

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

February 9, 2012

3:04 p.m.

MEMBERS PRESENT

Representative Wes Keller, Chair
Representative Alan Dick, Vice Chair
Representative Bob Herron
Representative Paul Seaton
Representative Beth Kerttula
Representative Bob Miller
Representative Charisse Millett

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

PRESENTATION: OFFICE OF CHILDREN'S SERVICES

- HEARD

PRESENTATION: ALASKA TRIBAL HEALTH CONSORTIUM

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

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

POSITION STATEMENT: Answered questions during the presentation from the Office of Children's Services.

VALERIE DAVIDSON
Senior Director
Legal & Intergovernmental Affairs
Alaska Native Tribal Health Consortium

Anchorage, Alaska

POSITION STATEMENT: Presented a PowerPoint, "Alaska Tribal Health System" and answered questions.

STEWART FERGUSON, PhD

Chief Information Officer

Alaska Federal Health Care Access Network (AFHCAN)

Alaska Native Tribal Health Consortium

Anchorage, Alaska

POSITION STATEMENT: Presented a PowerPoint, "The AFHCAN Telehealth Program."

JAY BUTLER, MD

Senior Director

Division of Community Health Services

Alaska Native Tribal Health Consortium

Anchorage, Alaska

POSITION STATEMENT: Presented a Power Point, "Alaska Native Tribal Health Consortium- Role in Public Health and Health Education."

MATT DIXON, P.E.

Vice President of Operations

Division of Environmental Health and Engineering

Alaska Native Tribal Health Consortium

Anchorage, Alaska

POSITION STATEMENT: Presented a PowerPoint entitled, "Division of Environmental Health and Engineering Lasting solutions to promote healthy communities."

ACTION NARRATIVE

[3:04:20 PM](#)

CHAIR WES KELLER called the House Health and Social Services Standing Committee meeting to order at 3:04 p.m. Representatives Keller, Dick, Herron, Seaton, Millett, and Miller were present at the call to order. Representative Kerttula arrived as the meeting was in progress.

Presentation: Office of Children's Services

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CHAIR KELLER announced that the first order of business would be the response from Office of Children's Services to the earlier Citizens Review Panel report.

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CHRISTY LAWTON, Director, Central Office, Office of Children's Services (OCS), Department of Health and Social Services (DHSS), offered to respond to the report from the Citizens Review Panel presented to the House Health and Social Services Standing Committee on February 7, 2012. She explained that the OCS data was used as a management tool. She clarified that departing OCS staff were not required to partake in an exit interview, although it was requested. She referred to the 23 exit surveys OCS had received over the prior six months, and shared that the three biggest reasons for departure were: personal or family (16 percent); another job with better pay and benefits (18 percent); and, an unmanageable work load (14 percent). She stated that the unmanageable work load reason was not a surprise. She referenced the results from the annual staff surveys, noting that the results were posted on the OCS website. She shared that the biggest reasons for which staff chose to stay with OCS were: "they value the security and benefits of working for the state;" "they find the job duties challenging and it allows them to use their skills, talents, and problem solving abilities;" "they enjoy the challenges of working to ensure the well-being of children;" "they enjoy the positive working relationship with their supervisors;" and, "they enjoy working with their co-workers and the contributions that they make to job satisfaction." She reported that the top three responses for better ways to retain staff included: overall reduction in workloads, increase in social service associate support, and increase in pay and benefits.

