H. Hess

Interim

Committee

Report.

12/1981

SENATE HESS COMMITTEE
INTERIM REPORT 1981

SHESS 81/82

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M E M O R A N D U M

DATE: December 1981

TO: Senator Jalmar Kerttula, President of the Senate

FROM: Senator Charlie Parr, Chairman, Senate HESS Committee

RE: Senate HESS Committee Activities during Interim

* *

This report is a summary of the activities and findings of the interim work of the Senate HESS Committee.

Staff work began during July and August on Health Systems Agencies, Emergency Medical Services, availability of medical care providers, causes of morbidity and mortality, and preparation and distribution of questionnaires. Historically, public hearings during the summer have been poorly attended, so hearings were held between September and December.

At the September 12 hearing in Fairbanks, the major topic of testimony related to problems of the handicapped; on September 26 in Kenai-Soldotna, major concerns were the expansion plans of the two Peninsula hospitals; at the Nome hearing on November 7 testimony revolved around alcoholism, the major health problem; while Bethel residents on November 14 were mainly concerned with the effects of federal budget cuts on the rural health delivery system. Finally, the major thrust of the Anchorage testimony on December 15 was the uncertain future of health planning and the Health Systems Agencies. (Section 1)

The Committee viewed hospital facilities in Anchorage, Bethel, Nome, Soldotna and Palmer.

Prior to the public hearings, questionnaires concerning major health care issues were sent to each hospital and licensed health care provider. A different questionnaire was sent to 3,000 member of the general public, using names selected at random from the voter registration list. Because of inadequate return from consumers, the original 3,000 questionnaires were supplemented with an additional 2,000 sent in November. A report on the consumer quesionnaire results will be forthcoming in January.

The 5,279 questionnaires sent to health care professionals revealed that malpractice insurance, defensive medicine and inappropriate emergency room use coupled with a lack of outpatient care were viewed as major causes of inflation in health care costs. Professionals favored efforts to limit Medicaid fraud and abuse, wellness promotion and

health screening and education.

A majority of respondents found unique conditions affecting their professions in Alaska. Most, except for nurses and pharmacists, feel that they are reasonably reimbursed for their work. Although 87% report having taken continuing education classes, and a majority feels continuing education should be mandatory, the unavailability of such education locally plus the expense of time off and travel are major issues. A majority of the respondents list mental health services, alcoholism treatment and nurses as local needs in the 32 communities they represent. (Questionnaire summary Section 2; Health Professionals Questionnaire Report Section 3)

Nationwide the health systems agencies (HSAs) are in the process of being defunded by the federal government. Alaska's three HSAs currently exist on a mixture of federal and state funds. If they are to survive the state must pick up full funding within the next two years. Although opinion has been very mixed on the value of the HSAs to Alaska as presently constituted, a somewhat new form and format for the Alaska HSAs is being proposed that might prove of value in regional health planning and promotion to the state. The legislature must decide if the restructured HSAs can be of sufficient value to the state to justify full state funding, and if so how the new agencies will interface with the Department of Health and Social Services. (Sections 4 and 5)

Emergency Medical Services (EMS) has existed as a function of state government since the mid-seventies. EMS's stated mission is to reduce human suffering and economic loss to society resulting from premature death and disability due to accidents and sudden illness. To accomplish this goal Alaska EMS has helped establish regional councils to provide and plan for emergency medical services, and to train emergency medical technicians. Testimony to the Committee during the interim hearings was highly in favor of the state EMS program. However, problems in areas of standardizing training, upgrading and replacing equipment, and improving communications need and are receiving attention. (Section 6 and 7)

Investigation into mortality and morbidity reveals that Southeast Alaska more closely resembles the nation in causes of death, but that accidents surpass heart disease in the rest of the state. Rates for specific causes have declined since 1950, particularly for tuberculosis, diseases of early infancy, maternal and heart disease; while causes relating to lifestyle such as accidents, homicide, suicide and alcoholism fluctuate at levels higher than the national averages. (Section 8)

A nurse shortage is plaguing the country and many areas of Alaska, but the state as a whole has a higher ratio of nurse population than the U.S. average. Although many professions have been approximating the national ratios, we still have fewer physicians and optometrists. The number of pharmacists has actually dropped in the last ten years. (Section 8)

A copy of this summary is being furnished to all members of the legislature. The complete report is available from the Senate HESS Committee on request.

CEP:dm

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

INTERIM 1981

FINAL REPORT

CHARLIE FARR, CHAIRMAN
TERRY STIMSON, VICE-CHAIRMAN
VIC FISCHER
TIM KELLY
MIKE COLLETTA

DECEMBER, 1981

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SECTION 1

PUBLIC HEARING SUMMARY

SENATE HEALTH, EDUCATION AND SOCIAL SERVICES
INTERIM COMMITTEE

PUBLIC HEARINGS - 1981

Fairbanks - September 12, 1981

Present: Senator Charlie Parr, Rep. Hugh Malone, Rep. Sally Smith, Rep. Fred Brown, Ginger Baim for Sen. Vic Fischer, Jens Zehbe for Rep. Mike Beirne.

Sixteen people testified.
The major subject of testimony was problems of the HANDICAPPED related to living situations, parking and plates, transportation and health insurance. It was suggested that an information and referral service and a state disability determination would be beneficial to this group. Other topics included: EMERGENCY MEDICAL SERVICES - Communication needs were identified in major links on the haul road, and a training site with salary for instructors. Difficulty in receiving payments for services was discussed as well as a need for completion of EMT regulations. Tied in with training is a need for continuing education for other health professionals including village health aides. Rural concerns regarding federal budget cuts were mentioned in the areas of clinic leases and clinic phone expansions being halted. The standing of the CHA was subject for discussion, as they have no formal state recognition, and it was felt that salary and training and pharmaceutical regulations should be looked at, in view of their great responsibility.

Kenai-Soldotna - September 26, 1981

Present: Sen. Charlie Parr, Sen. Mike Colletta, Rep. Hugh Malone, Rep. Sally Smith, Rep. Terry Martin, Jody Sutherland for Rep. Mike Beirne.

Ten people testified.
The major subject of testimony related to the expansion plans of the two peninsula hospitals, Central Peninsula and South Central, and the financial requests to the legislature planned by the hospital boards.

Local needs mentioned in testimony were a detox center on the peninsula and staff trained in alcoholism and mental health outreach, education and prevention. Support for health planning was also a topic, stressing the need for local input to continue after the Health Systems Agencies are defunded.
The committee toured the new Central Peninsula Hospital facility.

Nome - November 7, 1981

Present: Sen. Charlie Parr, Sen. Mike Colletta, Ginger Baim for Sen. Vic Fischer, Jody Sutherlund and Barbara Wilkins for Rep. Mike Beirne.

Seventeen people testified.
The major subject of testimony referred to ALCOHOLISM, which is the number one health problem in Nome, particularly with local option happening in the surrounding villages escalating the problem in the city. Needs were identified for a larger alcohol treatment facility and the development of support structures within the villages for alcohol and mental health, acknowledging the socio-cultural needs of rural Alaska. Other rural concerns related to operation and maintainence of water and sewage systems, loss of IHS funding for travel and services and licensure requirements for supervision of rural psychologists. Emergency Medical Services also have funding concerns related to training, ambulance operation, communications equipment maintainence, as well as difficulty in equipment retrieval.
The committee toured the Norton Sound Hospital prior to the hearing.

Bethel - November 14, 1981

Present: Sen. Charlie Parr, Sen. Mike Colletta, Jens Zehbe and Barbara Wilkins for Rep. Mike Beirne.

Eleven people testified.
The prime thrust of testimony in Bethel revolved around the effects of federal budget cuts to the Indian Health Service. The concerns were for reductions in hospital services to non-natives, loss of staff providing other medical services and travel funding. Also,

a reduction in salary and training funding for Community Health Aides at a time when requests for their services are expanding, particularly identified was the need to provide more preventive and educational services within the villages. Better coordination and staffing for mental health and alcohol services, as well as increased rural outreach were also suggested as local needs. Communication problems still persist with village phones, and will get worse with the lack of federal support in the phone expansion program compounded by loss of clinic leasing funds. The committee toured the Bethel PHS Hospital prior to the hearing.

Anchorage - December 15, 1981

Present: Sen. Charlie Parr, Rep. Mike Beirne, Rep. Terry Martin.

Eight people testified.
Concern for the future of health planning after the Health Systems Agencies are defunded was the major topic of testimony in Anchorage. Alaska Health Coalition, made up of the existing HSAs, presented their views of the future of health planning with community assistance, health promotion and regional perspectives prioritized. Draft legislation was presented to the committee and discussed. The three bills were concerning health education, Medicaid budget review and the licensing of chiropractors. Information was also presented about the achievements of the Southern Region Emergency Medical Services Council in FY 81 with federal funding. The committee also heard testimony against the passage of HB 41. On December 14, the committee viewed Providence Hospital, Alaska Psychiatric Institute and the Valley Hospital in Palmer.

SECTION 2

Health Professionals Questionnaire Summary

SUMMARY

Senate HESS Interim Committee

Health Questionnaires - Health Professionals

5,279 questionnaires were sent to health professionals licensed to practice in Alaska. The names were obtained from the Division of Occupational Licensing. 425 questionnaires were returned with the following information:

Changes in service, delivery and utilization of:

HOSPITALS

*Less inappropriate Emergency Room use

*More outpatient care/ambulatory surgery

*Multiple health systems cause duplication of services

CLINICS

*More prevention, screening and education

*More availability of outpatient care

*Reduced cost/sliding scale fees needed

LONG TERM CARE

*More facilities closer to home

*More Home Health care

*Higher standards of personal care

Suggested activities for state to control health expenditures:

*Limit Medicaid fraud and abuse

*More prevention programs

*Stay out of health care

	YES	NO
Should the state fund HSAs?	24%	40%
Have you had contact with your HSA?	39%	58%
Does your HSA fairly represent your profession?	2%	58%
Should health planning be restructured?	42%	1%
Are there unique professional conditions here?	64%	1%
Is there an increased need for para-professionals?	36%	34%
Do you receive an adequate wage/salary?		
Physician	67%	27%
Nurse	39%	57%
Physician Assistant	66%	33%
Pharmacist	46%	53%
Psychologist	69%	23%
Dentist	78%	21%
Dental Hygienist	100%	

Optometrist	83%	16%
Optician	50%	25%
Chiropractor	77%	
Administrator	25%	50%

	YES	NO
Have you had contact with your Board of Regulation?	69%	23%
Are they efficient?	46%	15%
Do you perform services as defined by law?	84%	.01%
Have you taken continuing education courses?	87%	.02%
Should continuing education be required?	65%	.24%
Have you contacted the Div. of Occupational Licensing?	74%	17%
Are they efficient?	44%	25%

	Percent of positive response	
Is health care accessible?	89%	
Is transportation a problem?	28%	
Are Emergency Medical Services available?	92%	
Are they efficient?	88%	
Do you have an alternative birth center?	2%	
Is there a demand for one?	24%	
Is there a doctor doing home births?	13%	
Is there a lay midwife?	1.9%	
Is there a nurse midwife?	34%	
Should the state license lay midwives?	37%	44%-No
Have you had contact with Home Health?	50%	
Is there a demand for it?	34%	
Are mental health services available?	73%	
Are alcohol/drug abuse services available?	81%	
Is family planning available?	60%	
Is health ed. in the school curriculum?	31%	
Are hospice services available?	36%	
Is there a demand for it?	36%	

All communities listed prevention programs available through Public Health nurses only, and these services are mostly maternal and child oriented.

Community All Number of respondents 425

		Yes	No	Unknown
1.	Is health care accessible in your area?	379	11	
2.	Is transportation to facilities a problem?	121	268	1
	Comments			
3.	Are Emergency Medical Services available?	392	3	1
	Do they function efficiently?	377	8	
4.	Does your area have an alternative birthing center?	88	133	3
	Is there a demand for one?	105	52	12
5.	Does any doctor in your area do home births?	59	210	30
6.	Is there a lay midwife in your area?	88		
	Is there a nurse midwife in your area?	146		
	Should the state license lay midwives?	158	189	47
6.	Have you had contact with Home Health?	213	144	11
	Is there a demand for this service?	146	10	11
	Comments Good program 183 Cost Effective 28 Needs more funds, staff 44 Needs RN 9 Expand program 22			
7.	Does your area have mental health services?	313	31	6
8.	Does your area have alcohol/drug abuse services?	348	13	7
9.	Is Family Planning available?	257	9	4
10.	Is health education in your school curriculum?	128	30	35
11.	Does your area have hospice services?	149	196	53
	Is there an interest in services for the terminally ill?	154	31	31

What services and providers are needed in your area?

Respondents listed services and providers not available in their community. 425 professionals responded from 32 locations.

SERVICE NEEDED	Number of Communities
Mental Health	20
Alcohol treatment	17
Nurse	17
Physician	10
OB-GYN	10
Prevention program	7
Sheltered care	6
Family Planning	5
Home Health	5
Long term care	5

	Percent of positive response	
Is health care accessible?	89%	
Is transportation a problem?	28%	
Are Emergency Medical Services available?	92%	
Are they efficient?	88%	
Do you have an alternative birth center?	2%	
Is there a demand for one?	24%	
Is there a doctor doing home births?	13%	
Is there a lay midwife?	1.9%	
Is there a nurse midwife?	34%	
Should the state license lay midwives?	37%	44%-No
Have you had contact with Home Health?	50%	
Is there a demand for it?	34%	
Are mental health services available?	73%	
Are alcohol/drug abuse services available?	81%	
Is family planning available?	60%	
Is health ed in the school curriculum?	31%	
Are hospice services available?	36%	
Is there a demand for it?	36%	

All communities listed prevention programs available through Public Health nurses only, and these services are mostly maternal and child oriented.

The Senate Health, Education and Social Services Committee sent out health questionnaires during the 1981 session interim to 5,279 health professionals in the state of Alaska. The names were obtained from the Division of Occupational Licensing, and forms went out to only those professionals who had a resident address. The breakdown on the questionnaires is as follows:

PROFESSION	SENT OUT	%	RETURNED
Physician	623	18%	116
Nurse	3,446	.05%	189
Advanced Nurse Practitioner	33	24%	8
Physician Assistant	116	10%	12
Pharmacist	173	.09%	15
Psychologist	66	19%	13
Dentist	290	.08%	23
Dental Hygienist	181	.03%	6
Optometrist	27	22%	6
Optician	42	.09%	4
Chiropractor	44	20%	9
Administrator	29	13%	4
Anonymous/Occupation unknown			20
TOTAL	5,279	.08%	425

HEALTH CARE COSTS

What is your estimate of the major cause of health care cost

inflation

	Physician	Nurse	ANP	PA	Pharmacist	Psychologist	Dentist	Dental Hygienist	Optometrist	Optician	Chiropractor	Administrator	Unknown
Inflation	2	2	3	3	2	2	1	2	2	2	2	2	3
New Medical Technology	2	4	2	4	3	4	3	4	3	4	3	3	3
Hospital Services	3	4	4	3	5	4	4	4	4	3	2	2	4
Population Increases	4	6	7	6	7	8	8	5	7	1	2		4
Increase in Health Manpower	6	7	6	8	6	6	6	5	4	7	6		6
Retrospective method Of Insurance paymt.	5	4	5	3	5	3	5	4	6	8	3	1	5
Government Programs Medicare/Medicaid	3	3	3	5	4	3	4	3	2	9	3	1	2
New Services	4	5	5	6	4	6	4	8	7	6	5		5

	OTHER FACTORS	TIMES REPORTED
1.	Malpractice Insurance, cost of defensive medicine	48
2.	Government regulation and paperwork	26
3.	Physician fees	20
4.	Increased patient awareness and demands	16
5.	Lack of prevention, lifestyle	15
6.	Inappropriate use of health providers and facilities	10
7.	Increases in hospital employees salaries	10
8	Greed	8
9.	Full coverage Insurance	6
10.	Hospital waste	6
11.	Alcohol	4
12.	Travel costs for health care	4
13.	Prescription drug costs	4
14.	Duplication of services and equipment	3
15.	Increasing elderly population	3
16.	Excessive hospital administration	3
17.	Insurance abuse	2
18.	Lack Of Competition	2
19.	Lack of quality control	2
20.	Political power of the AMA	2

2. Do you see any need for changes in the service, delivery or utilization of:

HOSPITALS

1.	Less inappropriate Emergency room use	24
2.	More outpatient care/ambulatory surgery	24
3.	Multiple health systems(native, non-native, military) duplicate services	16
4.	Shorten patient stay in hospital	13
5.	Inappropriate use of facilities by providers	10
6.	Government regulation and paperwork	10
7.	Duplication of services/equipment	8
8.	Need quality control	7
9.	Need more competent personnel	6

HOSPITALS CON'T

10.	More personal care	5
11.	Better management	5
12.	Insurance require copayments	5
13.	Nurse shortage	5
14.	More patient education/prevention	4
15.	Foster competition in health care	4
16.	Reduce services of small hospitals	3
17.	Better coordination between facilities	3

CLINICS

1.	More prevention, screening, education	34
2.	More outpatient care available	17
3.	Reduced cost/sliding scale fees	16
4.	More facilites needed locally	13
5.	Better utilization, instead of E.R.	10
6..	Longer hours	8
7.	Better third party coverage	6
8.	Less government regulation and paperwork	4
9.	Copayments required for all insurance	3
10.	Public health clinics are understaffed	3
11.	More mental health services needed	3

LONG TERM CARE

1.	More facilities, closer to home	100
2.	More home health care	56
3.	Higher standards of personal care	15
4.	Hospice services	15
5.	Better access to Medicare	13
6.	Too expensive, need cost effective alternatives	12
7.	Rehabilitation facility needed	10
8.	Fewer government regulations	8
9.	Need residential facilites, adult day care	7
10.	Reimbursement for day care, respite care, home health	4
11.	Patients inappropriately kept in acute care facility: costly, need "swing beds"	3

3. Do you have any comments on HOUSE BILL 41(State Comprehensive Health Plan)?

Opposed	85
Favor	22

Comments:

1.	State should stay out of further involvement in health	24
2.	Too costly	24
3.	Should include all phases at inception	7
4.	Include patient education, wellness promotion, prevention	3
5.	Screen recipients carefully	3
6.	Guarantee native inclusion	2

4. From your professional viewpoint, can you envision any activites the state can pursue to control health expenditures?

	COMMENTS	TIMES REPORTED
1.	Limit Medicaid fraud and abuse	71
2.	More prevention programs	64
3.	State not get involved	36
4.	Fewer government regulations/paperwork	30
5.	School health education	26
6.	State coordinate services with Indian Health Services	15
7.	Publish rates/set ceilings for hospitals and doctors	14
8.	Create "wellness" incentives	12
9.	Provide more residential facilites, sheltered living	10
10.	Limit Malpractice Suits	10
11.	Control duplication os services	9
12.	More efficient management of Department of Health and Social Services	8
13.	Upgrade care in Level I and Level II communities	8
14.	Support education of more mid-level practitioners	7
15.	More home health services	7
16.	More support for Public Health Nurses	6

HEALTH PLANNING

1. The Federal government plans to discontinue funding health planning agencies (HSAs) by 1983, do you think the state should continue funding our three HSAs?

Yes	103
No	171
No response	95
Unknown	54

2. Have you had any personal contact with your HSA?

Yes	169
No	247
No response	16

In what capacity?

Observer	50
Member	32
Advisor	30
Through C.O.N.	18
Provider	11
Testifies	4
Task Force	3
Hospital Committee	3

3. Do you think your HSA does a fair representation of your profession?

Yes	90
No	146
No response	105
Unknown	82

4. Can you see any needs for restructuring state health planning?

Yes	181
No	39
No response	177
Unknown	26

What issues need more attention?

1.	Prevention, wellness promotion	61
2.	Rural health accessibility, mobile clinics	35
3.	School Health Education	19
4.	Cross-cultural planning, prevention of service duplication	16
5.	More local planning control	14
6.	Alcoholism	10
7.	Competition in private sector	9
8.	EMS council, communication, transfer agreements	8
9.	Reduce political nature of HSA	8
10.	More local mental health services	7
11.	Services for the elderly	6
12.	More professional planners, fewer government planners	6
13.	More advertising, consumer information	6
14.	Reduce CON paperwork	5
15.	Include rural hospitals in planning	5

5. Is the catchment area of your HSA meaningful?

Yes	66
No	50
No response	254
Unknown	53

If no, how would you envision its redefinition?

1.	Abolish HSAs	32
2.	Separate Anchorage	16
3.	One HSA only	9
4.	Create Rural HSA	2

PROFESSIONAL

6. Are there conditions effecting your profession that you think are unique to Alaska?

Yes	272
No	66
No response	73
Unknown	14

COMMENTS	TIMES REPORTED
1. Continuing Education not local, travel, expense. time off	56
2. Isolation/rural	51
3. Travel for health care	50
4. Lifestyle-violence, accidents, alcoholism, transience	31
5. Rural professionals more responsibility, distance from supervisor	23
6. Travel to give care, itinerant	19
7. Weather	14
8. Difficult to continue patient follow-up	12
9. Socio-cultural differences, dual system-native/non-native	11
10. Overhead/cost of living	11
11. Isolated, lack of professional stimulation	8

8. Do you see an increased need for Para-professionals?

Yes	154
No	145
No response	26
Unknown	9

COMMENTS	TIMES REPORTED
1. Mid-level practitioners needed for rural	58
2. Too many health care providers at present	26
3. Need to sponsor training for ANP and family practice RN	20
4. EMS/EMT special training	11
5. Routine Primary care.	11
6. Prevention/Education	9
7. Efficient, cost effective, immediate care	8
8. Poorly trained, dangerous	8

PARA_PROFESSIONALS CON'T

	COMMENT	TIMES REPORTED
9.	Provide specialized training for CHA	9
10.	Only under M.D. supervision	6
11.	Charge reasonable fees	6
12.	Train for Home Health and Mental Health	5

5. Do you feel that you receive a wage/salary commensurate with your professional education and preparation?

	Yes	No	No Response
Physician	78/67%	32/27%	6/.5%
Nurse	74/39%	109/57%	6/.3%
Physician Assistant	8/66%	4/33%	
Pharmacist	7/46%	8/53%	
Psychologist	9/69%	3/23%	1/.7%
Dentist	18/78%	5/21%	
Dental Hygienist	6/100%		
Optometrist	5/83%	1/16%	
Optician	2/50%	1/25%	1/25%
Chiropractor	7/77%		2/22%
Administrator	1/25%	2/50%	1/25%
Occupation Unknown	7/35%	10/50%	1/25%

All physicians were sent a copy of HB 327, concerning the licensing of Naturopathic Practitioners, and the questionnaire asked for comments. Those received were:

4	Favor
57	Opposed
5	Unknown
12	No comment

Remarks:	Number of respondents
Quackery	25
Poorly trained, inadequate for duties in bill	18
Licensing would mislead public, danger to citizens	15
May delay needed treatment	9
No surgery, x-ray	9
No obstetrics	9
No prescription capabilities	8
Fraudulent, life threatening	8
State cannot legislate hospital privileges	7
State should investigate practitioners for education/ preparation; followup on fraud and incompetence	4
Responsibilities too broad	4
Waste of state money	2

All Physicians were asked if they had any contact with the rural health delivery system, and for comments

45	Yes
25	No
44	No response
2	Unknown

Comments	Number of respondents
System in good balance, appropriate, constantly upgraded	18
Health Aides work well, need more financial support, skill upgrading	10
Need alcohol abuse education	7
Need EMS communications upgrading	5
Need more health promotion, prevention	5
Expensive	5

Need more Mental Health Services(violence, lifestyle)	4
Travel greatest problem	4
Unsophisticated, minimal care	3
PHS should not compete with private practice	3
Need survival techniques	3
Need more school health education	3
Abolish ANHS/IHS	2
No payment mechanism for M.D. fees	2
Need rehabilitative medicine, specialists	2

Other comments:

The state needs to promote older, more experienced physicians looking for a change in lifestyle to work in rural alaska.

Federal and state regulations are incompatible for rural health and hospitals.

Travel and lodging payments to physicians would encourage more to have rural clinics, as fees do not meet expenses.

State needs to assist Native Corporations as they assume health care responsibilities, and local control.

Need strict penalties for alcohol related crime.

EMT skill, improved communication and transportation have greatly upgraded care in the Fairbanks area

Profession Physician Number of respondents 116

Have you had any contact with the Board that regulates your profession?

Yes	72
No	28
No response	6
Unknown	1

Does the Board function efficiently?

Yes	44
No	21
No response	20
Unknown	11

COMMENTS:

Ineffective in investigating incompetency 22
Police Medicare/Medicaid abuse 2
Regulate only for fraud 6
Too political 4
Too slow in issuing P.A. regulations 2
Not enough communication 1
It doesn't seem to function at all 1

Do you perform services in your occupation as defined by law and regulation?

Yes	84
No	1
No response	19
Unknown	

What changes would you want to see in the regulation of your profession?

None 25
Peer review 2
Less regulations 12
Change continuing ed requirements 5
Limit chiropractors/Naturopaths 3
License lay midwives 1
Better definitions in regulations 1

Physician

3. Have you participated in professional continuing education?

Yes	97
No	
No response	19
Unknown	

Do you feel that continuing education should be required by all health care professionals?

Yes	69
No	37
No response	3
Unknown	12

COMMENTS:

Difficult to regulate, no guarantee of learning 10
Expensive for rural practitioners 1
Need CME quality control 3
Mandatory increases hospital costs

4. Have you had contact with the Division of Occupational Licensing?

Yes	79
No	28
No response	9
Unknown	

Do you feel they function efficiently?

Yes	43
No	19
No Response	50
Unknown	4

COMMENTS:

Slow 18
underfunded 5
Provide inaccurate information 4
Fair under the circumstances 4

Profession Nurse Number of respondents 189

Have you had any contact with the Board that regulates your profession?

Yes	130
No	61
No response	8
Unknown	

Does the Board function efficiently?

Yes	95
No	19
No response	44
Unknown	10

COMMENTS:

AMA members do not understand nursing and specialty groups 9
Too little communication 12
Too political 3
Should investigate incompetence 2
All nurses should have copies of the nurse practice act 1
Decisions take too long

Do you perform services in your occupation as defined by law and regulation?

Yes	178
No	5
No response	18
Unknown	

What changes would you want to see in the regulation of your profession?

Licensing unrealistic for Alaska, needs to be modified 6
Representation on Board 12
Nurses should promulgate ANP regulations 2
Reciprocal licensing agreements 5
Firmer job descriptions 5
Require CME 4
State LPN requirements same as National 2
Medicaid/Medicare reimbursement for nursing services 2

Nurse

3. Have you participated in professional continuing education?

Yes	172	
No	11	(3 unemployed)
No response	6	
Unknown		

Do you feel that continuing education should be required by all health care professionals?

Yes	129
No	43
No response	14
Unknown	3

COMMENTS:

Need local CE, difficult financially, distance -ime off 31
Mandated is no insurance of learning 5
free courses for low paid personnel 7
Count in service training as CE 2
Do not require CE 2

4. Have you had contact with the Division of Occupational Licensing?

Yes	145
No	35
No response	8
Unknown	1

Do you feel they function efficiently?

Yes	98
No	44
No Response	31
Unknown	16

COMMENTS:

5-6 months to get license 5
received confusing information 2
Slow 22

Profession Physician Assistant Number of respondents: 12

1. Have you had any contact with the Board that regulates your profession?

Yes	9
No	3
No response	
Unknown	

Does the Board function efficiently?

Yes	4
No	3
No response	5
Unknown	

COMMENTS:

P.A. regulations made without real understanding of the profession. 2

Board too political 1

2. Do you perform services in your occupation as defined by law and regulation?

Yes	10
No	
No response	2
Unknown	

What changes would you want to see in the regulation of your profession?

None 3

More flexibility for rural care 1

P.A. on Board 5

PA

3. Have you participated in professional continuing education?

Yes	12
No	
No response	
Unknown	

Do you feel that continuing education should be required by all health care professionals?

Yes	11
No	1
No response	
Unknown	

COMMENTS:

Have recertification exams. 1

4. Have you had contact with the Division of Occupational Licensing?

Yes	9
No	3
No response	
Unknown	

Do you feel they function efficiently?

Yes	7
No	2
No Response	3
Unknown	

COMMENTS:

Very slow 2

Profession Dentist Number of respondents 23

Have you had any contact with the Board that regulates your profession?

Yes	22
No	1
No response	
Unknown	

Does the Board function efficiently?

Yes	13
No	9
No response	1
Unknown	

COMMENTS:

Too political 1
Need to concentrate on more enfocement 6
Philosophy outdated 1
Fewer lay members on Board 1

2. Do you perform services in your occupation as defined by law and regulation?

Yes	23
No	
No response	
Unknown	

What changes would you want to see in the regulation of your profession?

New regulations for dental assistants 2
Recertification exams 1
Anesthesia regulations 2
Fewer regulations 2
Reciprocal licensing with other states 1

Dentist

3. Have you participated in professional continuing education?

Yes	23
No	
No response	
Unknown	

Do you feel that continuing education should be required by all health care professionals?

Yes	10
No	13
No response	
Unknown	

COMMENTS:

Should remain voluntary

4. Have you had contact with the Division of Occupational Licensing?

Yes	19
No	4
No response	
Unknown	

Do you feel they function efficiently?

Yes	12
No	7
No Response	3
Unknown	1

COMMENTS:

Profession Dental Hygienist Number of respondents 6

Have you had any contact with the Board that regulates your profession?

Yes	5
No	
No response	1
Unknown	

Does the Board function efficiently?

Yes	2
No	2
No response	2
Unknown	

COMMENTS:

Too political 1

Do you perform services in your occupation as defined by law and regulation?

Yes	6
No	
No response	
Unknown	

What changes would you want to see in the regulation of your profession?

Reciprocal licensing agreements with other states 1
Anesthesia administered by dentist only 1
Representation on Board 1

Dent. Hyg.

3. Have you participated in professional continuing education?

Yes	6
No	
No response	
Unknown	

Do you feel that continuing education should be required by all health care professionals?

Yes	5
No	1
No response	
Unknown	

COMMENTS:

Need locally available Continuing ed. 1

4. Have you had contact with the Division of Occupational Licensing?

Yes	6
No	
No response	
Unknown	

Do you feel they function efficiently?

Yes	4
No	2
No Response	
Unknown	

COMMENTS:

Supply confusing infor,ation 1

Profession Pharmacist Number of respondents 15

1. Have you had any contact with the Board that regulates your profession? Does the Board function efficiently?

Yes	15	Yes	11
No		No	4
No response		No response	
Unknown		Unknown	

COMMENTS:

Rotate Board membership
Too political 2
No communication with members 3
Board should handle licensing 1

2. Do you perform services in your occupation as defined by law and regulation?

Yes	15
No	
No response	
Unknown	

What changes would you want to see in the regulation of your profession?

More enforcement of incompetence
Not enough regulations 2
Investigate Rx abuse 2

Pharm.

3. Have you participated in professional continuing education?

Yes	15
No	
No response	
Unknown	

Do you feel that continuing education should be required by all health care professionals?

Yes	13
No	2
No response	
Unknown	

COMMENTS:

Need local C.E. available

4. Have you had contact with the Division of Occupational Licensing?

Yes	15
No	
No response	
Unknown	

Do you feel they function efficiently?

Yes	4
No	11
No Response	
Unknown	

COMMENTS:

Lose important records 6
slow 1
Renewal cost too expensive 2

Profession Psychologist Number of respondents 13

1. Have you had any contact with the Board that regulates your profession?

Yes	10
No	1
No response	2
Unknown	

Does the Board function efficiently?

Yes	6
No	1
No response	4
Unknown	2

COMMENTS:

Poor staff support
Had to go to court to get license
Use National exam
Be more responsive to members

2. Do you perform services in your occupation as defined by law and regulation?

Yes	12
No	
No response	1
Unknown	

What changes would you want to see in the regulation of your profession?

Simplify law, too difficult to get license 7
Enforce violations 2

3. Have you participated in professional continuing education?

Yes	13
No	
No response	
Unknown	

Do you feel that continuing education should be required by all health care professionals?

Yes	10
No	3
No response	
Unknown	

COMMENTS:

4. Have you had contact with the Division of Occupational Licensing?

Yes	11
No	
No response	2
Unknown	

Do you feel they function efficiently?

Yes	6
No	5
No Response	2
Unknown	

COMMENTS:

Lost application 1

Profession Optometrist Number of respondents 6

1. Have you had any contact with the Board that regulates your profession?

Yes	5
No	
No response	1
Unknown	

Does the Board function efficiently?

Yes	5
No	
No response	1
Unknown	

COMMENTS:

Board elected

2. Do you perform services in your occupation as defined by law and regulation?

Yes	6
No	
No response	
Unknown	

What changes would you want to see in the regulation of your profession?

Change regulations for drug use

Optom.

3. Have you participated in professional continuing education?

Yes 6
No
No response
Unknown

Do you feel that continuing education should be required by all health care professionals?

Yes 6
No
No response
Unknown

COMMENTS:

4. Have you had contact with the Division of Occupational Licensing?

Yes 6
No
No response
Unknown

Do you feel they function efficiently?

Yes
No 6
No Response
Unknown

COMMENTS:
Poor staff support, inefficient 3

Profession Optician Number of respondents 4

1. Have you had any contact with the Board that regulates your profession?

Yes	3
No	1
No response	
Unknown	

Does the Board function efficiently?

Yes	2
No	1
No response	1
Unknown	

COMMENTS:

Board should be elected, not appointed 1

2. Do you perform services in your occupation as defined by law and regulation?

Yes	3
No	
No response	1
Unknown	

What changes would you want to see in the regulation of your profession?

Contact lens regulations

Optician

3. Have you participated in professional continuing education?

Yes 3
No
No response 1
Unknown

Do you feel that continuing education should be required by all health care professionals?

Yes 3
No
No response 1
Unknown

COMMENTS:

4. Have you had contact with the Division of Occupational Licensing?

Yes 3
No
No response 1
Unknown

Do you feel they function efficiently?

Yes 1
No 1
No Response 2
Unknown

COMMENTS:

Profession Chiropractor Number of respondents: 9

Have you had any contact with the Board that regulates your profession?

Yes	9
No	
No response	
Unknown	

Does the Board function efficiently?

Yes	8
No	1
No response	
Unknown	

COMMENTS:

Less governmental influence 1

Do you perform services in your occupation as defined by law and regulation?

Yes	9
No	
No response	
Unknown	

What changes would you want to see in the regulation of your profession?

Regulations too strict 1

Certification for Chiropractors using physical therapy 1

Need access to hospital

Chiro.

3. Have you participated in professional continuing education?

Yes	9
No	
No response	
Unknown	

Do you feel that continuing education should be required by all health care professionals?

Yes	9
No	
No response	
Unknown	

COMMENTS:

Need local C.E. 1

4. Have you had contact with the Division of Occupational Licensing?

Yes	7
No	1
No response	1
Unknown	

Do you feel they function efficiently?

Yes	2
No	5
No Response	1
Unknown	1

COMMENTS:

Slow 1

Ineffective

Profession Occupation unknown Number of respondents: 20

1. Have you had any contact with the Board that regulates your profession? Does the Board function efficiently?

Yes	12	Yes	7
No	4	No	4
No response	4	No response	10
Unknown		Unknown	

COMMENTS:

Too much paperwork 1
Too little communication 1

2. Do you perform services in your occupation as defined by law and regulation?

Yes	13
No	
No response	7
Unknown	

What changes would you want to see in the regulation of your profession?

Unknown

3. Have you participated in professional continuing education?

Yes	17
No	
No response	3
Unknown	

Do you feel that continuing education should be required by all health care professionals?

Yes	13
No	2
No response	5
Unknown	

COMMENTS:

4. Have you had contact with the Division of Occupational Licensing?

Yes	15
No	1
No response	4
Unknown	

Do you feel they function efficiently?

Yes	8
No	5
No Response	7
Unknown	

COMMENTS:

Inefficient 5

Lost important papers 3

Community Anchorage Number of respondents 183

		Yes	No	Unknown
1.	Is health care accessible in your area?	169	4	
2.	Is transportation to facilities a problem?	24	164	
	Comments old, handicapped and poor 7 poor public transportation 2			
3.	Are Emergency Medical Services available?	182	1	
	Do they function efficiently?	182	1	
4.	Does your area have an alternative birthing center?	157	7	19
	Is there a demand for one?	18	8	5
5.	Does any doctor in your area do home births?	28	56	76
6.	Is there a lay midwife in your area?	27		
	Is there a nurse midwife in your area?	93		
	Should the state license lay midwives?	70	80	18
6.	Have you had contact with Home Health?	83	73	10
	Is there a demand for this service?	50	3	6
	Comments good program 78 need more funds/staff 36 need RN 4 cost effective 21 preserve dignity at home 17 local control 2			
7.	Does your area have mental health services?	151	3	3
8.	Does your area have alcohol/drug abuse services?	165	1	2
9.	Is Family Planning available?	92		8
10.	Is health education in your school curriculum?	119	3	35
11.	Does your area have hospice services?	56	64	43
	Is there an interest in services for the terminally ill?	69	2	9

What services and providers are needed in your area?

Nurse 16	high quality mental health 6	sheltered care 11
OB-GYN 13	specialists 17	transition care 7
Surgeons 16	prevention/adult screening 18	therapists 4
Long term care 4	child protection 4	

Community Fairbanks Number of respondents 67

		Yes	No	Unknown
1.	Is health care accessible in your area?	66		
2.	Is transportation to facilities a problem?	15	43	
	Comments distance/rural 14 expense 3 weather 4			
3.	Are Emergency Medical Services available?	62		
	Do they function efficiently?	61	3	3
4.	Does your area have an alternative birthing center?	24	19	11
	Is there a demand for one?	19	5	9
5.	Does any doctor in your area do home births?	10	32	19
6.	Is there a lay midwife in your area?	1		
	Is there a nurse midwife in your area?	16		
	Should the state license lay midwives?	26	21	7
6.	Have you had contact with Home Health?	33	24	
	Is there a demand for this service?	21		
	Comments good program 28 contract locally 1			
7.	Does your area have mental health services?	44	4	1
8.	Does your area have alcohol/drug abuse services?	47	2	3
9.	Is Family Planning available?	33	1	2
10.	Is health education in your school curriculum?	14		9
11.	Does your area have hospice services?	3	15	9
	Is there an interest in services for the terminally ill?	10	1	2

What services and providers are needed in your area?

Nurse 10
specialists 12
ancillary services 4
long term care
mental health follow up/sheltered living 15
rehabilitation facility 5
alcohol halfway house 8
radiation therapy 2

Community Juneau Number of respondents 30

		Yes	No	Unknown
1.	Is health care accessible in your area?	28	1	
2.	Is transportation to facilities a problem?	10	16	1
	Comments expense 3 rural non-natives served in Juneau			
3.	Are Emergency Medical Services available?	29		
	Do they function efficiently?	24		
4.	Does your area have an alternative birthing center?	13	18	2
	Is there a demand for one?	14	3	2
5.	Does any doctor in your area do home births?	2	25	2
6.	Is there a lay midwife in your area?	4		
	Is there a nurse midwife in your area?	10		
	Should the state license lay midwives?	26	21	7
6.	Have you had contact with Home Health?	23	7	
	Is there a demand for this service?	12		
	Comments good program 21 cost effective 6 better staff pay 7 expand to rural 2 need foster care 1			
7.	Does your area have mental health services?	25	2	
8.	Does your area have alcohol/drug abuse services?	29		
9.	Is Family Planning available?	26		1
10.	Is health education in your school curriculum?	18	10	2
11.	Does your area have hospice services?	18	12	
	Is there an interest in services for the terminally ill?	23	2	5

What services and providers are needed in your area?

General Practitioners 7
OB-GYN 15
nurse 4
specialists 10
Mental Health 8
halfway house 3
child protection 3
Accident prevention 3
adult screening 6
expand WIC 2
Prevention 8

Community Palmer-Wasilla Number of respondents 20

		Yes	No	Unknown
1.	Is health care accessible in your area?	17	3	
2.	Is transportation to facilities a problem?	12	8	
	Comments weather 3 distance, expense 5			
3.	Are Emergency Medical Services available?	18	1	1
	Do they function efficiently?	19		
4.	Does your area have an alternative birthing center?	1	15	1
	Is there a demand for one?	12	3	
5.	Does any doctor in your area do home births?	3	12	8
6.	Is there a lay midwife in your area?	6		
	Is there a nurse midwife in your area?	6		
	Should the state license lay midwives?	5	9	1
6.	Have you had contact with Home Health?	10	6	
	Is there a demand for this service?	9		
	Comments good program 9 expansion needed 5			
7.	Does your area have mental health services?	12	4	1
8.	Does your area have alcohol/drug abuse services?	15	2	
9.	Is Family Planning available?	17		1
10.	Is health education in your school curriculum?	9	1	7
11.	Does your area have hospice services?	2	14	1
	Is there an interest in services for the terminally ill?	6	4	3

What services and providers are needed in your area?

