

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

February 7, 2012

3:06 p.m.

MEMBERS PRESENT

Representative Wes Keller, Chair
Representative Alan Dick, Vice Chair
Representative Bob Herron
Representative Paul Seaton
Representative Bob Miller

MEMBERS ABSENT

Representative Beth Kerttula
Representative Charisse Millett

COMMITTEE CALENDAR

PRESENTATION: ALASKA HEALTH CARE COMMISSION

- HEARD

PRESENTATION: CITIZEN REVIEW PANEL

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

WARD HURLBURT, M.D.
Chief Medical Officer
Director
Division of Public Health
Office of the Commissioner
Department of Health and Social Services
Anchorage, Alaska

POSITION STATEMENT: Presented a PowerPoint, "Alaska's Approach to Increasing Value in Health Care."

DEBORAH ERICKSON, Executive Director
Alaska Health Care Commission
Office of the Commissioner

Department of Health and Social Services
Anchorage, Alaska

POSITION STATEMENT: Answered questions during the PowerPoint presentation.

SUSAN HEUER, Chair
Citizen Review Panel (CRP)
Anchorage, Alaska

POSITION STATEMENT: Presented a PowerPoint, "Alaska's Citizen Review Panel."

PAT HEFLEY
Citizen Review Panel
Juneau, Alaska

POSITION STATEMENT: Answered questions during the CRP PowerPoint presentation.

CHRISTY LAWTON, Director
Central Office
Office of Children's Services
Department of Health and Social Services
Juneau, Alaska

POSITION STATEMENT: Answered questions during the presentation by the Citizen Review Panel.

ACTION NARRATIVE

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CHAIR WES KELLER called the House Health and Social Services Standing Committee meeting to order at 3:06 p.m. Representatives Keller, Dick, Miller, and Herron were present at the call to order. Representative Seaton arrived as the meeting was in progress.

CHAIR KELLER announced that the first order of business would be a presentation by the Alaska Health Care Commission.

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WARD HURLBURT, M.D., Chief Medical Officer, Director, Division of Public Health, Office of the Commissioner, Department of Health and Social Services, introduced himself as the Chair of the Alaska Health Care Commission, and mentioned that Chair Keller was also on the commission. He stated that one important reason for the Alaska Health Care Commission was to better

understand the increasing cost of health care. He presented a PowerPoint, "Alaska's Approach to Increasing Value in Health Care:" and pointed to slide 2, "Presentation Overview." He listed the PowerPoint topics to include the background, the process and strategy, the findings to date, the recommendations and the next steps to take.

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DR. HURLBURT, directing attention to slide 3, "Commission Background," stated that the purpose of the commission was "to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility and availability of health care for all citizens of the state." He pointed out that the commission was advisory, established in 2009 with 14 members appointed by the Governor, and represented the needs of all Alaska.

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DR. HURLBURT moved on to slide 4, "International Comparison of Spending on Health, 1980 - 2009," pointing to the graph on the left, which depicted the average per capita spending on health care. He affirmed that the U.S. had the highest average per capita spending and the highest spending on health as a percent of the national Gross Domestic Product (GDP) of any of the industrialized countries. He pointed out that U.S. spending was 50 - 100 percent more than any of the other countries. He surmised that, as the average life expectancy for an American was lower and the infant mortality rate was higher than almost all the other industrialized countries, the U.S. health care expenses did not guarantee a better product. He noted that almost 18 percent of the current U.S. gross domestic product was spent on health care, and the Center for Medicare and Medicaid Services was predicting this to reach 21 percent by the end of the decade. He recognized the dilemma of where to fund.

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DR. HURLBURT furnished slide 5, "Cost of Health Care in Alaska," which projected the Institute of Social and Economic Research (ISER) analysis for the cost of health care in Alaska. He declared that costs will double in the next ten years, and the cost of health care in Alaska will equal the value of the extracted oil.

CHAIR KELLER declared his concern that current health care costs were half of the cumulative wages of all Alaskans.

