HB
396

'IOUSE COMMITTEE REPO

(7)
Date Referred to Committee: January 25, 2006 FURTHER REFERRALS: Finance

Date of Committee Action: Apr.l 27, 2006

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 396

HOUSE BILL NO. 396 ALASKA COMMISSION ON HEALTH CARE

"An Act establishing the Alaska Commission on Health Care; and providing for an effective date."

Recommends it be replaced with [ ] HCS *or* [ ] CS for ______ (______)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR______ [ ] Same Title [ ] New Title

[ ] attach amendments
[ ] add new referral to __________ Committee
[ ] Letter of Intent__________Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LEG
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW FISCAL NOTES *Assigned by Chief Clerk's Office

List by Dept(s):	*FN#	Fiscal	Indet.	Zero
HSS		X		
ADM				X

PREVIOUS FISCAL NOTES

List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
[signature]	CISSNA	✓			
Berta Gardner	Gardner	X			
[signature] Kohring	Kohring			✓	
Chair: Peggy Wilson	WILSON			✓	✓
Chair:					

Alaska State Legislature

Representative Ethan Berkowitz

Sponsor Statement
House Bill 396
"Establishing the Alaska Commission on Health Care"

Alaskans are looking for quality, affordable health care. When you get sick or hurt, you shouldn't have to choose between going to the doctor and going broke. In Alaska and nationwide, escalating medical costs pose a serious threat to businesses, government budgets and family health.

HB 396 creates the Alaska Commission on Health Care to bring interest groups together in an effort to produce quality, affordable health care.

A panel composed of representatives from a broad range of health care related interests will select the commission. The commission will develop strategies and recommendations to improve public health and health care and reduce health care costs for Alaska businesses and citizens. It will address:

- an affordable, effective and quality health care system for Alaska;
- access to affordable health insurance;
- issues of wellness and individual responsibility for personal health;
- disease prevention and management;
- workforce shortages among health care providers;
- health care providers shifting costs among patient groups to make up for insufficient reimbursements and the costs of the uninsured;
- improving public health;
- the public availability of health care cost information;
- the development of a statewide health information technology network; and
- the establishment of a state health care court system.

We can find health care solutions that will improve the quality and reduce the cost of care. We just have to do the work to start developing and implementing them now.

For additional information, see:

Health Care Solutions: http://nchc.org/
Information Technology: http://www.os.dhhs.gov/healthit/
http://www.state.de.us/dhcc/information/dhin.shtml
Health Courts: http://cgcod.org/brochure-hcare.html

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB3__-DHSS-FMS-04-21-06
( ) Publish Date:

Revision Date/Time (Note if correction):

Dept. Affected: Health & Social Services

Title: ESTABLISHING THE ALASKA COMMISSION ON HEALTH CARE

RDU: Departmental Support Services

Component: Health Planning & Infrastucture

Sponsor: BERKOWITZ

Requester: HOUSE (HES)

Component No. 2765

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	235.6	242.0	249.3	256.8	264.5	272.4
Travel	84.7	42.1	42.1	42.1	42.1	42.1
Contractual	86.2	86.2	86.2	86.2	86.2	86.2
Supplies	15.0	15.0	15.0	15.0	15.0	15.0
Equipment	20.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**441.5**	**385.3**	**392.6**	**400.1**	**407.8**	**415.7**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts						
1003 GF Match						
1004 GF	441.5	385.3	392.6	400.1	407.8	415.7
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	**441.5**	**385.3**	**392.6**	**400.1**	**407.8**	**415.7**

Estimate of any current year (FY2006) cost:

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Full-time	3	3	3	3	3	3
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

House Bill 396 would create, in the Governor's Office, the Alaska Commission on Health Care. The commission would meet at least quarterly to develop strategies and recommendations to improve public health and health care, and to reduce health care costs for Alaska residents and businesses. The commission would conduct statewide outreach to assess health care needs and solicit ideas for improving care and reducing costs. The charge in the bill is broad, even requiring the commission to explore the efficacy of establishing health courts in Alaska and to research and design a statewide health information network to benefit all Alaskans.

To carry out its many duties, the commission would need professional staff which is assumed to be housed in the Department of Health and Social Services: an Executive Director (Range 22 - $96,300 for salary and benefits; an H&SS Planner II (Range 19 - $82,700) and an Administrative Assistant (Range 13 - $56,600). (cont. on Page 2)

Prepared by: Richard Mandsager, M.D. Phone 465-3092
Division: Public Health Date/Time 02/10/2006

Approved by: Karleen Jackson, Commissioner Date 04/21/2006
Agency: Department of Health and Social Services

STATE OF ALASKA
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

That totals $235.6 in the Personal Services line for FY07. In subsequent years, the Personal Services line is increased by 3 percent annually.

Other costs for HB 396:

Travel: $84.7 ($42.1: 13 commissioners and 2 staff to four quarterly meetings: $600 airfare + $42 per diem + $26 car rental + $20 parking/incidentals = 60 trips at $688 per trip). It is assumed commission staff will be based in Juneau, and that the quarterly meetings will be held in different regions of Alaska. It is also assumed the Special Committee on Health Courts would hold two face-to-face meetings in FY07 ($19.2.: 12 members + 2 staff = 28 trips at $688 each), as would the Special Committee on Health Information Technology ($23.4: 15 members + 2 staff = 34 trips at $688 each). Because the special committees sunset after one year, their travel costs are not included for FY08 and beyond.

Contractual. $86.2 - Statewide surveys and assessments of health care needs ($10.0); other contracts entered into by state agencies as requested by commission ($10.0); preparation and distribution of annual reports ($15.0); professional services contract(s) on development of health information network ($25.0); teleconferences among staff, commissioners, special committees ($5.1: estimated 51 teleconferences at $100 per call); lease costs / rent for 3 full-time staffers ($19.1); facility costs for 4 regional meetings ($2.0).

Supplies: $15.0 for basic needs of 3 full-time staff and commission and special committee members.

Equipment: $20.0 for start-up costs in FY07 for 3 full-time staff (computers, furntiture, phones, etc.)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB396-DOA-CO-04-24-06
() Publish Date:

Revision Date/Time (Note if correction): 4/21/06 9:09 a.m.
Title: An act establishing the Alaska Commission on Health Care:...
Sponsor: Representative Berkowitz
Requester: (H) HES

Dept. Affected: Administration
RDU: Centralized Administrative Services
Component: Commissioner's Office
Component No. 45

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

HB 396 would create, in the Governor's Office, the Alaska Commission on Health Care. The commission would meet at least quarterly to develop strategies and recommendations to improve public health and health care, and to reduce health care costs for Alaska residents and businesses. The commission would conduct statewide outreach to assess health care needs and solicit ideas for improving care and reducing costs. Travel and other related costs associated with the Commission will be requested through the Department of Health & Social Services; therefore, a zero note is being submitted.

Prepared by: Gary Zepp, Budget Analyst — Phone 465-5654
Division: Administrative Services — Date/Time 4/21/06 9:09 a.m.
Approved by: Michael Tibbles, Deputy Commissioner — Date 4/24/2006
Agency: Administration

(Revised 9/7/2005 OMB)

STATE OF ALASKA
Department of Health & Social Services
OFFICE OF THE COMMISSIONER

FRANK H. MURKOWSKI, GOVERNOR
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MEMORANDUM

TO: The Honorable Peggy Wilson
Alaska House of Representatives
State Capitol, Room 108

THRU: Karleen Jackson
Commissioner
Department of Health and Social Services

FROM: Richard Mandsager, M.D.
Director, Division of Public Health
Department of Health and Social Services

DATE: February 21, 2006

SUBJECT: HB396 – Alaska Commission on Health Care

You have asked for a quick review of projects, initiatives and special emphasis underway in Alaska to address the issues of improving public health and health care and reducing health care costs. As you are aware, much of the work on these broad topics occurs outside the purview of the Division of Public Health (DPH).