Mental health counseling, residential 6
Nurse/mid-level 3
OB-GYN 2
Family planning(minimal, infrequent)
residential detox 2
health ed.(Palmer) 2
Dental/optical 3

Community Kenai Peninsula Number of respondents 22

		Yes	No	Unknown
1.	Is health care accessible in your area?	20	2	
2.	Is transportation to facilities a problem?	15	5	
	Comments expensive 2			
3.	Are Emergency Medical Services available?	22		
	Do they function efficiently?	22		
4.	Does your area have an alternative birthing center?		22	
	Is there a demand for one?	19	3	
5.	Does any doctor in your area do home births?	6	16	
6.	Is there a lay midwife in your area?	12		
	Is there a nurse midwife in your area?	9		
	Should the state license lay midwives?	9	12	1
6.	Have you had contact with Home Health?	15	6	1
	Is there a demand for this service?	12	1	3
	Comments good program 11 Need RN 4 More funding/staff 2			
7.	Does your area have mental health services?	21	1	
8.	Does your area have alcohol/drug abuse services?	20	2	
9.	Is Family Planning available?	20	1	1
10.	Is health education in your school curriculum?	14	3	5
11.	Does your area have hospice services?	2	20	
	Is there an interest in services for the terminally ill?	13	9	

What services and providers are needed in your area?

Nurse 4
OB-GYN 3
Mental Health 3
Specialities 16
Family planning(Homer)
Surgery 4
inpatient mental health 4
Detox 9
sheltered living 5
optical
diagnostic

Community Kodiak Number of respondents 10

		Yes	No	Unknown
1.	Is health care accessible in your area?	10		
2.	Is transportation to facilities a problem?	4	6	
	Comments weather 1			
3.	Are Emergency Medical Services available?	10		
	Do they function efficiently?	10		
4.	Does your area have an alternative birthing center?	6	4	
	Is there a demand for one?		3	
5.	Does any doctor in your area do home births?	5	5	
6.	Is there a lay midwife in your area?	3		
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	2	7	
6.	Have you had contact with Home Health?	8	1	
	Is there a demand for this service?	3		1
	Comments good program 8 needs expansion 6			
7.	Does your area have mental health services?	8	1	
8.	Does your area have alcohol/drug abuse services?	10		
9.	Is Family Planning available?	9	1	
10.	Is health education in your school curriculum?	6		4
11.	Does your area have hospice services?	5	4	
	Is there an interest in services for the terminally ill?	6		1

What services and providers are needed in your area?

Nurse 3
therapy 2
specialists 4
Home Health 2
OB-GYN 2
Mental health outpatient and follow-up 4
Psychiatrist 2
Prevention/adult screening 7

Community Valdez Number of respondents 3

	Yes	No	Unknown
1. Is health care accessible in your area?	3		
2. Is transportation to facilities a problem?	3		
Comments weather 2			
3. Are Emergency Medical Services available?	3		
Do they function efficiently?	3		
4. Does your area have an alternative birthing center?		3	
Is there a demand for one?	2	1	
5. Does any doctor in your area do home births?		2	1
6. Is there a lay midwife in your area?			
Is there a nurse midwife in your area?			
Should the state license lay midwives?	2		1
6. Have you had contact with Home Health?		3	
Is there a demand for this service?		2	1
Comments			
7. Does your area have mental health services?	3		
8. Does your area have alcohol/drug abuse services?	3		
9. Is Family Planning available?	1		1
10. Is health education in your school curriculum?	3		
11. Does your area have hospice services?	3		
Is there an interest in services for the terminally ill?	1	2	

What services and providers are needed in your area?

Surgery 2
specialists 2
alcohol crisis intervention
prevention
school health ed. inadequate 1

Community Ward Cove Number of respondents 2

		Yes	No	Unknown
1.	Is health care accessible in your area?	2		
2.	Is transportation to facilities a problem?	2		
	Comments Expensive 1			
3.	Are Emergency Medical Services available?	2		
	Do they function efficiently?	2		
4.	Does your area have an alternative birthing center?		2	
	Is there a demand for one?		1	1
5.	Does any doctor in your area do home births?		2	
6.	Is there a lay midwife in your area?	2		
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1	1	
6.	Have you had contact with Home Health?	1	1	
	Is there a demand for this service?	1		
	Comments good program 1 needs better funding 1			
7.	Does your area have mental health services?	2		
8	Does your area have alcohol/drug abuse services?	2		
9.	Is Family Planning available?	2		
10.	Is health education in your school curriculum?	1	1	
11.	Does your area have hospice services?		2	
	Is there an interest in services for the terminally ill?	2		

What services and providers are needed in your area?

Dentist
Physician

Community Haines Number of respondents 3

		Yes	No	Unknown
1.	Is health care accessible in your area?	3		
2.	Is transportation to facilities a problem?	3		
	Comments air travel expense 1 weather 1			
3.	Are Emergency Medical Services available?	3		
	Do they function efficiently?	3		
4.	Does your area have an alternative birthing center?		3	
	Is there a demand for one?		2	1
5.	Does any doctor in your area do home births?	1	2	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?	1		
	Should the state license lay midwives?	1	2	
6.	Have you had contact with Home Health?	1	2	
	Is there a demand for this service?	2		
	Comments good program 1			
7.	Does your area have mental health services?		3	
8.	Does your area have alcohol/drug abuse services?	3(A.A.)		
9.	Is Family Planning available?	2	1	
10.	Is health education in your school curriculum?	2	1	
11.	Does your area have hospice services?		3	
	Is there an interest in services for the terminally ill?		2	1

What services and providers are needed in your area?

family planning
mental health 2
Home Health 1
specialist 3
counseling
alcohol halfway house

Community Petersburg Number of respondents 9

		Yes	No	Unknown
1.	Is health care accessible in your area?	9		
2.	Is transportation to facilities a problem?	4	3	
	Comments weather 4 travel expense 2			
3.	Are Emergency Medical Services available?	9		
	Do they function efficiently?	8		
4.	Does your area have an alternative birthing center?	2	7	
	Is there a demand for one?	4	1	
5.	Does any doctor in your area do home births?		9	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1	8	
6.	Have you had contact with Home Health?	7	2	
	Is there a demand for this service?	6		
	Comments good program 5 Need Visiting Nurse 1 Need expansion 3			
7.	Does your area have mental health services?	7	1	1
8.	Does your area have alcohol/drug abuse services?	8		1
9.	Is Family Planning available?	9		
10.	Is health education in your school curriculum?	8		1
11.	Does your area have hospice services?		9	
	Is there an interest in services for the terminally ill?	2	1	

What services and providers are needed in your area?

RN 3	EMS equipment	halfway house
M.D. 2	Specialists 6	Home Health
OG-GYN 1	Psychiatrist	adequate school ed.
ANP 1	Detox	alcohol follow-up

Community Ketchikan Number of respondents 6

		Yes	No	Unknown
1.	Is health care accessible in your area?	6		
2.	Is transportation to facilities a problem?	3	3	
	Comments			
3.	Are Emergency Medical Services available?	6		
	Do they function efficiently?	5		
4.	Does your area have an alternative birthing center?		6	
	Is there a demand for one?		4	2
5.	Does any doctor in your area do home births?		6	
6.	Is there a lay midwife in your area?	5		
	Is there a nurse midwife in your area?	3		
	Should the state license lay midwives?	1	5	
6.	Have you had contact with Home Health?	4	1	
	Is there a demand for this service?	4		
	Comments good program 3 needs expansion 3			
7.	Does your area have mental health services?	6		
8.	Does your area have alcohol/drug abuse services?	5	1	
9.	Is Family Planning available?	6		
10.	Is health education in your school curriculum?	3	3	
11.	Does your area have hospice services?		6	1
	Is there an interest in services for the terminally ill?	3	1	

What services and providers are needed in your area?

Physician 2
Nurse 1
prevention/diagnostic specialists 3
Psychiatrist
Detox 4
Acute Mental Health
EMT training

Community Wrangell Number of respondents 4

		Yes	No	Unknown
1.	Is health care accessible in your area?	4		
2.	Is transportation to facilities a problem?	1	2	
	Comments			
3.	Are Emergency Medical Services available?	4		
	Do they function efficiently?	3	1	
4.	Does your area have an alternative birthing center?		4	
	Is there a demand for one?		4	
5.	Does any doctor in your area do home births?		4	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1	3	
6.	Have you had contact with Home Health?	4		
	Is there a demand for this service?	3		
	Comments good program, cost effective, need funding	2		
7.	Does your area have mental health services?	3	1	
8.	Does your area have alcohol/drug abuse services?	4		
9.	Is Family Planning available?	4		
10.	Is health education in your school curriculum?	2	1	1
11.	Does your area have hospice services?		4	
	Is there an interest in services for the terminally ill?	3		

What services and providers are needed in your area?

Physician 2
Mental health 1
Long term care
Diagnostic
Detox
Specialists 2
Larger alcohol facility

Community Pelican Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?			
6.	Have you had contact with Eore Health?	1		
	Is there a demand for this service?	1		
	Comments Hard to find staff, need better pay			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

What services and providers are needed in your area?

Physician
X-ray
Detox

Community Sitka Number of respondents 9

		Yes	No	Unknown
1.	Is health care accessible in your area?	9		
2.	Is transportation to facilities a problem?	4	5	
	Comments distance, weather 2			
3.	Are Emergency Medical Services available?	9		
	Do they function efficiently?	6		
4.	Does your area have an alternative birthing center?	9		
	Is there a demand for one?	3	1	1
5.	Does any doctor in your area do home births?		9	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?	2		
	Should the state license lay midwives?	5	3	
6.	Have you had contact with Home Health?	6	3	
	Is there a demand for this service?	3	2	
	Comments good program 6 need expansion 1			
7.	Does your area have mental health services?	9		
8.	Does your area have alcohol/drug abuse services?	8		
9.	Is Family Planning available?	8		
10.	Is health education in your school curriculum?	7	1	1
11.	Does your area have hospice services?	4	5	
	Is there an interest in services for the terminally ill?	4	2	1

What services and providers are needed in your area?

Nurse 2
Pediatrician 3
OB-GYN 2
Mental health facility, counseling 4
tertiary care 3

Community Bethel Number of respondents 4

	Yes	No	Unknown
1. Is health care accessible in your area?	4		
2. Is transportation to facilities a problem?	4		
Comments weather 2 lost PHS funding 1			
3. Are Emergency Medical Services available?	4		
Do they function efficiently?	3	1	
4. Does your area have an alternative birthing center?		4	
Is there a demand for one?	3		1
5. Does any doctor in your area do home births?		4	
6. Is there a lay midwife in your area?	1		
Is there a nurse midwife in your area?	2		
Should the state license lay midwives?		3	1
6. Have you had contact with Home Health?	2	2	
Is there a demand for this service?	4		
Comments good program 3 needs better funding 2			
7. Does your area have mental health services?	3	1	
8. Does your area have alcohol/drug abuse services?	4		
9. Is Family Planning available?	4		
10. Is health education in your school curriculum?	2		2
11. Does your area have hospice services?		3	
Is there an interest in services for the terminally ill?	1		3

What services and providers are needed in your area?

Physicians 2
Nurse 1
Specialists 4
CMHC 1
counseling 4
Psychiatrist 3
sheltered living 3
inhalation therapy 1

Community Nome Number of respondents 3

		Yes	No	Unknown
1.	Is health care accessible in your area?	3		
2.	Is transportation to facilities a problem?	2	1	
	Comments weather 2 expense PHS funding cut			
3.	Are Emergency Medical Services available?	3		
	Do they function efficiently?	3		
4.	Does your area have an alternative birthing center?	1	2	
	Is there a demand for one?	1	2	
5.	Does any doctor in your area do home births?		3	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1	1	
6.	Have you had contact with Home Health?	3		
	Is there a demand for this service?			

Comments

7.	Does your area have mental health services?	3		
8.	Does your area have alcohol/drug abuse services?	3		
9.	Is Family Planning available?	2	1	
10.	Is health education in your school curriculum?	1		1
11.	Does your area have hospice services?		2	
	Is there an interest in services for the terminally ill?	1		1

What services and providers are needed in your area?

Nurse 3
Home health
Physician 2
Education 2

CAP alcohol funding gone
need alcohol staff support

Community McGrath Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?		1	
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?	1		
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Healt ?	1		
	Is there a demand for this service?			
	Comments not available			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			1

What services and providers are needed in your area?

residential mental health facility

Community Chevak Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments expensive			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?	1		
	Is there a demand for one?		1	
5.	Does any doctor in your area do home births?	1		
6.	Is there a lay midwife in your area?	1		
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments good program			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?		1	
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			1

What services and providers are needed in your area?

optometry
dental
counseling
sheltered living
stress relief
school health ed inadequate
Mental health and alcohol

Community Barrow Number of respondents 2

		Yes	No	Unknown
1.	Is health care accessible in your area?	2		
2.	Is transportation to facilities a problem?	1	1	
	Comments			
3.	Are Emergency Medical Services available?	2		
	Do they function efficiently?	2		
4.	Does your area have an alternative birthing center?		2	
	Is there a demand for one?	1	1	
5.	Does any doctor in your area do home births?		2	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	2		
6.	Have you had contact with Home Health?	1	1	
	Is there a demand for this service?	2		
	Comments lay adequate supervision 1			
7.	Does your area have mental health services?	2		
8.	Does your area have alcohol/drug abuse services?	2		
9.	Is Family Planning available?	2		
10.	Is health education in your school curriculum?	1	1	
11.	Does your area have hospice services?		2	
	Is there an interest in services for the terminally ill?	1	1	

What services and providers are needed in your area?

Long Term Care
Ob-GYN
Specialists 2
residential mental health
Detox 2
nurse 2
Physician 2

Community Tok Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?		1	
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?			1
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments			
7.	Does your area have mental health services?			
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?			1
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			1

What services and providers are needed in your area?

specialists

Community Healy Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?		1	
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments			
7.	Does your area have mental health services?	1		
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?		1	
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

What services and providers are needed in your area?

Hospital

specialists

Community Galena Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments			
3.	Are Emergency Medical Services available?		1	
	Do they function efficiently?			
4.	Does your area have an alternative birthing center?	1		
	Is there a demand for one?			
5.	Does any doctor in your area do home births?		1-no M.D.	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?			
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments good program. expand			
7.	Does your area have mental health services?	1		
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

What services and providers are needed in your area?

Physician
Hospital 300 mi.
Home health

Community Seward Number of respondents 7

		Yes	No	Unknown
1.	Is health care accessible in your area?	7		
2.	Is transportation to facilities a problem?	2	5	
	Comments			
3.	Are Emergency Medical Services available?	7		
	Do they function efficiently?	7		
4.	Does your area have an alternative birthing center?	7		
	Is there a demand for one?	3	3	1
5.	Does any doctor in your area do home births?		7	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?	1		
	Should the state license lay midwives?	3	2	
6.	Have you had contact with Home Health?	1	6	
	Is there a demand for this service?	4		2
	Comments good program 4			
7.	Does your area have mental health services?	7		
8.	Does your area have alcohol/drug abuse services?	6	1	
9.	Is Family Planning available?	5	1	1
10.	Is health education in your school curriculum?	3	2	2
11.	Does your area have hospice services?		7	
	Is there an interest in services for the terminally ill?	7		

What services and providers are needed in your area?

RN 3
Physician 2
Pharmacy 1
Diagnostic services 1
Specialists 4
Detox 3
Alcohol halfway house 2
Home Health

Community Hope Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?	1		
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?		1	
9.	Is Family Planning available?		1	
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?	1		

12. What services and providers are needed in your area?

Specialties

Family planning

Community Anchor Point Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?		1	
4.	Does your area have an alternative birth-in center?		1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?	1		
	Is there a nurse midwife in your area?	1		
	Should the state license lay midwives?			1
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?			
	Comments			
7.	Does your area have mental health services?	1		
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?		1	
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?		1	

What services and providers are needed in your area?

counselin outpatient mental health

Community Seldovia Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?	1		
	Is there a demand for one?			
5.	Does any doctor in your area do home births?	1		
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?	1		
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments			
7.	Does your area have mental health services?	1		
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

What services and providers are needed in your area?

OB-GYN
Pediatritian
Mental Health facility and funding
Preventive Program

Community Glenallen Number of respondents 2

		Yes	No	Unknown
1.	Is health care accessible in your area?	2		
2.	Is transportation to facilities a problem?	2		
	Comments weather 2			
3.	Are Emergency Medical Services available?	2		
	Do they function efficiently?	2		
4.	Does your area have an alternative birthing center?		2	
	Is there a demand for one?		2	
5.	Does any doctor in your area do home births?		2	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		2	
6.	Have you had contact with Home Health?	2		
	Is there a demand for this service?	2		
	Comments			
7.	Does your area have mental health services?		2	
8.	Does your area have alcohol/drug abuse services?	2		
9.	Is Family Planning available?	2		
10.	Is health education in your school curriculum?	2		
11.	Does your area have hospice services?		2	
	Is there an interest in services for the terminally ill?			2

What services and providers are needed in your area?

Community Delta Junction Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?	1		
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?	1		
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?		1	
	Is there a demand for this service?	1		
	Comments			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

What services and providers are needed in your area?

Dental
Opthamology
Laboratory
X-ray

Preventative program

Community Dillingham Number of respondents 2

		Yes	No	Unknown
1.	Is health care accessible in your area?	2		
2.	Is transportation to facilities a problem?	2		
	Comments weather 1 rural 1			
3.	Are Emergency Medical Services available?	2		
	Do they function efficiently?	2		
4.	Does your area have an alternative birthing center?	1	1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?		2	
6.	Is there a lay midwife in your area?	1		
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?		2	
	Is there a demand for this service?			1
	Comments			
7.	Does your area have mental health services?	2		
8.	Does your area have alcohol/drug abuse services?	1	1	
9.	Is Family Planning available?	2		
10.	Is health education in your school curriculum?	2		
11.	Does your area have hospice services?		2	
	Is there an interest in services for the terminally ill?			1

What services and providers are needed in your area?

nurse
Emergency room
EMT
Psychiatrist

Community Port Lions Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments rural			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?			
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1		
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?			
	Comments good program 1 needs expansion 1			
7.	Does your area have mental health services?	1		
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?	1		

What services and providers are needed in your area?

Resident RN
alcohol rehabilitation

Community Naknek Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?		1	
2.	Is transportation to facilities a problem?	1		
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?		1	
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1		
6.	Have you had contact with Home Health?		1	
	Is there a demand for this service?		1	
	Comments good program 1			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?		1	
9.	Is Family Planning available?		1	
10.	Is health education in your school curriculum?		1	
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?		1	

What services and providers are needed in your area?

Family planning
hospital

Community Dutch Harbor Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?		1	
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?		1	
	Is there a demand for this service?		1	
	Comments			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?		1	
9.	Is Family Planning available?	1		
10	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

What services and providers are needed in your area?

OB-GYN

Mental Health

Community King Salmon Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments weather 1			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	just starting		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?			
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?		1	
	Is there a demand for this service?			1
	Comments			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?		1	

What services and providers are needed in your area?

Public health nurse
ANP
EMT training
mental health crisis intervention
counseling
alcohol abuse personnel

Many respondents included pages of written remarks about subjects in the questionnaire and other health related areas, as well as several articles from professional journals. All of the comments could not be included in this report, so they have been summarized in the following text:

Concern for the future direction of Public Health Nurses highlighted many responses, since Federal budget cuts are slicing into rural health care budgets for programs that have not yet reached maintenance levels. "A problem that should be addressed is the plight of the non-native low income client. The provision of health services to natives by the Federal government, services that are prohibitively expensive for others, drives a wedge of prejudice between the two groups."

Public Health nurses stated that they would like to see their program expanded to include adult screening, stress relief and wellness promotion. More and better health education was frequently listed as the first step in changing habits and lifestyles, as many respondents noted that school health curriculums were inadequate or solely dependant on the classroom teacher and not a school policy:

"Needed for children:

1. Low cost physical exams, including sport physicals.
2. Hearing specialist and follow-up.
3. Low cost optometry.
4. Low cost dental/orthodontic care.
5. Allergist.
6. Family counseling - including parenting skills, abuse and neglect, and suicide prevention."

In many areas, mental health services were seen as "episodic and not very beneficial" with a great need for local trained people and a better transition from facilities back into the community. Although 73% of those answering said that mental health services were locally available, 20 of the 32 areas listed mental health facilities and personnel as needs.

Elderly care, including long term care facilities, sheltered living and Home Health services, are of great concern. Nearly 25%

of the respondents want to see more facilities closer to home. "I am a staff nurse in a nursing home where we receive patients from all over the state. Several of those admitted over the last 6-8 months are basically geriatric who speak little or no English and who have probably never been out of their small village. The cultural shock plus the inability to communicate plus separation from family and friends is a very real problem..."

"A problem rarely addressed is the use of acute care beds for elderly patients while waiting for arrangements to be made for care..."

"...Facilities should beging to emphasize harmonious living for mutual benefit among residents and staff..."

"It seems very unfair to put the aged in an institution with the mentally ill (particularly the potentially dangerous person)...Alaska definitely needs a facility for the chronic Psych patient."

A residential facility in Homer called Detente received praise from several peninsula nurses for their philosophy"...to provide a home-like atmosphere...in which people can make choices in their lives and receive the support they need to get well."

"Comfort and the clients wishes take precedence over a rigid routine."

Any program enabling a person to remain close to the community was prefered by respondents. As one nurse wrote concerning the Home Health Program "...it preserves the dignity of the person able to remain in familiar surroundings."

Many were concerned over the issue of Midwives. "There is a great inequity in restricting nurse midwives and having no regulations for anyone else who chooses to have babies."

Personal knowledge of lay midwives have influenced professionals' thinking, depending on the people they have known: "The public has no way of being protected from people claiming to be competent."

Licensing lay midwives is seen as an advantage by some "because the state can assure that they have necessary knowledge...also, they will have to keep books and report earnings to the IRS." Others felt that lay midwives should only practice under physician supervision, and rural providers stated that midwifery is a tradition in village life"...home births will continue regardless of anyone's feelings."

Although abortion received very few comments, one Southeastern nurse wrote that "Money needs to remain available for abortions since they will always exist...someone should not be deprived of safe medical care on the basis of income. Abortions have always been available and will continue to be available - legality did not change that. The degree of risk was based on money, lets not go back to that archaic standard."

Family Planning is available in virtually every community in Alaska through Public Health nurses, though many reported that rural communities may only have the opportunity to see someone twice a year. Professionals noted that family planning was "too low profile" and see a need for more adolescent counseling about pregnancy and venereal disease without resorting to "scare tactics."

Better training for Day Care Center staffs was the topic of one physician's lengthy remarks, who recommended the Tanaina Child Development Center at the U of A in Anchorage as a model. "Today most day care centers are hot-beds of disease and breeding grounds for emotional disorders because the staffing is by untrained people receiving minimum wages. The economic drain caused by loss of time from work for adults whose children have become sick at day care, the cost to Medicaid for these illnesses could be avoided by putting health dollars into improvement of the day care situation." The doctor also refered the committee to Dr. Middaugh's report, from state epidemiology, concerning the spread of intestional disease and its prevention in Day Care centers.

Continuing Medical Education is an important subject to the state's health providers, particularly those in rural areas, who find little available locally and the cost of travel outside to be prohibitively expensive. "Providers in smaller areas cannot keep skills current when they may only see one person with a particular problem in several years."

Many would like the U of A to have travel funds for CME available for low paid providers. One Continuing Education Coordinator wrote that "...funding is insufficient to even keep books much less

coordinate for quality training."

Some felt the U of A should make it easier for nurses to attain degrees "...giving credit for training and work experience." Nurses particularly noted the financial drain (57% felt they were underpaid), and difficulty getting time off for training. Rural ca e givers found the lack of professional stimulation and peer interaction a factor, as well as the added responsibility of duties they may not feel they are prepared to shoulder. Only 11 respondents said they have not participated in CME.

Reduced funding to the Health Sciences Library concerned some "It is a superb source of rapid comprehensive medical information for either direct application in medical care or for continuing education activities. There is no other resource even comparable."

Availibilty of health professionals in rural Alaska is a universally recognized problem. "Neither Federal or state policies are geared to the unique economic condition that exists in rural Alaska. Money seems to be available for everything medical except the payment of physicians' fees."

One physician who practices in a remote area writes: "After seven years we are approaching subsistence income level from medical practice."

Most agree that services could be provided more economically with a resident physician, who can assist others (particularly the elderly) in remaining in their homes. "A large percentage of the rural medical care dollar subsidizes air carriers and hotel keepers."

Another doctor who travels to rural areas for speciality clinics says the cost of travel and lodging far exceeds any money collected in fees, but continues because "The doctors there appreciate and need the teaching sessions I give as a vital adjunct to their continuing medical education, and I provide services to the children not available to them otherwise." The physician goes on to suggest that "Reimbursement of basic travel costs would be very important in upgrading the quality of care."

One provider suggests"...state subsidy for mobile medical clinics." Another: "WAMI medical schools need to develop more clinical rotations for medical students in Alaska to encourage students to return to Alaska to practice medicine."

Many providers said that the lowered rates paid by Medicare and Medicaid and the payment delay "...exclude many from care since physicians are unwilling to take them as patients." Many noted that the loss of income from Federal programs are merely added to the bills of others. A dentist commented that more care needs to be available to "young patients under 21 and also the older segment of our population who cannot afford decent dentistry" and goes on to ask that the state "...keep Delta Dental as the agency that processes our Medicaid forms. We do not get our entire fee but they are prompt and can be called if there is a problem."

The dangers of overexposure to radiation from improperly done x-rays was the basis for comments of another physician concerned that unnecessary and poorly done x-rays are a patient hazard. "I urge you to consider legislation to eliminate this excess use of x-ray and put it where it belongs - in the hands of those trained to use it properly and safely."

Numerous and lengthy remarks on health care costs show that many professionals agree that "the cost will always expand to fill the available money" in a system giving "...economic incentives for health providers to increase the cost of health care." The largest problem lying in the " 'Cost insensitivity' among hospitals, doctors and consumers."

Others blame the insurance system and the method of payment "...many could be treated on an outpatient basis if these costs were paid for by insurance - resulting in a savings of nearly half the cost."

Wellness promotion and incentives for good health were often suggested, but as one nurse wrote: "Healthy individuals are not desired by the profit-seeking medical-industrial complex...as they consume less medical care and profics would decrease." An M.D. included an article about a California county that instituted a reward system for public employees who used less health care, therein evading another problem. "Organized labor has found that employee-provided health care plans are a very large benefit since these have been tax-free to the employer; labor has therefore attempted to make such plans include first dollar coverage and be as complete as possible. Health care providers have in general been

paid in proportion to services provided. It is therefore of little wonder that costs have escalated."

Hospital based professionals commented on their perceptions that Medicaid and full coverage patients abuse services "When they feel there's no charge, why not take advantage rather than evaluate the situation...it's time people started being responsible for themselves."

"Anything free is quickly judged as having no value."

"Costs should be paid, in part, by the recipient so long as there's no hardship..."

Malpractice Insurance and its contribution to health costs was mentioned by 11% of the respondents. "...one does not mind paying for legitimate knowledge and expertise. But when half the cost is to assauge someone's fear and goes into an insurance underwriter's pocket, then I question it." Suggestions were made for limiting lawsuits, as other states have done because "...the overwhelming 'sue everybody' mentality has assaulted the physician's instinct for self-preservation." The insurance cost, which is considerable, is added to consumer costs while additional tests and procedures "not to help the patient, but to protect himself (the doctor)" adds further expenses.

Alcohol and health related problems from its overuse is foremost in everyone's mind, and the scope of the issue is immense in Alaska. As one nurse from King Salmon wrote "...half the community are alcoholics --where do we start?" Suggestions ranged from taxing alcohol with the money to ge to education and prevention, strict penalties for alcohol-related crime, to severe punishment for drunk drivers. Although 81% of the respondents said their area had services for alcoholism, 17 of the 32 represented communities had professionals listing alcohol facilities and personnel as needs.

SECTION 4

Health Systems Agencies:

An Overview

HEALTH SYSTEMS AGENCIES: AN OVERVIEW

Prepared for
the Senate Health, Education
and Social Services Committee,
Second Session, 12th Legislature,
Senator Charlie Parr, Chairman.

By
Sandra S. Stringer
December 1981

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ALASKA LEGISLATURE

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M E M O R A N D U M

DATE: December 1981

TO: Members of the Senate HESS Committee

FROM: Sandra Stringer, Legislative Assistant

SUBJ: Interim Report

* * * * * * * * * * * * * * * * *

At the request of the committee I have prepared this interim report on the three Health Systems Agencies operating in Alaska. The report is a brief overview of the history and functions of the HSA's, an outline of their present difficulties, and a review of proposed changes in both the functions of the HSAs and in their relationship to the State of Alaska. It should be noted that the report is designed more as a "briefing paper" for the Committee than as a comprehensive review of the health systems agencies.

The report is structured in two parts. The first is a narrative summary of information on various topics. The second is a series of appendices containing additional information on HSAs comments from public hearings, letters, etc. In addition, the Committee master file will contain further data reviewed for but not included in this report.

Much of this report is a compilation of existing written material. Some of it is based on interviews, conversations and meeting notes assembled over the past several months. I would like to especially acknowledge assistance given to me by the staff of the Northern Alaska Health Resources Association, and by NAHRA's executive director, Dr. Charles Kaltenbach.

A final note should be made of the fluidity of the current relationship between the federal government and the HSAs. As of the time this report is being prepared (early December 1981) the federal funding formula for the HSAs for FY 83 is still somewhat uncertain and will probably remain so for at least the next six weeks. Also, Alaska HSA-coalition proposed changes in the HSAs function and relationship to the state is still in the process of being developed, and the copy of the proposal included in this report should be viewed as a document still subject to coalition revision.

SS:dm

BACKGROUND

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) established area wide health planning organizations known as health systems agencies (HSAs). These organizations, together with Statewide Health Coordinating Councils (SHCC) and State Health Planning and Developing Agencies, were given broad authority over the allocation of health resources.

For further discussion of Alaska SHCC and related topics, please refer to the yearly updates of the State Health Plan for Alaska, prepared by the Statewide Health Coordinating Council and the Division of State Health Planning and Development, Department of Health and Social Services, available in the Committee master file. Additional material on P.L. 93-641 is available in Appendix 1, attached to this report.

Alaska has three Health Systems Agencies. These are the Northern Alaska Health Resources Association, Inc. (NAHRA), the Southcentral Health Planning and Development, Inc. (SCHPD), and the Southeast Alaska Health Systems Agency (SEAHSA). The geographic area served by these HSAs is coextensive with the boundaries of various of the Native regional corporations. (See map on following page.)

The rationale behind Congressional enactment of P.L. 93-641 and subsequent development of regulations governing the direction of growth of HSAs might best be summarized by quoting from the NAHRA Annual Report of FY 79. (The entire report is available in Committee files.)

"In spite of enormous amounts of money spent by private citizens and governments, health care in the United States is in many respects unsatisfactory - wasteful and inefficient, unevenly distributed, short on efforts to prevent disease and not matched closely to the needs of the people. And, despite the superb quality of our medical care, America has fallen behind several other nations in such key indicators of the state of public health as infant mortality, life expectancy, and the incidence of preventable disease.

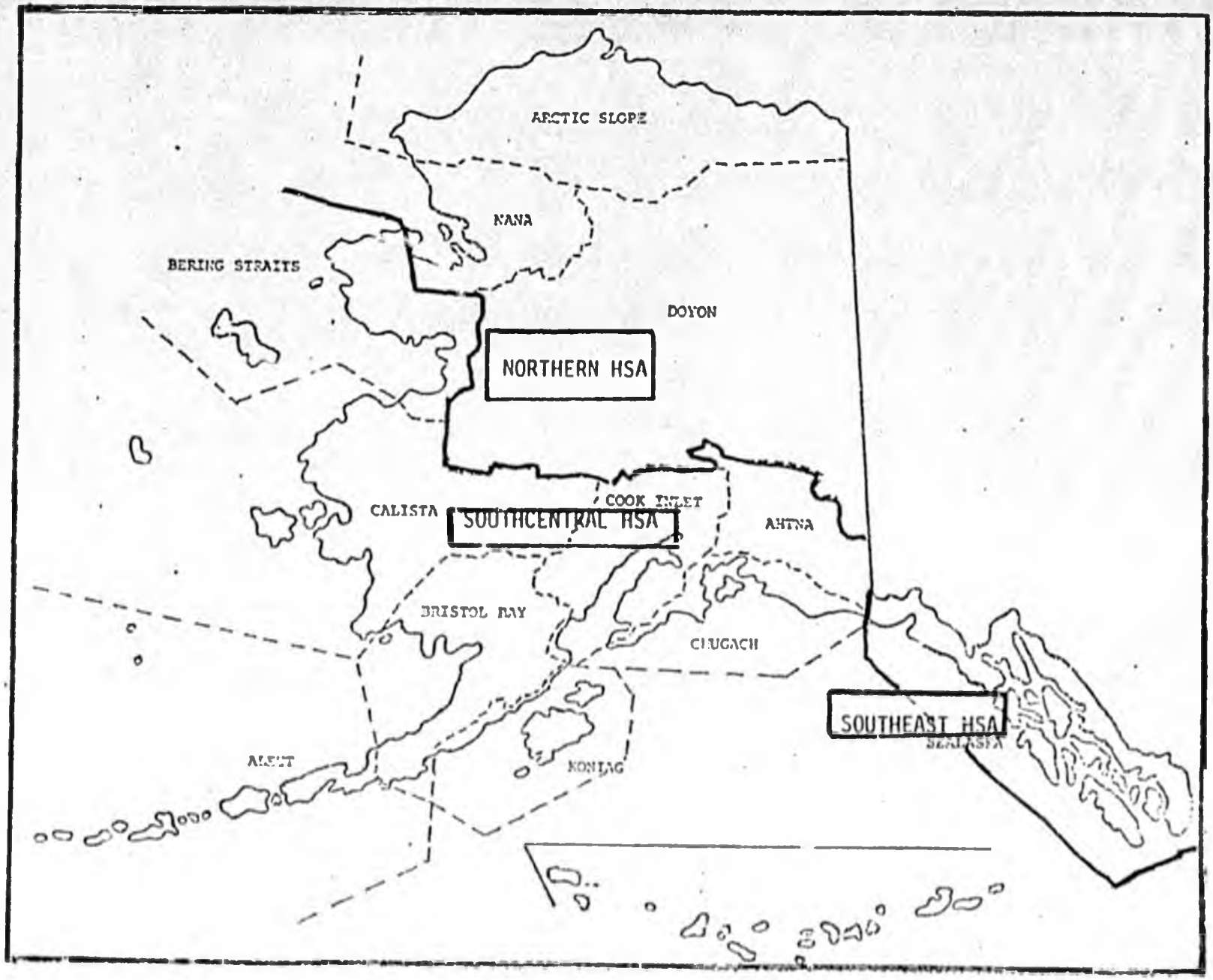
The United States Congress took a look at health care costs, health status, and regionwide planning in 1974. They found national planning efforts to be fragmentary, duplicative, and non-systematic, with the result that Americans were not getting the most effective care for their health dollar.

Congress decided that a mechanism should be designed: (1) to control health care costs; (2) to focus on the people's priority needs; (3) to address the entire range of physical and mental health services from primary prevention and a healthful environment to highly technological specialized services; and (4) to link them all together into a continuum of quality services which are accessible, available, and affordable to all."

MAP TAKEN FROM THE 1980 STATE HEALTH PLAN

HEALTH SERVICE AREAS

NATIVE REGIONAL CORPORATIONS



The result of this Congressional concern was the establishment of the health systems agencies, and the promulgation of numerous federal regulations setting guidelines for the definition of their areas of action.

Present Situation

The Alaska HSAs are non-profit corporations supported by federal and state grants. (See figure on following page.) They are controlled by regional health boards of directors composed of health care providers and consumers. By law a majority of the members of the boards must be representatives of the health care consumers of the region served by the HSA. In addition to the HSA governing boards, each HSA has various volunteer advisory committees to provide advice and assistance in technical matters.

The State of Alaska and the federal government have assigned the HSAs "the responsibility for determining what the major health problems of...Alaska are, assessing the services and resources currently available to meet the problems, and developing plans for coordinating or developing services to address unmet and future needs while containing the cost of these services." (NAHRA Annual Report, FY 79.)

Although each of the Alaska HSAs has developed a somewhat different approach and emphasis in meeting this mandate, and each is free to develop its own yearly work plan, all HSAs must still direct their efforts in such a way as to meet the requirements set forth primarily by federal guidelines. (See Committee master file for a copy of the guidelines.)

It has been argued that many of the regulations that have accompanied federal funding of the HSAs have resulted in activities that have been somewhat marginal to the needs of health planning in Alaska. In a young, geographically large but population small state, controlling the number of competing health care facilities has usually been less of a problem than trying to determine how best to provide health care services where no service at all may have previously existed. In addition, since the HSAs have no reviewing authority over federal health care providers (including Indian Health Service and the military), Alaska HSAs have been unable to directly influence developments among a significant segment of health care providers in the state. Other regulations governing such varied areas as the composition of HSA boards and the frequency of preparations of regional and state health plans have tended to impede the ability to develop local responses to state problems.

In a very real sense, however, all of the above is moot. The Reagan administration is proposing to phase out federal support for public health planning established under P.L. 93-641 over the next two federal fiscal years. The State of Alaska has the opportunity to decide for itself whether or not to continue state

Sources of Revenues for Health Planning Agencies
FY81[1]

	Federal[2] Funds	State Funds	Contracts, Interest & Other	Total
Health Systems Agencies				
Northern Alaska Health Resources Assoc.	349,377	100,000	30,000[3]	479,377
South Central Health Planning & Development	390,291	100,000	12,120	502,411
Southeast Alaska HSA	369,038	100,000	12,500	481,538
Subtotal	1,108,706	300,000	54,620	1,463,326
Statewide Health Planning (SHPDA & SHCC[4])	432,846[5]	299,700	-0-	732,546[6]
Total Expenditures	1,541,552	599,700	54,620	2,195,872
Percentage of Total	70.2%	27.3%	2.5%	100%

1. The fiscal year periods for the HSA's are somewhat unconventional since they are dependent upon the date at which the federal government officially "designated" the agencies. Because the HSA's begin their fiscal years late in the federal budget cycle, the effects of a federal budget cut would not be felt for nearly one year. Thus, if the federal government eliminates funding for HSA's in the federal fiscal year beginning October 1981, the HSA's in Alaska could continue their operations through their 1982 fiscal year.
2. The federal government has provided a minimal grant of $255,000 to each HSA. Additional federal funds have been made available to HSA's which serve large geographic areas. The federal government also provides matching funds to HSA's which received state support in the preceding fiscal year.
3. This figure does not include interest.
4. The budget for the Statewide Health Coordinating Council is a component of the State Health Planning and Development Agency. In FY81, the SHCC budget was $87,000, which is 12.8 percent of the SHPDA budget.
5. Federal funding for SHPDA activities (including SHCC) totalled $432,846 in FY81, of which $47,746 were for indirect costs.
6. This figure included "indirect costs" for SHPDA activities funded by federal sources. The Alaska Department of Health and Social Services does not include the indirect costs in their budget for SHPDA which is based upon direct support totalling $684,800.

This figure was taken from page 39 of the May/June 1981 copy of Alaska Medicine, from an article by Mim Dixon on the HSAs referred to elsewhere in this report.

health planning and promotion through the mechanism of the HSAs, and if so how the HSAs might best be restructured to serve state needs, and at what costs.

Policy Issues

Several policy issues must be addressed by the state in any consideration of whether to retain part or all of the Alaska HSAs as a portion of state government health planning. Some of the issues that must be considered are as follows:

Does the state wish to pursue a policy of any kind of coordinated health planning?

If the state does continue a coordinated health planning effort, should such an effort be structured to include and/or encourage formalized regional input?

What should be done to systematically coordinate among the many private, city, borough, state and federal entities currently providing health care within Alaska?

Is there a need for some state entity to review proposed new health care facilities and programs in an attempt to avoid duplication and inefficiency?

If the answer to all of the above questions is "yes", then another question needs to be asked:

Are the three HSAs, as currently structured, suitable to serve such state needs?

Two articles which appeared in Alaska Medicine this past summer and a proposal put together by a recently formed ad hoc committee of Alaska HSAs are attached as appendices to this report.

