ALASKA STATE LEGISLATURE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE
Anchorage, Alaska
October 25, 2006
10:08 a.m.

MEMBERS PRESENT

Representative Peggy Wilson, Chair
Representative Paul Seaton, Vice Chair
Representative Sharon Cissna

MEMBERS ABSENT

Representative Tom Anderson
Representative Carl Gatto
Representative Vic Kohring
Representative Berta Gardner

OTHER LEGISLATORS PRESENT

Senator Bettye Davis

COMMITTEE CALENDAR

USING ALASKA'S HEALTHCARE DOLLARS WISELY: MISSIONS AND MEASURES REVIEW

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

KARLEEN JACKSON, Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Offered comments regarding the missions and measures review.

STEPHANIE BIRCH, Chief
Women & Children, Family Health
Division of Public Health
Department of Health and Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Provided information during the presentation and answered questions.

TAMMY GREEN, Chief
Chronic Disease
Division of Public Health
Department of Health and Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Provided information during the presentation and answered questions.

CRISTY WILLER, Director
Central Office
Division of Behavioral Health
Department of Health and Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Provided information during the presentation and answered questions.

JERRY FULLER, Project Director
Office of Program Review
Office of the Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Provided information during the presentation and answered questions.

STEPHANIE WHEELER, Executive Director
Office of Faith Based and Community Initiatives
Department of Health and Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Provided information during the presentation and answered questions.

ACTION NARRATIVE

CHAIR PEGGY WILSON called the House Health, Education and Social Services Standing Committee meeting to order at 10:08:09 AM. Representatives Wilson and Seaton were present at the call to order. Representative Cissna arrived as the meeting was in progress. Senator Davis was also in attendance.

CHAIR WILSON announced that the only order of business would be a summary of using Alaska's health care dollars wisely and a review of the missions and measures of each division.

USING ALASKA'S HEALTHCARE DOLLARS WISELY: MISSIONS AND MEASURES REVIEW

10:10:47 AM

KARLEEN JACKSON, Commissioner, Department of Health and Social Services (DHSS), began by stating that one of the biggest challenges in healthcare and social service work is balancing the competing needs of access to care, quality of care, and cost of care. Today, she said, the focus would be on the missions and measures that the departments are required to use in order to evaluate whether the services being funded are producing results.

10:12:18 AM

COMMISSIONER JACKSON noted that all of this relates to the budget process. At this point, departments have provided suggested budgets in to the Office of Management & Budget (OMB). The OMB, she said, is now compiling a statewide budget which will then be submitted to a transition team after the 2006 gubernatorial election. It is the transition team, she said, that produces the final document to be released by December 15, 2006. The final decision will be made by the legislature. The DHSS, she said, prioritized the budget line-items within each division. This year, there are a total of 98 budget line-items for DHSS. These line-items were broken into the following themes: sustaining services; compliance issues; quality assurance; healthy futures. She explained that the "healthy futures" category was broken into two areas: projects with measurable results and projects that "show promise." There are, she said, flaws and benefits when prioritizing budget items. One benefit is the ability to see the important programs, when funding is short. However, there may be a low priority item with demonstrative results, and a high priority item that does not have results. Therefore, it is not simply a matter of funding the first 50 items.

10:16:17 AM

COMMISSIONER JACKSON, in regard to prevention, posed the following question: How can we prevent future funding [by funding the types of programs that ensure less substance abuse and lower suicide rates]? Another "lens" used to prioritize items was "making sure that [DHSS] was truly looking at measurable results." She opined that Cristy Willer has been doing "an amazing job" of creating a way to prioritize grantees and contractors in a way that shows whether the work is providing the desired results. The federal government, she said, is also "pushing in that direction."

[Due to technical difficulties, a portion of the audio is repeated.]

10:17:35 AM

COMMISSIONER JACKSON then explained how to find the OMB Missions and Measures web site. Once on the web site, she said, it can be browsed by agency, overview, or by resource center. She directed the members' attention to the agency section pointing out that from here, various departments can be reached, and noted that the missions and measures of other departments affects the DHSS. From the DHSS section, she said, you can access the "results summary," which gives an indication of any problems in a particular division. Each division also offers more specific indicators, which give more information on the end result and the strategy used. This is a "work in progress."

10:28:48 AM

STEPHANIE BIRCH, Chief, Women & Children, Family Health, Division of Public Health, Department of Health and Social Services (DHSS), explained that the post neonatal death rate measures the death rate of infants from one month after birth through the first year. In regard to the post neonatal death rate in Alaska, she said that the rate for Alaskan Natives is 4.1 times higher than the rate for non-Alaskan Natives. She pointed out the Healthy People target is 1.5 deaths per thousand live births. She explained that many factors "feed into" the post neonatal death rate, beginning prior to conception. The overall health of women, including level of obesity and chronic diseases plays a role. She stated that in the 1980s, it was "very rare to see anyone coming in with any ... chronic diseases]. Over the last 20 years, this amount has grown to almost 50 percent of women coming into pregnancy; in Alaska, this is "fairly acute." Having access to early and continuous prenatal care has been a struggle. She explained that reducing the rate of smoking and drinking during the first trimester of pregnancy would greatly improve the outcome, in addition to having continuous prenatal care visits with trained professionals. Ms. Birch stated that some early warning signs are not recognized and the mothers are not transferred in for care as early as is needed. This is also true of "urban mothers." In addition, the program has shown poor outcomes in regard to the low birth rate for African-American women.

10:33:06 AM

CHAIR WILSON inquired as to how often the problem is that the mother doesn't go to prenatal care visits.

MS. BIRCH replied that the data collected in 2003 indicates that over 40 percent of women who wanted prenatal care were unable to receive it. She explained that this is partly due to insurance coverage, and opined that nationally, there is less emphasis on the importance of early prenatal care. She went on to say that often, the first visit isn't scheduled until the 12 or 14 week of pregnancy. She stated that the lifelong costs associated with preventable birth defects are "quite outstanding." Continually, she said, between 450-500 infants are delivered and admitted to the neonatal intensive care unit, level three, at Providence Alaska Medical Center. She said "what's impressive about that number – you would think ... over time we would have improved. But the babies are getting smaller.... So, that tells us that we're not doing as good a job, in terms of picking up on some of these chronic diseases [and infections] of moms."

MS. BIRCH went on to say that nationally, there is a focus on improving oral healthcare for pregnant women, as high amounts of bacteria in the system can cause infection of the placenta and result in early delivery. Ideally, she said, women would come in prior to pregnancy. She then explained that folic acid supplements have made a huge impact on children born with neuro-tube defects, adding that progress is being made in regard to women's knowledge of folic acid, through the DHSS partnership with the March of Dimes. The Special Supplemental Program for Women, Infants and Children (WIC), she said, has worked with DHSS to educate Alaskan Native women on the importance of folic acid, along with the traditional foods with high folic acid content. However, she said, there is still "a long way to go."