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MS. LAWTON responded to the three concerns raised by CRP during its PowerPoint presentation. She defined "in home services" as any situation where the child remained in the biological family home, whether or not OCS had custody. She stated that OCS worked to keep the family intact and to develop a case plan with the parents. She emphasized that a safety plan was also in place to monitor child safety during the resolution of issues. Referring to a CRP concern that policies and procedures were not clear, she directed attention to a quality assurance unit lead by a senior employee, expert in child welfare. She shared that federal authorities had recognized the quality assurance unit as

"being one of the best they've seen out of all the states they visited." The unit did annual on-site case reviews in all 26 OCS field offices, to review what areas needed improvement for both in-home and out-of-home cases. She said that the main difference to in-home cases were the involvement of fewer legal parties. These cases were based on the parents' voluntary willingness to engage with OCS, and she shared that currently there were only 47 such cases, among 2,000 children in care. She addressed the third CRP concern for a requirement to use licensed foster homes, even if there were allegations of abuse or neglect against the home. She reported that this greatly concerned her, and that she was working to identify this scenario, as this was not an OCS practice. She noted that with instances where abuse was suspected, but not proven, the OCS staff was not required to place children in these licensed homes.

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MS. LAWTON addressed the questions received earlier from Representative Herron [Included in members' packets]. She directed attention to the 2011 OCS Response to CRP Annual Report [Included in members' packets], and stated that some of Representative Herron's questions were answered in this report.

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CHAIR KELLER clarified that this report could also be accessed on the OCS website.

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MS. LAWTON addressed the first question from Representative Herron, which reflected concerns about the culture within OCS. She listed the things being done to improve morale and the culture in the statewide offices. She noted that this morale problem had most often cycled during the resulting stress of vacancy or turnover. She touted the staff advisory board, comprised of members from each of the five regions, as an opportunity to address suggestions, concerns and needs. She said this committee would also be used as a sounding board for new departmental ideas. She expressed her hope that this would improve the morale and communication issues.

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MS. LAWTON directed attention to the supervisory council, with which she met regularly, and its primary goal to implement the strategic plan to improve child welfare supervision in Alaska. She noted that this council offered skills training and guidance for OCS supervisors. She reported on the statewide policy and procedures group, consisting of front line staff, staff, and supervisors, which worked on revision and development of policies. She said that all the draft policies were posted on an in-house site, available for comments and feedback by any staff member.

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REPRESENTATIVE HERRON reflected on this opportunity for OCS to leave an imprint, something that people can trust. He asked that Ms. Lawton also respond to question 5.

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REPRESENTATIVE HERRON asked that Ms. Lawton respond to question 2: "OCS expects parents, or foster parents, to be full time... but does OCS expect to be available 24/7 to the children in State care?"

MS. LAWTON, in response to question 2, explained that OCS was not mandated in policy for its case workers to be available 24/7 to the clients, but that OCS did have a protocol to be available at all times. She shared that many workers did extend after hours information to clients, but that it was necessary to find a balance.

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REPRESENTATIVE HERRON offered his belief that the expectations for the foster parents were higher than the expectations for OCS staff.

CHAIR KELLER stated that this highlighted a challenge for OCS.

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MS. LAWTON responded to question 5 from Representative Herron, which read:

we understand that OCS has a long range plan of a statewide hotline that would provide 24-hour coverage by social workers with expertise to handle these

reports of harm. The barrier to implementation is funding.

She stated that OCS staff answered the after hours' hotline, but that after hours emergency calls were forwarded to law enforcement. She reported that law enforcement had the necessary authority to remove a child from a home, and that an OCS worker would be in consultation with law enforcement during any such move. She reflected on her desire to have an OCS hot line, as law enforcement was not equipped to make OCS decisions. She opined that OCS staff working in conjunction with law enforcement on the scene could often avoid a foster care placement, although she acknowledged the challenges due to the geography of Alaska. She noted that the OCS regional structure, with a hub office taking reports, had shown an increase in calls. She reported that this system required specialized skills for in-take functions, and the process was still being reviewed for any necessary modifications.

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CHAIR KELLER established that a foster care alumnus had stated a need for more investigation. He acknowledged the immensity of the challenge for in-take function, and the need for those special skills.

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MS. LAWTON informed Representative Herron that she would send a written response to all his questions.

Presentation: Alaska Tribal Health Consortium

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CHAIR KELLER announced that the final order of business would be a presentation by the Alaska Native Tribal Health Consortium.