The first article (Appendix 2), is authored by Mim Dixon and appeared in the May/June 1981 issue of Alaska Medicine. In it Ms. Dixon review the subject of the HSAs in light of proposed federal budget cuts and possible state incorporation of aspects of previously federally sponsored health planning programs. She discusses at some length the question of adapting existing HSAs versus creating new agencies to meet state needs. She also offers several suggestions for "new agenda items" for the state to consider should it decide to continue with some form of health planning agencies.

The second article (Appendix 3), was written by Ron Hammett, administrator of the Southcentral Health Planning and Development agency (the Southcentral HSA), and appeared in the July/August 1981 issue of Alaska Medicine. Although Mr. Hammett was writing as a private citizen, his experience with an HSA makes his analysis particularly interesting. The focus of his article is on possible new models for planning and delivery of health care in the state.

The proposal by the HSA coalition is an attempt to work out a revised structure and somewhat revised areas of emphasis for the state HSAs, should a decision be made to retain them. Chuck Kaltenbach, director of the Northern Alaska HSA plans to attend the Senate HESS Committee hearing in Anchorage on December 15 and will speak to this proposal.

At this time it is not clear if the Alaska Department of Health and Social Services is actively working on the HSA situation. Earlier this year the HSAs requested additional funding from the State to replace anticipated loss of federal revenues. Commissioner Beirne replied that she was unable to include additional funds for regional health planning in her budget, but that the Department of Health and Social Services will "continue to be supportive of efforts to revise and finance a system that is even more responsible to the variety of health related needs Alaskans have." (Copies of both letters are included in Appendix 4.) Commissioner Beirne will also be attending the December 15 meeting and may have further comment on this subject then.

Summary

At this time the Alaska HSAs are in the process of drawing up a "coalition" proposal for a health systems agency model that would be more in tune with the needs of the state. (See Appendix 5.) Such a model would be developed along lines independent of current federal guidelines. The implication, of course, is that such a model would also be funded chiefly, if not entirely, by state monies.

Currently, it appears that for the upcoming federal fiscal year (FY 83), the federal government will be funding the three Alaska health systems agencies to the amount of $100,000 each. It is expected that the State of Alaska will also be requesting an additional $100,000 per HSA be funded to each HSA from state revenues. Finally, the federal government is expected to allot each HSA a certain added amount of funding, anywhere from 25 cents to 53 cents on the dollar, based on the state matching funds of $100,000 per HSA.

As noted in the introduction to this report, the uncertainty regarding exact amount of federal funding for the HSAs is likely to continue for some time. Actual dollar amount figures are unlikely to be available before mid-January at the earliest. The only real certainty appears to be that funds for HSAs will be much reduced for FY 83 in comparison to previous years, and that the HSAs will essentially be receiving phase-out funding from the federal government for the next one or two years.

This puts the question of the continuation of some form of health systems agency, or agencies, for the purpose of regional health care planning and promotion in Alaska squarely before the state Department of Health and Social Services and the Alaska legislature. If the decision is made to continue the HSAs under state sponsorship, additional monies may be needed to be put into the HSAs' state budgets

for FY 83. This may be both for purposes of planning a new HSA-State of Alaska relationship, or for carrying out such a new relationship if one is worked out in the context of the legislative committees this coming session. If the decision is made not to pick up sponsorship of the HSAs, then the legislature should look at the possibility of devising some other method to obtain regularized regional input to state health care planning and promotion.

In an effort to assist the Senate HESS Committee with this decision the final appendices to this report contain a summary of verbal and written comments made to the Committee on the subject of the HSAs during the interim, and a copy of the results from the returned questionnaires sent out to health care professionals on the same subject. (Additional information from the questionnaires sent out to health care consumers should be available some time early in the session.)

SECTION 5

Appendixes:

Health Systems Agencies

APPENDIX I: Information related to Public Law 93-641. (A complete copy of P.L. 93-641 is available in the Committee master file.)

Public Law 93-641
93rd Congress, S. 2994
January 4, 1975

An Act

To amend the Public Health Service Act to assure the development of a national health policy and of effective State and area health planning and resources development programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; TABLE OF CONTENTS

National Health Planning and Resources Development Act of 1974. 42 USC 300k note.

SECTION 1. This Act may be cited as the "National Health Planning and Resources Development Act of 1974".

TABLE OF CONTENTS

88 STAT. 2226

TABLE OF CONTENTS—Continued

FINDINGS AND PURPOSE

42 USC 300k.

SEC. 2. (a) The Congress makes the following findings:

(1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.

(2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.

(3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;

(B) maldistribution of health care facilities and manpower; and

(C) increasing cost of health care.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF STATE HEALTH PLANNING & DEVELOPMENT

POUCH H 01A
JUNEAU, ALASKA 99811
PHONE:

August 14, 1981

Charles Kaltenbach
Executive Director
Northern Alaska Health
Resources Association, Inc.
529 Fifth Avenue, Suite 8
Fairbanks, AK 99701

Dear Mr. Kaltenbach:

Enclosed is a memorandum from the Department of Law to Commissioner Beirne related to the legal status of health systems agencies. As I interpret this memorandum, the state could continue its general fund support of HSAs, assuming that the federal legislation was not repealed. I would expect, as well, some revised application process, particularly a revised work program if federal support diminishes or is eliminated.

We will need to keep in touch on this issue as new dimensions develop.

Sincerely,

Phoebe A. Lindsey
Director

Enclosure

MEMORANDUM State of Alaska

TO: Honorable Helen D. Beirne
Commissioner
Department of Health and
Social Services

DATE: July 14, 1981

FILE NO:

TELEPHONE NO: 465-3603

FROM: WILSON L. CONDON
ATTORNEY GENERAL

SUBJECT: Legal Status of Health Systems Agencies

by: THR
Thomas H. Robertson
Assistant Attorney General

You have asked for a determination of the "legal status" of Health Systems Agencies (HSAs) after July 1, 1982. You have informed us that on that date the federal government intends to stop funding them while making no changes in statutes bearing on their operation.

It appears likely that after July 1, 1982, HSAs will be significantly poorer. Without more, we perceive no change in what might be described as their legal status.

HSAs are organized in accordance with the National Health Planning and Resources Development Act of 1974. 42 U.S.C. §300K, et seq. Under 42 U.S.C. §300L-1(b)(1), an HSA may be organized as a non-profit private corporation, a public regional planning body, or a unit of general local government. See, National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City, ___U.S.___, 49 U.S.L.W. 4672,4674 (June 15, 1981). The legal structure of an HSA, which is addressed only indirectly by Alaska law, would thus not necessarily be altered by a mere loss of federal funds.

If you have further questions on this regard, please do not hesitate to let me know.

THR/bap

Repeal of former chapter. — Section 1, ch. 275, SLA 1976, repealed former Chapter 07, entitled "Comprehensive Health Planning." The former chapter consisted of §§ 18.07.010 — 18.07.100, and derived from § 1, ch. 78, SLA 1973; §§ 29, 30, ch. 127, SLA 1974.

Editor's note. — Section 3, ch. 275, SLA 1976, provides: "Planning grants to health systems agencies. (a) A health systems agency designated under P.L. 93-641 is entitled to grants for the first four years of operation as follows:

(1) $100,000 during fiscal year 1977;
(2) $75,000 during fiscal year 1978;
(3) $50,000 during fiscal year 1979;
(4) $25,000 during fiscal year 1980.

(b) A health systems agency designated under P.L. 93-641 is entitled to a grant in an amount equal to but not exceeding

(1) $25,000 during fiscal year 1977;
(2) $50,000 during fiscal year 1978;
(3) $75,000 during fiscal year 1979; and
(4) $100,000 during each succeeding fiscal year."

Section 4, ch. 275, SLA 1976, provides: "All health care facilities in existence or under construction prior to July 1, 1978 shall be issued a certificate of need."

Article 1. Planning Agencies.

Section

11. Statewide Health Coordinating Council
21. State Health Planning and Development Agency

EFFECTIVE: 1977

Sec. 18.07.011. Statewide Health Coordinating Council. There is created the Statewide Health Coordinating Council. The council shall be organized in the manner described by § 1524(b), P.L. 93-641, § 237(a)(1)(A), P.L. 94-63 and AS 47.30.605(a). The council shall perform the functions listed in § 1524(c), P.L. 93-641, § 237(a)(1)(A), P.L. 94-63 and AS 47.30.605(b). (§ 2 ch 275 SLA 1976)

Sec. 18.07.021. State Health Planning and Development Agency. The office of planning and research in the department is the state health planning and development agency designated under § 1521(b)(3), P.L. 93-641. The office shall perform the functions enumerated under § 1523, P.L. 93-641, administer the certificate of need program outlined in §§ 41 — 111 of this chapter, and other functions prescribed in this chapter. (§ 2 ch 275 SLA 1976)

Article 2. Certificate of Need Program.

Section

31. Certificate of need required
41. Standard of review for applications for certificates of need
51. Terms of issuance of the certificate
61. Modification and termination of activities
71. Temporary and emergency certificates
81. Proceedings for modification, suspension, and revocation
91. Injunctive relief; penalties; right of action
101. Regulations
111. Definitions

Effective date. — Section 2, 1976, provides: "Secs. 1 18.07.101 take effect on July

Sec. 18.07.031. Certi
undertake the follow
certificate of need issu
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(2) alteration of the
(3) addition or elimin
a health care facility. (

Sec. 18.07.041. Stan
of need. The office sha
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good health of Alaska

Sec. 18.07.051. Term
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Sec. 18.07.061. Modi
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certificate before termi
terms of issuance, but t
acquiescence of the
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notify the office 60 d
certificate to the office
1976)

Sec. 18.07.071. Tem
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under § 41 of this chap
hearing, that the act o
repairs.

(b) The office may g
temporary operation o
shows by affidavit or f
(1) the necessity for

APPENDIX II: Excerpt from an article in Alaska Medicine, Volume 23, Number 3, May/June 1981, by Mim Dixon. Title: Health Planning in Alaska: A New Agenda for the 80's.

administration, thereby removing one underlying objective of the health planning agencies. Also President Reagan has taken a more direct approach to reducing the federal Medicaid budget.

Furthermore, the philosophy integral to the health planning activities of P.L. 93-641 has been to avoid duplication of costly medical technologies and services in a given area and thereby reduce costs through higher utilization. This approach appears to be philosophically antithetical to the conservative Republican economic models which rely upon competition to reduce costs. Another feature of P.L. 93-641 which could make it inherently politically unceptable to the new administration is that it requires states to pass "Certificate of Need" legislation which restricts the private sector from making new investments in health care facilities and equipment without posing the same limitations on the federal government.

Is there a need for health planning agencies in Alaska?

The need for health planning in Alaska has probably never been greater than during this present period of rapid change. In its unique position of having a surplus of state revenues, the Alaska Legislature is finding that proposals for state spending are far exceeding the abundant revenues. While the Legislature has focused its attention on issues related to resources development, expansion of the physical infrastructure within the state and investment policies, most legislators acknowledge the unmet need to address "human problems." Perhaps now more than ever before the Legislature needs advice on how to spend its resources in a prudent and effective manner to reduce the suffering in Alaska from our major health problems: alcoholism, accidents, violence in the home.

Health planning agencies are in an excellent position to provide this advice. The comprehensive health planning which they have performed in the past five years has sought means to address these problems at a time when budgets were tight and there was a need for prudent planning. Furthermore, the health planning agencies have developed mechanisms for formulation and review of their plans by a broad cross-section of individuals who represent both consumers and agencies from diverse geographic areas of the state.

Recent developments in Alaska and the nation are changing the social, economic and political context for health care. Among these developments are the following:

- Recent oil wealth and state budget surplus in Alaska.
- Growing national need for domestic energy resources which is stimulating development of those resources in the Western States and the Outer Continental Shelf.
- A combination of escalating fuel costs and the deregulation of the airline industry which is increasing the cost of air transportation and decreasing the number of scheduled commercial flights.
- National political trends which indicate reduced federal expenditures for health and social services, federal deregulation and a more powerful role for state governments.

These trends have significant implications for the future of health care delivery systems in Alaska which potentially creates a whole new agenda for health planning activities. Issues which have not been addressed previously in Alaska must be. Change can be very disruptive unless there is adequate planning and coordination. There are many health care delivery systems and many constituencies in Alaska which must be included in the planning processes to assure equitable outcomes.

The question asks is there is a need for health planning "agencies" in Alaska. The implication is whether the health planning needs in Alaska can be met by a single statewide agency, most likely located in the Alaska Department of Health and Social Services, or whether the needs can be better met through several regional agencies. Nearly every area of state government acknowledges the diversity of geographic regions in Alaska, the need for decentralization in planning and policy development and the importance of broadly representative citizen participation. This usually requires several regional advisory boards, rather than a single statewide advisory committee. For advisory groups to be effective, they usually require staff and budgets over which they have control. If "agency" is defined in this broad context as an organization with a board of directors, staff and budget, then there is probably a need for more than one health planning agency in Alaska. The specific structure and staffing of these agencies, however, need not be the same as that prescribed by P.L. 93-641.

Adapting existing agencies versus creating new agencies to meet state needs

At the present time, it may be very difficult for the health planning agencies created by P.L. 93-641 to justify their continued existence as state programs. The organizations were forced upon the state originally under the threat of discontinuation of federal funds for health programs.[1] Without this threat, the incentive to continue the organizations may be dimished considerably.

Furthermore, the goals, agendas and work plans of these agencies have been derived from federal guidelines. Alaska and some other Western states have argued that the federal guidelines are not appropriate because health care institutions in those states are underdeveloped rather than superfluous. Federal regulations require HSA's and the SHPDA to produce massive health systems plans, annual implementation plans and grant applications on an annual basis. Generation of this paperwork has in turn influenced the staffing and accomplishments of the organizations.

At the present time, the activities of the health planning agencies in Alaska can be characterized as fine-tuning the existing health care delivery systems in

compliance with regulations promulgated by federal agencies to further P.L. 93-641. Since the majority of funding for HSA's, SHCC and SHPDA comes from federal sources, they are obligated to structure their planning agendas in response to these federal mandates. Furthermore, they are obligated to structure their organizations according to federal guidelines.[2]

The argument could be made that the growing trend for the private sector to use health planners[3] has diminished the need for public sector planners and that the health planning needs in Alaska could be met through the private sector rather than continuation of existing governmental and quasi-governmental health planning agencies. There are two types of health planners in the private sector in Alaska.

The first type of health planner has been hired by agencies which provide health care services primarily to write grants and to respond to the massive paperwork requirements of state and federal legislation. While this type of health planner may participate in interagency activities, the role of this individual is clearly to serve the organization which employs him or her and this creates an inherent conflict of interest for comprehensive health systems planning.

The second type of health planner in the private sector is the private consultant. One might anticipate a growth in the number of private consultants as a result of President Reagan's budget cuts. However, private consultants can only provide health planning services if they are hired by clients. While the organizational structure of health planning agencies in Alaska could be altered to rely more extensively upon private consultants than internal staff, the agencies must be continued in order both to hire the private consultants and to provide direction, review and implementation for the planning products.

One of the major goals of health planning agencies is to achieve some degree of consensus on future activities of organizations and institutions. This can be done only by an organization which has been carefully structured to be representative and politically acceptable particularly when the issues involve the distribution of public funds.

While the concept of P.L. 93-641 may be politically unacceptable in the national sphere, agencies created under that law have achieved a high level of acceptability in local political spheres. Each of the three HSA's in Alaska has a Board of Directors at least 51 percent of whom are health care consumers. A relatively high turnover in consumer representation on the Boards of Directors of the HSA's and the 30-member SHCC (which is also over 51 percent consumers) has created a relatively sophisticated network of health care consumers throughout the state who are familiar with problems of health and the delivery of health services and committed to improvements through the processes developed by health planning agencies.

Health planning agencies have also provided a forum for health care providers from diverse agencies and professions to communicate, coordinate and resolve existing and potential conflicts. In a state as large as Alaska with as many health care institutions, the value of this formal association and the accompanying informal interactions cannot be underestimated. To start from scratch to develop new organizations may be demoralizing to the individuals who are expected to participate in them when they have already made significant investments in existing organizations. Furthermore, new organizations take time to develop by-laws, staff, operating procedures and working relationships.

Both the state and federal government have invested several million dollars in the development of health planning agencies under P.L. 93-641. More importantly, the voluntary board members and professional staffs of the agencies have invested an enormous amount of time and emotional energy in developing organizations which are functional and politically acceptable. On the one hand, these investments may have created organizations which are too rigid to adapt from federal directives to a state orientation. On the other hand, these investments may have lain the groundwork for effective organizations which are capable of responding to new agendas.

New agenda items

Consistent with federal goals, the current goals of Alaska's health planning agencies have been to encourage prevention of health problems through an emphasis on health education, to allocate new technology within existing systems without unnecessary duplication and to achieve levels of health care considered appropriate for community size and function. The challenge for health planning agencies in Alaska today is to develop an agenda for the next decade which will address the major changes anticipated in the state and assist in planning health services which are appropriate and responsive to those changes. In the short-term, this requires not only a reformulation of goals but also a restructuring of the health planning agencies to address these new goals with the necessary expertise and with organizations which are streamlined to be efficient and responsive.

The following is a sampling of items which may be on the agendas of health planning agencies in Alaska in the 1980's.

Item 1: Planning for boroughs to replace native non-profit corporations in the provision of health services

The Alaska constitution requires that the state be divided into regional areas called "boroughs."[4] Some of the areas were expected to have regional governments titled "organized boroughs."[5] Areas without regional government were called "unorganized boroughs" and the state legislature was to serve in the capacity of the Borough Assembly. By law, all first and second class boroughs have the following powers: 1) education 2) assessment and taxation and 3) planning, platting and zoning.[6] Through prescribed

procedures, boroughs may also adopt other powers such as the provision of health services.

Despite repeated attempts by the Alaska State Legislature to organize the unorganized boroughs,[7] in most areas of the state rural residents have adamantly opposed the formation of local government. The reasons for this opposition has been two-fold: 1) people do not want to be regulated by another level of government particularly with regard to land use and 2) people do not want to pay additional taxes to support local government services. The changing political and economic situations within Alaska may eliminate the basis for this opposition to borough government. Through the establishment of Regional Education Attendance Areas (REAA's)[8] and Coastal Resource Service Areas (CRSA's),[9] some borough functions have already been assumed on a regional basis with local control, thereby making these functions more acceptable and developing the local expertise for future leadership roles in borough government.

State oil wealth may eliminate the need for local taxation thus removing the opposition to borough government on that premise. Certainly, state school foundation support will continue to grow as well as state capital expenditures for projects including schools and other public facilities which may become the debt-free property of newly-created boroughs. Pipelines and Outer Continental Shelf oil development may provide an incentive for local government to reap the benefits of those tax bases rather than forfeit them to the state. However, it is doubtful that any other area of Alaska will have a tax base the magnitude of the Prudhoe Bay tax base which has funded the North Slope Borough government. Nevertheless, the North Slope Borough does represent a prototype model for resource development providing a tax base to stimulate the formation of local government.

While erasing the disincentives for local government, resource development also may create new incentives for local government. Population growth resulting from resource development will change the distribution of population in Alaska so that a larger percentage of rural residents are non-Natives. This group currently has no representation in governmental and quasi-governmental organizations in rural areas such as village councils formed by the Indian Reorganization Act (IRA Councils) and Native profit and non-profit corporations. Because Natives and non-Natives currently do not have equal access to and control over local decisions and services, there will be a growing demand for greater participation by non-Natives. Natives will likely resist relinquishing political and economic control in the face of losing majority status and becoming minority populations in those areas. At the same time, resource development will intensify the demand for services which are more appropriately administered at the local level than by state government.[10]

As a result of these forces and the recent efforts in the State legislature and administration to plan to organize the unorganized borough,[11] it may be predicted with a fair degree of confidence that there will be more organized boroughs in rural Alaska in the near future. Although borough governments have no requirements to assume health care functions, other forces suggest that boroughs will replace Native non-profit corporations as regional health providers.

One might anticipate diminished funding for the Indian Health Service, possible even termination of Indian Health Service programs in Alaska, as a result of policies of the Reagan administration to reduce government spending. There is acknowledgement of this alternative in the Alaska Native Claims Settlement Act.[12] Also there is a national perception that the State of Alaska can afford to provide these services. If the Indian Health Service budget in Alaska is cut, then the operating budgets of the Native non-profit corporations also will be cut. Reduced budgets will result in reduced services in rural areas. At the same time, there likely will be an increased demand for health services from the growing populations in those areas. Boroughs may have access to revenues to provide health services at a time when funding for Native non-profit corporation health services is scarce, thereby facilitating the transfer of responsibility for health services from the Native non-profit corporations to boroughs in rural areas.

Anticipating the emergence of borough governments in rural areas of Alaska, the established health systems agencies can identify the potential alternatives for the delivery of health services and assist in defining the appropriate roles for existing agencies and future agencies. Competition for limited resources and resultant hostilities could be avoided through the HSA's acting effectively in mediating and planning roles.

Item 2: Assisting the State of Alaska in developing a health insurance program

Proposals have already been introduced in the Alaska State Legislature which would create a state health insurance plan.[13] State oil wealth make this approach economically feasible and there appears to be political support for it.

Alaskans are becoming increasingly aware that present schemes to return the state's oil wealth to its citizens through cash disbursements result in greater federal personal income tax. Because there is no cost of living adjustment in the federal tax, Alaskans already pay a disproportionate federal income tax relative to their real incomes. One could therefore anticipate a growing demand by Alaskans to redistribute the state oil wealth by reducing the cost of living in Alaska through the subsidy of high cost goods and services, such as transportation, energy and health care, which would not be considered taxable income by the federal government.

It is likely that the existing proposal could be expanded to provide health insurance coverage for all Alaskans similar to a national health insurance program. A comprehensive state health insurance

program would change the financing structure for health care in Alaska. This would likely stimulate the growth of the private sector of medicine and promote the decline of the Indian Health Service in Alaska. It would also provide greater third-party coverage for health services provided by the National Health Service Corps and local governments in rural Alaska.

Health systems agencies could serve the state by providing detailed planning documents which would show the implications of alternative state health insurance programs for the health care delivery systems in their regions. These documents could then be subjected to a review process which would assist in the selection of the most appropriate alternatives and facilitate an orderly transition.

Item 3: Planning health systems response to changing transportation patterns in Alaska

The combination of high fuel prices and deregulation of the airline industry in the United States will have a significant effect on transportatin patterns in Alaska. With a high degree of certainty, one can anticipate reduced airline services and increased costs for air transportation-both within Alaska and between Alaska and Seattle.

Within the state, one possible implication is that there will be a shifting reliance from air to surface modes of transportation. The Alaska Legislature and Governor have committed the state to using its budget surplus for capital improvements and roads historically have been desirable capital projects. Current needs assessments suggest a strategy of connecting communities within regions to the regional centers by surface transportation rather than the previous strategy of connecting regional centers with urban centers by roads.[14] Since these are smaller projects they may be more politically acceptable. At the same time, resource development, trucking and Teamster interests will likely provide political pressure to extend the highway, marine highway and railroad systems in Alaska.

The implications of an expanded road and highway system in Alaska upon health and the delivery of health services are two-fold. First, more roads will mean more highway traffic accidents in rural Alaska which will require an expanded emergency medical service system and one which is adapted to surface, rather than air, transportation of victims. Secondly, surface transportation within a region may change the accessibility of health services and thereby the criteria for distribution of health services. The goals for distribution of health services in rural Alaska may more closely approximate those in the "lower 48" states (i.e. 30-minutes driving time to a health care provider) which may in turn change the desired service delivery patterns.

In the event that surface transportation does not flourish, the higher cost of air transportation may have other implications for the delivery of health services. When one considers the cost of tranporting patients as part of the cost of health care, it may become more economically feasible to locate more sophisticated medical practitioners in remote areas than to evacuate patients to a regional or urban center. Similarily, the high cost of transportation may create a greater demand for sophisticated medical services in the urban areas of Alaska reducing the reliance upon Seattle as a medical center for Alaskans.

At the present time there is an unmet need for health planners to work in conjunction with transportation planners to anticipate the demands for health services generated by changes in the transportation systems in Alaska. Within this context, the concept of levels of care which has been the basis of health planning in Alaska may have to be revamped and assessments of health manpower needs revised.

Item 4: Planning for the growth of industry in Alaska

The national demand for domestic resource development will create a growth in the extractive industries in Alaska. This, in turn, will create greater needs for planning in the area of industrial health. Little attention has been given to industrial health in Alaska because it has been assumed that industry is largely non-existent in this state in which more than a third of the employment is in the public sector.

Industrial health issues in Alaska differ from those that predominate in the rest of the states. For example, in Alaska the workplace is generlly not a factory but the out-of-doors. Accident patterns in factories are likely to be very different from accident patterns in logging camps and construction sites. The natural environment is a greater factor in industrial health in Alaska posing problems such as hypothermia. Work sites in Alaska are relatively isolated and, therefore, workers do not have access to health services usually accessible to workers in urban areas. Also, there may be some unique mental health and social problems associated with the social context of work in isolated places in Alaska: workers are separated from their families for extended period of time; living conditions lack privacy and autonomy; daily and weekly working hours are often longer than the standard 8-hour day and 40-hour week; and workers do not have control over aspects of their daily life such as food, social associations, recreational opportunites, spatial relationships and decor in the living environment.

Because of these unique aspects of industrial health in Alaska, the growth of industrial employment in the state will create a growing need for research related to industrial health. Greater state involvment in socio-economic planning for large-scale resource development and a greater awareness by private industry will increase the demand for industrial health planning in the state. The future role of health systems agencies with regard to industrial health may lie in the coordination of industrial health programs with other health programs in the state.

APPENDIX III: An article appearing in Alaska Medicine, Volume 23, Number 4, July/August 1981, by Ron Hammett. Title: The Alaskan Opportunity to Plan and Develop Health Care Resources and to Promote Improved Health Status.

THE ALASKAN OPPORTUNITY

TO PLAN AND DEVELOP HEALTH CARE RESOURCES

AND TO PROMOTE IMPROVED HEALTH STATUS

Ron Hammett

Because of promised Federal reductions in health funding assistance to states, Alaskans are going to have an opportunity to decide what to keep, what to add and what to change. The effort should focus on functions rather than existing structures.

The Federal government has for many years been concerned with the health care status of Americans and with the adequacy of their health care. This concern has been translated into a series of Federal laws including the Hill-Burton program, promoting the development of health care facilities; hospital regional planning legislation; the Comprehensive Health Planning and Regional Medical Programs; and most recently the National Health Planning and Resources Development Act of 1974, which among other things established Health Systems Agencies (HSAs), State Health Planning and Development Agencies (SHPDAs), and State Health Coordinating Councils (SHCCs). In Alaska three HSAs were formed covering the northern interior area (Northern Alaska Health Resources Association), the south central and western regions (South Central Health Planning and Development, Inc.) and southeastern Alaska (Southeast Alaska Health Systems Agency). In addition to Federal designation and financial support the State of Alaska has officially recognized all five organizations and contributed funds to their support.

The Reagan administration has proposed that Federal financial support for P.L.93-641 as amended which established the health planning programs be phased out over the next two federal fiscal years. In Alaska this would mean that Federal support and regulation of the Alaska HSAs would end in mid 1982. After a slight increase during the period from July 1, 1982 to July 1, 1983, Federal financial support for the SHPDA and SHCC would also terminate. Further, the Reagan administration has indicated an intent to change the form of other Federal support for certain health services from categorical grants to block grants with the associated lessening of Federal requirements for advisory boards.

Except for the loss of Federal funds these two developments should be viewed as positive and as an opportunity for Alaska to make its own decisions about health care and health promotion.

In arriving at these decisions, good planning procedures should be followed and should start with the assumption that the structures and boards as we know them which were established under Federal law do not exist. This is not to say that either that structure or their functions should be discarded and in fact much may be retained. However, that is a matter for determination after decisions are made about what Alaska wants to do about health care and health promotion.

To start, we need to answer the question: what should government and public effort do that the private sector cannot be expected to do either entirely or in major part? To answer that question it is necessary to identify the universe of things that can be done in the name of health. One listing might be as follows:

1. To care: performing traditional diagnosis, treatment and rehabilitation services intended to restore a healthy state when disease or accident has lessened it.
2. To fund: granting awards of funds, setting

Ron Hammett is administrator of South Central Health Planning and Development agency. The opinions expressed in the paper are his own. 1135 W. 8th Ave., Anchorage, Alaska 99501

standards and criteria, reviewing and monitoring and providing financial support.

3. To plan: collecting and analyzing data, describing existing services and conditions, establishing goals and objectives, developing policy.
4. To develop: providing technical assistance and advocacy, community organization, evaluation of assets and liabilities and implementation planning.
5. To promote: conducting disease and accident prevention services, educational and informational services, promotional program development.

While none of the categories described above would be expected to be the exclusive province of either the private or public sector there is some difference as to where primary or "lead" responsibility falls. Usually care as defined here encompasses those things provided in large part by physicians and hospitals and supplemented by a variety of other health care providers and facilities generally through a structure of fees for services. These are things most easily defined and assigned an immediate dollar value and therefore most amenable to solution through private enterprise. Care may also be provided through government and non-profit organizations to specific populations such as through the IHS and by specialized clinics.

The other four areas are less easy to identify and tie to cost and are therefore more easily provided for primarily in the public or non-profit sector.

Funding and planning are traditionally the responsibility of government both state and local. Some private money will supplement government support. There should be a large citizen involvement, both provider and consumer, into the funding decisions of government. However, the major responsibility for funding a variety of programs will rest with the state. The provision of financial support should be dependent on planning. Planning, the establishment of goals and objectives and the development of policy, although ultimately the responsibility of government, should require much citizen participation.

Resource development and health promotion are probably best accomplished through heavy involvement of both consumer and provider with a degree of support and influence by government. A mechanism here could be a private non-profit corporation with some basic state financial support and a wide base of involvement and assistance.

An Alaska State health system model following this might appear as follows:

1. Health care: provided by physicians, hospitals and other private practitioners on both fee-for-service and salary basis; regional health corporations, the Indian Health Service and other Native health care groups; and various private profit and non-profit organizations delivering health care to specific and general groups. Might include some innovative schemes of single financing mechanisms.
2. Funding support: provided by a State granting program (similar to current DHSS responsibility) combining all the current categorical State support along with Federal support funneled through the State in a new configuration depending in part upon the ultimate structure of Federal block grants and the State's administration of those funds.

   While this would be primarily a State responsibility there should be citizen advisory contributions. This would include the functions now provided by the DHSS categorical committees and the review/recommendation activities of the SHCC and HSAs.
3. Planning: ultimately a State responsibility (SHPDA present role) with State established goals and objectives and policy but with citizen advice. The State needs to establish consistent policy concerning financial support of facilities and services. A statewide citizen advisory body and local groups should have specific rules. These are some of the functions now performed by the SHCC and HSAs
4. Resource development: there would be a statewide private non-profit corporation (replacing SHCC) to provide actual resource development activities including technical assistance and implementation planning consistent with State established policy goals and objectives. A variety of local private non-profit organizations (replacing HSAs) might also be involved. (The private non-profit approach is suggested to insure staff and budget control by the governing body, both in performing functions 4 and 5 and in advising under functions 2 and 3.)
5. Health Promotion: a second primary responsibility of the private non-profit mechanisms noted in 4 above with State advice.

In summary, it is important that we not let ourselves be caught in the "survival" trap. The health planning organizations (SHPDA's, SHCCs, and HSAs) which are losing Federal funding came into existence as the result of a 1974 Federal law and can hardly be considered institutions. However, in the short range view it's easy to jump to the conclusion that replacement funding must be found to support the good they are doing. We are reluctant to "reinvent the wheel" even when it needs reinventing.

We need to focus on what Alaska wants to do about health care, planning, development and promotion. The process should start with identification of discrete categories describing the universe of health concerns (such as the five listed here), proceed to assignment of primary and supportive responsibility, followed by a description of mechanisms and functions and ultimately identifying the resources needed for implementation.

The opportunity presented to Alaska is the chance to determine the functions and describe the structure without the encumbering Federal guidelines that have in the past accompanied the promise of funding support.

APPENDIX IV: Copies of letters from NAHRA to Commissioner Helen Beirne requesting increased funding for Alaska HSAs, and from Commissioner Beirne to NAHRA in reply to request.

northern alaska health resources association, inc.

August 02, 1981

Helen Bierne, Ph.D.
Commissioner
Department of Health & Social Services
State of Alaska
Pouch H-01 A
Juneau, Alaska 99811

Dear Commissioner Bierne:

The Resolution which is enclosed was developed as a result of discussion which occurred at NAHRA's most recent meeting of the Board of Directors on July 24, 1981. At the time the Resolution was discussed we were still under the impression that the DHSS budget proposal for FY-1983 would contain a request over and above the traditional $300,000 that has supported Health Systems Agencies in recent years. To our dismay, I have learned through Phoebe Lindsey this week that you have decided not to include a request for increased funds for the purpose of maintaining a health planning network in this State. This news is particularly discouraging when I look back over the past three months and realize how much time and effort the staff and board members of the three HSA's have put in developing "transition proposals" for your consideration. The abruptness of this action given the preparatory steps we have gone through is puzzling to me.

In light of the enclosed Resolution and the outcome of the U.S. House and Senate Conference on budget reconciliation which this week supported continued authorization for Health Systems Agencies, I would like to urge you to earnestly reconsider the Department's position with regard to funding for the HSA's. The reconciliation proposal which emerged from the House-Senate negotiations this week reduces the minimum funding level for HSA's to $100,000/year. If we assume that we will continue to receive matching funds from DHSS, based upon the State of Alaska's support of health

529 5th avenue, suite 8 fairbanks, alaska 99701 telephone (907) 456-2553

planning, then a modest increase of $75,000-$100,000 per HSA from the State would support the continued operation of the health planning network throughout the State. A $600,000 price tag for health planning seems very reasonable when one considers the total health care bill in Alaska (approximately $500,000,000 in 1980).

We would appreciate your response to the concerns addressed in the Board of Director's Resolution and the issues I have raised regarding the Department's position on future funding for HSA's.

Sincerely,

Charles M. Kaltenbach, Dr. P.H.
Executive Director

CMK:flr

cc: Governor Jay Hammond
Paul Sherry, President, NAHRA
South East Alaska Health Systems Agency
South Central Health Planning & Development

RESOLUTION
of the
BOARD OF DIRECTORS
NORTHERN ALASKA HEALTH RESOURCES ASSOCIATION, INC.

Requesting the Commissioner of Health and Social Services, State of Alaska, to support Regional Health Planning

WHEREAS:

1. There are presently three Health Systems Agencies (HSA's) in the State of Alaska which are supported, in part, by both the State and Federal Government; and

2. The Federal Government is proposing to eliminate its support of Health Systems Agencies throughout the United States; and

3. The Board of Directors of the Northern Alaska Health Resources Association, Inc. firmly believes that the presence of HSA's in Alaska has contributed significantly to a more coordinated and cost-effective system of health care delivery; and

4. The Board of Directors believes it is in the best interests of the people of this State to continue to provide local planning for the efficient and effective delivery of health services, through the continued operation of the regional HSA's.

NOW THEREFORE LET IT BE RESOLVED THAT:

The Board of Directors of the Northern Alaska Health Resources Association, Inc. do respectfully request that the Commissioner of Health and Social Services, State of Alaska, include sufficient operating funds in the FY83 State Budget to adequately support the continued operation of the three Health System Agencies.

CERTIFICATION

This is to certify that on July 24, 1981, in a meeting assembled at Fairbanks, Alaska, the Board of Directors of the Northern Alaska Health Resources Association, Inc. duly considered the foregoing resolution at which a quorum was present and that same was passed by a vote of 23 in favor and 0 opposed.

Paul Sherry
President, Board of Directors

Motion: Marguerite Stetson
Second: John Blower

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

August 20, 1981

Charles H. Kaltenbach, Dr. P.H.
Executive Director
Northern Alaska Health Resources
Association, Inc.
529 5th Avenue, Suite 8
Fairbanks, Alaska 99701

Dear Dr. Kaltenbach:

Thank you for your letter of August 2, 1981 requesting support for regional health planning. I appreciate the work that the three HSAs, the SHPDA staff, the regional corporations and the SHCC have undertaken in recent months to define a continuation approach for health planning.

As you are aware, our interests in calling together the health planning strategy group were twofold: a definition of what future efforts should be and determination as to whether such efforts could be further supported by this Department. I am aware of your agreement on proposed functions, and while I believe this effort could be subject to further study and refinement, particularly as this Department more clearly defines its approaches to overall planning and to regionalization, this effort is a good start. Congress' recent action on the Reconciliation Act and the continued but limited federal funding proposed for HSAs for state fiscal year 1983 should serve as the basis for continued discussions among us.

From the outset, our discussions on additional Departmental support focused on the development of our policy budget and the competition of a number of expanded or new program efforts for limited resources. Divisions and separate offices submitted to my office in late July their proposed program activities for FY 83. On the basis of anticipated revenues, this office then directed the Divisions to refine those proposals which most clearly met the Department's needs and for which resources could be anticipated. The Division of State Health Planning and Development was directed to develop a budget increment that would replace lost Federal funds (both reductions in the SHPDA grant amount and major cutbacks in Title XVIII funds) and create the nucleus for a department wide program analysis and planning capability. The total amount available to SHPDA for these purposes was $200,000, far short of the additional $800,000 - $900,000 needed to reinstate lost HSA funds. Each program request had to be weighed against our urgent need for additional correctional facilities; our need to produce a comprehensive public health plan that addresses our

our relationships to the Alaska Native Health Service and our role, if any, in the direct delivery of services; the need to cope with the rising demand for mental health services including those of emotionally disturbed children, and overall management and information processing needs. A key factor in this evaluative process is our awareness of executive and legislative branch interest and our own commitment to restraining the growth and expansion of state government programs. The urgent needs identified and a limit on what increase in overall budgets could reasonably be defended did not permit us to include an additional $800,000 - $900,000 for regional health planning efforts.

Our inability to include additional funds for regional health planning in our proposed budget cannot be interpreted as a lack of support or interest in this capability. Alaska has in fact, supported this effort more extensively than any other state of which I am aware. I have strong interest in a capability that will provide input and insight from a regional level on the wide range of health, social service and correctional issues this Department is responsible for addressing. I believe we are in agreement that the health planning system as we know it could profit by the elimination of many compliance type activities and the freedom to focus on and assist in resolving issues of mutual concern. This Department will continue to be supportive of efforts to revise and finance a system that is even more responsive to the variety of health related needs that Alaskans have.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

cc: Jay S. Hammond
Paul Sherry
SEAHSA
SCHPD

APPENDIX V: Proposal by state HSA-coalition for revised Alaska HSA.

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.

I. 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.

APPENDIX VI: Testimony from HESS interim hearings.

The following comments are taken from remarks made at the Committee hearings in Fairbanks, Soldotna, Nome and Bethel during the interim between the first and second sessions of the Twelfth Legislature. They are included here as part of the record on HSAs.

Note will be made of any remarks addressed to this subject at the Anchorage HESS hearing and will be added to the committee files prior to the beginning of the next session.

Fairbanks Senate HESS hearing, September 12, 1981:

Charles Kaltenbach is the executive director of the Northern HSA (NAHRA). He stated that the federal government had overstructured the HSAs and expected too much from the agencies. He spoke of the functions of the HSAs, and felt they could and should be modified to reflect needs of the State. He agreed that a fresh look at the HSAs is needed, and mentioned some specific functions that could be carried on by a revised HSA. He stated that the NAHRA board was unanimous in its opinion that the present limit on certificates of need was too low, and pointed out that in its proposal review function NAHRA had managed to help save (or keep from being spent) hundreds of thousands of dollars which would have gone to provide duplicate or unneeded services in its region.

Michael Graf is director of mental health services for the Tanana Chiefs Conference. He commented that he is an advocate of the HSAs, and that he does not apply for funds without first checking with the HSA staff so that he might take advantage of their expertise He stated he felt there might be some dissatisfaction with the HSAs because they sometimes had to say "no" to those who were applying for funds for health care programs or facilities, and whose applications were reviewed through the HSA reviewing process. As a member of the SHCC he said he knew how much state agencies relied on HSA provided information.

Wayne Myers spoke in a capacity as private citizen. He remarked that the HSAs were the only group with no vested interest in specific health care programs, and that therefore their function was particularly useful.

Soldotna Senate HESS hearing, September 26, 1981:

Karen Carpenter, has been in Alaska since 1970, and is trained as a nurse. She commented that although she had served on the Southcentral HSA (SCHPD) board from 1976 - 1978, she felt she had had no real opportunity to give an opinion on many of the issues that came before the board.

