1981
INTERIM
NOME
11/7/81

Original sponsors: Buchholdt, Gardiner, Clocksin, et al

Offered: 4/16/81
Referred: Rules

1 IN THE HOUSE BY THE FINANCE COMMITTEE

2 CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 41 (Finance) (efd failed)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TWELFTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the health of residents of the
7 state."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 18 is amended by adding a new chapter to read:

10 CHAPTER 27. STATE HEALTH INSURANCE.

11 Sec. 18.27.010. STATE COMPREHENSIVE HEALTH PLAN. (a) The com-
12 missioner shall establish minimum benefit standards for the state
13 comprehensive health plan and shall provide for the underwriting and
14 administration of the state comprehensive health plan.

15 (b) A resident of the state is entitled to enroll in the state
16 comprehensive health plan.

17 (c) The state comprehensive health plan shall provide for copay-
18 ments and deductibles, and shall provide an annual limit on the total
19 amount of copayments and deductibles for each enrolled resident and the
20 covered dependents of the resident for each year. The annual limit
21 shall be the same regardless of family size.

22 (d) The commissioner shall contract for the administration and
23 may contract for the underwriting of the state comprehensive health
24 plan. A contract entered into under this subsection shall be based on
25 competitive bids and shall be for a three-year period.

26 (e) Notwithstanding the provisions of (c) of this section and the
27 limitations in AS 18.27.020(b), an individual eligible for a permanent
28 fund dividend under AS 43.23.010 may, to the extent of his eligibility
29 under AS 43.23.010,

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(1) enroll in the state comprehensive health plan or in an individual health insurance plan certified under AS 18.27.020(a)(1);

(2) direct the commissioner of revenue to use as much of the permanent fund dividend to which the individual is entitled under AS 43.23.010 as is necessary to pay a cost of the individual incurred in participation in the state comprehensive health plan or in an individual health insurance plan certified under AS 18.27.020(a)(1).

Sec. 18.27.020. STATE HEALTH INSURANCE COST SHARING PROGRAM. (a) A resident of the state is entitled to cost sharing under the state health insurance cost sharing program if

(1) the resident is enrolled in the state comprehensive health plan or an individual health insurance plan which the insurance company has certified to the commissioner as equivalent to or exceeding the benefit standards of the state comprehensive health plan established by the commissioner under AS 18.27.010(a);

(2) the resident is not enrolled in a group health insurance plan or in a federal health plan; and

(3) the resident qualifies for cost sharing under (b) of this section.

(b) The commissioner shall pay the state share of the costs of health insurance incurred by a resident of the state and his covered dependents qualifying for cost sharing under the following formula:

Kugzruk - vary according to region

(1) if the total adjusted gross income of the resident and his dependents is at or below 75 percent of the base income, 100 percent of the premium cost of health insurance;

(2) if the total adjusted gross income of the resident and his dependents is between 75 percent of the base income and 125 percent of the base income, a graduated percentage of the premium cost of health insurance between 100 percent and zero percent;

(3) if the total adjusted gross income of the resident and his dependents is at or below 45 percent of the base income, 100 percent of copayments and deductibles;

(4) if the total adjusted gross income of the resident and his dependents is between 45 percent of the base income and 95 percent of the base income, a graduated percentage of the copayments and deductibles from 100 percent and zero percent;

(5) if a resident is enrolled in an individual health insurance plan certified to the commissioner under (a) of this section, the state share of the cost of health insurance for the resident is limited to the amount that the state's share would have been if the resident had been enrolled in the state comprehensive health plan.

(c) The commissioner shall adopt minimum benefit standards and guidelines for determining benefit equivalence for the certification of plans under (a)(1) of this section.

(d) Notwithstanding the provisions of an individual health insurance plan, a plan certified by an insurance company to the commissioner under (a)(1) of this section provides the minimum benefits and the equivalent benefits required for certification.

Sec. 18.27.030. DEFINITIONS. In this chapter

(1) "adjusted gross income" means the adjusted gross income of the resident determined under the regulations of the commissioner;

(2) "base income" means

(A) family median income for Alaska determined by the federal Office of Human Development Service; and

(B) regional adjustments established by the commissioner to the family median income for Alaska determined by the federal Office of Human Development Service which are based on relative costs of living in the state;

1 (3) "benefit equivalence" means that the benefits provided
2 in an individual health insurance plan and certified to the commis-
3 sioner under AS 18.27.020(d) are equivalent to benefits provided under
4 the state comprehensive health plan;
5 (4) "commissioner" means the commissioner of administration;
6 (5) "copayment" means the portion of covered expenses pay-
7 able by the resident after the deductible has been met;
8 (6) "insurance" means prepaid plans or indemnity plans.
9 * Sec. 2. The commissioner of administration shall report by the 30th
10 day of the Second Session of the Twelfth Legislature on
11 (1) proposed minimum benefit standards and estimated actuarial
12 costs of the state comprehensive health plan (AS 18.27);
13 (2) the anticipated number and characteristics of participants in
14 the state health insurance cost sharing program (AS 18.27.020) and the
15 projected cost to the state;
16 (3) a proposed plan for
17 (A) implementation of AS 18.27;
18 (B) eligibility determinations under AS 18.27;
19 (C) payment of the state share of premium costs and copay-
20 ment and deductibles incurred under AS 18.27; and
21 (D) informing the public of benefits under AS 18.27;
22 (4) recommendations for amendments to AS 18.27.
23 * Sec. 3. Coverage under the state comprehensive health plan (AS 18.27.-
24 010) and the state health insurance cost sharing program under AS 18.27.020
25 begins on July 1, 1982.
26 * Sec. 4. AS 21.54.060 is amended by adding a new paragraph to read:
27 (7) under a policy issued to the state to insure residents
28 of the state under AS 18.27.
29 * Sec. 5. AS 39.30.090(1) is amended to read:

(1) A group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audio-visual insurance, alcoholism and drug dependency insurance, or other medical care insurance.

* Sec. 6. AS 39.30 is amended by adding a new section to read:

Sec. 39.30.092. COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a) The group insurance policy under AS 39.30.090(1)

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(1) shall provide coverage for alcoholism and drug dependence to include

(A) inpatient detoxification benefits for not less than 14 days of benefit each calendar year in a state-approved treatment facility or licensed hospital; payment of institutional and professional benefits shall be equal to and payable as any other covered condition, except a covered condition which, by the terms of the policy, has an internal restriction;

(B) inpatient treatment coverage benefits for not less than 30 days of benefit each calendar year in a state-approved treatment program; payment of institutional and professional benefits shall be at the same level as any other covered condition, except a covered condition which, by the [illegible]s of the policy, has an internal restriction; and

(C) outpatient treatment coverage benefits of not less than 30 visits each calendar year if treatment is provided by a licensed physician, state-approved treatment program, or state-certified professional substance abuse counselor; coverage shall include individual, family or group therapy; benefits shall be paid a[illegible] less than 75 percent of the usual, customary and

1 reasonable charge for a medical procedure, treatment or service in
2 the geographic area;
3 (2) may not exclude dependents otherwise covered and may not
4 limit coverage for alcoholism or drug dependence because of age, sex or
5 state of illness;
6 (3) may not apply preexisting or named condition exclusions
7 to deny coverage for alcoholism or drug dependence; and
8 (4) may require a physician's certification of necessity as
9 a condition of payment for alcoholism or drug dependence treatment.
10 (b) The provisions of this section apply to group health insur-
11 ance contracts and group service or indemnity type contracts issued to
12 provide coverage for employees of the state and may apply to contracts
13 for the benefit of employees of other participating governmental units
14 only if the governing body of the governmental unit elects to have the
15 provisions apply.
16 (c) In (a) of this section,
17 (1) "alcoholism" means an illness or condition characterized
18 by the habitual lack of self control in the use of alcoholic beverages,
19 or use of alcoholic beverages to the extent that health is substantial-
20 ly impaired or endangered, or social or economic function is substan-
21 tially disrupted;
22 (2) "drug dependence" means the condition of being physi-
23 cally or psychologically addicted to an opiate, opiate derivative,
24 tranquilizer, amphetamine, barbiturate, or similar substance, but
25 excluding nicotine, caffeine and alcohol;
26 (3) "state" means any state in the United States and in-
27 cludes the District of Columbia.
28 * Sec. 7. AS 39.30.100 is amended to read:
29 Sec. 39.30.100. DEFINITIONS. In AS 39.30.090 - 39.30.100 [AS 39.-

1 30.090]

2 (1) "eligible employee" means

3 (A) an employee who has served in permanent full-time

4 or part-time employment with the same governmental unit for 30

5 days or more, except an emergency or temporary employee, and

6 (B) an elected or appointed official of a governmental

7 unit, effective upon taking the oath of office;

8 (2) "governmental unit" means the state, a borough, munici-

9 pal corporation, or other political subdivision of the state, and the

10 North Pacific Fishery Management Council;

11 (3) "insurance", "insurance carrier" and "insurance policy"

12 include health care services, health care service contractors and con-

13 tracts.

14 * Sec. 8. The provisions of secs. 5 - 7 of this Act apply to group poli-

15 cies or contracts which provide coverage under AS 39.30.090 - 39.30.100 and

16 which are delivered, issued for delivery, or renewed in this state after the

17 effective date of this Act. A policy or contract providing coverage for

18 eligible employees in this state under AS 39.30.090 - 39.30.100 delivered,

19 issued for delivery, or renewed after the effective date of this Act provides

20 the minimum coverage required by this Act even if the language of the policy

21 or contract does not specifically so provide.

22 * Sec. 9. AS 47.05 is amended by adding new sections to read:

23 Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CON-

24 TRACTS. (a) The commissioner shall use medical assistance funds to

25 purchase and pay premiums on policies of insurance or pay the expenses

26 on health care service contracts that provide one or more of the ser

27 vices available under state medical assistance programs.

28 (b) The policy of insurance or the contract financed under this

29 section must guarantee to

(1) provide services and supplies under policies of insurance or contracts under AS 21;

(2) provide the statistical data, records, and reports relating to the provision, administration, and costs of providing services and supplies as required by the commissioner.

Sec. 47.05.080. IMPLEMENTATION. The commissioner shall implement the provisions of AS 47.05.070 when he determines that comparable benefits are available at equal or less cost than direct payments by the department to the providers of services and supplies.

Sec. 47.05.090. INTERIM PAYMENT. If the commissioner determines under regulations adopted by him that a provider of medical services is expected to serve a large volume of medical assistance clients, he may make an interim payment before receipt of billing for services to the provider.

Sec. 47.05.100. INTEREST ON LATE PAYMENTS. When presented by a provider of medical services with a clean claim, the commissioner shall pay

(1) interest at the rate of one percent per month when payment is delayed more than 45 days after presentation of the clean claim;

(2) interest at the rate of two percent per month when payment is delayed more than 90 days after presentation of the clean claim; and

(3) the interest for a full month if the overdue clean claim is not paid by the 15th day of a calendar month.

Sec. 47.05.110. DEFINITIONS. In AS 47.05.070 - 47.05.110

(1) "clean claim" means a claim for payment which can be processed without obtaining additional information from the provider of the service or from a third party; it includes a claim with errors

originating in the department's claims processing system, but does not include claims from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity;

(2) "commissioner" means the commissioner of health and social services;

(3) "health care service contract" means a contract with a nonprofit corporation which accepts prepayment for health care services and is sponsored by or associated with a group of physicians or a group of hospitals or both or by a health maintenance organization recognized under federal law;

(4) "medical assistance" means Medicaid (AS 47.07), general relief medical (AS 47.25.120), catastrophic illness (AS 47.08), and crippled children's and maternal and child health programs (AS 18.05.-010).

* Sec. 10. AS 47.07.020(b) is repealed and reenacted to read:

(b) A resident of the state for whom the provisions of the Social Security Act in effect on March 1, 1981, allow optional medical coverage qualifying for federal financial participation is eligible for medical assistance. A resident of the state qualifying as medically needy is not eligible for medical assistance.

* Sec. 11. AS 47.07.030 is repealed and reenacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include those services eligible for federal financial participation under the provisions of Title XIX of the federal Social Security Act in effect on March 1, 1981.

* Sec. 12. AS 47.07.080 is amended by adding new paragraphs to read:

(5) "medically needy" means a person who meets the categorical requirements of eligibility for medical assistance but whose income

(A) exceeds the income standard for categorical assist-

ance; and

(B) is less than the medically needy income standard after the deduction of allowable medical expenses;

(6) "categorical requirements of eligibility" means the standards established under 42 C.F.R., secs. 435.500 - 435.541;

(7) "medically needy income standard" means the standards established under 42 C.F.R., secs. 435.800 - 435.816.

* Sec. 13. (a) By the 30th day of the Second Session of the Twelfth Legislature the Legislative Council shall study and make recommendations to the legislature

(1) for federal improvements in the Indian Health Service delivery system;

(2) on the alternatives available to the state to complement the funding of the Indian Health Service;

(3) on the alternatives available to the state to complement services available to the senior citizens of the state under Medicare.

(b) The Legislative Council shall seek participation in the study by

(1) the Health, Education, and Social Services Committees of the legislature;

(2) the Alaska Native Health Board;

(3) regional health organizations;

(4) other providers and consumers of health care;

(5) the Department of Health and Social Services;

(6) the Alaska Area Native Health Service, United States Public Health Service.

* Sec. 14. AS 47.07.020(d) is repealed.

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11/7/81

Testimony to HESS Committee
by
Nancy M. Mendenhall, Community Health Services Director

Thank you for the opportunity to testify at this hearing. I will address two areas of health care delivery today: Dental Services and Eye Care. To this date both have been funded through our contract w/ IHS, have never actually met the need.

Eye Care services in the region presently are very limited. Norton Sound Health Corp. employs a trained Eye Care technician who is able to do refractions for eye glasses, eye glasses repair, some eye disease screening. She maintains an office in Norton Sound Hospital and makes her services available to the public in Nome. People pay for the actual purchase of the glasses themselves. She also assists opthamalogists who come to Nome to do speciality clinics.

There are two serious problem with this service delivery which we are going to be unable to resolve using I.H.S. money. First, being a one person office, with the loss of her CETA assistant this year, she is unable to keep up with the need here in Nome and is beginning to experience a back log of patients. Second, she or the PHS opthamologists are scheduled to travel to each of the 15 outlying communities of the region only once a year.

This year, there is a strong possibility that area office IHS staff will not be able to cover their share of the villages, which is normally one half.

This would leave some villages without eye services for the year. As you are probably aware, there is a lot of need for vision correction in Arctic Alaska. We are especially concerned about the effect of budget reductions on services to school children. The technician has already informed us that if she has no assistant next year, she will be unable to cover school screening on her trips to the villages. This function can be covered by P.H.Ns but expansion of state eye services to outlying communities to include eye glass refractions would appear to be a very needed function soon.

Another area of even more critical concern is dental disease. Norton Sound Board of Directors recognizes dental disease as one of our major health problems, and it is an established fact which Norton Sound acknowledges that we are falling behind in the larger villages in our attempt to overcome this health problem.

Norton Sound provides that each village in the region is visited once or twice a year, either by our own PHS dentists or by private dentists which we contract to cover PHS eligible patients. This field trip is of one week duration in the smaller villages, two weeks in the larger. Because of size, nine of our villages get only a one week trip once a year. Our budget will not permit more than this. Some villages attempt to supplement the days by contributing to dentists' per diem costs from their own city accounts. The two weeks allowed to the larger villages is not enough to cover the extent of disease, and the dentists report that in some sites the condition of childrens teeth is getting worse not better. Many children by the time they reach school age have not a usable tooth left in their head.

The present benefits offered through our IHS contract have been: general routine care to recipients under 20 years of age, but no dentures or other prosthetics; this plus prosthetics to medicaid eligible over 55 years or under 20; emergency care only to other adult recipients.

Two private dentists reside in Nome who can provide dentures at market cost, but this is extremely expensive, out of reach for most village families, when you consider the travel costs involved in getting this prolonged work done.

This fall for the first time we are opening up our benefits to include non-emergent routine care to adults on a cash market-price basis. The purpose is to try to do more to get the maintenance level up. However, many families will not be able to afford this, and the village trips will still be limited to the one or two a year.

Another effort by NSHC has been in the area of prevention, specifically fluoride treatments, which are managed through the health aide program. But much more needs to be done in the way of dental education and prevention. For the last year Norton Sound has employed a dental hygienist whose position is presently on the budget "cut list". The person attempts to work with patients directly and with Nome schools, but has no travel funds for village work.

Clearly dental services to remote communities is an area of health which the state needs to involve itself immediately in, with the contraction of services by Indian Health Services threatened. I.H.S. has never met the need even in its better funded days.

A need implied in my comments on dental and eye care needs is a third serious area of deficiency which we face in the reduction of our IHS Contract, and this is patient travel costs. The average one way fare from a village into Nome for treatment at our hospital is $75.00. For the last four years we have asked the patient to pay one way while NSCH picks up the return trip. We are now looking at the very real possibility that NSHC may not be able to cover this half of the travel costs. For most families this type of expense will be difficult and may result in them delaying necessary treatment. A similar situation prevails in travel between NSRH and ANS in Anchorage, in which case we pay one way and ANS the other. ANS informs us as of this week that they will not be able to cover their half except in emergency cases, and as stated above, we will have the same problem.

In order for rural populations to have equity of access to health services with urban populations, it may be necessary for the State to consider subsidizing travel costs to medical facilities.

Thank you for considering this testimony.

NSHC

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...RATION

COMPREHENSIVE ALCOHOL PROGRAM (CAP)
PUBLIC TESTIMONY ON HEALTH CARE

7 November 81

The Comprehensive Alcohol Program (CAP) recommends that in all considerations before the Senate Committee concerning Health Care that persons suffering from alcoholism or other medical conditions arising from alcohol abuse be given equal treatment as a patient presenting symptoms of any other disease. This includes the availability and accessibility of services, health planning (HSA), and prevention and education information.

We specifically request that the treatment of alcohol and drug abuse not be considered as a separate issue in House Bill 41. The State Comprehensive Health Plan as described in HB41 appears to be meant for all eligible Alaska residents who wish to enroll. We would like an explanation of two specific items:

page 5 Why is there a separate section dealing specifically with alcohol and drug abuse?

page 6 Why does this section appear to be meant for only state employees?

In this remote area of Alaska alcohol is the major contributing factor to a series of illnesses, diseases, and injuries which, as a whole, is the number one public health problem for our population. In addition to alcoholism as a disease and the related diseases such as liver cirrhosis, pancreatitis, gastric ulcers, and the like, there are many debilitating illnesses which are brought about or worsened by alcohol abuse. Further, there are almost no violent crimes and assaults in this area which are not alcohol related. There is child abuse and neglect and spouse battering which damages both bodies and minds.