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DR. HURLBURT expressed his concerns that this business was too important not to be dealt with, and that, as these costs increased, they would need to be addressed by the medical community or there would be "a slash and burn" response because the costs would become unsustainable. He opined that this was a mission of the Alaska Health Care Commission.

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DR. HURLBURT moved on to slide 6, "Affordability - Cost vs. Inflation, Earnings," which viewed national workers' earnings and costs from 1999 to the present. He reported that, during this time period, inflation had increased 38 percent, worker earnings had increased 50 percent, health insurance premiums had increased 160 percent, and workers contribution to health care premiums had increased 168 percent.

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DR. HURLBURT provided slide 7, "Affordability - U.S. Families," which stated that, although the median family income had increased by \$23,000 between 1999 and 2009, the out of pocket costs for health care had increased by the same amount.

DR. HURLBURT addressed slide 8, "Affordability - Alaskan Families," which reflected cost increases from 1982 to 2010. He assessed that housing had increased about 76 percent, overall costs had increased 96 percent, energy had increased, specifically in the last six years, by 280 percent, and medical care had increased by almost 420 percent.

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DR. HURLBURT presented slide 9, "Affordability - Alaskan Employers," and stated that Alaskan employers, especially small employers, were offering fewer health benefits. He observed that commercial insurance premiums in Alaska were the highest in the United States, 30 percent higher than comparable states, with an average cost of almost \$12,000 per employee. Employee cost for family coverage had increased from 17 percent to 22 percent from 2003 to 2010. He reported that although Premera [Blue Cross] had 60 percent of the health care business in

Alaska, its profit margin had been less than 1 percent over the last ten years.

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REPRESENTATIVE MILLER asked for clarification to the profit that Premera [Blue Cross] showed.

DR. HURLBURT offered his belief that the profit was reflected after paying all expenses, including shareholders.

REPRESENTATIVE MILLER asked what costs were the drivers for these increases.

DR. HURLBURT replied that he would address that.

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DR. HURLBURT summarizing slide 10, "Value in Alaska's Health System," stated that Alaska had about 14 percent uninsured, and that its per capita health care expenditures were second only to Massachusetts, and its health care reform program. However, for all this expenditure, Alaska only ranked 38th for health care quality, and was only the 35th healthiest state.

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DR. HURLBURT indicated slide 11, "What System?" and asked how to redesign the system to deliver the best possible health care at the lowest possible cost. He clarified that this did not include rationing or denying care, but that full value for the expenditure was necessary. He declared that the goal was to prudently and responsibly provide the best health care in the world for Alaskans.

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DR. HURLBURT quoted slide 12, "The Conundrum," "If we don't cut costs, we'll have to cut care."

DEBORAH ERICKSON, Executive Director, Alaska Health Care Commission, Office of the Commissioner, Department of Health and Social Services, referring to slide 13, "The Answer," stated that the question seeking an answer was "How can we make health care less expensive by making it better." She directed attention to slide 14, "5 - Year Strategic Planning Process," which detailed that process for the Commission: develop a

vision for the ideal Alaska health care system, diagnose the problems for achievement of the vision, and identify strategies for movement toward the vision. She described this vision, slide 15, "The Future," as a focus beyond delivery of health care services, to create a healthy Alaska population. She declared an important component of the vision was for it to be sustainable for the long term, with high value, safe, affordable, and accessible care. She declared the necessity for both patients and providers to be satisfied with the system.

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MS. ERICKSON referred to slide 16, "Health Care Transformation Strategy," which defined the building blocks for a strong health care system in Alaska. These included building a foundation of leadership and health information technology, while designing policies to support healthy life styles with innovations in the delivery of patient centered health care. She reviewed slide 17 and slide 18, "Diagnosing the Problem," and listed the discussion of current challenges to include the fragmentation and duplication in the system, and the unique logistical challenges for health care delivery in Alaska. She relayed that the focus for the past year had been on the cost of health care. She referenced the ISER study for total health care spending now and in the future, which identified the payers and in what service categories the funds were spent. She spoke about the Milliman, Inc. study which focused on health care pricing in Alaska. She noted that, of the \$7.5 billion spent in 2010 for health care, about 60 percent was for hospital and physician services, as detailed on slide 19, "What do Alaska's Health Care Dollars Buy?"

