to payment reform, accompanying
23 that, Dr. Urata said.

24 COMMISSIONER MORGAN: Yes, unless you're a large ACO, you
25 can't really move that way without a grant, do that

1 transition, because we have not, in the major payers, and
2 they're, you know, Medicaid, the ones you talked about, where
3 on the sheet you handed out to the small minority, there is no
4 way any organization can internalize that.

5 So payment reform has to be coupled with, if we really
6 want people to move to do the patient-centered/medical
7 home/whatever it is, to have all of those services bundled up,
8 those services do have costs and you have to have a way of
9 getting reimbursed for them, and since we don't have an HMO,
10 any HMO or managed care in the state, there is no, send a bill
11 out once a month to be a member.

12 Outside of tribal, there really is no one that has that
13 depth and width and can show the savings from that internally
14 to justify the loss, the change up front in the way you
15 deliver that bundle of services in primary care. It's hand-
16 in-hand and until you get both in sync and going together, it
17 won't happen. It just simply can't.

18 COMMISSIONER LOUDON: Yeah (affirmative), I'm sorry, I
19 just didn't follow, as you brought up a point that's pretty
20 critical. To me, when I've been studying payment reform
21 models, probably since 2009, 2008, trying to come up with
22 different model, the patient-centered medical home means
23 something specific.

24 It's a payment model that was adopted or created by the
25 AMA. It's focused primarily on primary care providers. So

1 it's the gain share model in primary care with referrals to
2 specialists. So it doesn't necessarily involve a specialist.
3 It's really focused on primary care. It's a good model, but I
4 think there's limited communities in Alaska where that's going
5 to be effective.

6 So just advancing PCMH itself, I would have a hard time
7 voting that should be one of our top priorities that we should
8 do. That's why I go back to the data, you know, what is
9 really going to work and should we look at other models that
10 are similar, but maybe different?

11 What I heard the Commissioner talk about when he's
12 speaking specifically about Medicaid reform was dedicating
13 primary care providers, and that's really important, because
14 one of the things we can't do is measure quality with
15 providers. We can measure quality with hospitals very easily,
16 but because Alaskans skip around to different providers, we
17 can't measure the effectiveness of treatment for different
18 disease states. So that means something different, having a
19 PCP than having a primary care or patient-centered medical
20 home model.

21 MS. ERICKSON: Yeah (affirmative), and I think the
22 patient-centered medical home model was something that the
23 Commission identified, what, three years ago or so, when we
24 were first studying this, and we haven't updated it.

25 I think the other thing I would suggest is, as we

1 continue working on actual action around supporting
2 implementation, if we find that we have new information or
3 evolved understanding and learning over the past three years,
4 that we wouldn't need to stick with the letter of the law with
5 these recommendations.

6 There's no reason why we can't focus -- we wouldn't
7 necessarily have to focus on a patient-centered medical home
8 model, but take those characteristics that have been
9 identified as making a difference and facilitate that and
10 incorporate that learning into future revisions of our
11 recommendations.

12 So I would suggest that you could take that first one,
13 but then not assume that you're going to implement the
14 accredited version of a patient-centered medical home, but
15 figure out -- one of the first steps might be to, either
16 through stakeholder sessions or additional learning, might be
17 to identify what the most effective approach to payment
18 reform, by starting with primary care, would look like. Does
19 that make sense?

20 CHAIR HURLBURT: I think one perspective, and as Deb just
21 noted, we have recommended the patient-centered medical home,
22 but in our process of where we put our dots, as I mentioned
23 yesterday, one of the things in my mind is where do we have a
24 unique role to play, and I think, you know, looking at this --
25 these numbers that Lori gave us, and again, what I said, that

1 the biggest payer is Medicaid, in the state, and Medicaid has
2 that on their plate.

3 It is their plans. They do want to do some trial things
4 related to that. Bill Streur, just as we were talking before
5 we got started, said he would like to get his Medicaid role,
6 he's assigned to a primary care provided. It's not moving
7 along at warp speed, but I think Medicaid is pursuing that.

8 All the challenges that you just described are there, but
9 I see it as something that others are trying to do and because
10 of the challenges that you described, because the biggest
11 payer already has it outlined on what they would like to do, I
12 come to the same conclusion you do, Greg, that it may not be
13 the most productive for us to focus a lot of time on that, on
14 the patient-centered medical home, although, I think it's a
15 model that we need to get back to. We've said all along, we
16 don't really need more physicians. We need more primary care
17 physicians and less non-primary care physicians.