The philosophy of CAP is that alcoholism is a treatable disease. It is our opinion that cultural stress plays a significant role in the causal factors of alcoholism in the Norton Sound and Bering Straits region of

Serving the communities of: ... Elim, Gambell, Golovin, Koyuk, Nome, St. Michael,

northwest Alaska. We believe that prevention is the highest level of alcohol abuse treatment and, therefore, emphasize concentrating efforts on a strong foundation of alcohol abuse prevention education. Included in our philosophy is a belief that a health systems approach is critical to the solutions desired in the area of alcohol abuse as it affects our region. Planning must be at the least regionwide and long-term, wherein the whole rather than the individual is stressed.

In 1956 the American Medical Association recognized alcoholism as a disease process. Like heart disease it can be triggered and worsened by an unhealthy lifestyle; unlike heart disease persons with alcoholism are often denied equal medical treatment as if the disease were a moral or character weakness. In 1965 the American Psychiatric issued a statement which included reference to the fact that general medical and psychiatric facilities commonly discriminate against the patient with alcohol problems:

> "Such meager services as they do render are offered in a spirit of therapeutic pessimism. What is needed are properly equipped and adequately staffed wards prepared to offer prompt and adequate treatment of acute and chronic physiological, psychological, and social disturbances associated with alcohol problems, and all of this in close coll borative relationship with other community agencies concerned with the management of such problems. The principle of a continuum of services in the community applies here as well as to other disorders.
>
> All prepayment plans for defraying the cost of medical care through insurance should cover the person presenting symptoms of alcohol problems who seek treatment in medical settings on the same basis as for other illnesses."

It is the CAP position that this is as true today in 1981 "bush" Alaska as it was sixteen years ago.

Overview of the Norton Sound CAP Project

The Norton Sound CAP is a department of the regional health corporation. It is funded almost entirely through a state grant with some in-kind match and cash grants from the city and the health corporation for other components of the project. The services are comprehensive and include emergency care, medical detoxification, intermediate care at a residential treatment center, outpatient services through the community mental health agency, outreach through the women's shelter and the court-referral program, village coordination and technical assistance program, aftercare, and consultation and education.

There arises the question of what model to adopt to measure success. Keeping in mind the disease process of alcoholism and the many interrelated factors, it becomes evident that the recovery process is also complex. Recovery from alcoholism or other alcohol-related health conditions must be accomplished with a change in lifestyle. In this part of Alaska if a person is to learn to abstain from or reduce alcohol consumption he must learn to do it in what was, at the height of the illness, an alcohol-filled environment. A person recovering from heart disease learns to eat healthier foods, seek less stress-filled employment, get routine medical checkups, quit smoking, and so forth. Similarly, the recovering alcoholic or alcohol abuser must build these healthier changes into his treatment plan. The heart patient sometimes has relapses, sometimes eats unhealthy food, sometimes sneaks a cigarette, sometimes indulges in stressful situations. The recovering alcoholic also relapses during the recovery process. Such relapses are predictable, are measurable, and should be considered in designing an evaluation model.

At Norton Sound CAP we believe that not all persons suffering from alcohol problems have the same affliction; however, we do believe that for those who have progressed to the stage of alcoholism, drinking alcohol is contraindicated. Therefore, for such persons success can be measured in increasing periods of sobriety between relapse until a state of relative "remission" is reached (most researchers tend to believe that to reach this state is a two- to three-year process). Other ways of measuring successful client outcomes include increased quality of life, better financial status, ability to seek and maintain employment, and the like.

For persons who have alcohol problems less severe, success can be measured in improved health, lowered consumption, better quality of life, improved attitudes. Ideally we will deliver services and health care for all patients with alcohol-related problems in a setting as close to their own environment as possible. In our case this means acute care at the regional hospital, intermediate care at the regional treatment center, aftercare at the village level or local level for Nome residents. We tabulate patient contacts and operate on the principle of a continuum of services. If we can show ever-increasing levels of professionalism for our service providers, increasing hours of patient contact, better results from medical exams, increasing days of employment for active clients, positive reports from significant others in the clients' lives--we consider these to be measures of success which will ultimately move us toward the goal of reducing alcohol abuse in the region and thereby reduce the physiological, psychological, and social problems which it causes.

These physical and mental health care services attack only half of the cycle of alcohol abuse. The balance is education and prevention. Recovering alcoholics <u>are</u> sober role models and therefore treatment is needed for those suffering. Education is needed to remove the myths, teach coping skills for those in alcohol abusing situations, to reveal equally enjoyable alternatives to abusive drinking, and so on. Prevention can take many forms, and limiting availability is a significant one. This is something that the local option laws are addressing, as is other legislation enacted or under consideration, such as sanctions for serving inebriates and efforts to shorten serving hours for licensed premises.

We believe that money being filtered into "bush" programs such as ours is being carefully and frugally managed. We recommend that such "bush" programs be allowed to develop evaluation models unique to rural Alaska which will give the interpreters a truer picture of the progress being made with regional projects.

Submitted by:

Constance L. Hollenbeck
Acting CAP Director

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Status of Water Projects

Norton Sound Area

November, 1981

1. NOME: Year of last water project: Summer, 1981

   - Complete Water & Sewer System
   - Received +$4 million for connecting existing housing units to city water and sewer
   - Existing sewage treatment plant is undersized and is presently being by-passed; discharging raw sewage into Snake River.
   - No plans for enlarging sewage treatment plant
   - Utilizes honeybucket haul service and water delivery
   - Community landfill and an aluminum recycling program
   - Plans to construct causeway at mouth of Snake River. May extend sewage discharge pipe along causeway for ocean disposal.

2. UNALAKLEET: Year of last water project: 1981

   - Complete Water & Sewer System ($35/mo/home)
   - 30 new housing units present being connected
   - Community landfill

3. SAVOONGA: Year of last water project: 1980

   - Watering Points (3) and washeteria
   - Planning for a community landfill and honeybucket disposal site
   - City developing a water delivery and honeybucket disposal service
   - BIA operates and maintains pumphouse facility
   - Well source

4. GAMBELL: Year of last water project: 1980

   - Watering point and washeteria
   - (4) 4 kw-wind generators; inoperable
   - Shallow well (REAA H. School and washeteria and spring gallery (watering point) sources
   - Replaced gallery transmission line-summer, 1980

Gambell (cont)

- gallon steel water storage tank
- REAA feels that the H. School is not provided with an adequate water supply
- Fenced-in community landfill
- Community honeybucket waste disposal bunkers
- City to receive grant money for purchasing 3 windchargers
- Possible lead problem in H. School water system; recheck chemical samples will be collected to verify

5. SHISHMAREF: Year of last water project: 1977

- Watering Point
- Fill and draw system; pond source
- 300,000 gallon steel water storage tank
- REAA planning to construct new elementary school and swimming pool/ fire reservoir
- 16 HU housing units to be constructed - 1982
- PHS planning to upgrade existing water system
- REAA H. School presently utilizes half of community stored water supply
- City developing garbage pickup service
- Individual honey bucket disposal
- Community open dump
- New runway to be constructed - 1982
- REAA conducting feasibility studies for developing conceptual designs for new community sanitation facilities
- Residents do not utilize existing water systemdue to objections of the reservoir adjacent to the cemetery
- Proposal submited for an erosion control project
- Proposal submitted fro landfill equipment
- Was placed on the VSW priority list for improvements to existing water system. Was placed 7th on the PHS priority list for regular peojects

6. STEBBINS: Year of last water project: 1981

- Watering point and washeteria
- Fill and draw system; pond source
- 500,000 gallon steel water storage tank
- 3.5 miles P.E. transmission water line
- New REAA H. School to be completed - 1982
- REAA to provide additional water storage for H. School
- PHS planning renovations to existing system - 1982
- BIA school does not drink school well water due to oil contamination
- City desires summer water line
- No primary water operator
- Was placed 11th on the PHS priority list for regular projects

7. ST. MICHAEL: Year of last water project: 1981

- Watering point
- Fill and draw system; pond source
- 3.5 mile 4" aluminum transmission line
- 400,000 gallon steel water storage tank under construction (VSW & PHS)
- BIA school connected to existing pumphouse; 100,000 gallon steel water storage tank.
- City submitted DEC application for community landfill and road development
- Lead problem in BIA school water system

8. ELIM: Year of last water project: 1981

- Complete water and sewer; spring gallery source
- Presently connecting 35 new housing units
- Sewage treatment plant being replaced with dual community septic tank systems
- City decided against a washeteria facility due to financial problems in 1980
- Community landfill site location under study by PHS
- City submitted grants for purchase of heavy equipment for road and landfill maintenance purposes
- City submitted grant for bulk fuel storage tanks

9. TELLER: Year of last water project: 1981

- No community water system
- City summer water haul service; Blueston River - 18 mi.
- Individual solid waste and honeybucket disposal
- REAA school well brackish; utilize hauled water for drinking purposes. No additional water storage
- Teller townsite located in flood plain
- REAA school district proposing to construct a one million gallon community water storage tank.
- PHS developed a watering point for new site. Marginal source due to freezing over of creek
- Placed as top priority on both the VSW & PHS priority lists

10. KOYUK: Year of last water project: 1981

- Watering point and washeteria - completed fall '81
- Well source - 90' deep
- Fenced-in community landfill disposal site
- Honeybucket disposal bunkers filled with water - useless
- Summer water distribution line
- DEC funded 4 x 4 truck for community garbage pickup service

11. SHAKTOOLIK: Year of last water project: 1980

- Watering point and washeteria
- Fill and draw system; creek source
- 2.5 mile transmission line

Shaktoolik (cont)

- 800,000 gallon steel water storage tank
- REAA Elementary and H. School utilize community source
- Received emergency state funds Fall '81 due to backup of septic tank system for washeteria
- Tank did not get re-filled for this winter. Water to H. School was consequently cut off.

12. BREVIG MISSION: Year of last water project: 1979

- No existing community water system
- Watering point/washeteria facility destroyed by fire - Jan. 1980
- No water system for the REAA H. School
- REAA school district proposes to construct a community water system
- Extent of construction unknown. May receive additional funding from state.

13. WALES: Year of last water project: 1979

- Community washeteria and watering point
- Residents haul water from creek in summer; do not utilize watering point
- Individual garbage and honeybucket disposal
- Poor O & M of existing system
- Gallery water source

14. WHITE MOUNTAIN: Year of last water project: 1982

- Community washeteria and watering point under construction - PHS & VSW
- Well source
- 16 HUD housing units to be constructed - 1982

15. GOLOVIN: Year of last water project: 1979

- Community washeteria and watering point
- Fill and draw system; creek source
- 10,000 foot water transmission line
- 15 HUD housing units to be constructed - 1982
- 300,000 gallon wood-stave tank; residents complain of faulty tank: leaks
- Operation and maintenance of system unreliable; system has frozen almost every winter since its completion in 1977
- Fish Co-op utilizes existing system in summer months
- No trained water operator
- REAA H. School has no water system
- Community to be provided electricity - '82
- REAA submitted a budget for a community water system. Extent of construction activities unknown.
- BIA school well brackish; school utilizes hauled water for drinking purpose
- Residents utilize hauled water; do not trust quality of community water
- PHS is planning on renovating existing water facility in conjunction with new housing

16. DIOMEDE: Year of last water project: 1973-74

- Community watering point
- 150,000 gallon wood-stave tank; spring source
- BIA operates and maintain water system in return for water usage
- Existing tank undersized for both community and school usage
- Old summer transmission line and tank needs repairing
- New REAA H. School to be constructed - 1982
- REAA proposes a horizontal storage tank; size of tank unknown
- Washer, shower, and drier facilities available in the BIA school for community use

17. COUNCIL: Year of last water project: 1978

- VSW watering point
- Wind generator - presently inoperable
- Well source

MC GRATH-ANVIK COMMUNITY & FAMILY SERVICES
BOX 44
MC GRATH, ALASKA 99627
(907) 524-3867

September 8, 1981

Enclosed is a paper put together by a committee of rural/bush mental health program directors. It is a beginning attempt to look at rural/bush mental health issues and needs and to come up with a plan for service delivery and outcome indicators.

This paper will be presented by one of our committee members at the Governor's Advisory Council meeting on September 25th. Rural program directors will attend this meeting and are willing to engage in a work session with the Council if they are interested.

We recognize that this is just a beginning effort toward the accomplishment of the goal of developing a solid, effective plan for rural mental health services through activities that can be quantified and assessed.

Your comments and suggestions would be appreciated.

Sincerely,

Nettie D. Scott, M.S.W.
Clinical Director

COMMUNITY MENTAL HEALTH IN RURAL ALASKA

INTRODUCTION

In response to a request from the Governor's Mental Health Advisory Council, the rural Community Mental Health Center(CMHC) directors met to formulate a statement defining and describing rural/bush services and service delivery models. The committee consisted of the following CMHC program administrators: Nettie Scott, Susan Soule, Daniel Bill, Jeff Friedman, Boy Collier, Sharon Walluk, Evelyn Wiszinckas, and Michael Graf. The document is an attempt to identify specific issues and circumstances common to Alaska's rural and urban community mental health programs. It is hoped that this document will be adopted by the Council and the Division of Mental Health in developing orientation materials, in establishing funding criteria, in developing a more meaningful management information system format, in evaluating program effectiveness, and in preparing statewide planning documents.

MISSION STATEMENT

Community mental health programs in Alaska should provide a broad range of locally determined mental health services. These services should be accessible, responsive, adaptive, and should be founded upon a service philosophy, plan, and delivery system based upon local need. They should promote the well-being of the larger community, the family and the individual.

Planning, monitoring, and evaluating programs and services require criteria broad enough to encompass the various social and cultural contexts in which services are to be delivered, yet specific enough to provide clear direction. Following is a description of common rural community characteristics and a comprehensive listing of program functions, applicable not only to the rural program, but to more urban programs as well.

CHARACTERISTICS OF SMALL COMMUNITIES

Small Alaskan communities have important characteristics which differ substantially from those of larger urban settings. These characteristics are not totally unique to rural communities and exist to a lesser extent in urban areas. In rural communities, because they predominate, they play a large role in program development, service delivery, and overall program activities. These characteristics derive from the healthy need of a small community to survive independently and they are necessary and adaptive in allowing the small community to sustain itself. The generalized conservatism associated with these characteristics imposes certain unique demands on any program which has potential impact on the social structure and social functioning of the community. Some of these characteristics are:

1. A conservative social system in which there is a slowness to accept new persons and new ideas in the community.
2. A sense of tradition and resistance to rapid change.
3. An investment of trust in individuals rather than in roles or agencies.
4. Homogenity of life, people, activities and expectations.
5. A special relationship to the physical environment which may include a benign acceptance of natural phenomena.
6. A discrepancy between realistic lifestyle options of a small community and expectations aroused by exposure, often only media exposure, to urban styles and options.
7. Problems of transportation, communication, unavailability of materials, as well as the inaccessibility and high cost of goods and services.
8. A lack of employment opportunities.
9. No anonymity.
10. The ethic and historical necessity of community, familial and individual self-reliance.

Some of these general characterisitcs have clear implications for the acceptance of mental health services and interact with a variety of other specific characteristics, which include the following:

1. Conflicting and unclear expectations about services.
2. Frequently realistic expectations, based upon experience, that service may be erratic and providers transient.
3. Confusion about, and distruct of, mental health providers, agencies, and government organizations, based in part on past experience.
4. A proportionately greater stigma associated with the use of mental health services.
5. A lack of comprehensive or specialized services within the community or region.
6. Relative lack of access to services outside of the community or region.
7. Insufficient population to support community, district or regionally based specialized services.

8. A benign acceptance of physical phenomena which may be extended to a similar acceptance of human events.

9. A high tolerance for individual differences and exccentricities.

10. Confidentiality as an intensely significant issue in small communities where personal privacy is rare.

Culture-specific factors play a large part in determining the necessities of program style, goals, objectives, and activities. Rapid cultural change has led in some communities to factors including:

1. An erosion of traditional support systems.

2. Lowered self-esteeem.

3. An attitude of learned dependency.

4. Changing attitudes toward both cash and subsistence economies.

5. Difference in language and in communication styles.

6. Identify confusion.

7. Shifting child-rearing practices.

8. Ambivalence and conflict about competition and individual achievement.

A rural CMHC service delivery system must be sensitive to characteristics inherent to the populations served. Population and area-specific characteristics create a particular set of needs and a particular climate, which, although not necessarily unique, require a variable degree of emphasis on locallly determined approaches.

A RURAL MENTAL HEALTH DELIVERY SYSTEM

The achievement of CMHC goals in rural and bush areas is directly dependent upon the extent to which program development and activities are responsive to community characteristics. These communities lack specialty services, put little faith in roles or agencies, admit new people only after a period of trial and observation. These are culturally distinct populations. They resist rapid cultural change and embrace attitudes and values which differ substantially from those common to urban America.

Such communities will neither use nor likely benefit from a case-oriented urban service model. They demand instead a community-oriented, personal-involvement approach. The community itself is the object of intervention.

The intervenor to a large extent is not a program or an expert, but an individual. Resistance to case-oriented treatment typically stems from:

1. Mistrust of professionals and outsiders.

2. Unclear expectations about services to be provided.

3. Stigma associated with the use of mental health services.

4. The ethic of self-reliance

5. The tendency to accept as natural events that in other environments would provide motivation for change.

6. An intense fear of gossip.

Further, the traditional case oriented model relies to a greater or lesser extent on the client's ability to develop new support systems and new patterns for spending time. A small rural community where destructive patterns of living may be community-wide phenomena does not readily offer new, positive support systems nor a wide variety of ways to spend time. Out of this latter characteristic comes the need for the community itself to be the object of intervention.

Finally, the mistrust of professionals, programs and persons from outside the community, coupled with the homogeneity of life, people and activities within the community leads to the need for the intervenor both to work at a personal level and to make efforts in terms of his or her own life-style to become a community member both in actions and in understanding.

Both in terms of adequate local client treatment and the prevention and reduction of "casualties", effective community interventions are clearly the treatment of choice. This requires not that rural CMHCs ignore the full range of accepted services, but that a priority be given to the development and maintenance of village networks, advocacy of healthy attitudes and behaviors, and other interventions. Because of the complex variables involved in this social and cultural milieu, this method of intervention requires a proportionately higher expenditure of time as compared with the more traditional case services. It should be stressed that rural programs, while providing some individual case services, cannot be expected to fit or to evolve into an urban-style delivery system.

Numerous factors must be taken into account in the delivery of

rural services. Some of these factors are:

1. The program and its personnel must be prepared for a lengthy period of community scrutiny before being accepted. This process will be repeated with each change in program personnel.

2. Both the program and its personnel are faced with the task of offering diverse services. Although such services may or may not be typically regarded as community mental health services, they are critical to the ultimate acceptance of the program.