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MS. ERICKSON, indicating slide 20, "Premiums" and slide 21, "Cost Drivers: Utilization," noted that health insurance premiums, compared to the national average, were about 30 percent higher per member in Alaska, even though Alaska had 29 percent fewer hospital admissions and 23 percent fewer inpatient bed days, with 21 percent more outpatient visits.

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REPRESENTATIVE SEATON, indicating slide 21, asked if the fewer admissions and inpatient bed days were an inverse cost driver for the 30 percent higher health insurance premiums in Alaska.

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DR. HURLBURT, in response to Representative Seaton, said that this information was not age adjusted. He reported that although Alaska had the fastest growing senior population by percentage, there was still half the percentage of seniors as in most other states. He pointed out that hospital visits increase after the age of 65. Directing attention to slide 22, "Utilization - Milliman's Conclusion," he opined that Alaska's utilization did not appear to be driving the high premiums.

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DR. HURLBURT, in response to Representative Seaton, clarified that the rate of increase to seniors over 65 in Alaska was higher than any other state, but the relative percent to the absolute population of Alaska was still much lower.

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REPRESENTATIVE DICK gave an example of personal health costs which he questioned.

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DR. HURLBURT moved on to slide 23, "Alaska prices* are significantly higher than comparison states," and explained that physician services were 69 percent higher for commercial payers and 60 percent higher for all other payers, including Workers' Compensation, Medicaid, Medicare, and Veterans Health Care. He pointed out that this varied by specialty, noting that pediatrics were 43 percent higher and cardiology was 83 percent higher in Alaska. He reported that the hospital rates in Alaska were 37 percent higher for commercial payers and 36 percent higher for Medicare than in the comparison states. He declared that there were very wide price disparities to each payer.

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DR. HURLBURT moved on to slides 24 - 25, "Sample comparisons: Mean commercial allowed charges non-facility based professional svcs," which compared procedural charges in Alaska to five other states. He stated that Alaska charges were often twice those of other states. Directing attention to slides 26 - 27, "Sample Comparisons: within Alaska, by payer," he pointed out that although the Medicare rates were the lowest, the Workers' Compensation rates were the highest.

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DR. HURLBURT assessed slide 28, "Cost (Price) Drivers- Operating Costs" and stated that medical salaries in Alaska were 2 - 10 percent higher in Alaska; the cost of living in Alaska was 15 - 20 percent higher; and that hospital operating costs were 38 percent higher than comparable states. He pointed out that these higher hospital operating costs included the rural hospital operating costs which were 86 percent higher on average.

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REPRESENTATIVE DICK asked if this included the Alaska Native medical centers.

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DR. HURLBURT, in response to Representative Dick, said that the salary and wage statistics reflected the marketplace, but that the comparisons for operating costs and profit margins excluded tribal and federal hospitals.

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DR. HURLBURT discussed slide 29, "Cost (Price) Drivers - Provider Discounts" which depicted the discount percentage to bill charges that payers negotiated with providers. He stated that, as bill charges were not fixed, the health payers did not want to contract for billed charges; instead, payers negotiated a case rate and a per diem rate. He offered that the only reason for a payer to contract for billed charges was due to a lack of competition and a need to have the provider. He reported that this precluded the provider from balance billing the difference to the patient.

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DR. HURLBURT introduced slide 30, "Private Hospital Sector Average Operating Margins," which compared the operating margins of comparison states and the nationwide average with those margins in both urban and rural Alaska. He concluded that Alaska's operating margins were more than twice as high as the comparison states, and even higher when just comparing the urban hospitals with those of other states. He analyzed slide 31, "Milliman's Cost (Price) Driver Conclusions," clarifying that

these conclusions were just reflecting private hospitals. He reported that the operating costs were driving higher prices in rural Alaska, but that the operating margins were driving the higher prices in urban Alaska hospitals. Pointing to physician services, he stated that the high prices were driven by lack of competition and by Alaska statute, which locked payers to pay at least 80 percent of the billed charges. He shared that the low Medicare rates also created upward pricing to other payers.