Beth Taescher has been a school nurse in Alaska for 12 years. She stated that she was interested in seeing health planning continuing, but that it should be set apart from government... HSAs had provided for local input and raised consciousness. She was not sure if the present (HSA) system of health planning should continue as such, or a different system for local input be devised. She has been a member of the Southcentral HSA (SCHPD) board for three years.

Michael Herring is administrator of the South Peninsula Hospital in Homer. In response to a direct question regarding the HSAs, he commented that most members of the hospital association questions the need for three HSAs in Alaska, although maybe they had a valid function as reviewers of capital projects, as opposed to acquisition of new equipment.

Nome Senate HESS hearing, November 7, 1981:

The hearing opened with Jeanette Morton, representing the Norton Sound Health Corporation, reading testimony from William Dann, former executive director of the corporation. Mr. Dann's written comments on HSAs are included in the following appendix which includes written testimony received by the Committee.

Bethel Senate HESS hearing, November 14, 1981:

George Peratrovich, a member of the Southcentral HSA (SCHPD) had questions regarding legislative plans for the future of the HSAs in Alaska. He stated that the HSA had been very useful in providing technical assistance in Bethel, and that the HSAs are looking at forming a coalition, reducing board numbers and changing the types of services rendered. It was also stated that there should be better coordination between the HSA and alcohol programs (presumably to review the same).

APPENDIX VII: Written comments on HSAs submitted to Senate HESS Committee during the interim.

ALASKA
CHAPTER

NATIONAL
ASSOCIATION OF
SOCIAL WORKERS, INC.

P.O. BOX 10430
FAIRBANKS, ALASKA 99701
907 - 456 - 5914

October 29, 1981

Senator Charlie Parr
SR Box 50599
Fairbanks, Ak. 99701

Dear Senator Parr:

We are writing to express our support for the Northern Alaska Health Resources Association. We understand they are seeking state funding during this next legislative session to replace the anticipated loss of federal funding for their program.

We are aware that a few individuals have expressed opposition to this agency and have publicly stated that the way to improve health and social services in our community would be to eliminate the "bureaucrats" and put more money into direct service delivery. We wish to state our opposition to that type of shortsighted thinking.

Since the Reagan administration has singled out social services for deeper reductions based on his belief that the disadvantaged should be helped by "charities" rather than government intervention, we can expect more cuts next year. As program dollars become tighter, there is a risk that program administrators will cut back on services to client groups where the costs are greater--the rural poor, minority groups, the severely disabled,etc. Thus,.there is a greater need for agency planning, evaluation, and monitoring to insure that the programs are reaching the clients they are designed to serve.

NAHRA has played a vital role in the northern region in needs assessment and program evaluation. Some of the programs, for example, that they have not recommended for funding would have cost us a lot of money. Other health and social service agencies in the community rely upon them for statistical information to help them plan better programs. For example, they have done extensive research on the alcoholism problem and just recently their staff and Board members were instrumental in sponsoring an Alcohol Awareness week program.

We do not believe this agency is duplicating the services of any other group in the community including the City's Health and Social Service Commission. We urge you to consider funding this agency and are willing to supply your committee with additional information if needed.

Sincerely,

Marsha Schneider, MSW
Executive Director

ms/ms

CHARLIE PARR

ALASKA LEGISLATURE

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November 3, 1981

Marsha Schneider, MSW
Executive Director-Fairbanks Chapter
National Association of Social Workers, Inc.
P. O. Box 10430
Fairbanks, Alaska 99701

Dear Ms. Schneider:

Thank you for your letter of October 29 regarding continuation of the health systems agencies. The Senate HESS Committee has been studying this question (along with many others) during the interim.

In addition to holding public hearings in Fairbanks, Anchorage, Nome, Bethel and Soldotna, we have sent questionnaires to every health care professional in the state and 3,000 out to the general public. Sandra Stringer has also been doing research on this matter.

Out of all this will come the Committee's recommendations. Your letter is appreciated and copies will be made for all committee members as we try to decide what to do about the Federal funding cuts for these agencies.

Sincerely,

Charles H. Parr

cc: Sandra Stringer
Senate HESS Committee members

CHP:dm

NORTH STAR COUNCIL ON AGING, INC.
P.O. BOX 73888 • FAIRBANKS, ALASKA 99707-3888
AREA CODE 907-452-1735

September 10, 1981

Senator Charles Parr, Chairman
State of Alaska Legislature
Health, Education and Social Services Committee
SR Box 50599
Fairbanks, Alaska 99701

Re: Health Care Costs and Concerns

Dear Senator Parr:

We have your communication of August 18th concerning the for-hcoming public hearings on the above subjects. As we are all deeply involved in some activities for the North Star Council on Aging on Saturday, September 12, 1981, it will not be possible for us to be in attendance. We have therefore decided to provide you with our written input, trying to include answers to some of the questions posed in your included questionnaire.

HEALTH CARE - It is our feeling that there is not sufficient coverage included in the present health care provided within this community. What is there is good but it doesn't begin to meet the needs either physically or financially. We are well aware that the home health aide and the home health care visiting nurses have reached a maximum number of clients to serve under their present staffing and funding.
We do not see any particular transportation problems for receiving health care except possibly for weekend occurences. It has been our experience that the EMS answers calls very promptly and does an excellent job.

HEALTH CARE COSTS - We are cognizant of the fact that many of our Seniors have allowed their health care coverage to lapse due to increased premium costs as well as insufficient rebates received because of the excessive costs by both physicians and hospitals within the State of Alaska. We especially find this to be of utmost concern to women between the ages of 60 and 65 years of age, extreme to some points where it has caused an extremely depressive mental condition for some.

Major reasons for rising costs of health care listed in priority order include: (1) Salaries and increase in number of health personnel perhaps due to population increases (2) Too rapid perhaps hospital expansion and new equipment costs; we feel that insurance companies are perhaps being exploited by both doctors and hospitals particularly since Medicaid has almost become a blank check coverage (3) Inflation.

Suggestions to curtail health costs include a closer audit/scrutiny of medicare/medicaid billings; unless a person is insistent on receiving an itemized statement for services rendered and supplies furnished, there is no requirement on the part of hospitals/doctors to furnish itemized statements;

since there is no particular check on the individuals particularly receiving medicaid coupons for treatment, there is the opportunity for "padding" of bills.

HEALTH PLANNING - We have very mixed emotions concerning the maintenance of funding for three health care systems in the state. It is our feeling that our interior agency, Northern Alaska Health Resources Association, does an excellent job and we look to them for much guidance when writing our own grants and always appreciate their review of our grant applications. However, it is also the concensus of many of the Alaskan Project Directors, such as myself, that the other two agencies within the state do not collaborate with the projects in depth as does NAHRA. We enjoy a mutual contact with NAHRA.

We do feel however that if the health systems agencies continue to be funded, then there is much need for more public education particularly in the rural areas; needs assessments are completely useless unless the results and planning as a result of these assessments can be implemented.

GENERAL - We are aware of the following services available within the Fairbanks community: family planning, physicians doing home deliveries/ nurse midwife/lay midwife, homemaker/home health services, long term care for the elderly and disabled, community services for the mentally ill, community services for the alcohol/drug dependent, preventive health services.

We are extremely concerned for the future of our youth and feel that it should be included in the mandatory curriculum of the public schools that health education, particularly alcohol and drug abuse, be implemented as quickly as possible.

We appreciate having the opportunity to comment on the above matters and hope that the next year will see some changes made in the health care coverage not only for the elderly but for all Alaskans as well. These comments are made by the staff of North Star Council on Aging from our personal observation and knowledge about the clients that we serve.

With our best wishes, we remain

Sincerely,

Genevieve Reininger
Executive Director

GR:s

TANANA VALLEY MEDICAL-SURGICAL GROUP, INC.
(A PROFESSIONAL CORPORATION)
1001 NOBLE STREET • FAIRBANKS, ALASKA 99701 • PHONE 452-1511

September 16, .981

Senator Charlie Parr
Chairman
Senate Health, Education and
Social Services Committee
545 3rd Avenue - Suite D
Fairbanks, Alaska 99701

Dear Senator Parr:

I regret that I did not have time to testify before your committee when you held open hearings here in Fairbanks concerning health care and health care delivery systems in Alaska. I think that many answers to the questions raised by your committee can be found in the several studies made by the Northern Alaska Health Resources Association, Inc. which, of course, the State of Alaska has supported financially for several years. These people have been trying to find the answers to health related problems for some time and they have, as a result, learned a great deal about the subject.

There are several items that I would like to address in my comments here; they are as follows:

1) I do not think that the State of Alaska should provide medical assistance beyond what it is now providing, for two reasons:

   a) Free and unrestricted support of a medical service program would be enormously expensive to the State of Alaska.

   b) The Department of Health and Social Services is in no shape to take on the responsibility of administering a much larger program.

   (The latter I specifically mention since we have been involved in health support services (Medicaid) for many years. During that time, we have suffered untold frustrations, deceptive and deceitful business practices, not to mention financial loss in our dealings with the State Department of Health and Social Services.)

2) I do not believe that the State should provide a subsidy for health insurance coverage for all Alaskans because most of them have this coverage already in one form or another which is in most cases adequate and compared to the type

of health insurance coverage suggested by House Bill 41, costs practically nothing. Furthermore, it is my belief that the type of health insurance coverage inferred by House Bill 41 would actually be a step backward for quality medical service in Alaska because it would allow people who are really not sick to jam doctor's offices and make it difficult for sick people to get the kind of care that may be needed. I do, however, feel that catastrophic cases do not receive the attention they deserve.

3) I think the emergency medical services system in Alaska is working very well at the present time, progress seems evident and under the circumstances, there does not appear to be any real need for State assistance beyond what is offered at this time.

4) The Northern Alaska Health Resources Association has done a very commendable job of structuring regional health planning and has spent a great deal of time and money already. Therefore, to duplicate this effort would be wasteful and unnecessary.

5) The Northern Alaska Health Resources Association has done a great deal in the areas of prevention and promotion of health matters. It would seem to me that this group should be encouraged and supported. If there are weaknesses in our delivery system, it would seem likely that they could be helpful.

6) A great deal is happening on a statewide basis in the health services field. Not only is there a great effort being made in the Alaska Native Health Services area, but the doctors throughout the state are united in attempting to improve their approach to medicine through self-evaluation and peer review. There are a good many professional organizations such as N.A.N.R.A. who are directly involved and working in the medical services area also. In view of this great activity, it does not appear that an additional agency of any kind would be needed; rather, it would seem that an evaluation of what services are being offered to various groups of Alaskan citizens to learn if there is a maldistribution of medical services and if there is, in what areas of medical service does this disparity exist.

There has been criticism regarding the costs of medical and dental care. I am not in a position to defend the cost of dental care, but I do know that medical care, as far as physicians' charges are concerned, has advanced at about the same rate as any other good or service in the state of Alaska. To confirm this statistic, I refer you to the last issue of the "Fairbanks North Star Borough Community Research Quarterly." On page 74, you will note that Fairbanks, even though

situated in a very high cost area, is only .5 of 1% higher than the national norm. These figures, of course, are only for the most recent 12 month period. However, they are quite typical of the trend set some years back. Yes, medical/dental prices are too high, but so are food prices, housing prices, apparel prices, transportation costs and all other costs too high, in my view.

There has been some mention made of residential care for handicapped children and adults. Under a state-sponsored program, the Fairbanks Health Center is doing a creditable job and certainly before anything further is done, agencies like the Fairbanks Health Center should be brought into the planning process and their experience utilized. From such contributions by state agencies, it can be pretty well determined what the real need might conceivably be on a long-term basis.

Thank you very much for inviting me to appear before your committee, and I apologize once more for not having been able to make an appearance there. Perhaps you will accept this letter as a substitute.

Very truly yours,

Ralph A. Wells, M.D.

RAW/das

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.

initiated to have the United States match 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 be 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 data 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's 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-

Alaska Weekly Vol 11 #49 6/12/81 P 11

Health Agency Accountability, Methods Are Questioned

By FRANK GOLD
Executive Director, KILA, Inc.

On April 21, 1981, I attended a meeting of the Northern Alaska Health Resources Association (the regional health systems agency for Northern Alaska).

On May 4, 1981, I read a short bit of fluff in the Fairbanks Daily News-Miner which bore little relationship to what happened at the meeting. It was then that I suddenly realized that no members of the press was present at the meeting nor were any other members of the public.

[illegible]

STATE OF ALASKA
Rural Development Council Meeting

June 19-20

[illegible]

UNION DIRECTORY

PLUMBERS AND STEAMFITTERS

[illegible]

APPENDIX VIII: Information on HSAs taken from responses to Senate HESS questionnaire sent to professional health care providers.

The Senate Health, Education and Social Services Committee sent out health questionnaires during the 1981 session interim to 5,279 health professionals in the state of Alaska. The names were obtained from the Division of Occupational Licensing, and forms went out to only those professionals who had a resident address. The breakdown on the questionnaires is as follows:

PROFESSION	SENT OUT	%	RETURNED
Physician	623	18%	116
Nurse	3,446	5%	189
Advanced Nurse Practitioner	33	24%	8
Physician Assistant	116	10%	12
Pharmacist	173	8%	15
Psychologist	66	19%	13
Dentist	290	7%	23
Dental Hygienist	181	3%	6
Optometrist	27	22%	6
Optician	42	9%	4
Chiropractor	44	20%	9
Administrator	29	13%	4
Anonymous/Occupation unknown			20
TOTAL	5,279	8%	425

HEALTH PLANNING

1. The Federal government plans to discontinue funding health planning agencies(HSAs) by 1983, do you think the state should continue funding our three HSAs?

Yes	103
No	171
No response	95
Unknown	54

2. Have you had any personal contact with your HSA?

Yes	169
No	247
No response	16

In what capacity?

Observer	50
Member	32
Advisor	30
Through C.O.N.	18
Provider	11
Testifies	4
Task Force	3
Hospital Committee	3

3. Do you think your HSA does a fair representation of your profession?

Yes	90
No	146
No response	105
Unknown	82

4. Can you see any needs for restructuring state health planning?

Yes	181
No	39
No response	177
Unknown	26

What issues need more attention?

1.	Prevention, wellness promotion	61
2.	Rural health accessibility, mobile clinics	35
3.	School Health Education	19
4.	Cross-cultural planning, prevention of service duplication	16
5.	More local planning control	14
6.	Alcoholism	10
7.	Competition in private sector	9
8.	EMS council, communication, transfer agreements	8
9.	Reduce political nature of HSA	8
10.	More local mental health services	7
11.	Services for the elderly	6
12.	More professional planners, fewer government planners	6
13.	More advertising, consumer information	6
14.	Reduce CON paperwork	5
15.	Include rural hospitals in planning	5

5. Is the catchment area of your HSA meaningful?

Yes	66
No	50
No response	254
Unknown	53

If no, how would you envision its redefinition?

1.	Abolish HSAs	32
2.	Separate Anchorage	16
3.	One HSA only	9
4.	Create Rural HSA	2

SECTION 6

Alaska's Emergency Medical Services

CHARLIE PARR

ALASKA LEGISLATURE

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M E M O R A N D U M

DATE: December 1981

TO: All members of the Senate HESS Committee

FROM: Sandra Stringer, Legislative Assistant

SUBJ: Alaska's Emergency Medical Service

* * * * * * * * * * * * * * * * *

This report on the State of Alaska's Emergency Medical Service was prepared at the request of the Senate Committee on Health, Education and Social Services. It is intended not as a comprehensive overview of Alaska EMS, but rather as a compendium of information that is hoped will prove useful to the Committee in its legislative deliberations.

The report is designed in two parts. The first is a narrative summarizing and enlarging upon information obtained during the interim between the first and second sessions of the 12th legislature through interviews, attendance at numerous meetings and a review of various pertinent written documents. The second portion of the report is a series of appendices containing copies of miscellaneous reports, letters, etc., thought to be of use in expanding understanding of related subtopics. Also, throughout this "briefing paper", reference is made to additional material on EMS contained in the Committee master file but too lengthy to reproduce in this report.

I would like to especially thank Mark Johnson, State EMS Coordinator, Jennifer Gleason, Laura Anderson and Tom Scott, Regional EMS Directors, Jeanne Ostness, Interior Region Sub-area Coordinator, and Dr. Bill Wennen, M. D., Chairman of the Advisory Council on Emergency Medical Services, for their assistance and patience in responding to numerous requests for information during the preparation of this report.

SS:dm

Emergency Medical Services: History

In the fall of 1966 the National Academy of Sciences published a document entitled "Accidental Death and Disability: The Neglected Disease of Modern Society." At that time only three or four states were offering courses specifically designed for the training of ambulance personnel. Partly as a result of the National Academy of Science's report the Highway Safety Act of 1966 was enacted, charging the federal Department of Transportation with the responsibility of establishing national emergency medical services standards.

The goal of establishing EMS standards was to assist state and local communities in upgrading their prehospital emergency medical care. A series of national training courses were developed establishing a set of skills the mastery of which resulted in the emergence of a new profession, the emergency medical technician.

By 1973 the federal government had enacted Title XII of the Public Health Service Act, the Emergency Medical Services System Program (PL 93-154), later amended in 1976 and 1978. The purpose of this legislation was to provide assistance and encouragement for the development of comprehensive emergency medical services systems throughout the United States.

(The preceding information is taken from a report prepared by Jeanne Ostnes, Interior Region EMS Council. Please see Committee master file for complete, untitled, report.)

Although various communities in Alaska were able to take advantage of federal EMS funding, by 1978 federal funding was dwindling. However, 1979 saw the enactment of Chapter VIII of Title XVIII of the Alaska Statutes (see Appendix I), and the beginning of state funding for Alaska Emergency Medical Services.

The Emergency Medical Services Section, Division of Public Health, Department of Health and Social Services, is responsible for carrying out the mandate of AS 18.08.010.

"'The department is responsible for the development, implementation and maintenance of a statewide comprehensive emergency medical services system and, accordingly, shall...

1. Coordinate public and private agencies engaged in the planning and delivery of emergency medical services to plan an emergency medical services system;

2. Assist public and private agencies to deliver emergency medical services through the award of grants in aid.'

Furthermore, the EMS Section is responsible for carrying out the provisions of federal grants received by the state under Title XII of the Public Health Service Act relating to emergency medical services." (Quoted from Page 3 of A Five Year Plan For Emergency

Medical Services Along Alaska's Highways: 1980 through 1984, prepared by the Alaska EMS Section of H & SS. A copy of the complete report is available in the Committee master file.)

In carrying out its responsibility, the Alaska EMS Section of the Department of Health and Social Services works in conjuction with various other groups and agencies, including Highway Safety Planning Agency of the Alaska Department of Public Safety. (The EMS Section assists Highway Safety in developing the EMS component for the Highway Safety Program. In return the HSPA helps EMS via financial assistance available through the federal Highway Safety Act Program.)

Emergency Medical Services: Structure

The Emergency Medical Services Section provides technical assistance and awards grants to the three (soon to be four: see Appendix II) EMS regions within Alaska. In general, state EMS fills a coordinating function, as described in the previous section. A diagram, taken from page 15 of the Five Year Plan, might best serve to illustrate the EMS Section's relationship to other elements of state goverrment. (See Figure I on following page.)

In addition to the staff of the EMS Section (see Appendix III), a physician, Dr. Tim Samuelson, State EMS Medical Director, is employed part-time to provide overall medical direction. (Also, all regional programs have medical directors working at the regional and local levels to provide additional medical supervision and direction.)

In any discussion of EMS mention must also be made of the State Advisory Council on Emergency Medical Services (ACEMS), referenced in the diagram cited above. ACEMS was established in 1977. It is mandated to:

1) Advise the Commissioner of Health and Social Services with regard to the planning and implementation of a statewide emergency medical services system;

2) Assist the Statewide Health Coordinating Council in performing its duties under AS 18.07.011 relating to emergency medical services.

The purpose of ACEMS is to:

"1. Bring together technical resources, experience and knowledge to assist the development of an EMS system in Alaska;

2. Advise the State EMS staff and Regional Coordinators regarding public education and generation of broad community support for the goals of the EMS program;

3. Recommend EMS program policy;

4. Provide guidance and direction to State EMS staff;

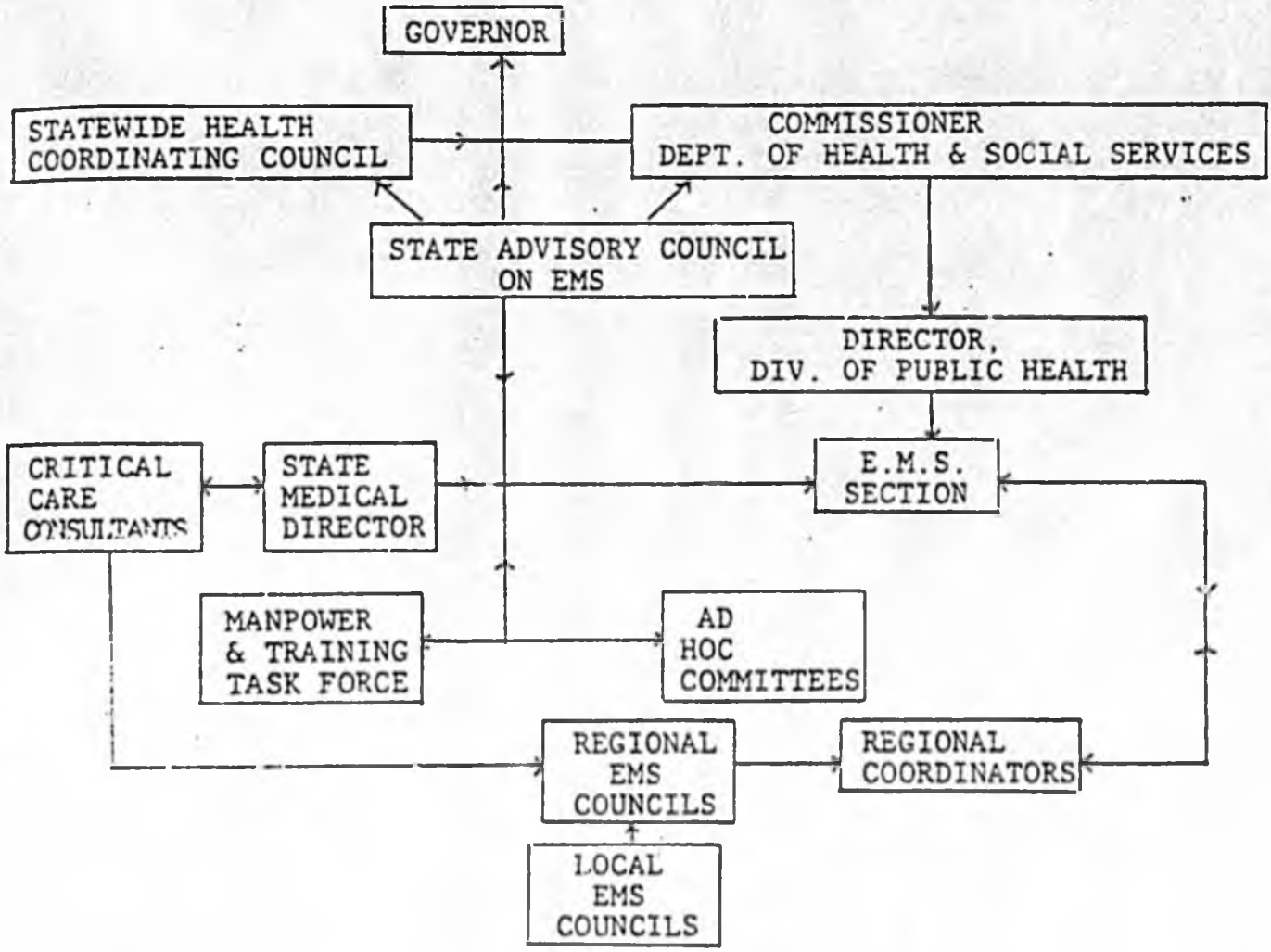

Figure I:
Relationships Between EMS Officials and EMS Advisory Bodies

Figure reproduced from page 15, "Five Year Plan for EMS Along Alaska's Highways: 1980 - 1984."

5. Review EMS or EMS-related program proposals per request of the Statewide Health Coordinating Council (SHCC) and the EMS staff;

6. Review EMS budgetary allocations and program priorities and advise the Commissioner on these matters."

(Quoted from Page 12 of A Five Year Plan for EMS Along Alaska's Highways: 1980 through 1984. Additional information on ACEMS, its composition and some of its accomplishments, may be found in Appendix IV.)

Emergency Medical Services are delivered on a local level within the state. Planning for and coordination of delivery of these services is currently carried out under the oversight of three EMS regional councils. (See Figure II, map.) In addition, each council is composed of membership from many local advisory groups. The relationship of the regional and local advisory groups might best be summarized as follows:

"EMS systems development in all three regions is coordinated through nonprofit incorporated Councils: the Northern Region EMS Council, Inc.; the Southern Region EMS Council, Inc.; and the Southeast EMS Council, Inc. All three Councils, in addition to carrying out their powers and functions as boards of directors, provide advisory council functions as well. They represent professional, consumer and geographic interests, including representation from each sub-area or major community in each region. All Native organizations active in EMS are also represented.

In addition to the region-wide councils, most sub-areas also now have active advisory councils. In some sub-areas associated with Native Health Corporations, the Boards of these corporations also serve as the EMS Board. Others have separate EMS advisory groups.

Currently, there are three sub-regional councils in Northern Region; seven sub-regional councils in Southern Region; and in Southeast, there are active local EMS councils in eight communities." (Quoted from Page 18, A Five Year Plan For Emergency Medical Services Along Alaska's Highways: 1980 through 1984.)

Lists of EMS Coordinators, Medical Advisors, Regional Council Membership, the ACEMS Board, etc., may be obtained in the 1981 Alaska EMS Directory, prepared by the EMS Section, and available in the Committee master file.

Emergency Medical Services: Goals and Problems

The overall goal of the EMS program is to "establish a comprehensive, coordinated system of emergency medical services which assures that citizens and visitors gain easy access to services; that initial response is expeditious; that appropriate life saving and stabilization measures are rendered at the scene; and that patients are transported or transferred in a timely and efficient manner to facilities capable of effecting maximum recovery and rehabilitation." (Quoted from Page

1. *NORTHERN*
   - *a. North Slope*
   - *b. N.A.N.A.*
   - *c. Interior*

2. *SOUTHEAST*

3. *SOUTHERN*
   - *a. Norton Sound*
   - *b. Yukon-Kuskokwim*
   - *c. Mat-Su*
   - *d. Anchorage*
   - *e. Copper River*
   - *f. Prince William Sound*
   - *g. Kodiak*
   - *h. Aleutian/Pribilof*
   - *i. Bristol Bay*
   - *j. Kenai Peninsula*

* *The three EMS regions are contiguous with the three HSA's (Health Systems Areas) in Alaska.*

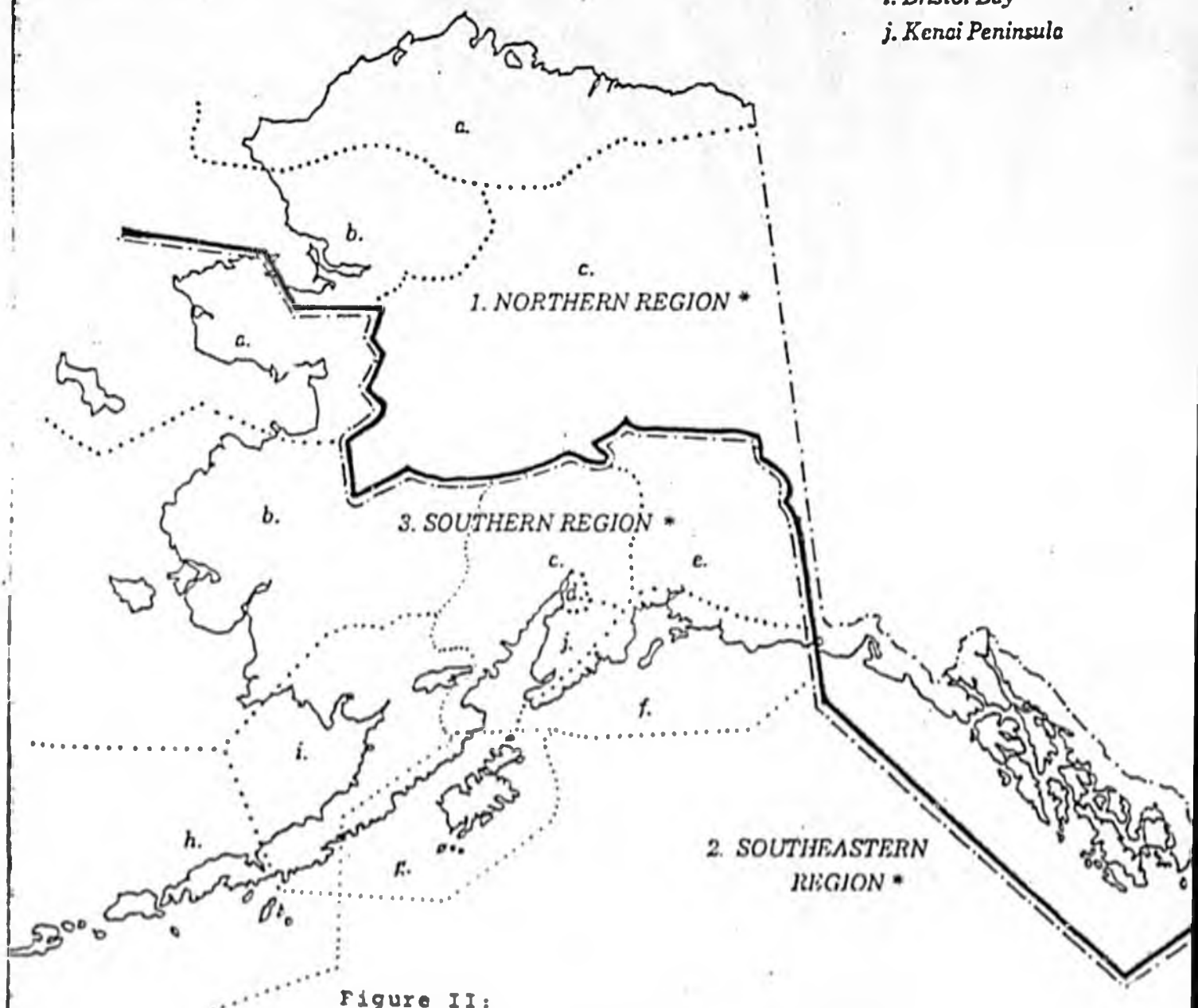

Figure II:
ALASKA EMS REGIONS & SUB – AREAS
FY 81
Copied from: "A Five Year Plan for EMS Along Alaska's Highways: 1980 - 1984."

VI-11, Alaska EMS Goals, A Guide for Planning Alaska's Medical Services System, printed in 1981, by the EMS Section, Alaska DHSS.)

Nationally, fifteen components have been identified as essential in establishing a comprehensive EMS system. Goals for state and local EMS programs in Alaska are grouped according to these fifteen components. (See Appendix V for a list of these goals.)

Whatever the stated goals, because of the large size of Alaska, small population and many scattered rural communities, Alaska EMS has its work cut out for it in attempting to organize a comprehensive and quality emergency medical service program statewide. In a draft copy of the Department of Public Safety Highway Safety Plan for FY 82 the situation is summed up as follows:

"Large areas have no communications either by telephone, radio or any other rapid means. This prevents the few existing ambulance services from being notified of accidents. Dispatch services are often non-existent.

The few sparsely inhabited communities that are located along the highway system lack a tax base to support EMT training, purchase equipment and supplies, or provide anything else to implement viable EMS services.

Existing ambulance services often have no agreements covering procedures for back-up support, patient transfer from service to service, or equipment compatability and retrieval. Protocol for air evacuation has not been developed.

Public awareness of the nearest emergency medical services and the means to access them must be developed and expanded. In 1978, the number of travelers entering Alaska at the Alaska-Canadian Border Station was 109,621; in 1979 slightly fewer travelers entered the state. These persons particularly need information before traveling on the Alaskan highway system.

In summary, the major problems are: 1) lack of communication; 2) lack of EMS services, and 3) lack of consumer awareness of EMS services."

In addition "...emergency medical services are inadequate because of antiquated or lack of equipment, insufficient communication networks and lack of initial and standardized training of personnel."

Emergency Medical Services: Problems and Solutions

Having outlined the major basic problems facing EMS in Alaska, it might be appropriate to outline some of the plusses. The following comments are taken from Mark Johnson, Alaska EMS Coordinator, in the EMS-Alaska Response publications, for May/June/July 1981, page 3 and4:

"Now that the Alaska EMS program is 100 percent funded by the state, it may be a good time to reflect on what has been accomplished, and to decide future priorities...

Since the first EMTs were trained more than a decade ago at the Public Safety Academy, there has been phenomenal progress in EMS in Alaska. At last count, there were at least 65 ambulance services statewide, with 14 new services organized within the past year. Virtually all of these services have basic or advanced trained EMTs with modern vehicles, equipment, and radio communications. There also are more military and civilian helicopters, and other aircraft, available for medical transportation. Throughout the state, there now are more than 3,000 certified EMTs with many more people trained as EMTs, but not certified. This gives Alaska the distinction of having more EMTs per capita than any other state. In urban areas, there are 47 licensed paramedics, with 6 more soon to be licensed.

We have seen the birth of emergency medicine as a board certifiable medical specialty, and a few urban hospitals in Alaska now are employing emergency physicians to staff emergency departments. In addition to the array of medical specialities and specialized critical care units now available in our urban areas, we have seen large numbers of physicians, nurses, and mid-level practitioners throughout the state certified in the American Heart Association Advanced Cardiac Life Support course. Numerous other courses on emergency medical topics also have been offered to hospital and pre-hospital personnel, and recently a course adopted by the American College of Surgeons, called Advanced Trauma Life Support, has been offered to physicians, primarily from rural areas, who ofte don't have surgeons and other specialists immediately available.

Thousands of citizens and first responders, statewide, have been trained with assistance from the Red Cross, Heart Association, and EMS providers in first aid, CPR, or emergency trauma training, with increased efforts directed to training in remote areas, including logging camps and other high risk occupation sites. Successful efforts also have been made in many communities to get some of these courses offered in schools.

Emergency communications have improved greatly, although much more still needs to be done. By the end of next year, most ambulance services along major highways will be able to talk to their base stations, troopers, and hospitals. However, gaps continue to exist in some places. Communications also have improved in many bush areas, but reliability contirues to be a problem in many villages. In urban areas over 80% of the population now can access emergency services by dialing the universal access number 911. This means that a larger of Alaska's population is covered under a 911 central access number than any other state. A few major communities still need to upgrade to the 911 system, which has been proven through numerous studies to reduce response times from the onset of medical emergencies until medical responders arrive at the scene.

Disaster planning also has been given increased attention in many communities. Emergency services personnel throughout the state have had training in aircraft and other mass casualty disaster response,

and disaster drills have been conducted with involvement of military and civilian personnel. An example of the pay-off of these cooperative efforts was the fantastic rescue of all passengers and crew from the burning ship "Prinsendam" in the Gulf of Alaska last fall.

Given the tremendous progress that has been made so far, any consideration of future priorities should not hinder progress in these essential program areas. Rather, we should endeavor to continue the progress which already has been made in addition to adopting any new priorities."

In the same article, after summarizing program accomplishments, Johnson continues by discussing EMS priorities for the near future.

"Some new priorities of the State EMS Office are based on legislative mandate, such as standardizing the certification of EMTs These regulations soon will be adopted and have involved input from dozens of EMTs, physicians, and ambulance services during the past three years. During the next few months, this office will begin all certification of EMT-Is, IIs, IIIs and Instructors. To assist us in this effort, a training committee has been established by the State Advisory Council on EMS; a state training coordinator position is being established; and a computerized system to keep track of each EMTs certification status will become operable, with one one of its main functions being to notify EMTs in a timely fashion of their recertification requirements.

We also hope to use the new, statewide instructional television network to provide training and continuing education programs to EMS responders and citizens throughout the state, and we plan to work with EMS experts in developing more definitive, up-to-date field treatment guidelines for especially difficult medical conditions. This year the emphasis will be on hypothermia and cold water near-drowning.

Other priorities include increased attention to evaluation of programs to determine their potential impact on saving lives and reducing disability; imporved coordination between EMS responders and accident prevention programs; and more communication between all levels of EMS professionals and volunteers.

Public information and education programs also should be given major emphasis. As a beginning toward this effort, we recently have developed two brochures - one titled "EMS on Alaska's Highways" and the other titled "Welcome to Alaska - Have a Safe Trip!" which provides safety tips for tourists planning to visit our state. Another program we hope to initiate during the coming year, in cooperation with the Alaska Division of Emergency Services, is a public education program on what to do, or what not to do, during a major earthquake."

(Note: the regulations referred to in this article become effective January 1, 1982. Please see Committee master file for a copy. The two brochures are included in the Committee master file.

Emergency Medical Services: Observations and Recommendations

For purposes of discussion emergency medical services can be broken down into several categories: personnel, communications, equipment and transportation. The following is a summary of these categories, plus some recommendations for possible Committee action.

Personnel

People are the underpinning of EMS. Many emergency medical technicians (EMTs) are volunteers, members of volunteer ambulance departments, volunteer fire departments, or just people who want to be ready to help others in a medical emergency should the need arise. Other EMTs are paid professional members of police or fire departments, the military, village health aides, etc. EMT training emphasizes emergency (not routine) medical procedures designed primarily to provide prehospital stabilization and immediately needed medical assistance to people involved in accidents or experiencing a medical crisis. The skill classifications of EMTs are defined as follows:

ETT (Emergency Trauma Training): A 40-hour course developed by the Public Safety Academy and the Southeast Region EMS Council, especially for workers at isolated high risk occupation sites, which emphasizes emergency care for trauma victims, as well as medical communications and med vac preparations.

EMT-I (Emergency Medical Technician I): An EMT-I, as certified by the Alaska Department of Health and Social Services, has successfully completed a course, at least 81 hours in length, which incorporates the in-classroom objectives of the U.S. Department of Transportation, Basic Training Course/Emergency Medical Technician, plus knowledge and skills of pneumatic anti-shock device application. To be certified, the EMT-I may perform basic life support and emergency care, and apply pneumatic anti-shock devices (MAST suits).

EMT-II (Emergency Medical Technician II): An EMT-II, as certified by the Alaska Department of Health and Social Services, may perform the activities of an EMT-I, and under verbal or written orders of a supervising physician, insert esophageal obturator airways, apply rotating tourniquets, start peripheral IVs and use D5 & W, Ringers lactate, sodium bicarbonate, 50% glucase, and Narcan. The certified EMT-III must have sucessfully completed a Department-approved 50 hour course based on the appropriate modules of the U.S. Department of Transportation's National Training Course/EMT Paramedic; and must have six months experience as an EMT-I; and must pass a written and practical examination.

EMT-III (Emergency Medical Technician III): An EMT-III, as certified by the Alaska Department of Health and Social Services, may, in addition to performing the activities of an EMT-I and EMT-II, apply electrodes and monitor cardiac activity; defibrillate life threatening arrhythmias; use lidocaine, morphine for severe pain in trauma of the extremities, and epinephrine 1:1000 for anaphylaxis. The EMT-III must work under supervision and written or verbal orders of a sponsor physician; must have successfully completed a Department-approved course

of 24 or more hours; and must pass a written and practical examination.

Regulations governing training and certification of EMTs will go into effect on January 1, 1982. (See Committee master file for a copy of the regulations.) Within six months of this date all currently certificated EMTs must begin recertification, meeting standards set forth in the new regulations.

The state EMS Section, as well as each regional and local EMS advisory group, has medical advisory personnel whose purpose is to provide medical oversight and help provide training to Alaska EMTs. (Among other duties these medical providers devise "protocols" for EMTs to refer to in order to provide standardized treatment in particular types of medical emergencies. See Appendix VI for an example of such protocol.)

A frequent comment made to the Committee during interim hearings and during the course of research preparing this paper was the need for training EMTs. This need is expressed not only as a desire to train new EMTs to fill "holes" in the system, but also as a necessity to improve EMT skills through ongoing education, and to help prevent "skill decay".

Skill decay in EMTs was a topic mentioned with concern. Skill decay is loss of expertise in certain areas of medical practice not often called upon for use. Lack of use of various techniques leads to poor retention of skill in these areas. One method of skill retention is, of course, to see more patients with conditions requiring practice of these skills. This solution is usually impractical in a small and relatively scattered population. Another method is constant retraining of EMTs in order to retain and upgrade all skills, with special emphasis on strengthening these skills called upon less frequently in common practice.