3. Service delivery must be informal and flexible if it is to succeed.

4. Professional staff members, particularly directors of one-person programs, must be willing and capable of accepting roles which include the following: visible and involved community member, outreach worker, broker, advocate, teacher, behavior changer, mobilizer, data manager, administrator, fiscal and personnel manager, secretary, grants-writer and grants manager, janitor, public relations officer, caregiver, community planner, consultant, and model.

5. The professional must be willing to develop and utilize both formal and personal community relationships as vehicles for change.

6. Professional and program staff must be capable of maintaining an effective program despite minimal ancillary services and limited levels of personal, social and material resources.

7. Program personnel must be prepared to cope with the length of time required to develop community relationships and the delays inherent in delivery of services on an itinerant basis.

RURAL COMMUNITY MENTAL HEALTH CENTER FUNCTIONS

Thus far, a descriptive set of community characteristics and factors has been presented which impinge upon community mental health program development. The nature of the situation in rural communities dictates the performance of certain service activities. The proportion of energy devoted to each activity varies according to the nature of the communities served as well as the program's current stage of development. For example, rural centers will devote more time to some activities than will urban centers.

Chart 1 on Page 6 graphically displays some of these differences in terms of the stage of development of a rural

CHART 1

AN ESTIMATE OF PROPORTIONATE PROGRAM EFFORT BY PROGRAM FUNCTION

Program Function	WEIGHT 1	2	3	4	5	6	7	8	9	10
Visibility	****	****	****	****	****	****	****	****	****	****
	+++									
	####	####	####	####	####	####	####			
Outreach	****	****								
	++++									
	####	####	####							
Brokerage/ Advocacy	****									
	++++	++++								
	####	####	####	####	####					
Assessment/ Evaluation	****	****								
	++++	++++	++++	++++	++++					
	####	####	####	####						
Teaching/ Educating	****	****	****	****	****	****	****			
	++++									
	####	####	####	####	####					
Community Resources Alternatives Devel.	****	****								
	++++									
	####	####	####	####	####	####	####			
Consultation	****	****	****	****	****					
	++++	++++	++++	++++	++++					
	####	####	####	####						
Direct Services	****	****	****							
	++++	++++	++++	++++	++++	++++	++++	++++	++++	++++
	####	####	####	####	####	####				
Data Management	****	****	****							
	++++	++++	++++	++++	++++					
	####	####	####	####						
Administration	****	****	****	****	****	****	****	****	****	****
	++++	++++	++++							
	####	####	####	####	####	####	####			

KEY: **** New Program - Rural
++++ Urban Program
+5-year Stage Rural Program

program and in comparison with a typical urban mental health center.

The functions that follow are presented not as an exhaustive listing of all possible service activities, but rather are a set of common CMHC functions. These CMHC functions include:

1. Outreach: Identifying and making purposeful contacts with people in need of mental health services.

2. Brokerage and Advocacy: Facilitating access to and usage of existing services; actively pursuing appropriate services, policies, rules and regulations; advocating and modeling healthy values, behaviors, attitudes and decisions. At times this may include such activities as assisting with tax and other business forms, filling grocery orders, etc.

3. Assessment and Evaluation: Assessing individual, family, and community needs, and providing evaluation services.

4. Teaching and Education: Providing a range of instructional and informational services. This includes developing and training local resource persons.

5. Community Resources/Alternatives Development: In collaboration with other community groups planning and developing needed programs and services; insuring the local availability of recreational, vocational, educational, and cultural activities and alternatives; promoting networking.

6. Consultation: Providing technical input to other providers and agencies concerning problems, needs, and programs.

7. Direct Service Provision: Providing counseling, psychotherapy, crisis intervention, and supportive services to identified persons and groups in need, sometimes of necessity such services are provided on an informal basis in an informal setting.

8. Data Management: Performing all aspects of data handling, gathering, tabulating, analyzing, and program monitoring.

9. Administration: Activities aimed at maintaining the agency or institution rather than activities directed to community or client services.

10. Visibility/Acceptability Promotion: Advertising the availability and promoting the acceptability of mental health services in the community through highly visible physical presence in the community, newletters, sponsorship of community functions and active participation in community life, not limited to professionally-related activities, etc.

PROGRAM MONITORING

The existing procedures for program monitoring do not adequately reflect what rural programs do, why they do it or how they do it. The following breakdown is a beginning effort at re-thinking one of these measures--the staff log. A workable, realistic procedure for program monitoring will require effort on the part of Division staff and program directors if the format is to be equitable to both rural and urban efforts.

A Categorical Break-Down by Service Function
For Reporting and Measurement

I. Services
   A. Community-Oriented
      1. Community Resources/Alternative Development
   B. Client/Community
      1. Evaluation
      2. Teaching/Education
      3. Consultation
   C. Direct Client-Centered Services
      1. Brokerage/Advocacy
      2. Direct Treatment
      3. Outreach

II. Visibility/Acceptability Promotion

III. Administration
   A. Data Management
   B. Administrative Services

SUMMARY STATEMENT

In summary, a set of common CMHC functions has been identified which are readily applicable to the activities of both rural and urban programs. Characteristics of rural Alaskan communities have been presented. Program planning, monitoring, and evaluation as well as the selection, orientation and training of service providers can be enhanced by an appreciation of the factors discussed. These characteristics dictate that rural programs will differ substantially from more urban programs in the emphasis placed on the various program functions.

CITY OF NOME

P.O. BOX 281 - NOME, ALASKA 99762
TELEPHONE (907) 443-5242

November 10, 1981

Senator Charles H. Parr, Chairman
Health & Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

At a recent Senate HESS hearing in Nome, there was a great deal of discussion about rising crime and alcohol problems.

We recently received a letter (copy enclosed) from one of the finest District Attorney's we have had in Nome in a long time who has addressed these issues. Sadly, he is leaving Nome to work in Anchorage. It is difficult to see him go. However, Mr. White clearly states the magnitude of the problems we face here in Nome. This is especially true with many of the neighboring villages opting to go "dry". As more of these problems ' inkers gravitate to our city, we shall be hard pressed to keep up with them and the problems they cause.

My intent is not to ask for assistance to upgrade the Police Department, but to impress you with the idea that more money is needed to deal with alcohol and its attendent problems.

Thank you for your concern.

Sincerely,

Ivan L. Widom
City Manager

cc: Governor Hammond
Senator Frank Ferguson
Representative Jack Fuller
Mayor & Council
Dr. Bob Johnson, Kodiak

CHARLIE PARR

ALASKA LEGISLATURE

S.R. Box 50599
Fairbanks, Alaska 99701
(907) 456-5029

Fairbanks Interim Office
545 Third Avenue, Suite D
Fairbanks, Alaska 99701
(907)456-8925

Pouch V
Juneau, Alaska 99811
(907) 465-4907

DATE: October 19, 1981

TO: Senator Colletta, Senator Fischer, Senator Kelly and Senator Stimson

FROM: Senator Charlie Parr, Chairman
Senate HESS Committee

SUBJ: Flight info and hotel accomodations for Nome and Bethel hearings

* *

November 7, 1981
Saturday

Wien Flt. 61 departs Anchorage at 8:50 a.m.
arrives Nome at 9:25 a.m. (daily)
Alaska Flt. 51 departs Anchorage at 8:30 a.m.
arrives Nome at 8:55 a.m. (daily)
Wien Flt. 61 departs Nome at 10:05 a.m. (via Fairbanks)
arrives Anchorage at 1:55 p.m. (daily)
Alaska Flt. 51 departs Nome at 9:40 a.m. (via Fairbanks)
arrives Anchorage at 1:15 p.m. (daily)

The Nugget offers single rooms for approximately $75.00 a night.

November 14, 1981
Saturday

Wien Flt. 31 departs Anchorage at 7:45 a.m.
arrives Bethel at 9:00 a.m. (daily)
Wien Flt. 35 departs Anchorage at 5:40 p.m.
arrives Bethel at 6:55 p.m. (daily)
Wien Flt. 36 departs Bethel at 7:45 p.m.
arrives Anchorage at 8:45 p.m. (daily)

The Kuskokwim Inn offers single rooms for approximately $55.00 a night

CHP:dm

✓ Jeanette Morton Norton Sound Health Corp. [illegible] 9661

✓ Connie Hellenbeck Norton Sound Comprehensive Alcohol Program

Sharon Wallulis Norton Sound Family Services Box 966 [illegible]

✓ [illegible] [illegible]

✓ FRED ANGLETON EMS ADVISORY COUNCIL [illegible]

✓ Robb Stokes Self

✓ Nancy H. Mendenhall Norton Sound Health Corp.

✓ Geoff LANGER " "

✓ Frank D. Costanzo Chairman Norton Sound Comp. Alcohol Counsels

✓ Doreen Dailey

✓ VERNON KUGZRUK SEL (Staff Kawerak, Inc. Board Member BSNC Nome)

✓ DICK BULLOCK N.S. EMS

✓ FRANK J. POPLAWSKI BERING SEA WOMEN'S GROUP

✓ IVAN L. WIDOM CITY OF NOME

✓ LaVonne [illegible] NORTON SOUND HEALTH CORP. - NOME TSSN HEALTH DIRECTOR

✓ R. R. "BOB" Blodgett Bering Strait REAA & Coastal Resource Planning Board

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPARTMENT OF LAW

DISTRICT ATTORNEY — SECOND JUDICIAL DISTRICT

BOX 160 — NOME 99762

November 4, 1981

Mr. Ivan Widom
City Manager
Nome, AK 99762

Dear Ivan:

As you may be aware, I will be leaving my position as District Attorney for the Second Judicial District (Nome and Kotzebue), on November 24, 1981.

I take this opportunity to point out the high level of police work I have encountered in your city, and to make some observations of trends I have observed regarding crime in the Second Judicial District.

There has been a sharp increase of violent crime in the Second Judicial District.* Between 1979 and 1981, there has been more than a 300% increase in felony cases filed in the Superior Courts. In 1979, there were 31 felony cases filed; in 1981, 109. To this date in 1981, there have been many more felony convictions than in the entire years of 1979 and 1980. This increase is all the more significant when it is considered that in 1981 a Pre-Trial Intervention Program was initiated which has diverted cases from the Court system.

It seems to me that the character of crime has changed also. Where in the past there were 'acquaintance' sexual assaults, this office is now deluged with violent 'attack' type sexual assaults. In the past year there have been at least two such assaults or attempts, on elderly women in their homes. This office has been vigorously prosecuting such cases and the Superior Courts have been issuing stiff sentences, however, it has done little to prevent such acts by others. It surely will get worse in Kotzebue and Nome, as village "problems" are increasingly transferred into the cities due to the village movement to get "drier" and "drier" with the new local option provisions.

* Statistics in this letter relate to crimes upon which a felony charge has been filed in Court. In other words, crimes reported in which a charge has not been filed are not considered. The statistics are derived from Department of Law internal statistics as well as from those published by the Court system. Statistics for 1981 are projected based on actual figures through Sept. 30, 1981.

NORTON SOUND
HEALTH CORPORATION

P.O BOX 966
NOME, ALASKA 99762
(907) 443-5411

STATE TO SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

November 7, 1981

Sharon Walluk, Director NSFS

I would like to speak to issues in the areas of the delivery of Mental Health Services. We are greatly concerned with the methods currently being used by the State to determine levels of funding for programs around the State.

Last June at the Governor's Advisory Council for Mental Health meeting in Anchorage it became apparent to those of us from the Bush that some of our programs were being cut to fund programs in larger more urban areas. The basis for this action was evaluating all programs by a model of mental health service delivery that is questionnable not only in the bush but also in more urban and even lower '48 areas. What was happening was that unless we were pushing numbers through our doors and seeing people in one to one therapy sessions we weren't doing any work.

As the result of this a group of bush program directors met in August in McGrath to discuss and evaluate what we are doing out here, why we are doing it and why we feel it works. The result of this meeting is what is now being called the McGrath paper which is a beginning step in defining a more functional service delivery system for the bush/rural areas of the State. We went back to the Advisory Council in September with this paper and after spending a full day of their two day meeting discussing the paper the Council voted to support this concept paper and recommended to the Staff in Juneau to take this paper into account when making any future plans for service delivery, program planning, etc., in the State. When I have this statement typed I will attach a copy of the McGrath paper.

The reason I'm presenting this issue is to make you people aware of the situation that is beginning to occur more and has been unlying the system for as long as I have been here. Mental Health and from my experience Alcohol too, in the State feels hard pressed to justify their existence so in order to do this they have grabbed on to models of programs, treatment services, delivery systems that belong maybe in L.A. but certainly not in Stebbins or Diomede. Since I've been here, 6 years, we have burnt out 1 Psychiatrist, and 5 PhD. psychologists. The reasons for this are many but probably the biggest is simply that their skills, what they know how to do simply doesn't work with our people, in [illegible] situation. The problem is that this model of service-delivery is the only one that the State sees as legitimite (or at least is strongly moving in that direction as of last June) and thus will fund. The result is if this occurs is a system of delivery that for this area has not worked in the past, won't work in future but which we will have to at least pretend to use if we expect any State funding.

Three to four years ago the only people being served by our clinic were those from the lower '48 that had moved up here. The local people would come once or twice and never return. Since then we've developed for the villages an alternative model that seems to be working. Our problem is getting State support of this system to develop it further, to get evaluation criteria etc. We have what we feel works, what we need is back-up from the State to evaluate it and make it legitimate, to get rid of the bugs. We have at this time a choice, either accept a model that fits only a small minority of people who come and go from our area or to develop a system that will work for everyone here.

I'm asking you as legislatures to be aware of these issues that the Mental Health and again I include Alcohol programs are in danger, because of the need to justify themselves, of accepting systems that don't work just so they can get money now. The result will be - when it doesn't work monies will be cut, programs will disappear and the people won't have any help. We need the chance, the expertise, to develop Alaskan based systems.

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-5411

HEALTH CORPORATION

COMPREHENSIVE ALCOHOL PROGRAM (CAP) 7 November 81

PUBLIC TESTIMONY ON HEALTH CARE

The Comprehensive Alcohol Program (CAP) recommends that in all considerations before the Senate Committee concerning Health Care that persons suffering from alcoholism or other medical conditions arising from alcohol abuse be given equal treatment as a patient presenting symptoms of any other disease. This includes the availability and accessibility of services, health planning (HSA), and prevention and education information.

We specifically request that the treatment of alcohol and drug abuse not be considered as a separate issue in House Bill 41. The State Comprehensive Health Plan as described in HB41 appears to be meant for all eligible Alaska residents who wish to enroll. We would like an explanation of two specific items:

page 5 — Why is there a separate section dealing specifically with alcohol and drug abuse?

page 6 — Why does this section appear to be meant for only state employees?

In this remote area of Alaska alcohol is the major contributing factor to a series of illnesses, diseases, and injuries which, as a whole, is the number one public health problem for our population. In addition to alcoholism as a disease and the related diseases such as liver cirrhosis, pancreatitis, gastric ulcers, and the like, there are many debilitating illnesses which are brought about or worsened by alcohol abuse. Further, there are almost no violent crimes and assaults in this area which are not alcohol related. There is child abuse and neglect and spouse battering which damages both bodies and minds.

The philosophy of CAP is that alcoholism is a treatable disease. It is our opinion that cultural stress plays a significant role in the causal factors of alcoholism in the Norton Sound and Bering Straits region of

northwest Alaska We believe that prevention is the highest level of alcohol abuse treatment and, therefore, emphasize concentrating efforts on a strong foundation of alcohol abuse prevention education. Included in our philosophy is a belief that a health systems approach is critical to the solutions desired in the area of alcohol abuse as it affects our region. Planning must be at the least regionwide and long-term, wherein the whole rather than the individual is stressed.

In 1956 the American Medical Association recognized alcoholism as a disease process. Like heart disease it can be triggered and worsened by an unhealthy lifestyle; unlike heart disease persons with alcoholism are often denied equal medical treatment as if the disease were a moral or character weakness. In 1965 the American Psychiatric issued a statement which included reference to the fact that general medical and psychiatric facilities commonly discriminate against the patient with alcohol problems:

> "Such meager services as they do render are offered in a spirit of therapeutic pessimism. What is needed are properly equipped and adequately staffed wards prepared to offer prompt and adequate treatment of acute and chronic physiological, psychological, and social disturbances associated with alcohol problems, and all of this in close collaborative relationship with other community agencies concerned with the management of such problems. The principle of a continuum of services in the community applies here as well as to other disorders.
>
> All prepayment plans for defraying the cost of medical care through insurance should cover the person presenting symptoms of alcohol problems who seek treatment in medical settings on the same basis as for other illnesses."

It is the CAP position that this is as true today in 1981 "bush" Alaska as it was sixteen years ago.

Overview of the Norton Sound CAP Project

The Norton Sound CAP is a department of the regional health corporation. It is funded almost entirely through a state grant with some in-kind match and cash grants from the city and the health corporation for other components of the project. The services are comprehensive and include emergency care, medical detoxification, intermediate care at a residential treatment center, outpatient services through the community mental health agency, outreach through the women's shelter and the court-referral program, village coordination and technical assistance program, aftercare, and consultation and education.

There arises the question of what model to adopt to measure success. Keeping in mind the disease process of alcoholism and the many interrelated factors, it becomes evident that the recovery process is also complex. Recovery from alcoholism or other alcohol-related health conditions must be accomplished with a change in lifestyle. In this part of Alaska if a person is to learn to abstain from or reduce alcohol consumption he must learn to do it in what was, at the height of the illness, an alcohol-filled environment. A person recovering from heart disease learns to eat healthier foods, seek less stress-filled employment, get routine medical checkups, quit smoking, and so forth. Similarly, the recovering alcoholic or alcohol abuser must build these healthier changes into his treatment plan. The heart patient sometimes has relapses, sometimes eats unhealthy food, sometimes sneaks a cigarette, sometimes indulges in stressful situations. The recovering alcoholic also relapses during the recovery process. Such relapses are predictable, are measurable, and should be considered in designing an evaluation model.

At Norton Sound CAP we believe that not all persons suffering from alcohol problems have the same affliction; however, we do believe that for those who have progressed to the stage of alcoholism, drinking alcohol is contraindicated. Therefore, for such persons success can be measured in increasing periods of sobriety between relapse until a state of relative "remission" is reached (most researchers tend to believe that to reach this state is a two- to three-year process). Other ways of measuring successful client outcomes include increased quality of life, better financial status, ability to seek and maintain employment, and the like.