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REPRESENTATIVE SEATON, referring to the aforementioned Alaska statute, asked for further definition to the 80 percent required payment. He asked if the Department of Health and Social Services (DHSS) supported this.

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DR. HURLBURT opined that DHSS had not taken a position, but that the Alaska Health Care Commission had determined this to be a driver for higher health care costs.

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REPRESENTATIVE SEATON asked if there was a purpose for the 80 percent reimbursement.

DR. HURLBURT postulated that historically the legislature was concerned about enough health care for Alaskans, so incentives were created to attract the medical community. He noted that this had included legislation to limit malpractice rates in Alaska.

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REPRESENTATIVE SEATON asked if the Certificate of Need program compounded the problem of inadequate competition.

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DR. HURLBURT specified that the aforementioned legislation applied only to physician charges, not hospital charges. He reported that the cost disparity for hospital charges was not as wide as for individual provider charges. He pointed out that, as the Certificate of Need applied to institutions, it should have no effect.

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DR. HURLBURT provided slide 33, "5% of the U.S. population required 50% of health care spending in 2009," and reported that "5 percent of the population consume about 50 percent of the health care dollars," whereas, "50 percent of the population consumes about 3 percent of the health care dollars." He observed that, narrowing this down, about 1 percent of the population consumed 25 - 30 percent of the health care dollars. He declared that it was necessary to keep this in mind when planning to control costs.

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REPRESENTATIVE HERRON, referring to slide 33, asked about recommendations for change.

DR. HURLBURT replied that, philosophically, it was not worth the time to intervene with the 50 percent healthy population. He reflected on a prior management role he had, and cited that targeting some groups to reduce their needs for hospital visits could result in significant savings.

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DR. HURLBURT, in response to Representative Herron, suggested that improving the health of the 5 percent would decrease the health expenditure, as shown on slide 33.

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DR. HURLBURT, in response to Representative Herron, agreed that it could either lower the actual cost or the percentage of health care cost to GDP.

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DR. HURLBURT moved on to slide 34, "Focus on Health & Value," and suggested to focus on prevention for the healthy population in order to keep them healthy. He opined that this generation of kids may be the first that does not live as long as its parents. For the mild to moderate illnesses and conditions, he suggested high quality, evidence-based, efficient, effective care to prevent conditions from worsening. With the most complex conditions, the cost increased, and it becomes necessary to provide care coordination and management.

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DR. HURLBURT presented slide 35, "Ensure the best available evidence is used for making decisions," stating that evidence based medicine was a difficult concept for both the public and medical professionals. He touted the use of evidence to make coverage and clinical decisions. He opined that a randomized, blind study offered the highest grade of evidence, while consensus conference, or expert opinion, elicited the lowest grade of evidence. He opined that 30 to 40 percent of health care was not supported by evidence, and he offered a number of examples.

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DR. HURLBURT directed attention to slide 36, "The need for application of high grade evidence," and offered as an example Vioxx, a drug which was used without the high grade evidence.

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MS. ERICKSON presented slide 39, "Enhance quality and efficiency of care on the front end," and slide 40, "Commission Recommendations." She mentioned both patient centered primary care and patient centered medical homes as ways which offered relationships and good access with primary care providers to better manage early conditions. She said the commission researched state initiatives regarding successful models for patient centered primary care, and then convened a panel to review the challenges and opportunities these created for Alaska. She noted that the successful programs had strong medical leadership and management, a lot of flexibility for individual participating physician practices, and a focus on improving care for the complex case management of patients with multiple chronic conditions. She emphasized that the initiatives were grounded in the idea to make the patient care better. She pointed to the attributes for success which included upfront investment by the payer, shared learning environments, and timely access to patient data.

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MS. ERICKSON continued on to slide 41, "Commission Recommendations, Trauma Systems," and announced support for the continued implementation of the recommendations by the 2008 American College of Surgeons.

MS. ERICKSON, noting slide 43, "Commission Recommendations, Preliminary Steps Toward Transparency," said that for price and quality transparency it was necessary to have full participation in the Hospital Discharge Database, and to study the feasibility of an All-Payers Claims Database.