10:38:45 AM

REPRESENTATIVE CISSNA, in regard to folic acid, stated that it this is not easy to obtain in many rural settings, and inquired as to whether this relates to lack of access to prenatal care in rural areas.

MS. BIRCH replied that having a supplement is preferable, adding that the only way to get the supplement is to receive prenatal care. Late access to prenatal care is the largest challenge to Alaskan Native women, she said.

CHAIR WILSON opined that most of the clinics have vitamins to give the women.

MS. BIRCH pointed out that women have to know that they're pregnant. Furthermore, between pregnancies is an important time to continue taking folic acid and identify and address other issues.

10:41:04 AM

MS. BIRCH emphasized the need to focus on prevention. In conclusion, early identification, prevention, and intervention are the focus of the "improving birth outcomes" measurement.

10:42:38 AM

REPRESENTATIVE SEATON, in regard to sonograms and a possible link to autism, inquired as to whether the prenatal use of sonograms is restricted to medical necessity.

MS. BIRCH replied that she has not seen any scientific data on that; however, Medicaid covers one ultrasound unless it is a medical necessity. She added that in the private sector, there has been much advertisement for women receiving ultrasounds in order to have a photograph of the baby in utero; however, this is not common.

REPRESENTATIVE SEATON asked "has the state done anything to raise the red flag to the medical community about that?"

MS. BIRCH replied that she would need to discuss this further with Medicaid.

CHAIR WILSON opined that this issue came up as a result of a wealthy person purchasing a sonogram machine during pregnancy.

10:45:23 AM

TAMMY GREEN, Chief, Chronic Disease, Division of Public Health, Department of Health and Social Services (DHSS), stated that she would be speaking about diabetes and obesity in Alaska. In regard to Diabetes, she stated that there are "broad range ramifications for the healthcare system." It impacts the quality of life for patients experiencing the disease, as well as affecting the healthcare system as a result of other issues such as renal failure and dialysis, which are "very costly" to treat. Diabetes is a "multi-faceted problem." There has been,

she said, a rise in Type II diabetes in youth, which is related to obesity.

MS. GREEN moved on to discuss obesity in Alaska. She pointed out the goal of decreasing the adult obesity rate to less than 18 percent. If "overweight" is combined with obesity, she said, the total is about 63 percent of the population. Obesity has been linked to cancer, heart disease, stroke, and high cholesterol, in addition to poor body image and emotional issues. Obese and overweight people are less likely to want to exercise, she said. A recent study showed that overweight youth experience the same level of emotional trauma as those experiencing cancer and chemotherapy. She said:

> That really gives you that magnitude of what it's like for a child to be overweight. And what we know is that – if a child is overweight, it used to be that people would say "Oh, they'll grow out of it, it's baby fat," but the research doesn't bare that out. It shows that, if a child is overweight coming into school, the likelihood that they're going to "normalize" or come out on the other end being a normal weight is ... very unlikely. So, the sooner a child experiences overweight or obesity, the more likely they're going to be overweight as an adult. Thus leading to all of the chronic diseases that are going to impact their quality of life.

MS. GREEN went on to say that there is an obesity prevention and control program that works with schools and communities in an effort to make exercise more accessible along with finding easier ways to get fruits and vegetables to the more rural areas. The idea behind this, she said, is to make it easier to live a healthy lifestyle.

10:52:53 AM

REPRESENTATIVE CISSNA expressed concern with regard to the obesity chart. In 1999, she pointed out, Alaska was ahead of the nation in obesity by a slight margin, but in 2005 the state has moved ahead significantly.

CHAIR WILSON surmised that doctors are "really aware" of the problem, which makes a difference.

MS. GREEN indicated that another year of information is needed to show "trend data." At the current rate, she said, in the

next ten years, 80 percent of the population will be overweight or obese. The Chronic Disease Policy Academy, she said, has been looking at various areas regarding chronic disease over the last few years, and supporting the idea of working with communities.

10:55:53 AM

REPRESENTATIVE SEATON opined that it would be helpful to view the information on a graph showing the national trend-line and the Alaska trend-line.

MS. GREEN agreed that seeing the trends helps "crystallize" the information.

10:56:37 AM

MS. GREEN moved on to discuss the measures relating to the Division of Public Health. Specifically, she said, they would be looking at coronary heart disease. She read from a handout as follows: Alaska's coronary heart disease death rate is less than 120 per 100,000 population. She pointed out that Alaska is showing a decrease in death rate, and met the target in 2001 and 2002. She posed the question "how is this happening, [when] we have these other things happening in terms of obesity and diabetes, things that are impacting coronary heart disease?" She then explained that this is specifically talking about the death rate, rather than the incidence of the disease. There have been, she said, "tremendous strides" in the treatment of coronary heart disease, noting that these treatments include medications, in addition to technical treatments. She pointed out an error in the handout regarding the national death rate, noting that it should read "n/a," as the data was not available.

CHAIR WILSON commented that "it's pretty exciting" for Alaska. Especially, she said, because Alaska has so many difficult to reach areas that face additional obstacles in emergency situations.

10:58:53 AM

REPRESENTATIVE SEATON asked if the incidence rate of coronary heart disease is available.

MS. GREEN replied that only the death rate is available at this time.

REPRESENTATIVE SEATON inquired as to whether people with coronary heart disease that "left Alaska for treatment and died outside [of Alaska]" would be reported as an Alaska death or an "outside death."

MS. GREEN replied that it "could be either." She explained that it would depend on where the patient died. Other states will report to vital statistics if the individual is still a resident of Alaska. She opined that the reporting process has improved. In addition, she said, more people are choosing to stay in Alaska for treatment as a result of the higher level of care available to them.

11:00:25 AM

REPRESENTATIVE CISSNA expressed interest in knowing whether the lower death rate has any correlation to the success of smoking cessation in the state.

MS. GREEN replied that while it is difficult to make direct cause associations, the department is attempting to gather this information. The national data shows that the rates are going down due to increased treatment options more than smoking cessation or weight loss.

REPRESENTATIVE CISSNA, in regard to the coronary heart disease and cancer death rates, requested that the national numbers for 2005 be sent to offices via email.

MS. GREEN agreed to do so.

11:02:43 AM

MS. GREEN continued with Alaska's cancer death rate, which has also decreased. This is due to early detection, which effects the length and quality of life. However, the incidence of cancer has increased. Lung cancer, she said, is the biggest cause of cancer related death in Alaska, and noted that this is directly related to smoking. She said "we have good news on this front, but we still have a lot of work to do, in terms of really trying to educate people and help people understand what ... they can do." She stated that people may feel helpless about how they get cancer. There are many lifestyle changes that can help to prevent cancer from occurring.

11:04:22 AM

MS. GREEN, in response to Chair Wilson, identified the following four diseases as the top diseases in Alaska: lung cancer, breast cancer in women, prostrate cancer in men, and colon cancer.