Here is a very general list of work being undertaken in Alaska that involves staff from the Department of Health and Social Services (DHSS). This is by no means intended to be a comprehensive analysis but instead a broad-brush outline.

This listing of ongoing work involving the Department is organized according to the issues identified in Sec. 44.19.277 of HB396, which describes the fundamental powers and duties of the proposed commission:

1) Establishment of an affordable, effective, and quality healthcare system

- Revision of Certificate of Need regulations, standards and methodology to assure that new facilities and services are built only in response to need.
- Obtaining federal funds for support of the primary care and rural health systems to:

- Provide data support for Community Health Center and other safety net provider applications, and improve data availability through diverse means;
    - Complete health professional shortage area designations;
    - Coordinate recruitment efforts (National Health Service Corps, J-1 visa program, 3R-Net, SEARCH);
    - Conduct workforce studies; and
    - Support quality improvement and network development in the health care system (rural hospitals, primary care providers, integrated services for primary care and behavioral health, emergency medical services).
- DHSS Commissioner has co-chaired the Alaska Telehealth Advisory Council and Department staff work to support telemedicine development to reduce costs and improve quality of care.
- Establishment of a Regional Health Information Organization/Health Information Exchange workgroup.
- Work with Denali Commission to ensure funding for improvements in the health care infrastructure.
- Through the Denali Commission, coordinate regional planning efforts in the Mat-Su, on Prince of Wales Island and the Copper River region.
- Assist small rural hospitals to evaluate the possibility of converting to Critical Access Hospital classification.
- Foster the development through grant funding of the Alaska Hospital and Nursing Home Association in the establishment and development of the Alaska Small Hospital Improvement Program in meeting member hospitals' PPS, HIPAA and QI collective needs.
- Support the Alaska Hospital Performance Improvement Project, focusing on three small hospitals to identify potential improvements in reimbursement and patient care.
- Much work is underway in the Division of Behavioral Health in the area of integrating substance abuse and mental health treatment. This applies not just to adults, but also to children (DHSS' Bring the Kids Home initiative).
- Participation as a member of the All-Alaska Pediatric Partnership with the goal of improving and further developing the delivery of medical services to children.

2) Access to affordable health care

- Creation of Denali KidCare.
- Expansion of the federal Section 330 Community Health Center program in Alaska.
- Evaluating progress toward Healthy Alaskans 2010 goal to cover the uninsured through household and employer surveys, identifying who is

uninsured and why, and inter-departmental work on insurance issues and options for improving access to affordable insu ce and care. (Health Planning and Systems Development work is now underway with HRSA funds to expand these efforts, to display and explain the nature of the problem, and the direct and indirect costs of people being uninsured.)

- Telemedicine support and coordination that provides for greater degree of on-site care provision with less travel costs and less use of antibiotics.
- Telehealth expansion plans that will result in availability of clinical telehealth services in Community Health Centers.
- TeleBehavioral Health Program.
- Worked with the Anchorage Access to Healthcare Coalition to develop Anchorage Project Access, which is a volunteer provider network to increase access to individuals who cannot afford care and do not qualify for any assistance programs.

3) Individual responsibility for personal health and wellness; and

4) Disease prevention and management

The Section of Chronic Disease Prevention and Health Promotion in DPH includes several programs *(Cancer Prevention and Control Program, Diabetes Prevention and Control Program, Arthritis Program, Hearth Disease and Stroke Program, Obesity Prevention and Control Program, Tobacco Prevention and Control Program, School Health Program and the Health Promotion Program)* that are currently addressing the issue of disease prevention and management as well as the promotion of health and wellness. An overarching goal of all of the Section's programs is that they focus their efforts on creating and establishing policy and environmental changes that enable individuals to make healthy lifestyle choices. Additionally many of the programs are working with communities, businesses, healthcare providers and other partners to support and sustain these efforts. Evidence based public health practices support this approach, which will enable long term and sustainable changes in societal norms and health behavior that will ultimately result in improved health outcomes.

Here are some examples of program activities:

- Worksite Wellness Project - This is a collaborative project between all of our chronic disease programs and Aetna to implement a pilot project with four small businesses to determine a set of best practices for developing worksite wellness programs in Alaska.

- Chronic Disease Self Management - This is a collaborative project with all of our chronic disease programs that provides training to health care

providers statewide to teach them how to work more closely with patients to address their patients ability to manage their chronic disease(s).

- Obesity and School Health programs are working with schools and communities to address the surging epidemic of childhood obesity.

5) Workforce shortages among health care providers

- Work with the Alaska Workforce Investment Board and conduct workforce studies.
- Partnership between the University of Alaska and the health care industry to expand the number of nurses graduating from UAA.
- In cooperation with the university, establishment of the Alaska Physician Supply Task Force.
- Maintaining current Health Professional Shortage Area applications for health, mental health and dental designations throughout Alaska.
- Coordinate recruitment efforts that focus on opportunities for loan repayment, scholarships and student/resident rotations (National Health Service Corps, J-1 visa program, 3R-Net, SEARCH student rotations).
- Coordinate and lead Comprehensive Integrated Mental Health Program Plan to help improve access to care for Alaskans with behavioral health needs and developmental disabilities.

6) Cost shifting by health care providers caused by insufficient reimbursement or lack of insurance

- Collaboration amongst the Medicaid program and the tribally administered programs so that cost efficiencies are maximized.
- Integrating tribal and community supported health care providers to maximize local dollars minimize redundant/competing systems. The "Tribal Program" in DHSS is an effort to provide state government responsiveness and assistance to solve problems, build and maintain capacity to assure access, and encourage efficiency.
- Establishment of State Planning Grant to document issues related to the uninsured and underinsured residents in Alaska.
- Distribution of Disproportionate Share Hospital funding allocations.

7) Need for courts with specialized jurisdiction to consider health issues

- Nothing is underway in Alaska that we are aware of; however, this is actually a question for the Department of Law and Alaska Court System.

8) Improvements in public health

- The passage of a comprehensive new public health law to better protect the public while strengthening due process rights. The new statutes (incorporated by HB95, passed by the 2005 Legislature) are critically important to public health practice because they provide the framework within which governmental public health agencies operate, as well as the legal authorities required to monitor health status in communities, identify health threats, and to control the spread of disease.
- A newly consolidated certification and licensing function in state government that better protects the public safety by coordinating background check functions, on-site reviews and other requirements to make hospitals, nursing facilities and assisted living homes as safe as possible.
- Pending construction of a modern virology laboratory in Fairbanks to replace an outdated, overcrowded facility. The safe and efficient operation of the virology lab is vital to the detection, treatment and control of highly infectious and serious diseases in Alaska.
- Creation of statewide plan to prepare for the possibility of pandemic flu in Alaska. The plan describes a coordinated strategy to prepare for and respond to an influenza pandemic in five key areas: surveillance and investigation; health care systems; community disease control; vaccines and antiviral medications; and communications.

9) Public availability of health care cost information

- The Department publicly reports the annual cost of Medicaid services in Alaska and regularly cites estimates from the federal government of costs associated with various health problems (i.e., according to CDC, Alaska's annual medical costs for tobacco use are approximately $132 million).
- As for public information about costs and comparisons for specific types of medical care or procedures, nothing substantive is underway in Alaska that we are aware of.

Cc: Sherry Hill
Special Assistant
Office of the Commissioner
Department of Health and Social Services

Patricia A. Carr, MPH
Health Planning and Systems Development
Alaska Office of Rural Health
Office of the Commissioner
Department of Health and Social Services

WHAT IS THE DELAWAR HEALTH CARE COMMISSION?

The Delaware General Assembly created the Delaware Health Care Commission n June of 1990 to develop a pathway to basic, affordable health care for all ...wareans.

The Delaware Health Care Commission embodies the public/private efforts which have traditionally spelled success for problem solving in Delaware. Four government officials - the Secretary of Finance, Secretary of Health & Social Services, Secretary of Children, Youth & Their Families and the Insurance Commissioner - are joined by six private citizens appointed either by the Governor, the Speaker of the House or the President Pro Tempore of the Senate. The composition is a balance between the executive and legislative branches of government and the public and private sectors.