For persons who have alcohol problems less severe, success can be measured in improved health, lowered consumption, better quality of life, improved attitudes. Ideally we will deliver services and health care for all patients with alcohol-related problems in a setting as close to their own environment as possible. In our case this means acute care at the regional hospital, intermediate care at the regional treatment center, aftercare at the village level or local level for Nome residents. We tabulate patient contacts and operate on the principle of a continuum of services. If we can show ever-increasing levels of professionalism for our service providers, increasing hours of patient contact, better results from medical exams, increasing days of employment for active clients, positive reports from significant others in the clients' lives--we consider these to be measures of success which will ultimately move us toward the goal of reducing alcohol abuse in the region and thereby reduce the physiological, psychological, and social problems which it causes.

These physical and mental health care services attack only half of the cycle of alcohol abuse. The balance is education and prevention. Recovering alcoholics are sober role models and therefore treatment is needed for those suffering. Education is needed to remove the myths, teach coping skills for those in alcohol abusing situations, to reveal equally enjoyable alternatives to abusive drinking, and so on. Prevention can take many forms, and limiting availability is a significant one. This is something that the local option laws are addressing, as is other legislation enacted or under consideration, such as sanctions for serving inebriates and efforts to shorten serving hours for licensed premises.

We believe that money being filtered into "bush" programs such as ours is being carefully and frugally managed. We recommend that such "bush" programs be allowed to develop evaluation models unique to rural Alaska which will give the interpreters a truer picture of the progress being made with regional projects.

Submitted by:

Constance L. Hollenbeck

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Acting CAP Director

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NORTON SOUND HEALTH CORPORATION

HESS COMMITTEE HEARING

November 7, 1981

At the last NSHC Board of Directors' meeting in October, the need for adequate Water & Waste Systems were called out as the top priorities of village needs.

Since the early 1960's when the 1st 86-121 projects were constructed by PHS in Alaska, many problems have been encountered which has affected the type and design of sanitation facilities built today. Before, systems were constructed in villages without any thought as to how the villages were to operate, maintain and manage these systems. However due to many complicated factors and to what has been learned from past mistakes it has become necessary to place more emphasis on the operation and maintenance and management of the systems constructed and those to be constructed.

The construction of sanitation facilities, especially in Alaska, is not an easy task to say the least. All of the "bush" villages would like to have not only a safe water supply, but also a sanitary and safe means for the disposal of both sewage and solid wastes. They want this not only for convenience, but also for the health and safety of their families. These needs are real, but due to a combination of various factors, the fulfillment of these needs is rather difficult to say the least. Even so, these needs (safe water and disposal of wastes) are real and essential at any cost - as essential as schools, safe airports, health clinics and other public facilities.

Some factors which result in inadequacies in both the quality and quantity of facilities and service are:

1. severe cold climates
2. permafrost and cold stress
3. swampy soil conditions
4. no economic base (subsistence, welfare, etc.)
5. inflation (fuel, electricity, everything has increased)
6. inadequate cold region technology
7. inadequate transportation & communications
8. lack of coordination of efforts among the different agencies involved
9. lack of materials for repairs
10. lack of skilled manpower and lack of training for local manpower
11. lack of community organization and/or council development
12. small populations
13. beliefs, culture, habits & lifestyle
14. in some cases, shortage of water & land availability
15. economic feasibility
16. the capability of communities to operate, maintain, and support facilities

In summary, it is most difficult if not impossible, for most communities to financially support systems constructed with current technology. Facilities

can no longer be constructed with tools and methods borrowed from the lower 48. Facilities need to be custom designed to truly meet the sanitation needs of Alaskans.

No project should be approved for construction until both the funding for construction and the funding for continuing operation and maintenance can be assured.

The efforts by PHS and DEC of designing and constructing present day systems are commendable but problems with the lack of operation, maintenance, management and support of these systems is unreliable to say the least. The problems involved are social as well as economical; physical as well as technical.

In addition, the majority of the villages in the Norton Sound area are in drastic need for funds to correct disposal problems of sewage and solid waste. Due to saturated soil conditions and the high costs for haul systems, conventional "lower 48" methods are obsolete in the "bush". These reasons are valid, but something still needs to be done now.

Communites, which are aware of the seriousness of the problem, that are trying to solve the solid waste/honeybucket disposal problems are:

Savoonga
Elim
St. Michael
Shishmaref
Stebbins

The lack of funding is the main barrier against solving their problems.

SUMMARY:

The problems of obtaining safe water supplies and for disposing of honeybucket and solid waste are unique to the "bush"areas; unlide populated areas as Anchorage and Fairbanks where these needs are more easily met.

The "bush" area communities account for a small percentage of the state population, but their basic needs in areas of water and waste disposal should be a higher priority than funding some the nicer conveniences such as new offices in Anchorage and Fairbanks.

Past inequities to the "bush" are reflected in the present conditions of the villages and in the high incidence of water and skin related diseases as hepatitis, dysentery, scabies, impetigo, etc. Also, failure to pass House Bill No. 334 support this statement.

Bush life can hazardous to one's health as well as life threstening. The problems for obtaining safe water and a safe means for the disposal of sewage and solid wastes is not an unusual encounter.

For example, last year a man from Shishmaref was caught in a storm in the middle of winter while traveling nearly 20 miles to obtain potable water for his family. He nearly died doing so. This is only one example to how basic the need is for the villages. I realize the bush is easier to ignor since we are so inaccessible, but please be aware that even the most basic needs are still out there and still need to be met.

208 Village Facilities Assistance Grant

Because the operation, maintenance and management of sanitation facilities is a major undertaking for most villages, and is a combination of complex factors, the 208 Grant was developed to:

1. Study and analyze with the community the potential of those communities to provide long range support for the operation and maintenance of existing facilities.

2. Provide emergency technical assistance on maintenance.

3. Provide O-J-T training for the water operators.

4. Council development and management training

5. Provide training to the village public on the correct use of facilities and the prevention of water/wastes related diseases.

6. In those communities to get new systems, try to coordinate planning with the city councils, PHS, and other involved agencies to get a feasible system in those communities.

This grant is not for a new water project or facilities, but rather it is a project or facilities, but rather it is a planning grant to study, and analyze the problems encountered, make recommendations, and to provide technical assistance and training unique to each village, with each village.

Recommendations will come from the villages themselves as well as from the Norton Sound staff. Recommendations will go to PHS, DEC, and any other agencies involved in the design and/or construction of water and waste disposal systems. Recommendations will be geared towards customizing systems to the unique needs of each village in terms of environmental factors affecting design, operation & maintenance needs, feasibility of existing system and areas needing improvements, economic support of existing or planned systems and training needs for village operators of each village.

It w ould behoove the State to consider the recommendations coming out of this project, as they come from the village and regional prospectus. If this project is successful, I would recommend that the necessary funding be allocated to expand this project into other villages in the region as well as statewide. Successful coordination of this project may not only mean having more feasible systems in each village, but could also mean savings in actual cost for operation and maintenance of these systems, as the villages begin

to feel more responsible towards the planning and use of their water and wastes disposal systems.

In other words, the benefits would not only be to the villages in getting more feasible systems, but to the State, as well, as reflected in the money saved on possible replacement and/or renovations to existing systems, as well as reduced State assistance needed for operation and maintenance costs, i.e., fuel, electricity, etc.

Needless to say, more research is needed to find practical, feasible and economical answers.

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Southern Region EMERGENCY Medical Services Council, Inc.

PRESIDENT'S REPORT

November 12, 1981

Since becoming involved with the Southern Region E.M.S. in 1976, I have seen it grow from:

Approximately a $50 000 contract to $826,429 presently

Serving a

Population in 1976 of 205,681 to 266,037

And from

100,000 square miles to 260,000 square miles.

From an original staff of 2 to a present staff of 10.

This past year has been one to remember. Our third Executive Director, Tom Scott, was hired, replacing Richard Pauley. Rich replaced Maurice Messer. I was on the hiring committee for each and each has been special in his own way.

As the old saying goes, "a new broom sweeps clean", is probably true of Tom. He has been cleaning house ever since he started.

This also has been our first year of only State funding. Although no Federal Funds have been funneled through Southern Region's office, each of the Native Corporations has received funding through their Indian Health Service grants and in most cases have a very workable relationship.

As taken from the Quarterly Progress Report, I have found the following information not only interesting, but informative:

Since inception in December of 1975, the SREMS has been promoting the development of EMS Systems in the geographical areas that make up the region. During fiscal years 76-78, the primary emphasis was on providing EMT training statewide and developing advanced life support training programs for the rural parts of Alaska. In FY 79, we received a 1202(1) Grant and followed that in sequence with 1203(1) and 1203(2) grants in FY 80 and FY 81 respectively. At the same time we continued EMT training with funds appropriated by the Alaska Legislature.

The major achievements of the last year of federal funding are as follows:

-Gaining the financial support of the Alaska Legislature to continue funding SREMSC at a level consistent with federal funding levels assuring not only maintenance of the improved levels of care achieved with federal funds, but providing support for continued development and improvement of a total EMS system.

-Complete a comprehensive assessment of the status of each community in the region relative to the new Alaska EMS goals which provides the planning foundation for future activities.

-Administer the purchase and distribution of $188,000 in communications, medical, and training equipment for the EMS providers in the region. The funds were state funds obtained by the Highway Safety Planning Agency.

-Contributed to a training program that put on some 69 EMT courses (EMT-A, Refresher, EMT-II and EMT-III) that trained 636 individuals during the year.

-Provided travel for continuing medical education in each of the hospitals in the region.

-Conducted and supplemented an additional $800,000 plus of Indian Health Service EMS funds used to improve care in those villages and communities that are predominately Alaska Native.

-Anticipating end of federal funding, converted evaluation specialist position to clinical specialist to coordinate continuing education for hopsital and clinical staffs.

-Provided travel funds for the Outreach Worker from the Providence Hospital Thermal Unit to do continuing education programs in care of the burn victim, air transport, and care of the frostbite patient to hospital, ambulance service, schools, and industry in communities in the region. Program was highly rated by all participants.

-Assisted with the development of a new ambulance service at Glacier View on the Glenn Highway. Trained new responders at Cold Bay and Sand Point, will receive new ambulances from the Alaska Legislature in FY 82.

-Conducted system design to improve ambulance to hospital communications on the highways of the Central Kenai Peninsula.

The federal funds provided under the EMS System Act of 1973 and subsequent amendments have enabled the Southern Region to make significant progress in the development of Basic Life Support Systems in the region. In 1975, there were eleven ambulance services in the region which were manned by EMT-As. Today there are twenty-nine such services, most of which are trained to at least the EMT-II level with physician control.

In 1975, only Anchorage had a 911 telephone number with central dispatch. Today, 10 of the 13 other major communities in the region have 911, including the Copper River area's which works at long last.

In 1975, there were no special care units other than ICU/CCU's in the region. Today there is a regional Thermal (Burn & Cold) Unit, a statewide perinatal unit, and a statewide Poison Control Center. More importantly, however, is that transfer agreements between these units and the federal (IHS-military) hospitals have been developed and implemented.

In 1975, there were no ACLS trained personnel in the region's hospitals. Today there are ACLS providers in each facility in the region. Furthermore, each facility either has physicians in the ER [illegible] a day or the on-call physician has VHF radio contact with the hospital and the ambulance.

In short, the support of the federal government has enabled the Southern EMS Region to bring most of the populated portions of the region to a true BLS capability and has enabled us to demonstrate our viability to the Alaska Legislature to assure continued programs towards the national goals of developing true systems.

FY 81 TRAINING

EMT-III Date	Location	Students	Completed	Certified	Total Yearly To Date	Total to Date	Total Certified Year/Total	
Total FY 80					NA	NA		
March	Kodiak	8	8	8	8	19	8	19
April	Homer	6	6	6	14	25	14	25
	Barrow	3	3	-	17	28	-	-
May	Kenai	5	5	4	22	33	18	29
	Alyeska Pipe.	16	16	-	38	49	-	-
EMT-I.I/R								
April	Homer	3	3	3	3	3	3	3

FY 81 TRAINING

EMT-II Date	Location	Students	Completed	Certified	Total Yearly To Date	Total to Date	Total Certified Year/Total	
Total FY 80					128	417		
July	Valdez	15	15	9	15	432	9	190
	Homer	5	5	2	20	437	11	192
	Ft. Rich	5	5	2	25	442	13	194
August	Unalaska	9	9	7	34	451	20	201
	Pond Reef	7	7	6	41	458	26	207
October	Nome	6	5	5	46	463	31	212
November	Barrow	5	5	1	51	468	32	213
	Girdwood	11	10	4	61	478	36	217
	Seldovia	4	4	2	65	482	38	219
December	Talkeetna	3	3	3	68	485	41	222
January	Willow	8	7	3	75	492	44	225
	Chugiak	4	4	2	79	496	46	227
	Palmer	7	7	7	86	503	53	234
February	Soldotna	4	4	4	90	507	57	238
	Willow	8	7	4	97	514	61	242
March	Dillingham	6	6	-	103	520	-	-
	Port Graham	6	5	-	108	525	-	-
April	Alyeska Pipe	19	19	1	127	544	62	243
	Homer	5	5	1	132	549	63	244

FY 81 TRAINING

EMT-R Date	Location	Students	Completed	Total Yearly To Date	Total To Date	Passed NREMT Took/Pass/%		
Total FY 80				100	284			
October	Glacier View	15	11	11	295			
	Willow	15	14	26	309			
November	Barrow (II/R)	2	2	28	311			
	Seldovia	7	7	35	318			
	Kotzebue	11	11	46	329			
	[illegible]ugiak	15	14	60	343			
	Chugiak (II/R)	8	8	68	351			
December	Trapper Cr.	11	11	79	362			
January	Alyeska Pipe	17	17	96	379			
February	Willow	14	13	109	392			
March	Dillingham	6	6	115	398			
	Cantwell	4	3	118	401			
	St. Paul Is.	4	4	122	405			
April	Seward Inst. Wkshp.	20	20	142	425			
May	McKinley	13	13	155	438			

FY 81 TRAINING

EMT-I Date	Location	Students	Completed	Total Yearly To Date	Total To Date	Passed NREMT Took/	Pass/	%
Total FY 80				198	1014			
October	Wasilla	8	8	8	1022	4	4	100%
	Nome	11	6	14	1028	-	-	-
	Barrow	17	15	29	1043	15	13	87%
November	Iliamna	10	10	39	1053	10	7	70%
	Nikiski	12	11	50	1064	11	11	100%
	Ninilchik	13	9	59	1073	8	8	100%
December	Talkeetna	7	7	66	1080	7	7	100%
	Trapper Cr.	4	4	70	1084	4	4	100%
	Seldovia	13	13	83	1097	12	12	100%
January	Cold Bay	11	11	94	1108	11	11	100%
	Whittier	11	11	105	1119	11	10	91%
	Evans Island	7	7	112	1126	7	7	100%
February	Port Graham	6	6	118	1132	6	5	83%
	Port Alcan	5	5	123	1137	-	-	-
	So. Naknek	6	6	129	1143	6	6	100%
	Naknek	8	6	135	1146	6	5	83%
	Kodiak	15	15	150	1161	6	4	67%
March	St. Paul Is.	9	9	159	1170	9	7	78%
	Cantwell	7	6	165	1176	5	3	60%
	Copper River	8	8	173	1184	6	6	100%
April	Prudhoe Bay	37	37	210	1221	35	32	91%
	Homer	18	18	228	1239	18	18	100%
	Chugiak	10	7	235	1246	7	7	100%
May	Dillingham	12	7	242	1253	-	-	-
	Kotzebue	14	14	256	1267	-	-	-
June	Barrow	18	14	271	1282	-	-	-
	Prudhoe Bay	37	37	308	1319	37	-	-

SOUTH CENTRAL HEALTH PLANNING & DEVELOPMENT, INC.
"A Health System Agency"

Lynne Johnson-Joseph
Health Promotion

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TOPICS OF DISCUSSION

I. Transportation:

A) Medicaid travel to ANS facilities

B) Emergency travel - authorized at local level

II. Communication:

A) Need for greater coordination in communities planning between IHS, Regional Corporations and State, to provide low maintenance cost, highly reliable, comprehensive EMS communication system in bush Alaska.

B) Assumption of responsibility for black phone medical communication system.

III. Clinic Operation & Maintenance Support:

Regs. require to be 2nd class city rev. shar. money inadeq. to even maintain heat for clinic. Clinic leaves frozen – no operation funds

A) Revise clinic revenue sharing regs to allow village to apply to increase amount and to require maintenance of environmental standards.

IV. Environmental Health:

Indian Health Service Programs are being cut - Regional Corporations can provide infrastructure to deliver these services in rural areas.

V. Community Health Aide Program

Federal reductions threaten to seriously errode the quality and scope of services provided on training a supervision of CHA's is curtailed to preserve funds for salary maintenance.

Legislation should be drafted to provide training support for CHA services.

3rd Pty. / licensure to support CHA & Clinic
Community Health Representatives outreach worker – many do alcoholism, mental health, soc. ser., WIC etc. Environ. health – very flexible by village these responsibilities go to CHA – 30% cut this yr.

VI. Need for a formal review of State statutes and administrative regulations that prevent Regional Corporations from acting as comprehensive health service provider in rural areas.

1) PHN Service - Contractibility of functions that are provided for under statutory authority.

2) Board requirements that are inconsistent or unclear; ie: Mental Health/Alcohol Program, etc.

3) Medicaid reimbursement for IHS clinical facilities in Juneau, Fairbanks, and Ketchikan.

4) Various enforcement authorities in Environmental Health.

5) Various regulations governing facility ownership and construction, etc.

VII. General discussion of successes and failures of alcoholism programs in rural areas.

VIII. Additional Areas of Interest:

Support HSA's?

#5-8 million shortfall in $ this yr. (equiv. to 20% reduction in staff)

Testimony Offered before the
Senate Health, Education and Social Service Committee

December 15, 1981

As the Chairperson of the Alaska Statewide Health Coordinating Council, probably better known as SHCC, I am here to represent that 30 member body to express to you our concerns on how to facilitate the best health care possible for all citizens of Alaska. Specifically, we wish to indicate our support of the regional entities described here earlier today by the ~~Northern~~ Alaska Health Coalition ~~Resources Association, South Central Health Planning & Development and Southeast Alaska Health Systems Agency~~. Their evolution into State and locally supported entities specifically charged to perform health promotion, technical assistance to communities in the development of local health programs, and data collection and analysis is one which will preserve and strengthen the functions most needed now out of all those presently performed by the Health System Agencies.