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VALERIE DAVIDSON, Senior Director, Legal & Intergovernmental Affairs, Alaska Native Tribal Health Consortium, presented a PowerPoint, "Alaska Tribal Health System," and directed attention to slide 3 "Great Partnerships," stating that the Alaska Tribal Health System benefited everyone in the State of Alaska, as the existing health care system in Alaska was partially financed by the federal government through the Alaska

Tribal Health System infrastructure in many of the rural communities. She pointed out that immunization rates had dramatically improved. She noted that there was a savings to the state general fund whenever Indian Health Service (IHS) beneficiaries, who were also Medicaid beneficiaries, were treated in a tribal health facility.

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MS. DAVIDSON detailed slide 4, "More Opportunities to Save," and described a partnership initiated by the legislature for expanding the IHS care capacity, while saving general fund dollars, by investing in Long Term Care services in tribal facilities. This program would generate an annual savings opportunity for \$19 million to the general fund. She listed four facilities which generated an annual \$8.15 million in general fund savings.

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MS. DAVIDSON, moving on to slide 5, "More Opportunities to Save," spoke about the sanitation facilities in rural Alaska. She acknowledged the challenge to sustain this investment and support community savings of these costs. She described the Alaska Rural Utilities Collaborative which allowed communities with water operators to be supported, as these systems needed properly trained workers available daily. She pointed out that this training had lowered the worker turnover rate from 75 percent to 8 percent, and had increased the on time utility payment rate by individuals to over 90 percent. She expressed the desire to increase the collaborative by 15 communities. She suggested that an expansion of the energy audit program to include sanitation facilities was an opportunity for a 50 percent energy savings.

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MS. DAVIDSON, addressing slide 6, "More Opportunities to Save," explained another challenge for the Alaska Native Medical Center to be housing for rural citizens during visitations to the specialty medical services. She declared that the current 54 bed facility was inadequate, with a need for 100 beds.

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MS. DAVIDSON introduced slide 7, "Indian Health Service," which briefly described tribal health care in Alaska.

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MS. DAVIDSON moved on to slide 8, "IHS Delivery Models: I/T/U," and explained that all the Indian Health Service (IHS) care was provided by tribal organizations. She declared that tribal status qualified for federal funding to health care in rural Alaska. She pointed out that, as tribal health care was the only health care in rural Alaska, it was available to everyone.

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MS. DAVIDSON presented slide 9, "Alaska Native health history," and shared that Alaska Native families want what every family wants: for the family, children, family members, friends and the community to be healthy, happy, and live in safe communities. She opined that, as the communities were so often rural, it could require flexibility to a different approach. She moved on to slide 11, "Alaska Tribal Health System," and detailed that it was a voluntary affiliation of 30 Alaskan tribes and tribal organizations, with about 7,000 employees. She pointed out that each community was autonomous and served a specific geographical area.

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MS. DAVIDSON, describing slide 12, "Alaska Tribal Health Compact," stated that there was one Tribal Health Compact with a commitment for all to work together. She noted that the Alaska Native Tribal Health Consortium served all 229 federally recognized tribes in Alaska.

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MS. DAVIDSON reported that the 140,000 Alaska Natives represented 20 percent of the Alaska population, slide 13, "Alaska Native Demographics." She noted that the median age for Alaska Natives was 23.6 years compared to 32.4 for all Alaskans. She discussed slide 15, "Medical Care Service Levels," and detailed this tiered system to include small community primary care centers, sub regional mid-level care centers, multi-physician health centers, regional hospitals, and the Alaska Native Medical Center in Anchorage.