By creating the Commission as a policy-setting body the General Assembly gave it a unique position in state government. It is intended to allow creative thinking outside the usual confines of conducting day-to-day state business. The Commission is expressly authorized to conduct pilot projects to test methods for catalyzing private-sector activities that will help the state meet its health care needs. To achieve its goals, the Commission strives to balance various viewpoints and perspectives.

The Commission generally has followed a strategy built on the notion that initial efforts should target areas most in need and gradually build toward a more comprehensive plan. Since 1995, the Commission has used a committee system as a means of reaching out to the community and involving those impacted by its decisions in the consensus building process.

In 1996, the Commission assumed administrative responsibility for the Delaware Institute of Medical Education and Research, which serves as an advisory board to the Commission. Placing the administration of DIMER within the Commission enhanced its ability to accomplish its primary goal of providing Delaware residents greater opportunity for a medical education, while also expanding its mission to help the state meet its broader health care needs.

In 1997, the Commission assumed responsibility for the creation and maintenance of the Delaware Health Information Network (DHIN). The DHIN is a public instrumentality of the state charged with the design, operation and maintenance of facilities for public and private use of health care information. A community-based health information network for communicating patient clinical and financial information, the DHIN's purpose is to increase the efficiency and quality of health care in Delaware.

The Commission strives to balance access, quality and cost concerns and develop recommendations that represent the best policy for the most Delawareans.

For More Information Contact:

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Last Updated: Friday, 21-Oct-05 16:51:21

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Delaware Health Care Commission (DHCC)

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THE DELAWARE HEALTH INFORMATION NETWORK (DHIN)

Click here to learn more

The DHIN was created in July 1997 as a public instrumentality of the state to advance the creation of a statewide health information and electronic data interchange network for public and private use. It functions under the direction and control of the Health Care Commission. It addresses Delaware's needs for timely, reliable and relevant health care information.

A statewide health information network such as is envisioned by this legislation would coordinate public and private efforts related to the collection, exchange, analysis and dissemination of access, cost, and quality utilization and other performance data. This can be used to reduce costs, stimulate competition based on quality, improve access and help determine the most appropriate ways to target resources.

The Delaware Health Care Commission in 1998 moved the Delaware Health Information Network from conceptual idea to reality. Building on the 1997 legislation which enabled the DHIN's creation, the Commission impaneled a DHIN Board of Directors which elected officers, established standing committees and adopted a mission statement. The DHIN Technology Committee will help the Board facilitate the development of uniform standards for the electronic interchange of health information and assist with the compatibility of technology. The Policy and Procedures Committee will assist with the development of guidelines and the promulgation of regulations governing the manner that the DHIN conducts business. In addition, this committee will address issues pertaining to the privacy and confidentiality concerns of health information.

Reflecting the breadth of the DHIN's importance, the mission of the DHIN as adopted by the Board is as follows: "To facilitate the design and implementation of an integrated, statewide health data system to support the information needs of consumers, health plans, policymakers, providers, purchasers and research to improve the quality and efficiency of health care services in Delaware."

Working with the Technology Committee, the DHIN drafted a "Plan of Study" which is designed to yield an initial strategic plan for development and implementation of an electronic data interchange network for public and private use. As a first step, the plan called for assessing existing health information, by examining both state and national efforts, and determining their compatibility. The second step is to determine what additional data or information is needed. A key challenge in accomplishing this task will be determining the questions that the information should answer. This will be necessary to determine additional data needed and avoid unnecessary data collection or analysis.

Through the Policy and Procedures Committee, the DHIN drafted regulations to address the duties of officers of the Board, terms of office, establishment and

powers of an executive committee, meeting notice publications, public access to records regarding DHIN activities as well as health data and health information of the DHIN, conflicts of interest and resolution of disputes among Board members.

The DHIN in 1998 also adopted the following tasks for the organization, agreeing that the short-term and long-term tasks can be tackled simultaneously. The DHIN also recognized the short-term activities related to electronic transactions among payers and providers will help provide the infrastructure necessary to carry out the long-term goals.

Short-term goals of the DHIN should be limited to and focused on tasks which can be accomplished with relative ease, will establish trust and result in early success. Specifically, the DHIN should promote the use of electronic data interchange to enable providers to electronically exchange the following information, which for the most part is currently moved via paper transactions:

- Query eligibility of covered benefits, i.e. co-pays and deductibles.
- Send and receive referral authorizations for approval and routing to specialty providers.
- Submit electronic claims.
- Receive electronic payment vouchers.
- Receive electronic mail, such as capitation lists and other notices.
- Send claims inquiries and receive responses.

In accomplishing these tasks, the DHIN agreed to promote the use of uniform transmission standards, keeping in mind that national standards are under development, and in some cases already exist, and that "re-inventing the wheel" should be avoided.

Long-term concept goals relate to research and policymaking activities, and include, but are not limited to, having the information needed to:

- Identify and understand health care problems.
- Measure and understand changes in health status.
- Develop a more competitive and consumer-oriented health care marketplace, within which value can be gauged in terms of cost, quality and access.
- Analyze comparative information on health status and socioeconomic indicators.
- Utilize national regional and "best practice" benchmarks.
- Make comparisons between actual circumstances and ideal situations.

DHIN Board of Directors

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Robert F. Miller
Delaware Health Care Commission

Vice-Chair
Joseph M. Letnaunchyn
Delaware Healthcare Association

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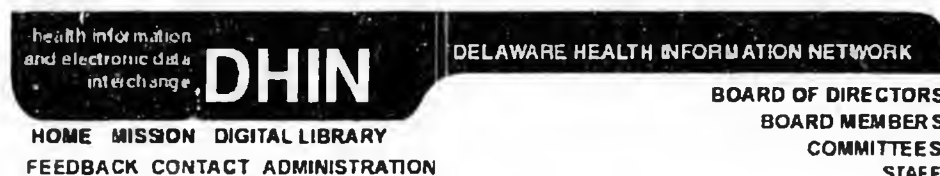
Ex-Officio Director of Public Health or Designee

Robert J. Varipapa, MD
Medical Society of Delaware

Robert J. White
Delaware Health Care Commission

Last Updated Tuesday, 25-Oct-05 14 10 47



DHIN UTILITY

What is the clinical information sharing utility?

The clinical information sharing utility will offer a way to connect patients (and their personal health information) electronically with their health care providers for the purposes of getting medical care. The utility, when developed, will be a computerized network by which a patient can consent to have hospitals, labs, diagnostic facilities (e.g.., x-ray facilities) and insurers make their clinical information available, to the patient's health care providers at the time and place they are getting care, any time of the day or week. The information will be sent in a "near real time" environment.

A distributed model for data-sharing will include lab, radiology, prescription, diagnosis, procedure and allergy information. That is, the data will reside within the organization at which the data originated. DHIN will not develop a database or data repository for the purpose of the Utility. Additional components to the Utility likely will include a patient portal, a disease management/decision support module, audit trail and billing functions, claims retrieval and processing, and secured messaging/email to facilitate improved provider-to-provider and patient-to-provider communication.

These DHIN partners have remained committed to the vision of creating and implementing a system by which clinical information may be shared among providers for the purpose of improved patient care and clinical outcomes, improved privacy and security of health information, improved patient-practitioner relationships, and controlled healthcare costs.