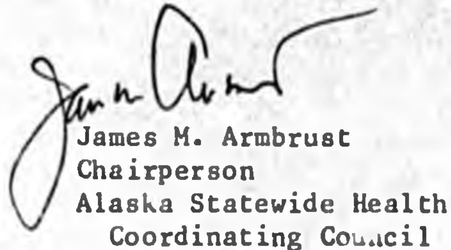
Before elaborating on why we give support to this changed functional emphasis, I shall review briefly the function, makeup, and, therefore, perspective of SHCC on this issue. The Alaska SHCC is authorized under Alaska Statute 18.07.011 to establish priorities for the orderly development and implementation of health care delivery in Alaska. The expression of those priorities is found in the State Health Plan, a document authored by the Council. Because the State Health Plan is based upon regional plans developed by the individual health system agencies, the State Plan is a result of regional and local perspectives put into an expression of priorities with a statewide outlook. In conducting all secondary functions of SHCC, including review and comment or approval activities, the State Health Plan is used as the basis for decision making. Likewise, SHCC membership, a majority of whom are not providers of health care, consists of individual citizens from all over the State: 60% nominated by the Health Systems Agencies and the remaining 40% directly appointed by the Governor. The result is statewide expression on health delivery issues with a local and regional foundation.

Federal support for health planning, as we have known it for the past six years, is being discontinued. Given the size of Alaska and the magnitude of resources presently being spent on health facility and program development, coupled with the present concerns for long range health policy issues now before the citizens and legislature of Alaska, it seems most logical and reasonable that local and regional voices of concern continue to have a means by which those concerns can be expressed.

Alaskans are committed to local input on statewide issues. It would be a shame to totally discard the valuable resources which have been built at a regional level in the form of the three Health Systems Agencies. Those resources are human in the for of well-qualified, respected and knowledgeable professionals as well as knowledgeable lay board members who have freely given thousands of hours to the goal of better health care for their fellow citizens; those resources also include non-human resources in the form of extensive data profiling regional health delivery capability and shortcomings.

You are urged to take these valuable resources and give them a new charge to function as regional health resource organizations. They should be responsible to: (1) promote the develoment and maintenance of health education and self-care programs; (2) coordinate and facilitate local and regional participation in identifying and then responding to health care delivery needs; and (3) maintain the capability to provide local and regional current, accurate health related data for planning, review and resource development activities.

In summary, the Alaska Statewide Health Coordinating Council urges your thoughtful support of the proposal for establishing regional health resource organizations to preserve and maintain local and regional voices committed to the facilitation of the best health care possible for our citizens.



James M. Armbrust
Chairperson
Alaska Statewide Health
Coordinating Council

Proposed legislation relating to the Medicaid budget review process.

First Draft, December 11, 1981

Section ______. FINDINGS AND DECLARATION OF POLICY. The legislature finds and declares that health facilities are an integral part of the infrastucture of the State of Alaska. Accordingly, it acknowledges the need to reimburse health facilities for services provided beneficiaries of state programs at a level which will meet the true financial requirements of the institutions. In order to accomplish this end in a prudent fashion it is necessary that rates of reimbursement to be paid to health facilities by the Medicaid and General Relief/Medical program should be prospectively negotiated so that appropriate and equitable funding decisions can be made.

SECTION _____. REIMBURSEMENT FOR COST SETTLED PROVIDERS. The payment rate for health facilities shall be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. Reimbursement shall reflect a reasonable return on investment in addition to the other financial needs of the facility. Reimbursement shall be made for, by way of example and not by limitation, the following:

(a) Costs of current operating requirements, including but not limited to:

(1) Health facility operating expenses such as wages and salaries, purchased services,

supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and minor remodeling;

(2) Bad debts;

(3) Education;

(4) Research; and

(5) All costs associated with preparing budgets and negotiating rates under this section.

(b) A reasonable operating margin, in order to provide for:

(1) Working capital necessary to meet current obligations as they come due; and

(2) Capital necessary for

(i) Major renovations and repairs;

(ii) Replacement of plant and equipment;

(iii) Expansion; and

(iv) New technology.

(c) A reasonable return on equity.

SECTION _______. BUDGET DETERMINATION. (a) No less ninety 90 before the start of the health facility's fiscal year, the Division of Public Assistance shall provide it with an estimate of its volume for that fiscal year.

(b) No less than 60 days before the start of the health facility's fiscal year, the health facility shall submit its proposed rates for Medicaid reimbursement and its budget projections on forms prescribed by the commission.

(c) Within 45 days after the proposed rates and budget projections are submitted, the commission shall review the proposed rates and the budget projections and shall, in accordance with section _____, issue a written decision. Reimbursement shall be made in accordance with the rates established in that written decision. The health facility shall be permitted to present oral testimony and a documentation in support of its proposed rates and budget projections. If the commission fails to issue a written decision within that period, the health facility's rates will be deemed approved.

(d) Within 30 days of issuance of the decision, the health facility may request the commission to reconsider the decision. Whether or not reconsideration is requested the health facility has the right to de novo judicial review of the decision by the superior court under the Rules of Appellate Procedure. During any reconsideration or appeal the health facility shall receive payment according to the rates approved by the commission.

(e) Any health facility may submit amended proposed rates and an amended budget during its fiscal year. Within 60 days of submission the commission shall review the amended proposed rates and amended budget and shall issue a written decision. If the commission fails to issue a

written decision within that period, the health facility's amended rates and amended budget shall be deemed approved.

(f) Within 90 days after the close of the health facility's fiscal year, it shall submit to the commission, on forms prescribed by the commission, which forms shall be consistent with the budget projection forms, a report on its financial performance during that fiscal year.

SECTION _______. AUDIT AND INSTITUTIONAL REVIEW.

(a) As a condition of participation in the Medicaid program, health facilities must provide the division reasonable access to fiscal records of all Medicaid beneficiaries.

(b) Health facilities must allow inspection of fiscal records by the division and other state and federal agencies to the extent required by federal law and regulation.

SECTION ____. REIMBURSEMENT TO HEALTH FACILITIES UNDER GENERAL RELIEF/MEDICAL PROGRAM. (a) Reimbursement to health facilities under the General Relief/Medical program shall be made at the same rates as those established for Medicaid reimbursement.

(b) Health facilities shall submit all claims for reimbursement on invoices prescribed by the division and in accordance with its provider manuals.

(c) Claims for reimbursement must be filed promptly following the provision of care, and reimbursement shall be promptly made.

SECTION ____. MEDICAID BUDGET REVIEW COMMISSION. There is created in the Governor's Office the Medicaid Budget Review Commission.

SECTION ____. COMPOSITION OF COMMISSION. The Commission consists of the following persons:

(1) The chief executive officer of a health facility which is licensed by the state but not owned or operated by the state or federal government and which is subject to the budget review process as prescribed in section ______ through _______;

(2) A person with a professionally relevant background appointed to represent the insurance industry;

(3) A physician licensed by the state and actively engaged in the practice of medicine in the state who is not employed by the state or federal government;

(4) A person with a professionally relevant background appointed to represent the business community; and

(5) A person appointed to represent consumers of health services who does not have an interest, direct or indirect, in an entity engaged in health care delivery.

SECTION ____. APPOINTMENT OF MEMBERS. Members of the commission are appointed by the governor and shall serve at his pleasure.

SECTION ____. TERM OF MEMBERSHIP. Members shall be appointed for terms of three years, and they may not be appointed to successive terms. Terms shall be staggered. The initial terms shall be two members serving for three years, two serving for two years and one serving for one year. For purposes of initial appointments, appointing successors or filling vacancies, all terms shall be measured from January 1 of the year in which the term of the vacant position began, regardless of when the vacancy is filled. A member appointed to fill a vacancy serves for the unexpired term of the member he succeeds.

SECTION ____. COMPENSATION. The members of the commission serve without compensation but are entitled to per diem and travel expenses authorized by law for other boards and commissions.

SECTION ____. OFFICERS. At the first meeting of each year, the commission shall elect a chairman from among its members.

SECTION ____. MEETINGS AND QUORUM. The commission shall meet as frequently as necessary to conduct its business efficiently and expeditiously. Three members of the commission constitutes a quorum.

SECTION ____. DUTIES OF THE COMMISSION. The commission shall have sole responsibility to review proposed rates and

budgets of health facilities and establish Medicaid and General Relief/Medical reimbursement rates for health facilities pursuant to Sections ____ through ______.

SECTION _____. EMPLOYMENT OF PERSONNEL. The commission may employ and determine the salary of an executive director. The executive director may, with the approval of the commission, select and employ additional staff as necessary. The executive director and all employees of the commission are in the exempt service under AS 39.25.

SECTION ____. AS 47.07.070 is repealed.

SECTION ____. AS 47.07.080(1) is repealed.

SECTION ____. DEFINITIONS. In this chapter,

(1) "health facility" shall include hospitals, skilled nursing facilities, intermediate care facilities, intermediate care facilities/mentally retarded, inpatient psychiatric facilities, home health agencies, rural health clinics, and out patient surgical clinics and any other entity which receives Medicaid or General Relief/Medical reimbursement for services traditionally provided in health facilities;

(2) "commission" shall mean the commission created pursuant to Section _____;

(3) "division" means the Division of Public Assistance of the Department of Health and Social Services; and

(4) "volume" means the total services provided to Medicaid and General Relief/Medical beneficiaries.

SECTION ____. This act takes effect January 1, 1983.

ALASKA STATE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811

DEC 18 1981

REGIONAL INFORMATION OFFICE
1024 West 6th Avenue
Anchorage, Alaska
99501
(907) 278-3668

12-16

Senator Parr,

This was brought in today the gentleman asked that I forward it to you.

Nicki Mattingley

LAA 11
(1-26-79 M)

Nancy To be
This seems to be
written version of
oral testimony by
Miss Burrell in
Anch on Dec 15.
Charles

Hearing Dec. 15, 1981
Hastily made notes
with appologies.

Sen. Parr
Dr. Beirne

Request: catastropic Insurance or State provide Major Medical and Doctors care to those who have applied to various insurance companies and have been refused because of major health problems. State Insurance premium to be based on individuals income; and in line with charges made to individuals buying insurance and not refused coverage.

Request: also Temporary medical coverage to (middle aged) divorced ~~women~~ people who have not worked in the marriage or not for years; has no individual Insurance plan and small income, below poverty level, but or has Temporary restraints made by court orders on property and bank accounts. Can not qualify for poverty assistance because of existing real property in addition to ~~her~~ the home. NO Children in household. therefore no legal or medical aid available.

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/367-1000

Please attach this Endorsement to your Group Conversion Certificate. Your hospital in-patient benefits will be increased for hospital admissions on or after the date your new rates become effective, provided you are admitted to the hospital on or after your effective date of coverage.

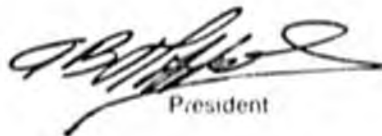
Endorsement to Hospital Service Surgical and Medical Certificate Group Conversion

Maximum Room Allowance of $75.00

In consideration of the advance payment of the required subscription charges, the Certificate to which this Endorsement is attached is amended.

Part V, Benefits, paragraph A.1.a is amended as follows: the reference to a maximum room allowance is hereby modified to provide up to seventy-five dollars ($75.00) per day.

Blue Cross of Washington and Alaska



President

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361-3000

November 30, 1981

Ms. [redacted]
37 [redacted]
Anchorage, Alaska ??504

Dear Ms. [redacted]

Every application for transfer from our Group Conversion Program to our Individual Program must meet membership requirements and be reviewed by our Underwriting Committee. The Committee carefully reviews each health statement and membership records.

After reviewing your application and membership records it is the Committee's decision that the medical underwriting requirements have not been met because of your combined medical history of arthritis, [illegible]s, residuals of polio including tendon transplants and spinal fusion, a lumpectomy with atypical cell growth and menopausal syndrome. Although we are unable to accept you for our Individual Program, we are pleased to continue your coverage on our Group Conversion Program. Our records show that you are currently paid to December 1, 1981.

Blue Cross of Washington and Alaska has established medical underwriting guidelines. We screen each application for the Individual Program according to these guidelines. We would like to offer coverage to everyone who applies. However, in order to offer coverage to people at a cost that most people can afford, some restrictions are occasionally necessary. This means, of course, that some applicants cannot qualify.

Although you may not perceive the conditions to be acute or a threat to good health, our determination was consistent with rating provisions for the Individual Program.

Thank you for your interest in the Individual Program.

Sincerely,

Sharon S. Thompson R.N.

Sharon S. Thompson, R.N.
Individual Underwriting

cc: 18A/15

1-800-6400 426

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P.O. Box 327
Seattle, Washington 98111
206/361 3000

September 1, 1981

[redacted]
[redacted] :ive
Anchorage, Alaska 99504

Was fully covered thru husband, by Blue Cross, State of Alaska. Lost this coverage at divorce, put in Group Conversion refused adequate coverage offered in Individual Program

Dear Ms. [redacted]

Every application for transfer from our Group Conversion Program to our Individual Program must meet membership requirements and be reviewed by our Underwriting Committee. The Committee carefully reviews each health statement and membership records.

After reviewing your application and membership records it is the Committee's decision that the medical underwriting requirements have not been met because of your combined medical history. Although we are unable to accept you for our Individual Program, we are pleased to continue your coverage on our Group Conversion Program. Our records show that you are currently paid to August 1, 1981.

Blue Cross of Washington and Alaska has established medical underwriting guidelines. We screen each application for the Individual Program according to these guidelines. We would like to offer coverage to everyone who applies. However, in order to offer coverage to people at a cost that most people can afford, some restrictions are occasionally necessary. This means, of course, that some applicants cannot qualify.

Your application is enclosed. Thank you for your interest in the Individual Program.

Sincerely,

Sharon J. Thompson R.N.

Individual Underwriting

P.S. Your money will be applied toward your current group conversion program.

lk

Enclosures

age 57½

Group
cost $120 - 1/2 year
$75 a day allowed
no doctors in office
up to $125 total doctor in hospital
totally small - rediculous surgery fee schedule

Individual $654
$109 x 6
full hospital room coverage
Doctors office, after $200 deductible
Full fee paid doctors in hospital
full fee surgery

(1)

Crash Sale

Government Cruel & ruthless
When comes to forced disposal
of land, 50% of value
to discount Fair Market Value
Land least fluid asset, yet
best investment for someone
who can not ~~[illegible]~~ earn a current
Cost of living wage. Part time, good
paying jobs not available.
Temporary poverty or permanent
poverty, the older divorced women
goes without medical attention.
A Widow receives possibly a pension for
24 years a marriage. The older woman

divorced has nothing. Small Bank account eaten up by attorney fees. Husband has been running up bills & eating away assets before leaving the woman. If there are children, there is "aid to dependant children", rarely support orderd to the older now single woman. It is uncollectable except by private attorney; the woman has to have money up front, or sign away over 1/2 if collected & still pay Court costs. She goes without food & medical care to "save her home". While trying to adjust to the totally unfamiliar work world

& Compete c̄ women just out of school & 30 years younger - an old arthritic condition or a major stroke occurs. Her mental health from sheer terror & lack of family makes her prey to every sharpie in town, She needs financial & medical help now. the Criteria for qualifying for medical care favors the very poor with no assets other than a home & a long history of receiving Government aid. The woman must meet requirements of Bankruptcy

before she can received medical help. She must "liquidate" her means she held to prevent her from being a permanent welfare recipient. If she has no idea of market value or is so sick she sells ~~for a penny~~ for pennies on the dollar. Her nest egg gathered in 24 years of marriage is gone. In a state that allows a mate to walk out, mostly with no strings, why isn't there medical care available to an abandoned mate, when needed?

We spend millions in amusement, leisure time luxury; the arts center, the

sports arenas; a huge covered dome stadium — all of the expense of upkeep will move that women out of her home faster. ~~State~~ thru property taxes State income tax relief benefits the rich in a great & grand proportion and ignores the sick, the old, & the abandoned. In Canada, medical care is available to everyone. Its available to the rich & the poor here.

Major medical Insurance is denied the person who needs it the most. We allow the insurance companies to skim the cream of the milk. They choose the well & the employed to insure, & refuse to insure the seriously ill. Or if through previous insurance, thru a husband, they set up a conversion

appendicites (6) - not complicated
cost
$ 1200 for doctor only
$ 285.00 allowed by Blue cross
$ 75 a day for Hospital
No office calls

plan, which they say is meant only to cover the employable while they are between jobs." The rates are a rip-off. $ 110 every 2 months, with no doctors office fees paid. $ 480.00 allowed in the hospital (Example) for $ 2600.00 doctors fees charged.

For a major surgery;

$ 75.00 for a Hospital room that costs the patient $ 240.00 a day. A normal hysterectomy would cost the patient ~~$ 5,490~~ $ 2966.00 plus the $ 720.00 paid yearly to blue cross for a total of $ 3686.00 or more. Without this "insurance" ie no conversion rights it would cost $ 5,400. It takes a year to adjust to that surgery. If your sick, how can you pay it off? Meanwhile the ex husband goes back to job - employed complete coverage with all benefits for $ 109 or far less payment than a work plan.

If the husband is military; he has
medical coverage, free, for life
& the ex military wife has nothing —
not even a pot hole plan.
Your lack of aid in these
circumstances causes life long
hardship, break down in the
individuals ability to adjust
& an agonizing jolt into
into the world of poverty.
Aren't people more important
than the Hotels & Sullivans
Convention center?
Why is health care a luxury &
Project 80 a necessity?

TESTIMONY BEFORE THE SENATE, HEALTH & SOCIAL SERVICES COMMITTEE

NOME, ALASKA

November 7, 1981

By: William M. Dann
Former Executive Director of
Norton Sound Health Corporation

I appreciate the opportunity to submit testimony to you and regret that I am unable to be in attendance during the hearings. I understand you wish to hear testimony on categories that you have previously publicized and I will try to address those areas.

HOUSE BILL 41:

Over the last four years, the Norton Sound Health Corporation has been receiving approximately a 10% annual cost of living increases in its contract with the Indian Health Service. Whereas the actual cost of doing business has gone up about 15% annually, we have therefore had a 20% reduction in real dollars available for services over the last four years prior to any impact of the Reagan budget cutting process. We have absorbed this impact through elimination of our Planning Office (which prevents us adequately planning and documenting health problems in our area and services to meet them), elimination of training positions for development of local manpower, reduction of patient travel, failure to keep pace with comparable salaries in the region and throughout the state, reduction of training opportunities for our employees, reduction of the manpower available to train our Community Health Aides, reduction or elimination of training available to Alternate Health Aides to provide coverage to the villages during weekends and leave for educational and other purposes of the primary Community Health Aides. These are specific examples.

At the present time, the salaries of Norton Sound Health Corporation employees are approximately 30% below comparable state salaries. Anticipated salaries for State employees in the Fall will further widen this gap. We have experienced instances in which a number of our employees have left the Corporation in order to seek State employment. Continuity of personnel for purposes of learning the unique aspects of our delivery system and cross-cultural communication with patients is critical to maintain and improve the quality of health services delivery, therefore failure to keep pace with salaries poses a real problem. This will worsen significantly with the impact of the Reagan budget cuts.