One controversial area in the providing of emergency medical service in Alaska that will probably be brought to the legislature's attention again this session is the question of paramedics.

A paramedic is someone who has obtained EMS training over and above that of an EMT-III, with special emphasis on advanced assistance given to victims with cardiac problems. At least one volunteer fire department in Alaska now has on staff paramedics trained outside the state with state funds, and whose salaries are being paid with state monies. There are indications that at least two or three additional requests for funding paramedic training will be made to the legislature this session.

The controvery over paramedics revolves primarily over the issue of whether or not paramedical skills are needed in Alaska. Although the EMS state goals aim for paramedics in large, urban communities, testimony has been received that such skills cannot be kept upgraded by the few opportunities for their practice in Fairbanks. This may also be true of the situation in Anchorage. This argument views paramedics essentially as emergency care personnel whose main value lies in being able to provide immediate response (within minutes) primarily to victims of heart conditions (mainly elderly), and preferably while keep-

ing in radio communication with a physician while speeding the victim to a hospital. Others, however, argue that the greater skills of a paramedic make him/her a more valuable emergency medical care provider all around, and highly suitable as a trainer for other, lower skill grade, EMTs.

Other areas worth consideration while on the topic of paramedics are availability of training and funding. If the state deems paramedic skills worthy of encouragement and funds individuals to train for them, should the state also look at the possibility of setting up a source of paramedic training here in the state? And, once trained, should the state follow the precedent already set and plan to fund salaries for some or all paramedics working in Alaska? (For further information and background on the controversy over paramedics, please see Appendix VII.)

Currently, the state EMS Section is in the process of hiring an EMS training/coordinator. Some of the other needs expressed in the area of training at the local level have been the desire in some areas for Alaska-specific (and sometimes regional-specific) training manuals for EMTs, the need for new and replacement training equipment, and the need for a training building in the Interior region.

In order to provide training for EMTs, regional EMS councils employ training personnel who offer classes for teaching and upgrading of EMS skills. (To become certified, EMTs must pass nationally prepared exams.) In addition, the state EMS Section provides additional opportunities to upgrade skills through sponsoring a yearly symposium in Anchorage. The symposium features as speaker experts in various areas of emergency medicine and also an EMS skills competition. This year's symposium, held in mid-November, drew several hundred emergency medical personnel form all over the state. (A copy of the program guide for the symposium is in the Committee master file.)

The question has arisen of providing EMTs with legal protection from law suits. There are presently three versions of Good Samaritan legislation in Alaska statute. While some feel there is adequate protection for EMTs under present law, others do not. Early this summer draft legislation designed to deal with this problem was drawn up for the Department of Health and Social Services. The Department planned to offer this draft as a bill to the legislature during the second session. Since that time, on advice of the attorney general, the decision has been made not to offer the proposed bill to the legislature on the basis that such legislation, if ever challenged in court, would likely prove unconstitutional. A copy of this draft legislation plus much additional material on this subject can be found in the Committee master file. Other references on the topic are available through a small library on the subject at the state EMS office. A draft position paper from the EMS Section appears in Appendix VIII.

The question of providing insurance for Alaska EMTs has also been raised. The little testimony received on this topic is contradictory. The Committee may, however, wish to pursue the topic with the state EMS Section this coming session.

In the area of personnel, final mention might be made of the recently published Alaska EMS Goals: A Guide for Planning Alaska's Emergency

Medical Services, published by the EMS Section of the Department of Health and Social Services in 1981. This document lists ultimate EMS manpower goals according to a breakdown of communities bases on the "levels of care" system presented in the Alaska State Health Plan. Excerpts from this report are included in Appendix IX.

Communications

Many comments pointed out communications as a general problem area in EMS. However, aside from a few specific suggestions, the general feeling seemed to be that the problem was being worked on and that what was needed for the present was time to fully develop a communications plan for EMS. Work is proceeding on this plan with the newly organized Division of Communications in the Department of Administration.

Each Regional EMS council has a communications committee working in conjunction with the state, and with the communities within the region.

A compilation of material on EMS communications needs was made last session by Brad Brooks on behalf of Representative Brian Rogers. This compilation is available in the Committee master file.

Two communications areas that might require legislative assistance are continued funding of repair of present EMS communications equipment and possible pick-up of funding for village health aide (also used for EM phone lines, where such funding has been dropped by Indian Health Service. (See transcription of comments made at Nome HESS interim hearing in Appendix X.) Further information on these needs will probably be presented directly to the Finance Committees, along with requests for funds in these areas.

A final mention under communication might be made of the value to EMS of a centralized, coordinated dispatch system, especially the "911" system. Legislative encouragement of as many communities as possible adopting this system statewide would do much to expedite faster delivery of emergency medical services in Alaska. This could probably best be done by appropriations to assist communities in adopting or adapting to the 911 central dispatch system.

Equipment

The most frequently made comments regarding EMS equipment were those emphasizing need for funds to purchase new and replacement training equipment for the various regions, remarks about the difficulties in retrieving equipment (stretcher, etc.) sent in with a patient to a central hospital, and the need for medical oversight of major equipment requests made by local and regional EMS organizations to the legislature.

Theoretically, requests for capital monies for equipment purchases are made through the EMS Section's official presentation to the legislature. The equipment requested in this fashion has been screened through examination of the requests at the local, regional and state levels by medical and communications consultants and vetted for need and suitability. In actuality, while many requests do come in this

fashion, others are made by local or regional EMS groups directly to individual legislators. The main problem with this failure to go through "channels" is the increased likelihood of state funds being spent for inappropriate equipment. However, there does not seem to be an immediate solution to this problem. The Advisory Council on Emergency Medical Services (ACEMS) has expressed to the governor a willingness to review the appropriateness of any request for EMS equipment that might come to him from the legislature.

Mini-grants of $2,500 per year have recently been made available through the EMS Section to volunteer EMS groups for upkeep of equipment.

Little can be done externally about the problem of equipment retrieval other than to keep in mind that the situation does drive up the costs of EMS equipment by making purchases of extras of various "vanished" items necessary.

Some EMS groups have established a local share policy for purchase of emergency equipment. While this practice may work in some areas and for some types of equipment purchases, other groups with a lesser tax base or less community EMS involvement have expressed fears that should such a policy become mandatory statewide it would seriously hamper their ability to purchase needed equipment.

Transportation

The major problems mentioned under the heading of transportation are accessibility and cost. Many small community EMS groups are now obtaining ambulances. However, with few roads and great distances between communities air transport is frequently (or in many cases always) a necessity in rural areas of Alaska. Many times chartered aircraft are necessary to evacuate critically ill or injured people, and this drives the cost of medical transportation even higher. In the past, Indian Health Service funds have been used to help underwrite at least a portion of EMS transportation costs, but with federal cutbacks these funds are increasingly unavailable. If the situation continues to deteriorate, the legislature may have to look at methods of funding some EMS transportation in rural areas.

Another difficulty mentioned under the general heading of transportation is the problem of volunteer ambulance services and air taxi operators have being reimbursed for their services. In the case of ambulance services, in an area with little or no tax base to help cover costs the ambulance must depend upon patient reimbursals to defray expenses. Where these are not forthcoming the costs must be met through some other means. A resolution from the Tanana Chiefs Conference, passed by the recent AFN Convention, addresses the legislature on this topic. (See Appendix XI.)

The air taxi operators have a somewhat different problem. Often they do not know the name or address of the patient they are transporting on an emergency evacuation. If the patient is critically ill or injured they may not be able to obtain this information from him or her

before offloading the patient at an airfield nearest the hospital to which he or she is being taken. Privacy considerations currently prevent hospitals from later releasing this information from their files to air taxi operators. Therefore, unless the patient contacts the air taxi operator there is no way for the operator to present, let alone collect, a bill for transportation services rendered. As many such patients may be out of state residents who return home after their recovery, the likelihood of the air taxi operator ever receiving payment under these circumstances is very slight. The Committee may wish to look at means of legalizing the release of information on air evacuated patients to air taxi operators to help alleviate this situation.

Emergency Medical Services: Summary

As a final observation, it might be noted that the emergency medical services programs in the state received excellent reviews in the returned health systems survey questionnaires sent to health care providers around the state (See Appendix XII). Comments made during testimony to the Committee, while focused on problems facing EMS, were also generally positive in tone, and the EMTs and others contacted during the course of this research were to a person enthusiastic about the functions of Alaska EMS. It should be remembered that many of the EMTs associated with the emergency medical service system in the state have volunteered considerable amounts of their time and a fair amount of money to learn and practice their skills. For a program with such ambitious goals, serving a large and geographically diverse state with a significant portion of its personnel comprised of volunteers, Alaska EMS appears to be operating very well.

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SECTION 7

Appendixes:

Emergency Medical Services

APPENDIX I: Statutory Authority for Alaska EMS (Title XVIII, Chapter VIII).

Chapter 08. Emergency Medical Services.

Sec. 18.08.010. Administration. The department is responsible for the development, implementation and maintenance of a statewide comprehensive emergency medical services system and, accordingly, shall

(1) coordinate public and private agencies engaged in the planning and delivery of emergency medical services to plan an emergency medical services system;

(2) assist public and private agencies to deliver emergency medical services through the award of grants in aid. (§ 1 ch 100 SLA 1977)

Sec. 18.08.020. Advisory Council on Emergency Medical Services. There is established in the department an Advisory Council on Emergency Medical Services. The council shall

(1) advise the commissioner with regard to the planning and implementation of a statewide emergency medical services system;

(2) assist the Statewide Health Coordinating Council in performing its duties under AS 18.07.011 relating to emergency medical services. (§ 1 ch 100 SLA 1977)

Sec. 18.08.030. Composition. The council shall consist of 11 members appointed by the governor. Four of the members shall be consumers of emergency medical services, and one from each judicial district in the state. (§ 1 ch 100 SLA 1977)

Sec. 18.08.040. Term of office. (a) Members of the council shall be appointed for overlapping terms of four years.

(b) Of the 11 initial appointments to the council, two shall be appointed for one-year terms, three for two-year terms, three for three-year terms, and three for four-year terms. A consumer shall be appointed to each of these overlapping terms. Appointments made on the expiration of the initial appointments shall be made for four years.

(c) A vacancy occurring in the membership of the council shall be filled by appointment by the governor in the same manner as original appointments, and when a seat is vacated before expiration of a term, the vacancy shall be filled for the unexpired portion of the vacated term. (§ 1 ch 100 SLA 1977)

Sec. 18.08.050. Compensation and per diem. Members of the council receive no salary, but are entitled to per diem, reimbursement

for travel, and other expenses authorized by law for boards and commissions. (§ 1 ch 100 SLA 1977)

Sec. 18.08.060. Meetings. The council shall meet at the call of the chairman not less frequently than twice a year. A majority of members constitutes a quorum. (§ 1 ch 100 SLA 1977)

Sec. 18.08.070. Special committees. The council may create special committees or task forces outside its membership and may appoint persons who are not members of the council to serve as advisors or consultants to any committee created to carry out the purposes of the council. (§ 1 ch 100 SLA 1977)

Sec. 18.08.080. Regulations. The department shall adopt, with the concurrence of the Department of Public Safety, regulations establishing standards and procedures for the issuance, renewal, reissuance, revocation, and suspension of certificates required under AS 18.08.084, as well as other regulations necessary to carry out the purposes of AS 18.08.010 — 18.08.090. (§ 1 ch 100 SLA 1977; am § 1 ch 78 SLA 1978)

Cross references. — As to the power of a municipality to provide emergency medical services and facilities, see AS 29.48.030 (a)(23). As to the authority of a municipality to provide emergency medical services outside its boundaries and to regulate their use and operation, see AS 29.48.037(a).

Effect of amendments. — The 1978 amendment rewrote this section.

Sec. 18.08.082. Issuance of certificates. (a) The department shall prescribe by regulation a course of training or other requirements prerequisite to the issuance of certificates which provide for the following:

(1) certifies that a person meets the training and other requirements as an emergency medical technician;

(2) authorizes an emergency medical technician certified under AS 18.08.010 — 18.08.090 to provide under the written or oral direction of a physician those advanced life support services enumerated on the certificate;

(3) certifies that a person, organization, or government agency which provides an emergency medical service meets the minimum operating standards prescribed by the department; and

(4) authorizes an emergency medical service certified under AS 18.08.010 — 18.08.090 to provide under the written or oral direction of a physician those advanced life support services enumerated on the certificate.

(b) The department shall be the central certifying agency for personnel certified under (a)(1) and (2) of this section and under regulations adopted under AS 18.08.080. (§ 2 ch 78 SLA 1978)

Sec. 18.08.084. Certificate required. (a) No person may represent himself, nor may an agency or business represent an agent or employee

of that agency or business, as an emergency medical technician certified by the state unless the person represented is certified as an emergency medical technician under AS 18.08.082.

(b) No person, organization, or government agency may represent itself as an emergency medical service or ambulance service certified by the state unless the person, organization, or government agency is certified as an emergency medical service under AS 18.08.082.

(c) No person may provide, offer, or advertise to provide advanced life support services outside a hospital unless authorized by law.

(d) No person, organization, or government agency which provides, offers, or advertises to provide an emergency medical service may provide advanced life support services unless authorized under AS 18.08.082. (§ 2 ch 78 SLA 1978)

Sec. 18.08.086. Immunity from liability. (a) No person certified under AS 18.08.082, or person or public agency which employs, sponsors or controls the activities of persons certified under AS 18.08.082, who administers emergency medical services to an injured or sick person may be liable for civil damages as a result of an act or omission in administering those services, if done in good faith and if the life of the injured or sick person is in danger. This subsection does not preclude liability for civil damages which is the proximate result of gross negligence or intentional misconduct, nor preclude imposition of liability on a person or public agency which employs, sponsors, or controls the activities of persons certified under AS 18.08.082 if the act or omission is a proximate result of a breach of duty to act created under AS 18.08.010 — 18.08.090. For the purposes of this subsection, "gross negligence" means reckless, wilful, or wanton misconduct.

(b) No physician who in good faith arranges for, requests, recommends, or initiates the transfer of a patient from a hospital to another hospital may be liable for civil damages as a result of arranging, requesting, recommending, or initiating the transfer if

(1) in the exercise of that degree of knowledge or skill possessed, or that degree of care ordinarily exercised by physicians practicing the same specialty in the same or similar communities to that in which the physician is practicing, the physician determines that treatment of the patient's medical condition is beyond the capability of the transferring hospital or the medical community in which the hospital is located;

(2) the physician has confirmed that the receiving facility is more capable of treating the patient; and

(3) the physician has secured a prior agreement from the receiving facility to accept and render the necessary treatment to the patient.

(c) No registered nurse or licensed practical nurse who escorts a patient in a means of conveyance not equipped as an ambulance may be liable for civil damages as a result of an act or omission in administering patient care services, if done in good faith and if the life of the injured or sick person is in danger. This subsection does not preclude

liability for civil damages which are the result of gross negligence or intentional misconduct. (§ 2 ch 78 SLA 1978)

Sec. 18.08.088. Penalty. Any person who violates a provision of AS 18.08.010 — 18.08.090 is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than $1,000, or by imprisonment for not more than 90 days, or by both. Each violation is a separate offense. (§ 2 ch 78 SLA 1978)

Sec. 18.08.090. Definitions. In AS 18.08.010 — 18.08.090,

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

(2) "consumer of emergency medical services" means a person who is not a provider of emergency medical services as defined in this section;

(3) "department" means the Department of Health and Social Services;

(4) "emergency medical services system" means a system which provides for the arrangement of personnel, facilities and equipment for the effective and coordinated delivery of health care services under emergency conditions, occurring either as a result of the patient's condition or of natural disasters or similar situations, and which is administered by a statewide network which has the authority and resources to provide effective administration of the system;

(5) "provider of emergency medical services" means a person whose occupation or profession is, or has been, the delivery or administration of emergency medical services; a person who has a fiduciary position with, or has a fiduciary interest in, a health activity, facility or other health agency, or a legal or financial interest in the rendering of any component of emergency medical services;

(6) "Statewide Health Coordinating Council" means the council created under AS 18.07.011;

(7) "advanced life support" means emergency care techniques provided under the written or oral orders of a physician which include, but are not limited to, electric cardiac defibrillation, administration of antiarrythmic agents, intravenous therapy, intramuscular therapy, or use of endotracheal intubation devices;

(8) "ambulance" means any publicly or privately owned means of conveyance intended to be used and maintained or operated for the transportation of persons who are sick, injured, wounded, or otherwise helpless;

(9) "emergency medical care" means the services utilized in responding to the perceived individual needs for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury;

(10) "emergency medical technician" means a person trained in emergency medical care and certified in accordance with the regulations prescribed under AS 18.08.080;

(11) "emergency medical service" means the provision of emergency medical care and transportation of the sick and injured. (§ 1 ch 100 SLA 1977; am § 3 ch 78 SLA 1978)

Effect of amendments. — The 1978 amendment added paragraphs (7) through (11).

Chapter 15. Disease Control.

Article
2. Physical Examination of Nonresident Employees (Repealed)

Article 2. Physical Examination of Nonresident Employees.

Section
60—110. [Repealed]

Secs. 18.15.060 — 18.15.110.

Repealed by § 1 ch 130 SLA 1976.

Editor's notes. — The repealed article derived from §§ 1 — 5, ch. 103, SLA 1949.

Chapter 16. Regulation of Abortions.

Section
10. Abortions

Sec. 18.16.010. Abortions. (a) No abortion may be performed in this state unless (1) the abortion is performed by a physician or surgeon licensed by the State Medical Board under AS 08.64.200; (2) the abortion is performed in a hospital or other facility approved for the purpose by the Department of Health and Welfare or a hospital operated by the federal government or an agency of the federal government; (3) consent has been received from the parent or guardian of an unmarried woman less than 18 years of age; and (4) the woman is domiciled or physically present in the state for 30 days before the abortion. "Abortion" in this section means an operation or procedure to terminate the pregnancy of a nonviable fetus. Nothing in this section requires a hospital or person to participate in an abortion, nor is a hospital or person liable for refusing to participate in an abortion under this section.

(b) A person who knowingly violates a provision of (a) of this section, upon conviction, is punishable by a fine of not more than $1,000, or by imprisonment for not more than five years, or by both. (§ 65-4-6 ACLA 1949; am § 1 ch 103 SLA 1970; am § 22 ch 166 SLA 1978)

APPENDIX II: Formation of New EMS Regional Alignments.

Northern Region Emergency Medical Services Council, Inc.

P.O. Box 2120 Fairbanks, Alaska 99707 (907)456-3970

STATUS REPORT
on the
NORTHERN, INTERIOR, NANA REGION, AND NORTH SLOPE
EMERGENCY MEDICAL SERVICES PROGRAMS

by

Jennifer A. Gleason, RN, Exec. Director

The Northern Region EMS Council was incorporated two years ago to address the clinical training needs of the three subregions, to provide technical assistance as needed, and to be better aligned for federal funding and evaluation. Since that time the focus of the director has been to bring clinical specialists into the region to provide physician and nursing workshops, workshops for the outlying physicians' assistants and nurse practitioners, and provide on-site technical assistance as requested. Each of the hospitals has had yearly Advanced Cardiac Life Support training and the Council has provided equipment and organizational assistance for physician Advanced Trauma Life Support training.

Equipment needs for both hospital training and patient care have been identified and funded this year. Due to severe cuts in IHS funds, one might expect to see increased needs for rural hospital and clinic equipment and professional education support.

The Northern Region EMS Council remains committed to seeing that professional level emergency education and equipment receive the same degree of support that all of the first responder and ambulance programs do. The prehospital phases of the EMS program are carried out under the three subregional councils and their advances are described within this packet. The Northern Region Council feels, however, that the clinical goals of the program will best be carried out with a different organizational structure. At their Board meeting a few weeks ago, they took the recommendation of their director, Jennifer Gleason, and decided to dissolve at the end of the fiscal year.

All clinical goals described in last year's request will be carried out, and the clinical needs of each subregion will be clearly identified so that they might contract with their own clinical resource people next year. This local control in identifying clinical resource people should enhance all three programs.

APPENDIX II

Daily News-Miner, Fairbanks, Alaska, Thursday, Dec. 10, 1981—5

Medical Council to end clinical organization

The clinical organization of the Northern Region Emergency Medical Service Council Inc. will phase out by June 30, following the council's board vote Monday on that action.

According to Jeanne Ostness, the Interior, North Slope and NANA northern regions voted to phase out the organization. Plans for the phase out should be complete by March. Ostness is executive director of the Interior Region Emergency Medical Services Council.

The northern region provided clinical support, Ostness said, supplying physican's assistants, nurses, initial health education, refresher training and equipment purchases. They provided clinical direction necessary in all three regions, Ostness said.

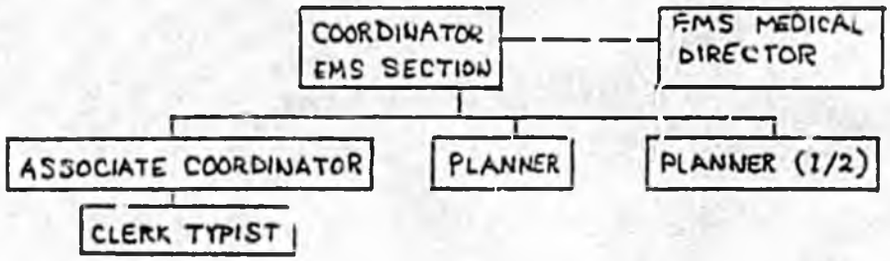
However, Barrow and Kotzebue populations usually refer their patients to Anchorage rather than Fairbanks. Therefore, the North Slope and NANA regions may form another emergency medical services unit to fill their needs.

Meanwhile, the Interior Region Emergency Medical Services Council plans to hire someone to carry on clinical services for Fairbanks.

In other business, the Interior council voted to share office space with the local Red Cross chapter in the Emergency Medical Services building at 1881 Marika. Red Cross closed its downtown office recently due to lack of funding. Red Cross programs to be lodged at the EMS office include water safety and first aid.

APPENDIX III: List of Staff in EMS Section Office.

STAFFING PLAN AND DUTIES OF KEY PERSONNEL



EMS Coordinator — Mark S. Johnson, B.A.: Coordinates and administers the development of EMSS throughout the State, secures and administers grants; integrates state and regional EMS Systems; interagency liaison.

Health & Social Services Planner II — Gloria Houston Way, M.P.H: Primarily responsible for short and long-range EMS plan development in accordance with State health policy; responsible for areas of data, evaluation, and systems management; public information and education; staffs the Advisory Council on EMS; writes and edits RESPONSE, the bi-monthly newsletter.

Associate Coordinator — Carol A. Taplin, M.A.: Administers grants from federal EMS, writes, negotiates and administers grants to Regions and contracts for specific tasks; prepares fiscal part of state budget; responsible for all fiscal activities; supervises support staff; responsible for office management; staffs the Manpower & Training Task Force of the Advisory Council on Emergency Medical Services. Prepares drafts of certification standards for EMT's and regulations; collects information on specific issues for the Task Force.

Health & Social Services Planner I (1/2 time) — Under supervision of the Planner II, researches and analyzes data; develops systems for standardized data collection and evaluation; identifies program needs on data analysis.

Clerk Typist III — : Performs varied typing and clerical work, directs work production and flow, operates office machines, etc.

APPENDIX IV: Composition and Accomplishments of the Advisory Council on Emergency Medical Services (ACEMS).

D. Composition

Four of the members appointed are consumers and represent each of Alaska's judicial districts. Two members are Alaska Natives and one member is a consumer member of the Statewide Health Coordinating Council (SHCC). The remaining seven provider categories represent two physicians, two nurses, a hospital administrator, a Native Health Corporation Director, and an EMT-Paramedic.

Ex officio membership includes a State of Alaska Senator and Representative, the State EMS Medical Director, a representative from the Alaska Area Native Health Service, the Department of Public Safety and the Division of Emergency Services, Department of Military Affairs.

E. Some Council Accomplishments During 1978 and 1979, its First Two Years of Operation

1. Established By-laws; roles & responsibilities document; policies & procedures manual;

2. Established Manpower & Training Task Force to set standards for training, curriculum, qualification for certification and recertification of all levels of emergency care personnel.

3. Established Critical Care Committee of physicians specializing in six critical care areas to develop standards for critical patient care, including transport and transfer standards. This Committee is not formally functional at State level; however, most of these physicians are serving regional Councils and act as consultants to the state medical director.

4. Established Annual Governor's EMS Award Program and set criteria for selection of three categories of recipients. Two annual awards banquets have been sponsored.

5. Instrumental in first-time appropriation of State funds for EMS, and in assuring continuation of funding.

6. Reviewed and recommended modification in proposed State Health Plan, re. "Levels of Care" conceptual model.

7. Established a permanent working relationship with SHCC.

8. Each year, reviewed and prioritized EMS and EMS-related applications for state and regional funding and recommended approval/disapproval to the Commissioner, DHSS.

9. Assisted in development of long-range planning document, "Standards and Goals for EMS in Alaska."

10. Sponsored resolutions on state funding; gas pipeline specifications; inter-departmental coordination in communications planning; clarification of state EMS leadership role.

11. Established a Task Force to develop long-term funding strategy for statewide EMS.

F. Some Current Council Projects for Remainder of FY 80

1. Review of grant applications, budgets and objectives of regional and state programs for recommendations to SHCC and the Commissioner of DHSS.

2. Review and approval of EMT, and EMT Instructor standards and draft regulations.

3. Adoption of "Standards and Goals for EMS in Alaska" for recommended incorporation into State Health Plan.

4. Task Force on long-term funding strategy for Statewide EMS.

G. Some Council Projects for FY 81

1. Adoption of EMT regulations.

2. Review, approval/modification, adoption of standards for remaining prehospital personnel standards.

3. Adoption of ambulance regulations.

4. Annual Governor's EMS Awards Program.

5. Implementation of long-term funding strategies.

APPENDIX V: List of Alaska EMS Goals.

Appendix V

THE MISSION OF THE ALASKA EMERGENCY MEDICAL SERVICES PROGRAM

The mission of the Emergency Medical Services (EMS) program in Alaska is to reduce both the human suffering and economic loss to society resulting from premature death and disability due to accidents and sudden illness.

GOALS OF THE EMERGENCY MEDICAL SERVICES PROGRAM

The overall goal of the Alaska Emergency Medical Services (EMS) program is to establish a comprehensive, coordinated system of emergency medical services which assures that citizens and visitors gain easy access to services; that initial response is expeditious; that appropriate life-saving and stabilization measures are rendered at the scene; and that patients are transported or transferred in a timely and efficient manner to facilities capable of effecting maximum recovery and rehabilitation.

Fifteen components have been identified by the national EMS program as essential in establishing a comprehensive EMS system. Systems goals for state and regional EMS programs in Alaska are grouped according to these fifteen components:

1. Manpower

   A. The number of qualified EMS administrators, clinical experts and technical specialists should be adequate to provide the necessary direction and assistance to regional EMS systems development.

   B. An adequate supply of trained EMS prehospital and hospital personnel to provide quality 24-hour-a-day, 7-day-a-week coverage of emergency medical services appropriate to each "level of care" should be maintained throughout the state.

2. Training

   A. Basic and advanced trained EMTs and paramedics should be certified according to state statute and regulations.

   B. Recommended standards for training, continuing education, certification and curricula for all other categories of emergency care personnel should be established to assure quality of patient care throughout the state.

   C. Training programs and resources within Alaska should be adequate to meet all EMS prehospital manpower needs.

   D. Continuing education and specialized EMS training for hospital personnel should be provided within Alaska to the greatest extent possible.

The recommendations listed on these pages are not to be interpreted as regulations; they have not been adopted under the Alaska Administrative Procedures Act, A.S. Chapter 44.64, nor are they intended for future adoption as regulations.

3. Communications

A. Local and regional EMS communication systems should be established and maintained which will assure residents and visitors easy access into a medically controlled system and which will assure the most rapid dispatch of appropriate personnel and transportation vehicles, assure coordination among public safety agencies, and provide flexibility to handle emergencies of any magnitude.

B. All EMS communications systems development should be in keeping with an overall state EMS communications plan, utilizing existing systems and resources in a cost efficient, practical manner.

C. All EMS communications systems should maintain a minimum of 95% reliability and be provided with back-up systems in event of primary systems failure.

4. Transportation

A. There should be available an adequate number of air or surface vehicles, suitably staffed and equipped, to ensure timely response and transport to medical facilities in order to minimize personal injury and loss of life for accident and illness victims.

B. Ambulance services in Level II, III and IV communities and on highways receiving state financial assistance should be certified according to state statutes and regulations.

5. Facilities

A. There should be an adequate number of accessible medical facilities - clinics, emergency departments and critical care units - to provide service on a 24-hour-a-day, 7-day-a-week basis, which maintain state recommended standards, and which are coordinated with other health care facilities within the system.

6. Critical Care

A. The treatment and transfer of the critically ill or injured patient, from the point of systems entry through rehabilitation, should be carried out according to protocols appropriate for regional capabilities, designed for maximum recovery.

B. All critically ill or injured patients should receive care at the most appropriate facility the regional system offers for their condition, or if necessary, should be transferred in a stabilized condition to an appropriate facility outside the region.

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7. Public Safety Agencies

A. All public safety agencies involved in emergency response should be coordinated to provide the most effective utilization of appropriately trained personnel and equipment for emergency patient care.

8. Consumer Participation

A. Consumer participation in all aspects of EMS systems planning and policy setting should be encouraged through a policy of responsiveness and accessibility, and assured through the mechanism of local, regional and state EMS Councils.

9. Accessibility to Care Without Ability to Pay

A. Services should be financed so that ability to pay or economic status of the consumer does not interfere with delivery of needed services at the time of need and does not affect the quality of health service provided.

10. Transfer of Patients

A. The transfer of patients to facilities offering the definitive follow-up care and rehabilitation necessary for maximum recovery should be facilitated through established transfer mechanisms, with recommended protocols available.

11. Coordinated Recordkeeping

A. There should be a coordinated EMS patient recordkeeping system which follows the patient from initial entry into the EMS system through discharge and follow-up and which is consistent with other medical recordkeeping within the state.

B. All regional EMS systems development data should be in keeping with a coordinated State EMS information system.

12. Public Education and Information

A. Alaska residents should know how to access their local EMS system and should know how to render appropriate first aid in a medical emergency.

B. Visitors to Alaska should know how to access the EMS system and how to take appropriate action in time of emergency.

The recommendations listed on these pages are not to be interpreted as regulations; they have not been adopted under the Alaska Administrative Procedures Act, A.S. Chapter 44.64, nor are they intended for future adoption as regulations.

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13. Evaluation

A. There should be a functioning system for periodic and objective review of the quality and extent of EMS systems development at both state and regional levels, for the purposes of evaluation and needs assessment.

14. Disaster Response

A. Local, regional and statewide EMS disaster planning and emergency medical resources should be adequate to deal effectively with any major disaster situation and should be coordinated with the Division of Emergency Services, Dept. of Military Affairs.

15. Mutual Aid Agreements

A. Necessary back-up and support services in time of emergency should be assured through mutual aid agreements between inter-regional, state and federal agencies.

THE ROLE OF THE EMERGENCY MEDICAL SERVICES SECTION

The Emergency Medical Services Section seeks to fulfill its mission and goals by:

1. Coordinating federal, state and regional official and voluntary agencies involved in Alaska's EMS system.

2. Recommending standards for EMS which are appropriate for Alaska.

3. Providing overall medical direction for statewide EMS systems development.

4. Certifying personnel and services according to legislative mandates to assure certain minimum standards of emergency medical care.

5. Providing and administering financial assistance for regional EMS system development.

6. Providing technical assistance to regional and local EMS agencies.

7. Educating the public on appropriate action in emergencies and on emergency procedures.

8. Seeking improved emergency medical services through legislative action.

9. Monitoring and evaluating EMS systems development throughout the state.

10. Planning and prioritizing continued program development based on systematic needs assessment, and epidemiological research.

The recommendations listed on these pages are not to be interpreted as regulations; they have not been adopted under the Alaska Administrative Procedures Act, A.S. Chapter 44.64, nor are they intended for future adoption as regulations.

THE ROLE OF THE REGIONAL EMS COUNCILS

1. Facilitating the development and maintenance of local and regional emergency medical services to provide a continuum of patient care.

2. Coordinating regional, subarea and local official and voluntary agencies involved in EMS.

3. Assisting local emergency medical services and facilities to meet recommended standards and regulations of the statewide EMS program.

4. Providing technical assistance and medical consultation to regional and local EMS agencies and medical facilities.

5. Administering funds granted by the Emergency Medical Services Section, as well as income derived from other sources.

6. Providing financial assistance to local emergency medical services.

7. Coordinating and providing training of EMS personnel within the region.

8. Educating the public on appropriate action in emergencies and on emergency preparedness.

9. Monitoring and evaluating regional EMS development.

10. Planning and prioritizing continued regional program development based on systematic needs assessment.

The recommendations listed on these pages are not to be interpreted as regulations; they have not been adopted under the Alaska Administrative Procedures Act, A.S. Chapter 44.64, nor are they intended for future adoption as regulations.

Appendix VI: Sample Medical Protocol for Use by EMTs

RESULTS OF A CONFERENCE ON HYPOTHERMIA AND COLD WATER NEAR DROWNING

July 11 and 12, 1981 in Anchorage, Alaska
Participants: William Doolittle, M.D.
John Haywa-d, Phd.
William Mills, M.D.
Martin Nemiroff, M.D.
Tim Samuelson, M.D., Moderator

HYPOTHERMIA

I. General Points

A. The evaluation and treatment of hypothermia whether wet or dry, on land or water, is essentially the same. Ther fore, we do not specifically distinguish between chronic and acute, or wet and dry in the following discussion.

B. In the setting of the cold patient, a rectal temperature is one of the vital signs. In terms of the ABC's it would be -

A. Airway
B. Breathing
C. Circulation
D. Degrees

C. "Low Reading" thermometers are important in the care of the hypothermic patient. Regular thermometers are useless and probably dangerous in this setting. (SF. is going to purchase a certain brand)

D. Obtaining a temperature is important and useful for treating hypothermia. However, there is tremendous variability in individual physiologic responses at specific temperatures. In addition, there will frequently be times when a low reading thermometer is not available. Therefore, these guidelines are not based on the patient's measured temperature.

E. Axiom: With the hypothermic patient, THINK HEAT.

1. No cold IV's.
2. No cold ventilation therapy.
3. No cold treatments of any kind.

F. We must, at least, <u>prevent further heat loss at the core</u>. This can only be done by insulating the entire patient plus adding heat to the "core areas" (head, neck, chest, and groin.)

G. <u>Adding heat</u> gradually and gently implies:

1. External warm objects - hot water bottles, "warm packs", (e.g. chemical heat packs, etc.), warm rocks (wrapped in towels), warm bodies, etc. - applied to the head, neck, chest and groin.

2. Breathing warm, moist air or oxygen.

* The term "adding heat" is used rather than "rewarming" because often the patient is not actually any warmer with the addition of heat, but rather only a further loss of heat is prevented.

H. Do not ever try to cool the extremities or use tourniquets or other occlusive dressings.

I. Be wary of statements or actions while working on patients who are unconscious or requiring CPR. These patients frequently remember what is done and said and it can produce severe psychological problems later on. This statement applies equally well to warm and cold patients.

J. Preplanning regarding how you will handle these problems, who will be in charge, and being familiar with the appropriate equipment is absolutely necessary.

K. A note on transport: Air travel in Alaska is obviously favored. But if air travel is not possible, other types of transport should be utilized, such as snowmachine, dog team, cars, and especially boats in areas with water access.

L. The inside of the ambulance and any rooms where such patients are treated should be "room temperature" (approximately 65 to 72 degrees F.[18 to 22 degrees C.]).

II. Evaluation and Treatment

GENERAL PUBLIC/FIRST RESPONDER

A. If the patient is cold and has any of the following signs or symptoms:

1. Depressed vital signs.
2. Altered level of consciousness, including slurred speech, staggering gait, decreased mental skills.
3. Temperature = 90 degrees F. (32 C.) or less.
4. No shivering in spite of being very cold (the presence of alcohol intoxication throws this sign off).
5. Associated significant illness or injury that is present or that may have permitted the hypothermia to develop.

....He is considered to have <u>severe hypothermia</u>.

If he is cold and does not have severe hypothermia, as defined above, he has <u>mild to moderate hypothermia</u>.

B. Basic Treatment

1. Treat very gently. (rough handling releases detrimental chemicals from the
2. Remove wet clothing. Replace with dry clothing or dry coverings of some kind.
3. Insulate from the cold.
4. Add heat to the head, neck, chest and groin externally (See G. under General Points on Page 1.), or internally, if a system for breathing warm moist air is available. Avoid attempts to warm the extremities.
5. When the first responder adds heat to the very cold patient (temperature less than 75 degrees F.[24 degrees C.]) the idea is to prevent further heat loss, <u>not</u> raise the core temperature which will cause electrolyte, acid-base and hydration that the first responder will not be able to treat.

this assumes a better quality of help is on hand or not far away

HYPOTHERMIA - GENERAL PUBLIC/FIRST RESPONDER - BASIC TREATMENT (Con't.)

6. No rubbing or manipulation of the extremities.
7. No coffee or alcohol.
8. Do not put patient in a shower or bath.
9. Warm fluids can be used only after uncontrolled shivering stops with a clear level of consciousness, with the ability to swallow, and evidence of rewarming already.
10. If severe hypothermia is present, treat as above and transport to a higher medical facility.
11. If there is no way to get to a higher medical facility, rewarm the patient slowly, cautiously and gradually with the methods indicated in G. under General Points on Page 1.

C. Severe hypothermia with no life signs (CPR required).

1. Basic treatment as indicated above.
2. Carefully assess the presence or absence of pulse or respirations for one to two minutes.
3. If no pulse or respirations, start CPR.
4. Use mouth-to-mouth rather than bag/mask breathing.
5. Obtain a rectal temperature if possible.
6. If you are than less than 15 minutes to a higher medical facility, do not bother trying to add heat.
7. If you are greater than 15 minutes to a higher medical facility, add heat gradually and gently.
8. Reassess the physical status periodically.
9. Transfer to a higher medical facility in all cases.

D. Severe hypothermia with signs of life (i.e. pulse and respirations present).

1. Basic treatment. (Do not use CPR.)
2. Add heat with the methods indicated in G. under General Points on Page 1 if you are greater than 15 minutes from a higher medical facility.
3. Transfer to a higher medical facility.

EMERGENCY MEDICAL TECHNICIAN I*

A. Treat as the GENERAL PUBLIC/FIRST RESPONDER with the following additional guidelines:

1. Do not use oxygen unless you are performing CPR or you are specifically told to do so.
2. Pneumatic antishock trousers are not indicated for hypothermia, but may be used to treat hypovolemic shock in a hypothermic patient.
3. The indications for oral airways are the same in the hypothermic and the warm patient.
4. Communicate with a higher medical facility.

* Note: Alaska Native Village Health Aids are, for purposes of these protocols, considered to fall into this category.

HYPOTHERMIA (Con't.)

EMERGENCY MEDICAL TECHNICIAN II

A. Treat as an EMERGENCY MEDICAL TECHNICIAN I, with the following additional guidelines:

1. IV therapy (Note: Do not delay transport, communications, or other therapy by taking a long time to start an IV. IV's are difficult to start in cold patients):
   a. All patients with severe hypothermia should have an IV started after other stabilization.
   b. Use D5W at a rate of 75 cc. per hour.

B. Additional medications: (Note: Medications are inefficient and are metabolized much more slowly in the hypothermic patient.)

1. Narcan and 50% Dextrose are not to be used unless specifically instructed to do so by a physician.

C. The Esophageal Airway Device: The indications and contraindications for the esophageal airway device are the same in the hypothermic and the warm patient.

D. Communicate with a higher medical facility.

EMERGENCY MEDICAL TECHNICIAN III

A. Treat as an EMERGENCY MEDICAL TECHNICIAN II, with the following additional guidelines:

1. In cardiac arrest:
   a. Attention to the ABC's.
   b. CPR.
   c. Attempt defibrillation once with 400 w/s's if the patient is in ventricular fibrillation or ventricular tachycardia. (Note: Shivering can mimic ventricular fibrillation.)
   d. Add heat if greater than 15 minutes from the hospital.
   e. Repeat defibrillation may be attempted only if the core temperature is 85 degrees F.(30 degrees C.) or higher.
   f. If cardioversion is successful, give Lidocaine, approximately 1 mg. per kilogram IV bolus, followed in 15 minutes by a second bolus at 0.5 mg. per kilogram.
   g. If heart rhythm is asystole: Do not attempt defibrillation and treat as an EMT II.
2. Morphine is contraindicated in the hypothermic patient.
3. Cardiac monitoring is indicated in all hypothermic patients as long as its use does not unnecessarily delay other or further care.