REPRESENTATIVE SEATON asked if data is available regarding what has been done to lower the smoking rate in Alaska.

MS. GREEN related that tremendous strides have been made with the smoking cessation program. Within a year, she said, more information will be available regarding what is working and what is not working, in addition to where efforts should be increased. The Quit Line program has had a good success rate, and now offers nicotine replacement patches to callers who wish to quit smoking. In addition, she said, the annual report on tobacco cessation will give an update on the success of the program.

CHAIR WILSON agreed with Representative Seaton regarding the importance of seeing the aforementioned data.

11:07:57 AM

MS. GREEN moved on to discuss reducing the rate of smoking among Alaskan youth. The goal, she said, was to have less than 19 percent of high school aged youth in Alaska use tobacco products. This goal was met in 2003. In 1999, when the youth risk behavior survey was conducted, the smoking rate was around 37 percent. This decrease was correlated with the increase in the statewide tobacco tax, in addition to higher funding for prevention. In 2005 there was no data due to the effort required to obtain parental consent forms and ensure that enough surveys are collected for "weighted data." Hopefully, she said, the department will obtain enough data to show what has happened between 2003 and 2007. Nationally, she said, the rates have started to "flatten, and ... go up again." There has been a "great amount of success." However, the department must ensure that it continues to move in the right direction.

11:10:01 AM

CHAIR WILSON recalled that the active questionnaire requires parental consent, and inquired as to whether the schools were having trouble with the rate of return.

MS. GREEN replied that the law changed from "passive" to "active" parental consent, adding that oftentimes, parents will

forget to respond. If the response rate is not high enough, the data is not representative of the entire population, which is what happened in 2003. She also noted that the scope of the survey reaches beyond tobacco to include all areas that affect chronic disease.

CHAIR WILSON offered her understanding that without the correct data to show whether or not a program is effective, the state is not allowed access to funding grants that it might otherwise receive.

MS. GREEN replied yes, and agreed that this would benefit from further review by the legislature. In response to a question from Representative Seaton, she explained that a bill to change from "active" to "passive" consent failed to pass during the previous legislative session.

11:13:16 AM

CRISTY WILLER, Director, Central Office, Division of Behavioral Health, Department of Health and Social Services, began by reminding the committee of Alaska's rates in relation to behavioral health. She explained that there are many societal costs in addition to the human costs. In the United States, she said, 500 million workdays were lost due to alcoholism. $277 paid by each taxpayer goes towards dealing with the consequential burdens of substance abuse, while only $10 is put towards prevention. Approximately 13 percent of each states budget is put toward these issues. She cited a 2005 report by the McDowell Group which shows a $738 million loss to the state each year in terms of productivity, criminal justice, healthcare, traffic accidents, and public assistance, in addition to roughly $50 million given out in the form of grants for direct treatment and prevention.

11:17:26 AM

MS. WILLER pointed out that many of the missions and measures are attached to the departments because they are multi-faceted. She then turned attention to the Bring the Kids Home program, which would bring Alaskan youth back from out of state placement, in addition to preventing youth from being placed out of state. She directed attention to the first of three charts, which is a line chart. She explained that this is not as useful in terms of annual trends; however, it shows that in 2006, less youth were being sent out of state during the last few months. The bar chart, she said, shows the "turn the curve idea."

REPRESENTATIVE WILSON related a story of a family where five children were removed and sent to separate homes. The state then had to pay for the children to fly and see a counselor in a different town. She opined that if the counselor had come to the children this would have saved the state money and been "less traumatic" for the children. She inquired as to the rules regarding this type of situation.

11:23:23 AM

MS. WILLER replied that she does not "know the regulations well enough to understand how that could happen." She noted that some children and adults in Alaska are "falling through the cracks" as a result of funding regulations and priorities. The department has had meetings to identify which type of family is most likely to experience this, and how to solve this problem.

11:24:45 AM

REPRESENTATIVE SEATON opined that the graph shows less in-state occupancy than in 2001. He said "We had a couple of years where we improved a little, and now we've dropped right back to where we were in 2002." He inquired as to whether this interpretation of the graph is correct.

MS. WILLER replied that the graph shows the "relative nature of in-state and out-of-state." She then referred to a table showing the number of youth in residential psychiatric treatment placement over the last four years. The out of state placements on the aforementioned table, for 2003 and 2004, shows an increase in the number of youth sent out of state. She said "the next two change numbers under it are showing less kids being sent out of state. So, it's another turn." When the out-of-state placements are subtracted from the total, the remainder is youth in-state. She opined that an additional column would make this clearer.

REPRESENTATIVE SEATON offered his understanding that the number of youth out-of-state lowered from 2003-2006, adding that for 2001, the number of in-state youth would have been even higher.

CHAIR WILSON commented that the chart is confusing.

11:28:34 AM

MS. WILLER offered to redo the charts in order to graphically illustrate the changes. She then expressed the need to keep in mind that the emphasis of this program was in 2004. She went on to explain that more beds have been added in-state, in addition to increasing services with community service providers.

11:30:24 AM

CHAIR WILSON recalled that Bring the Kids Home is really about providing more treatment in Alaska rather than sending them outside to do so.

MS. WILLER agreed and noted that other systems have been offered, such as the "gatekeeper system," which analyzes out-of-state referrals to ensure that an "appropriate situation" for the child to be in closer to home.

CHAIR WILSON recalled that previously there had been discussion that parent or guardian insurance would be utilized prior to Medicare.

11:32:32 AM

JERRY FULLER, Project Director, Office of Program Review, Office of the Commissioner, Department of Health and Social Services (DHSS), stated that this was a requirement of HB 426. He explained that in the current Medicaid program, if a child has insurance that would cover the needed services, the insurance company is billed for the service. Unfortunately, he said, most insurance companies do not cover [residential] psychiatric treatment of youth.

11:33:23 AM

REPRESENTATIVE CISSNA commented that she has tracked the history of "high-risk" youth for several decades. In the 80s, she said, there was implementation of "wraparound services," which was replicated in other states, although Alaska no longer offers these services. Alaska, she said, has "moved away" from local community solutions, along with losing grants that would allow services that Medicaid does not. She said "services were delivered that simply cannot be delivered under our present funding source." She opined that the current system, in regard to a rural setting, takes youth away from families permanently, as the culture has been taken away from the child. She said "I think it would be great for us to look back at our history, figure out what did work in the past, and figure out what's

still here that might be used. ... I think if we're going to really fix the problem, we have to ... use some of the talent that ... is in the state, not constantly import new people."

MR. FULLER related that during a meeting of the Medical Care Advisory Committee in Barrow, a recommendation was made for a study to look back at the environment when behavioral health was a "general funded program" with little Medicaid funds. The Mental Health Trust Authority is funding such a study, he said, which currently is in the beginning stages.

11:38:22 AM

REPRESENTATIVE SEATON inquired as to whether tickets must be purchased in advance for parental visits, so that the state is not paying the highest prices.