Throughout the budget cutting process over the last four years, contrary to practice of Indian Health Service, the Board of Directors of the Norton Sound Health Corporation who are consumers throughout the region and represent village or city constituencies, have consistently chosen to maintain services and cutback in administrative and benefits areas. This has hindered our ability to attract personnel and additional funding as well as to effectively plan, however, we are now at the point where further reductions in these categories are no longer possible and the impact of future Reagan cuts will adversely impact services.

The minimal impact that I foresee of the Reagan budget cuts would be as follows:

1. Elimination of laboratory technician position
2. Elimination of inservice training
3. Elimination of the Respiratory Therapy and Respiratory Thereapy Dept.

4. Reduction in travel of the sanitarian to the villages for inspection of water supplies, provision of rabies clinics, inspection of village clinic facilities, inspection of school food handling, etc.
5. Reduction in eye care services to the villages so that about 25% of the villages will receive no eye glass diagnostic and prescription services each year.
6. Continued elimination of the Planning Office
7. Elimination of the Boarding Home program (this program houses patients while they are awaiting delivery and/or return to village after having been seen in the hospital.
8. Reduction in patient travel. We have reduced patient travel over the last year by virtue of a 30% reduction in travel to Anchorage. This is either due to a change in the pattern of disease being seen at the hospital or a change in the pattern of practice by physicians. Unfortunately, lack of a Planning Office makes it difficult us to diagnose this.
9. Elimination of filing of village community health aide encounters in patients charged here at the hospital.
10. Elimination of training for the Board of Directors.
11. Provision of primary community health aide training only once every two years. This would mean we would fall far short of the State Health Plan and South Central Health Planning & Development, Inc. plan of having a certified Community Health Aide in each village.
12. Elimination of a clerical position in our Outpatient Dept. eliminating the ability to track chronic disease patients to call them in for follow-up, adequatrack chronic patients in the village. [illegible] examples of the impact of further budget cuts.

It is possible that the ultimate impact this year of the Reagan budget cuts depending how Congress and the President choose to make those cuts may additionally result in:

1. Elimination of additional position including direct care position in the hospital.
2. Downgrading other positions to nine month positions.
3. Reduction in salaries with the result we will fall critically below salaries needed for recruitment and retention.
4. Elimination of annual village meetings in which consumers provide input into our planning and prioritizing process
5. Elimination of travel to the villages by the Emergency Medical Services Dept. to establish Search & Rescue teams, training school children and adults in First Aid, etc.

As you know, the proposed cuts in fiscal year '82 are only the first of a four year plan for a massive reduction in Federal effort. The potential impact on the Indian Health Service would be disastrous. It was learned that during this year's appropriations process in the Senate, there was introduction of an amendment to completely eliminate the community health aide program in Alaska. This program provides more than half of the total ambulatory care in our region and would set health care in rural Alaska back 20 years. The purpose in reviewing this information with you is to point out that it is imperative that the State of Alaska now establish a policy as to what responsibility it will take for provision of health services to its citizens. Like the commitment that the State has made in education, a similar commitment will need to be made for health services. With the oil wealth available to us, there should be some consideration of investment in human resources of the State and

not merely development of renewable and non-renewable natural resources. The Medicaid program must be expanded and a health security program provided to insure that those who are unable to access services due to the high cost of travel and using those services will not be prevented from receiving medical care that is required. Principal problems in the health delivery system of Alaska is accessibility. The cost now of a trip from an outlining village to Nome to acccess can run up to a $100 one-way. With the cutbacks in the BIA Social Services and other social programs, it is becoming an increasingly difficult for patients to come up with funds to meet these needs.

I would propose that the State of Alaska establish a policy whereby a minimum benefit package not unlike that in House Bill 41 would be provided to all citizens. A sliding fee scale would be established, that takes into account regional differences in costs, and has the State participating for its percentage of those costs. Policies would have to include whether or not employers could meet that need directly or would buy into that same program administered by the State and/or have other options. The State of Alaska could then seek to negotiate with the Federal government a commitment so that the Federal government will meet the on-going costs of a certain basic minimal set of services as part of its obligation to Native Americans. The legal obligation of the Federal government in its press for responsibility to provide these services is very clouded. The Snyder Act which is the enabling act for the Indian Health Service, says only that Congress has the option to provide funds for provision of health services. The original treaty agreement between Russia and the United States stipulated that the United States must continue to provide services to Alaska Natives. It may be that if negotiations between the the State and Federal government fall down, a legal effort could be

initiated to have the United States honor its original treaty responsibility. At any rate, the Federal government is likely in such a negotiated agreement to reduce the services well below what is being provided now. This short-range cost only speaks to the inevitable long-range cost and would allow the State to prevent short-range drastic cuts to come from the Reagan budget cuts.

House Bill 41 must treat all Alaskans alike. Differences should be drawn based on income levels and costs in accessing as well as utilizing health services. That is, a deductible, based on the total amount that would be paid out on behalf of any individual for services in a given year should he stipulated and maintained across the State.

In the negotiations with the Federal government, I believe the State should begin taking full responsibility for mental health services as well as environmental health services. The part of the Indian Health Services that has going to this purpose should be shifted into medical services.

HEALTH PLANNING:

Evidence prior to the establishment of health systems agencies in Alaska has proven that the development of accurate and respected State health plans that have positive impact on moving the health systems forward cannot be created on a Statewide basis. The existing State health plan which is well respected, is the result of massive input from the health systems agencies. The function of the State office is merely one of coordination as called for under Federal planning legislation. I believe the State of Alaska must provide funds to continue the health planning effort for the following reasons:

1. Regional priorities and input are necessary in order that a realistic and respected State health plan can be developed.
2. State health policy, which has been woefully absent, must be guided by such a plan. This would include the allocation of resources by the Legislature and the Administration.
3. Data cannot be collected on a Statewide basis without its filtering through a regional planning effort that can test that data. The need of the State to contract out an inventory of clinic facilities and accurate hospital information bespeaks my point.
4. The Legislature and the Administration need comment from regional planning groups regarding proposed programs and policies to improve the health status of Alaskans. Again, I do not feel that the Statewide form is sufficient in this regard.
5. The State should provide seed funds for the establishment of a public interest consulting firm that would work with communities to develop strategies for impacting Alaska'a major health status problems. The major health status problems of Alaska are those resulting from decisions Alaskans make as to how they live their lives. That is the decision to consume alcohol, smoke cigarettes, overeat, fail to get exercise, fail to practice accident preventive practices, etc., and are not amendable to solutions by the medical care system. The educational process and/or community and peer pressure are necessary to exert changes. Alaskans must have an informed choice as to how to live their lives. Persons should be taught through community or educational system mechanisms the effects of lifestyle decisions upon their future health. Further, many communities, wish to on their own initiative, develop services in their communities. They need expertise on how to apply for grants, how to work within commu-

nities to gain support for programs, etc. The cutbacks in funding to the regional health corporations will make it very difficult for them to provide the kind of technical assistance to communities to meet these needs. Where the State of Alaska to fund HSA's on a minimal basis to provide the above functions, they could then offer services to communities and/or providers on a consulting non-profit basis to perform the following:

a. Training of staff or Board Members
b. Development of long-range plans
c. Development of short-range plans
d. Grant writing
e. Systems analysis
f. Development of local resources and community action for preventive and educational services

Essentially my proposal is a compromise. It provides the needed seed money for HSA's who have interest in resource development to maintain an office and avail themselvs to communities for that purpose. If they are not successful in marketing their services, then their staff will be severely limited and provide only the data input.

DEVELOPMENT OF REGIONAL HEALTH CORPORATION:

I believe the State must streamline the contracting process to enable services to be contracted to regional health entities. The State will need to look at its need for representation from all aspects of the community and the regional health corporations need to abide by the regulations of the Indian Self-

Determination Act which requires representation only from tribes. I believe this could be worked out with the Indian Health Service.

Presently the regions are pulling away from increased responsibility for provision of services to populations in their regions. The reason for this is the cutback in Federal funds. If the State is going to be supportive to the forthcoming cutbacks in services by the Federal government, it will need to have regional non-profit entities operating those services. I don't believe the State will be inclined to provide direct or insurance assistance to a Federally operated facility. Therefore, the State has some interest in the development of the regional health corporation's ability to provide services. This could take the place of provision of additional training through the community colleges or the universities, the provision of grants for development purposes (these were formally provided by the Indian Health Service but has since then been largely eliminated), seminars, etc.

George Peratrovich

MARILYN OHOHANEY, M.D.

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

Bethel Hearing
Nov. 14, 1981
(1)

George Kratovich - HSA - SouthCentral Bethel rep.

concern over future of HSA. Nov 6-7 met in Anch. all three. Provided much technical assistance in Bethel. Looking at forming a coalition - reducing board members, changing types of service given

alcoholism program - need more co-ordination between agencies/funding mechanisms. Could not have local input on grants coming to Bethel - not enough money to travel to regional meetings. Block grant money now

Marilyn Chohaney MO - Med. Direct. YKHC

Elimination of travel funding (50-70,000 sq miles) The reason health care has worked in this area is because of CHA. Average CHA - woman in 30's H.S. education, bilingual, [illegible] children [illegible] training key person in community, daily radio contact w/ physician in Bethel. Travel fund cut makes CHA more resp. for primary care.

Clinic (heat, lights, communication, Rx storage) problems with all of these physical structures in [illegible]. Have been federally funded, staffed, training. Village Council has lease w/ PHS - funds frozen, no inflation increase

DHS funding a flat amt. per village with the com. req. expected to make up the difference.

Betsy Weiss - hosp.

Gradual increments in improvement in communications still an imperfect system.

Dr. John Weatherly -

Many villages have phone in public place, - no privacy with charts - sometimes phones don't work. Emergencies can generally be handled, but routine care has prob. w/ comm. with physician on a daily basis.

15 villages with phones in clinics. 48 have side band radio - Communicate mainly w/ these.

TRAVEL FUNDING - Some villages (ie St. Mary's) using 168 monies for health travel ($5,000)

Joe Ryan - hosp. admin - $32,000 travel for St. Mary's Emergency travel (charters) are the most expensive

priority here:

- resources of CHA -
- travel & communication

Gina Peltier - Pub. health Nurse

per capita funding not high, costs extreme. ($550/per load) Compensation in line for rural area.

Mary Pavlo - Director Y.KHC

Medicaid problems - Medicaid will not pay from village to Bethel - only Bethel to Anchorage. Need Medicaid access for all transportation. Agreement between AANHS & H&SS.

IHS responsible for travel to their facility. YKHC (eye care, maternal/child, mental health) are judged IHS resources & Medicaid will not pay. Only $70,000 IHS funds in M.H.

Jeff Friedman - Dir. Mental Health YKHC

Mental Health not IHS though H&SS considers it such. Psychiatric services is once a month in Bethel from Anch. psychiatrist. Medicaid coupons not cover travel

Helen Collins - PHS supervisor

Medicaid pays for child for EPSD
3-4 visits yearly in village. (4 to 5 days)
doctor once a year.

Joe Ry... - abruptness of present cuts create difficult time in cutting services people have come to expect.

Trust relationship not an entitlement. lack of relationship between all those investigating health care and native relationship.

Currently
avg. pt. load 33/day (40-80%)
14 doctors (1 an administrator) 1 for radio comm/pay, 2 for inpatient
62 nurses!
50,000 outpt. visits yr.
only 1/4 people who travel to hospital have transportation pd. boarding home funds also cut, cut operating expenses for ambulance, money cut for village sanitation travel, may have to cut prematernal home.
Non-natives (about 2,000) have no access to health care other than IHS. Hospital has no mechanism to collect money (Fed. law)

Dina Pelletier
need for Prevention - maternal & child nutrition
village must mobilize access to good food. - stores don't carry the proper food, people can't afford to buy it.

Nancy Bill Health Educator YKHC
school health, pt. ed, community health ed
many outpatient visits are for infectious diseases tied to lifestyle, sanitation etc. Villages need education on basic areas - require deep personal habit change. health aides can be best utilized for prevention but are taken up w/ care.

Jeff Friedman – M.H.

primary prevention/ed.

facility being constructed in Mtn. Village as a district health center for villages in that area

State subsidy of health aide program. They make $12-14,000/yr. — sub standard care for responsibility.

PHN only has time for mandated activities & chronic pts. No time for education.

7 itinerant nurses, 2 for Bethel. keeps radio contact w/ CHA.

"Here's looking at you" should be mandated by state.

EMS does pt. ed in villages periodically – also MH/dental.

village airports – runways poorly maintained, no lights

10 village-based alcohol programs others get only 3-6 days of program a year. Need more volunteer people

AKP might have info.

Estimated that villages are growing and not dying. People migrate to Bethel but return for lack of jobs etc. Much depends on subsistence. Few have any income from any industry. Only 5-6 villages have TV — (potential for ed??

Wally Richardson – LIO

teleconference network can be an educational tool

Can dial in to villages from Anch, Jnu, FBKS.
Could have speaker-phone in village to broadcast to a roomful of people.

Early Childhood programs important to villages — Infant Learning, Parent-child (funded by RuralCap) for 6 mos — 3 yrs. stress on teaching parenting — play, reading etc.

YKHC runs Ed programs at pre-maternal home
Trying to implement WIC program in area

Mary has proposal for supplementing salaries of CHA's in Bethel area. Also need to upgrade skill-level — will save travel costs.
* Standardize health wide capabilities??

Legal protection for CHA? under supervision of IHS physicians covered by Fed. Torts — will provide defense but no real statement of liability.

4 villages do not have clinics — use BIA schools, so in summer, are locked and no access to phone at some times.

Joe Ryan - Every 3 years — a comprehensive study of the clinics. lease space from village council

64 primary CHA's
48 alternates.

HB 41

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

Discussion Paper

Development of Regional Health Resources Organizations

Prepared by

Alaska Health Coalition

November 6-7, 1981

Agreed To In Principle by:

Statewide Health Coordinating Council

Northern Alaska Health Resources Association, Inc.

South Central Health Planning and Development

Southeast Alaska Health Systems Agency

December 15, 1981

OVERVIEW

Members of the Board of Directors and Staff from each of the Health Systems Agencies (HSA's) in Alaska have been grappling for several months with the problem of how to maintain a regional health perspective or voice within the State when Federal support for health planning is discontinued. Early in 1981, the Commissioner of Health and Social Services expressed a desire to support the continuation of a regional health planning program. HSA's were invited to develop a proposal for her consideration as part of the Governor's budget for FY-83. After the HSA's agreed on a core of five functions, each developed a proposal for the Commissioner based on local needs and submitted them in August, 1981. After considering the proposals, the Commissioner elected not to include additional funds for HSA's in the Department of Health and Social Service budget basically because of other departmental priorities in the areas of corrections and mental health.

Following the Commissioner's decision the HSA's reassessed their position and agreed that if the worthwhile functions of the HSA's were to be maintained, an effort must be launched to gain legislative support. Subsequently, the Board Presidents, other board members, and staff from each of the Agencies met in Anchorage for a two-day session to develop a proposal and a strategy for approaching the State Legislature. We carefully examined all of the activities we have been engaged in over the past five years and compared them with what we believed to be the needs of the State. This led to the development of a proposal for regional technical assistance centers for health which would have as their core functions: 1) community assistance, 2) health promotion, and 3) regional perspective.

To promote the proposal within the State those present at the November 6-7, meeting elected to form a coalition with representation, at the present time, made up of HSA Board Presidents and Executive Directors, and the Chairman of the Statewide Health Coordinating Council. The primary mission of the Alaska Health Coalition - as it was named - is "to review the need for health planning, development, and promotion activities and to develop goals, describe functions and recommend structures to achieve optimal health for the citizens of the State of Alaska."

The core functions are outlined below with examples of activities which would be carried out within each of the functions.

1. COMMUNITY ASSISTANCE

   To assist communities in identifying problems and developing plans to solve them. Activities would include:

   A. Organizing key individuals within the community or region to address important health issues.

B. Gathering ideas/opinions from community members on specific issues or needs.

C. Analyzing problems and assisting in the development of local strategies for dealing with unmet needs.

D. Assisting communities to implement strategies.

E. Conducting public hearings on issues of local or regional concern.

F. Providing direct technical assistance to individuals, service programs, and communities in:

- defining needs
- identifying resources (manpower, financial, services)
- preparing grant applications
- assisting with program implementation
- assisting with program evaluation

II. HEALTH PROMOTION

To promote the development and maintenance of health promotion and prevention programs through:

A. Determining the prevention and health promotion needs of the region.

B. Assisting the currently existing programs to improve their effectiveness through coordination and cooperation with other programs.

C. Providing a forum for prevention and health promotion interests.

D. Developing new prevention or health promotion programs to meet the special health problems of Alaska.

III. REGIONAL PERSPECTIVE

A. To maintain a local/regional capability to provide current, accurate, health-related data for planning review, and resource development activities by:

1) Assisting individuals, communities, service programs, and the Department of Health and Social Services to define data requirements to support regional and statewide planning activities.

2) Maintaining a regional data library which would contain current information on the population, socioeconomic status, health status, and health care system for use by all citizens.

3) Coordinating data collection activities with local agencies, regional Native corporations, and statewide agencies and organizations.

B. To maintain coordination with State government by:

1) Providing a community/regional perspective to the Legislative and Executive Branches of State government on health-related issues.

2) Conducting local reviews of grant applications and proposals for local or State health-service funds in cooperation with the Commissioner of Health and Social Services.

3) Conducting local reviews of proposals for new institutional health services (hospitals, nursing homes) as required by the Alaska Certificate of Need Law.

4) Studying and developing recommendations on policy issues suggested by the State Legislature, the Department of Health and Social Services, or other policy setting bodies.

C. To conduct research activities and program evaluations in response to regional and State priorities by:

1) Conducting health-service and health-policy research on issues of local, regional or statewide interest.

2) Assisting health service programs to develop and implement program evaluation activities within their agencies.

3) Assisting local and State funding agencies in conducting evaluations of health service programs.

OTHER FUNCTIONAL CAPABILITIES

Another function currently performed by regional health systems agencies which is considered important, but which should be de-emphasized is plan development. After five years of developing and revising regional health systems plans, we believe that much less time should be spent on the paperwork of plan development. Instead more emphasis should be placed on implementation of existing plans.

Regional health systems plans are important especially as they relate to the State Health Plan and other State planning documents. We recommend a five-year planning cycle for the regional health plan interspersed with subject-specific plans such as mental health, facilities, manpower, etc.

GOVERNANCE

We propose that regional health resources organizations be private, non-profit corporations governed by a board of directors made up of consumers and providers from throughout the different regions. Appointment to the governing board would be by locally-elected officials, health boards, or by election of the general membership of the corporation.

The number of governing board members should not exceed 20 nor be fewer than 10.