Our Partners

An assembly of public and private organizations is involved in the development of the utility. The DHIN is the oversight body and is comprised of representation from:

- Consumers
- Delaware Health Care Commission
- Delaware Healthcare Association
- Delaware State Chamber of Commerce
- Delaware Department of Health and Social Services
- Delaware Department of Insurance
- Delaware State Budget Office
- Insurance providers, including Aetna, Blue Cross Blue Shield and Delaware Physicians Care
- Large employers, including AstraZeneca, Dupont and MBNA
- Medical Society of Delaware

In addition to the DHIN board, other project participants include: the offices of Congressman Michael Castle and Senator Thomas Carper, three hospital organizations-Bayhealth Medical Center (including two acute care and one behavioral health hospitals); Beebe Medical Center (a rural health system, including an acute care hospital, home health services and satellite lab and imaging); and Christiana Care Health System (an urban health system, including two acute care and one rehabilitation hospitals, a long term care facility, home health care and a health plan)-as well as, the Department of Technology and Information and the Medicaid program overseen by the Division of Social Services.

Why is it important to share Health information?

Healthcare in Delaware, as in much of the Nation, is provided by a dynamic and increasingly complex array of caregivers. While receiving care, a patient frequently encounters primary care physicians (i.e., a family doctor), hospitalists, specialists (e.g., cardiologist), ancillary providers (e.g., physical therapist, etc.,) pharmacies, home care providers, hospitals, free-standing surgical centers, laboratories, imaging centers and public health facilities. To further complicate matters, the majority of these caregivers function within their own information silos, and even though the patients may move from place to place in the healthcare environment, their information frequently does not. Therein lays the potential for an error-prone and inefficient healthcare delivery system.

Providers attempt to share information by telephone, fax, mail, or print but, when faced with the difficulties of locating and obtaining the information, physicians frequently resort to ordering duplicate studies and tests rather than searching for results that may or may not exist. The time and effort spent manually processing this information reduces efficiency, increases duplication of effort, and adds considerably to the cost of providing care.

Why benefits will the DHIN Utility bring to the citizens of Delaware?

When healthcare providers and consumers have access to a complete health and treatment history as proposed for the DHIN Utility, there is the potential for a significant improvement in the delivery of health care.

- **Improved quality of care** - when a doctor or hospital has information about a patient's prescription medications, medical history, treatment history and allergies, he/she can make better clinical decisions, which result in better health outcomes for the patient.

- **Improved patient-provider communication** - When a patient has access to more information, he/she is more likely to engage his/her health care providers in communication about treatment options and wellness opportunities. As a result, the patient is more involved in treatment decisions, improving compliance and overall health outcomes.

- **Reduced duplication of services and treatments** - Two of the most significant cost drivers in the health care industry are prescription drugs and high technology diagnostic and testing services, such as MRIs and CT scans. Compounding these costs is the potential for duplication of these treatments or tests. For example, a prescribing provider is unaware that the patient has been prescribed a medication by another doctor and he/she prescribes the same drug or one of the same drug class. At best, this is an added expense; at worst, it can lead to potentially deadly interactions or overdosing. With respect to diagnostic testing: unbeknownst to the provider, a test has been completed on a patient recently. The provider, unaware of the results, requests a duplicate test.

What does it mean to me as a patient?

The following real-life scenarios illustrate the need for and benefit of sharing your clinical health information among your attending providers-your family doctor, your specialist, your pharmacist, the emergency room doctor, the lab where you get your blood drawn, and the facility that takes your x-rays.

. patient with severe back pain requiring the use of narcotics is seen at a clinic. The staff attempts to take a ... olete history, but the patient is not fully capable of cooperating because of the combined sedative effects of ... le relaxants and narcotic analgesics. An MRI of the spine is ordered and more narcotics are prescribed until ... er assessment of the problem can be made. Several weeks later the clinic staff finds that the patient already ... an MRI done, which was prescribed by another doctor just two weeks prior to the patient's first visit. The other physician is unaware of the clinic visit and is still seeing the patient and is also prescribing narcotics. As a result, the patient receives two expensive and identical tests and twice the narcotics he needed.

* * *

A patient with severe hypertension is discharged from the hospital on three out of her four blood pressure medications. The fourth was withheld during her hospitalization because she was acutely ill from another illness and did not require her usual dose of blood pressure medication. When she was next seen by her regular doctor, her blood pressure was very high. When questioned, she stated she was taking all the medications as instructed; she forgot to mention instructed by whom-the hospital or her doctor. Because the doctor thought she was still taking all four of her medications, he began adding new and considerably more expensive medications to her

regimen. This resulted in higher pharmaceutical costs, a greater chance of side effects, several extra office visits to titrate medications, and longer exposure to high blood pressure for the patient

* * *

A patient brought into the emergency room (ER) unconscious from a car accident is unable to give the doctors a list of his allergies and current prescription drugs he is taking. The hospital in the next county has information on file that the patient has a severe allergy to the dye used for the MRI. The emergency room doctor caring for the accident victim, having no medical history available to him on this patient, orders an MRI to evaluate for internal injuries. The MRI is administered using the dye and the patient goes into heart failure. This complication could have been avoided if the patient's medical information from the hospital in the next county had been available to the emergency room doctor when making critical medical decisions.

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iser_publications-admin@lists.uaa.alaska.edu wrote:

Date: Wed, 08 Mar 2006 14:26:14 -0900
To: iser_publications@lists.uaa.alaska.edu
From: iser_publications-admin@lists.uaa.alaska.edu
Subject: [Research Matters] ISER Research Matters No. 13

ISER Research Matters is our effort to quickly let Alaskans know about research findings from the Institute of Social and Economic Research (ISER), at the University of Alaska Anchorage. We'll post these periodically on our Web site and also distribute them by e-mail. If you'd like to be removed from our e-mail list, send us a message at ResearchMatters@uaa.alaska.edu.

ISER Research Matters No. 13. Alaska's $5 Billion Dollar Health Care Bill—Who's Paying?
March 8, 2006

Spending for health care in Alaska was an estimated $5.3 billion in 2005, up from about $1.6 billion in 1991. Taking population growth into account, that's an increase of more than 170% per person in 15 years. Those are among the findings of a new ISER research summary, "Alaska's $5 Billion Health-Care Bill—Who's Paying?" The authors are Mark Foster and Scott Goldsmith. The 8-page summary also reports:

- The $5.3 billion spent for health-care in Alaska in 2005 was about one-third the value of North Slope oil exports—in a year when oil prices were high. It's one-sixth the value of everything Alaska's economy produced last year.
- Individual Alaskans spent about $1 billion of the total in 2005, up from $360 million in 1991.
- Employers (government and private) spent over $2 billion in 2005. For comparison, employers spent about $11.8 billion for wages last year.
- Government programs paid $2.2 billion of the $5.3 billion total. Medicaid alone made up nearly $1 billion of that spending.
- National data show that just 5% of patients account for nearly half of all U.S. health-care spending. The average high-cost patient is middle-aged, sees doctors several times a year, is in the hospital for a few days for surgery, and spends considerable money on prescription drugs.
- Health-care spending in Alaska could double again by 2013, if current trends continue.

Click here to see the entire research summary.

Study: Already high health care costs on track to double

By Melissa Campbell
Alaska Journal of Commerce
Publication Date: 03/19/06

Alaska businesses and their employees are paying more than ever in health care costs, according to a new study. And if current trends continue, their costs will double by 2013.

This comes as no big surprise as current trends go, but the study, conducted by the University of Alaska Anchorage's Institute of Social and Economic Research, put some tangible numbers to a gnawing concern held by employers across the state.

Future research will attempt to determine what is driving the costs, and that could lead to ideas on how to stem the flow.

Spending for health care hit $5.3 billion in 2005, compared to $1.6 billion in costs in 1991, the last time ISER reviewed health care costs. That averages about 9 percent growth a year.

Health-care spending included such costs as hospital stays, doctor and dentist visits, prescription drugs, as well as program administration and public health programs. It does not include capital spending, which would include a new hospital wing or the medical equipment to fill it.

Part of the increase in spending can be attributed to the state having more people. Alaska has grown from a population of 570,000 in 1991 to about 665,000 last year. Costs for goods and services in general have also increased, by about 43 percent nationwide and nearly 40 percent in Anchorage.