MR. FULLER replied that the parents are encouraged to see their children on a routine basis. He stated that he does not know whether the parents are required to purchase tickets in advance, adding that the state does have a preferred contract with Alaska Airlines, and should be receiving a reduced rate. More details regarding this issue can be provided, he said.

REPRESENTATIVE SEATON said "I'd just appreciate getting [this information]."

11:40:24 AM

MS. WILLER, in regard to closer case management of youth out-of-state, stated that parental visits are not vacations, but are "therapeutic events" for the family. To work closer with the therapist, she said, means that any travel and communication is planned out. In regard to the additional beds, she stated that they are usually added in the larger communities. The program, she explained, is intended to provide accessible services outside of the residential programs. Currently, she said, there are around 110 youth participating in individualized services. These include in home services, independent living skill training, treatment and foster care facilities, after school programs, and parenting programs. The idea, she said, is not to rely completely on residential programs.

11:42:22 AM

REPRESENTATIVE CISSNA recalled that the state had previously done a study in collaboration with University of Alaska

Anchorage (UAA), which looked into how the states child welfare programs were working, and if they were not working, why not. She offered her understanding that the program did not have a "good track record" of following a model program. She opined that it may be helpful to the committee to revisit this study.

MS. WILLER replied that these studies can be found on the web site, and agreed to forward this information to the members'.

REPRESENTATIVE CISSNA asked if the programs being utilized are fitted with evidence-based models.

MS. WILLER replied the aforementioned study was used to develop the standards and evaluate the need for "step down" services.

11:45:14 AM

CHAIR WILSON related her belief that more children need mental health services each year, and inquired as to whether a study has been done to discover the reason for this.

MS. WILLER answered that there are national prevalence studies that show this information, and offered to research this. She related that the aforementioned beds were already filled, and said:

> So ... I'm seeing the moving target that you're describing, that really, the impact we're making on that is going to be interesting to judge, because it's against the growing trend line of needs. And, in order to discuss the one, we have to discuss the other with more specificity, you're right. So, that's something we need to work on. We're working on ... ball-parking prevalence studies for specific populations of young people and adults: FASD, traumatic brain injury, [autism]. As a way to identify special populations of those kids that we're ill-serving because, as I mentioned before, they're falling through the cracks. But, in terms of causality, I think we'll have to look more to the national [studies].

11:48:50 AM

REPRESENTATIVE CISSNA said that over the past few years, she has noticed individuals in community mental health discussing the increase in the chronic mental health, while the capacity to

handle them is decreasing. She inquired as to how much the department tracks these types of concerns.

MS. WILLER replied that there are four large provider groups in the state, each of which she meets with on a monthly basis. For the last 10 years, she said, due to a reduction in grant funds, more programs have had to serve a "more acute" population. In regard to why the population is growing, she stated that this because the department is not able to focus on intervention and prevention. She stated that the it is important to look at the affects these issues have on jobs, primary care, and other areas. Employees and practitioners are voicing frustration that they must focus on populations in crisis.

11:53:38 AM

CHAIR WILSON pointed out that while school funding has been increased over the last six years, the schools are still unable to fund in-school counselors. She opined that it is "pretty crucial" to look at school funding in this way, and ensure each school has a counselor.

11:55:15 AM

MS. WILLER moved on to a chart showing the suicide rate in Alaska. She explained that Alaska has double the US suicide rate, and the Alaskan Native rate is four times the US rate. Suicide is the number one cause of death for people under the age of 50, and claims around 125 lives each year. She has looked at studies done, and approximately 50 percent of the family of the deceased reported that the person had a drinking problem. 36 percent were arrested for drinking behavior, 50 percent were intoxicated with alcohol or other drug at the time of death. 45 to 50 percent of the individuals were on drugs of some kind. She related that 39 percent of the individuals had insurance coverage for mental health issues. 50 percent were depressed, 46 percent experienced a traumatic event, 92 percent owned firearms, 53 percent had previous thoughts of suicide, and 20 percent experienced some form of abuse prior to the age of nine. 25 percent witnessed violence, and a high percentage of the individuals had a family member die during childhood. This last factor, she said, may be tied into neonatal care.

MS. WILLER moved on to discuss attempted suicide. The study shows that more than $4 million per year is used for hospitalization of those who attempt suicide. This number does not include specialization or technology, and at least $1

million each year is absorbed by the hospital. This is, she said, one of the nexus points of behavioral health issues, and connects with employment, poverty, cultural dislocation, among other things. She said "this is the low point of where these things combine to disrupt a person's life. And obviously, a whole family-and communities, when there are cluster suicides, of course, we see entire communities at risk." She noted that the division has a suicide prevention program, which she feels is a unique program because the money goes directly to the community. She opined that the communities "make wrong guesses sometimes," and suggested a follow-back study to show which programs are the most successful. The ability of the division to make a direct connection with the leaders of small communities is "a good strategy."

12:00:58 PM

CHAIR WILSON inquired as to whether the aforementioned program is working. She said "if we're spending money there, and we haven't seen the results that we would like, maybe we should be putting the money in a different area." She stressed the importance of knowing where the money is going and whether or not these programs are effective.

12:04:13 PM

MS. WILLER agreed that it is important to know what is working. The prevention department is putting together an epidemiological work group, which will produce the information that is needed. The group is called "EPI group," she said, and offered to distribute the minutes from the first meeting to the members'. She then moved on to discuss the Alaska Psychiatric Institute (API) readmission rate. This shows that 12.7 percent of patients at API have been patients previously. This is much higher than the national average, and shows that the community services around the state are not equipped to handle the individuals returned to the general population well enough to keep them from returning.

REPRESENTATIVE SEATON offered his understanding that the patients had not only been admitted before, but were admitted again within 30 days of being discharged. He suggested that this may be related to the lack of space or ill-equipped community services.

MS. WILLER agreed that this is the case. She added that the length of stay may be too short to "do the job."

CHAIR WILSON noted that the funding has been increased for API personnel, adding that this may result in additional registered nursing staff. She stated that hopefully, this would make a difference.

COMMISSIONER JACKSON noted that there has been a positive trend line over the last few years.

MS. WILLER added that this is a “multiplex” issue. Increased salaries will improve the in-house services; however, the state must “look elsewhere” for solutions.

12:07:50 PM

REPRESENTATIVE SEATON asked if an analysis would be done to identify what API believes is the cause of the returning patients.

MR. WILLER replied that the division has done work in this area, relative to budget requests in addition to looking at what was intended to happen when the program was downsized. The division has also been looking at new ideas that may be more efficient. The solutions include: better detox and crisis respite, discharge planning, and housing.

CHAIR WILSON noted that some items are not available due to lack of funding by the legislature. She inquired as to whether there is a way to show the cause and effect of not funding these areas.

MS. WILLER replied that this may be possible.