SUNSET PROVISION

It is suggested that a "sunset provision" be included in any legislation or regulations which may come about as a result of this proposal. It seems reasonable to set a three-year time limit on the initial development of regional health resources organizations followed by a legislative review before additional funding could be forthcoming.

STRUCTURE

We propose that at least three regional health resources organizations be established along boundary lines which are coterminous with those of the regional Native corporations. Provisions should be included to allow further division of a region to recognize established health resource activities (municipalities with health powers, Native health authorities).

The uncertainty created by the Federal budget process has made it difficult to propose a formal working relationship between the State Department of Health and Social Services and the regional health resources organizations. At the present time, the Federal government mandates and funds the Division of State Health Planning and Development and the Statewide Health Coordinating Council (SHCC). Regional health systems agencies are formally linked to these two entities, as provided in PL 93-641 and PL 96-79 and would continue that relationship as long as Federal funds were supporting any part of the health planning and resources development network.

In the absence of Federal funds, which will most assuredly occur in the FY-83 Federal budget process, the State of Alaska must reassess the relationship between the State Department of Health and Social Services and its constituents. The regional health resources organizations will be prepared to work cooperatively with the Department of Health and Social Services and the State Legislature to develop a formal working relationship which maximizes the flow of information and resources throughout the health system in the most efficient and effective way possible.

Each center would be staffed by at least three professional people and additional clerical staff. Estimated budget would be $300,000 ± $50,000 for each center (about two-thirds the current level of funding for the Health Systems Agencies).

AUTHORITY

We are proposing that the regional health resources organization be vested with the authority to have "review and comment" and/or "review and approval/disapproval" responsibility over State funds which are awarded to health service programs within their jurisdiction. Although technical assistance provided to a potential applicant for State funds is believed to have the most impact on the final delivery of services, we also recognize that, without the authority which accompanies project review, health service agencies would have very little incentive to shape their programs to meet local needs.

Authority to review the expenditure of State funds for the development or expansion of health facilities, major medical equipment, and for operational costs associated with new services should also be included in legislation or regulations establishing health resources organizations. We propose that the threshold limits for "Certificate of Need" review be raised to at least $600,000 for capital expenditures; $400,000 for major medical equipment; and $250,000 for operational costs associated with new services.

Franz A. Stiegemeier
Box 302
Bethel, Alaska 99559
Pub. Comm.

18.27.020(a) 2: is IHS/PHS considered an adequate federal health program? adeque ~~If it is not equal the~~

18.27.030 ~~E~~ Sec 2 P2 ~~if the area population~~
15,000 Enrollees
15,000 enrollees for whom the state will bear 100% of copayments and deductible.
(Estimate $15,000,000?)

47.05.070(a): simply cannot be done with the feds lack of a billing procedure, there would be no assurance that moneys would be returned to the ~~a~~ utilized unit.

In regard to this I feel the best thing the legislature of the state of alaska could do for rural health care would be to help liberate the regional hospitals from the clutch of the federal government to the regional health corporation. As autonomous health organizations the would be eligible for a 100% return of their billings. And in a state with comprehensive health ~~ph~~ insurance, those revenues (access to NPS) will be considerable.

47.05.120 (1) the federal (IHS/PHS) health system, at the present time, is incapable of submitting a clean claim to third party insurance, due to their inability to break down, itemize, services on the bill

47.07.030 - Med services to be offered
noise about Medicaid travel, the hospital will ask that the ~~IHS~~ state pay for travel via TR mechanism. The ~~fee for travel portion~~ travel ~~portion~~ could as easily be an ~~itemized~~ item on a bill which is submitted for medicaid payment. Unfortunately the local hospital would lose ½ of the returns

funds ~~to medicaid~~ to AREA administrator.

WHY DOES AREA administrator

keep 50% returned medicaid money?

General observation re. H.B. 41.:

As long as who feds control rural health -
H.B 41 will yield little to rural residents.

23. Any injury or illness resulting from war or any act of ware, declared or undeclared, or from commission of a felony by the covered person.

24. Expenses incurred prior to the effective date of this schedule of benefits or for services rendered after this schedule of benefits is terminated by contractual or Congressional Act or eligibility of a person terminates.

25. Inappropriate use of ER.

26. Inappropriate use of ambulance

27. Abortions: There is a strong likelihood that in the near future the IHS will not be able to pay for elective abortions.

14. Any mental health, alcoholism, or chemical dependancy services not specifically covered in the benefits described under Mental Health; Alcoholism, and Chemical Dependancy Services.

15. Any mental health services.

15. Specialized evaluation and therapy to include: Speech therapy hearing therapy, therapy for learning disability, communication delay, perceptual disorders, mental retardation and related conditions, behavior disorders, mulitiple handicapped, hyper-activity, sensory deficit and motor dysfunction, developmental and neuroedurational testing or treatment, sleep therapy, hypetherapy and bio-feedback, behaviorial training, myofunctional therapy, neuromuscular rehabilitation and other special therapy.

16. Marriage counseling.

17. Vocational rehabilitation.

18. Acupuncture.

19. Procedures, services, and supplies related to sex transformation. Reversal of voluntary sterilization procedures and related procedures.

20. Surgical treatment for obesity.

21. Home delivery for child birth.

22. Artificial aids and external prosthetic devices, artificial limbs, corrective appliances, rental or purchase of durable equipment and supplies.

3. ~~Care in an Extended Care Facility~~, or Skilled Nursing ~~Facility~~:

4. Custodial care domiciliary care or nursing home care.

5. Home health services except as provided per professional judgment by the KANA physician or community health aide.

6. Audiological (hearing) screening, hearing aids, and the fitting of hearing aids.

7. Eyeglasses except as provided for under Special Services and Supplies.

8. Cosmetic surgery or conditions for which plastic surgery is indicated primarily for cosmetic purposes, except as provided for under Medical Services.

9. Dental care including dental x-rays except as provided for under Dental Care.

10. Third party physical examinations such as those for employment or for purchase of insurance, (except to the extent that the normal physical examination schedule is applicable). School physicals will be provided at the KANA medical clinic.

11. Any procedures which can be classified by the Alaskan Medical Community as experimental, investigative, unusual, or not customary in Alaska medical practice.

12. Any out of Area Service.

13. Pediatric or chiropractic services.

Mary P.

EXCLUSIONS

All services for conditions within any of the following classifications shall be excluded from coverage:

1. Illness, injuries, or conditions covered by services, idemnification, or reimbursement available either:

   a. Pursuant to any federal, state, county (borough), or municipal workman's compensation or employee's liability law or other legislation of similar purpose or import:

   b. Pursuant to benefits available from federal, state, county, municipal, or other governmental agencies, including the Veterans Administration for service connected disabilities or injuries; benefits available through the Indian Health Service and/or Alaska Area Native Health service are specifically excluded from this subpart;

   c. Pursuant to any federal, state, or other legislation, such as Medicare or Medicaid;

   d. Pursuant to benefits entitled to any covered person under any automobile liability or medical payments policy; and

   e. Services for bodily injury, illness, or disease arising out of motor vehicle accidents for which there is available other valid and collectable insurance under the provision of Alaska statutes.

2. All medical specialty care except when cleared on a case by case basis [illegible]

Send copy of B Dann's
test. to Jody Sutherland

Don Sloan Dir. Nort Sound Hosp.

Nome hearing
Nov. 7, 1981

Charlie - introduction

Jeannette Morton - reading Bill Dann's testimony

HB 41 - (for 4 yrs. been getting 10% C.O.L. increase from IHS. Have absorbed impact by:

Eliminating training/planning
reducing travel funds
30% below comp. State salaries for staff

Concern over further budget cuts. Can no longer cut admin. etc. Will have to cut service:

lab tech
therapy
reduce village sanitarian travel
reduce training
village eye care
planning office
boarding home prog. (for villagers)
reduce pt-travel
CHA training every 2 yrs.
Elim. outpt. clerical staff

potential impact on IHS in 4 yrs disasterous.

State needs to estab. policy for health services. Invest in human resources. Expand Medicaid travel services.

accessibility - major prob.

BIA Soc. Ser. cut - affects travel $

State needs to negotiate w/ Feds over obligation for health care

HB41 treat all Alaskans alike - sliding scale, income, C.O.L.

more resp. for mental health services.

Health Planning

Existing state health plan function of HSA -

1. regional priorities/input
2. need state policy
3. few data collected
4. need public interest consulting re: health care - prevention/education change lifestyle.
5. need grant assistance
6. state need monies for HSAs

Develop of Reg Health Corp

attitude of resp. for IHS to serve only native pop need to change

Connie Hellenbeck – Coord for Alcohol Program.

Comprehensive Alcohol Program recs:
1. avail/access of services
2. included in planning/ed.
3. Not a separate issue in HB 41

Alcohol no1 prob. in Nome).
Ins needs to cover alcohol like any other medical condition
State funded
- Detox/medical (acute)
- Resid treat.
- CMHC
- Women's center
- After care
- Consult/educ

Villagers come to Nome to drink w/ local options.
Need local treatment – learn to change life style in our environment.
- measuring outcome
  - quality of life
  - financial status
  - ability to seek/hold job

CAP operates on a continuum of services
Ed. for coping skills
Need to limit alcohol availability – not serve inebriates, limit hours etc.

12 bed fac. 45 day program (1 yr. in after) stays full
80% villagers! 90% all court referrals - follow-up part of probation - volunteer after care in villages
pilot project - alcohol Ed. Sponsored by Court will share w/ Governor this year. Class for credit.

Sharon Walluck Director CMHC

M.H. hard to justify existence locked into reg. programs though those skills are not applicable here. Heart of service delivery is funded by State
McGrath Paper - alternative program need help from State to develop Evaluation.
service/delivery
Evaluation
One on one counselling does not work. Developing community support (extended family, elders, village council) for chronic M.H people in villages. Community Model - peer pressure more relevant than counseling. IHS no longer funds. Do not keep people on medication in villages, but nutrition/vitamins

Darryl Tracy - Board Member Norton Sound, Nat. Health concerns w/ language in HB41
* "annual limit regardless of size of family;"

Insurance on alcohol needed in bush — object to giving it to State employees. Is it a pilot project / how long.

define "federal health plan"

will natives be in between IHS & MSHI? What is the relationship between them.

HB 151 – (Trust money into General fund for M.H.)
taken years to build MH trust funds, so much is needed, why deplete funds

Jeff Langer – Sanitarian NSHC

top priority in villages – water & sewages.
more emphasis on operation & maintenance of facilities than in past.
Golovin – Brevig Mission need high schools with no running water. Golovin water off freezes everywhere
Some villages have lead in water because of poor solder used in construction
Shishmaref has water supply next to cemetary – unsafe
real problem with garbage – no funds to haul away.
208 grants by N.S.H.C to do feasibility,

village safe water - Dr. Max Brewer made recs, etc (1971?)
1980 $23 million approp. for safe water. Priority decision made by a Board of Native Organizations members.
Need to coordinate agencies so as not to duplicate water supply for village use and school use.

Frank Costanzo - Chairman CAP Committee
involved in alcohol programs for 12 yrs.
Western therapeutic alcohol programs not effective in villages. Villages are now looking at alcohol, recognizing it as a problem, deciding how to develop their programs.
Economic development in villages. A board wants to develop fishing industry in Nome area. Unalakleet has training program in fishing skills. Want to train folks to commercial fish rather than just subsistence. Want to develop a hatchery - will come to the Legislature for funding.

Nancy Mendenhall - Director, Community Health Services
outreach programs
Dental/optical - have depended almost completely on IHS for funding. funded at 1981 level but another 10% cut coming
Eye care - IHS has never met the need.

(1)

A technician ~~An (optician)~~ operates at hospital. Opthamologist comes in twice yearly. This one person cannot keep up w/ demand. ~~[illegible]~~ Travels to village once a year; may not be able to continue this because of lack of PHS funding. Very concerned about school age children, does screening in school.

Dental disease / prevention - major health problem, falling behind in status of ~~health~~ dental care in larger villages (5 of them) provide services to those under 20 + adult emergencies. Some villages pay per diem costs for dentists.

Prevention:

1. Flouride program (run by CHA)

Eye care gets no state assistance.

Rob Stokes - Staff Psychologist

Psychological Licensure

~~AS~~ 12 AAC 6080 #3

Supervised experience for licensure - no supervisor available so it discriminates for rural.

difficulty w/ recruitment of mental health professionals + attrition rates for keeping staff

Vernon Sillner study - MH professionals in rural Ak.

license required only for private practice. Supervision monthly would be feasible for rural people.
refer to Regulation/Review Committee

Daley -
has a PHD in clinical psychology
also required to get 1 yr. post doctoral supervision. There are other alternatives to supervision — telecomm., videotaping etc.

Vernon Kurzuru -
1972 Gov. Alc/Drug Abuse
Ak Native panel Alcoh/Drug Abuse.

support testimony of CAP staff & Board member.
HB 41:
definition for "resident"

Dick Bullock - EMS Coord.
problems with programming - loss Fed. travel funds to travel to villages to give instruction.
Cost of maintenance of communications from feds also incr.
No disaster training or drilling ever done here.
EMT regulations will change, new regs not out yet.
trained Nat'l Guard, 6 health aides.

not enough funds to cover village clinic, so that CHA can come in to Nome for training.

Hard to maintain a steady supply of EMTs to run ambulance. turn-over great. 120 hrs. for EMT I training

ambulance operating cost $14,000/yr monthly rent for garage - $880.00. owned by Norton Sound Health Corp. EMS Advisory Council contracts for work. Hospital does all bookkeeping

equipment retrieval a problem

Frank Proplacky - Bering Sea Women's Group / Men's Battering group.

finds the detox facility to be inadequate - inebriates locked up in jail or put in hospital.

Ivan Widom - City Manager

- with villages going dry, anticipate more of an alcohol problem in Nome. Trouble collecting sales tax

per capita funding used 1980 census rather than 1981 CERA figures - lost money in Nome - over $350,000 City put 100,000 into social programs (child care, women's shelter etc.) also $28,000 to Ber. St. treatment Center.

City putting in new water & sewer - money from State matched by DEC.

Receiving home - pres Board of Directors. inadequate facility. Would like funding for joint shelter, receiving home.

New youth facility in Nome, not functioning yet. Also selling 2 acres to State for new jail site.

Lavonne Hendricks - 12 yrs of health provider/educator in Nome. (PHN)

More energy into school health education. Doing a risk reduction program - nat'l recognition for innovations & cultural relativity. Use students teaching students to change attitude & behavior. 5 yr. funding of this program, to be included in Block Grant. Governor's Advisory Council coming to Nome Dec. 4th - for student health fair.

Wants components of this program in school curriculum. Not enough health ed. in schools.

Bob Blodgett

Fred Angleton - Alaska State Trooper / EMS Advisory Council.

transportation - air costs going up & often never

Charter raising cost to $300-$500 round trip

Communications - most equipment at least 12 yrs. old. All villages have phones except Bering Mission. Making a study for a communications network on West Coast to serve EMS, search and rescue, police etc. (put together info from many studies into a packet)

Having 1st person in court soon for bootlegging into dry village. (local option)

Civil air patrol here - forming - getting hangar and a plane soon. Two pilots here qualified for civil air patrol work.

There is a village public safety officer in all 15 villages (high turnover) They are uniformed but unarmed. Employed by non-profit corp or city.

Stan Sorrskinski

asked about passage of drug law

Name	Organization
✓ Jeanette Morton	Norton Sd Health Corp. Box 966 Nome
✓ Connie Hallenbeck	Norton Sound Comprehensive Alcohol Program
Sharon Walluk	Norton Sound Family Services Box 966 Nome
✓ Darryl Trigg	Norton Sound
✓ Fred Angleton	EMS Advisory Council Pres.
✓ Robb Stokes	Self
✓ Nancy H. Mendenhall	Norton Sound Health Corp.
✓ Geoff Langer	" "
✓ Frank DiCostanzo	Chairman Norton Sound Comp. Alcohol Council
✓ Doreen Dailey	self
✓ Vernon Kugzruk	SELF (Kawerak, Inc. staff, BSNC board member Nome)
✓ Dick Bullock	N.S. EMS
✓ Frank J. Poplawski	Bering Sea Women's Group
✓ Ivan L. Widom	City of Nome
✓ LaVonne Hendricks	Norton Sound Health Corp. - Nome Teen Health Program
✓ R. R. "Bob" Blodgett	Bering Strait REAA & Coastal Resource Planning Board
Stan Sovalikuski	

PLEASE SIGN your name if you are interested in testifying to the Committee:

DENNIS DeWitt - Medicaid

Paul Sherry - HSA

Lynne Johnson-Joseph - Health Ed.

Adrian Barber - Chiro. - 1577 C Street, Suite 102 99501

Don Bantz HB41

T Burrell

Jan M. Armbrust HSH

Tim Scott EMS

Dr. Beirne Terry Martin Anch. Dec 15 (1)
Charlie
Jody Sutherland
Sandra

Anchorage - Dec 15, 1981

Dennis DeWitt = pres. Ak. Hosp. Assoc.
important issues:

Pioneer - support money following pioneers (HB 225) rather than force them to leave their community to go to P. Home. Should finance alternatives.

C.O.N. - support governor's prop. to increase threshold for CON. Will support abolishing the process - no value to health planning

Construction Support - esp. for rural hospitals. Many in disrepair, the communities financially unable to rebuild the institution. HSS finalizing survey of health facilities - reflect needs to replace and repair facilities 3-5 yrs. Need orderly plan for funding.

(1st priorities)

Assoc. has task forces on
(handout) [illegible] Revenue Sharing / Gov't programs
Believe priorities are necessary. First is facilities that are falling down, below code etc.

MEDICAID - for 2 mos. have responded to HSS in looking at Medicaid. Feels HSS

should not expand services before dealing w/ commitment to other groups. Have supported prospective reimbursement as a matter of principle. Lon Mirgon head of Task Force — supporting negotiated rates for nursing homes/hospitals.

Oppose 9% "cap"

Have proposed leg. - have shared w/ Medical Care advisory committee

* need to be statutory in base

small institutions need to be able to deal w/ the system. must be approved by Feds.

principles of reimbursement & rates are set by payers

need an appeals mechanism

need a separate Commission to negotiate

must be reimbursable by Medicaid 100%

System:

costs included in budget: capital needs, operational budget etc. Commission review budget and set rates according to need. appeals. supplemental budget needs in place. H&SS forecast Medicaid users. Actual budget review at year end.

H&SS supports concept. Some technical pts. of conflict — fiscal year etc.

interior owned Nakoya, Carriage House

Handout.