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MS. DAVIDSON, pointing to the map on slide 16, identified the large footprint of referral for the Alaska Native Health Care System. She presented slide 17, "Village-Based Medical Services," and explained that the community health aides performed the majority of care in the 180 small village health centers. She reviewed slide 19, "Subregional Clinics," confirming that these subregional clinics served a cluster of small surrounding villages, provided a higher level of care than the village based clinics, and included mid-level providers, modest radiology and lab services, dental operatories, and behavioral health professionals. She listed the six regional hospitals on slide 20, "Regional Hospitals." She said that the Southcentral Foundation, slide 21, "Southcentral Alaska," provided regional primary care and community health services.

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MS. DAVIDSON pointed out that the Alaska Native Tribal Health Consortium (ANTHC) had been created by the U.S Congress in 1998 to provide the statewide tribal health services, slide 22, "Alaska Native Tribal Health Consortium." She established that the 1900 employees of ANTHC provided tertiary and specialty medical care. She jumped to slide 24, "Alaska Native Medical Center," and reported that the center had more than 9100 in-patient admissions, 383,000 outpatient admissions, and 1500 infants delivered annually. She directed attention to slide 29, "Why invest in sanitation?" and explained that an investment in sanitation "makes good public health sense" as infants in communities without adequate sanitation were 11 times more likely to be hospitalized for respiratory infections and 5 times more likely to be hospitalized for skin infections.

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MS. DAVIDSON addressed slides 31 - 32, "Sustainability Issues," stating that federal funding was only to half the level of need, so grants and reliance on third party insurance was necessary for the balance. She said, "one of the things that we know is that as resources get tighter, that individuals in our communities and the facilities that provide their care are really going to feel the impact more than any other." Indicating slide 33, "Why?" she shared that unemployment in Indian Country was 75 percent, with some of the lowest income levels and poorest health status in the rural communities. She indicated that access to care, the high cost of providing care, and a high cost of living for limited incomes were problems.

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MS. DAVIDSON assessed slide 34, "Impact," and stated:

when people finally do get the care they need, they have traveled farther with money they don't have, they're sicker than the average person, and they're seen in clinics and hospitals that have fewer resources than almost any other clinic and hospital in the country, that, because they are rural, also have a higher cost of providing care.

MS. DAVIDSON declared another challenge, slide 35 - 36, "Sustainability Issues," to be for reimbursement of care to returning veterans. She listed the impact on health service from the price of fuel.

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MS. DAVIDSON encouraged the real life test, slide 41, "Real Life Test:"

at the end of the day, are people that we know by name in our communities regardless of where they live in the state ... getting enrolled in programs that we know they're eligible for, do they have meaningful access to care, can they travel to where the nearest care is available, is the facility that's there able to provide the full spectrum of services that they need ... because if they can't have continual access to health care over time, we know that that's not gonna get the job done.

MS. DAVIDSON addressed slide 42, "Real Life Opportunities," and asked if there was currently appropriate investment to maximize general fund savings into the future, to include the aforementioned programs for Long Term Care, Sanitation Facilities Operational efficiencies, and Patient Housing opportunities. She emphasized the ANTHC vision that "Alaska Natives are the healthiest people in the world."

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STEWART FERGUSON, PhD, Chief Information Officer, Alaska Federal Health Care Access Network (AFHCAN), Alaska Native Tribal Health Consortium, presented a PowerPoint, "The AFHCAN Telehealth Program," and directed attention to slide 3, "AFHCAN

Telehealth," noting that the terms telemedicine and telehealth were used interchangeably. He stated that the AFHCAN telehealth program had been operational for 11 years, providing care for 125,482 cases. He detailed that the customer base included 59 operational systems, with 1443 providers and 22,763 patients in 2011. He stated that the primary reason for telehealth in Alaska was that doctors were not where the patients were. Explaining slide 4, "Alaska's Physicians," he reported that 49 percent of the physicians in Alaska were primary care, while 28 percent was the average in the lower 48. He noted that, in Alaska, 65 percent of the doctors were in Anchorage.