PARAMEDICS

A. Treat as an EMERGENCY MEDICAL TECHNICIAN III with the following additional guidelines:

1. Paramedics in isolated areas in Alaska should function as an EMT III in regards to the hypothermic patient, unless they are under the specific on-line direction of a physician, or until a patient reaches a level of adequate physiological response (temperature higher than approximately 90 degrees F.)
2. Endotracheal intubation: The indications and contraindications for ET tube placement are the same in the hypothermic and the warm patient.
3. Cardiac arrest: Treat as an EMT III.
4. Additional medications: Since medications are inefficient and also poorly metabolized in the hypothermic patient, no additional medications are indicated.

SMALL/BUSH CLINICS

A. The extent of the evaluation and treatment in small/bush clinics is defined by the training of the personnel and the available equipment as outlined in the foregoing guidelines.

For transfer to a higher medical facility, the patient must be stabilized in the clinic rather than transferred as an unstable patient. Therefore, if the patient is requiring CPR or is otherwise with unstable vital signs, necessary equipment and trained personnel, if not already at the clinic, should be sent to the clinic in order to stabilize the patient enough for transfer to a higher medical facility.

Once the rewarming process has started in the clinic, it should be continued with slow, gradual techniques until transfer is possible and appropriate.

HOSPITALS

A. Some general points:

1. Treat to the level of your ability as your hospital equipment, staff, and skills dictate.
2. All patients should be stabilized before any transport to another facility. The patient should be kept in the sending hospital until the patient is stable.

B. Evaluation

1. Initial attention to the ABC's and CPR as needed.
2. Vital signs, including rectal temperature.
3. Brief history.

4. Brief physical exam: Feel for skin coldness or warmth, level of consciousness, shivering, cardiopulmonary exam, and associated trauma.

Then:

5. Chest x-ray.
6. 12 lead electrocardiogram.
7. Urine for urinalysis, sodium and osmolality.
8. Blood for CBC, BUN, creatinine, electrolytes, sugar, platelets, PTT, Prothrombin Time, Liver Function Tests, amylase.
9. Arterial blood gases.
10. Weight.

C. Monitoring and Treatment

1. Cardiopulmonary monitoring.
2. An IV and/or central venous pressure line (in the superior vena cava, not the right heart), with D5W at 75 cc. per hour. IV fluid and rate of infusion will vary depending on the patient's level of hydration and laboratory data.
3. Urinary bladder catheter.
4. Nasogastric tube, if the patient is unconscious and the airway is protected.
5. Endotracheal/Nasotracheal tube is indicated in the unconscious patient after careful neck evaluation.
6. Daily weights; I&O.
7. Always ventilate with warm, moist air or oxygen (typical unwarmed ventilation is approximately 72 degrees F.[22° C.]).
8. Sodium bicarbonate administration is based on arterial blood gases.
9. Adding heat: The recommended possibilities include:

External Methods	Internal Methods
1. Gradual spontaneous rewarming.	1. Warm steam inhalation/ ventilation.
2. Warming blankets, warming mattresses, etc.	2. Peritoneal lavage.
3. Tub bath.	3. Warm IV fluids.
	4. Extracorporeal circulation (AV shunt).

General notes about rewarming techniques:

1. Regardless of the method chosen for adding heat, the patient must be under total physiologic control, to allow you to deal with the metabolic needs of the patient.
2. Tub bath is the most rapid method and requires immediate laboratory results and extremely close physiological monitoring to maintain control of the situation.
3. Do not compromise extremity circulation by using tourniquets, MAST pants or ice packs.

4. The recommended temperature is about 105 to 110 degrees F. (40 to 43 degrees C.) for all methods.

   a. For severe hypothermia without signs of life (requiring CPR):

      1. Warm the core as rapidly as you can handle, using one or more of the methods. (For example, warming mattress, warm steam inhalation, and peritoneal lavage), trying to get the patient greater than approximately 85 degrees F., (30 degrees C.)
      2. For severe hypothermia with life signs: Use your judgement, utilizing one or more of the methods.

10. Continue monitoring until stable and warm.

D. Most common problems

Note: Drug therapy should be moderated because in the cold patient medications are both inefficient and poorly metabolized.

1. Arrhythmias - these are usually atrial arrhythmias.

   a. If very cold, these atrial arrhythmias will usually convert spontaneously with rewarming.
   b. If the temperature is rising and the arrhythmia does not convert, you may want to use the usual medications. (Inderal may be the drug of choice in atrial arrhythmias in this setting.)
   c. If the treatment is not working, add more heat.
   d. Ventricular fibrillation in the very cold patient is treated with CPR, adding heat, AND after the temperature reaches approximately 85 degrees F. (30 degrees C.), defibrillation.

      In the patient whose temperature is rising, the standard (AHA, others) treatment for ventricular fibrillation should be utilized.

2. Dehydration - monitor and treat accordingly.
3. Hyperkalemia - monitor and treat accordingly (do not infuse potassium in IV's).
4. Hyperglycemia - monitor and treat accordingly.

E. Transferring Patients to Tertiary Care Facilities

The indications to transfer the patient from a smaller hospital to a tertiary care facility are:

1. In general, lack of nursing and support staff and equipment to properly provide for a critically ill patient, requires that the patient be transferred, once that patient is stable.

2. Specifically, the patient should be transferred if:

   a. There is no capability for rapid arterial blood gas results.
   b. There is profound neurological depression.
   c. There is associated significant trauma.

COLD WATER NEAR DROWNING

A. General Comments

1. Anyone submerged long enough to be unconscious and/or require CPR, who has been under water less than one hour, should be sent to the hospital.
2. If under water for more than one hour, no attempt at resuscitation should occur.
3. If we do not know how long the person has been under water, we err on the side of considering them under one hour.
4. There is no difference between fresh and salt water near drowning in regards to outcome or treatment.
5. These principles apply to any near drowning, not just those in cold water. The difference between warm and cold water is that in long submersions (greater than 6 minutes), survival in warm water is 50% at best. Therefore, attempt to get a temperature of the water at some point in time primarily for prognostic purposes. Obviously the colder the water, the better the chance for survival.
6. The level of coldness is rarely profound (below 85 degrees F.[30°C.]) in cold water near drowning, so the hypothermia aspect of the problem is less critical than the pulmonary or hematology aspects. Thus, rewarming is done very cautiously and gradually, without the need for invasive techniques such as peritoneal lavage or AV shunts.
7. Many near drowning victims die of a particular type of Disseminated Intravascular Coagulation, not from their pulmonary problems.

B. Evaluation and Treatment

For the general public/first responder, Emergency Medical Technician I, Emergency Medical Technician II, Emergency Medical Technician III, and the Paramedic, the treatment is the same as indicated for hypothermia, plus:

1. It is very important to clear the airway with any of the standard maneuvers, but no specific maneuvers are mandatory to expel water from the lungs. Do not do the Heimlich maneuver on these patients.
2. CPR must be started immediately.
3. Assess carefully for associated injuries.

HOSPITAL CARE

1. The evaluation is generally the same as for hypothermia, except for the laboratory evaluation which in near drowning should be, in order:

   a. Arterial blood gases.
   b. Chest x-ray.
   c. 12 lead electrocardiogram.
   d. Electrolytes, BUN, CBC.
   e. Scan the serum for pinkness (indicating hemolysis).
   f. Institute cadiorespiratory monitoring.
   g. IV therapy - D5W at keep open levels. (In children, ¼ - ½ mainterance rate).

2. Therapy:

   a. Attention to the ABC's, with respiratory support, intubation, etc., as needed.
   b. Rewarming. Active rewarming methods (warm air inhalation, external heat sources, etc.) should be used only while CPR is required.

      Once circulation has been established, do only passive rewarming (light sheets or light blankets, room temperature). Note that these patients often become hyperthermic.
   c. Aspiration pneumonitis and pulmonary edema may be treated with:
      1. Corticosteroids.
      2. Penicillin.
      3. Lasix.
   d. Profound neurological depression: Recommend cerebral resuscitation, as per CONN* with intraventricular pressure monitoring, diuretics, and barbiturates.
   e. Hemolysis - Treat as with any patient with hemolysis.
   f. Disseminated Intravascular Coagulation - treat as with any patient with DIC.
   g. Renal insufficiency - Treat as with any patient with renal insufficiency.

3. Transferring the near drowning patient to a tertiary care facility.

   a. The indications to transfer the patient from a small hospital to a tertiary care facility are:

      Note: The patient should be stabilized at the nearest hospital with intubation as necessary and ventilation.

      1. Lack of nursing and support staff and equipment to properly provide ongoing care for a critically ill patient requires that the patient be transferred, once the patient is stable.
      2. Specifically, the patient should be transferred if:

         a. There is no capability for rapid arterial blood gas results.
         b. There is deterioration of pulmonary status.
         c. There is renal insufficiency.
         d. There is hemolysis.
         e. There is profound neurological depression.
         f. There is significant associated trauma.

      3. Air transport should be in an aircraft pressurized to sea level or flying at sea level. You may need to increase oxygen supplementation depending on the level of pressurization.

*"Cerebral Salvage in Near Drowning following Neurological Classification by Triage," A. W. Conn, Canadian Anesthesia Society Journal, Volume 27, No.3, May, 1980.

Appendix VII: Background Information on Paramedics

MEMORANDUM State of Alaska

TO: William Wernen, M.D., Chairman
Advisory Council on Emergency Medical Services

DATE: October 20, 1981

FILE NO:

TELEPHONE NO: 465-3027

FROM: Mark S. Johnson, Coordinator
Emergency Medical Services Section

SUBJECT:

We missed you at the ACEMS meeting in Sitka. There was some discussion about the proposed use of the excess FY82 EMS funds for Northern Region, but some members were frustrated that they didn't have advance notice to review the requests. While I sympathize with this concern, there was nothing we could do about it, because the Interior and Northern Region Boards had just approved these requests one week prior to the ACEMS meeting.

The one funding request which generated the most discussion was the proposal to send EMTs from Nenana and Healy outside the state for paramedic training. As I see it, there are pros and cons to this proposal. I have listed some of these below:

Pros	Possible Cons
1) Advanced medical training is probably needed more in rural areas because of the long distances to acute care centers.	1) If we approve paramedic training for Healy & Nenana how many other rural services will request similar funding assistance in the future?
2) At least one of the EMTs desiring paramedic teaching is an instructor. Paramedic training will enhance this person's instructor capabilities.	2) Will there be enough calls to maintain skill levels?
3) Proximity to Mt. McKinley means that large numbers of tourists pass through the area in the summer.	3) Will these people be content with their current volunteer or low pay status after paramedic training?

Due to the complexity of the issue, some members of ACEMS would prefer that the decision be made at the regional level. ACEMS also voted to review this request again at their next meeting.

Therefore, I suggest that you bring this up at the next Interior Region Medical Advisory Board meeting. Also, if they endorse this request, I think it would be a good idea to set up a formal evaluation to determine the benefits of paramedic training in rural areas. This information would be especially useful because Senator Charlie Parr has suggested that Alaska should train paramedics in all subregional centers who could also assist with medevacs.

please see following letter

If there is, in fact, a growing demand for paramedic training, should we consider providing some or all of this training in-state?

I'll appreciate hearing your views on this subject.

MSJ/bb

cc: James Borden, M.D.
Tim Samuelson, M.D.
Jeanne Ostnes

CHARLIE PARR

ALASKA LEGISLATURE

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December 14, 1981

Tim Samuelson, M.D.
Medical Director, State EMS Office
Pouch H-06C
Juneau, Alaska 99811

Dear Dr. Samuelson:

I have recently seen a copy of your letter of November 2 to Dr. Wennen regarding paramedics in sub-regional centers in the rural part of the state. Unfortunately, someone has misinformed you as to my ideas on the subject.

I have never suggested paramedic staffing. Instead, I have suggested that we might consider the assignment of physician assistants to regional offices. This idea has never been advanced as something the state should do, only as an idea that should be considered. (After all, the Russians did it in Siberia thirty or more years ago!)

Scrry for the misunderstanding.

Sincerely,

Charlie Parr by dm

Charles H. Parr

P. S. The information about skill decay in your letter was quite helpful.

CHP:dm

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
EMERGENCY MEDICAL SERVICES SECTION

POUCH H-06C
JUNEAU, ALASKA 99811

EMS MEDICAL ADVISORS REPORT

November 12, 1981
Anchorage, Alaska

Present: Bill Dahl, M.D., Kotzebue
Dave Lonsdorf, M.D., Bethel
Stan Jones, M.D., Haines
Bill Wennen, M.D., Fairbanks
Jim Borden, M.D., Fairbanks
Bernard Gerard, M.D., Valdez
Myron Bloom, M.D., Ketchikan
Floyd Elterman, M.D., Tanana
George Garnett, M.D., Soldotna
Ron Gould, M.D., Tanana Chief's Conference
Tim Samuelson, M.D, State EMS Medical Director
Jennifer Gleason, EMS Coordinator, Fairbanks
Susan Ash, EMS Clinical Coordinator, Southern Region EMS
Susan Clark, EMS Clinical Coordinator, Southeast EMS
Susan Super, State EMS Staff
Mark Johnson, State EMS Coordinator
Laurel Anderson, Southeast Region EMS Council
Ross Van Camp, M.D., Glennallen

The meeting was held at the Anchorage Westward Hilton, and lasted from 9:00 a.m. to 2:00 p.m.

Hypothermia Protocols recently developed through the offices of the State EMS offices were presented by Dr. Samuelson. The group had a number of useful and helpful suggestions and these were incorporated into changes on a revised set of protocols. In particular, there seemed to be concern in regards to the medical/legal aspects of these protocols and several physicians felt that the way that certain parts of these protocols were written might be fuel for lawyers to produce successful suits against doctors.

The EMT Regulations were presented by Dr. Samuelson. Those parts of the EMT Regulations that impact on physicians and medical advisors were discussed and pointed out to those present. Several in the group expressed happiness that these regulations were finally coming to fruition while others in the group were concerned about them causing complications in regards to providing Emergency Medical Services. The regulations were discussed in detail.

The concept of Medical Control was discussed by the group and each of those present described how they provide leadership and quality control

DG-F4ELH

in their respective pre-hospital Emergency Medical Services. In this regard, the concept of bush or very rural paramedics was discussed and the group felt that the use of paramedics in such situations was generally inappropriate. What was needed in these areas, they believe, is someone with more general knowledge such as a Physician's Assistant rather than someone with very specialized knowledge involving only emergency care as is the case with the paramedics. In addition, the group felt that it may be difficult to find ~~a Physician's Assistant or~~ physicians willing to spend the time necessary to provide effective and proper medical control of such individuals. And finally, the group was concerned about the best use of money in that they felt that for the cost of providing paramedic services, the benefits to the population in general were quite low.

The document produced by the State EMS Office called "EMS Goals for the State of Alaska" was introduced to those present and discussed. The orientation of the document and the uses of the document were discussed and Dr. Samuelson stressed that it was merely a guide and not a document that rigidly instructed people in how to provide Emergency Medical Services. The document can be very useful in planning Emergency Medical Services in both small and large communities.

Prepared by Tim Samuelson, M.D.

TS:rlt

Appendix VIII: Draft Position Paper from EMS Section on Question of Good Samaritan Laws

POSITION PAPER

DRAFT

Liability of EMTs and Supervising Physicians

Alaska Statute 8.08.086 - IMMUNITY FROM LIABILITY

(a) No person certified under Section 82 of this Chapter (EMTs and Instructors) or persons or public agency which employs, sponsors or controls the activities of persons certified under Section 82 of this Chapter, who administers emergency medical services to an injured or sick person may be liable for civil damages as a result of an act or omission in administering those services, if done in good faith and if the life of the injured or sick person is in danger. This subsection does not preclude liability for civil damages the proximate result of gross negligence or intentional misconduct, nor preclude imposition of liability on a person or public agency which employs, sponsors, or controls the activities of a person certified under Section 82 of this Chapter if the act or omission is a proximate result of a breach of duty to act created under this Chapter. For purposes of this Section, "gross negligence" means reckless, willful, or wanton misconduct.

Section 08.64.366 - Liability for services rendered by a physician-trained mobile intensive care paramedic. No act or omission of a physician-trained mobile intensive care paramedic done or omitted in good faith while rendering emergency lifesaving service to a person who is immediate danger of loss of life shall impose any liability upon the physician-trained mobile intensive care paramedic, the supervising physician, a hospital, the officers, members of the staff, nurses or other employees of a hospital or upon a federal, state, borough, city or other local government unit or upon other employees of a governmental unit; however, this section does not relieve a physician or a hospital of a duty otherwise imposed by law upon the physician or hospital for the designation or training of a physician-trained mobile intensive care paramedic or for the provision or maintenance of equipment to be used by the physician-trained mobile intensive care paramedic.

The above statutes address the concerns, expressed by numerous emergency medical technicians, paramedics, ambulance service chiefs, and physician supervisors, about potential liability in rendering emergency medical care in a field setting. Since both of these statutes only address immunity from liability in life-threatening emergencies, the Emergency Medical Services Section and the State Advisory Council on Emergency Medical Services recommended that these statutes be amended to include any situation whereby the patient was in danger of "loss of life or serious harm." This, in effect, would cover all situations requiring the assistance of EMTs or paramedics. Unfortunately, the adiminisration chose not to sponsor this suggested legislative amendment.

However, based on the advice of Jim Page, a nationally noted EMS legal expert, any statute which attempts to grant immunity from liability to a specific group may ultimately be judged unconstitutional by the courts. Whether or not this is true, the statutes themselves do not preclude someon from filing a suit, which could result in costly legal expenses for the defendents, even if they are found not guilty.

Currently a law suit is pending against some Juneau Fire Department EMTs, physicians, Bartlett Memorial Hospital, and the City of Juneau regarding a 3-year-old cold water near-drowning case. While the City and Borough of Juneau can probably afford to cover its own legal defense, many volunteer EMTs, and rural physicians in Alaska may not be able to afford the legal expenses of such a case.

A recent report from the Emergency Medical Services Committee, National Research Council, National Academy of Sciences, also addresses legal issues in EMS:

4. Legal Considerations

"Experience of various EMS systems with and without medical control strongly suggests that a firm system of medical control, with treatment, triage, and transport protocols accepted by the medical community and enforced by the system's medical director is the best insurance against legal action. It does not appear that Good Samaritan laws, designed originally to protect lay persons offering assistance at an emergency, should be applied to professionally trained EMS

personnel. In any event, malpractice lawsuits involving EMS personnel are so rare that the question of legal liability does not appear to be a major barrier to the development of an ALS (advanced life support) system."

A."All persons within an EMS system who directly provide emergency medical care should be legally responsible for providing care appropriate to their training and skills. However, we recommend that the EMS system itself, or its parent body, such as a municipality, should bear insurance costs entailed in the legal liability of EMTs, paramedics, and of medical supervisors in their exercise of medical control functions. State Good Samaritan laws should apply only to lay persons providing aid at the scene of an emergency."

B."The responsibility to attempt resuscitation exists as long as there is possibility of brain life; once begun, resuscitation should be terminated only on order of the supervising physician. The question of possible liability for resuscitation after brain damage is unresolved, but does not appear to differ in kind from the more general questions related to artificial prolongation of life."

The key legal issue in the National Academy of Sciences report seems to be the recommendation that "the EMS system itself, or its parent body, such as a municipality, should bear insurance costs entailed in the legal liability of EMTs, paramedics, and of medical supervision in their exercise of medical control functions."

Given the fact that most EMTs in Alaska are volunteers, and the fact that physician supervisors often do not even reside in the same community, perhaps the question of state sponsored liability insurance for EMTs, paramedics, and physician supervisors should be explored. While it doesn't seem unreasonable to expect physicians to carry malpractice insurance for themselves, it also does not seem unreasonable that the state would provide insurance coverage for EMTs or paramedics under the supervision of these physicians. Of course, strict quality control must be a consideration. Otherwise EMTs in the field may not feel the need to continually train and update their skills.

The question of liability for emergency care is especially difficult because there often is not clear evidence of appropriate treatment for various types of emergency medical situations. Depending upon distance from a hospital and skill levels of personnel, treatment may differ. Furthermore, the patient may have undiagnosed complications which could result in unanticipated outcomes. Lawsuits stemming from these situations may discourage volunteers from getting involved in the system, or may result in an overly conservative approach to treatment. Perhaps state certified EMTs and paramedics could be extended the privileges of state employees for the purposes of insurance coverage.

In summary, the entire issue of potential liability for EMTs, paramedics, ambulance agency chiefs, and physician supervisors is extremely complex, and should be studied throughly by the state.

The EMS Section of the Division of Public Health and the State Advisory Council on Emergency Medical Services will be more than willing to offer additional assistance in exploring this issue.

Appendix IX: Excerpts from Alaska EMS Goals Outlining Ultimate, Ideal Deployment of EMS and Other Medical Personnel and Facilities in Alaska

LEVELS OF CARE:

ALASKA'S APPROACH TO ORGANIZING A HEALTH CARE SYSTEM

Organization of the Alaska health care system, as conceptualized in the Alaska State Health Plan, utilizes a regional approach, identifying appropriate health resources and services for five community levels. These levels are categorized as:

Level I	Village
Level II	Sub-Regional Center
Level III	Regional Center
Level IV	Urban Center
Level V	Metropolis

Health services, manpower and facilities generally appropriate for each of the five levels are recommended in the Plan. However, specific resources to be provided in any individual community are to be determined by considering such factors as population characteristics, health status, anticipated frequency that the service will be required, and economic feasibility of providing the service. Regardless of the level in which a community may be classified, economic realities may not permit provision of all recommended health resources in each community. Compromises also must be made with respect to time and distance from services as well as with the scope of services available.

The "levels of care" concept encompasses the elements of continuity, coordination and a continuum of service delivery and referral patterns, generally from one level to the next highest level. However, there will be times when a community will relate directly to the level which can provide appropriate care in the most expeditious and convenient manner.

Services for Level I Communities — Villages

Level I Communities are those equated with primary health care, those elements of health care that people use most frequently. Services allocated to Level I Communities generally meet one or more of the following criteria:

1. Services that can be provided conveniently at that level on a continuing basis.

2. Services designed primarily for ambulatory care.

3. Emergency measures that must be provided in a timely matter.

Primary health care in Level I Communities includes the range of services that will adequately provide for most daily personal health care needs. It includes continuing evaluation and management of conditions of general discomfort, early complaints and symptoms, problems and chronic aspects of disease. It also includes preventive health maintenance — health measures designed to reduce the incidence of sickness and disease, such as periodic health surveillance, immunizations, education and promotion of positive health habits.

Direction of patients to specialized health care is a major function of primary health care. Primary health care does not in itself provide total or comprehensive care. It does, however, have a unique potential for becoming the key element in a comprehensive community health care system.

Services for Level II Communities — Sub-Regional Centers

Level II Communities are also equated with primary health care. Generally, a broader range of services than those provided in Level I Communities would be available to the residents of Level II Communities. The additional services are not generally of an emergency nature, but include those that must be reasonably close to consumers to assure availability, accessibility and use as needed and appropriate.

Services for Level III Communities — Regional Centers

Level III Communities provide expanded services which can be equated with secondary health care. Services are extended to include basic hospital services and bed care in a facility which can provide for diagnostic workup, routine laboratory services, services for normal obstetrical cases, general surgery as appropriate and other hospital inpatient episodic care.

Services for Level IV Communities — Urban Centers

To Level IV Communities are allocated a larger range and scope of services, including those that do not need to be as close to people. These additional services tend to be institutionally related, more specialized and less frequently used than the services provided in Levels I, II, and III.

In addition to providing primary and secondary services, Level IV Communities act as a focal point for economically feasible specialized health services for a wide geographic area. Certain recognized centers for specialized services, such as those for neonatal intensive care, open heart surgery, treatment of head and spinal injury and of thermal injury, generally require a significant population base to justify their establishment and maintenance, according to national guidelines. The economic viability of these centers and the provision and maintenance of clinical expertise and technology are largely dependent on an appropriate population base which may not exist in each Level IV Community.

Services for a Level V Community — Metropolis

Presently within Alaska, no Level V Community exists. While future growth may foster a Level V Community in Alaska, the closest and most frequently used Level V is now Seattle, Washington. This is the Level which would encompass highly advanced, specialized and technologically sophisticated care. Alaska's population currently does not justify the expense of providing the type of care envisioned within this Level. Equally important is that this aspect of tertiary care often deals with entities of relatively low incidence in the general population, so that centralization is necessary for a sufficient case load to maintain the technical proficiency of the staff. Economics and quality thus warrant provision of Level V services outside of the state.

ON THE FOLLOWING PAGES ARE DEPICTED THE FIVE COMMUNITY LEVELS CATEGORIZED IN THE ALASKA STATE HEALTH PLAN. FOR EACH LEVEL THERE ARE LISTED THE CRITERIA CONSIDERED FOR DESIGNATING A COMMUNITY AT THAT LEVEL. LISTED ALSO ARE THE SERVICES, FACILITIES AND MANPOWER WHICH SHOULD BE PRESENT AT THAT "LEVEL OF CARE", INCLUDING THOSE RELATING TO EMERGENCY MEDICAL SERVICES.

THE RECOMMENDATIONS OUTLINED ON THE COLORED PAGES OF THIS EMS PLANNING GUIDE ARE AN EXPANSION OF THE RECOMMENDED SERVICES, FACILITIES AND MANPOWER GUIDELINES FOR EACH OF THESE COMMUNITY "LEVELS OF CARE". THE RECOMMENDATIONS FOCUS ON EMERGENCY MEDICAL SERVICES APPROPRIATE FOR EACH "LEVEL OF CARE".

LEVEL I

VILLAGE

CRITERIA

Population.....25 - 750, immediate community

Proximity*.....more than 30 minute access to a higher level (of care) by year-round surface transportation.

GUIDELINES

SERVICES

.Primary Care for common acute illness

.Reception, System entry

.Referral services

.Diagnostic screening, preliminary workup

.Preventive services

.Limited formulary pharmacy services

.Education, counseling

.Health Promotion Services

.Itinerant Services

- -Dental
- -Eye
- -Behavioral Health
- -Physician
- -Audiology
- -Preventive

.Home Health Aide/Homemaker Services

.Basic Life Support System

FACILITIES

.Space that can be used for Clinic purposes. As possible the space should be provided with:

- -Electricity
- -Water
- -Heat
- -Private Examination Area with Examination Table
- -Secure Storage
- -Reliable Communications Line to a Referral Center (Radio and/or Telephone)

MANPOWER

.Community Health Aide and Alternate Person, trained at EMT I level

.Homemaker

.Itinerant Public Health Nurse

.Itinerant Behavioral Health Worker

.Itinerant Health Specialist(s)

* Proximity refers to a given community's nearness to another community of the same and/or higher level. Proximity criteria are intended to prevent unnecessary duplication of resources.

LEVEL II

SUB-REGIONAL CENTER

CRITERIA

Government (or Social Organization).....	preferably incorporated government; de facto town council; active formal community organizations, especially those with human services orientation.
Population	500 - 2500 in immediate community or a service area population of at least 1000.
Proximity*	generally should be more than 30 minutes by year-round surface transportation from another community providing a Level II or higher level of services.
Accessibility**.....	generally should be within 30 minutes access time to outlying villages.
Transportation.....	transportation network to outlying villages and to a Level III or IV Community.
Communications.....	a reliable radio or phone service to a Level III or IV Community.
Economic Development.....	basic services to outlying villages.

GUIDELINES

SERVICES

- .All Services proposed for Level I
- .Consultation to Providers in Level I
- .Ambulatory Medical & Surgical Procedures
- .Supervised overnight Patient Care
- .Itinerant Dental Services
- .Basic Diagnostic Services Including Limited X-ray & Lab Capability
- .General Pharmaceutical Services
- .Education, Counseling, Promotive Services
- .Support, Supply, Administrative Services for Level I Communities
- .Long Term Care Alternatives
- .Nutrition Services
- .Advanced Life Support System without cardiac capability

FACILITIES

Health Center

MANPOWER*

- .Physician assistant or nurse practitioner
- .Public Health Nurse
- .EMT II
- .Behavioral Health Counselor
- .Home Health Aide(s)/Homemakers (as appropriate)

*(Manpower should be available as appropriate to the particular community)

** Accessibility refers to the ease with which a given community can be reached from outlying areas. Accessibility criteria are intended to foster access to resources.

LEVEL III

REGIONAL CENTER

CRITERIA

Government.....should be incorporated

Population .....1500 - 50,000 in immediate community and greater than 3,000 in Primary Service Area

Proximity*.....Should be more than 30 minutes by year round surface transportation from another community providing a level III or higher level of services.

Accessibility**.....Immediate community should be within 60 minutes travel time for at least 90% of population in Primary service area.

Transportation.....shculd have daily scheduled airline, rail, marine, or bus services to a Level IV or V Community, or should have less than 60 minutes travel time by private auto to a Level IV or V Community.

Communications..... Statewide phone network; radio, some T.V.

Economic Development..... serve as a service center (maintenance services, commodities, financial, transportation) to Level I and II Communities within its primary service area.***

GUIDELINES

SERVICES

.All Services Proposed for Level II
.Consultation to Level I & II Providers
.Short Stay Institutional Services
.Chronic Care & Long-Stay Institutional Services
.Pharmacy Services
.Optometrist Services
.Diagnostic X-ray Services
.Support, supply & Administrative Services to Level II
.Community Based:
  -Mental Health
  -Substance Abuse/Alcohol Rehab.
.Mobile EMS Capacity
.Short Term Shelter Care
.Detox. Capabilities
.Dental Services
.Clinical Laboratory Services including:
Walk-in Blood Bank
.Advanced Life Support Systems with Cardiac Capabilities

FACILITIES

.Hospital:
  -general surgery as appropriate
  -acute & long term beds
  -class 3 emergency care

.Health Center
.Community Mental Health Ctr.
.Physician Clinic(s)
.Dental Clinic(s)
.Nursing Home or LTC nursing beds associated with hospital

MANPOWER

.Same as Level II plus:
.Primary Care Physician(s)
.Itinerant Specialist Physicians.
.Hospital Support Staff:
  -X-Ray Technician
  -Medical Technologist
  -Lab Technician
.Dentist(s)

FACILITIES Con't.

- .Optometrist(s)
- .Pharmacist(s)
- .Psychologist/Mental Health Clinician(s)
- .MSW/Social Worker(s)
- .Sanitarian

***Primary service area refers to that area which rationally relates to the community for most of the services not provided elsewhere in that area and includes that population within the immediate and surrounding area.

LEVEL IV

URBAN CENTER

CRITERIA

Government	be incorporated and either be a unified home rule municipality (preferably having health powers and providing health services' or be located in an organized borough.
Population	30,000 - 750,000 immediate community.
Transportation.....	daily scheduled transportation services to Level III Communities within its health service area and to closest Level V Community.
Communications.....	statewide phone network; radio, T.V.
Economic Development.....	serve as a commercial service center including specialty health services to Level III Communities within its secondary service area (generally, a health service area); preferably some industrial activity

GUIDELINES

SERVICES

- .All Services Proposed for Levels 1, II, and III Communities
- .Consultation to Level 1, II, III Providers
- .Specialized Major Medical Services
- .Class II Emergency Services Capability (Hospital)
- .Major Diagnostic Services
- .Clinical Laboratory Services including Blood Bank
- .Basic Rehabilitation Services
- .Opthalmic Care Services
- .Center for a Uniform Health Information System
- .Communication Linkages to all Levels
- .Mechanisms for Mobilizing EMS Services for Catastrophic Disasters involving mass casualties
- .Therapeutic Radiation Capability
- .Pathology and Autopsy Capability
- .State designated Capacity for Mental Health & Alcoholism inpatient committal.

FACILITIES

See discussion of services on previous pages. Appropriateness in general will be determined on the basis of population and expected utilization of such facilities as well as economic & practical feasibility. Delineation of such facilities (or portions thereof) will occur through the review of new & existing institutional health services.

MANPOWER

To be determined according to services.

LEVEL V

METROPOLIS *

Government.....	Incorporated, within a higher level sub-state entity (county equivalent) having health powers and providing health services and/or health industry regulation.
Population.....	450,000 +, immediate community
Accessibility.....	daily major airline service to Level IV Communities.
Communications.....	sophisticated and comprehensive communications network.
Economic Development.....	major trade and service center; stable industry.

RECOMMENDATIONS

Highly advanced specialized care is recommended for Level V, including the following examples:

SERVICES	FACILITIES
Organ transplants Complex Pediatric Heart Surgery Burn Center	Medical/Dental School Facility

The SHCC will develop other recommendations to influence decisions concerning Level V services which serve as multistate resources.

* There are no Level V Communities in Alaska at present.

Appendix X: Transcript of EMS-related Testimony Presented at Senate HESS Interim Hearings

Senate HESS Committee Hearing in Fairbanks, September 12, 1981.

Jeanne Ostnes, Interior Sub-region EMS Coordinator: She spoke on several issues related to EMS problems in the Interior. Equipment retrieval (back to villages from hospitals) a continuing problem. More backup equipment is needed in the villages. Payment for transportation costs to private air ambulance carriers is a problem (no method of ensuring payment from private citizens, especially those who may reside Outside). Stresses all EMS funds should be funneled through the same department - suggest H & SS. Pointed out deficiencies in EMS communications. Statewide insurance package a possibility for ambulance services? (Insurance comes through fire departments at present...all except those of largest towns are volunteer. Stressed the need for an EMS training center in the Fairbanks area, where equipment could be stored and EMT training classes held. Discussed MAST (Military Assistance to Safety and Traffic) helicopter medivac.

Jennifer Gleason, EMS Northern Region Director: She touched on the need for someone to enforce the new EMS regulations when they come into effect in January 1982. She emphasized EMS on-going training was the biggest need, especially in rural areas, also the coordination between hospitals and EMT expertise in the field needed to be better. EMT training in field could be accomplished by "curcuit riders". She also pointed out that a central dispatch (911) was very helpful. She also felt liability insurance must be given consideration - Alaska has three sets of "Good Samaritan" laws. (Conflicting Attorney General opinion on this.)

Arturo Frizzera, Interior Region EMS: He said there were about 3,000 EMT-I, 1,500 EMT II, 100 EMT III and 35 licensed paramedics in the state at this time. He felt the state needed a trainer plus one staff person to coordinate regional trainers. The Interior needs a training facility (building) of its own, they are presently spending from $1,300 - 3,300 per class on renting school space. He praised the central dispatch system being set up in other communities and stressed the need for same in Fairbanks. Mentioned MAST helicopter service provided by the military to points in the Interior, and some problems with coverage of wide area.

Senate HESS Committee Hearing in Soldotna, September 26, 1981.

Michael Herring, South Peninsula Hospital Coordinator: In response to a question he stated that there were excellent EMTs associated with the fire department (in Homer? Peninsula wide?), but that their service district was very large... and also mentioned the problems the carriers had collecting from the emergency patients they hauled.

Senate HESS Committee Hearing in Nome, November 7, 1981.

Dick Bullock, Norton Sound EMS: Only 7 villages of 16 have phones (specifically) for health aides. Indian Health Service has stopped

funding the $850 per month to subsidize these phones. No privacy in discussion of patient's problems on public phone located in the store...also difficulties in access sometimes. NSEMS trained National Guard last year, eight of whom qualified as EMT-I. There are about ten EMTs in Nome at present, but there is a high turnover. Problems experienced with payment for ambulance. Equipment retrieval from Anchorage a problem. Problems with maintenance of EMS communications single sideband radios...equipment old. Trained village health aides in EMS techniques. Problems with funding - lost federal funding to travel to the villages to give instruction this past year. Hard to maintain enough EMTs to man the ambulance in Nome because of turnover in people. EMS trains for medical care (emergency) in the area, while the troopers provide search and rescue training. Disaster preparedness is not dealt with at all, funds being the big problem.

Fred Angleton, Alaska State Trooper, President of EMS Advisory Council: Air costs are going up and often must charter, trip from a village to Nome can run $300 - 500 for a round trip. Most single sideband communications equipment about 12 years old and in need of frequent repair. A study is being done at present to make plans for a communications network on the west coast to serve EMS, search and rescue, troopers, etc. The intent is to put together material from many sources into a packet before attempting to upgrade communcations.

Comments on EMS from Jeanette Morton, Norton Sound Hospital, during tour of hospital prior to public hearing: The Nome ambulance service is run by volunteers. The ambulance is owned by the Norton Sound Regional (Native) Corporation, which rents it back to the volunteers for a dollar a year.

Senate HESS Committee Hearing in Bethel, November 14, 1981.

Joe Ryan, IHS Hospital Administrator: Emergency charters are the most expensive forms of air travel, which is tremendously increasing in cost . Travel and communication a priority in area.

Dr. John Weatherby: Many villages have a phone in public places, 15 villages have phones in clinics, 48 have side-band radio communications. Emergencies can generally be handled with system, although phones sometimes don't work, privacy is a problem.

Joe Friedman: EMS does patient education in the villages occasionally.

Notes on the Senate HESS Committee Hearing in Anchorage, on December 15, 1981, will be available to the Committee at the start of the legislative session in January.

Appendix XI: Tanana Chiefs Conference Resolution, Presented at the 1981 AFN Convention

TANANA CHIEFS CONFERENCE, INC.

EMERGENCY MEDICAL ASSISTANCE

RESOLUTION NO. 81-08

WHEREAS, The State of Alaska bears the responsibility for emergency medical assistance for residents and visitors to the State, and

WHEREAS, currently State financial support for ambulance services in rural communities is not adequate to assist in offsetting costs incurred in responding to emergencies occurring inside/outside of their usual service areas, and

WHEREAS, reimbursement by consumers for the costs of these responses has been historically low, placing a financial burden on the ambulance services, and

NOW, THEREFORE BE IT RESOLVED that the Alaska Federation of Natives, Inc. hereby urges the Alaska State Legislature and the Division of Emergency Medical Services to provide adequate continuing supplemental financial assistance to ambulance services in rural communities to support their responses to remote emergencies.

APPROVED:

_____

Appendix XII: EMS Related Responses from Health Systems Questionnaire Sent Out By Senate HESS Committee to Health Care Providers

Health, Education and
Social Services Committee

Charlie Parr, Chairman
Terry Stimson, Vice-Chairman
Vic Fischer
Tim Kelly
Mike Colletta

Official Business

Alaska State Legislature

Senate

Pouch V
State Capitol
Juneau, Alaska 99811
465-4907
465-4906

June 1981

Dear Sir or Madam:

Health care issues and the cost of providing health services has become a national concern. Proposed changes in Federal funding and regulations makes this an appropriate time to reconsider the health systems in Alaska.

To this end, the Senate HESS Committee is investigating many health issues in preparation for the 1982 Legislative Session.

The Committee would appreciate your cooperation in promptly returning this questionnaire to the above address. Any further comments you wish to make on any health care topics will be welcomed and fully considered.

Sincerely,

Charles H. Parr
Chairman

THIS COVER LETTER ACCOMPANIED HEALTH CARE QUESTIONNAIRES SENT TO HEALTH CARE PROFESSIONALS STATEWIDE. SUMMARIZED RESPONSES FROM THOSE WHO RETURNED QUESTIONNAIRES FOLLOWS.

PROFESSIONAL

6. Are there conditions effecting your profession that you think are unique to Alaska?

Yes	272
No	66
No response	73
Unknown	14

	COMMENTS	TIMES REPORTED
1.	Continuing Education not local, travel, expense. time off	56
2.	Isolation/rural	51
3.	Travel for health care	50
4.	Lifestyle-violence, accidents, alcoholism, transience	31
5.	Rural professionals more responsibility, distance from supervisor	23
6.	Travel to give care, itinerant	19
7.	Weather	14
8.	Difficult to continue patient follow-up	12
9.	Socio-cultural differences, dual system-native/non-native	11
10.	Overhead/cost of living	11
11.	Isolated, lack of professional stimulation	8

Do you see an increased need for Para-professionals?