CHAIR WILSON opined that if there is a reason that API does not have the support services, it would not be APIs fault.

12:10:29 PM

REPRESENTATIVE SEATON recalled that the previous year, the local hospital funding issue was fixed. He inquired as to whether this has helped hospitals retain patients for the first 3-5 days without needing to send the patient to API.

MS. WILLER replied yes, but expressed the need to provide numbers and highlighted that it's a lower level of care. She opined that “loosening the reigns” has helped in rural areas, and will continue to do so. API, she said, is involved in

“tele-behavioral health solutions.” She stated that although this would not apply to a person in acute psychiatric crisis, it may impact APIs ability to contain those in need. Another problem is that API must take those individuals brought to them by the police, which is difficult, as it's a situation in which there is a legal issue.

CHAIR WILSON expressed frustration with the lack of therapy that the hospitals can provide because of the staff isn't qualified to provide such.

12:14:45 PM

MS. WILLER moved on to the division's missions and measures, and said that the two charts used represent responses for adults and youth. She pointed out that this year, the responses are 23 percent higher than in previous years. She explained that the charts show the results of surveys asking individuals in the treatment program questions related to productivity. She noted that this question is broad in order to include all types of productivity, and said “defined loosely, how productive do you feel? Because this is a therapeutic issue, this isn’t necessarily ... it’s feeling productive, if you have a place to go and work and feel like you’re an able member of society- [this] is a critical factor in well-being.” The survey also includes questions regarding physical, mental, and emotional health, thoughts of self-harm, family and social support, safety, sense of well-being, spirituality, financial security, and housing. She stated that the patients are asked when they arrive, when they leave, and after they have been on their own for 6 and 12 months. This information is then compared.

MS. WILLER went on to say that the first chart shows individuals self-assessment of their maintenance and improvement in each area, noting that the adults show more improvement than the youth. These surveys can be broken into more specific areas to determine where the funds would best be spent. In regard to the self harm measure, she explained that the question was “are you thinking less about self harm?” She pointed out that this is why it appears that the thoughts about self-harm are rising, however, due to the wording of the question, the opposite is true.

12:20:09 PM

REPRESENTATIVE SEATON, in regard youth productivity, offered his understanding that more than half felt more productive, while

roughly 40 percent felt less productive. He opined that it is important to provide individuals outlets "so that they feel they have a meaningful life." He stated that the importance of this measure needs to be communicated, adding that the 40 percent of people who are feeling less productive really needs to be addressed.

MS. WILLER agreed with this. She reiterated that one way to focus would be to sort the results into more specific areas. She opined that the concentration of suicidality among young native males is related to the loss of "a very productive, creative life, which now no longer is, for a variety of economic and social ... reasons." She commented that while the state is unable to have direct impact in all areas, it is attempting to identify these issues and help communities organize in order to have an impact.

12:24:09 PM

MS. WILLER moved on to explain the measure intended to track the number of native entities that are able to bill for Medicaid. She then explained the "satisfaction" measure. This shows results of a survey given to patients to track satisfaction with care. For residential programs, the patient is given the survey when they leave the program and then mails it back. This, she said, provides the patient with anonymity. The intent of the measure is to track whether the state is improving its ability to provide satisfactory treatment. The adult chart, which shows data over a three year time period, shows more satisfaction from 2004-2006. The family and youth responses are "less satisfactory." She pointed out that the youth were less satisfied in 2005-2006. The information was also broken down by ethnicity, and the youth, she said, were "fairly equal" in terms of satisfaction, with the exception of access to services and cultural sensitivities. In the aforementioned areas, she said, the Alaska Native youth were less satisfied. In addition, she pointed out that although the Alaska Native youth were less satisfied, the satisfaction level was still high. She said "This has something to do with outcomes, it has something to do with ... successive treatment - not everything. We don't expect people to be in our treatment programs to really like being there, always. We're a challenging place. But, we think it's certainly important to watch these trends and see where it slips and try to identify - in these components - what we can do better with.

CHAIR WILSON inquired as to the number of children versus adults in the program.

MS. WILLER replied that she does not have this information with her; however, the surveys received a 94 percent higher response, up from [2005]. She offered to forward this information.

CHAIR WILSON stated that this information would be "nice to have," adding that if the adults outnumber the children in the program, the program may need to focus more on the children in order to change the future number of adults in the program.

12:30:06 PM

REPRESENTATIVE SEATON asked for clarification regarding the numbers on the last chart.

MS. WILLER agreed to take a closer look at the charts to ensure that the numbers are correct.

REPRESENTATIVE SEATON in regard to the suicide rate, asked if those individuals with access to insurance had or had not utilized this insurance, and whether the programs used were affective. He commented that half of the individuals with mental health care available to them had committed suicide and posed the question "where's the problem?" He expressed hope that this information would be available in the future.

MS. WILLER agreed and added that she would like to find out how "insurance" is defined, also. She questioned whether this was referring to private insurers or Indian health services. In addition, she said, there were statistics showing how many of those individuals who committed suicide were seeing a therapist, and how many weeks it had been since the last visit. She offered to gather this information.

12:32:47 PM

COMMISSIONER JACKSON, in regard to the productivity measure, stated that the department had previously attempted to include a category titled "open opportunities" in the budget, which would have addressed the issue that individuals "need something that they can do that makes them feel productive." However, this was not included in the final budget. She said that, perhaps, the members would be able to come up with a better way to "frame this," as this is something that needs to be addressed.

12:33:24 PM

STEPHANIE WHEELER, Executive Director, Faith Based and Community Initiatives (FBCI), Department of Health and Social Services (DHSS), said that the national Faith Based and Community Initiatives (FBCI) program was established as a result of an executive order from the President in 2001, and is an expanded version of the previous administrations "Charitable Choice" program. The FBCI program, she said, seeks to strengthen and expand the capacity of faith based and community organizations, to provide federally and state funded social services. This would enable the community groups to meet the needs of local individuals facing life challenges. She noted that there has been controversy regarding the FBCI program, one of which is the "separation of church and state." She explained that the FBCI program has guidelines and regulations in place in order to deal with this. There are 11 federal agencies with FBCI offices, and the DHSS works closely with the federal agencies, as well as with regional partners. In addition, she said, 32 states currently have state FBCI offices.

MS. WHEELER moved on to explain the [federal] FBCI program priorities. These include: at-risk youth; domestic violence; substance abuse; homelessness; poverty; healthy marriage initiative; welfare-to-work; prison re-entry; HIV/AIDS. The Alaska FBCI office was established in January 2005, and is supported by an 22 member advisory council. The state priorities, she said, are "pretty much in-line" with the national priorities, and focus on healthcare related issues. In addition to the aforementioned priorities, the state has added suicide prevention and hunger.