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MR. FERGUSON moved on to slide 6, "Why do you do Telemedicine?" He stated that almost 100 percent of the patients liked it. He noted that surveys now asked patients why they used telemedicine, and the top two reasons were identified as an increase of access to care, and that it was best for patient care.

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MR. FERGUSON directed attention to slide 7, "Telehealth Impact on Extended Waiting Times" and analyzed that prior to telehealth, 47 percent of patients would wait five months or longer to see a specialist, whereas the current telehealth model had lowered this to 3 percent. Referring to slide 8, "Access," he reported that the decrease in access waiting time was accompanied by an increase in patient visits and cost savings.

MR. FERGUSON reported that, as diabetics were not getting annual eye exams, slide 9, "Joslin Vision Network (JVN)," a pilot program now flew a specialist into the villages, screened the patients, and sent the retina images to Arizona to a reading center. He stated that telehealth technology could be taken to the villages to find the patients who needed to enter the care system.

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MR. FERGUSON stated that 20 percent of specialty consultations in the villages could be turned around in 60 minutes, 60 percent of consultations in the same day, and he opined that this was better than any regular health care, slide 11, "ANMC Turnaround Time."

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MR. FERGUSON reported that telehealth was reimbursed at the same rate as an in-person visit, slide 15, "Medicaid Study: 2--3 - 2009." He said that the telemedicine consultations had prevented travel for 3,600 patients, a savings of about \$3 million in travel expenses. He affirmed that these funds were now spent on patients who needed to travel.

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MR. FERGUSON assessed that telemedicine prevented lost work and school days, slide 16, "Lost Work Days/School Days," and had saved almost \$9 million in patient travel, slide 17, "Annual Travel Savings (by Case Role)."

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MR. FERGUSON spoke about a new pediatric care telemedicine program, slide 19, which pediatric specialists in Anchorage had agreed to offer as a virtual specialty clinic. He noted that this program could save more than \$2.18 million in pediatric patient travel costs statewide, slide 21, explaining that the expert triage model would screen who needed to come in and how rapidly.

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MR. FERGUSON, referring to slide 22, "Reliable Service Has a Cost," stated that a reliable telehealth service had a significant cost, as people valued that most cases were turned around in the same day. He pointed out that this required reliable staffing to cope with the bulge times to demand. He declared that this required technical knowledge, often at the remote sites. He specified the need for staffing at the hub, and the costs for infrastructure.

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MR. FERGUSON examining slide 23, "Who Reaps the Financial Benefit?", stated that telehealth revenue was 45 percent less compared with in-person revenue, as it focused solely on the specialty, as opposed to a full work up, which was a more expensive consultation.

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MR. FERGUSON summarized slide 24, "Summary," and stated that Alaska had a very supportive reimbursement climate. He suggested that a better alignment of revenue with the costs would incentive expansion. He cited slide 25, "Care Closer to Home," a proposal for statewide specialty programs including pediatric, chronic and palliative care, and the expert triage program. He emphasized that Alaska had a world class telehealth system which included relationships with state, federal, tribal, and private partners. He shared that the AFHCAN telehealth software was being used on the space station for telehealth consults from outer space.

MR. FERGUSON, in response to Chair Keller, said that it was very feasible to have 100,000 consultations in the upcoming years.

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MR. FERGUSON agreed with the importance of the influence of U.S. Senator Ted Stevens to develop the program.

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JAY BUTLER, MD, Senior Director, Division of Community Health Services, Alaska Native Tribal Health Consortium, presented a PowerPoint, "Alaska Native Tribal Health Consortium - Role in Public Health and Health Education," and directed attention to slide 2, "ANTHC Division of Community Health Services: Core Services," which listed the five core services provided by Community Health Services: health surveillance and data analysis, disease prevention and health promotion, health education and research, technical assistance and statewide subspecialty care, and public health performance improvement.

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DR. BUTLER summarized slide 4, "Average Annual Age-Adjusted Unintentional Injury," which compared unintentional injury death rates for Alaska Natives, Alaska Whites, U.S. Whites, and the goal for healthy people. He pointed out that the unintentional death rates were about half the rate of 30 years prior for all Alaskans.