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CHAIR KELLER opined that although other states had already passed this legislation, the complexity of medical billing made it very difficult for the consumer. He identified this as possible legislation for the House Health and Social Services Standing Committee to address.

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REPRESENTATIVE SEATON asked about the feasibility of an index for the patient to find the cost and quality information.

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MS. ERICKSON replied that the consumer was one step removed from price concern when there was insurance coverage. Referring to slide 46, "All-Payer Claims Databases (APCDs)," she declared that some state models for APCDs required state legislation mandating that the payer data be available to consumers, which could incentivize the consumer to shop before medical decision. She relayed that the commission would work with a consultant on a feasibility and needs assessment study. She opined that this could be a more simple approach for transparency than for each provider to supply prices.

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REPRESENTATIVE SEATON asked about a mechanism for decision making about hospitals.

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DR. HURLBURT replied that the quality rating systems would be adjusted to account for the types of service.

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REPRESENTATIVE DICK asked if the cost of non-paying patients affected the cost of health service.

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DR. HURLBURT replied that the hospital profit margins were determined after all expenses, including the non-pay patients. He pointed out that profit margins were much lower in rural areas.

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REPRESENTATIVE DICK asked to clarify the percentage of cost to the system from non-paying patients.

DR. HURLBURT replied that he would research this.

CHAIR KELLER expressed his belief in the free market. He offered his belief that health care shopping now included more out of state spending.

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MS. ERICKSON moved on to slide 52, "'Continuum' of Payment Reform," and declared that most medical care was fee for service. She said that the commission was reviewing reform for the payment of services to better drive value and not just delivery of individual services. She directed attention to slide 53, "Payment Reform System Requirements," which listed various requirements necessary to payment reform. She stated that both payers and providers needed data and actuarial expertise if providers were going to assume more financial risk for providing service. She indicated that payment for outcome and value required a partnership between patients, providers, and payers, to keep the healthy population healthy, and to better manage the sick patients. She spoke of the movement to better integrate services, as it was necessary to better align payment policies.

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MS. ERICKSON reviewed slide 58, "Health Workforce," and referred to recommendations from an earlier report to build a sustainable work force and information infrastructure.

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MS. ERICKSON mentioned that obesity was the most significant public health challenge, immunization programs needed adequate

funding, and behavioral health needed to be integrated with primary care services, slides 61 - 63.

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MS. ERICKSON mentioned that the commission would review challenges that the provider community had identified as hampering innovation and driving increased costs, plans that the business community had to improve employee health plans, patient choices for end of life care decisions, and barriers to the use of telemedicine, slide 65, "Commission's 2012 Agenda."

MS. ERICKSON mentioned that the appendix of the Commission's 2011 Annual Report included an update on implementation of provisions in the Affordable Care Act.

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MS. ERICKSON, in response to Chair Keller, said that the Request for Proposal (RFP) for a health plan consultant by the Department of Administration (DOA) said that Commissioner Hultberg (DOA) and Commissioner Streur (Department of Health and Social Services) would work together on joint strategies, to redesign the employee health benefit plan and develop an employee wellness and health management program. She offered her belief that this would address opportunities for an alignment of strategies for Medicaid, Workers' Compensation, and other state health care programs.

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The committee took a brief at-ease.

Presentation: Citizen Review Panel

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CHAIR KELLER announced that the final order of business would be a presentation by the Alaska's Citizen Review Panel.

SUSAN HEUER, Chair, Citizen Review Panel (CRP), presenting a PowerPoint, "Alaska's Citizen Review Panel," stated that the mission was to provide oversight to the Office of Children's Services (OCS) and gather public input on how well child protection was being delivered statewide. She listed the places CRP had recently visited including Bethel, Wasilla, and

Fairbanks. She noted that, nationally, this was the only CRP funded by a state legislature.

MS. HEUER, directed attention to slide 7, "Benefits of CRP," and explained that the eight volunteer members annually contributed 250 hours of active service, and had the unique function of identifying and advocating for ancillary services and improvements that OCS could not request.