12:37:07 PM

MS. WHEELER stated that the state FBCI program has been working with the federal partners, and is considering three additional priorities. These are: combat war veterans; at-risk seniors; disaster relief planning. In regard to at-risk seniors, she explained that seniors are one of the fastest growing populations in the state. In addition, one third of the seniors in Alaska are living in poverty. She pointed out that Florida is considering providing preventative healthcare to its seniors, and is working on model projects which include faith-based organizations. The aforementioned projects would provide day-care services for seniors, and would provide supportive services on-site. The faith-based organizations would work with government agencies to provide these services. The model

programs, she said, are showing a decrease in cost of healthcare for the seniors involved in the programs. In regard to disaster relief, stated that faith-based organizations were affective in the aftermath of Hurricanes Katrina and Rita.

12:39:10 PM

MS. WHEELER then discussed the FBCI programs in Alaska. Project Access, she said, provides insurance coverage to uninsured and underinsured individuals. She referred to a previous PowerPoint presentation titled "Partnerships Leverage Resources," and stated that the aforementioned program is a "really good example of how partnerships really do leverage resources."

12:39:52 PM

REPRESENTATIVE SEATON referred to a recent newspaper article which stated that seniors would soon need to move from Alaska due to an inability to receive Medicare. He inquired as to whether the FBCI would influence the availability of Medicare for seniors in the state.

MS. WHEELER replied that the FBCI program does not; however, creating partnerships creates more ideas on how to provide these services to seniors. This includes pulling in faith-based organizations and volunteers to work on model projects.

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MR. FULLER explained that Medicare is federally operated, and therefore the state does not have influence over this program. He said:

> The issue in the newspaper, over the last several months, has to do with a reimbursement reduction to physicians that occurred in January of [2006], specific to Alaska. In January of [2007], at a national level, there is anticipated to be another 5 percent reduction to physician services. Our delegation, and I would say, all of the congressional delegations are very much aware of that. And they're all working very hard to have a legislative fix during this "lame-duck" session. Our delegation already has language written to repair the [2006 and 2007] damage, to tack on to the national movement. So, it remains to be seen, but ... it's strictly a federal issue that the state has no influence over.

REPRESENTATIVE SEATON requested clarification regarding when doctors cannot or will not take Medicare patients.

MR. FULLER replied that it is the physicians' choice. He explained that some physicians that have previously chosen to see Medicare patients are now informing the patient that he/she no longer accepts Medicare, and therefore can no longer see the patient. He said "Unless they want to pay cash. So, that's their access route at this point." Additionally, he said, if the patient is covered by any other type of insurance, including state insurance, Medicare must pay before the secondary forms of insurance will pay. He said "if the doctor drops his acceptance of Medicare, it affectively shuts them off from all their insurance benefits, whatever they might be." The remaining access, he said, is very minimal. Alaskan Native patients do still have benefits through tribal health corporations. There are also community clinics which receive public health service grants, which are often overloaded with patients.

REPRESENTATIVE SEATON asked if the only influence possible would be an expansion of the community health care clinics. He also inquired as to whether establishing these clinics is state or federally regulated.

MR. FULLER replied that the state has some ability to designate areas of the state "medically underserved," which is the "open gateway to the federal side." Over the last few years, he said, the state received a "huge expansion," and he is unsure of what the remaining opportunity is, in terms of expanding the capacity in the current areas or adding additional areas.

UNIDENTIFIED SPEAKER stated that there are community health centers in over 22 organizations throughout the state. These are distributed across 100 communities. These centers are federally funded. Many of the sites, she said, were tribal sites, with very few centers that are newly constructed. This is mainly expansion and reinforcement of many existing sites. Within the last week, she said, new access points have been announced by the Health Resources and Service Administration (HRSA). She explained that the communities must have a medically underserved area designation, which is federal designation. The majority of areas throughout the state which meet the criteria are currently designated as such. She noted that many communities interested in providing the services do not meet the criteria, adding that the sites must compete against other states and communities which have applied for the

same funds. In the past, she said, other state resources have been applied to primary care organizations and services; however, these were direct grants, and none are currently available.

REPRESENTATIVE SEATON inquired as to whether the community health centers accept Medicare.

UNIDENTIFIED SPEAKER replied yes, adding that the centers must first be attentive to the patient load distribution. She pointed out that Medicaid and Medicare must be included in the centers financial projection.

REPRESENTATIVE SEATON asked if the legislature plays a role in helping establish or continue access [to medical care] for the senior population that is not able to see a private doctor.

UNIDENTIFIED SPEAKER replied that she is unable to answer this question at this time. She explained that many of the sites receive a combination of state and federal funding.

12:49:49 PM

CHAIR WILSON surmised that the legislature could require the doctors to see a percentage of Medicare patients, or require the secondary insurance companies to pay, even if Medicare does not.

COMMISSIONER JACKSON suggested holding an additional meeting to discuss the difference between Medicare and Medicaid, in addition to what the legislature can do.

CHAIR WILSON agreed, adding that while the funding may currently be available, it is important to consider whether this can be sustained in the future.

12:52:09 PM

MS. WHEELER continued her presentation by discussing the healthy marriage initiative. Alaska, she said, had an opportunity to "do some creative things around the healthy marriage initiative." However, she said, this was very short-lived. In fiscal year 2005 (FY05) $150,000 was dedicated to healthy marriage initiatives, along with $500,000 the following year. Over half of the healthy marriage grantees were faith-based organizations. National research shows that children of families involved in the healthy marriage programs do better in school, have better access to healthcare, and show less at-risk

behavior. If the opportunity to recreate these programs were to arise, she would encourage the legislature to take a look at the national outcomes from this initiative.

CHAIR WILSON opined that one reason this program is no longer funded is due to a lack of evidence showing its effectiveness.

MS. WHEELER returned to health care and community initiatives. The FBCI program is developing healthcare ministries within faith-based organizations. There are, she said, over 46 faith-based organizations participating, adding that these are primarily prevention and intervention measures. She pointed out several different programs around the state which are involved in these initiatives, including one in Anchorage and Sitka. These programs are volunteer run. The Tribal Community Development Coalition oversees the Minority Education Health Committee, which is developing similar healthcare ministries. The FBCI program works closely with the Alaska State Community Service Commission (ASCSC), which tracks and recruits volunteers.

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MS. WHEELER moved on to discuss combat war veterans. In regard to Alaskan Native individuals who go to war, she stated that a number of healthcare issues are showing up. It is unknown whether these issues are preexisting or are aggravated by war conditions. The concern, she said, is when the aforementioned individuals return to the rural areas of the state – Nome, Bethel, Dillingham, and Juneau – there are no veteran outreach services. The veteran outreach programs are considering a partnership with the Indian Health Services in these areas in order to provide the appropriate services.

CHAIR WILSON asked if the veteran's family will have services available, also.

MS. WHEELER replied that this will be considered, as well.

CHAIR WILSON asked if the military provides funding for these services.

MS. WHEELER replied that because there are no veteran's services available, this is something that the veteran's administration will need to look at, and this is currently being done.