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DR. BUTLER stated that suicide was "a particularly vexing issue," as the suicide rates for Alaska Natives had been consistently high for the past 30 years, more than twice as high

as for other Alaskans, slide 5, "Average Annual Age-Adjusted Suicide." He noted that the rate among young adult Alaska Native males was almost four times that of females, slide 6.

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DR. BUTLER moved on to slide 7, "Age-Adjusted Cancer Mortality Rates," and reported that Alaska Native death rates for lung, colorectal, and stomach cancer were significantly higher than the U.S. rate, although the reasons for this disparity were not known.

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DR. BUTLER shared slide 8, "Average Number of Dental Caries in Primary Teeth," which compared the escalated number of cavities in the YK Delta with the rest of the United States.

DR. BUTLER discussed slide 9, "Public Health Challenges of 21st Century," which included unintentional injuries, suicide, alcohol abuse, cancer, tobacco, diabetes and other complications of obesity, and oral health.

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DR. BUTLER discussed slides 10, 11, 12 and 13, which pictured health promotion campaigns throughout Alaska, including life vests, fall prevention, and suicide prevention.

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DR. BUTLER noted that more than 60 people, statewide, were now certified as ASIST Trainers, slide 14, "ASIST Trainers." He moved to slide 15, "Help Yourself to Health," which included a booklet of information for available health screenings.

DR. BUTLER endorsed health education in the community, slide 16, "Nolan the Colon."

DR. BUTLER noted on slide 17, "Survey of ATHS Tribal Leaders and Providers," that this survey reported it was now easier to talk about cancer than it was five years ago.

DR. BUTLER shared that a group of regional health partnerships worked to bring colonoscopy screening to rural Alaska, slide 18, "Itinerant Colonoscopy Screening Clinics."

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DR. BUTLER shared that the colonoscopy screening project had increased the rates in the last two years, slide 19, "Colorectal Cancer Screening Rates, 2005-11."

DR. BUTLER said that obesity was addressed by programs including "The Store Outside your Door," slide 20, which discussed the gathering of traditional foods.

DR. BUTLER referred to the history of Community Health Aides, slide 22, "CHAP History," and directed attention to the Alaska map indicating 178 village clinics with 550 Community Health Aides, slide 23, "Community Health Aide/Practitioner Village Clinics." He reported there were now CHAP training centers in Anchorage, Sitka, Bethel, and Nome. He referenced the treatment guidelines contained in the "Alaska Community Health Aide/Practitioner Manual," slide 24, and said that an iPad version was being developed. He moved on to slide 25, "Dental Health Aide Therapist Program," and discussed the services available by these providers, after their intensive two year training program.

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DR. BUTLER discussed the topics, including cancer screening, tobacco cessation, oral health, and hepatitis listed on slide 26, "Health Research Topics." Moving on to slide 27, "Technical assistance and statewide subspecialty care," he discussed the HIV clinics for care and prevention and development of the cancer program services.

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DR. BUTLER pointed to slide 28, "Public Health Performance Improvement: CDC NPHII Program." He explained that the National Public Health Improvement Initiative (NPHII) supported this program to improve the efficiency of public health programs, document the best business practices, and measure the effectiveness to maximize the investment.

DR. BUTLER concluded with slide 29, "Our Vision," stating the vision of the Alaska Native Tribal Health Consortium to be "Alaska Natives are the healthiest people in the world," and, slide 30, "Progress Toward the Vision," recognizing the progress with more Alaska Native mothers breastfeeding and exercising,

fewer Alaska Native teens smoking, and fewer Alaska Natives drowning or dying in a fire.

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REPRESENTATIVE DICK pondered whether bug dope and mosquito coils were responsible for an increase of cancer.

DR. BUTLER, in response, stated that natural products were not necessarily associated with good health.