Still, the price of medical care nearly doubled during that time frame, the report said. And Anchorage's costs for health care rose faster than the national average. Overall medical costs are about 25 percent higher in Alaska than elsewhere in the country.

In 2005, some 80 percent of health care costs were paid by governments, as well as by for-profit and nonprofit businesses. The study noted, however, that individuals indirectly pay for these costs as well, as they buy goods and services, own businesses and pay taxes, all of which cost more because employers pass the costs of doing business along to their customers or constituents.

"These soaring costs are taking a growing share of family and government budgets, increasing labor costs, and putting businesses at a competitive disadvantage," the study said.

Private and government employers spent about $2 billion for employee health-care coverage, the study said. Of that, private business paid about 17 percent of the total costs, about $922 million. By comparison, they spent $11.8 billion in total wages.

Governments in 2005 spent $2.2 billion for health care programs - such programs as Medicaid or Medicare - compared to $736 million in 1991. Medicaid spending hit nearly $1 billion.

The remaining 20 percent in health care costs were paid by individual Alaskans, for a total of more than $1 billion, through payroll deductions and out-of-pocket expenses, items such as deductibles, co-pays and for some care not covered by a company health plan.

In 1991, Alaska households paid $361 million for their health care. That equates to about $2,900 per person, compared to the nearly $8,000 each Alaskan spent in 2005.

Premium impacts

About 87 percent of Alaskans have some form of health-care coverage, either through private insurance or government programs. That compares to 68 percent nationwide.

In 2003, insurance premiums for family coverage at private firms were about $10,500 in Alaska and $9,200 nationwide. That's a steep incline from 1993, when premiums cost $6,200 in Alaska and $4,800 nationwide.

In 2005, national premiums rose to more than $11,000. The updated figure was not available for the state.

As high as premiums seem, Alaskans tend to pay a smaller share. As of 2003, employees at private firms in Alaska paid 11 percent of the premiums for single-person coverage and 17 percent for families.

That compares to 17 percent for single coverage and 25 percent for families on a nationwide basis.

With costs rising, however, employers - especially smaller companies - are shifting more of the insurance costs to workers. A 2005 survey referenced in the ISER report said that employees of businesses nationwide paid 43 percent of the premiums for family coverage.

Small Alaska businesses are less likely to offer insurance coverage at all, the report said. Only about a third of companies with fewer than 50 employees offer coverage, compared to 43 percent nationwide.

The study also noted that rising costs are causing more businesses and governments to turn toward self-insuring rather than going through an insurance company in an effort to stem some of the costs.

Good investment?

It costs about 25 percent more for treatment in Alaska when compared to the national average, the study said.

Overall costs of medical and surgical procedures in Alaska were about 18 percent above the national average in 2001 and dental procedures were 37 percent more.

Average costs of a doctor's visit were 30 percent higher in Alaska. Costs of hospital care rose faster in the state than in the nation between 2000 and 2003. In 2003 average expenses for a day in an Alaska hospital were 42 percent above the U.S. average, compared to 30 percent in 2000.

And while Alaskans take fewer prescription drugs, we pay an average of 25 percent more.

Whatever the costs, it seems that Alaskans are getting a fairly good return on their health care investments. The study showed that Alaskans tend to be healthier in most aspects.

The rates of infectious disease, infant mortality and deaths from heart disease have declined in the past decade. The obesity rate, however, has increased slightly. Obese people are more likely to eventually require treatment for diabetes and high blood pressure.

"We have made significant gains," the study's author, Mark Foster, told members of Commonwealth North at a recent luncheon in Anchorage. "We have the ability to treat diseases that we couldn't treat before."

But finding ways to further improve on health care investments - keeping costs down while offering Alaskans the health care services they demand - will be complicated, he said.

"If we are getting more healthy, (are rising costs) a bad thing so long as the economy can increase its production?" he said. "There have been a number of reform efforts to control the costs, but few last more than a year or two. The demand for better care overtakes the cost concerns."

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Building a Better Health Care System

SPECIFICATIONS FOR REFORM

A Report from the National Coalition on Health Care

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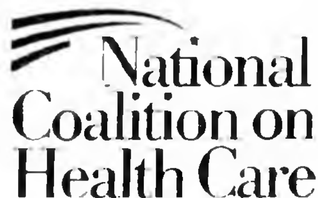

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Preface

The United States is on the cusp of a major new debate — a necessary debate — about the future of our health care system.

In 1993 and 1994, our nation had such a debate — in Congress, the press, and the polity — about a variety of proposals, from many quarters, for health care reform. Political leaders in both parties agreed that the problems confronting health care then — in particular, rising costs and increasing numbers of Americans without health insurance — constituted a genuine crisis and warranted an urgent policy response. That debate ended without legislative action. The health care system was not reformed, its problems remained unchecked, and the sense of urgency that had animated and permeated the debate dissipated.

The system-wide problems that triggered an intense national debate more than a decade ago are larger now than ever. The growth of these problems has overwhelmed incremental measures meant to alleviate them. If we needed comprehensive health care reform in 1993 and 1994 — and we did — we need it even more today.

The recommendations for comprehensive reform that you are about to read come not from a single organization or interest, not even from one sector of American society. They were developed, in a year of study and deliberations, by the National Coalition on Health Care, which brings together many interests and sectors. The Coalition is an organization of organizations — of nearly one hundred of America's largest businesses, unions, health care providers, associations of religious congregations, pension and health funds, insurers, and groups representing patients and consumers. Collectively, the Coalition is the nation's largest and broadest alliance working for the achievement of comprehensive health care reform. Our members represent — as employees, members, or congregants — at least 150 million Americans. They speak for a cross-section — and a majority — of our population.

The organizations that belong to the Coalition are united by their commitment to the pursuit of five principles or goals for a reformed health care system:

- Health Care Coverage for All
- Cost Management
- Improvement of Health Care Quality and Safety
- Equitable Financing
- Simplified Administration.

The Coalition is rigorously non-partisan. Its honorary co-chairmen are former Presidents George H.W. Bush, Jimmy Carter, and Gerald R. Ford. Its co-chairmen are former Iowa Governor Robert D. Ray, a Republican, and former Florida Congressman Paul G. Rogers, a Democrat. Our members believe that an effective response to the crisis in American health care is urgently needed and that it will require leadership from both political parties and a willingness to compromise across ideological, economic, and social divides.

It is in that spirit that we offer a series of interconnected specifications for reform. This brief document does not describe one plan, one potential course of action. Instead, it sets out objectives for reform, criteria by which alternative proposals can be assessed, and options for policymakers and the public to consider. Our hope is that these specifications will help to accelerate and frame a renewed national debate about how to build a better American health care system — and that they will help to embolden political leaders to act soon.

The specifications summarized here are tough, thorough, and ambitious. Our members have set aside their preconceptions and predispositions in order to forge a consensus document. Individual members may have different first preferences on some of the items addressed, but they recognize that for progress to be possible, a compelling national interest — in the assurance of excellent and affordable health care for all Americans, in the creation of a health care system that can serve us all well in the decades to come — has to be given precedence over narrow self-interest. They are unified in believing that these specifications represent a sound and sensible set of concepts and precepts for a public-private partnership to reform American health care.

That these recommendations were developed by such a diverse and large aggregation of powerful organizations — representing such a broad swath of our economy and society — should be heartening to those who had given up on the prospects for policy responses commensurate with the scope of the challenges we face. We should not be resigned to settling for small steps forward — not when the problems of the health care system are growing by leaps and bounds.

We need systemic, and rapid, reform.

COMMONWEALTH NORTH

Alaska Primary Health Care: *OPPORTUNITIES & CHALLENGES*

Approved by the Board of Directors on June 7, 2005
Updated July 31, 2005

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EXECUTIVE SUMMARY

Why Alaska health care issues must be addressed and solved

Health care is not a goal or end in itself. The ultimate goal of health care and of this study is health and wellness for Alaskans. Alaskans must identify and improve the aspects of health care that are under our control. Many health care issues are national, that Alaskans cannot affect. Therefore, it is even more important to address and solve issues we can do something about. Furthermore, the demographics of an aging population will put foreseeable pressure on all fronts.