Yes	154
No	145
No response	26
Unknown	9

	COMMENTS	TIMES REPORTED
1.	Mid-level practitioners needed for rural	58
2.	Too many health care providers at present	26
3.	Need to sponsor training for ANP and family practice RN	20
4.	EMS/EMT special training	11
5.	Routine Primary care.	11
6.	Prevention/Education	9
7.	Efficient, cost effective, immediate care	8
8.	Poorly trained, dangerous	8

All physicians were sent a copy of HB 327, concerning the licensing of Naturopathic Practitioners, and the questionnaire asked for comments. Those received were:

4	Favor
57	Opposed
5	Unknown
12	No comment

Remarks:	Number of respondents
Quackery	25
Poorly trained, inadequate for duties in bill	18
Licensing would mislead public, danger to citizens	15
May delay needed treatment	9
No surgery, x-ray	9
No obstetrics	9
No prescription capabilities	8
Fraudulent, life threatening	8
State cannot legislate hospital privileges	7
State should investigate practitioners for education/ preparation; followup on fraud and incompetence	4
Responsibilities too broad	4
Waste of state money	2

All Physicians were asked if they had any contact with the rural health delivery system, and for comments

45	Yes
25	No
44	No response
2	Unknown

Comments	Number of respondents
System in good balance, appropriate, constantly upgraded	18
Health Aides work well, need more financial support, skill upgrading	10
Need alcohol abuse education	7
Need EMS communications upgrading	5
Need more health promotion, prevention	5
Expensive	5

Need more Mental Health Services(violence, lifestyle)	4
Travel greatest problem	4
Unsophisticated, minimal care	3
PHS should not compete with private practice	3
Need survival techniques	3
Need more school health education	3
Abolish AANHS/IHS	2
No payment mechanism for M.D. fees	2
Need rehabilitative medicine, specialists	2

Other comments:

The state needs to promote older, more experienced physicians looking for a change in lifestyle to work in rural alaska.

Federal and state regulations are incompatible for rural health and hospitals.

Travel and lodging payments to physicians would encourage more to have rural clinics, as fees do not meet expenses.

State needs to assist Native Corporations as they assume health care responsibilities, and local control.

Need strict penalties for alcohol related crime.

EMT skill, improved communication and transportation have greatly upgraded care in the Fairbanks area

Community Anchorage Number of respondents 183

		Yes	No	Unknown
1.	Is health care accessible in your area?	169	4	
2.	Is transportation to facilities a problem?	24	164	
	Comments old, handicapped and poor 7 poor public transportation 2			
3.	Are Emergency Medical Services available?	182	1	
	Do they function efficiently?	182	1	
4.	Does your area have an alternative birthing center?	157	7	19
	Is there a demand for one?	18	8	5
5.	Does any doctor in your area do home births?	28	56	76
6.	Is there a lay midwife in your area?	27		
	Is there a nurse midwife in your area?	93		
	Should the state license lay midwives?	70	80	18
6.	Have you had contact with Home Health?	83	73	10
	Is there a demand for this service?	50	3	6
	Comments good program 78 need more funds/staff 36 need RN 4 cost effective 21 preserve dignity at home 17 local control 2			
7.	Does your area have mental health services?	151	3	3
8.	Does your area have alcohol/drug abuse services?	165	1	2
9.	Is Family Planning available?	92		8
10.	Is health education in your school curriculum?	119	3	35
11.	Does your area have hospice services?	56	64	43
	Is there an interest in services for the terminally ill?	69	2	9

12. What services and providers are needed in your area?

Nurse 16
OB-GYN 13
Surgeons 16
Long term care 4
high quality mental health 6
specialists 17
prevention/adult screening 18
child protection 4
sheltered care 11
transition care 7
therapists 4

Community Fairbanks Number of respondents 67

		Yes	No	Unknown
1.	Is health care accessible in your area?	66		
2.	Is transportation to facilities a problem?	15	43	
	Comments distance/rural 14 expense 3 weather 4			
3.	Are Emergency Medical Services available?	62		
	Do they function efficiently?	61	3	3
4.	Does your area have an alternative birthing center?	24	19	11
	Is there a demand for one?	19	5	9
5.	Does any doctor in your area do home births?	10	32	19
6.	Is there a lay midwife in your area?	1/		
	Is there a nurse midwife in your area?	16		
	Should the state license lay midwives?	26	21	7
6.	Have you had contact with Home Health?	33	24	
	Is there a demand for this service?	21		
	Comments: good program 28 contract locally 1			
7.	Does your area have mental health services?	44	4	1
8.	Does your area have alcohol/drug abuse services?	47	2	3
9.	Is Family Planning available?	33	1	2
10.	Is health education in your school curriculum?	1		9
11.	Does your area have hospice services?	3	15	9
	Is there an interest in services for the terminally ill?	10	1	2

12. What services and providers are needed in your area?

Nurse 10
specialists 12
ancillary services 4
long term care

mental health follow up/sheltered living 15
rehabilitation facility 5
alcohol halfway house 8
radiation therapy 2

Community Juneau Number of respondents 30

	Yes	No	Unknown
1. Is health care accessible in your area?	28	1	
2. Is transportation to facilities a problem?	10	16	1
Comments expense 3 rural non-natives served in Juneau			
3. Are Emergency Medical Services available?	29		
Do they function efficiently?	24		
4. Does your area have an alternative birthing center?	13	18	2
Is there a demand for one?	14	3	2
5. Does any doctor in your area do home births?	2	25	2
6. Is there a lay midwife in your area?	4		
Is there a nurse midwife in your area?	10		
Should the state license lay midwives?	26	21	7
6. Have you had contact with Home Health?	23	7	
Is there a demand for this service?	12		
Comments good program 21 cost effective 6 better staff pay 7 expand to rural 2 need foster care 1			
7. Does your area have mental health services?	25	2	
8. Does your area have alcohol/drug abuse services?	29		
9. Is Family Planning available?	26		1
10. Is health education in your school curriculum?	18	10	2
11. Does your area have hospice services?	18	12	
Is there an interest in services for the terminally ill?	23	2	5

12. What services and providers are needed in your area?

General Practitioners 7
OB-GYN 15
nurse 4
specialists 10
Mental Health 8
halfway house 3
child protection 3
Accident prevention 3
adult screening 6
expand WIC 2
Prevention 8

Community Palmer-Wasilla Number of respondents 20

		Yes	No	Unknown
1.	Is health care accessible in your area?	17	3	
2.	Is transportation to facilities a problem?	12	8	
	Comments weather 3 distance, expense 5			
3.	Are Emergency Medical Services available?	18	1	1
	Do they function efficiently?	19		
4.	Does your area have an alternative birthing center?	1	15	1
	Is there a demand for one?	12	3	
5.	Does any doctor in your area do home births?	3	12	8
6.	Is there a lay midwife in your area?	6		
	Is there a nurse midwife in your area?	6		
	Should the state license lay midwives?	5	9	1
6.	Have you had contact with Home Health?	10	6	
	Is there a demand for this service?	9		
	Comments good program 9 expansion needed 5			
7.	Does your area have mental health services?	12	4	1
8.	Does your area have alcohol/drug abuse services?	15	2	1
9.	Is Family Planning available?	17		1
10.	Is health education in your school curriculum?	9	1	7
11.	Does your area have hospice services?	2	14	1
	Is there an interest in services for the terminally ill?	6	4	3

12. What services and providers are needed in your area?

Mental health counseling, residential 6
Nurse/mid-level 3
OB-GYN 2
Family planning(minimal, infrequent)
residential detox 2
health ed.(Palmer) 2
Dental/optical 3

Community Kenai Peninsula Number of respondents 22

		Yes	No	Unknown
1.	Is health care accessible in your area?	20	2	
2.	Is transportation to facilities a problem?	15	5	
	Comments expensive 2			
3.	Are Emergency Medical Services available?	22		
	Do they function efficiently?	22		
4.	Does your area have an alternative birthing center?		22	
	Is there a demand for one?	19	3	
5.	Does any doctor in your area do home births?	6	16	
6.	Is there a lay midwife in your area?	12		
	Is there a nurse midwife in your area?	9		
	Should the state license lay midwives?	9	12	1
6.	Have you had contact with Home Health?	15	6	1
	Is there a demand for this service?	12	1	3
	Comments good program 11 Need RN 4 More funding/staff 2			
7.	Does your area have mental health services?	21	1	
8.	Does your area have alcohol/drug abuse services?	20	2	
9.	Is Family Planning available?	20	1	1
10.	Is health education in your school curriculum?	14	3	5
11.	Does your area have hospice services?	2	26	
	Is there an interest in services for the terminally ill?	13	9	

12. What services and providers are needed in your area?

Nurse 4
OB-Gyn 3
Mental Health 3
Specialities 16
Family planning(Homer)
Surgery 4
inpatient mental health 4
Detox 9
sheltered living 5
optical
diagnostic

Community Kodiak Number of respondents 10

		Yes	No	Unknown
1.	Is health care accessible in your area?	10		
2.	Is transportation to facilities a problem?	4	6	
	Comments weather 1			
3.	Are Emergency Medical Services available?	10		
	Do they function efficiently?	10		
4.	Does your area have an alternative birthing center?	6	4	
	Is there a demand for one?		3	
5.	Does any doctor in your area do home births?	5	5	
6.	Is there a lay midwife in your area?	3		
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	2	7	
6.	Have you had contact with Home Health?	8	1	
	Is there a demand for this service?	3		1
	Comments good program 8 needs expansion 6			
7.	Does your area have mental health services?	8	1	
8.	Does your area have alcohol/drug abuse services?	10		
9.	Is Family Planning available?	9	1	
10.	Is health education in your school curriculum?	6		4
11.	Does your area have hospice services?	5	4	
	Is there an interest in services for the terminally ill?	6		1

12. What services and providers are needed in your area?

Nurse 3
therapy 2
specialists 4
Home Health 2
OB-GYN 2
Mental health outpatient and follow-up 4
Psychiatrist 2
Prevention/adult screening 7

Community Valdez Number of respondents 3

		Yes	No	Unknown
1.	Is health care accessible in your area?	3		
2.	Is transportation to facilities a problem?	3		
	Comments weather 2			
3.	Are Emergency Medical Services available?	3		
	Do they function efficiently?	3		
4.	Does your area have an alternative birthing center?		3	
	Is there a demand for one?	2	1	
5.	Does any doctor in your area do home births?		2	1
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	2		1
6.	Have you had contact with Home Health?		3	
	Is there a demand for this service?		2	1
	Comments			
7.	Does your area have mental health services?	3		
8.	Does your area have alcohol/drug abuse services?	3		
9.	Is Family Planning available?	1		1
10.	Is health education in your school curriculum?	3		
11.	Does your area have hospice services?	3		
	Is there an interest in services for the terminally ill?	1	2	

12. What services and providers are needed in your area?

Surgery 2
specialists 2
alcohol crisis intervention
prevention
school health ed. inadequate 1

Community Ward Cove Number of respondents 2

		Yes	No	Unknown
1.	Is health care accessible in your area?	2		
2.	Is transportation to facilities a problem?	2		
	Comments Expensive 1			
3.	Are Emergency Medical Services available?	2		
	Do they function efficiently?	2		
4.	Does your area have an alternative birthing center?		2	
	Is there a demand for one?		1	1
5.	Does any doctor in your area do home births?		2	
6.	Is there a lay midwife in your area?	2		
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1	1	
6.	Have you had contact with Home Health?	1	1	
	Is there a demand for this service?	1		
	Comments good program 1 needs better funding 1			
7.	Does your area have mental health services?	2		
8.	Does your area have alcohol/drug abuse services?	2		
9.	Is Family Planning available?	2		
10.	Is health education in your school curriculum?	1	1	
11.	Does your area have hospice services?		2	
	Is there an interest in services for the terminally ill?	2		

12. What services and providers are needed in your area?

Dentist
Physician

Community Haines Number of respondents 3

		Yes	No	Unknown
1.	Is health care accessible in your area?	3		
2.	Is transportation to facilities a problem?	3		
	Comments air travel expense 1 weather 1			
3.	Are Emergency Medical Services available?	3		
	Do they function efficiently?	3		
4.	Does your area have an alternative birthing center?		3	
	Is there a demand for one?		2	1
5.	Does any doctor in your area do home births?	1	2	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?	1		
	Should the state license lay midwives?	1	2	
6.	Have you had contact with Home Health?	1	2	
	Is there a demand for this service?	2		
	Comments good program 1			
7.	Does your area have mental health services?		3	
8.	Does your area have alcohol/drug abuse services?	3(A.A.)		
9.	Is Family Planning available?	2	1	
10.	Is health education in your school curriculum?	2	1	
11.	Does your area have hospice services?		3	
	Is there an interest in services for the terminally ill?		2	1

12. What services and providers are needed in your area?

family planning
mental health 2
Home Health 1
specialist 3
counseling
alcohol halfway house

Community Petersburg Number of respondents 9

		Yes	No	Unknown
1.	Is health care accessible in your area?	9		
2.	Is transportation to facilities a problem?	4	3	
	Comments weather 4 travel expense 2			
3.	Are Emergency Medical Services available?	9		
	Do they function efficiently?	8		
4.	Does your area have an alternative birthing center?	2	7	
	Is there a demand for one?	4	1	
5.	Does any doctor in your area do home births?		9	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1	8	
6.	Have you had contact with Home Health?	7	2	
	Is there a demand for this service?	6		
	Comments good program 5 Need Visiting Nurse 1 Need expansion 3			
7.	Does your area have mental health services?	7	1	1
8.	Does your area have alcohol/drug abuse services?	8		1
9.	Is Family Planning available?	9		
10.	Is health education in your school curriculum?	8		1
11.	Does your area have hospice services?		9	
	Is there an interest in services for the terminally ill?	2	1	

12. What services and providers are needed in your area?

RN 3	EMS equipment	halfway house
M.D. 2	Specialists 6	Home Health
OG-GYN 1	Psychiatrist	adequate school ed.
ANP 1	Detox	alcohol follow-up

Community Ketchikan Number of respondents 6

		Yes	No	Unknown
1.	Is health care accessible in your area?	6		
2.	Is transportation to facilities a problem?	3	3	
	Comments			
3.	Are Emergency Medical Services available?	6		
	Do they function efficiently?	5		
4.	Does your area have an alternative birthing center?		6	
	Is there a demand for one?		4	2
5.	Does any doctor in your area do home births?		6	
6.	Is there a lay midwife in your area?	5		
	Is there a nurse midwife in your area?	3		
	Should the state license lay midwives?	1	5	
6.	Have you had contact with Home Health?	4	1	
	Is there a demand for this service?	4		
	Comments good program 3 needs expansion 3			
7.	Does your area have mental health services?	6		
8.	Does your area have alcohol/drug abuse services?	5	1	
9.	Is Family Planning available?	6		
10.	Is health education in your school curriculum?	3	3	
11.	Does your area have hospice services?		6	1
	Is there an interest in services for the terminally ill?	3	1	

12. What services and providers are needed in your area?

Physician 2
Nurse 1
prevention/diagnostic specialists 3
Psychiatrist
Detox 4
Acute Mental Health
EMT training

Community Wrangell Number of respondents 4

	Yes	No	Unknown
1. Is health care accessible in your area?	4		
2. Is transportation to facilities a problem?	1	2	
Comments			
3. Are Emergency Medical Services available?	4		
Do they function efficiently?	3	1	
4. Does your area have an alternative birthing center?		4	
Is there a demand for one?		4	
5. Does any doctor in your area do home births?		4	
6. Is there a lay midwife in your area?			
Is there a nurse midwife in your area?			
Should the state license lay midwives?	1	3	
6. Have you had contact with Home Health?	4		
Is there a demand for this service?	3		
Comments good program, cost effective, need funding	2		
7. Does your area have mental health services?	3	1	
8. Does your area have alcohol/drug abuse services?	4		
9. Is Family Planning available?	4		
10. Is health education in your school curriculum?	2	1	1
11. Does your area have hospice services?		4	
Is there an interest in services for the terminally ill?	3		

12. What services and providers are needed in your area?

Physician 2
Mental health 1
Long term care
Diagnostic
Detox
Specialists 2
Larger alcohol facility

Community Pelican Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?			
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments Hard to find staff, need better pay			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

12. What services and providers are needed in your area?

Physician
X-ray
Detox

Community Sitka Number of respondents 9

		Yes	No	Unknown
1.	Is health care accessible in your area?	6		
2.	Is transportation to facilities a problem?	4	5	
	Comments distance. weather 2			
3.	Are Emergency Medical Services available?	9		
	Do they function efficiently?	6		
4.	Does your area have an alternative birthing center?	9		
	Is there a demand for one?	3	1	1
5.	Does any doctor in your area do home births?		9	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?	2		
	Should the state license lay midwives?	5	3	
6.	Have you had contact with Home Health?	6	3	
	Is there a demand for this service?	3	2	
	Comments good program 6 need expansion 1			
7.	Does your area have mental health services?	9		
8.	Does your area have alcohol/drug abuse services?	8		
9.	Is Family Planning available?	8		
10.	Is health education in your school curriculum?	7	1	1
11.	Does your area have hospice services?	4	5	
	Is there an interest in services for the terminally ill?	4	2	1

12. What services and providers are needed in your area?

Nurse 2
Pediatrician 3
OB-GYN 2
Mental health facility, counseling 4
tertiary care 3

Community Bethel Number of respondents 4

		Yes	No	Unknown
1.	Is health care accessible in your area?	4		
2.	Is transportation to facilities a problem?	4		
	Comments weather 2 lost PHS funding 1			
3.	Are Emergency Medical Services available?	4		
	Do they function efficiently?	3	1	
4.	Does your area have an alternative birthing center?		4	
	Is there a demand for one?	3		1
5.	Does any doctor in your area do home births?		4	
6.	Is there a lay midwife in your area?	1		
	Is there a nurse midwife in your area?	2		
	Should the state license lay midwives?		3	1
6.	Have you had contact with Home Health?	2	2	
	Is there a demand for this service?	4		
	Comments good program 3 needs better funding 2			
7.	Does your area have mental health services?	3	1	
8.	Does your area have alcohol/drug abuse services?	4		
9.	Is Family Planning available?	4		
10.	Is health education in your school curriculum?	2		2
11.	Does your area have hospice services?		3	
	Is there an interest in services for the terminally ill?	1		3

12. What services and providers are needed in your area?

Physicians 2
Nurse 1
Specialists 4
CMHC 1
counseling 4
Psychiatrist 3
sheltered living 3
inhalation therapy 1

Community Nome Number of respondents 3

		Yes	No	Unknown
1.	Is health care accessible in your area?	3		
2.	Is transportation to facilities a problem?	2	1	
	Comments weather 2 expense PHS funding cut			
3.	Are Emergency Medical Services available?	3		
	Do they function efficiently?	3		
4.	Does your area have an alternative birthing center?	1	2	
	Is there a demand for one?	1	2	
5.	Does any doctor in your area do home births?		3	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1	1	
6.	Have you had contact with Home Health?	3		
	Is there a demand for this service?			
	Comments			
7.	Does your area have mental health services?	3		
8.	Does your area have alcohol/drug abuse services?	3		
9.	Is Family Planning available?	2	1	
10.	Is health education in your school curriculum?	1		1
11.	Does your area have hospice services?		2	
	Is there an interest in services for the terminally ill?	1		1

12. What services and providers are needed in your area?

Nurse 3
Home health
Physician 2
Education 2

CAP alcohol funding gone
need alcohol staff support

Community McGrath Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?		1	
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?	1		
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?			
	Comments not available			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			1

12. What services and providers are needed in your area?
residential mental health facility

Community Chevak Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments expensive			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?	1		
	Is there a demand for one?		1	
5.	Does any doctor in your area do home births?	1		
6.	Is there a lay midwife in your area?	1		
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments good program			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?		1	
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			1

12. What services and providers are needed in your area?

optometry
dental
counseling
sheltered living
stress relief
school health ed inadequate
Mental health and alcohol

Community Barrow Number of respondents 2

		Yes	No	Unknown
1.	Is health care accessible in your area?	2		
2.	Is transportation to facilities a problem?	1	1	
	Comments			
3.	Are Emergency Medical Services available?	2		
	Do they function efficiently?	2		
4.	Does your area have an alternative birthing center?		2	
	Is there a demand for one?	1	1	
5.	Does any doctor in your area do home births?		2	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	2		
6.	Have you had contact with Home Health?	1	1	
	Is there a demand for this service?	2		
	Comments lack adequate supervision 1			
7.	Does your area have mental health services?	2		
8.	Does your area have alcohol/drug abuse services?	2		
9.	Is Family Planning available?	2		
10.	Is health education in your school curriculum?	1	1	
11.	Does your area have hospice services?		?	
	Is there an interest in services for the terminally ill?	1	1	

12. What services and providers are needed in your area?

Long Term Care
OB-GYN
Specialists 2
residential mental health
Detox 2
nurse 2
Physician 2

Community Tok Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?		1	
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?			1
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments			
7.	Does your area have mental health services?			
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?			1
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			1
12.	What services and providers are needed in your area?			

specialists

Community Healy Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?		1	
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments			
7.	Does your area have mental health services?	1		
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?		1	
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

12. What services and providers are needed in your area?

Hospital

specialists

Community Galena Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments			
3.	Are Emergency Medical Services available?		1	
	Do they function efficiently?			
4.	Does your area have an alternative birthing center?	1		
	Is there a demand for one?			
5.	Does any doctor in your area do home births?		1-no M.D.	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?			
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments good program, expand			
7.	Does your area have mental health services?	1		
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

12. What services and providers are needed in your area?

Physician
Hospital 300 mi.
Home health

Community Seward Number of respondents 7

		Yes	No	Unknown
1.	Is health care accessible in your area?	7		
2.	Is transportation to facilities a problem?	2	5	
	Comments			
3.	Are Emergency Medical Services available?	7		
	Do they function efficiently?	7		
4.	Does your area have an alternative birthing center?	7		
	Is there a demand for one?	3	3	1
5.	Does any doctor in your area do home births?		7	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?	1		
	Should the state license lay midwives?	3	2	
6.	Have you had contact with Home Health?	1	6	
	Is there a demand for this service?	4		2
	Comments good program 4			
7.	Does your area have mental health services?	7		
8.	Does your area have alcohol/drug abuse services?	6	1	
9.	Is Family Planning available?	5	1	1
10.	Is health education in your school curriculum?	3	2	2
11.	Does your area have hospice services?		7	
	Is there an interest in services for the terminally ill?	7		

12. What services and providers are needed in your area?

RN 3
Physician 2
Pharmacy 1
Diagnostic services 1
Specialists 4
Detox 3
Alcohol halfway house 2
Home Health

Community Hope Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?	1		
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?		1	
9.	Is Family Planning available?		1	
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?	1		

12. What services and providers are needed in your area?

Specialties

Family planning

Community Anchor Point Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?		1	
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?	1		
	Is there a nurse midwife in your area?	1		
	Should the state license lay midwives?			1
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?			
	Comments			
7.	Does your area have mental health services?	1		
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?		1	
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?		1	

12. What services and providers are needed in your area?
counseling, outpatient mental health

Community Seldovia Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?	1		
	Is there a demand for one?			
5.	Does any doctor in your area do home births?	1		
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?	1		
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?	1		
	Comments			
7.	Does your area have mental health services?	1		
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

12. What services and providers are needed in your area?

OB-GYN
Pediatritian
Mental Health facility and funding
Preventive Program

Community Glenallen Number of respondents 2

		Yes	No	Unknown
1.	Is health care accessible in your area?	2		
2.	Is transportation to facilities a problem?	2		
	Comments weather 2			
3.	Are Emergency Medical Services available?	2		
	Do they function efficiently?	2		
4.	Does your area have an alternative birthing center?		2	
	Is there a demand for one?		2	
5.	Does any doctor in your area do home births?		2	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		2	
6.	Have you had contact with Home Health?	2		
	Is there a demand for this service?	2		
	Comments			
7.	Does your area have mental health services?		2	
8.	Does your area have alcohol/drug abuse services?	2		
9.	Is Family Planning available?	2		
10.	Is health education in your school curriculum?	2		
11.	Does your area have hospice services?		2	
	Is there an interest in services for the terminally ill?			2
12.	What services and providers are needed in your area?			

Community Delta Junction Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?	1		
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?	1		
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?		1	
	Is there a demand for this service?	1		
	Comments			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

12. What services and providers are needed in your area?

Dental
Opthamology
Laboratory
X-ray

Preventive program

Community Dillingham Number of respondents 2

		Yes	No	Unknown
1.	Is health care accessible in your area?	2		
2.	Is transportation to facilities a problem?	2		
	Comments weather 1 rural 1			
3.	Are Emergency Medical Services available?	2		
	Do they function efficiently?	2		
4.	Does your area have an alternative birthing center?	1	1	
	Is there a demand for one?	1		
5.	Does any doctor in your area do home births?		2	
6.	Is there a lay midwife in your area?	1		
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?		2	
	Is there a demand for this service?			1
	Comments			
7.	Does your area have mental health services?	2		
8.	Does your area have alcohol/drug abuse services?	1	1	
9.	Is Family Planning available?	2		
10.	Is health education in your school curriculum?	2		
11.	Does your area have hospice services?		2	
	Is there an interest in services for the terminally ill?		1	

12. What services and providers are needed in your area?

nurse
Emergency room
EMT
Psychiatrist

Community Port Lions Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments rural			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?			
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1		
6.	Have you had contact with Home Health?	1		
	Is there a demand for this service?			
	Comments good program 1 needs expansion 1			
7.	Does your area have mental health services?	1		
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?	1		

12. What services and providers are needed in your area?

Resident RN
alcohol rehabilitation

Community Naknek Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?		1	
2.	Is transportation to facilities a problem?	1		
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?		1	
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?	1		
6.	Have you had contact with Home Health?		1	
	Is there a demand for this service?		1	
	Comments good program 1			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?		1	
9.	Is Family Planning available?		1	
10.	Is health education in your school curriculum?		1	
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?		1	

12. What services and providers are needed in your area?

Family planning
hospital

Community Dutch Harbor Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?		1	
	Comments			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	1		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?		1	
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?		1	
	Is there a demand for this service?		1	
	Comments			
7.	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?		1	
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?			

12. What services and providers are needed in your area?

OB-GYN

Mental Health

Community King Salmon Number of respondents 1

		Yes	No	Unknown
1.	Is health care accessible in your area?	1		
2.	Is transportation to facilities a problem?	1		
	Comments weather 1			
3.	Are Emergency Medical Services available?	1		
	Do they function efficiently?	just starting		
4.	Does your area have an alternative birthing center?		1	
	Is there a demand for one?			
5.	Does any doctor in your area do home births?		1	
6.	Is there a lay midwife in your area?			
	Is there a nurse midwife in your area?			
	Should the state license lay midwives?		1	
6.	Have you had contact with Home Health?		1	
	Is there a demand for this service?			1
	Comments			
7	Does your area have mental health services?		1	
8.	Does your area have alcohol/drug abuse services?	1		
9.	Is Family Planning available?	1		
10.	Is health education in your school curriculum?	1		
11.	Does your area have hospice services?		1	
	Is there an interest in services for the terminally ill?		1	

12. What services and providers are needed in your area?

Public health nurse
ANP
EMT training
mental health crisis intervention
counseling
alcohol abuse personnel

Appendix XIII: Summary of Some of the Accomplishments to Date of the Three EMS Regions

Northern Region Emergency Medical
Services Council, Inc.

P.O. Box 2120 Fairbanks, Alaska 99707 (907)456-3970

STATUS REPORT
on the
NORTHERN, INTERIOR, NANA REGION, AND NORTH SLOPE
EMERGENCY MEDICAL SERVICES PROGRAMS

by

Jennifer A. Gleason, RN, Exec. Director

The Northern Region EMS Council was incorporated two years ago to address the clinical training needs of the three subregions, to provide technical assistance as needed, and to be better aligned for federal funding and evaluation. Since that time the focus of the director has been to bring clinical specialists into the region to provide physician and nursing workshops, workshops for the outlying physicians' assistants and nurse practitioners, and provide on-site technical assistance as requested. Each of the hospitals has had yearly Advanced Cardiac Life Support training and the Council has provided equipment and organizational assistance for physician Advanced Trauma Life Support training.

Equipment needs for both hospital training and patient care have been identified and funded this year. Due to severe cuts in IHS funds, one might expect to see increased needs for rural hospital and clinic equipment and professional education support.

The Northern Region EMS Council remains committed to seeing that professional level emergency education and equipment receive the same degree of support that all of the first responder and ambulance programs do. The prehospital phases of the EMS program are carried out under the three subregional councils and their advances are described within this packet. The Northern Region Council feels, however, that the clinical goals of the program will best be carried out with a different organizational structure. At their Board meeting a few weeks ago, they took the recommendation of their director, Jennifer Gleason, and decided to dissolve at the end of the fiscal year.

All clinical goals described in last year's request will be carried out, and the clinical needs of each subregion will be clearly identified so that they might contract with their own clinical resource people next year. This local control in identifying clinical resource people should enhance all three programs.

INTERIOR REGION EMS COUNCIL

The Interior Region EMS Council is staffed by Coordinator Jeanne Ostnes, Training Coordinator Arturo Frizzera (responsible for EMT level training), Basic Training Coordinator David Akin (in charge of developing regionwide CPR and First Aid training), and Judie Harrison, Administrative Assistant. A full time Trainer will be hired at the first of the year.

For the first time since its organization (5 years ago) and its incorporation (3 years ago), the Interior Region EMS Council has budgeted for bush representatives to travel to regularly scheduled meetings so that the program can better address overall regional needs. The Council has three types of communities whose needs it is trying to meet - bush (not attached to highways), highway, and urban (Fairbanks). The type of training, equipment and technical assistance required varies considerably.

During this past year, the Council has provided EMT training in the communities of Ft. Yukon, Galena, and Tanana, and assistance with courses in McGrath and Tok. Once a trainer in on board in January, courses will be offered in Northway, Galena, Ft.Yukon, and Tanana again before spring breakup. Council staff plan to provide more technical assistance in coordinating the local emergency response, as the EMT's need some specific guidelines that they may adapt to their own communities. EMT training around the Fairbanks and highway communities is usually carried out under contract with local instructors.

Basic Training Coordinator David Akin has provided CPR and First Aid Instructor training in Ft. Yukon and Tanana, so that they can carry out their own classes. The focus of his program is to make each subregion relatively self-sufficient for CPR and First Aid training by training local resource people.

EQUIPMENT

Almost all of the ambulance services placed their equipment requests through the Interior Region Council last year so the staff has been very busy working with the services to individualize the purchases. Galena, Ft.Yukon, Tanana, and Tok received ambulances last year, and this year funds were allocated for Nenana (back-up ambulance), the University of Alaska (back-up), the Steese area, the Ester area, and McGrath. The old Tok ambulance will be relocated in Northway. Funds have also been received for ambulance communication and patient care equipment.

During the remainder of this fiscal year, Council staff will be identifying and training individuals along the uncovered areas of the highway to be "first responders". Trauma kits and communication gear will be provided for these volunteer responders.

The Council has a five member Communications Committee that addresses regional communications needs. For large projects (microwave systems along the highways), they work with the Division of Telecommunications, although the backlog due to understaffing in that division is a problem.

INTERIOR REGION EMS COUNCIL

Through funding received this year the Communications Committee will be trying out a VHF communications system in the McGrath subregion that may have later applicability to other subregions. In the past the only communication between the larger clinic in McGrath and the villages has been the IHS Black Phone system. The reliability of this system is decreasing, so other options must be explored.

STATEWIDE PARTICIPATION

Staff and responders from the Interior Region provide input on statewide issues at regional and statewide meetings. Jeanne Ostnes is the Chair of the Statewide Training Committee, the interim body responsible for advising the State Office of EMS on the implementation of the new EMT Regulations. At the end of January, there will be a special training session for training Certifying Officers for EMT training who will be required according to the new regulations.

The Interior Region Council, which spearheaded getting the MAST (Military Assistance to Safety and Transport) emergency helicopter response in the Interior, provides ongoing assistance for its medical reviews. During the past year and a half, the unit has provided life-saving care and transportation in 150 cases, including the McKinley Park bus disaster.

NORTH SLOPE BOROUGH

TRAINING

The North Slope Borough EMS Program , under Coordinator Sarah Jacoby, has been strengthened by the hiring of Bill Jones as a trainer. Sarah is better able to focus on overall coordination and Emergency Medical Technician training, while Bill, for the meantime, will be concentrating on having CPR and First Aid training available throughout the Borough. They have already trained CPR and First Aid instructors for Barrow, and Bill is helping to identify indivuduals in the villages who might be good local trainers.

The EMS Coordinator has worked closely with the Health Educator to ensure that the school curriculum includes CPR and First Aid concepts at appropriate age levels. They are also developing an Arctic Survival manual for distribution throughout the borough prior to this spring's camping and hunting season.

As the borough has the responsibility for maintenance of some facilities at Prudhoe Bay, emergency training (the 40 hr,Trauma Training course) has been requested. Bill and Sarah have provided one class and plan to do two more this winter.

EQUIPMENT

Equipment to aid in the EMS response in the borough this year has included patient transport kits for the villages, including folding stretchers, and additional training mannikins and other training equipment. The hospital, which has been greatly taxed by Barrow's rapid growth, and the amound of trauma that surrounds the influx of people and industry, is receiving a blood gas analyzer, by which patients with respiratory distress or trauma can be better evaluated and monitored.

DISASTER PLANNING

The EMS Coordinator works closely with the Fire Department, the Department of Public Safety, and the Hospital in planning periodic disaster drills. This year the site of the "disaster" was one of the new borough apartment buildings. By choosing this location, all responders were able to work out any access problems that they might have to that building. Both the EMS Coordinator and the trainer discuss the problems of handling multiple injuries while they are training or carrying out site visits in the villages or at a work site.

STATEWIDE PARTICIPATION

North Slope Borough personnel and search and rescue responders worked with the NANA Region Search and Rescue to prepare a panel for the statewide EMS Symposium in Anchorage. Unfortunately, they were unable to attend,because they were involved in a search!

Both Sarah Jacoby, and Carl Hild, who were involved in a cold-water near- drowning rescue this year provided input to the physicians developing the statewide guidelines for treatment of hypothermia and cold water near-drowning.

NANA REGION

The Maniilaq Association EMS Coordinator, Aggie Lie, and the trainer, Skeeter Jepson, work under the advisement of the NANA Region EMS Advisory Council, which meets monthly. They have continued the well planned development of their regional EMS system during this past year. Of particular interest are the following activities and accomplishments:

TRAINING

Self-sufficiency in meeting regional training needs has been increased this past year in several ways. Skeeter Jepson was hired as a trainer and went to the Public Safety Academy to become an EMT Instructor. She has coordinated both Emergency Medical Technician and Emergency Trauma Technician classes for the area since then, utilizing local physicians, nurses, mental health counselors, and search and rescue personnel, who are familiar with local problems and solutions.

Upon completion of a course this past month, ALL the Community Health Practitioners in the NANA Region and their alternates have been trained to the EMT level. Also this past year, emergency training has been offered to the National Guard, Search and Rescue personnel, and the Fire Department. In addition, both Aggie and Skeeter are both CPR and First Aid Instructor Trainers. They have trained CPR Instructors for Kotzebue and now plan to train instructors for the villages so that they can do their own training.

The EMS Coordinator has also worked closely with the Northwest Arctic School District to ensure that CPR and First Aid training are part of the school curriculum. EMS personnel will be doing the training at the present time, but, in the future it may be possible to train some of the teachers to carry out some of the training. Both instructors are willing guest instructors in the schools as they visit villages.

EQUIPMENT

Equipment that has enhanced emergency response and treatment in the NANA Region include a new ambulance, a new search and rescue boat, and a Civil Air Patrol hangar, which will also be the base of all search and rescue operations. The outlying clinics are being upgraded with transport kits, beds, IV poles, and the hospital is getting a back-up cardiac monitor-defibrillator, and emergency room instruments that have been needed for some time.

Communication equipment has enhanced coordination between the fire department, the trooper, the hospital, and all other responders.

DISASTER PLANNING

The EMS Council coordinated two disaster drills with all local responders - Fire Department, Police, Alaska State Troopers, National Guard, Rescue Coordination Center, Civil Air Patrol, the Hospital, and Search and Rescue.

STATEWIDE PARTICIPATION

Both Aggie and Skeeter represent the NANA Region at regional and state meetings. Skeeter is also the Bush-Bilingual representative to the Statewide Training Committee - the interim body advising the State Office of EMS on the implementation of the new EMT regulations.

This year at the annual EMS Symposium in Anchorage, the NANA Region Search and Rescue jointly presented a workshop with the North Slope Borough Search and Rescue.

1135 West Eighth Avenue, Suite 7 • Anchorage, Alaska 99501 • (907) 274-3651

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.

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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 24 hours 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.

SOUTHEAST REGION EMERGENCY MEDICAL COUNCIL

PROGRAM SUMMARY

The Southeast Region Emergency Medical Services Council is a private non-profit corporation which receives operating funds through the State Office of Emergency Medical Services. Serving all of Southeast Alaska, from Yakutat to Ketchikan, the Council has been in operation since April, 1977.

The Council's purpose is to assist communities and agencies involved in emergency care in upgrading their capabilities to a degree that can be self-sustained. As the scope of emergency medical services covers the onset of injury or sudden illness, whether it be at a logging camp or on a ferry; through definitive treatment, which may require patient transport to a Seattle medical center; the assistance of many individuals and agencies is involved. The Council maintains close working relationships among these agencies and emergency care providers through their representation on the Board of Directors. Agencies represented include each of Southeast's hospitals, eight ambulance services, the Public Safety Academy, Public Health Nursing, the State Office of Highway Safety Planning, the State Division of Communications, the Alaska Logger's Association, the U.S. Forest Service and the U.S. Coast Guard. A list of present membership follows. The Council's Critical Care Committee, which is the only body representing physicians and nurses from each of Southeast's six hospitals, provides medical direction for Council programs.

Below are summarized major areas of Council involvement:

A. Community Development

The Council has promoted the formation of local EMS Councils, which bring together the various agencies and individuals involved in the community's emergency response including physicians and nurses, ambulance personnel, Coast Guard, air service operators, and police. These local councils act as a catalyst to improving the community's emergency medical response capabilities, and serve as a liaison with the Southeast EMS Council. All requests for EMS funding are first screened by local councils.

Examples of local EMS Council accomplishments include an annual Swimathon in Ketchikan which raises funds for community training and equipment, the development of a disaster plan in Wrangell, and the formation of the Medic I program in Juneau.

B. Training

Training is the most essential function of the Council since it is prerequisite to effective use of medical equipment and to improved response procedures. The Council offers a broad scope of emergency medical training from CPR for the general public through continuing education for physicians. In addition to provision of training sessions by staff and consultants; the Council, wherever possible, aims to develop community capabilities to provide their own training in a continuing fashion by training local instructors and assisting in the purchase or loan of training materials.

Cardiopulmonary Resuscitation (CPR) - The Alaska Heart Association has delegated to the Council the responsibility for CPR coordination and certification throughout Southeast. The emphasis of the Council has been upon increasing the availability of instructors, particularly in the smaller communities and logging camps where none were previously available; and providing organizational backup to assist the instructors in providing classes. In addition to providing texts, reference materials and audiovisual aids, the Council has made available matching funds for CPR training mannikins to communities with active instructors through legislative funds. During the past year, CPR instructors have been trained or recertified in Southeast who in turn have trained 800 persons in CPR.

Emergency Trauma Training (ETT) - This 40 hour course, incorporating hands on skill practice, lecture and audiovisual presentation, is geared toward those in high risk occupations or typical Alaskan remote living situations where self-reliance is required in medical emergencies. It is widely taught to loggers, fishermen, Forest Service personnel, search and rescue groups and residents of isolated communities. The Council, this year, has written and published a text for this course which emphasizes aspects characteristic to the Alaskan environment including cold water near drowning, hypothermia, and use of air services for patient transport.

The Council has received many verbal reports from physicians on the improved status of patients reaching hospitals from logging camps where the course was offered, and from logging camp operators on decreased insurance claims and accident rates following training. To confirm these reports, the Council is presently carrying on a study of the effectiveness of training in Southeast logging camps as reflected through Workmen's Comp statistics through a grant awarded by the Alaska Council on Science and Technology.

Emergency Medical Technician (EMT) - Under the new State EMT certifying regulations, the Council is assuming regional EMT certification responsibilities as delegated, as well as coordinating and providing EMT instruction throughout Southeast. This 95 hour course is offered to those with responsibilities for rendering emergency care to the public including ambulance attendants, health aides, and Coast Guard medical evacuation crew. In the larger communities, the Council focuses upon bolstering capabilities of local instructors by providing, through matching funds or on loan, textbooks, films and training aids; and by keeping them up-to-date on medical knowledge through instructor seminars. Several times a year, the Council brings together EMT trainees from smaller communities to a central location for EMT training. Physicians and nurses assist in instructing these classes which provides the added benefit of acquainting newly trained EMT's with the medical professionals to whom they will be sending patients. Very frequently, these EMT's serve as the sole emergency medical providers in their community due to the absence of local nurses or physicians.