18 MS. ERICKSON: Can I make another suggestion, too? I
19 mean, what we had grouped in that first policy recommendation,
20 two specific recommendations, and the first, really, was just
21 to implement payment reform, and part of what we might do, if
22 you wanted to go with that first grouping, again, involving
23 learning, I don't think it would lock us into going down a
24 path of focusing on patient-centered medical home,
25 specifically, but if implementing -- if the Commission is

1 going to take action to facilitate implementation, that it
2 might just be convening stakeholders, and if we just identify
3 that first group and not get too concerned about having to be
4 true to primary care and patient-centered medical home, the
5 first step is just convening stakeholders that would be
6 involved, and that we could provide a forum for that.

7 I guess, I recommend -- I'm suggesting, again, that we
8 don't need to, at this point, I think, get too caught up in
9 the specific details of what our policy recommendations and
10 start thinking about what we want to do to facilitate
11 implementation.

12 COMMISSIONER URATA: Let me see if I can bring an end to
13 this. I suggest implement payment reform, period, and also
14 look at care coordination, period, just those two things, and
15 how it looks, whether it's patient-centered coordinated care
16 or whatever, it doesn't matter at this point. What matters is
17 that I catch my plane at 3:00.

18 COMMISSIONER MORGAN: Yes.

19 COMMISSIONER ENNIS: Thank you, and if I could just make
20 a final comment? We heard Dr. Tierney talk about the 10%, and
21 again, I'd like to remind us that it does seem that 10% are
22 our number one Medicaid users, our individuals with behavioral
23 health, our seniors with increasing medical needs, and then
24 again, care givers, all of those can benefit from care
25 management, whether it's with the, you know, the formal

1 definition of patient-centered home model or not. I think
2 that, again, I do support hearing more about this and ways
3 that we can help implement a model, whether it's not the
4 model.

5 CHAIR HURLBURT: Yeah (affirmative), and the other side
6 of that coin is 50% spend 3% of your money, and you can pretty
7 well ignore those people, yeah (affirmative). They do just
8 fine.

9 MS. ERICKSON: We're not ignoring them. We're focusing
10 on prevention to keep them in the -- okay, so we have -- we
11 have a motion and in our informal process, I'm going to
12 suggest that this is what our current motion would read,
13 knowing that it's not perfect, but -- and this is for our
14 draft action agenda for the Commission for 2015 to 2017, for
15 release for public comment, that we add core strategy three,
16 pay for value policy recommendation one, implement payment
17 reform to support care coordination and care management,
18 and.....

19 COMMISSIONER URATA: Well, I would make that payment -- I
20 intended to make the payment reform more broad, but it should
21 include care coordination.

22 MS. ERICKSON: To include.....

23 COMMISSIONER URATA: Yeah (affirmative).

24 MS. ERICKSON: To include, not to support.

25 CHAIR HURLBURT: And a point of clarification, I assume

1 you're using the word care coordination as a fairly broad
2 term. Representative Higgins.....

3 COMMISSIONER URATA: yeah (affirmative).

4 CHAIR HURLBURT:talks about care management. We've
5 talked about case management, but you're using it as kind of a
6 broad generic term?

7 COMMISSIONER URATA: Yes.

8 COMMISSIONER YEAGER: So I certainly accept that friendly
9 amendment to the original motion.

10 CHAIR HURLBURT: Okay, to -- we have a motion. Now, do
11 we have a second again?

12 MS. ERICKSON: We already -- I think we already have a
13 second.

14 CHAIR HURLBURT: We have a second. That's been accepted.
15 Any further discussion? All those in favor, aye.

16 ALL: Aye.

17 CHAIR HURLBURT: Opposed, the same. Motion's carried.
18 Thank you. Thank you all very much for being here and we'll
19 see you in December.

20 MS. ERICKSON: Did anybody withhold their vote on that
21 last vote?

22 COMMISSIONER MORGAN: I mumbled (indiscernible - too far
23 from microphone) I said, "Kentucky votes yea."

24 CHAIR HURLBURT: Okay, we're adjourned.

25 12:17:24

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(Off record)

END OF SESSION