CHAIR WILSON opined that this information should be passed on to the congressional delegation, as there are "quite a few people from Alaska compared to other states." She surmised, then, that the congressional delegation may be able to channel additional funds to Alaska for this purpose.

MS. WHEELER said that a meeting is scheduled for December 6, during which she will bring up this issue. In 2005, she said, the DHSS implemented the Alaska Partnership for Healthy Communities. This initiative, she said, is intended to improve the collaboration among government agencies and communities. Several related projects also exist. In regard to the MatSu Family Centered Services pilot project, she said:

> Over the summer, [the department] did an evaluation of that MatSu pilot project. And what they found was that they took these 15 families, who are the hardest to serve, within the division of public assistance, and tried to figure out why these families were not moving towards self-sufficiency. And, putting all of the pieces together, 50 percent of these families actually had children who were involved with the juvenile justice center – and this is the ... beauty of community partnerships – 50 percent of the adults in those families ... had some kind of involvement with the adult criminal justice system, ... 70 percent of those families had some type of involvement with the Office of Children's Services, ... and ... many of these families were challenged with substance abuse, mental health issues, domestic violence, and other physical health issues. And so, when – if one agency who's working with these families, there wouldn't have been the opportunity to collaborate on looking at priorities for these families. Instead, what you would have had, was families running from agency to another agency, to another agency, and really feeling overwhelmed by the pressure of trying to meet the demands of all of these agencies that they're involved with. And so, this is a wonderful community collaborative partnership that really takes a look at these priorities for the families. Families are – this is family centered services, so these services are actually wrapped around these families to deal with each of their issues, one ... step at a time.... So, by working with community partners, organizations and agencies, they are better able to prioritize services, develop a common plan with all the agencies

involved, and are actually moving these families toward self-sufficiency. That was an eye-opener that we discovered over the summer, and ... a really good thing.

There is a similar project happening ... with the Fairbanks Family Centered Services pilot project. And ... you've heard already, some of the projects working under the children's policy team, regarding bringing the kids home. [In addition,] there's the early childhood development project and care coordination....

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CHAIR WILSON asked if missions and measures had been set up for the Family Centered Services pilot projects, in order to see the changes over time. She opined that this would be helpful during future presentations to the legislature.

MS. WHEELER agreed, and added that there has been discussion regarding ways to create similar projects in other communities. She concluded by saying that the FBCI office recently received a grant award through the Compassion Capital Funds (CCF) in the amount of $500,000. She explained that CCF is the cornerstone of the national FBCI program. This is, she said, the only "new pot of money" dedicated to FBCI. She went on to say that CCF is designed to help organizations partner with the federal government, in order to strengthen the organizations ability to serve those in need. It is also intended to increase effectiveness, enhance the ability to provide social services, and expand to create additional community collaboration. Last year, Alaska received $550,000 through the CCF capacity building grant. This year, she said, the amount "almost doubled," adding that the Eskimo Community Center in Nome was awarded $300,000, in addition to several smaller FBCI organizations around the state that received $50,000 each. The state office, she said, will work alongside the aforementioned organizations, and will provide training and technical assistance. In addition, she stated, it will be working with federal partners to do "more stringent evaluations" in order to see whether the FBCI programs are working.

1:08:45 PM

MR. FULLER began his presentation by stating that he would be available for follow-up discussions regarding long-term care.

He explained that a recent report projected out an extreme increase in cost for long-term care over the next 20-25 years, and the Medicaid budget would be "quadruple." This growth, he said, is mostly due to demographics: baby boomers, and individuals moving to Alaska to retire. If those who retire in Alaska have retirement benefits, this is good; however, when these benefits run out, Medicaid is used. He went on to say that the average daily rate for nursing homes in Alaska in 2005 was $371 per day, which is over $1,100 per month.

MR. FULLER stated that the "problem" with Medicaid is that "it's too successful," and is the "safety net" when other sources fail. He referred to a recent newspaper article which stated that private employers are either dropping health insurance coverage or charging more for it. He said:

> You can understand that, that's business. It's a global economy we're in ... competing with countries with no benefits. But, bottom line, those folks without benefits, will, when they need healthcare, find it someplace. Whether it's at the emergency room, or healthcare coverage for their children through Denali Kid Care. Sooner or later, it's gonna fall to Medicaid.

MR. FULLER went on to say that Alaska has done a "good job" containing costs. This has been done by keeping many nursing home bed rates "relatively flat, for quite a number of years," he said, adding that there are roughly 600 beds throughout the state. In addition to the aforementioned bed rates, he said, the state has provided waivers permitting people to live in their own homes, or in assisted living homes within their community. He noted that while these cost less than nursing homes, it is still a significant cost. Referring to a report done by The Lewin Group, he said that under the current system, the Medicaid budget will quadruple by the year 2025. He stressed the importance of finding a more sustainable approach.

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CHAIR WILSON asked if the state will be able to sustain the projected increase in the Medicaid budget.

MR. FULLER replied that this will depend on many factors, which are beyond his scope of knowledge. In response to an additional question, he surmised that using current rates and information, the state would not be able to sustain the aforementioned

increase. He opined that the state needs to make the program as sustainable as possible, and the needs to work with the governor and the legislature to make the necessary changes. In regard to the missions and measures for long-term care, he said that these are minimal and do not apply to the challenge faced by Medicaid. Once the necessary changes are decided on, new measures should be decided on, in order to show whether the changes are successful. He said:

> As you're well aware, you see all the inputs that go into all of the systems throughout the state. It's our job to come up with measurable outputs that show that we're meeting with challenges, if you will. And so, right now, it's totally inadequate, at least from my point of view.

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REPRESENTATIVE SEATON offered his understanding that a large percentage of costs utilized in the healthcare system are used within the last two months of life. He inquired as to whether the agency has begun looking for a programmatic way to address this issues. He opined that choices need to be made regarding maintaining quality of life and funding, adding in his opinion, funds should not be taken away from children's health and well-being and put into the last two months of life. However, he said, he does not know of any ideas addressing this issue.

MR. FULLER replied that a proposal is likely to be made to the governor during the next legislative session. On a national level, he said, there is indication that disease management programs can reduce the cost of care. He said:

> We've been flirting ... with proposing a couple different specific disease management scenarios where providing the case management and also working with the provider system about best practices to manage those disease states. Again, at the national level, the term is "return on investment." You spend a buck, what do you save? And that's really soft – that's why we've been reluctant to just go full boar with this. But, I think our judgment is that there's enough information out there that we should at least get started in that direction. Now, that's not going to create huge savings-it may not create any savings for the end of life issues, but it's a small beginning.