ACCESS

- Approximately 110,000 Alaskans have no health insurance coverage.
- Many others have minimal or inadequate coverage.
- Thousands are turning to hospital emergency rooms as a source of primary health care, often without ability to pay.
- Adequate health care in remote areas is a significant logistical, financial and educational challenge.

QUALITY

- Based on the 2004 National Healthcare Quality Report, Alaska has low rankings in several key measures of cancer, heart disease, maternal and child health, respiratory diseases, and nursing and home health care.
- Many Alaskans are in high-risk health categories, many are not receiving adequate care.

COST

- Alaska health care costs are approximately 40% higher than Seattle (per Premera, corroborated by Providence and Alaska Regional)
- Medicaid costs to the State of Alaska are rising dramatically, to over $1 billion in 2005. It is placing a strain on the state budget.
- Health care insurance premiums are also rising dramatically, creating a significant burden on employers and employees.
- Alaska hospitals are losing tens of millions of dollars from uncollectable accounts arising from excessive emergency room use and they are unable to reduce the amount of emergency room care provided due to Federal law.

What can we do?

There are four major interrelated factors driving primary healthcare in Alaska today:

1. Health and wellness of the population
2. Availability of care and insurance
3. Affordability of care and insurance
4. Financial health of the stakeholders, such as employers, providers and individuals

These drivers are currently interacting in a "cost spiral" that is creating a very serious situation nationally and in Alaska. The rate of increase in the cost of health care is unsustainable—if unchecked health care increases will price employers out of the market. Already industries such as automobiles are threatened. We need to avoid similar impacts in Alaska.

We believe that with focus and coordination Alaskans can impact this "cost spiral" positively through specific actions in the four areas mentioned above:

1. Lifestyle and prevention: Raise public awareness and increase personal responsibility for wellness
2. Access: Make services and insurance more widely available
3. Quality: Continue improving quality of care that is delivered
4. Costs: Reduce costs of service delivery and insurance to make them more affordable

There are many health care initiatives already underway in these areas by various governmental and non-governmental entities. Some have proven to be effective and cost-efficient. Others show significant promise. Health care reform is complex and controversial, with multiple players and competing interests. Inconsistent tracking and trending create significant factual disputes about healthcare systems. Any major reform has potential to create both winners and losers.

Given this environment, the Study Group came to three overarching conclusions:

1. The Study Group process itself has been enlightening, educational and productive.
2. Every aspect of health care is complex. Understanding the system and improving it is beyond the capacity of any one element within the system.
3. The Study Group recommends that an ongoing body be established to continue and deepen this Group's work.

The time to act is now. Involvement of Alaskans in the health care debate is vital. Reform of some sort is inevitable, and Alaskans should control it as much as possible to our own benefit. Since there is no single forum today where the disparate players can come together to agree on facts, share solutions and craft a win-win for our unique Alaskan conditions, this Study Group recommend formation of—

The Alaska Health Care Roundtable ("Roundtable")

The goals of the Roundtable are to continue communication and foster action among parties that have a long-term vested interest in health care reform. It must set a standard of credibility and create timely actionable ideas that can gather bipartisan support, get quick approval and become part of a long-term fiscal plan for Alaska. It would be a sounding board and facilitator for ideas and recommendations, with a focus on lifestyle and prevention, access, quality and cost.

The core membership in the Roundtable would be self-selecting, comprised of members with a long-term compelling interest in improving the Alaska health care system. Examples of core members would be major employers at risk, health care providers and local foundations. A wide variety of other potential members, resources and ad hoc participants could be included as needed. Funding would be by voluntary contributions by the participants and the community.

An Urgent Call for Special Health Courts:

American healthcare is in meltdown.
Costs are skyrocketing.
Thousands die from needless errors.
Doctors are quitting.

America needs a reliable system of medical justice.

COMMON GOOD℠
RESTORING COMMON SENSE TO AMERICAN LAW
WWW.CGOOD.ORG

Unreliable Justice Is Destroying American Healthcare

Medical Justice is Random.

Unreliable justice is not fair to anyone. Most patients harmed by medical errors get nothing. But doctors who did nothing wrong, especially in circumstances of human tragedy, are often hit with huge verdicts. There is no standard of care that doctors or patients can rely upon. One jury may make an award, and, on the same facts, the next jury may make a completely different judgment. Random justice infects the entire healthcare system with debilitating distrust.

Costs are Skyrocketing.

American healthcare now costs more than $6,000 per person—almost twice what other countries spend, but with no better results. Distrust of justice causes doctors to practice "defensive medicine," ordering billions of dollars of unnecessary tests and procedures each year. More than 45 million Americans are uninsured, in part because many small businesses cannot afford coverage. Fear of lawsuits makes it almost impossible even to talk about containing costs.

Medical Errors are Widespread.

Doctors and nurses are afraid of admitting uncertainty or mistakes, leading to needless medical errors. Thousands of Americans die each year unnecessarily from preventable slip-ups—like the wrong dosage of medicine—often in the same hospitals where miracle cures take place. Instead of providing incentives for doctors and hospitals to improve their systems, unreliable justice causes them to adopt a bunker mentality.

More and More Doctors are Quitting or Retiring.

Distrust of the current justice system is undermining the healthcare profession. Stunning increases in medical malpractice premiums are causing doctors to abandon high-risk specialties like obstetrics and neurosurgery. In 2004, only 65% of the ob-gyn residency slots in the nation were filled by the graduating classes at U.S. medical schools.

We Must Restore Reliability to Medical Justice.

A broad coalition of healthcare and other leaders—including leading patient advocates and employers—have come together behind the idea of creating reliable health courts. Common Good, a bipartisan organization dedicated to restoring common sense to American law, is helping spearhead this initiative.

"In our current system, both patients and physicians are often unjustly penalized. We need to create a means of delivering medical justice that is consistent, efficient and fair."

William R. Brody, M.D., Ph.D.
President, Johns Hopkins University

How Special Health Courts Would Solve the Problem

Reliable Justice

Health courts would have judges dedicated full-time to resolving healthcare disputes. The judges would make written rulings in every case to provide guidance on proper standards of care. Their rulings would set precedents on which both patients and doctors could rely. As with similar administrative courts that exist in other areas of law—for tax disputes, workers' compensation, and vaccine liability, among others—there would be no juries. To assure uniformity and predictability, each ruling could be appealed to a new Medical Appellate Court.

Fair Accountability

Patients injured by mistakes should be compensated for their injuries without waiting years and without paying one-third or more to lawyers. Good doctors, unfairly charged, should be affirmatively protected, without living for years under the threat of personal ruin. Special health courts would be reliable and speedy.

Reliable justice will not only clarify standards of proper care but provide incentives for doctors to keep up with the latest developments in medicine. Trust will be restored, encouraging the open professional interaction needed to reduce errors.

"When patients are injured through medical error, healthcare providers have an obligation to respond—not only with improved medical care but also with equitable compensation. Healthcare courts are needed to provide fair resolution to both patients and healthcare providers."

William L. Roper, M.D., M.P.H.
Dean, School of Medicine & Vice Chancellor for Medical Affairs,
The University of North Carolina at Chapel Hill;
CEO, UNC Health Care System

How Special Health Courts Would Work

Full-Time Judges.

The hallmark of the health courts would be full-time judges, dedicated solely to addressing healthcare cases. The judges would be appointed through a nonpartisan screening commission.

Neutral Experts.

Those judges would be able to choose from a panel of experts in each area of medicine, avoiding the dueling "hired gun" experts that confuse and prolong disputes today.

Speedy Proceedings; Lower Costs.

Most cases would be resolved within months. Except in exceptional cases, legal fees would be held to 20 percent, reducing current costs by almost half.

Liberalized Recovery for Injured Patients.