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MS. HEUER shared slide 8, "Issues CRP is monitoring," and said that CRP was focusing to resolve the struggles of the Wasilla OCS office, and to find solutions for the Bethel OCS office to ensure it was fully staffed and fully functional.

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CHAIR KELLER commented that the Department of Health and Social Services and OCS had been very responsive to the issues in Wasilla.

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REPRESENTATIVE HERRON reported that the Bethel OCS staff had challenges for discussion, and anticipated a visit from the Citizen Review Panel.

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MS. HEUER, directing attention back to slide 8, explained that the third issue to monitor was in-home safety, an OCS strategy to determine the safety of children remaining in the family home after a report of crime. She reported that CRP was working with OCS to acquire data to monitor the safety of the children in this situation.

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MS. HEUER, referring to slide 9, "2012 CRP Recommendations to OCS," presented input from statewide communities for OCS. The first recommendation was for OCS to use the data they collect as a management tool. She acknowledged that the often previously maligned ORCA system now appeared to be improved and was a good tool. She suggested that the ORCA data could offer reasons for the high turnover rate in the Wasilla office.

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REPRESENTATIVE SEATON asked if exit interviews would better address the reasons for low staff retention.

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MS. HEUER replied that there were no requests to improve ORCA. She clarified that staff turnover was merely an example of a use for the ORCA data.

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PAT HEFLEY, Citizen Review Panel, confirmed that there had been issues with the ORCA database, and that it could be better used as a management tool. He acknowledged a challenge to address the key workforce issues, such as training needs, salaries, or retention.

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REPRESENTATIVE SEATON asked if a requirement for an exit interview could be included in staff contracts.

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MR. HEFLEY replied that the use and understanding of why people leave was an issue throughout the state. He opined that an exit interview could only be required through the union contract.

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MS. HEUER encouraged the statewide use of data as a management tool. She moved on to slide 10, "2012 CRP Recommendations to OCS," and stated that protective service reports, or reports of harm, should ensure the safety of a child if they remain in a family home. She declared the difficulty to obtain information regarding a child's safety after a report of harm has been screened in to an "in-home" situation. She declared that it was difficult to establish when OCS staff initiated work with a family in an "in-home" situation, when the referral for services for the family was made, who was monitoring the child's safety, and what happened at the end of the six month "in-home" period. She suggested that this data could demonstrate the timeliness and effectiveness of referral and services to families and children. She declared it to be in a child's best interest if

family services could be received while a child remained in the home.

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MR. HEFLEY confirmed that OCS was trying to do a balancing act between keeping children safely at home and having them taken out of homes.

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MS. HEUER reviewed slide 11, "2012 CRP Recommendations to OCS," and recommended that OCS address the licensing for those foster homes where substantiated reports of problems were filed.

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MS. HEUER concluded with slide 12, "CRP Recommendations to the Legislature," which listed housing for OCS rural workers as a critical issue for staff retention. She offered some examples for solutions. She declared a need for more support staff to social workers, pending the results of the upcoming workload study. She pointed out that the Palmer court had struggled with the load from Wasilla OCS cases, and that there was also a need for an additional Office of Public Advocacy (OPA) Child In Need of Aid (CINA) attorney in the Palmer office.

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CHRISTY LAWTON, Director, Central Office, Office of Children's Services, Department of Health and Social Services, in response to the discussion of exit surveys, stated that OCS did request this from employees, but that it was not required. She acknowledged that this data was collected, and she reported that an additional staff survey was conducted annually to ascertain factors behind decisions to stay or leave the agency. She acknowledged that some reasons for departure included a lack of clerical support, as well as not having the time for one on one work with family members.

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MS. LAWTON respectfully disagreed with the allegation that OCS was not using the data they had collected. She declared that the ORCA capacity had increased, which allowed for collection of raw data, annual site reviews at each field office, and a

statewide analysis of workloads and available resources for guidance in scheduling.

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CHAIR KELLER asked that Ms. Lawton return to the next committee meeting, February 9, to finish the discussion.

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REPRESENTATIVE HERRON asked that Ms. Lawton, at her next presentation, address the culture within OCS.

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ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:07 p.m.