MR. FULLER went on to say that the current system needs to be examined for ways to use healthcare dollars wisely. One way would be to adapt technology to meet the needs of long-term care patients. This would include cameras and audio set up in-house, as a way to check in on those individuals. He opined that while this may not meet all the needs, all possibilities need to be considered. Currently, he said, Alaska considers "assisted living" to be anything from a single person in a private home to pioneer homes, which he opined does not make sense going forward. He surmised that the services provided would be different in a small residence compared to a larger facility. If this difference is significant, the reimbursement methodology needs to be reconsidered. He stated that over the next 5 years, the state needs to figure out what would best meet the future needs. He said "I wish I could say that if we do A, B, and C, it's gonna decrease the cost by ... 5 percent a year, but I'm not smart enough to be able to do that."

CHAIR WILSON stated her belief that this is not possible. Even, she said, if the cost per person is decreased, there will not be a drop in the cost, as there would be more people. She surmised, then, that if the growth could be contained, this would be fortunate.

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REPRESENTATIVE SEATON expressed concern that the assisted living models discussed would be "going by the wayside." He stated that several of his constituents who run small homes are being regulated out of business, which places the patients into the larger institutions. He opined that if these smaller homes go out of business, the state will have to "start from scratch" and decide whether to have assisted living homes or change to the larger institutions. He noted that the state does not differentiate between the two.

MR. FULLER replied that this is a good example of why the state needs to carefully consider what is termed "assisted living" and what the requirements are for a pioneer home versus a privately owned assisted living facility. He stated that the next legislative session would provide a good opportunity to deal with these issues and see whether the changes are statutory or regulatory.

CHAIR WILSON pointed out that this same scenario is occurring regarding daycare. She related the story of a constituent who remodeled her kitchen in order to meet the regulatory

requirements; however, when she was finished, she was told that there were additional requirements that needed to be met. She surmised that if a package of information was made available to business owners, this might be avoided. She opined that by adding requirements, the businesses have additional costs, which may result in an inability to remain in business. Additionally, the state does not allow these daycare providers to count children who do not show up, even if it is due to the irresponsibility of the parents.

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COMMISSIONER JACKSON replied that these issues were also noted during the certification and licensing centralization process. She said "If we have instances where things are not working for good providers that need to be operating, then we'd sure appreciate having specifics, so we can look into those and see what we can do to help them. ... It's about being sure we've got appropriate providers being supported in doing what they're doing."

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MR. FULLER returned to his presentation, stating that the department commissioned a long-term care study by Public Consulting Group (PCG). This study contains many recommendations. In addition, Senate Finance commissioned a separate RFP to look at the entire Medicaid program, and is due to the legislature in February. He surmised that this would contained significant recommendations in terms of changes to the long-term care system. He stated that he does not feel more studies are needed, but that the information on hand needs to be discussed.

MR. FULLER went on to discuss the transition. He said that this will take time. The providers will need time to make changes, and reimbursement methods will need to change in order to appropriately reimburse for the new system. Additionally, clients will need time to readjust. He opined that some individuals do not like change, therefore it needs to be done thoughtfully. The role and training needs of caregivers may change, he said, particularly if electronics are used. The state will also need to make changes to adjust. The state, he said, has a responsibility to have significant oversight to ensure that nothing is going wrong. He expressed hope that during the next legislative session, the philosophy of long term care will be discussed. He said:

> What's the states role, here? I mean, there's the Medicaid program that can finance a fairly broad array, but what's the state's philosophy for the Medicaid program? And, I just want to throw out-that you could view our long-term care system as full employment for everyone. Just ignore, completely, that it's taking care of people – of the frail and the elderly – you could view it as a complete employment system for the state. Because you could set it up to employ lots of caregivers. I don't think we want to do that, but we need to have that discussion, I think. And then, the parameters around aging and place. Additional, new supports that the state should provide or wants to provide, to keep someone living with that daughter or daughter-in-law an extra few months. Because, bottom line, those are the primary caregivers in our current system. Nothing to do with the state, just the family stepping up and taking care of those folks.

CHAIR WILSON said "If we had an income tax, we could give them a break on their income tax."

MR. FULLER opined that the state has many ways to support families in order to keep the elderly at home longer, which could be cost-effective if properly put together. He went on to say that this also relates to personal responsibility. In regard to those individuals who move to Alaska later in life and run out of personal insurance, he questioned whether it is the state's responsibility to subsidize this. He pointed out that services provided to Alaska Natives by tribal health corporations are federally funded, adding that there has been discussion with tribal health corporations regarding what might be done in the future to meet the needs of members. This would be funded by general fund savings, and is more "culturally appropriate." He stated that he is looking forward to working with the legislature and the governor to "move this forward," adding that "failing to do [something] is not acceptable."

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REPRESENTATIVE SEATON said that he looks forward to addressing these issues, and agreed that a goal, method, and philosophy are needed. He said "unless we have those, we're just seeing problems and trying to throw a band aid at it, but it doesn't get to the complexity."

1:33:33 PM

COMMISSIONER JACKSON said:

> It's not an easy process, it's easier to talk about other things, healthcare-dealing with access and quality, and costs is not going to get easier as time goes on. And a lot of things we haven't even touched on today, that you know are looming.... But I do think, that if we look at things, as Alaskans, in a new way, we can come up with some solutions that will work here, regardless of what happens with Medicare and Medicaid.

COMMISSIONER JACKSON went on to say that it is important to continue to stay involved, in order to continue the discussions. She urged the members' to become more familiar with the missions and measures, and hold the department accountable when these do not make sense or need to be "tweaked." In addition, she questioned what lens will be used for spending general fund dollars, and said "how do we honor people for giving something up to come together in partnerships, when in fact, it may not be in their individual business' best interest?"

CHAIR WILSON stated that she plans on having joint meetings in the future.

COMMISSIONER JACKSON, in regard to higher risk areas, encouraged the members' to consider getting the communities involved in finding an answer to the problem. She pointed out that one answer may be a pilot program such as the Family Centered Services pilot programs. She went on to say:

> As we work through this process, this committee has taken a leadership role in dealing with healthcare. And the department is trying to do that in small ways, as well, everything from trying to make sure our buildings are smoke-free at the state level ... to working with issues of obesity and diabetes down the road. So, I thank you for that, and I encourage you to continue it, all of you who may be here....

1:36:50 PM

REPRESENTATIVE SEATON asked what it would take for a pilot project that gives out vitamins to a specific region, in order to gather data that would show positive results.

COMMISSIONER JACKSON replied that this is a good idea, and offered to look into this and come back with a response.

CHAIR WILSON commented that this might be a good preventative measure.

REPRESENTATIVE SEATON opined that it is important to look at it and see if it solves broader community problems, in addition to the more specific issues discussed earlier. He noted that there are additional details to consider.

CHAIR WILSON added that there would be different needs for children and adults.

REPRESENTATIVE SEATON opined that purchasing a high quantity [of vitamins] in order to have a pilot project may "have some benefit."

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CHAIR WILSON stated that the next meeting will pull all the issues of the past few months together. The meeting is scheduled to occur on November 8, 2006.

1:47:40 PM

ADJOURNMENT

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at 1:48 p.m.