Once a mistake is verified, recovery would be automatic without the need to prove precisely how it happened.

Damages.

Patients would be reimbursed for all of their medical costs and lost income, plus a fixed sum that would be pre-determined according to a schedule addressing specific types of injuries. The schedule would be established by a panel of experts and updated periodically to reflect changing costs.

"The current legal system presents real barriers to improving the quality of American healthcare. A special health court could provide powerful incentives for honest reporting and analysis of errors, and to elevate standards of care."

Margaret E. O'Kane
President, National Committee for Quality Assurance

Coming Together for Our Common Good

"Our nation was built on a foundation of reliable law. Fixing American healthcare requires a basic shift in approach, aimed at making justice reliable for both patients and doctors."

Philip K. Howard
Chair, Common Good

America was built with a spirit of common sense and cooperation. Our nation's founders erected schools and hospitals because these common institutions were essential to a vigorous and free society. Today, the American legal system has unintentionally undermined this cooperative spirit. Legal fear is infecting daily choices, inhibiting doctors, teachers, little league coaches and others from making the reasonable judgments needed to serve the common good.

Common Good is a bipartisan coalition dedicated to restoring common sense to America. Working with experts in different fields, Common Good is developing practical solutions to restore reliability to American law, so that Americans in all walks of life feel free to do what is right and reasonable.

Common Good's board is composed of leaders in every field, including political figures from both parties such as Tom Kean, George McGovern, Newt Gingrich, Alan Simpson and Griffin Bell. Common Good's Chair, Philip K. Howard, is a prominent lawyer, civic leader and bestselling author *(The Death of Common Sense* and *The Collapse of the Common Good).*

"The current medical liability system is undermining patient safety. By creating incentives to hide errors, blame and never apologize, it fuels the epidemic of medical errors and consumer distrust. Piecemeal tort reform is not a solution. We must create a system of justice that can make the deliberate choices needed to fix healthcare and restore integrity in both law and medicine."

Martin J. Hatlie, J.D.
President, Partnership for Patient Safety;
Co-Founder, Consumers Advancing Patient Safety

BIPARTISAN LEGISLATION TO CREATE SPECIAL HEALTH COURTS IS INTRODUCED IN U.S. SENATE

The Bill, Advancing an Idea Championed by Common Good, Would Authorize Funding for States to Create Health Courts on a Pilot Project Basis
Common Good Press Release, June 30, 2005

Senators Michael Enzi (R-WY) and Max Baucus (D-MT) have introduced legislation in the U.S. Senate to create special health courts on a pilot project basis. Known as the *Fair and Reliable Medical Justice Act*, the bill is backed by a broad coalition of patient advocates and providers and responds to the Institute of Medicine's call for the development of alternatives to current medical tort litigation. Sen. Enzi is Chair of the Senate Committee on Health, Education, Labor, & Pensions. Committee hearings on the legislation are expected later this year.

The bill's purpose is:

- To restore fairness and reliability to the medical justice system by fostering alternatives to current medical tort litigation, including the creation of a special health care court, that promote early disclosure of health care errors and provide prompt, fair, and reasonable compensation to patients who are injured by health care errors;
- To promote patient safety through early disclosure of health care errors; and
- To support and assist states in developing such alternatives.

The bill would authorize the U.S. Secretary of Health and Human Services to award up to 10 demonstration grants to states for the development, implementation and evaluation of alternatives to current tort litigation for resolving disputes over medical errors. Within that context, the bill specifically authorizes the creation of a special health care court. The hallmark of such a court would be full-time judges with health care expertise, whose sole focus would be on addressing medical malpractice cases.

"This important bill, introduced by Senators Enzi and Baucus, points the way to making justice in health care serve our common goals," said Philip K. Howard, Chair of Common Good. "Special health courts can offer reliable justice for doctors and patients alike, while providing affirmative rulings to improve patient safety. Both Senators deserve great praise for advancing this bipartisan initiative."

"Reliable and timely decisions by expert courts are needed for real improvements in patient safety, as well as basic fairness," said Troyen Brennan, MD, M.P.H., a Professor at the Department of Health Policy and Management at Harvard School of Public Health. "The important legislation introduced by Senators Enzi and Baucus is a very significant step in the right direction."

The Enzi-Baucus legislation enjoys prominent, bi-partisan support. Here is what a few national leaders had to say:

"The current legal system presents real barriers to improving the quality of American health care. The legislation introduced by Senators Enzi and Baucus--oriented around exploring alternatives to the current malpractice system--represents a major positive development."--*Margaret E. O'Kane, President, National Committee for Quality Assurance*

"I've been working to improve patient safety since medical errors resulted in the death of my husband and a serious injury to my son--reforming the legal system is crucial. The legislation introduced by Senator Enzi and Senator Baucus is a very positive development."--*Susan E. Sheridan, Co-Founder, Consumers Advancing Patient Safety*

"The Progressive Policy Institute congratulates Senators Mike Enzi and Max Baucus for introducing legislation to create specialized health courts as pilot projects that could eventually replace America's broken system of medical justice."--*David Kendall, Senior Fellow, Progressive Policy Institute*

"The legislation introduced by my friends Senators Mike Enzi and Max Baucus represents a critically important step in developing a more reliable system of medical justice."--*Alan K. Simpson, Former U.S. Senator, Wyoming*

"The Enzi-Baucus bill to create health courts is

"The current medical liability system incentivizes cover-up and blame, fueling the epidemic of medical error," said Martin J. Hatlie, President of the Partnership for Patient Safety. "The legislation introduced by Senator Enzi and Senator Baucus can help create the system of justice that both consumers and providers need to restore trust between them, improve health care and save lives."

"Health courts are needed to provide fair resolution to both patients and health care providers," said William L. Roper, M.D., M.P.H., Dean of the School of Medicine and CEO of the University of North Carolina Health Care System. "The legislation introduced by Senators Enzi and Baucus represents an important step in developing a more reliable system of medical justice."

More than 80 of the nation's most prominent leaders in health care and law--including patient safety experts and 11 deans of medical schools or schools of public health--have called for the creation of special health courts as a way of restoring reliability to medical justice. Their call was precipitated by inadequacies and inequities in the current system:

- At present, less than two percent of patients with medical injuries due to substandard care file a claim, and even fewer receive compensation. Those fortunate enough to receive compensation will have waited an average of four years in the court system before receiving a dime.
- The current system cannot reliably distinguish good doctors from bad ones, which exposes medical professionals who have done nothing wrong to the risk of ruinous liability. Eighty percent of claims involve situations where doctors did no wrong. Nonetheless, plaintiffs receive compensation in a quarter of these cases.
- The current system harms patient quality and safety. Fear of litigation drives costly and inefficient "defensive medicine," while creating incentives for health care providers to cover up their own mistakes and the mistakes of their colleagues. This culture of silence prevents doctors from learning from mistakes, and leads to needless suffering and death.

a major step toward breaking the logjam over litigation reform. For too long doctors have been driven out of practice and Americans have found themselves losing their healthcare because of excess litigation. This bill is a very creative effort to find a new and better solution."--*Newt Gingrich, Founder, Center for Health Transformation, Former Speaker of the U.S. House of Representatives*

"The medical liability crisis is a serious problem that is driving up the cost of care, driving physicians out of the health care delivery system and not even effectively compensating those who have been hurt by medical errors. Aetna supports a liability system that is centered on patients and safety and one that uses the best medical expertise available to answer questions of fact in medical liability cases. The use of special health courts could be a key component of a comprehensive solution to the problem. The comprehensive solution should include efforts to (a) avoid medical errors in the first place and (b) establish an efficient mechanism to ensure that those who are hurt are fairly compensated. Special health courts that bring medical expertise to bear would be helpful, along with uniform medical liability reform, improved patient safety and better use of national medical data."--*John W. Rowe, M.D., Chairman and CEO, Aetna*

Read the *Fair and Reliable Medical Justice Act*

Read the Common Good press release.