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REPRESENTATIVE HERRON, referring to slide 7, asked if the rate for stomach cancer was even higher in Yukon-Kuskokwim (YK) Delta.

DR. BUTLER said that the rates of stomach cancer were even higher in rural Alaska, specifically areas with poor sanitation facilities.

REPRESENTATIVE HERRON asked that the graph reflect stomach cancer deaths for YK Delta natives, as well.

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MATT DIXON, P.E., Vice President of Operations, Division of Environmental Health and Engineering, Alaska Native Tribal Health Consortium, presented a PowerPoint entitled, "Division of Environmental Health and Engineering Lasting solutions to promote healthy communities." He shared his desire to "keep people from getting sick to begin with." He pointed out that this saved money for the health care system, and it allowed for a much higher quality of life. He moved to slide 3, "Health Impact of Improved Sanitation," and slide 4, which graphed gastrointestinal and post neonatal mortality rates, reflecting the decline of deaths with the increase of clean water into homes and dirty water out of homes.

MR. DIXON directed attention to slide 5, "Infant Hospitalization Rate," and slide 6, which showed the increase in respiratory infection, skin infection, and pneumonia without clean water in the home. He presented slide 7, "Impact of Improved Sanitation," which supplied data for the decrease in health impacts.

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MR. DIXON offered slide 9, "DEHE: Organization Profile," and stated that there were 250 staff who planned, designed, and built health and sanitation facilities in Alaska. He pointed out that the organization also hired local work forces. He listed the federal and state partnerships, slide 10, "Program Partners and Funding Agencies" and slide 11, "Program Partners-State of Alaska," including U.S. Environmental Protection Agency, U.S. Indian Health Service, and Denali Commission. He declared the closest partner to be the State of Alaska, and its' Department of Environmental Conservation. On slide 12, "Recent Project Successes," he listed the recently completed projects, including water service for more than 700 homes throughout rural Alaska. He noted that almost 20 percent of homes in Alaska did not have water or sanitation service.

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MR. DIXON, speaking about slide 13, "Rural Sanitation in Alaska," indicated the predominate demand to be in the interior and the western portion of Alaska, where 35,000 people had systems that needed to be upgraded or replaced.

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MR. DIXON referred to slide 18, "Capital Funding for Sanitation," and slide 19, "Needs vs. Funding," pointing out that federal funding was dropping, but the needs were increasing. He explained that this left Alaska "A Generation Behind," slide 20, as so many people did not have sanitation facilities. He explained that it was necessary to maintain or increase sanitation funding, research and develop innovative systems with the new technology, and ensure that the current systems were sustainable, slide 21 "Focus for Future Efforts." He confirmed that the problem was finding water, getting it to people, and getting waste out of the house.

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MR. DIXON furnished slide 23, "Long Term Sustainability," and emphasized that this was the most important focus. He said that his division had done 41 energy audits throughout Alaska, which had recognized a substantial savings. He spoke about the use of alternative energy, and improved operations and maintenance for systems to last.

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MR. DIXON spoke of the three challenges: keep money coming in, audit the systems for increased efficiency, and support strong operations and maintenance.

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REPRESENTATIVE DICK offered his experience for consultation to realistic solutions.

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MS. DAVIDSON pointed out that the State of Alaska was required to fund a minimum match of 25 percent to the federal funding. She pointed out that federal funding was decreasing, and she asked if the state would increase its match in order to provide the necessary sanitation services.

CHAIR KELLER affirmed the dilemma from a decrease to federal dollars.

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REPRESENTATIVE SEATON reflected on the use of sufficient Vitamin D as a preventative. He reminded that Fraser Canada had instituted a dose of 20,000 IU each week as a preventative for fractures to the elderly. He pointed out that low Vitamin D levels had also been attributed to suicides.

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CHAIR KELLER agreed that this was a very affordable prevention program.

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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 4:53 p.m.