Paul Sherry - Pres. North. Ak. Health Resources

Alaska Health Coalition - all 3 HSA'S

HSA only ones who have co-ordinated loc/Fed/State regulatory (CON) role has made them unpopular. Govt shifting to competitive model. CON legislation needs to be addressed. State must support fiscally. core functions:

1) community assistance - localities have no finances, manpower etc. to set health priorities.
2) Health promotion - since 1976 have identified this as priority for lifestyle related needs.
3) Regional perspective - guarantee local input / needs addressed

retain similar geographic areas

H work not medical oriented as much as health resources oriented. Questionnaire results -

Lynn Johnson Joseph - Alaska Health Ed. Consortium

priority in Health education. Gov. Bill Stinson will intro. - est. 3 regional health Ed. coordinators to give assistance to school districts in the State.

cost about $10.00/per student/year. No statement from DOE. but support from other groups (NEA, Sec. Sch. Principles Assoc. etc) DOE has changed specialist policies, no one provides this service). Local decision making insured.

Adrian Barber - Chiropractor (chair. leg. committee Alaska Chiro. Assoc

HB 41 - How will we pay for all these programs in 20 yrs.?

- more flow of money toward alcohol and drug abuse.

interest payments for late clean claims - penalize the bureaucracy for lateness - potential for vast financial impact.

If state passes HB41 -

Medicaid does not cover chiropractic care. Reimbursed through GR for chiropractic until 1975 now denies all claims regardless of referral. HB 41 also does not cover chiro. although other insurance & Worker's Compensation does cover this.

Handout → Physical therapy law includes chiro. A.G. opinion on this - statute questionable. Gov. office not submitting legislation on the Div. of Occup. Licensing. Board is thrown up.

Don Bang - Exec. Dir. Anch. Neighborhood Health Center

opposed to AB 41 -

unlimited demand/open-end financing of health care — will go unchecked. 3RD party payors provide incentive for more use. Consumer no judge of cost/ no responsibility

primary care oriented - prevention etc.

expansion of catastrophic illness program

"free" care is overutilized - 4-5% of population uses 25% of services.

sliding fee scale based on income - difficult to monitor, requires many staff.

support:

competitive bid section

J. Burrell - consumer.

RE: uninsurable.

temporary medical coverage for displaced homemaker who cannot qualify for welfare.

difficulty in obtaining insurance because of pre-existing conditions. Program available pays for small percentage of costs.

older person goes w/o medical care - a divorced elderly woman gets no support has few skills, mental health problems. Medical care favors poor with no assets - must be bankrupt and become welfare-oriented in order to get help.

Jim Armbrust - Chair. Ak. Statewide Health Coord. Council (SHCC)
30 members. meets 4X yr.
concern about HSA's/ maintenance of funding. possible loss of funding coming from Fed's.

admin. Tom Scott - S. Reg. Emerg. Med. Council
non-profit corp. Bd. of Direct. 30 people
funded by EMS (Pub. Health)
Staff of 10 (5 trainers, 1 nurse for C.E. develop., 4 admin/clerical).

Technical assist in service delivery, annual implementation plan. 3 ambulance services are paid — the rest are volunteer. 10 communities have 911, (Emergency)

EMT Certification - regs. to become effective Jan 1
training staff being put in the position of test monitors.
Para-medic - 6 mos. full time training; highly skilled

Highway gaps. / Palmer to Glenallen
(Portage to Soldotna to Seward)

GAPS:

1) Communication - highway system & in Bush areas.
2) need ambulance
   Tok cutoff
   Eureka (Glenn Hgwy)
   N Richardson toward Thompson Pass.
   area near Seward
   (looking at feasibility of helicopter ambulance)

liability - most ambulance services have general liability that covers malpractice. Nat'l agency provides malpractice insur. for $50/yr. $2500/yr mini grant from State to services from liability.

...airman State Medical Board

...nes, interior region EMS.

...ninger, Administrator Fairbanks Memorial Hospital

Jennifer Pearson EMS

Miss Moore home health

Sister McGinty Nat'l Assoc. of Soc. Workers

Rafferty handicapped.

David Mather health Director Tanana Chiefs

Barbara Dahle disabled

Arturo Frazera EMT training Coordinator

Charles Kalterbach director, NAHRA

Dr. Michael Graff MH Program Dir, Tanana Chiefs

Dr. Wayne Meyers U of A

Frank Cook

Joan Kingray

Mary Carey

Kenai-Soldotna Sept. 26 - 10

Mrs. Raymond Kinlein
Karen Carpenter "
Jim Jolin Chairman hospital Board (S.C.)
Burt Fossey nurse anesthetist
Debbie Rediske Admin Dir. CMHC
Justin Maile Hosp. Board
Sonya Bates
~~Bob Cowles Coord. ual. Alcohol Programs~~
Michael Herring Admin. SC Hosp.
Vivian Reiser Acting Admin. SC Hosp.
Beth Tashner Bd. Member SC HSA.

Nome 17

Bethel 11

George Kratovich HSA
Marilyn Chohaney Med. Dir. YKHC
Betsy Weiss hosp
John Weatherby
Joe Ryan Hosp. Admin.
Gina Pathier DHN
Mary Pavil YKHC Dir
Jeff Friedman MH Dir. YKHC
Helen Collins PHN Super.
Nancy Bill Health Educator YKHC
Walley Richardson LIO

Bethel

alcoholism - coord. between agencies, more village visits
M.H. - monthly psych. from Anch.

Rural health - elim. of travel funds.
rural clinic conditions, PHS lease
Communications - prob. w/ village phones.
CHA resources, training
Prevention/ed village training.

NOME

alcohol - no 1 prob w/ local options, detox inadequate,
MH - develop. community model, reg. services not effective.
water sewage in villages - emph. operation/maintenance. Garbage removal

licensure Psychologist - rural discrim. no supervisor to work under

EMS - training funds cut. communications maintenance
equip retrieval, operating ambulance

Dental/optical services.

Alcohol - Need NORTHERN Regional Center
RURAL DIFFERENCES MEAN Change in
Evaluation Method
Exp to prevention.

FBKS.

EMS - nonpayment for services.
comm - needs microwave system. major links on haul rd
training site. salary travel for instructors
Regs for EMT's need completed
→ CE - EMS, CHA

Medicaid - regs for reimb. for soc. workers & non-profit agencies. Non profits waited 7 yrs. for licensing issue. cannot get state contracts - no license

HANDICAPPED problems
Getting handicapped plates
Handicapped parking - NA or fixed / fine
information & referral
Indep. Living - home/vehicle conversion, equipment.
Legal Advocacy
- Transportation
Homemaker - travel time incl
Health Insurance
No State availability determination

Continuing Ed

Fed. Cuts - no clinic for rural clinics, phase expansion canceled,
CHA limitations (EMS, HH, MH dependence on CHA)
only facility & communicat - Dispensing Rx, Supervised by Fed. MD. no State recog./regs.

Kenai-Soldotna Sept. 26th

S.C. Hospital expansion completed planned OR expansion

Nurse anesthetist not incl in Nurse Practice Act.
Practice under Anesthesiologist supervision - not readily avail.

MH Prevention, Outreach, Education

Alcohol - need Detox Center on the Peninsula.

S Pen Hosp. expansion plans.

10.7
Continued local input in Health Planning

Nome 11/7/81

William Dann - written testimony - read by Joannette Morton
Jeannette Morton - NSHC hosp - 4 doctors, 12 nurses, 22 beds (of these 6 long-term, no nursing home in Nome). 13,000-14,000 outpatient contacts yearly. Two dentists (one out to villages at all times), also contract w/ private dentists

Connie Hellenbeck - NS Comp Alcohol Program (part of NSHC) 8 of 16 villages have gone dry (sale + importation) (started Aug 1 - Nov 1 - no experience yet)

Sharon Walluk - NS Family Services - (Comm MH Center)
- concerned about standards used to fund CMHC $
- nos of people + 1 to 1 contact being used (wrong)
- burn-out in 6 yrs: 1 psychiatrist, 6 PhD psychologists
- McGrath paper (alternative for rural communities)

Darryl Trigg - NSHC Board member and Ak Native Health Bd
- benefits same regardless of family size } HB 41
- why state employees only for alcohol insurance?
- what is "Federal health plan"? IHS won't pay if other insur
- danger gap in time when Native not eligible for state or IHS aid
- HB151 - shouldn't divert money from MH

Geoff Langer - NSHC sanitarian -
- New HS - Golovin + Brevig Mission no running water yet
- More money for 208 grants (see paper)
- Water point in Shishmaref next to cemetery - won't use it

7

Frank D. Constanzo - Ch NSHC Comp Alcohol Program
- 12 yrs w/ alcohol programs in Ak
- Western programs not successful w/ Ak Natives
- Local program has 6 Natives on 9-member board - team goes to village, ask them how to deal w/ problem. At first they said - "send to Nome," now villages are taking serious look at it. Have raised hopes in region, hopes will carry on. Not problem to be solved quickly.
- Need flexibility in approaches to alcoholism.
- NS Adv Bd - fishermen. Trying to develop self-sustaining program - raise average income from ca $3000 to $12000. Will be asking for fish hatchery for king salmon.

Nancy M. Mendenhall (NSHC) - outreach services
- IHS funds cut - have been almost completely dependent on them. Expect another 10% cut.
- eye care - NSHC has one technician* for screening, exam. Lost CETA aide, can't handle load now.
  * technician w/ 6 mos training course.
- dental care - falling behind. Two weeks in village not enough. Many kids no full set of teeth until age 12. Expanding service to adults who can pay.
- patient travel costs - $75 one-way average from village to Nome. Hosp has so far paid return trip if authorized visit.

Nancy M. Mendenhall – (cont)

– Had one-way deal w/ ANS Anch, too. ANS can no longer do it.

Rob Stokes – ~~[illegible]~~ psychologist – NSHC –

– protest regs, requirement for 1 on 1 supervision

– Stillner study 1979 showed 12-17 mos stay for MH prof in bush

– once a month OK, be more flexible

Doreen Dailey – Ph D psychologist – same opposition to regs

– wrote board about month ago, no reply yet

Vernon Kugzruk – member Bd BSNC, Kawerak staff, ex-member ANCADA, etc

– supports testimony of Hellenbeck & Constanze

– rate of alcoholism went up: (1) when Feds talked of banning duck hunting, (2) proposed moratorium on sea mammals, (3) time of ANSCA hearings (stress?)

–

Dick Bullock – N.S. EMS,

– 7 villages of 16 got phones for health aides – IHS stopped funding. Sideband maint problems

– $850 - month

– trained Natl Guard last yr – 8 qual as EMT-1

– EMT tng funds cut (trainer riding on Trooper money)

– ca 10 EMT's in Nome, high turnover

Dick Bullock (cont) -
- trying to fund ambulence on 70% -- 30% spl.
(30% toward replacement) -
- no problem w/ payment for ambulence, air taxi
- equipment retrieval from Anch problem

Frank J. Poplawski - Bering Sea Womens Group, men batterers
- need more detox facilities
- repeated de-tox 5-6 times, 2 yrs to decide to stay with it.
-

Ivan Widom - city manager Nome (ex Kodiak, Dillingham
- no [illegible] sleep-off center. Police take [illegible] drunks home or other place.
- Put $20,000 into B S Alcohol Program (from SB 168)
- Got 84.0 million (= 89.2 million w/ DEC match) for water + sewer
- hopes for statewide health care program.
- looking for jail site - Ak Gold has land, won't sell, city now selling state 2 acres.

La Vonne Hendricks - 12 yrs here, health provider (Pub H Nu
- spend more on prevention, education
-

R.R. Bob Blodgett - B.S. REAA, Costal Res. Planning Board -
- doesn't like prohibition
- escalating cost ins will drive up cost of air travel

R.R. Bob Blodgett (cont)

- people (many) drink from boredom, TV will help
- senatorial dist bringing in 80% revenues, not getting its share of funds
- PHS has obligation to provide water & sewer for Native communities
- Dick Holden long-range planner, working on simple practical solutions to water & sewer problems
- Real problem in B.S. area water -
- ① Use waste heat

Fred Angleton - EMS Advisory Council President

- Charter flight to village $300-500.
- most single sideband equip over 12 yrs old
- CB's now being used in search and rescue.
- started Civil Air Patrol unit last year

Stan Sobieczynski (sp?) -

- what action on drug bill?

Dick Bullock EMS

Nome Hearing
11/7/81

Jeanette Norton - speaking for Mr. Dam
EMS
can we get a copy of written testimony
elim of travel by EMS to villages

"imperative" - Alaska establ a policy on provision of health services

accessibility - prime problem in Alaska health

health planning - HSA - state office of health planning

Hospital tour - 22 beds, 6 (8?) chronic care - nursing home
no surgery except emergency
4 physicians
12 nurses RN's
2 dentists (also 2 in town)
both physicians & dentists tour villages (16?)
55% IHS funding - 80% of patients native

2 – Nome hearing

Q – what is the "health profile" of Alaska communities – i.e. 76x how many handicapped, diabetics, alcoholics, etc., etc.

IHS pays as last resort – private insurance & medicare(d.) provide dollars first
IHS cutbacks – "revenue sharing" (~~1000 per~~ SB 68") is providing a cushion at present
staff turnover a problem, both with physicians (2 yrs. in Nome average) & nurses
EMS volunteers run ambulance – regional corporations purchased them & "rents" back for $1 per yr
hospital was old Methodist, then 4 yrs ago new addition)

Connie Hellenbeck – acting director of the comprehensive alcohol program

(SB 127 – Sen Colletta)
(1) alcoholism is a disease – should be dealt with as such – a health problem not a character defect
(2) decentralized treatment

City of Nome really not interested in social services right now

12 bed
rehab also medical detox -
stays full, 80% villagers, 90% are
court referrals - good follow-up
done as part of probation

difficult to get the fire marshall to come
to Nome

~~Frank DiCostanzo~~
Sharon Walleck - mental health - "outsiders"
system - model of services delivered - does
not fit local needs but is insisted on
to insure local funding - alternative
programs being worked out, but doesn't
fit into the state's evaluation model

5 chronic patients that have been to API - work
out "support system" in village
IHS has been funding - chronic psychotics

Darrell Triggs - many people (Natives)
who are members of unions, etc.
come to Norton Sound hospital & don't
admit they have insurance - they are
fearful they will (later) be unemployed
& then not qualify for IHS coverage

what's the relationship between statute & regs 4

D. Trigg con't. – feels aspects of HB41 are discriminatory & the time may soon come that

HB151 – spoke against (mental health $ would be dispersed to other public purposes via this bill)

Lunch

~~Fangen~~

Jeff [illegible] for Norton Sound

Collette – speaks highly of [illegible] problems with water [illegible] "village safe water act"

"the way Reagan's [illegible] out $, the state's gonna have to play a bigger role"

$ to continue 208 grant model litter act

Mr. Constanga – ch comprehensive alcohol program for Norton Sound 13 bars in Nome – all out to make the most $ as possible

economic development in the villages -
Norton Sound advisory bd

~~Ms. Mong~~ Ms. Mendenhall
director of community health services -
non-hospital health outreach

eye care & dental services
IHS cutbacks - problems with
delivery of services
, funded almost entirely by IHS

because of IHS cutbacks, this year
eye care person unable to get to ~~all~~ any of
the villages this yr

dental disease is similar but
more serious problem - status of
dental health care going down -
no routine care for adults - only
1-20 yr olds get "preventative" care

patient travel costs -
funds available for this is being
cut - at this time, people being
asked to pick up 1 way of cost to Nome

C

Also a problem between Norton Sound & ANS in Anch — Norton Sound has pd 1 way ANS the way back — as of last week ANS told Norton Sound they couldn't pay way back & if Norton Sound gets a further IHS cut of 10%, they won't be able to pay for one way either — suggests state look at subsidizing travel

prob 80% of health care can be taken care of in the village itself

come in under several categories:
1. authorized in
2. medivac
3. come in for special clinics

patient travel seems to be dropping — each year fewer patients sent into Anchorage

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Mr. Rob Stokes. staff psychologist for Norton Sound health corp — points out sp. stat '2 AAC 6080 (?) reg specifically calling for supervisory

(Rob Stokes) - discriminatory, elitist & urban - regulation review com.
(Stillner, Bruce & Lipsner study)
R.S. supports supervision & licensure, but would like to see more flexible standards (maybe once a month)

(Reg. Review com. meets in Kdy 2nd week in Dec)

Ms. Daly - spoke to the same issue as R.S. [illegible]

Mr. Kungruk - Kaurwik - past member of com. on alcohol & drug abuse, etc. - various alcohol & drug abuse related experience

Backs Norton Sound Health Corps (AP - Connie Hollenbe[illegible] & others

HB 41 - sec 1 B - "resident of the state eligible to enroll [illegible] -
various other comments on particular sections of HB 41

tesspresses rate of alcoholism with specific events

8

taking away traditional rights of Natives

comments on subsistence

Dick Bullock — EMS — Norton Sound
state very helpful to EMS — tho EMS here does get some $ from IHS

state advisory council ACEMS

feds pd for travel to villages & state pays for equipment

programming / Comp equipment [illegible] is where EMS hurt

EMS trains for medical care, troopers provide search & rescue training

communications a problem —
ref. Alascom telephone —
phones / satellite — to Nome —
single side band (line of sight)
is the back ups

disaster preparedness not ~~too~~ dealt

with at all — again, funds for programing the big problem

7 villages out of 16 IHS funding to the tune of $875 per mo — there are dedicated lines in village health clinic

Nukluk telephone — private outfit — maintenance & etc. at whim of Bob Blodgett

villages have a line, but would like more privacy & reliability

emphasis ACEMS group as a screening

block monies — Norton Sound got a limited amount (prob. because of Duckworth)

prob. of maintaining a continuous level of EMTS — 81 hours min. amt. of training (3/4 females)

ambulance does not have space

to house ambulance — must be garaged elsewhere & rent just went up from 600 per mo to 850 per mo

ambulance run by volunteer groups have troubles being reimbursed

equipment retrieval a real problem

air carriers often ships

Frank Pabolosky — Bering Sea Women's Group + Men's Battering Group

identifies an inadequate detox facility as an important need

8 women & 15 children in the women's shelter

no non-medical detox

Wilson (?) Nome City manager — [illegible] Nome, [illegible] people come to Nome to drink, as villages go dry. The city receive 100% of all fees collected on alcohol (license fees & sales tax) in the city & the city is putting little or nothing back into

alcohol programs Dept. of Revenue has ~~to~~ records every month of all 13 bars in Nome

all alcohol could be put onto bond

SB168 – Gilman et al. holding hearings on it

Lavonne Hendricks – health serv. provider for 12 yrs. (public health nurse) – speaks for spending a bigger percentage of funding in preventing health problems – education

not enough health education in the school systems

Bob Blodgett – alcohol abuse – 10 [illegible] natives [illegible] but not 14,000

drunk natives on 4th [illegible]

has advent of TV in remote areas to less drinking in the villages

wants legislature to address total water & sewer needs treated – solved by Alaskans – not outside – experts

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