Read the American College of Obstetricians and Gynecologists' endorsement of the bill.

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MEMORANDUM

TO: The Honorable Peggy Wilson
Alaska House of Representatives
State Capitol, Room 108

THRU: Karleen Jackson
Commissioner
Department of Health and Social Services

FROM: Richard Mandsager, M.D.
Director, Division of Public Health
Department of Health and Social Services

DATE: February 21, 2006

SUBJECT: HB396 – Alaska Commission on Health Care

You have asked for a quick review of projects, initiatives and special emphasis underway in Alaska to address the issues of improving public health and health care and reducing health care costs. As you are aware, much of the work on these broad topics occurs outside the purview of the Division of Public Health (DPH).

Here is a very general list of work being undertaken in Alaska that involves staff from the Department of Health and Social Services (DHSS). This is by no means intended to be a comprehensive analysis but instead a broad-brush outline.

This listing of ongoing work involving the Department is organized according to the issues identified in Sec. 44.19.277 of HB396, which describes the fundamental powers and duties of the proposed commission:

1) Establishment of an affordable, effective, and quality healthcare system

- Revision of Certificate of Need regulations, standards and methodology to assure that new facilities and services are built only in response to need.
- Obtaining federal funds for support of the primary care and rural health systems to:

- Provide data support for Community Health Center and other safety net provider applications, and improve data availability through diverse means;
- Complete health professional shortage area designations;
- Coordinate recruitment efforts (National Health Service Corps, J-1 visa program, 3R-Net, SEARCH);
- Conduct workforce studies; and
- Support quality improvement and network development in the health care system (rural hospitals, primary care providers, integrated services for primary care and behavioral health, emergency medical services).

- DHSS Commissioner has co-chaired the Alaska Telehealth Advisory Council and Department staff work to support telemedicine development to reduce costs and improve quality of care.
- Establishment of a Regional Health Information Organization/Health Information Exchange workgroup.
- Work with Denali Commission to ensure funding for improvements in the health care infrastructure.
- Through the Denali Commission, coordinate regional planning efforts in the Mat-Su, on Prince of Wales Island and the Copper River region.
- Assist small rural hospitals to evaluate the possibility of converting to Critical Access Hospital classification.
- Foster the development through grant funding of the Alaska Hospital and Nursing Home Association in the establishment and development of the Alaska Small Hospital Improvement Program in meeting member hospitals' PPS, HIPAA and QI collective needs.
- Support the Alaska Hospital Performance Improvement Project, focusing on three small hospitals to identify potential improvements in reimbursement and patient care.
- Much work is underway in the Division of Behavioral Health in the area of integrating substance abuse and mental health treatment. This applies not just to adults, but also to children (DHSS' Bring the Kids Home initiative).
- Participation as a member of the All-Alaska Pediatric Partnership with the goal of improving and further developing the delivery of medical services to children.

2) Access to affordable health care

- Creation of Denali KidCare.
- Expansion of the federal Section 330 Community Health Center program in Alaska.
- Evaluating progress toward Healthy Alaskans 2010 goal to cover the uninsured through household and employer surveys, identifying who is

uninsured and why, and inter-departmental work on insurance issues and options for improving access to affordable insurance and care. (Health Planning and Systems Development work is now underway with HRSA funds to expand these efforts, to display and explain the nature of the problem, and the direct and indirect costs of people being uninsured.)

- Telemedicine support and coordination that provides for greater degree of on-site care provision with less travel costs and less use of antibiotics.
- Telehealth expansion plans that will result in availability of clinical telehealth services in Community Health Centers.
- TeleBehavioral Health Program.
- Worked with the Anchorage Access to Healthcare Coalition to develop Anchorage Project Access, which is a volunteer provider network to increase access to individuals who cannot afford care and do not qualify for any assistance programs.

3) Individual responsibility for personal health and wellness; and

4) Disease prevention and management

The Section of Chronic Disease Prevention and Health Promotion in DPH includes several programs *(Cancer Prevention and Control Program, Diabetes Prevention and Control Program, Arthritis Program, Hearth Disease and Stroke Program, Obesity Prevention and Control Program, Tobacco Prevention and Control Program, School Health Program and the Health Promotion Program)* that are currently addressing the issue of disease prevention and management as well as the promotion of health and wellness. An overarching goal of all of the Section's programs is that they focus their efforts on creating and establishing policy and environmental changes that enable individuals to make healthy lifestyle choices. Additionally many of the programs are working with communities, businesses, healthcare providers and other partners to support and sustain these efforts. Evidence based public health practices support this approach, which will enable long term and sustainable changes in societal norms and health behavior that will ultimately result in improved health outcomes.

Here are some examples of program activities:

- Worksite Wellness Project - This is a collaborative project between all of our chronic disease programs and Aetna to implement a pilot project with four small businesses to determine a set of best practices for developing worksite wellness programs in Alaska.

- Chronic Disease Self Management - This is a collaborative project with all of our chronic disease programs that provides training to health care

providers statewide to teach them how to work more closely with patients to address their patients ability to manage their chronic disease(s).

- Obesity and School Health programs are working with schools and communities to address the surging epidemic of childhood obesity.

5) Workforce shortages among health care providers

- Work with the Alaska Workforce Investment Board and conduct workforce studies.
- Partnership between the University of Alaska and the health care industry to expand the number of nurses graduating from UAA.
- In cooperation with the university, establishment of the Alaska Physician Supply Task Force.
- Maintaining current Health Professional Shortage Area applications for health, mental health and dental designations throughout Alaska.
- Coordinate recruitment efforts that focus on opportunities for loan repayment, scholarships and student/resident rotations (National Health Service Corps, J-1 visa program, 3R-Net, SEARCH student rotations).
- Coordinate and lead Comprehensive Integrated Mental Health Program Plan to help improve access to care for Alaskans with behavioral health needs and developmental disabilities.

6) Cost shifting by health care providers caused by insufficient reimbursement or lack of insurance

- Collaboration amongst the Medicaid program and the tribally administered programs so that cost efficiencies are maximized.
- Integrating tribal and community supported health care providers to maximize local dollars minimize redundant/competing systems. The "Tribal Program" in DHSS is an effort to provide state government responsiveness and assistance to solve problems, build and maintain capacity to assure access, and encourage efficiency.
- Establishment of State Planning Grant to document issues related to the uninsured and underinsured residents in Alaska.
- Distribution of Disproportionate Share Hospital funding allocations.

7) Need for courts with specialized jurisdiction to consider health issues

- Nothing is underway in Alaska that we are aware of; however, this is actually a question for the Department of Law and Alaska Court System.

8) Improvements in public health

- The passage of a comprehensive new public health law to better protect the public while strengthening due process rights. The new statutes (incorporated by HB95, passed by the 2005 Legislature) are critically important to public health practice because they provide the framework within which governmental public health agencies operate, as well as the legal authorities required to monitor health status in communities, identify health threats, and to control the spread of disease.
- A newly consolidated certification and licensing function in state government that better protects the public safety by coordinating background check functions, on-site reviews and other requirements to make hospitals, nursing facilities and assisted living homes as safe as possible.
- Pending construction of a modern virology laboratory in Fairbanks to replace an outdated, overcrowded facility. The safe and efficient operation of the virology lab is vital to the detection, treatment and control of highly infectious and serious diseases in Alaska.
- Creation of statewide plan to prepare for the possibility of pandemic flu in Alaska. The plan describes a coordinated strategy to prepare for and respond to an influenza pandemic in five key areas: surveillance and investigation; health care systems; community disease control; vaccines and antiviral medications; and communications.

9) Public availability of health care cost information

- The Department publicly reports the annual cost of Medicaid services in Alaska and regularly cites estimates from the federal government of costs associated with various health problems (i.e., according to CDC, Alaska's annual medical costs for tobacco use are approximately $132 million).
- As for public information about costs and comparisons for specific types of medical care or procedures, nothing substantive is underway in Alaska that we are aware of.

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