Continuing Medical Education for Clinics and Hospitals - Physicians and nurses in Southeast hospitals and midlevel practitioners in outlying clinics share the difficulties of keeping their skills up-to-date. The Council has

established several continuing medical education programs to assist in this aim. By training staff from each hospital as Advanced Cardiac Life Support Instructors, the Council has made this Heart Association certified course widely available. This has lead to improved cardiac care capabilities and procedures at Southeast hospitals and clinics. The Council also offers twice a year an American College of Surgeon's certified Trauma Life Support course with the aim of training all physicians with on call or emergency responsibilities in lifesaving surgical procedures. Several times a year, the Council brings critical care specialists from referral centers such as Harborview Medical Center to Southeast facilities to provide inservices. Preceptorships are also offered at major referral centers whereby Southeast physicians and nurses are offered an opportunity to spend a week or two working in a busy emergency department to update their skills.

C. Equipment

The Council's functions in assisting communities in assessing emergency medical equipment needed and in seeking matching funds for their purchase is closely related to its training program as training is prerequisite to the safe and effective use of medical equipment items.

Together with other EMS regions and the State EMS office, the Council has established EMS goals defining the optimal, yet realistic, capability levels for communities and facilities of various sizes throughout Alaska. These form a basis by which logging camps, villages, ambulance services, clinics and hospitals may assess each year the equipment items needed. After screening by local physicians, and the local EMS Council and the Southeast Region EMS Council Board; these requests are consolidated into a request for the legislature. Fifty percent of the items' cost is requested from State funds while communities provide the other fifty percent. Attached is a listing, by legislative district, of equipment expenditures this fiscal year.

D. Communications

Communications of medical information and the technology for it is another major focus of the Council. Presently, the Council is working with the State Division of Communications toward establishing priorities in EMS communications.

The Council assists communities both in determining how existing emergency networks can be accessed and in setting up emergency dispatch mechanisms. The Council has assisted in the development of local emergency communications systems in all communities providing ambulance service (13), and in several smaller communities where the most appropriate mechanism might be an air horn or emergency access to Cold Storage marine radios. This year, the Council is sponsoring a pilot project whereby electro-cardiograms may be relayed via telephone from the Pelican Health Clinic to Bartlett Memorial Hospital for diagnosis. This relatively inexpensive project may likely prove advisable on a Statewide level.

E. Coordination of Resources

In addition to assisting communities in ensuring that the personnel and equipment needed in an emergency are in place, the Council continually works toward the most efficient coordination and sharing of those resources. Through meeting with those involved in EMS in the communities, the Council is able to keep people up-to-date on resources available. This may include such topics as how to best access the Coast Guard, the availability of the Providence Hospital Neonatal Transport system, or the availability of a bargain deal on a used ambulance.

SECTION 8

* Health Statistics
* Other reports
* Background information

LEADING CAUSES OF DEATH BY REGION	RATE PER 100,000
KETCHIKAN	
1. Heart disease and hypertension	157.1
2. Accidents	107.6
3. Malignant neoplasms	82.9
4. Vascular lesions of CNS	44.5
5. Degenerative diseases	21.0
WRANGELL-PETERSBURG	
1. Heart disease and hypertension	173.0
2. Accidents	150.0
3. Malignant neoplasms	110.4
4. Suicide	29.4
5. Vascular lesions of CNS	22.1
SITKA	
1. Heart disease and hypertension	114.2
2. Accidents	108.3
3. Malignant neoplasms	93.7
4. Vascular lesions of CNS	32.2
5. Alcoholism/diseases of early infancy	23.4
JUNEAU	
1. Heart disease and hypertension	122.0
2. Accidents	104.1
3. Malignant neoplasms	75.1
4. Vascular lesions of CNS	32.4
5. Respiratory/ill-defined	17.1
CHUGACH	
1. Accidents	173.8
2 Heart Disease and hypertension	120.8
3. Malignant neoplasms	108.1
4. Influenza pneumonia/Respiratory	21.2
5. Vascular lesions of CNS/Cirrhosis	17.0
AHTNA	
1. Accidents	160.9
2. Malignant neoplasms	47.3
3. Heart disease and hypertension	42.6
4. Diseases of early infancy/Ill-defined	23.7
5. Suicide	14.2
COOK-INLET	
1. Accidents	125.5

2. Heart disease and hypertension	103.7
3. Malignant neoplasms	81.3
4. Vascular lesions of CNS	24.3
5. Ill-defined	22.4
ANCHORAGE	
1. Accidents	74.9
2. Heart disease and hypertension	54.6
3. Malignant neoplasms	46.2
4. Suicide	16.5
5. Cirrhosis	13.1
KONIAG	
1. Accidents	191.8
2. Heart disease and hypertension	93.7
3. Malignant neoplasms	56.7
4. Alcoholism	26.1
5. Vascular lesions of CNS	21.8
ALEUTIANS	
1. Accidents	81.4
2. Heart disease and hypertension	65.1
3. Malignant neoplasms	32.5
4. Vascular lesions of CNS	24.4
5. Diseases of early infance/Ill-defined	10.8
BRISTOL BAY	
1. Accidents	204.0
2. Heart disease and hypertension	61.9
3. Malignant neoplasms	51.0
4. Ill-defined	32.8
5. Vascular lesions CNS/Respiratory	25.5
CALISTA	
1. Accidents	181.7
2. Heart disease and hypertension	43.7
3. Influenza Pneumonia	31.0
4. Ill-defined	29.6
5. Diseases of early infancy	26.8
BERING STRAITS	
1. Accidents	258.0
2. Heart disease and hypertension	105.0
3. Malignant neoplasms	96.0

4.	Suicide	57.0
5.	Homocide/Ill-defined	30.0
NANA		
1.	Accidents	149.2
2.	Suicide	78.8
3.	Heart disease and hypertension	66.3
4.	Ill-defined	45.6
5.	Malignant neoplasms	51.5
DOYON		
1.	Accidents	142.1
2.	Heart disease and hypertension	72.9
3.	Malignant neoplasms	37.1
4.	Homocide	27.2
5.	Suicide	21.0
FAIRBANKS		
1.	Accidents	76.8
2.	Heart disease and hypertension	68.7
3.	Malignant neoplasms	54.5
4.	Vasculer lesiona of CNS	20.0
5.	Diseases of early infancy	17.3

Average annual rate 1974-1977 per 100,000 from DHEW statistics

	1977 LEADING CAUSES OF DEATH - UNITED STATES	RATE PER 100,000
1.	Diseases of the heart	331.3
2.	Malignant neoplasms	183.5
3.	Cerebrovascular disease	76.9
4.	Accidents	47.9
5.	Pulmonary disease	22.7
6.	Pneumonia/Influenza	20.0
7.	Diabetes mellitus	15.0
8.	Chronic liver disease	13.6
9.	Atherosclerosis	13.0
10.	Suicide	12.6

CAUSE OF DEATH	RATE/100,000 ALASKA	RATE/100,000 U.S.
Congenital Abnormalities		6.0
1. Nana	12.4	
2. Sitka	11.7	
3. Calista	11.3	
4. Bristol Bay	10.9	
5. Doyon	9.9	
Vascular Lesions of CNS		3.4
1. Ketchikan	44.5	
2. Juneau	32.4	
3. Sitka	32.2	
4. Bristol Bay	25.5	
5. Aleutians	24.4	
Accidents		47.7
1. Bering Straits	258.0	
2. Bristol Bay	204.0	
3. Koniag	191.8	
4. Calista	181.7	
5. Chugach	173.8	
6. Ahtna	160.9	
Homocide		9.1
1. Bering Straits	30.0	
2. Doyon	27.2	
3. Calista	19.7	
4. Nana	16.6	
5. Arctic Slope	13.1	
Suicide		13.3
1. Nana	78.8	
2. Bering Straits	57.0	
3. Wrangell-Petersburg	29.4	
4. Calista	23.9	
5. Doyon	21.0	
Alcoholism		2.4
1. Koniag	26.1	
2. Sitka	23.4	
3. Nana	20.7	
4. Ketchikan	19.8	
5. Bering Straits	18.0	

PROFESSION	RATE PER 100,000 POPULATION BY YEAR							
	1950	1965	1970		1975	1979		1981
	U.S.	U.S.	U.S.	AK.	U.S.	U.S.	AK.	AK.
PHYSICIAN	134.0	139.9	148.7		166.7	185.1	113.0	140.0
PHYSICIAN ASS'T								12.0
R.N.	218.1	337.6	363.9		448.1	520.8	689.6	831.0
L.P.N.						252.0		238.3
PSYCHOLOGIST							5.1	15.2
CHIROPRACTOR						10.0	8.0	11.0
OPTOMETRIST	9.6	8.8	8.9	5.5	9.3	9.7	6.2	6.3
DENTIST	49.8	46.5	47.1	42.0	50.3	54.0	47.3	49.1
PHARMACIST	56.6	52.5	54.4	46.0	56.2	62.4	56.4	43.1

All figures from DHEW Statistics except 1981 Alaska statistics which I took from the Division of Occupational Licensing(removing all non-residents from figures).

Figures seem to be besed on all licensed professionals, including those residing out of state and those not in active service.

MALE 1976-1977	Number of Deaths			Rate per 100,000 Two Year Average 1977 and 1978	FEMALE	Number of Deaths			Rate per 100,000 Two Year Average 1977 and 1978	TOTAL BOTH SEXES Rate per 100,000 Two Year Average 1977 and 1978
	1976	1977	1978			1976	1977	1978		
Tuberculosis	3	1	0	0.2*	Tuberculosis	1	1	3	1.1*	0.6
Other Infections	8	5	27	7.1	Other Infections	9	10	16	6.9	7.0
Inflammatory Diseases of CNS	8	4	2	1.3	Inflammatory Diseases of CNS	3	3	4	1.9	1.6
Gastritis and Enteritis	0	0	0	0.0*	Gastritis and Enteritis	2	0	0	0.0*	0.0*
Influenza and Pneumonia	30	20	35	12.2	Influenza and Pneumonia	18	8	20	7.4	10.0
Other Respiratory	18	17	18	7.8	Other Respiratory	10	15	15	7.9	7.9
Maternal	-	-	-	-	Maternal	0	1	1	0.5*	0.2*
Congenital Abnormalities	19	12	10	4.9	Congenital Abnormalities	18	21	19	10.6	5
Diseases of Early Infancy	31	27	37	14.2	Diseases of Early Infancy	16	15	15	7.9	11.4
Ill-Defined	38	41	33	16.5	Ill-Defined	23	27	25	13.8	15.2
Heart Disease and Hypertension	212	222	210	96.0	Heart Disease and Hypertension	100	91	99	50.3	75.2
Malignant Neoplasms	133	133	159	64.9	Malignant Neoplasms	100	116	117	61.7	63.4
Diabetes	8	3	6	2.0	Diabetes	4	5	5	2.6	2 3
Vascular Lesions of the CNS	29	34	30	14.2	Vascular Lesions of CNS	37	27	36	16.7	15.3
General Arteriosclerosis	6	18	7	5.6	General Arteriosclerosis	5	9	4	3.4	4.6
Chronic Nephritis	0	0	2	0.4*	Chronic Nephritis	1	1	0	0.3*	0.4*
Cirrhosis of Liver	33	17	26	9.6	Cirrhosis of Liver	18	20	13	8.7	9.2
Other Degenerative	16	22	23	10.0	Other Degenerative	11	20	16	9.5	9.8
Accidents	336	287	357	143.2	Accidents	95	78	94	45.5	98.6
Suicide	51	73	50	27.3	Suicide	16	16	9	6.6	17.9
Homicide	43	28	42	15.6	Homicide	9	8	18	6.9	11.6
Other External Causes	13	32	22	12.0	Other External Causes	4	12	5	4.6	8.6
Alcoholism	15	21	8	6.4	Alcoholism	12	10	9	5.0	5.8
All Other Causes	38	43	32	14.5	All Other Causes	18	32	29	16.1	15.2
TOTAL	1,088	1,060	1,126	496.0	TOTAL	529	546	572	295.9	399.2

*Rate based on number less than 5.

Source: Office of Information Systems, Alaska Dept. of Health and Social Services, Alaska Vital Statistics, 1976 and 1977; and Unpublished Data, 1979. Population by sex derived by

	Alaska Natives 1976-1978				NON-NATIVES				TOTAL ALL RACES
	Number of Deaths			Rate per 100,000 Two Year Average 1977 and 1978	Number of Deaths			Rate per 100,000 Two Year Average 1977 and 1978	Rate per 100,000 Two Year Average 1977 and 1978
	1976	1977	1978		1976	1977	1978		
Tuberculosis	2	2	2	2.9*	2	0	1	0.1*	0.6
Other Infections	8	6	16	16.0	9	8	26	4.9	7.0
Inflammatory Diseases of CNS	7	5	0	3.6	4	2	6	1.2	1.6
Gastritis and Enteritis	1	0	0	0.0*	1	0	0	0.0*	0.0*
Influenza and Pneumonia	26	8	25	24.1	22	20	29	7.1	10.0
Other Respiratory	9	7	10	12.4	19	25	23	7.0	7.9
Maternal	0	0	0	0.0*	0	1	1	0.3*	0.2*
Congenital Abnormalities	9	6	4	7.3	28	26	25	7.4	7.5
Diseases of Early Infancy	21	10	13	16.8	26	32	39	10.3	11.4
Ill-Defined	26	27	17	32.1	34	41	40	11.7	15.2
Heart Disease and Hypertension	69	57	65	89.0	243	256	244	72.4	75.2
Malignant Neoplasms	55	60	54	83.2	178	188	222	59.4	63.4
Diabetes	2	1	1	1.5*	10	7	10	2.5	2.3
Vascular Lesions of CNS	15	19	13	23.3	51	42	53	13.8	15.3
General Arteriosclerosis	3	4	2	4.4	8	23	9	4.6	4.6
Chronic Nephritis	1	0	1	0.7*	0	1	1	0.3*	0.4*
Cirrhosis of Liver	19	10	12	16.0	32	27	27	7.8	9.2
Other Degenerative	7	15	6	15.3	20	27	33	8.7	9.8
Accidents	131	110	122	169.2	298	255	328	84.4	98.6
Suicide	21	25	13	27.7	46	64	46	15.9	17.9
Homicide	20	11	25	26.3	31	25	35	8.7	11.6
Other External Causes	9	23	7	21.9	10	21	20	5.9	8.6
Alcoholism	22	17	10	19.7	5	14	7	3.0	5.8
All Other Causes	14	24	19	31.4	40	51	32	12.0	15.2
TOTAL	497	447	437	644.8	1,117	1,156	1,257	349.5	399.2

*Rate based on number less than 5.

Source: Office of Information Systems, Alaska Dept. of Health and Social Services, Alaska Vital Statistics, 1976 and 1977; and Unpublished Data, 1979.

RESIDENT DEATHS BY ACCIDENT

Alaska 1974-1978

(Rate per 100,000)

TYPE OF ACCIDENT	1974	1975	1976	1977	1978	U.S. 1977
Other Transport	0.0*	0.0*	0.2*	0.2*	0.2*	0.4
Motor Vehicle	20.5	29.4	27.6	32.3	29.1	22.9
Water Transport--Drown	8.3	12.1	7.7	7.5	14.4	0.6
Water Transport--Other	0.6*	0.5*	1.0*	0.2*	0.5*	0.0
Aircraft	14.5	16.8	14.5	10.2	23.8	0.8
Poisoning	4.0	5.2	5.1	2.7	3.6	2.2
Falls	6.3	3.0	5.6	5.8	4.1	6.4
Fire	10.5	5.4	5.6	5.4	4.8	2.9
Exposure	1.1*	2.5	3.6	2.9	1.7	0.3
Other Environment	6.8	3.0	1.5	1.0*	2.2	0.5
Drown--Non-transport	13.7	9.1	10.6	8.8	8.2	2.8
Suffocation	2.8	2.5	1.7	0.5*	2.2	1.4
Firearms	8.3	4.0	5.8	2.4	4.1	0.9
Other Accidents	13.4	7.9	13.8	8.8	9.6	5.5
TOTAL ALL ACCIDENTS	110.8	101.3	104.3	88.8	108.3	47.7

Source: Office of Information Systems, Alaska Department of Health and Social Services, Unpublished Data.

ALASKA

ALASKA 1974	ALASKA 1975	CAUSE OF DEATH	RESIDENT DEATHS BY CAUSE 1976 (Rate per 100,000) HSA SE	HSA SC	HSA N	PERCENT DIFFERENCE U.S.	RESIDENT DEATHS BY CAUSE 1977 (Rate per 100,000) HSA SE	HSA SC	HSA N	PERCENT DIFFERENCE U.S.	RESIDENT DEATHS BY CAUSE 1978 (Rate per 100,000) HSA SE	HSA SC	HSA N
2.3	1.5	Tuberculosis	2.0*	0.7*	1.2*	Alaska 33% lower	1.9*	0.4*	0.0*	Alaska 64% lower	0.0*	1.1*	0.0*
1.7	2.7	Other Infections	9.8	2.5	5.9	Alaska 35% lower	1.9*	3.9	4.1*	Alaska 45% lower	5.5*	10.0	14.6
1.1*	1.5	Inflammatory Disease of CNS	0.0*	3.2	2.4*	Alaska 27% lower	0.0*	1.8	2.7*	Alaska 50% lower	0.0*	1.1*	3.6*
0.3*	0.7*	Gastritis and Enteritis	0.0*	0.7*	0.0*	N/A	0.0*	0.0*	0.0*	N/A	0.0*	0.0*	0.0*
12.2	11.6	Influenza and Pneumonia	19.5	10.4	10.7	Alaska 60% lower	13.2	4.6	10.8	Alaska 71% lower	11.0	11.8	19.4
10.0	10.9	Other Respiratory	11.7	7.2	2.4*	N/A	11.3	8.1	4.1*	N/A	16.5	6.4	7.3
0.0*	0.0*	Maternal	0.0*	0.0*	0.0*	Alaska 100% lower	1.9*	0.0*	0.0*	No difference	0.0*	0.4*	0.0*
5.7	5.4	Congenital Abnormalities	9.8	9.0	8.3	Alaska 48% higher	11.3	6.7	10.8	Alaska 33% higher	7.4*	7.9	3.6*
19.1	12.6	Diseases of Early Infancy	5.9*	12.6	10.7	Alaska 2% lower	5.6*	9.9	14.9	Alaska 6% lower	18.4	12.5	8.5
14.0	12.6	Ill-Defined	9.8*	13.7	21.4	Alaska 3% higher	20.7	12.3	29.7	Alaska 11% higher	5.5*	14.3	18.2
83.7	64.7	Heart Disease and Hypertension	156.3	63.0	67.7	Alaska 78% lower	131.7	68.7	64.9	Alaska 77% lower	136.0	61.9	75.3
51.0	52.9	Malignant Neoplasms	95.8	50.0	53.5	Alaska 68% lower	88.4	58.1	50.0	Alaska 66% lower	90.1	65.4	53.5
4.3	3.5	Diabetes	5.9*	1.4*	3.9	Alaska 82% lower	1.9*	2.1	1.4*	Alaska 88% lower	3.7*	1.8	4.9*
27.1	18.3	Vascular Lesions of CNS	50.8	11.2	10.7	Alaska 82% lower	26.3	11.5	18.9	Alaska 82% lower	31.2	13.2	14.6
2.8	3.5	General Arteriosclerosis	17.6	0.7*	0.0*	Alaska 80% lower	26.3	2.5	8.1	Alaska 50% lower	5.5*	3.4*	4.9*
0.6*	0.5*	Chronic Nephritis	0.0*	0.4*	0.0*	Alaska 94% lower	0.0*	0.4*	0.0*	Alaska 94% lower	1.8*	0.4*	0.0*
10.5	12.1	Cirrhosis of Liver	19.5	13.7	3.6*	Alaska 16% lower	9.4	8.8	9.5	Alaska 37% lower	14.7	7.5	12.2
8.5	7.9	Other Degenerative	11.7	6.5	3.6*	N/A		9.5	6.8	N/A	20.2	8.2	6.1
110.8	101.3	Accidents	103.6	108.7	90.3	Alaska 122% higher	75.2	83.8	117.5	Alaska 86% higher	119.5	111.5	89.9
12.2	18.3	Suicide	15.6	18.0	10.7	Alaska 30% higher	22.4	21.5	21.6	Alaska 62% higher	18.5	15.7	7.3
9.7	6.4	Homicide	2.0*	15.1	9.5	Alaska 37% higher	0.0*	9.5	12.2	Alaska 3% lower	9.2	12.5	24.3
5.7	2.2	Other External Causes	3.9*	0.7*	15.4	Alaska 86% higher	11.3	8.1	20.3	Alaska 410% higher	3.7*	0.7*	27.9
10.0	11.4	Alcoholism	13.7	5.8	4.8*	Alaska 183% higher	18.8	4.2	12.8	Alaska 212% higher	7.4*	4.3	1.2*
14.8	13.4	All Other Causes	25.4	10.8	15.4	N/A	20.2	15.5	21.6	N/A	10.4	11.1	12.2
418.8	378.1	TOTAL	586.2	365.8	354.1	Alaska 56% lower	474.2	351.2	441.8	Alaska 54% lower	548.1	381.1	409.6

RESIDENT DEATHS BY CAUSE

ALASKA 1950 - 1978

SELECTED CAUSES OF DEATH	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978
Tuberculosis	177.0	145.2	97.4	24.4	22.7	24.6	8.8	8.1	7.8	5.3	3.7	3.6	3.0	1.6	1.5	1.5	1.0	.5	0.7										
Other Infectious	31.1	18.9	17.3	7.7	19.1	7.4	6.1	12.7	11.4	9.4	6.2	5.3	3.6	3.9	6.6	2.7	4.1	3.6	10.3										
Inflammatory Diseases of CNS	6.7	6.7	5.1	2.3	2.7	4.8	3.9	5.5	6.6	3.4	3.3	6.3	1.3	1.3	1.5	1.5	2.7	1.7	1.4										
Gastritis and Enteritis	5.2	3.7	4.1	3.6	6.8	6.6	10.5	5.5	6.2	9.8	1.5	3.2	1.6	.0	.9	.7	.5	0.0	0.0										
Influenza and Pneumonia	57.0	40.2	25.5	29.4	36.8	39.5	43.4	31.0	27.1	25.9	22.7	13.9	17.9	17.0	11.8	11.6	11.6	6.8	13.2										
Other Respiratory	9.6	13.4	12.0	10.6	14.5	15.8	12.7	6.4	14.0	14.7	9.5	8.5	13.2	13.8	6.8	10.9	6.8	7.8	7.9										
Maternal	6.7	2.4	2.6	1.8	2.3	1.8	0.4	1.3	2.1	1.1	0.4	0.7	.7	.0	.0	.0	0	.2	0.2										
Congenital Abnormalities	10.4	12.0	13.3	12.2	10.9	12.7	17.5	12.3	9.5	15.8	12.4	11.4	12.9	6.4	8.7	5.4	9.0	8.0	7.0										
Diseases of Early Infancy	45.2	63.4	50.0	57.0	64.5	64.0	63.1	59.8	49.7	40.2	34.3	34.1	25.5	22.8	19.6	12.6	11.4	10.2	12.6										
Ill Defined	34.8	41.5	32.1	25.3	21.4	21.1	19.7	21.2	10.5	12.0	10.6	22.8	14.2	8.8	13.3	12.6	14.8	16.5	13.9										
Heart Disease and Hypertension	169.6	139.0	111.2	106.3	103.6	96.0	107.4	103.5	109.3	103.7	87.7	94.6	87.3	86.6	99.0	64.7	75.6	76.1	74.2										
Malignant Neoplasms	66.7	43.9	42.3	39.4	47.7	50.0	50.9	54.7	50.6	62.8	54.4	54.4	61.8	65.3	65.8	52.9	56.4	60.6	66.3										
Diabetes	3.0	2.4	3.1	2.7	3.6	3.5	3.9	3.8	3.3	2.6	3.7	3.9	2.8	3.6	2.2	3.6	2.9	1.9	2.6										
Vascular Lesions of CNS	48.1	44.5	38.0	29.9	27.7	32.0	29.8	23.3	44.0	28.6	24.1	30.9	26.1	27.0	30.4	18.3	16.0	14.0	15.9										
General Arteriosclerosis	5.9	8.5	4.1	3.6	2.7	6.1	8.3	12.7	11.5	9.4	8.0	9.6	7.6	3.2	6.2	3.5	2.7	6.6	2.6										
Chronic Nephritis	3.7	4.3	4.1	5.9	3.2	4.4	2.2	1.8	3.3	1.1	1.1	2.8	1.6	.6	1.2	.5	.2	.2	0.5										
Cirrhosis of Liver	5.2	9.1	8.7	5.4	5.9	7.8	6.1	3.4	9.9	7.9	8.0	5.7	11.2	13.5	11.8	12.1	12.3	9.0	9.4										
Other Degenerative	12.6	11.0	12.2	12.2	10.0	12.7	10.6	10.2	9.9	16.5	9.1	11.0	13.9	10.9	12.1	7.9	6.6	10.2	9.4										
Accidents*	155.6	149.4	117.3	129.9	109.1	103.9	100.4	107.3	95.4	104.5	125.7	90.7	116.7	128.6	104.9	103.5	108.4	99.5	114.8										
Suicides	24.4	16.5	16.3	16.3	14.5	11.8	14.0	16.5	16.0	17.7	17.7	16.4	13.2	15.4	11.2	18.3	16.2	21.6	14.2										
Homicides	12.6	9.1	6.6	7.2	10.5	8.8	8.8	10.2	4.5	8.6	9.5	10.0	10.6	8.4	9.6	6.4	12.3	8.8	14.4										
Alcoholism	8.1	15.2	10.2	6.8	5.5	5.3	7.0	6.8	4.1	6.4	5.6	6.0	10.9	14.5	11.0	11.4	6.6	7.5	4.1										
ALL OTHER CAUSES	40.7	39.0	24.0	18.1	17.7	21.1	18.9	24.2	20.1	18.8	20.1	15.6	15.9	15.4	19.2	13.6	13.6	18.2	12.2										
TOTAL	940.0	840.0	659.2	566.1	563.6	561.0	654.6	544.3	537.6	526.1	407.0	461.1	473.3	467.7	455.4	376.1	391.3	390.6	407.8										

Source: Office of Information Systems, Alaska Department of Health and Social Services, Alaska Vital Statistics, 1966, 1974-1977 and unpublished data 1977, 1978, 1979.

*Because Accidents and Other External Causes are grouped together in early Alaska mortality data, Accidents and Other External Causes are grouped together in this table.

ALASKA & THE U.S. 1970

Age-Specific rate per 100,000

Age	Alaska	U.S.	Percent Difference In Age-Adjusted Rates
0 - 4 years	635.8	494.7	Alaska 29% higher
5 - 14 years	56.4	41.4	Alaska 36% higher
15 - 24 years	221.2	126.7	Alaska 75% higher
25 - 34 years	217.5	159.8	Alaska 36% higher
35 - 44 years	391.9	314.1	Alaska 12% higher
45 - 54 years	785.1	724.9	Alaska 8% higher
55 - 64 years	1657.1	1662.4	Alaska 1% lower
65 + years	5340.4	5890.1	Alaska 9% lower
All age groups	476.4	940.4	Alaska 49% lower

Alaska & U.S. 1977

(Age-Specific Rate per 100,000)

Age	Alaska	U.S.	
<1	1,480.1	1,485.6	Alaska <1% lower
1 - 4	106.3	68.8	Alaska 55% higher
5 - 14	39.4	34.6	Alaska 14% higher
15 - 24	207.4	117.1	Alaska 77% higher
25 - 34	268.5	136.2	Alaska 97% higher
35 - 44	255.8	247.5	Alaska 3% higher
45 - 54	549.4	620.7	Alaska 11% lower
55 - 64	1,450.1	1,434.9	Alaska 1% higher
65+	5,003.4	5,288.1	Alaska 5% lower
All Age Groups	390.6	878.1	Alaska 56% lower

Source: Office of Information Systems, Alaska Department of Health and Social Services, Alaska Vital Statistics for Health Systms Agencies, 1977. Office of State Health Planning and Development, Alaska Department of Health and Social Services, Unpublished Data, 1979. National Center for Health Statistics, U.S. DHEW, Monthly Vital Statistics Report, Final Mortality Statistics, 1977.

LEADING CAUSES OF DEATH BY AGE

Alaska and U.S. 1976 & 1977

(Average Annual Rate* per 100,000)

	Alaska	U.S.	% Difference
UNDER AGE 1			
1. Diseases of Early Infancy	546.3	778.6	Alaska 30% lower
2. Ill-Defined	362.2	174.3	Alaska 108% higher
3. Congenital Abnormalities	319.2	271.0	Alaska 18% higher
4. Influenza and Pneumonia	73.7	59.0	Alaska 25% higher
5. Accidents	55.2	39.2	Alaska 41% higher
All causes	1,540.8	1,540.3	Alaska <1% higher
AGE 1-4			
1. Accidents	56.5	27.6	Alaska 105% higher
2. Homicide	9.2	2.6	Alaska 254% higher
3. Congenital Abnormalities	6.1	8.9	Alaska 32% lower
3. Ill-Defined	6.1	2.6	Alaska 135% higher
All causes	109.9	69.4	Alaska 58% higher
AGE 5-14			
1. Accidents	23.9	17.2	Alaska 39% higher
2. Malignant Neoplasms	3.9	4.9	Alaska 20% lower
3. Homicide	2.2	1.2	Alaska 83% higher
3. Suicide	2.2	0.4	Alaska 450% higher
3. Congenital Abnormalities	2.2	2.0	Alaska 10% higher
3. Inflammatory Diseases of CNS	2.2	0.3	Alaska 633% higher
All causes	43.3	34.7	Alaska 25% higher
AGE 15-24			
1. Accidents	149.1	61.2	Alaska 144% higher
2. Suicide	32.1	12.6	Alaska 155% higher
3. Homicide	11.9	12.6	Alaska 6% lower
4. Malignant Neoplasms	7.1	6.5	Alaska 9% higher
5. Heart Disease & Hypertension	2.4	2.6	Alaska 8% lower
All causes	218.0	115.3	Alaska 89% higher
AGE 25-34			
1. Accidents	151.9	43.8	Alaska 247% higher
2. Suicide	36.6	16.8	Alaska 118% higher
3. Homicide	13.6	16.5	Alaska 17% lower
4. Malignant Neoplasms	9.5	14.5	Alaska 34% lower
5. Heart Disease & Hypertension	8.1	8.7	Alaska 7% lower
All causes	253.6	136.2	Alaska 86% higher
AGE 35-44			
1. Accidents	90.0	37.4	Alaska 141% higher
2. Heart Disease & Hypertension	36.0	50.7	Alaska 29% lower
3. Malignant Neoplasms	23.7	51.2	Alaska 54% lower
4. Cirrhosis of Liver	16.4	16.1	Alaska 2% higher
5. Homicide	14.7	14.4	Alaska 2% higher
All causes	243.0	250.8	Alaska 3% lower
AGE 45-54			
1. Malignant Neoplasms	127.8	182.2	Alaska 30% lower
2. Heart Disease & Hypertension	125.1	198.4	Alaska 37% lower
2. Accidents	125.1	40.1	Alaska 212% higher
3. Cirrhosis of Liver	46.2	34.4	Alaska 34% higher
4. Suicide	20.4	19.0	Alaska 7% higher
4. Homicide	20.4	9.9	Alaska 106% higher
All causes	589.9	627.8	Alaska 6% lower
AGE 55-64			
1. Heart Disease & Hypertension	469.5	544.9	Alaska 14% lower
2. Malignant Neoplasms	389.7	439.4	Alaska 11% lower
3. Accidents	168.3	7.8	Alaska 252% higher
4. Cirrhosis of Liver	67.9	46.5	Alaska 46% higher
5. Vascular Lesions of CNS	47.2	82.6	Alaska 43% lower
All causes	1,491.0	1,455.2	Alaska 3% higher
AGE 65+			
1. Heart Disease & Hypertension	1,801.9	2,383.3	Alaska 24% lower
2. Malignant Neoplasms	1,097.3	983.8	Alaska 12% higher
3. Vascular Lesions of CNS	433.2	676.2	Alaska 36% lower
4. Accidents	196.4	103.5	Alaska 90% higher
5. General Arteriosclerosis	179.0	119.3	Alaska 50% higher
All causes	4,880.2	5,357.7	Alaska 9% lower

State Hospital Cost Containment Programs

During the seventies, seventeen states initiated programs to screen costs of hospitals to guarantee to all purchasers of hospital health care services that total hospital costs were reasonably related to total services, and that such rates are set equitably among all purchasers of these services. Most of the programs are controlled by commissions independent of state agencies, and all are mandatory (although two have voluntary compliance).

Many agree that the most successful of these is the Washington State Hospital Commission implemented in March 1973. The rate of cost increase per admission in 1978 was 5% in Washington versus 10 to 12% in the Nation; the cost per average patient day was 5% versus 9.6% in the U.S. The reason for these differences is that Washington includes:

Uniform budget and reporting system
A prospective budget review system
A cooperative attitude by hospitals
A shortened length of stay
An independent commission of interested citizens
A system of grouping hospitals

The commission encourages hospital management to initiate their own cost containment programs founded on the requisite reporting system, based on flexible accounting principles.

Each year the hospitals make a statement including goals and objectives; action plans by cost and revenue centers; operational and contractual arrangements/statistics by service units and direct expense by centers; details and summaries of budgeted revenues and expenses; capital expenditures; and sinking funds for depreciation.

Classification of hospitals includes case, staff, physician, and service mixes; area population and its financial potential; differences in locations, organizations and resources of providers; plant conditions; state and other subsidies; and reimbursements.

The Commission uses an "exception review" process to identify potentially high cost operations that are subjected to a more thorough review. Each hospital's budgeted review is compared to its peer group classification.

The Commission has the power to set fees, but uses this power

only in certain cases. Instead, a rate concept is used to control fees, costs and charges. A rate is defined as the total revenue requirements of a revenue center divided by the number of procedures.

In addition, the Commission makes allowances for contractual adjustments, bad debts and charitable services; and allows a planned capital and service component for justifiable and needed replacement and expansion, additional working capital and feasibility studies.

The review takes place at an informal, open meeting and a hospital may appeal at a formal hearing if it disagrees with the findings. Although the Commission has enforcement and subpoena powers, it has never had to use them, nor has there ever been a formal hearing.

The Commission is also working in conjunction with HCFA on a prospective reimbursement program in which all payments by contract third party payors are determined by an apportionment of each hospital's total budget. Many variables relating to location, costs and utilization are figured in these determinations.

The Washington State Hospital Commission is a five member indendent commission appointed by the Governor and approved by the Senate. It is comprised of members of labor, business, and hospitals as well as consumers. Rules and regulations for rate setting are issued under direct authority of the commission. An 11 member technical advisory board, also appointed by the Governor, assists the Commission. The rate review is performed by a full time professional staff, headed by an executive director appointed by the Commission.

HEALTH PLANNING

Authorizations for the health planning program for FY 82 are contained in the Omnibus Budget Reconciliation Act of 1981 signed by the President on August 13. The Act sets upper limits on amounts that may be appropriated. The law(P.L. 97-35)authorizes appropriations of $102 million for health planning for 1982($65 million for local agencies, $35 million for state agencies, and $2 million for health plannong centers).

The health planning provision would:

1. Reduce minimum funding levels from $245,000 to $100,000 for local planning agencies.

2. Allow local agencies to accept operational funds in contributions from health insurance companies.

3. Enable a governor to eliminate any and all HSAs if assurances are given to the Department of Health and Human Services that the purposes of the program can be met without them and if the HHS Secretary approves the proposal.

4. Raise the threshold for Certificate of Need reviews to $600,000 for capital expenditures, $400,000 for major medical equipment, and $250,000 for new institutional services.

5. Allow local departments with HHS approval to stop appropriateness reviews, reviews of proposed uses of Federal funds, and the collection and dissemination of charge information for the 25 most frequently used hospital services.

There is every reason to believe that funding for HSAs will cease in FY 83, and because of budget limitations it is unlikely that H&SS will be able to increase funding to local planning agencies. Local input remains important in advising the state agency, but no plans have yet been made for implementing regional planning in 1983. It would seem likely that the Legislature would be approached for supplemental funding in this area.

BLOCK GRANT INFORMATION - DEPARTMENT OF HEALTH AND SOCIAL SERVICES

The final Block Grant regulations have fallen far short of the Reagan administration's promises of flexibility on the state level, with the Budget Reconciliation Bill listing complete specifications for spending Federal funds. Although the paperwork has been streamlined, the administrative responsibility falls almost totally to the state financially. The Department of Health and Social Services has already hired a full time coordinator for the Block Grants, John Taber, who came onboard in August.

The scope of the Block Grants has diminished since the original plans, as many targeted programs have retained categorical funding status. Alaska has a particular problem, as many programs are funded through the state or IHS(particularly in the Preventive Health Block Grant), and the Department anticipates major budget cuts in IHS monies in 1982 which will further burden the state in financial obligations. All told, the amount of Federal money is small for all Block Grants, less than 1% of the National total. H&SS has already notified the Federal Government that they are ready to take over the administration of Block Grants, though C&RA has requested the next year to prepare for administering the Community Services Grant.

I have identified the following as important points:

1. Very little regulation will need to occur for the Block Grants since the Budget Reconciliation Bill clearly specifies how funding, reporting and auditing will be accomplished.

2. Most of the Grants require that the Legislature hold public hearings throughout the state following the end of FY 82 and the beginning of FY 83, with rep to the Secretary.

3. Five of the Block Grants specify that any native organization may request that they receive their share of the Block Grant on a yearly basis. The Native Lands Settlement Act recognized over 300 such organizations in Alaska, and although a request for an individual Grant will not exempt them from other state services and funding in that area, it will complicate planning for H&SS It will be very important to the Department to obtain some agreement with tribal er s on this issue.

4. The Primary Care Block Grant will not go into effect until

FY 83. There is some concern over the funding of the Anchorage Community Health Center, as it is operating on 45% carry-over funds from FY 80, which will not be counted when the Block Grant allocation for FY 83 is figured.

Please note: BIA general assistance money will cease in mid-November affecting at least 4,000 Alaska residents. This will have a definite affect in the rural economy, and there is no state program to cover this loss. There will be a meeting in Anchorage in the Native Health Building solarium concerning this and other native health issues. I am enclosing a copy of the agenda, you may find it very helpful to attend this meeting.

May 27, 1981

The Honorable Jalmar M. Kerttula
President of the Senate
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Mr. President:

This letter is to inform you of plans for interim activity by the HESS Committee. One thing that has become increasingly clear during my tenure in the Legislature is that there is no completely integrated health care system in the State. Our effort in this direction is fragmented; although there has been some improvement since the creation of the State Health Coordinating Council and the three health care systems agencies.

There seems to be reason to believe that the Federal Government will drop all funding for these agencies. This fact, together with the pending Battelle Study on Health Care Financing and the fairly recent sunset reviews of the various health boards, makes this an appropriate time to review the structure of the system.

It is my intent, during the interim, to investigate the following:

1 - Availability, accessibility and affordability of health care in the State.

2 - Relationships between various health professions.

3 - The need for regulation of presently unrecognized and unregulated groups, such as naturopaths and lay midwives.

4 - The provision of emergency medical service and financial problems of volunteer agencies furnishing this service.

5 - Actions which the State might take to remedy deficiencies.

I propose to use questionnaires to members of the various health professions, and to the general public, to research the actions of other States, and to hold some committee hearings. The Committee has received Parts I and II of the Battelle Study and will maintain liaison with the persons working on that study in order not to duplicate. (It should be noted that the Battelle Study is concentrating much more heavily on payment for health care than on availability and accessibility).

It is expected that legislation will be introduced at the beginning of the 1982 Session as a result of the interim work of the Committee.

Sincerely,

Charles H. Parr

CHP:vc
Encl: Proposed Budget

SENATE HESS COMMITTEE

Budget for Interim Activity - 1981

TRAVEL (3 Committee members & 2 staff)	
1 Day Hearing in Fairbanks	$ 944.00
1 Day Hearing in Bethel	2,122.00
1 Day Hearing in Nome	2,375.00
1 Day Hearing in Soldotna	1,282.60
3 Day Hearing in Anchorage	1,294.00
2 Day Staff Meeting in Anchorage	1,796.00
1 Day Meeting in Juneau	399.00
(20% for travel rate changes)	1,463.00
Travel and Per Diem Total..	$ 11,674.60
Staff Salary (1 full-time, 1 half-time, 1 temporary clerical)	$ 34,786.35
Postage	$ 400.00
Advertising	500.00
Newspaper Questionnaire	500.00
Xerox	100.00
Telephone	975.00
Miscellaneous	1,062.05
GRAND TOTAL	$ 50,000.00